The American Academy of Nursing

The Imperative for Patient, Family, and Population Centered Interprofessional Approaches to Care Coordination and Transitional Care

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The American Academy of Nursing (AAN), representing nurse policy leaders, scientists, and clinicians, applauds the Centers for Medicare and Medicaid Services’ (CMS) recognition and support of evidence-based care coordination and transitional care. As CMS moves forward with policies for care coordination under Medicare and Medicaid, the American Academy of Nursing urges the agency to consider the framework it uses for thinking about care coordination and the evidence to support that framework. The Academy seeks to share its perspectives on crucial elements of such a framework to support the integration of care coordination and transitional care into the U.S. health care system to meet the three-part aim of better health, better care, and lower costs.

Care coordination and transitional care services are strategically important for achieving the priorities in the National Quality Strategy and the Partnership for Patients. Current models alone are not sufficient to meet these priorities. Swift recognition and payment for additional interprofessional models is needed to deliver on the promises of better care, better health, and reduced costs through improvement. To that end, the AAN recommends that CMS and the payer community:

1. Adopt clear definitions of care coordination and transitional care that are patient, family, caregiver, and population centered that can be used consistently among all stakeholders.

2. Implement payment models expeditiously for evidenced-based care coordination and transitional care services delivered at the community level by teams led by the best professional to coordinate the care, including nurses and other professionals as well as physicians.

3. Ensure replicability and sustainability of care coordination and transitional care models through improved performance analytics and workforce development
   a. Expedite funding to develop, implement, and evaluate performance measures that address gaps in effective and efficient care coordination and transitional care.
   b. Invest in workforce development to better prepare all team members to deliver effective and efficient care coordination and transitional care services.

AAN supports the need for expanding and accelerating implementation of effective care coordination and transitional care models. Care coordination as defined by AHRQ (McDonald, et al, 2010) is the deliberate organization of patient care activities across time and settings to facilitate appropriate delivery of health care services. Transitional care, an important component
of care coordination, is usually targeted to populations at high risk of poor and/or costly outcomes as they cross care settings. AAN supports the need for more interprofessional, team-based, and nurse-led or managed models to increase access, improve care and reduce costs for all in need. AAN urges CMS to recognize and pay for proven models and approaches including those that do not require physician stewardship.

Models that Work
A number of care models exist that apply care coordination and transitional care led and/or carried out by nurses and other non-physician providers with demonstrated positive impact on clinical and economic outcomes. Examples, with details on some included in Appendix A, include:

- Programs to enable frail elders to remain in their communities, preserve function, decrease hospitalizations and emergency room visits, improve other clinical outcomes, and contain costs below that of nursing homes. (Appendices A-1 and A-2)

- The Nurse-Family Partnership model providing care coordination for impoverished, high-risk, first-time pregnant women has documented effective short-term and long-term outcomes for both mothers and babies through rigorous comparative evaluations. (Olds et.al. 2010)9 (Appendix A-3)

- The primary care-based nurse-managed health clinic model, defined in the Affordable Care Act, has strong care coordination practice as its hallmark (Appendices A-4 and A-5)

- Transitional care approaches to reduce avoidable emergent care and rehospitalization1,5-8,10 (Appendix A-6)

Guiding Principles
AAN recommends the following guiding principles for implementation, evaluation, and payment for care coordination and transitional care models:

- Models are patient and family caregiver-centered in concept and design that support shared decision making.
- Interprofessional teams match services to patient and family needs to gain highest value.
- Team leadership shifts according to patient and family needs, preferences, and expertise of team members.
- Existing and new payment mechanisms recognize evidence-based models led by any discipline that are associated with improved quality outcomes and cost reduction.
- Explicit and seamless links connect patients, providers, and care givers to community resources.
- Teams have high reliance on the expertise, skills, and services of registered nurses.
- Care coordination and transitional care provide seamless transition experiences for patients and family caregivers.
- Ongoing quality measurement and comparative effectiveness research is needed to test these assumptions and define best practices.

**Specific Recommendations**

1) **Clear definitions of care coordination and transitional care:**
   
   Adopt clear definitions of care coordination and transitional care that are patient, family caregiver, and population centered that can be used consistently among all stakeholders.

   - Definitions should be patient, family, and population centric.
   - Definitions should address services provided by any qualified professional based on the risk status and needs of the patient, family, or population.
   - Be easily used and understood by the public, providers, and payers.

2) **New payment and delivery models that recognize and incentivize teamwork:**
   
   Implement payment models expeditiously for evidenced-based care coordination and transitional care services delivered at the community level by teams led by the best professional to coordinate the care, including nurses and other professionals as well as physicians.

   - Recognize and pay for models that provide effective organization and management of care across providers and settings.
   - Models must rely on effective communication and timely teamwork.
   - Models, while team-oriented, typically highlight the central role of registered nurses.

3) **Replicability and sustainability of care coordination and transitional care models through improved performance analytics and workforce development:**
   
   Invest in workforce development to better prepare all team members to deliver effective and efficient care coordination and transitional care services.

   - Invest in research linking care coordination interventions to quality and cost outcomes with urgency to show the impact on complications and readmissions.
   - Invest in workforce capacity-building and ongoing development
   
   Expedite funding to develop, implement, and evaluate performance measures that address gaps in effective and efficient care coordination and transitional care.

   - Move beyond existing care coordination performance measures that are largely provider-centered and condition-specific.
   - Create new shared accountability composite measures targeting process and outcomes that extend beyond minimalist checklists to address changing risk and patient complexity. The following key measures are recommended to be included:

   1"Qualified professional" is defined as health care professionals who are educated and trained to coordinate the care of people at varying levels of risk. While some professionals may be skilled at coordinating care for high risk patients, others may qualify only for managing low risk patients. Determining who is “qualified” should reflect the specific needs and health problems of the patient and family.
Care Coordination: Priorities for Measurement

Cross-cutting issues
• The need for examination of measure denominators and risk adjustment strategies that capture differences in care coordination and transitional care intensity across patient populations.
• The need for a common denominator to identify the general population for care coordination and transitional care across settings moving beyond diagnosis and condition-specific denominators.

Patient and Family Experience of Care Coordination
• Measures that address timeliness and responsiveness of care and services.
• Measures that capture patient and family goals and preferences for care and services.
• Measures that consider unique care coordination and transitional care needs of children and their families.
• Measures that consider the extent to which care coordination and transitional care are culturally appropriate.

Process Measures of Care Coordination
• Measures of the development, implementation, and regular review of an integrated plan of care incorporating patient and family preferences and goals.
• Measures of timely and accurate communication of the plan of care across providers and settings.

Outcome Measures of Care Coordination
• Standardized measures of preventable hospitalizations and emergency room visits.
• Measures of patient and family satisfaction with care coordination and transitional care.
• Measures of quality of life and functional status across the continuum of care.

Structural Measures
• Measures of staff and team competence in care coordination, particularly competence in complex care coordination and transitional care for seriously ill patients and their families.
• Measures addressing access to appropriate and competent care coordination and transitional care.

We acknowledge the contribution to our thinking by members of the American Academy of Nursing’s Expert Panel on Quality Health Care and the National Quality Forum’s Measures Application Partnership Post-acute and Long-term care Workgroup and Care Coordination Steering Committee.
The American Academy of Nursing urges rapid recognition, implementation, compensation, and evaluation of a broader range of evidence based interprofessional care coordination and transitional care models. Escalating payment eligibility will not only promote greater access but will also promote earlier success achieving improved quality and efficiency.
References


Appendix A

A number of care models that apply care coordination and transitional care led and/or carried out by nurses and other non-physician providers with demonstrated positive impact on clinical and economic outcomes. The nurses in the following examples have been designated as Edge Runners by the American Academy of Nursing for their innovative models of care that have improved clinical outcomes while containing or lowering costs (www.aannet.org/edgerunners). Examples include:

Programs to enable frail elders to remain in their communities, preserve function, decrease hospitalizations and emergency room visits, improve other clinical outcomes, and contain costs below that of nursing homes.

- Appendix A-1 The Aging In Place Project at the University of Missouri School of Nursing, a state-academic-private partnership\textsuperscript{11}
- Appendix A-2 University of Pennsylvania School of Nursing's Living Independently for Elders (LIFE), a PACE program\textsuperscript{12, 13}

Care coordination for impoverished, high-risk, first-time pregnant women has documented effective short-term and long-term outcomes for both mothers and babies through rigorous comparative evaluations.\textsuperscript{9}

- Appendix A-3 The Nurse-Family Partnership model.

The primary care-based nurse-managed health clinic model, defined in the Affordable Care Act, has strong care coordination practice as its hallmark. Nurse practitioner led interdisciplinary teams: 1) build solid relationships with its patients; 2) facilitate the exchange of information between providers and patients; and 3) integrate the care provided by multiple professionals with outside resources and services.\textsuperscript{14-18}

- Appendix A-4 The Eleventh Street Family Health Service
- Appendix A-5 Family Practice and Counseling Network

Transitional care approaches to reduce avoidable emergent care and rehospitalization:

- Appendix A-6 Transitional Care Model (TCM) at the University of Pennsylvania School of Nursing\textsuperscript{5-8}

*The Rush Enhanced Discharge Planning Project*\textsuperscript{19} that uses Masters-prepared social workers to help elders increase their understanding of prescribed medications; it decreases patient and care giver stress.

*The Care Transition Program* at the University of Colorado\textsuperscript{1} uses registered nurses, social workers, or community workers as transition coaches to promote self-management and greater family involvement to bridge transitions between hospital and community settings. “Care Transition Intervention” emphasizes medication self-management, patient-centered health records, appointment scheduling, and recognizing indicators of deteriorating condition.
Background
Many senior citizens and their families seek to postpone or avoid nursing home care, preferring to remain at home.

Goal
The Aging in Place Project, through RN Care Coordination, health promotion, and early illness recognition, aims to provide more and higher-quality services at home, allowing people to “age in place” and avoid or delay hospitalizations by creating Sinclair Home Care.

Center Background
Sinclair Home Care is a licensed home care agency within the University of Missouri Sinclair School of Nursing that currently provides community-based care to residents of Tiger Place to support the aging in place program. Based on individual choice and autonomy, both the building and the services maximize each elder person's mental, physical, and psychosocial strengths. Specific services that integrate mind and body are: a country club dining experience for meals; a sports bar; private completely accessible apartments with screened porches; an on-site veterinary clinic, doors to the outside from each apartment with safe walking paths for personal pets; and health promotion and wellness programs with registered nurse care coordination and 24-hour nurse response on call. The combined housing and care cost for any resident has never approached or exceeded the national average cost for nursing home care.

Evidence of Success
- Sinclair Home Care (in operation since 1999)
  - Has produced significantly better outcomes of pain, shortness of breath, and ADLs through AIP nurse care coordination for several hundred elders living in the community.
  - Provided, through RN care coordination, $482.85 per month savings to the total Medicare and Medicaid costs of health care when compared to home and community-based services during a CMS-funded evaluation (1999-2003). Total Medicare and Medicaid costs were $1591 lower per month than in a comparison nursing home group.
  - Has provided more than 700 nursing students with clinical experiences, as well as experiences for many engineering, communication, business, PT, SW, and medical students.
- Tiger Place (in operation since 2004)
  - Facilitates development and evaluation of technology in a collaborative setting.
  - Has reduced hospitalizations, sustained outcomes of maintaining mobility and independence, early illness recognition, involvement in life and community activities, and successful hospice care for those at end of life.
  - Costs for any at TigerPlace nursing home eligible participant has never approached or exceeded nursing home care (average annual care cost for 2008 was $7,331 plus the housing cost). For those not nursing home eligible the annual average care cost was $2,591.

About Raise the Voice
Raise the Voice is an initiative of the American Academy of Nursing. For more information about this Edge Runner and others, please visit www.AANnet.org.
Background
Frail, inner-city seniors facing complex medical, functional and psycho-social problems who are nursing home-eligible but want to remain in the familiar surroundings of their own homes and communities.

Goal
Living Independently for Elders Care strives to provide integrated nurse led comprehensive mental and physical health care and social service program through a coordinated integrated health plan.

Living Independently for Elders Center
Providing Quality Care to Seniors - At Home

Center Background
The Living Independently for Elders (LIFE) Center is a nurse led academic Program of All-Inclusive Care for the Elderly (PACE) program, owned and operated by the University of Pennsylvania’s School of Nursing, which provides alternatives to nursing home admissions for West Philadelphia residents. Teams of health care providers manage the complex medical, functional and psycho-social problems faced by elderly clients.

What It Does
- Delivers comprehensive care 24 hour/7 day per week services through a team of primary care nurse practitioners and physicians who have privileges at the University of Pennsylvania Health System (UPHS).
- Currently provides meals, recreational activities, nursing and health care, medications, treatment, physical therapy, art and music therapy and personal care services like laundry, showers and hair care to more than 430 clients daily. The program grows on average by 2 members per month.
- Provides round-the-clock services to poor urban residents who would otherwise need nursing home care. Clients are transported from home by LIFE vans to the LIFE Center and health appointments. At the LIFE Center, they engage in recreational activities and received care and meals. Care is provided at home on an as needed based on a plan of care that includes the family and older adult. The LIFE Center is responsible for care 24/7.
- Promotes independence and the highest levels of functioning while allowing choice and dignity for the members and their families.
- Serves as a model for integration of practice, education and research, not only in nursing but in health care.
- Serves as a model of integrating fiscal responsibility, access to service, and quality of care using a Medicare/Medicaid capitated per member per month rate.

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How it Stands Out

• Acute care hospital admission for LIFE members are only 7.5 (1.7%) per 430 members – only about 2/3 the rate of those in Pennsylvania nursing home facilities.
• Emergency department visits occur at a very low rate of 2.6 (0.6%) per 435.
• High member and family satisfaction rates, preserves community neighborhoods.
• Saves the Pennsylvania Department of Public Welfare 20 percent annually in Medicaid reimbursement costs.
• Saves Medicare for cost of hospitalizations and emergency department visits.
• Is completely self-supporting and fiscally sound; earns reinvestment funds for the Penn School of Nursing.
• Nursing home services are reduced by number of admissions and length of stay.
• Care in hospital is provided by or coordinated by the LIFE nurses, social workers and physicians ensuring continuity of care delivered by a team familiar to the member and their family.
• Serves as an educational facility for interprofessional learning among nursing, social worker, medicine, dental, and rehabilitation services.
• Serves as an innovation learning laboratory for faculty and students in health care business and health services outcomes research that is patient-centered.

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Background
Every year, more than 800,000 children are born first-time mothers living in poverty. Without intervention, these births all too often lead to a pattern that is destructive for both the mother and the child. The mother feels trapped in her situation and gives up on continuing her education or finding a good job. The child grows up without a role model to show a way out of poverty and in a culture that encourages repetition of the cycle.

Goal
Nurse-Family Partnership’s goal is to help parents in targeted communities give their children a better start by providing care in the home, via a registered nurse, from pregnancy through the child’s first two years of life — to improve pregnancy outcomes, child health and development, and the economic self-sufficiency of the family.

Evidence of Success
• 79% reduction in preterm delivery for women who smoke; 35% fewer hypertensive disorders of pregnancy; and a decrease in smoking.
• 39% fewer injuries among children, including a 56% reduction in emergency visits for accidents and poisonings from birth to age 2, and a 32% reduction in emergency visits in the second year of life.
• The Washington State Institute for Public Policy found that the program had the highest return on investment among all home visiting and child welfare programs evaluated, with a net benefit to society of $17,180 (in 2003 dollars) per family served, which equates to a $2.88 return per dollar invested in NFP.
• For the higher-risk families now served by the program, a 2005 RAND Corporation analysis found a net benefit to society of $34,148 (in 2003 dollars) per family served, with the bulk of the savings accruing to government, which equates to a $5.70 return per dollar invested in NFP.
• The New York City Department of Health and Mental Hygiene projected the expected cost savings to the city per 100 families served by the program, based on the published programmatic outcomes. The estimates are based on the cost of services that would not be needed as NFP achieves its intended positive effects and include:
  • 35% reduction in pregnancy-induced hypertension: 3.5 fewer cases, saving $29,500;
  • 50% reduction in child abuse and neglect, 0-2 years: 2 fewer cases, saving $38,500;
  • 35% reduction in emergency room visits overall, 56% reduction in emergency room visits for accidents and poisonings: 16.8 fewer visits, saving $11,584;
  • 50% decrease in language delays at 21 months: 8 fewer children, saving $133,000-$440,000.

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Background
Poor and minority populations suffer from disparities in healthcare when compared to other populations. More than 46 million Americans lack health insurance, with 17 million more “underinsured.” Minority populations suffer from a greater incidence of diseases such as diabetes and from related complications.

Goal
Eleventh Street Health Services goal is to work in partnership with the community to develop a healthy living center that is community-based and culturally relevant, providing not only access to clinical services but also to a wide-range of health promotion and disease prevention services to reduce health disparities in an underserved population.

The Eleventh Street Family Health Services, Drexel University
Serving Medicaid Patients and the Uninsured in an Urban Community

Center Background
Eleventh Street Family Health Services, Drexel University is a Healthy Living Center operated by the College of Nursing & Health Professions that provides access to a broad trans-disciplinary team of health professionals with clinical services sustained through a partnership with the Family Practice & Counseling Network. It also has a strong educational and research component; serving as a clinical practice site for many students of the University and conducting research and documenting outcomes of the trans-disciplinary approach to care. It provides comprehensive, trans-disciplinary care to residents of public housing communities and other vulnerable populations including 26,676 clinical service visits and 1,676 home visits to pregnant or new mothers and 6,827 patient encounters in health education and wellness programs.

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Evidence of Success
• Reduced pre-term births to 2.5% in African American women seen at 11th Street compared to 15.6% in Philadelphia (2011).
• Improved Quality of Life for patients participating in the fitness program, as measured by the SF 36, with a significant increase in perceived health status at 3, 6 and 12 month follow ups (2011).
• Decreased unnecessary medical specialty workups for children whose issues are family/behaviorally based, such as enuresis, through the integration of a pediatric behavioral health consultant in primary care.
• Increased the use of self-care plans for patients with chronic illness to 100% and increased patients’ self-efficacy through the Living with Chronic Illness Program (2010-2011). (continued on back)
Evidence of Success (continued)

• Recognized by the Pennsylvania Governor’s Chronic Care Collaborative as one of 3 state-wide practices with an innovative approach to lowering blood pressures in patients with serious diabetes.

• Replicated the Kaiser Permanente Adverse Childhood Events study with the 11th Street adult patient population, revalidating the role of childhood trauma and adversity in the development of health problems in adults. Used these data to plan relevant programs to address trauma (2010).

• Received a Healthy Workplace Award from the Philadelphia Business Journal for its efforts to provide time and opportunities for staff to participate in health promoting activities (2010 & 2011).

• Included as a case study in the IOM report on The Future of Nursing to illustrate community partnerships to reduce health disparities.

• Named on the Innovation Exchange of the federal Agency for Health Quality Research (AHQR) for opening access to care.

• Serves as a clinical practicum site undergraduate nursing, nurse practitioner, physical therapy, creative arts therapies programs and from Drexel’s School of Public Health.

• Received more than 20 million dollars in grant funding from federal agencies, private foundations and corporations since 1998 to build and support the 11th Street trans-disciplinary model of care.

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Background
Public housing residents often are exposed to violence. As a result, they suffer trauma, post-traumatic stress disorder (PTSD) and many other physical and mental health issues. Furthermore, many public housing residents have problems accessing primary health care.

Goal
Family Practice and Counseling Network brings care directly to public housing residents in a cost-effective manner that fosters better care through nurse-managed clinics comprised of an inter-disciplinary health team that has been trained to address public housing residents’ special needs.

Family Practice and Counseling Network
Addressing the Special Health Care Needs of Public Housing Residents - Particularly Behavioral Care

Center Background
Family Practice and Counseling Network (FPNC) is a system of three nurse-run health centers located in or near public housing communities in Philadelphia. They are based on a “one-stop shopping” model where patients receive care – seeing a behavioral health therapist, podiatrist, optometrist, dentist all on the same day. Prescriptions can be filled at the pharmacy or dispensary and patients can be transported to and from the health center via the health center van. There is a special $4 prescription fee for uninsured patients. Centers are accessible by means of location, ease of appointment, acceptance of all patients regardless of ability to pay and by creating a warm, inviting and friendly atmosphere. The primary care visit is charged on a sliding scale, based on federal poverty guidelines for patients who are uninsured, and lab work is included in that fee.

Evidence of Success
• In 2011:
  • Received $500,000 HRSA Award to open a new site in York, PA to serve public housing residents. Only 2 awards were given in PA and 60 in the country.
  • FPNC was accepted into the state Phase 2 collaborative aimed to improve chronic and preventative care outcomes. It is a three year initiative.
  • FPNC was subcontracted to provide services through a state grant called PA Cure Grant. The grant is a three year initiative that will be studying the effects of drug and alcohol screening, treatment, and referral in a primary care setting.
  • FPNC was awarded a PEW grant to place Peer Specialists in health centers to improve the mental and physical health of patients with serious mental and physical health problems. A Peer Specialist is someone with lived experience with mental illness who acts as a coach and mentor to their patients.
  • FPNC has demonstrated their capacity to manage the fiscal operation and has realized a surplus in all but one of its nineteen years. This year’s surplus is 1.1 million dollars.

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Evidence of Success

- Clinical outcomes (for 2009 alone)
  - 70% of pregnant patients received prenatal care in the first trimester
  - 85% of children age two were fully immunized
  - 63% of Diabetic patients had HbA1c under 9
- In 2009, 98% of Diabetic patients were taking renal protective medication (ACE or ARB) and 100% had self-management plans and had received smoking cessation/reduction counseling
- Financial outcomes
  - Numbers of patients grew from 6,391 in 2005 to 14,645 in 2009
  - Numbers of visits in all disciplines increased from 30,254 in 2005 to 66,453 in 2009 and is projected to reach 75,000 in FY 2011
  - Prescriptions filled grew from 5,800 in 2007 to 11,964 in 2009. Center pharmacies under the 340B federal drug program allowed the health center to shift from spending $70,000 for medications for uninsured patients to gaining a surplus of $70,000 from insured patients – money which then was used to purchase drugs for uninsured patients.

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## Background

High rates of poor post-discharge outcomes put elderly patients back in the hospital soon after their release following treatment and up to one-third of those hospitalizations are considered preventable.

## Goal

To focus on transitional care lead by master’s-prepared advanced practice nurses (APRNs) in conjunction with the patient’s entire healthcare team, targeting high-risk patients at risk for poor post-discharge outcomes in order to improve post-discharge outcomes. This lowers the rates of re-hospitalization and thereby reducing health care costs.

### Center Background

It is an evidence-based innovative model of hospital-to-home care in which APRNs work to ensure a smooth transition from hospital care to home care. The program assures that APRNs: establish a relationship with patients and their families soon after hospital admission; design the discharge plan in collaboration with the patient, the patient’s physician, other involved providers and their family caregivers; and implement the plan in the patient’s home following discharge, substituting for traditional skilled nursing follow-up. This reduces the incidence of poor communication among providers and health care agencies, inadequate patient and caregiver education and poor quality of care as well as enhances access to quality care.

### Evidence of Success

- Since 1991, when compared to standard care, the TCM has demonstrated longer intervals before initial re-hospitalizations, fewer re-hospitalizations overall, shorter hospital stays and better patient satisfaction.
- A four-year trial (1997-2001) with a group of elderly patients hospitalized with heart failure, the APN Care Model cut hospitalization costs by more than $500,000, compared with a group receiving standard care – for an average savings of approximately $5,000 per Medicare patient.
- Demonstrated efficacy in translating the evidence based innovation into practice, in partnership with a major insurer (Aetna, Inc.) targeting their Medicare Advantage consumers (2005-2007). The program was offered as an ongoing benefit for their high-risk members experiencing transitions from acute care to home in a select market (2011).
- An ongoing clinical trial (2005-present) with hospitalized, cognitively impaired older adults and their family caregivers reveal similar health resource utilization outcomes as prior studies; health, quality of life and cost analyses ongoing.

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