

## Edge Runners



### **Making Transitional Care More Effective & Efficient APNs Ensure Smooth Transition From Hospital to Home, Cutting Re-Hospitalization Rates for Geriatric Patients**

#### **The Challenge:**

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

#### **The Goal:**

**Improve post-discharge outcomes – lowering rates of re-hospitalization and thereby reducing health care costs.**

#### **An Innovative Solution:**

**Focus on transitional care lead by master's-prepared advanced practice nurses (APNs) in conjunction with the patient's entire healthcare team, targeting high risk patients at risk for poor post-discharge outcomes.**

#### *Where To Learn More*

Mary D. Naylor, PhD, RN, FAAN  
Marian S. Ware Professor in  
Gerontology  
Director, NewCourtland Center  
for Transitions and Health  
University of Pennsylvania School  
of Nursing  
Ralston Penn Center  
3615 Chestnut Street, RM 320  
Philadelphia, PA 19104-2676  
(215) 573-4471  
[naylor@nursing.upenn.edu](mailto:naylor@nursing.upenn.edu)

#### **What It Is**

- An evidence-based innovative model of hospital-to-home care in which APNs work to ensure a smooth transition from hospital care to home care.

#### **What It Does**

- Assures that APNs: 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, and family members; and implement the plan in the patient's home following discharge, substituting for traditional skilled nursing follow-up.
- Reduces the incidence of poor communication among providers and health care agencies, inadequate patient and caregiver education and poor quality of care; enhances access to quality care.

#### **How It Stands Out**

- Findings from three clinical trials funded by the National Institute of Nursing Research consistently demonstrate that the APN Transitional Care Model improves quality of care and substantially decreases health care costs.
  - Compared to standard care there are longer intervals before initial re-hospitalizations, fewer re-hospitalizations overall, shorter hospital stays and better patient satisfaction.
  - Following a four-year trial 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.

With the support of the Commonwealth Fund, Jacob and Valeria Langeloth Foundation, the John A. Hartford Foundation, Inc., the Gordon & Betty Moore Foundation, and the California HealthCare Foundation., efforts are underway to test the “real world” application of this model in collaboration with Aetna, Inc., and Kaiser Permanente.