



APN Transitional Care Model

Purpose

To reduce readmission rates after hospitalization by ensuring a smooth transition from hospital to home care for geriatric patients¹

Target Population

Geriatric patients currently in and recently discharged from a participating hospital²

Goals

- Improve post-discharge outcomes
- Lower rates of re-hospitalization
- Reduce health care costs³

Years in Operation

1999 – present

Results

- Findings from three clinical trials demonstrate that the APN Transitional Care Model improves quality of care and 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 Transitional 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.⁴

Funding

National Institute of Nursing Research; Commonwealth Fund; Jacob and Valeria Langeloth Foundation; John A. Hartford Foundation, Inc.; Gordon & Betty Moore Foundation; California HealthCare Foundation⁵

Key Partners

Advance practice nurses (APNs) and other providers, patients and caregivers. Aetna, Inc. and Kaiser Permanente are testing “real world” applications of this model.⁶

What Works and Why

The model uses a holistic approach of “health care team management,” led by an advance practice nurse. APNs begin to work with the patient and the patient’s family and health care team to design an individualized discharge plan while the patient is in the hospital. By engaging and

working with the caregivers and patients before discharge, there is better, on-going communication about post-discharge care and expectations.

Costs are lowered because the approach reduces the number of re-admissions of elderly patients caused by not understanding or following post-discharge care instructions, a lack of care coordination among providers, and not understanding symptoms that require immediate attention.

Structure and Operations

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.

Barriers to Success

The APN Transitional Care Model was tested in a clinical trial setting. Real world experience may differ.

For More Information

Additional information is available online:

<http://www.nursing.upenn.edu/centers/hcgne/TransitionalCare.htm>

