The Transitional Care Model: A Randomized Controlled Trial

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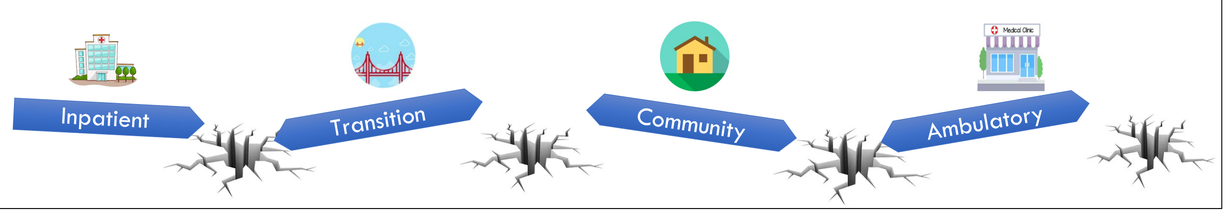
Background

Fragmentation across the care continuum has been linked to poor ratings of the care experience and further declines in health status for hospitalized older adults. This problem impacts UCSF Health True North pillars of **Patient Experience** and **Quality & Safety** and **Strategic Growth**.
The Transitional Care Model (TCM) is a nurse-led intervention targeting older adults at risk for poor outcomes as they move across healthcare settings and between clinicians. The TCM is backed by rigorous and consistent evidence of sizable reductions in rehospitalizations and net healthcare costs among Medicare beneficiaries as demonstrated in multiple NIH funded randomized controlled trials (RCTs). Arnold Ventures committed $6.8M to support the TCM team at the University of Pennsylvania (Penn) and partnering health systems, **including UCSF Health**, to conduct a large, multi-site RCT with an external evaluator, Mathematica.



Project Goals

Our goal is to replicate the TCM Model with fidelity to core components to determine if the health and economic effects of the TCM demonstrated in the NIH funded clinical trials can be replicated in "real world" health systems such as UCSF Health.

- RCT enrolling 1000+ patients (500 intervention and 500 control) at UCSF and four other partnering health systems across four states
- UCSF Goal: **281 enrolled patients**
  - Patients who are 65+ years old and admitted with symptoms of Heart Failure, COPD and/or PNA who reside in the San Francisco area and have one or more risk factors

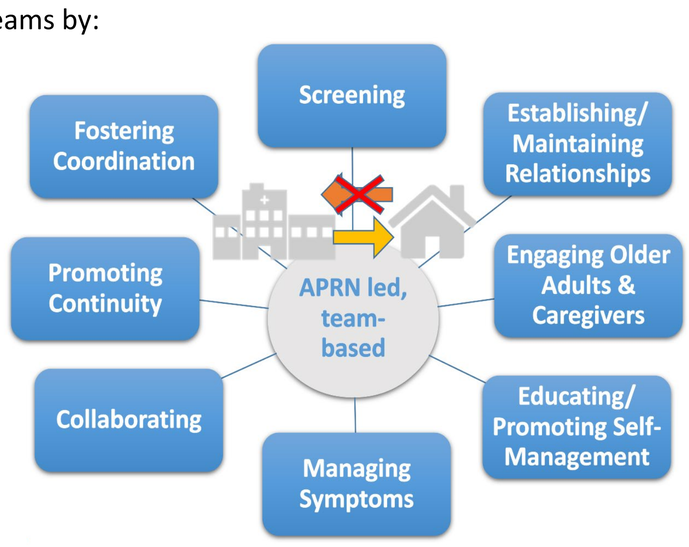
PROBLEM STATEMENT: By replicating this model, will UCSF have the same results (as prior TCM studies), of improved patient outcomes and better patient experience for a lower cost of care?

UCSF is participating in a multi-site Randomized Control Trial study replicating the Transitional Care Model to determine if this nurse-led intervention will decrease readmissions and improve health care for patients.

Project Plan and Interventions

Patients are identified during hospital admission as eligible for the RCT by an enrollment coordinator, then approached to participate (no cost to patient or health plan). If agreeable to participate and consent complete, the patient is randomized into CONTROL or INTERVENTION. If in the intervention group, an Advanced Practice Registered Nurse (APRN) collaborates with the patient, their caregivers, and health care teams by:

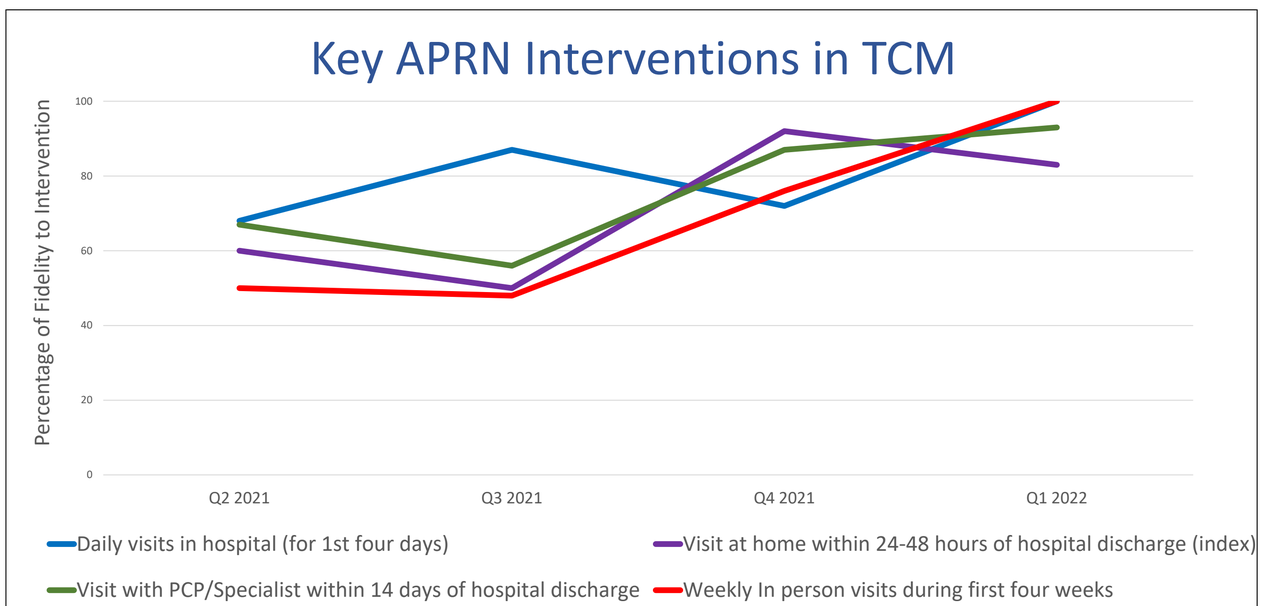
- Visiting and developing individualized care plans while patient is in the hospital
- Visiting patient in the home within 24-48 hours of hospital discharge
- Accompanying patient to their first physician visit
- Maintaining regular contact through home visits (in-person and telephonic) over two to three months to monitor patients' symptoms, ensure patients' adhere to their care plans, and position patients and family caregivers to manage future health needs in a manner consistent with their goals and preferences



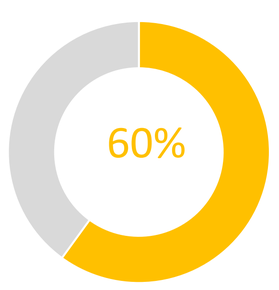
Hirschman et al., 2015, OJIN.

Health Equity: *UCSF is a unique site in that patients are able to be enrolled in the RCT by proxy (screened as cognitively impaired) as well as if their primary language is one of the four site-approved including Russian, Chinese, Spanish and English.*

Project Results & Impact



APRNs strive to meet specific interventions, such as daily visits in the hospital, timely follow up appts, and weekly home visits post-discharge, to improve patient outcomes!



Progress toward Enrollment Goal

Conclusions, Next Steps, & Lessons Learned

- *LESSONS LEARNED:*
  - *Fidelity to core components improved with 2 APRNs and 7 days a week coverage (from Q3 2021 to Q4 2021), as well, as weekly meetings around clinical discussions and tracking fidelity to the model.*
  - *A Transitions of Care Social Worker is an excellent resource for patients with psychosocial needs that can greatly affect their ability to care for themselves at home.*
  - *Challenges included: staffing model, access to primary care, and COVID pandemic.*
- *NEXT STEPS:*
  - *Continued intervention through December 2022.*
  - *Study data and analysis by Mathematica including primary outcome measurement of **total number of hospitalizations in year following enrollment in RCT** along with secondary measurements of use of other health/social care services, health and quality of life, and time to first rehospitalization and/or death.*
- *CONCLUSIONS*:
  - *The value of bridging patients from inpatient to outpatient with a trusted clinician, patients setting their own goals, and coordination of care in a complex, growing health system will guide strategic planning and engagement with senior leadership to implement TCM at UCSF Health.*

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