

Background

Project Goals

The Transitional Care Model (TCM) is an APRN-led intervention for older adults at risk for poor outcomes as they move across healthcare settings and between clinicians. The benefits of the TCM have been demonstrated in multiple NIH-funded randomized controlled trials

Promote quality & equity of care and improve health outcomes for all of our patients
Quality & Safety

In partnership with University of Pennsylvania and supported by a 6.8M investment by Arnold Ventures, UCSF was part of a multi-site RCT that applied this evidence-based intervention proven to reduce likelihood of readmission and lower cost per patient.

Advance innovation through sharing our transformative models of health care delivery
Learning Health System

To approach and enroll all eligible patients into the RTC in order to assess the effect the TCM would have on outcomes such as experience with care, rehospitalizations, quality of life and emotional health status.

Standard Eligibility criteria included:

- patients 65+ years old
- admitted with symptoms of Heart Failure, COPD and/or Pneumonia
- reside in the San Francisco area
- have one or more risk factors

Health Equity:
UCSF was the only site that included Russian, Chinese, and Spanish speaking eligible patients

PROBLEM STATEMENT:

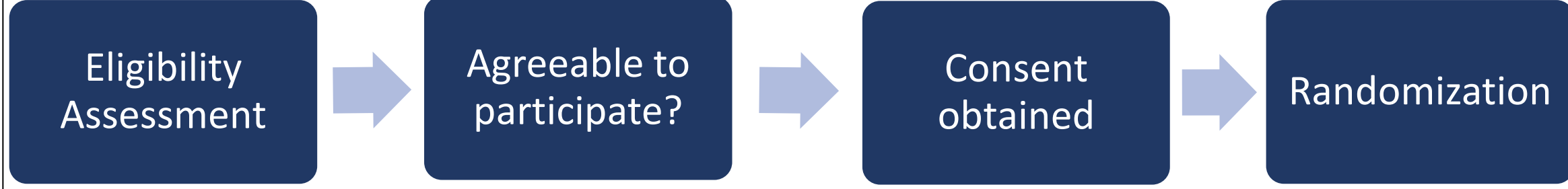
To determine if the health and economic effects of the TCM demonstrated in the NIH funded clinical trials can be replicated in “real world” health systems such as UCSF Health.

In this Randomized Control Trial, the preliminary results show that patients receiving the Transitional Care Model intervention had a lower 30-day readmission rate than the control group

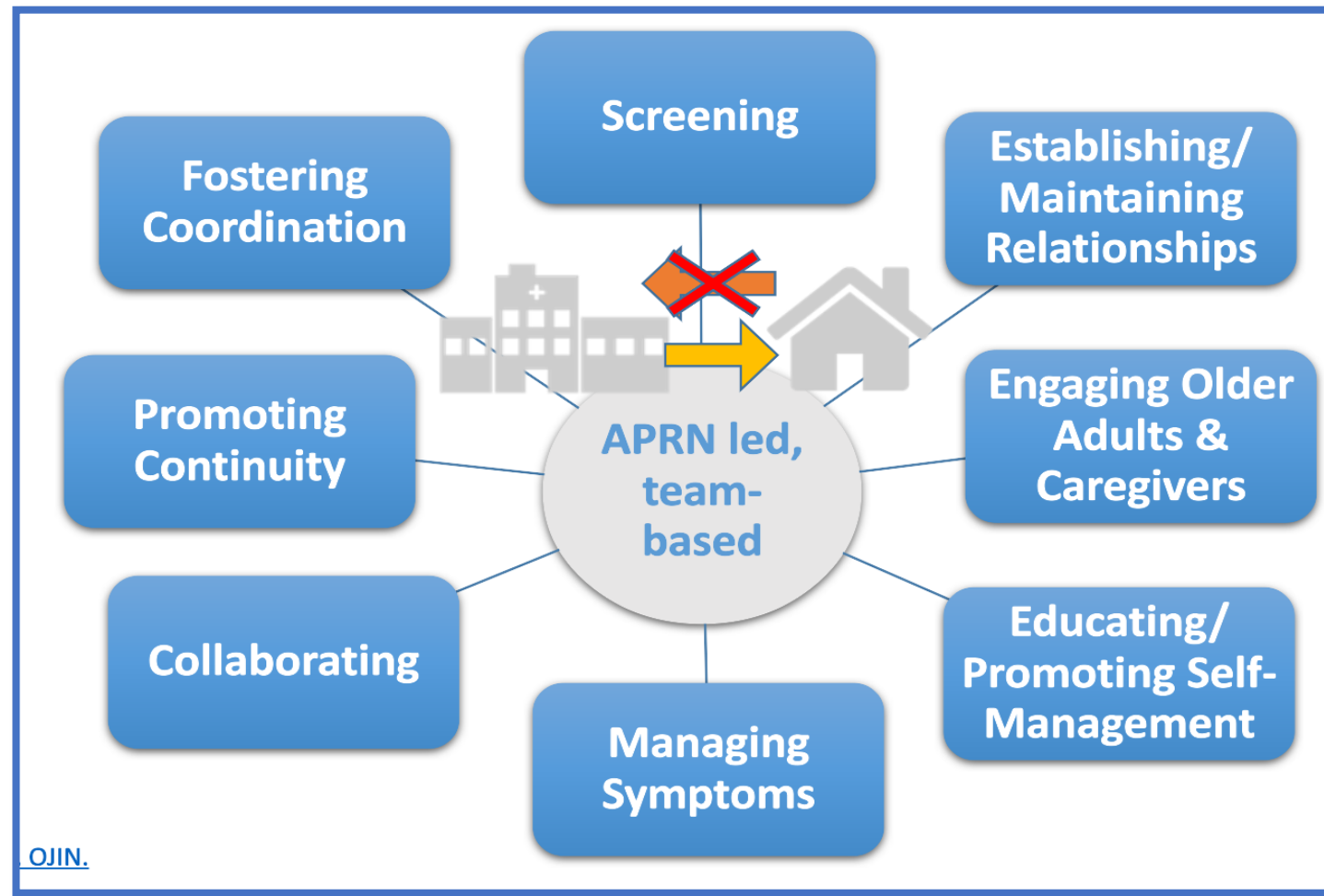
Project Plan and Interventions

Project Outcomes, Results & Impact

Patients were identified during hospital admission as eligible by an enrollment coordinator. If agreeable to participate and consent complete, the patient was randomized into CONTROL or INTERVENTION groups.



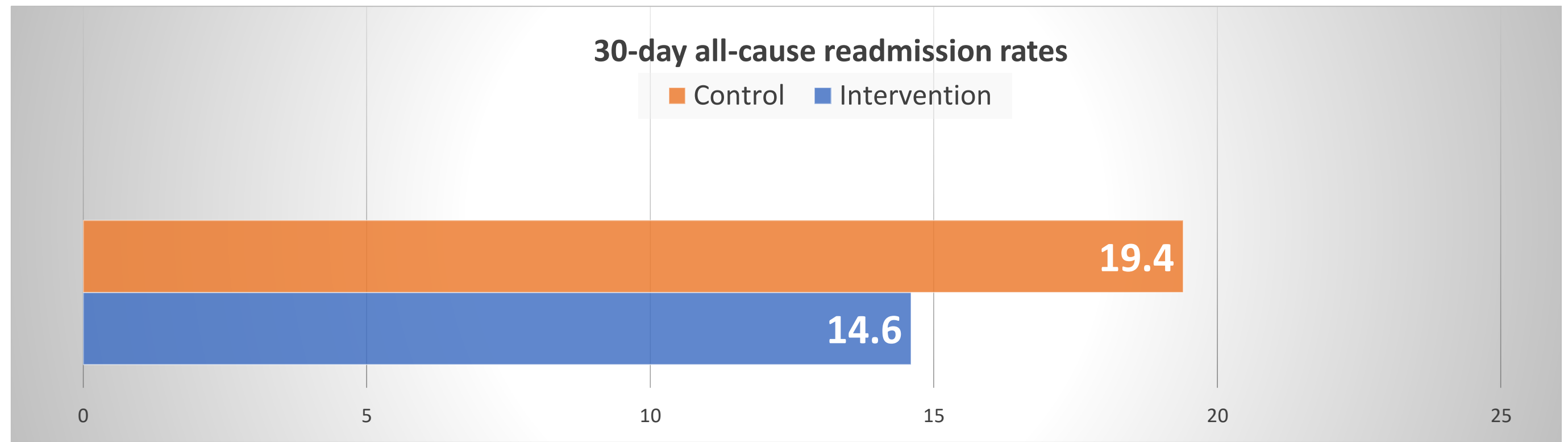
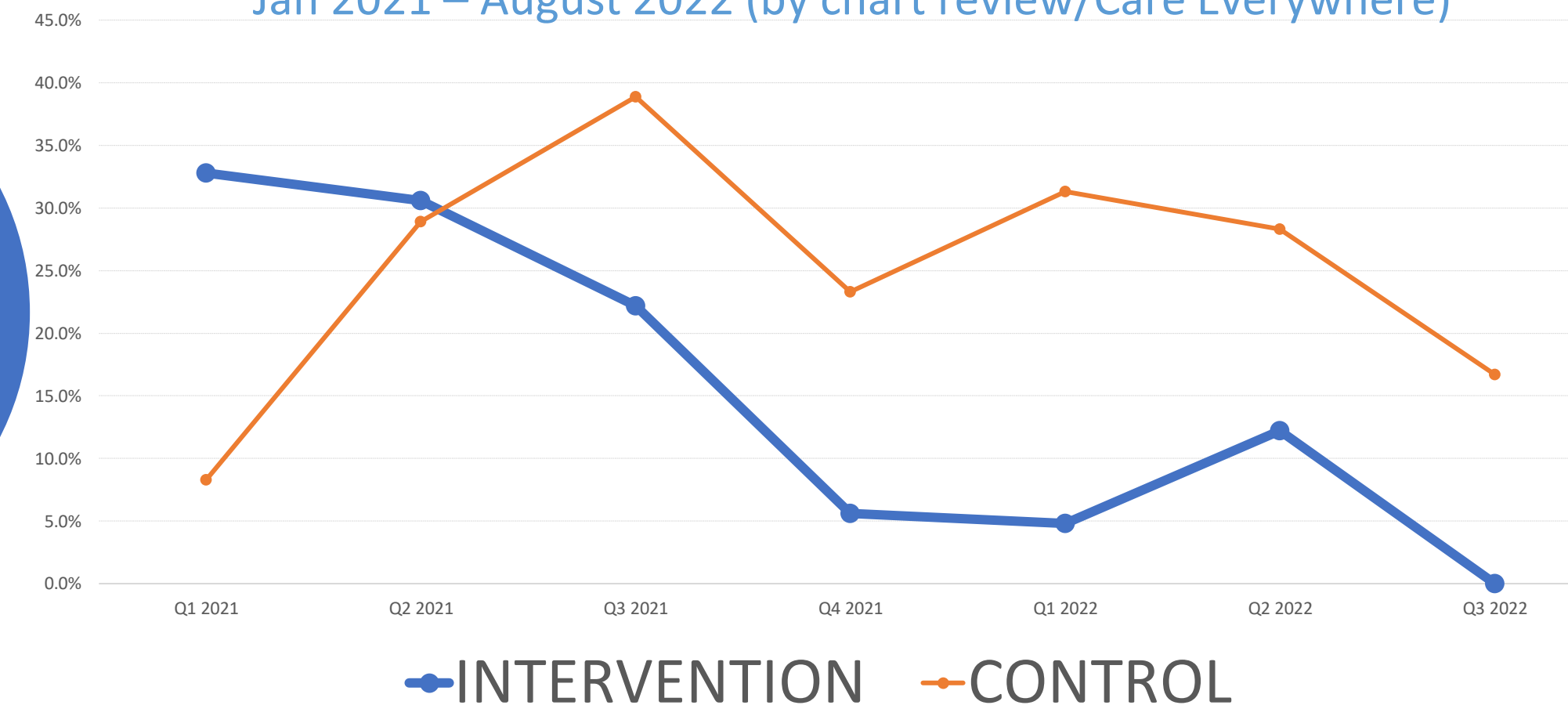
The intervention group received support from an Advanced Practice Registered Nurse (APRN) who collaborated with the patient, their caregivers, and health care teams for up to 3 months.



Our hypothesis was that the intervention group would have a lower 30-day all-cause readmission rate.

245 enrolled patients

30 Day Readmission Rates by Quarter
Jan 2021 – August 2022 (by chart review/Care Everywhere)



Conclusions, Next Steps, & Lessons Learned

Final data and results expected Fall 2024

Conclusions: Based on preliminary results, we anticipate that our findings will replicate that of the original TCM studies and will again demonstrate improved clinical outcomes, better experience with care, and reduce health resource utilization for those who received the TCM. In addition, the implementation of this study has provided opportunity to recommend design improvements, as well as a multidisciplinary team, of the TCM model to be implemented at UCSF Health.

Next steps : Study data synthesis and analyses by Mathematica: **Fall 2024**

- Primary outcome measurement of total number of hospitalizations in year following enrollment in RCT
- Secondary outcome measurements: experience with care, physical and emotional health status, quality of life, and time to first rehospitalization and/or death.

Lessons Learned: The challenges with enrollment into an RTC can be overcome with patient centered approach with enrollment coordinator. Other lessons we have learned are the importance of patient/family engagement and goal setting, collaboration with providers and post acute partners, care delivery via a multidisciplinary team, and 7 day a week coverage between only 1-2 APRNs is not sustainable.