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Best Practices in Nursing Care to Older Adults
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The Transitional Care Model (TCM): Hospital Discharge Screening Criteria for High Risk Older Adults

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WHY: Older adults hospitalized for a newly diagnosed acute condition or an exacerbation of a chronic condition are at heightened risk of re-hospitalization due to poorly managed transitions from hospital to home or other care setting. For older patients with multiple chronic conditions this "hand-off" period takes on even greater importance. One-quarter to one-third of these patients are re-hospitalized due to preventable complications. This evidence-based practice approach addresses needed hospital discharge assessment that should be completed by registered nurses or advanced practice nurse staff managing the complex care of hospitalized older adults.

BEST PRACTICE: The Transitional Care Model (TCM): Hospital Discharge Screening Criteria for High Risk Older Adults identifies 10 screening criteria developed and modified based on the results of completed randomized clinical trials of older adults with common medical and surgical DRGs (e.g., heart failure, angina, cardiac surgery, etc) and found to correlate to higher risk on transition from hospital to home (Transforming Care at the Bedside How-to Guide: Creating an Ideal Transition Home for Patients with Heart Failure. Institute for Healthcare Improvement. Robert Wood Johnson Foundation. 2007. http://www.ihi.org). Positive findings should be discussed with the patient, caregiver, physician or other provider and discharge planning staff to ascertain inclusion of these considerations in the discharge plan and need for further assessment of needs on transition to home or other care setting.

TARGET POPULATION: Older adults hospitalized for an acute illness or exacerbation of a chronic condition.

VALIDITY AND RELIABILITY: Since 1989, three NIH funded randomized controlled clinical trials have tested and refined an innovative model of care coordination, the Transitional Care Model (TCM). The TCM has consistently demonstrated improved patient outcomes and substantial decreases in health care costs, and is the source of the high risk factors in the screening criteria. Evidence from these trials has shown that presence of two or more of these screening criteria significantly heightens the probability of a poor post-hospitalization transition and would be highly likely to require some level of post-discharge intervention. The TCM emphasizes achieving *longer term* positive outcomes by assuring that patients and their family caregivers have the knowledge and skills to recognize and address health care problems as they arise.

STRENGTHS AND LIMITATIONS: A major strength of the Transitional Care Model (TCM) Hospital Discharge Screening Criteria for High Risk Older Adults is its ability to identify patients at high risk for poor outcomes after hospitalization for an acute or exacerbated chronic illness. This screening is easy and quick to administer and does not require advanced training to complete. All of the instruments used in the screening can be found as part of the *Try This* series. There are no limitations to completing the screening as outlined, only the ability to refer and availability of transitional care services in many settings. Any suspected or diagnosed cognitive impairment with or without the screening criteria would independently trigger post-discharge intervention to assure appropriate information transfer and follow-up after discharge to home or other care setting.

FOLLOW-UP: The potential for improved patient outcomes and decreased health care costs warrants ongoing development and refinement of discharge assessment skills to prevent untoward events post-discharge. Nurses should actively work with their clinical leadership to identify patterns occurring in their unique populations and additional risks to be considered, and incorporate these findings once validated to enhance the tool to best meet their organization's needs and population served.

MORE ON THE TOPIC:

Best practice information on care of older adults: www.ConsultGeriRN.org.

Transitional Care Model Home Page: www.transitionalcare.info.

Naylor, M.D. (2006). Transitional care: A critical dimension of the home healthcare quality agenda. *Journal for Healthcare Quality*, *28*(1), 48-54.

Naylor, M.D., Stephens, C., Bowles, H.K., & Bixby, M.B. (2005). Cognitively impaired older adults: From hospital to home. *AJN*, *105*(2), 52-62.

Naylor, M.D. (2004). Transitional care model for older adults: A cost-effective model. *LDI Issue Brief; 9*(6), Apr/May.

Naylor, M.D., Brooten, D.A., Campbell, R.L., Maislin, G.M., McCauley, K.M., & Schwartz, J.S. (2004). Transitional care of older adults hospitalized with heart failure: A randomized clinical trial. *JAGS*, *52*(5), 675-684.

Naylor, M., Brooten, D., Campbell, R., Jacobsen, B.S., Mezey, M.D., Pauly, M.V., & Schwartz, J.S. (1999). Comprehensive discharge planning and home follow-up of hospitalized elders: A randomized controlled trial. *JAMA*, *281*(7), 613-620.

Naylor, M., Brooten, D., Jones, R., Lavizzo-Mourey, R., Mezey, M., & Pauly, M. (1994). Comprehensive discharge planning for the hospitalized elderly: A randomized clinical trial. *Annals of Internal Medicine*, *120*(12), 999-1006.

Transitional Care Model (TCM): Hospital Discharge Screening Criteria for High Risk Older Adults

Are the following statements true for the patient? Check if yes.

- ☐ Age 80 or older
- ☐ Moderate to severe functional deficits (e.g., HARP score >2, KATZ < 4, Lawton <5)
- ☐ An active behavioral and/or psychiatric health issue (e.g., GDS >5)
- ☐ Four or more active co-existing health conditions
- ☐ Six or more prescribed medications
- ☐ Two or more hospitalizations within the past 6 months
- ☐ A hospitalization within the past 30 days
- ☐ Inadequate support system
- ☐ Low health literacy
- ☐ Documented history of non-adherence to the therapeutic regimen

If 2 or more findings are present further investigation is warranted and formal collaborative assessment of discharge planning – transitional care needs should be initiated.

- ☐ Cognitive impairment (e.g., Mini-Cog positive)

Any suspected or diagnosed cognitive impairment with or without the above screening criteria would independently trigger post-discharge intervention to assure appropriate information transfer and follow-up after discharge to home or other care setting.

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