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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 rehospitalization 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 older adults with multiple chronic conditions are re-hospitalized due to preventable complications (Lochner et al., 2013). This evidence-based practice approach addresses needed hospital assessment and transition planning that should be completed by registered nurses or advanced practice nurses in 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 diagnosis related groups (DRGs) (e.g., heart failure, angina, cardiac surgery, etc.) and found to predict higher risk on transition from hospital to home (Nielsen et al., 2008). Patients identified as high risk for poor outcomes in the transition from hospital to home benefit from collaborative discharge and transitional planning. Health care providers and discharge planning staff anticipate needs, consider goals and preferences, and implement strategies to ensure sharing of information and preparing patients and families to self-manage their health conditions. This process begins with effective screening to identify patients at risk for poor outcomes.

There are several high risk criteria that may alert staff to the need for effective transition planning. These high risk criteria include:

- being age 80 or older,
- moderate to severe functional deficits [screened using standardized tools such as Hospital Assessment Risk Profile or HARP (>2), Katz Index of Independence in Activities of Daily Living (ADL) (<4), Lawton Instrumental Activities of Daily Living (IADL) Scale (<5)],
- depressive symptoms [measured using tools such as Geriatric Depression Scale or GDS (>5), Patient Health Questionnaire-9 or PHQ-9 (>9)],
- four or more active co-existing health conditions, and/or
- six or more prescribed medications.

In addition, a patient is considered high risk for poor transitions if they have had two or more hospitalizations in the past 6 months or a hospitalization in the past 30 days.

Finally, patients are also considered high risk for poor outcomes during hospital to home transitions if they are found to have:

- an inadequate support system,
- low health literacy,
- documented history of nonadherence to the therapeutic regimen, or
- cognitive impairment such as diagnosis of dementia or positive screening assessment using standardized tools such as the Mini-Cog (positive), Montreal Cognitive Assessment or MoCA (<26), Confusion Assessment Method or CAM (positive), Six-Item Screener (≤3) or impaired clock drawing task

(You may refer to https://consultgeri.org/ for *Try This:*® Issues with information related to the following assessments: HARP; Katz ADL; Lawton IADL; GDS; Mini-Cog; MoCA; CAM; Executive Function)

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 (Naylor et al., 1994, 1999, 2004), one comparative effectiveness clinical trial [funded by the NIA and Marion S. Ware Alzheimer Program (Naylor, Hirschman et al., 2014)] and one study translating research into clinical practice (Naylor et al., 2013) 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. This research identified (1) the high risk factors in the screening criteria, and (2) evidence that presence of two or more of these criteria significantly heightens the probability of a poor post-hospitalization transition, highly likely to require post-discharge intervention. Implementation of the TCM has demonstrated that *longer term* positive outcomes are achievable when patients and their caregivers have the knowledge and skills to recognize and address health care problems as they arise and post discharge providers have up to date information to respond promptly to needs. If cognitive impairment is detected, patients should be considered high risk even if other high risk criteria are not present.

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. Many of the instruments used in the screening may be found as part of the *Try This:*® series. The only limitation to consider is substitution of another instrument to detect a risk factor. The instruments noted in the screening criteria were tested in the TCM research. Substitution of another valid and reliable instrument may be appropriate but the implementation team should carefully evaluate findings.

FOLLOW-UP: The potential for improved patient outcomes and decreased health care costs warrants ongoing development and refinement of discharge assessment skills, collaboration between hospital and community providers, and strong attention to patients' individualized needs to prevent untoward events post-discharge. Nurses should actively work with their clinical leadership to standardize identification of high risk patients and develop comprehensive discharge planning, patient/family education and collaboration with post hospital providers and services. Efforts to identify patterns and any additional risks occurring in their unique populations is important. Incorporating any findings, once validated, to enhance the screening criteria and individualize organizational needs and population served is likely to sustain positive patient outcomes.

MORE ON THE TOPIC:

Best practice information on care of older adults: https://consultgeri.org/.

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

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