

Transitional Care: A Curriculum Mandate for Nurse Practitioner Education

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Abstract

Present nurse practitioner (NP) curricular elements undoubtedly focus on the increasing prevalence of chronic disease, the aging population, increased complexity of care delivered across the health care system, and the high cost of care. Content related to transitions of care and transitional care is essential to understand the implications of these transformative changes, and their impact on quality patient care and advanced nursing practice outcomes. The nationally validated set of core competencies for NPs created by the National Organization of Nurse Practitioner Faculties (NONPF) (2011) provides the framework for integration of transitional care knowledge into the NP curriculum. Clinical experiences to support transitional care competencies will be discussed. NP students need to increase their awareness of complex patient and system level factors that occur during transitions of care and be prepared to assume leadership roles to support and coordinate quality transitional plans of care for high risk patients.

The demands of clinical practice related to an increasingly complex health care system necessitate ongoing reassessment of nurse practitioner (NP) education. In decisive reports, the Institute of Medicine (IOM) (2000, 2001, 2003) focused attention on heightened problems of health care delivery, patient safety, health professional education, and leadership. These reports strongly identify the errors and financial burden caused by fragmentation and health care system failures. The reports recommend that health care organizations and professionals promote health care that is safe, effective, client-centered, timely, efficient, and equitable (IOM, 2001). In 2011, the IOM called upon nurses to lead the way towards an improved, efficient, consumer driven health care system that improves outcomes and decreases costs.

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Transitional Care

Transitional care is a set of actions designed to ensure coordination and continuity of care based on a comprehensive plan of care with current information about the patient's treatment goals, preferences, and health or clinical status (Coleman & Berenson, 2004). The National Transitions of Care Coalition (NTOCC) reports that there is significant evidence to conclude that poor transitions compromise patient safety and quality of care, place significant burden on patients, families and caregivers, and increase costs to patients, providers and payers (2008).

Quality issues are especially troubling for patients with complex medical problems and regimens who are routinely hospitalized, require multiple providers to manage their care, and move frequently across health care settings. Caregivers and patients experience transfers or transitions of care in and out of primary care, acute care, long-term care, and home care with poor communication between institutions and providers, often while patients are becoming increasingly at risk for poor outcomes. It is not uncommon for a patient to be discharged from the hospital to a nursing home; return to their home; go back to the Emergency Room (ER); and require rehospitalization. They may be moved to an intensive care unit (ICU), to a step down unit, and possibly to palliative or end of life care. The processes of care and the patient and family experiences during those transitions are known as transitional care.

Integration of Transitional Care into Nurse Practitioner Core Competencies

In 2011, NONPF released the most current, nationally validated set of core competencies for nurse practitioners. Those competencies define entry into practice for Master's or Doctor of Nursing Practice (DNP) level of preparation. The nine core competencies include: scientific foundation, leadership, quality, practice inquiry, technology and information literacy, policy, health delivery system, ethics, and independent practice. Integration of transitional care content is essential to achieve each competency and should be taught in core

courses including Health Policy, Health Delivery Systems, Research and Evidence-based Practice, Informatics, and Ethics. Population focused clinical courses must include content on transitional care to achieve leadership and independent practice competencies. Suggested content for integration of transitional care knowledge will be discussed as it relates to selected competencies within each core competency.

Scientific Foundation Competencies

- Critically analyzes data and evidence for improving advanced nursing practice.
- Translates research and other forms of knowledge to improve practice processes and outcomes.

Nursing science has contributed substantially to knowledge development in transitional care. The student should analyze evolving models of transitional care to achieve the scientific foundation competencies. Advanced practice registered nurses (APRNs) have been studied in several models of care with high risk or vulnerable patients who require transitional care. Over the past 10 years, Mary Naylor PhD, RN has done extensive research with APRNs in a transitional model with high risk older adults. Naylor uses a transitional care model that identifies patient goals, provides coordination and continuity of care throughout episodes of illness, and develops a plan with the active engagement of patient and family in collaboration with the patient's providers and other health team members. APRN's with expertise in older adult care are used in Naylor's transitional care model (Naylor & Keating, 2008).

A physician, Dr. Eric Coleman developed the Care Transitions Intervention which provides support and education for the patient and family caregiver. Traditionally, the patient and the caregiver must learn to become their own care coordinators and struggle to manage multiple factors. In Coleman's model, patients with complex care needs and family caregivers work with a "Transition Coach" and learn self-management skills to support the transition from hospital to home during the four-week program. The coach is an APRN or a registered nurse (RN) who has received training in the Care Transitions Intervention program. This intervention is centered on four pillars: (a) Medication self-management; (b) The Personal Health Record; (c) Timely primary care/specialty care follow up; and (d) Knowledge of red flags that indicate a worsening in their condition and how to respond (Coleman & Berenson, 2004) Efforts to translate and disseminate both models have been successful but continue to face barriers. The NP student should critically evaluate barriers as well the advantages and disadvantages of transitional care models that derive from major culture change, complex payment mechanisms, and patient and provider concerns.

Leadership Competencies

- Provides leadership to foster collaboration with multiple stakeholders (e.g. patients, community, integrated health care teams, and policy makers) to improve health care. Students need to expand upon the identification of stakeholders essential to the communication processes during transitional care. They should identify specific members of the team at assigned sites of care who support the transition process including discharge planners, case managers, key personnel in home care agencies, assisted living or nursing homes, and in primary care or specialty offices. Most clinicians have minimal experience in more than one level of care and find it difficult to support effective cross-site collaboration (Wachter & Goldman, 2002). Interprofessional learning experiences should be identified to help the NP student understand the roles of their colleagues in transitional care, and to be prepared to create and lead an effective transitional care team.

Students should review and discuss the Core Competencies for Interprofessional Collaborative Practice, published in 2011 by the Interprofessional Education Collaborative (IPEC). That document identifies individual core competencies needed by all health professionals to provide integrated, quality care.

Quality Competencies

- Uses best available evidence to continuously improve quality of clinical practice.
- Evaluates the relationships among access, cost, quality, and safety and their influence on health care.
- Evaluates how organizational structure, care processes, financing, marketing and policy decisions impact the quality of health care.

The IOM released two seminal reports related to patient safety and quality of care (1999, 2001) and students should be required to review the executive summaries of those documents. Quality care was defined as safe, effective, efficient, patient centered, and timely. Patient centered care includes information, communication, education, coordination and integration of care across conditions and settings, and over time.

Within 30 days of discharge, 19.6% of Medicare beneficiaries are rehospitalized (Jencks, Williams & Coleman, 2009), and the Medicare Payment Advisory Commission (MedPAC, 2007) estimates that up to 76% of these readmissions may be preventable. Data from these critical documents should frame a discussion that considers the major concerns related to quality and costs of transitional care.

Students should have an understanding of how to measure quality and define specific performance measures for transitional care (IOM, 2001). Measurement and feedback are

fundamental to quality improvement. Transitional care by definition is a very complex and challenging process to measure. Performance measurement needs to be understood from multiple perspectives including that of the patient, the family, the discharge care team, the receiving care team, and hopefully, at some point, across the system of care. Ideally, the patient or caregiver should be able to define the level of satisfaction of their transitional experience. From the patient's perspective, the transitional experience creates a higher level of vulnerability with lack of clarity about what their role should be. Families are dissatisfied with problems related to their coordination of care including unanswered questions from clinicians who are not aware of their unique problems, or the necessity of providing the same information to multiple providers (Harrison & Verhoef, 2002). It is critical that students analyze their role in transitional care to improve the patient and family experience during transitions of care.

Students need to be aware of national organizations that work to improve quality of care. Quality Improvement Organizations (QIOs) provide technical assistance to providers, hospitals and nursing homes to improve the value of health care services that are paid for by Medicare. The Centers for Medicare & Medicaid Services (CMS) selected 14 QIOs to participate in a 3-year project to facilitate community-wide quality improvement (QI) activities and implement evidence-based projects related to care transitions. NP students should analyze the main findings of those efforts which determined that hospitalizations and rehospitalizations declined nearly twice as fast in the intervention communities (CMS, 2012).

The *Quality and Safety Education for Nurses (QSEN)* project has defined the competencies for integrating a quality and safety framework for nursing (Smith, Cronenwett & Sherwood, 2007; Cronenwett et al, 2009). Funded by the Robert Wood Johnson Foundation (RWJF), QSEN identified the knowledge, skills and attitudes for the six attributes of quality identified by the IOM. All health professionals must deliver patient-centered care using teamwork and collaboration, while incorporating evidence-based practice, QI, safety, and informatics. With a growing focus on quality, efficiency and measurement of outcomes QSEN and AACN collaborated on a project to provide educational resources and training to support master's and doctoral nursing faculty to teach quality and safety competencies (AACN, 2012). The NTOCC published a document to assist with system level evaluation plans to support the development of measures of structure, process, and outcomes related to transitions of care (2008). Master's or DNP students can define aspects of a quality initiative on transitional care that will include elements of structure, process and outcomes. Initial transitional care efforts usually involve the system's structural elements such as information technology (IT) to support improved outcomes. Process elements can be better defined and discussed by students, for

example, required collaboration between the hospital or ER nurse and the home care nurse or primary care provider. Root cause analysis (RCA) and process mapping are QI tools. RCA uses problem solving methods aimed at identifying the root causes of problems or events. The analysis involves defining the problem, gathering evidence, identifying possible root causes, their underlying reasons, and then deciding which causes can evolve (Colorado Foundation for Medical Care, 2012). RCA is appropriate for a quality improvement initiative in transitional care where it is essential to assess existing structure and process prior to making major change. Process mapping can also be used to describe the patient journey through the system of care (Siriwardena, 2009).

Practice Inquiry Competencies

- Provides leadership in the translation of new knowledge into practice.
- Disseminates evidence from inquiry to diverse audiences using multiple modalities.
- Analyzes clinical guidelines for individualized application into practice

Evidence-based Models of Transitional Care

Extensive research is available related to general issues of transitional care including rehospitalization, costs, medical errors, adverse events, avoidable complications and models of transitional care that improve patient outcomes. Evidence based models of care should be an integral part of the NP student's courses on Research and Evidence. Present evidence based models focus on the transitions between hospital and home, as well as transitions to and from long term care. Naylor's transitional care model has been rigorously tested and has demonstrated to reduce readmissions by 36% and costs by approximately \$5000 per patient (Naylor, Aiken, Kurtzman, Olds & Hirschman (2011). Eric Coleman's Care Transitions Intervention has demonstrated to reduce average costs per patient by 20% (Coleman, 2004).

Several additional models are effectively used in acute care settings. Better outcomes for older adults through safe transitions, also known as Project BOOST, were developed by the Society of Hospital Medicine. The program incorporates improved communication with community providers, expanded admission and discharge tools, and an assessment of preparedness for the patient and family prior to discharge (Society of Hospital Medicine, 2008). The Hospital to home (H2H) initiative was developed by the American College of Cardiology and the Institute for Healthcare Improvement (IHI) to specifically reduce cardiovascular-related hospital readmissions and improve the transition from acute care to outpatient status for those hospitalized with cardiovascular disease (American College of Cardiology, 2011). Re-engineered Discharge (RED) is a research group at Boston University Medical Center that develops and tests strategies to improve the hospital discharge process in order to improve

patient safety and reduce readmissions. The RED group is now looking at discharge needs for specific patient groups such as those with depression.

A well known and increasingly replicated evidence based program in long term care facilities is INTERACT or Interventions to Reduce Acute Care Transfers. INTERACT is a QI program designed to improve the care of nursing home residents by identifying situations that commonly result in transfers to the hospital. Education and resources are available for nursing home staff to help them manage those situations effectively and safely in the nursing home without transfer when possible. This culture shift provides a framework in which the decision to hospitalize focuses less on institutional and medical personnel needs, and more on the quality of life of older individuals and the most appropriate setting for their care (INTERACT, 2011)

Clinical Guidelines

The American Medical Directors Association (AMDA) has published *Transitions of care in the long term care continuum clinical practice guideline* (2010). Students in long term care settings should carefully review this guideline, as well as the resources of INTERACT. They can then determine which elements are utilized in their assigned settings, or consider the implications of not having any transitional care guidelines in place.

Transitional Care Evidence Related to Chronic Disease

Heart failure is the principle diagnosis for approximately one million hospital discharges annually in the U.S. alone (American Heart Association, 2012). More than 26% of these patients are readmitted within 30 days of discharge (Jenks et al., 2009) and 65% of patients over the age of 65 are readmitted within one year (Funarow & Peterson, 2009). A Joanna Briggs systematic review (Slyer, Concert, Eusebio, Rogers & Singleton, 2011) determined that nurse led transitions of care interventions can reduce the rate of readmission for patients with heart failure. In addition to the biopsychosocial evidence for management of heart failure, students should be familiar with the evidence to support transitions of care for chronically ill patients with heart failure.

Technology and Information Literacy Competencies

- Integrates appropriate technologies for knowledge management to improve health care.
- Translates technical and scientific health information appropriate for various users' needs.
- ❖ Assesses the patient's and caregiver's educational needs to provide effective, personalized health care.
- ❖ Coaches the patient and caregiver for positive behavioral change

Information systems are not typically connected across settings or within a system e.g. acute care to home care or long-term care, and each setting requires unique databases and documentation (IOM, 2003). Jencks (2010) states that the primary uses for Information Technology (IT) are to transmit information, assess risk, educate patients, involve the patient and family in the plan of care, and provide real time information to providers. Coleman (2011) and others recognize that communication across settings is central to achieving quality transitional care. A large scale study within the Veterans Health Administration demonstrated that technology can improve medication adherence, medication reconciliation, patient monitoring, communication strategies, and risk assessment. The study also demonstrated fewer hospitalizations and ER visits, increased patient satisfaction, and decreased costs (Darkins et al., 2008). Patients and caregivers may be more connected to the care process with the use of technology which offers improves education and management of their overall health (Center for Technology and Aging, 2010).

Federal guidelines aimed at promoting the meaningful use of health information technology were recently implemented (Coleman, 2011). In 2009, President Obama signed the Health Information Technology for Economic and Clinical Health (HITECH) Act, as part of the American Recovery and Reinvestment Act (ARRA). Under HITECH, the government financially rewards physicians who purchase and make meaningful use of electronic medical records (EMRs). Starting in 2015, providers are expected to have adopted and be utilizing EHRs in compliance with the meaningful use requirements (Buppert, 2010). NPs and other advanced-practice nurses were not included in the HITECH legislation but will be involved in the use and expansion of any technology. NP students need to be comfortable with each of the primary uses of IT that support evidence based care, quality, and safety.

The NP student may feel comfortable in the “coaching” role based on past nursing experience. Coaching is an expected and essential NP competency in order to empower patients and families to manage self care and remain out of high cost settings. Coaching provides an opportunity to evolve traditional patient/provider relationships and motivate patients toward behavior change. Students should be encouraged to strengthen positive patient behaviors that are supported by technology including personal health information files, updated medication lists, involvement in support networks, or improved communication with providers.

Policy Competencies

- Demonstrates an understanding of the interdependence of policy and practice.
- Analyzes ethical, legal, and social factors influencing policy development.
- Analyzes the implications of health policy across disciplines.

It is essential for NP students to be aware of policy changes that affect quality, cost and specific transitional care efforts. Increased complexity of care, chronic disease and the aging population are shifting the way medical care is organized from incident-based care to episode-based care resulting in major change in how that care is paid for. The legislative mandates and reimbursement structures of the Patient Protection and Affordable Care Act (ACA) (2010) encourages health care systems to move away from the fragmented fee-for-service care, to bundled and coordinated care, reimbursed on the basis of quality and not volume (Keith, Lucia, & Corlette, 2013).

The ACA authorizes 5 year bundled payment pilots for Medicare and Medicaid which make single payments for an episode of care, e.g. a hip fracture. The bundled payment is shared among all providers promoting an incentive to work together to ensure that patients receive all the services they need including hospital and follow up care. The bundled payments will inherently support the use and cost of transitional care services (Health Policy Brief, 2012). Bundled payments will go to Accountable Care Organizations (ACOs), groups of providers, hospitals, and other health care organizations that create one entity. When the ACO succeeds in delivering high-quality care and reducing costs, it will share in the savings with Medicare. As of January 2013, more than 250 Medicare-related ACOs exist, covering nearly 4 million Medicare beneficiaries (DeCamp, 2013).

The Patient-Centered Medical Home (PCMH) is another innovative program for improving primary care. Standards describe specific criteria for primary care practices to collect data and share information in order to provide patient-centered care, work in teams, and coordinate and track care over time. Requirements include improved access and communication with patients, patient tracking, care management, electronic prescribing, referral tracking, patient self management and performance reporting and improvement (National Center for Quality Assurance (NCQA), 2012).

The ACA also includes a 200 million dollar grant to increase the number of APRNs trained in care transition services, chronic care management, preventive care, and primary care to support Medicare patients (Health Policy Brief, 2012).

Health Delivery System Competencies

- Minimizes risk to patients and providers at the individual and systems level.
- Evaluates the impact of health care delivery on patients, providers, other stakeholders, and the environment.
- Collaborates in planning for transitions across the continuum of care.

Errors from poor communication among health care providers profoundly affect quality of care. Fifty percent of medication errors and 20% of harmful adverse drug events (ADEs) occur at transition points in care because of poor communication among health care providers (Mayhew, 2010). Common transition points in care are admission or discharge to an ER or hospital, home care, or long term care, and visits to specialists, or changes in primary providers. Physicians typically receive a hospital discharge summary for their patients only 12-34 percent of the time prior to post discharge visits. Even when discharge summaries are received, they lack test results, treatments, discharge medications, and follow-up plans. (Kripilani, 2007) Primary providers no longer visit patients when hospitalized because care is managed by hospitalists. Although that change of provider has improved quality, it has led to an increased need for care coordination and communication.

Understanding the acute care health utilization patterns of patients is critical to design systems to address the needs of unique groups of patients. An additional level of care is required for populations who are considered to be at risk for poor outcomes. Vulnerable community dwelling persons have been defined as individuals at increased risk of death or functional decline (Saliba et al. 2001). Older adults are particularly vulnerable as they are more likely to have a new diagnosis, symptom, or sudden change in health status and require significantly different supports and resources to prevent poor outcomes (Coleman et al. 2004; Naylor, 2004). Some of the most vulnerable groups include seniors who are ethnic minorities or recent immigrants (Graham, Ivey and Neuhauser, 2009). Specific recommendations have been made for other diverse groups of patients including children with diabetes, (Faulkner, 2003), high risk neonates (Brooten et al. 1988), and pediatric heart transplant patients (Anthony et al. 2009).

Patients with dementia have a much higher risk for poor outcomes than other patients. Patients with cognitive impairment are more likely to be discharged to a nursing home and are less likely to regain their preadmission level of function (Maslow & Mezey, 2008). Hospitalized patients with dementia have distinctly worse outcomes including re-hospitalization, higher mortality, longer lengths of stay, and higher costs (Sparks, 2008). Students should identify other groups of patients who require additional levels of transitional care based on their high risk status.

Patients and Families as Members of the Team

In order to create a culture of safety, organizations and providers must include collaboration with patients, and families. (Angood et al., 2010). Involvement of patients and families is essential to any attempt to improve the quality of transitional care. Patients should be

encouraged to state their values and preferences, and providers must honor these preferences which can include the intensity of services they receive, or the settings in which they receive them. Patients should not only have access to their care plan, they should be considered as members of the team with the ability to change the plan of care. NP students need to actively educate patients and families about what to expect during transitions of care, and about individual provider responsibilities during those transitions.

Health care systems must focus on decreasing the human cost of the hospitalization experience, as well as the economic and resource requirements. NP students need to evaluate the knowledge base, potential risk factors, and preferences for care for their patients and families.

Ethics Competencies

- Applies ethically sound solutions to complex issues related to individuals, populations and systems of care.

Pronovost and Vohr (2010) state that we have a moral obligation to work together to improve care for patients. Lack of accountability during transitions of care is a complex ethical issue. In most health care transitions, there is no identified individual accountable for patients once they leave a particular setting, nor is there an identified individual responsible for care across settings. Patients making transitions have a right to understand which professional is accountable for their care at all times. The Transitions of Care Consensus Policy Statement states that the sending care team should maintain responsibility for the care of the patient until the receiving care team has reviewed the goals for care and transfer information, clarified questions or concerns, and acknowledged responsibility (Coleman, 2011). Students need to determine if this accountability policy is implemented in their sites of care.

Additional ethical concerns include the patient's decisional capacity and the involvement of family members in decision-making. Discharge planning from most sites of care is determined by the interaction of diverse interests including the discharge planner, the medical staff, patients and families, reimbursement structures, and availability of beds. Frail or exhausted patients may not participate in decision making related to discharge and it is likely that unintentional and unrecognized interactions may restrict patient's choices and control over decisions. The ethics of transitions of care needs to be included in any Ethics curriculum

Independent Practice Competencies

- Manages the health/illness status of patients and families over time
- Provides patient-centered care recognizing cultural diversity and the patient or designee as a full partner in decision-making

- Works to establish a relationship with the patient characterized by mutual respect, empathy, and collaboration.
- Creates a climate of patient-centered care to include confidentiality, privacy, comfort, emotional support, mutual trust, and respect.
- Preserves the patient's control over decision making by negotiating a mutually acceptable plan of care.

The independent practice competencies which reflect patient centered care and the nurse practitioner/patient relationship is the most essential component of transitional care. Qualitative researchers have found that patients with multiple medical problems are anxious to experience person centered care consisting of “knowing and being known” (Bayliss, Edwards, Stiner and Main, 2008, p.290). Patients want to understand their problems and choices and desire a relationship with a health professional that understands and respects their values. Shared decision making of clinicians with patients and families is essential to safe care and to understand the patient's experience of care (Hurtado, Swift & Corrigan, 2000). Comprehensive, accurate data at the time of patient transition is essential to support clinical problem solving and decision making that enhances function and quality of life. Medical treatment that is not intrusive and supports function and quality of life reflects appropriate clinical problem solving and decision making.

Transitional Care Clinical Experiences

Traditional NP role responsibilities, settings, and boundaries are blurred or no longer exist. APRNs will be asked to adopt new, broader roles across a wider variety of practice settings. Effective implementation of new delivery models, such as medical homes and ACOs, which provide chronic disease management and transitional care, requires the establishment of interdisciplinary teams in which APRNs provide a range of services including case management and health and illness management. Medical homes and ACOs are rapidly expanding, utilize increasing numbers of NPs, and are available for student NP clinical experiences.

Students should evaluate the quality and components of transitional care in each assigned clinical setting, including the use of evidence based models or tools. They should be responsible for phone follow up for all of their assigned patients. An assignment to follow one chronically ill patient over several semesters would allow the student to understand the importance of education and collaboration with patient, family, specialty providers and other members of the team. Opportunities to promote team-based care, both within and across providers, should be explored by faculty and students.

Conclusions

NP students must be prepared to assume leadership roles to support and coordinate quality transitional plans of care for high risk patients. Well informed academicians and nurse researchers are critical to the education of competent NPs who are prepared to lead the effort to provide transitional care and implement major policy changes. Students need to have clinical experiences and classroom discussions that increase their awareness of complex patient and system level factors that occur during transitions of care. High risk, vulnerable patients reflect the true necessity for transitional care and will increasingly be the focal point of practice for NP students and expert clinicians.

This discussion has focused on an integration of transitional care knowledge for NP students. Defining attributes of transitional care are essential components of NP core competencies including ethical care, accountability, and the evolving plan of patient centered care with an awareness of individual values and goals. Additional attributes include interdisciplinary collaboration and ongoing communication, expert problem solving and decision making to prevent adverse outcomes, and the use of evidence based models and tools.

Keywords nurse practitioner core competencies; transitional care; transitions of care; collaboration; coordination; person-centered care; evidence-based models

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Additional Resources

Care Transitions InterventionSM
<http://www.caretransitions.org>

The Bridge Program
<http://hmprg.org/programs-projects/illinois>

GRACE Geriatric Resources for Assessment and Care of Elders
<http://medicine.iupui.edu/IUCAR/research/grace.asp>

Guided Care[®]
<http://www.guidedcare.org/>

Hartford Institute for Geriatric Nursing
APRN Faculty Resource Center
Case Study: Transitional Care for the NP
<http://consultgerirn.org/aprncenter>

QSEN
<http://www.qsen.org/competencies.php>

The Transitional Care Model
<http://www.transitionalcare.info>