Development of an Educational Tool: Transitional Healthcare Planning in the Community Setting

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Disclosure

• Sharon C. Jones DNP RN – no conflict of interest

• Learner Objectives:
  – Identify need for educational tools
  – Identify Transitional Nursing History assignment components
  – Determine potential applications for TNH tool within clinical teaching areas

• Employer: Vanderbilt University School of Nursing
Establishing Aims for the 21st-century Health Care System

- Safe
- Effective
- Patient-centered
- Timely
- Efficient
- Equitable

IOM, 2001
IOM Rules for Redesign

- Care is based on continuous healing relationships
- Care is customized according to patient needs and values
- The patient is the source of control
- Knowledge is shared and information flows freely
- Decision making is evidence-based
- Needs are anticipated

IOM, 2001
Key Areas Necessary to Change the Healthcare Delivery System

- Use of information technology
- Payment policies
- Development of best practices, decision support tools, and an accountability system
- Professional education and training

IOM, 2001
Care Transition Definition

“Describes a continuous process in which a patient’s care shifts from being provided in one setting of care to another, such as from a hospital to a patient’s home or to a skilled nursing facility and sometimes back to the hospital.” (Health Affairs, RWJ Foundation, 2012, p. 1)
Impact of Poor Care Transition

• 1 in 5 Medicare patients discharged from a hospital are readmitted within 30 days – cost of $26 billion per year (CMS, 2016)

• 2011 Inadequate care coordination - $25-45 billion is wasteful spending (RWJ, 2012)

• Uncoordinated care resulted in 75% higher cost compared to matched patients with coordinated care (Owens as cited in IOM, 2010)
Root Causes of Ineffective Transitions of Care

• Communication breakdown
  ▪ Expectations between senders/receivers of patients in transition
  ▪ Culture does not promote successful hand-off
  ▪ Inadequate amount of time provided
  ▪ Lack of standardized procedures (SBAR, etc.)

• Patient education breakdown

• Accountability breakdowns

The Joint Commission, 2012
The Value of Nursing Care Coordination: A White Paper of The American Nurses Association

- ANA’s Scope and Standards of Professional Practice and ANA’s position statement, The Nurses’ Essential Role in Care Coordination, should be foundational documents for nursing education related to care coordination.

- **QSEN competencies** should be incorporated across pre-licensure and graduate nursing programs, with specific curriculum components to promote RN and APRN competencies related to care coordination.  

  ANA, 2012
Literature Search

(transitional care[tiab] OR transitional health care[tiab] OR continuity of care[tiab]) AND (nursing students OR nursing education OR nursing schools)


Results seem to improve greatly by removing the terms, 'community health nursing' and 'continuity of [patient] care'.
Nursing Curriculum

• 14 articles identified: 1 nursing curriculum
• Pilot study; 20 senior nursing students
• Utilized concept based learning methods (on transitional care and practice environment), did performance improvement projects (30-40 hours), had integrated post conference and learning reflections

Mood, 2014
Common Themes in Literature

- Individual focused care planning
- Patient/caregiver/family education
- Empowerment
- Medication reconciliation
- Discharge planning role ambiguity
- Home health important role

Bray-Hall, 2010; Schoenborn, 2013; Arbaje, 2014
VUSN PreSpecialty Program

- Accelerated BSN equivalent component of an MSN program
- Three semester (fall, spring, summer) for Community Health
- Approximately 140 students/academic year
- 18 Community Health Clinical Sites
Bridging the Gap Between Education and Practice
Need for Transitional Nursing History (TNH)

- Recognition of the personal and economic impact of ineffective care transitions
- Identified gap in the curriculum to assess transitional needs of patients
- Recognize the need for nurses to be an active part of the transition process
TNH Objectives

Provide students with the opportunity to identify Determinants of Health factors and their rationales related to transitioning clients from the hospital to home.

Enable students opportunities to build upon their community assessment and prioritize healthcare needs for clients (and their families) returning to the community setting.
TNH Process

• The patient is chosen from the student’s inpatient clinical rotation

• Patient at risk for issues/complications when transitioning out of the hospital.

• For the assignment, plan the transitional care as if patient is returning to the community for their assigned community health clinical
TNH Process

• Incorporated Determinant of Health (DoH) concepts into inpatient clinical Plan of Care (PoC) assignment
• Students provided time during inpatient clinical to ask additional TNH tool questions
• Student identified key DoH concepts per the 5 DoH categories, based on assessment
Determinants of Health (DoH) Framework

- Biology and Genetics
- Social DoH: Social Aspects
- Social DoH: Physical Aspects
- Health Services
- Individual Behaviors

https://www.healthypeople.gov/
TNH Components

- Biographical Data
- Past Medical History
- Family History
- Psychosocial History
- Cultural/Spiritual Health
- Environmental Health
- Pharmacology Data
- Laboratory Data
TNH Components

• Biographical Data:

BMI
Identified caregiver
Client and/or caregiver instructed about home care (meds, txs, ambulation and transfers, pain control, S&S of problems/reasons to call HCP, resources, etc.)

• Past Medical History:

Mental health diagnosis, dental, vision,
Does your current insurance coverage meet your healthcare needs? (Y/N) If not, do you care to explain?
TNH Components

• **Family History:**
  Draw a genogram with your client with 3 family generations

• **Psychosocial History:**
  Support systems?

  Traumatic/grief experience?
  Does client feel safe?
  Food desert?
  Transportation methods?
  Tobacco/alcohol/illicit drug usage?
Family Genogram
TNH Components

- Cultural/Spiritual Health
  - Client’s definition of health?
  - Likert scale 1-5 rating spiritual needs in healthcare plan

- Environmental Health:
  - Client feels safe in community?
  - Length of time in residence(s)?
  - Work exposures?
  - Community exposures?
TNH Components

- **Pharmacology Data:**
  Implications for effective home management?

- **Laboratory Data:**
  Implications for effective home management of abnormal lab values?
Data Synthesis: The So What?

Based on the information for each section, what are the additional considerations for the caregiver/family related to transition to home/community?
Data Synthesis

• Primary Prevention
  – Nutrition adequacy, preventative medical care, tobacco/ETOH/drug usage

• Secondary Prevention
  – Periodic health exams, self-exams, screenings

• Tertiary Prevention
  – Access to medical services, protocol for diagnosis, adherence
Concept Map Components

• Problem/Concept/Nursing Diagnosis related to the Determinant of Health category
• Supporting Data
• Education for patient/caregiver/family
• Expected client outcome at 48 hours and 30 days
• Intervention/s to promote successful transition
• Evaluation methods/tools at 48 hours and 30d
TNH - Social DoH

Concept: Risk for Depression

Related DoH: Social determinants

Supporting Data: JW would be an easy target for bullying at school r/t being very thin, white child (the minority in the community), Mickey button, grades may be low due to ADHD. More dangerous to be outside due to crime and violence. Due to relative food dessert may find it difficult to meet goals set by providers and to have access to food he wants to eat. Schools may not understand child with ADHD or how to adapt teaching skills. Mom may not feel safe letting JW go play at classmate’s houses. (Wouldn’t see his girlfriend in Powell)

Education for patient/caregiver: Teach caregiver the importance of safe social interaction for JW, the importance of play for children even at age of 8. Teach caregiver the importance of exercise, sleep, and nutrition to be happy and not feel depressed. Teach signs and symptoms of depression: irritability or anger, social withdrawal, change in sleep, headaches that don’t go away, thoughts of suicide.
TNH – Social DoH

ECO at 48 hours: Patient will not show signs of depression.

ECO at 30 days: Patient will not show signs of depression and will exercise minimum of 3 times/week-soccer, basketball, running or whatever he likes to do. Document in food journal.

Intervention: SN will teach/provide times of Napier elementary after school programs and directions to nearest YMCA since they do have a car for transportation. Make goal to exercise 3 times a week for minimum 30 minutes.

Methods/tools applicable for evaluation at 48 hours: During scheduled phone call to check on G tube feeding, use the Center for Epidemiological Studies Depression Scale for Children (CES-DC) only takes 3-5 minutes to assess depression

Methods/tools applicable for evaluation at 30 days: At 1 month appointment with PG clinic at Vanderbilt check food/exercise journal to see how much he is exercising and use the Center for Epidemiological Studies Depression Scale for Children (CES-DC) to screen for depression.
Concept Map Discussion

Medical Dr: Acute Appendicitis

Overweight

Primary Nursing Diagnosis:
At risk for ineffective coping

Biology & Genetics
Concept: At risk for obesity
BMI: 23.2
picky eater
doesn’t play outside
9 years old

Individual Behaviors
Concept: At risk for ineffective coping
Client will be changing schools
Concrete operational stage of cognitive development
Educate parents on SIB’s
Childhood depression
Client can utilize 3 methods of coping

Social Doll: Social
Concept: At risk for inadequate socialization
“I don’t have many friends”
“industry vs. Inferiority” stage of development
Encourage school/community program involvement

Social Doll: Physical
Concept: At risk for decreased nutrition and physical activity
Community is “Red Desert”
Lack of knowledge/autonomy on food choices
Transition from rural to urban limited parks, safe sidewalks

Health Services
Infestation risk
Need back to school nurse, educate about hand washing

Vanderbilt University School of Nursing
Concept Map Grading

Original plan of care from inpatient clinical sent to faculty

Discussion with Community Health Clinical Group
- Background
- Assessment
- Concept Map
- Pearl of Wisdom
- Verbal Analysis Connecting Concepts
- Facilitation of Group Discussion
Student Feedback

• “The Transitional Plan of Care was helpful and really made me think through the needs of the patient I had.”

• Knowledge and application of community resources and barriers to promote successful transition

• Greater appreciation of the impact related to medication management and abnormal laboratory values on successful transition
Student Feedback

• Transitional Nursing History provides template to assess Determinant of Health factors that impact health outcomes

• Concept map enabled active learning in community health clinical groups

• Concept map visually demonstrated the interconnectedness of DoH factors on health outcomes for patient/caregiver/family unit
Student Reflection

• “I knew going into healthcare that I wanted to approach it from a biopsychosocial model, and I believe that both community health and N247 have given us the opportunity to begin to understand how to approach and practice that model. In other words, these clinical experiences have given me the opportunity to begin to discover my own personal approach to holistic care, and also expand my knowledge on what I can and cannot do as a nurse.”
Faculty Feedback

• Inpatient Clinical Faculty: increased awareness and comprehension for the patient/family needs as they transitioned from inpatient to outpatient settings

• Community Health Faculty: increased appreciation/knowledge of community resources
Recommendations for Implementation

- Program director support
- Course coordinator collaboration
- Concept map promotes active student learning
- TNH assignment/discussion in community health rotation
Potential Applications?

How do you think this tool might be used in your clinical setting with students?
References


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