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Patient Engagement in Transitional Care

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University of San Francisco

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Abstract

The Clinical Nurse Leader Master's project was conducted about a public health program called the Transitional Care Program that was working in partnership with a county hospital system, Santa Clara Valley Medical Center. The specific aim was to reduce hospital re-admissions of high-risk patients by supporting patient motivation and engagement in the Transitional Care Program by May 2015. Over a four-month period, data was collected through ten client visits, interviews with two public health nurses, information available about the program, and current research conducted on transitional care, hospital discharges, and patient engagement. Various aspects of the program were assessed, such as the general microsystem relationships, stakeholders involved in the program, the patient population at risk for re-admissions, and processes of the program. Findings identified weaknesses and strengths of the microsystem and challenges that decrease that ability of the program staff to prevent re-admissions into the hospital system. Evidence-based research collected highlighted communication as a pain point in transitional care practices. Focus of project development was aimed at the nurse-patient relationship in transitional care, and a communication tool was developed to engage the patient in goal development and decrease the risk of hospital re-admissions. This tool was presented to the program staff for review and approval of testing with clients. Implementation of the communication tool was used with two client cases and at the close of each case, the patient will be asked to fill out a survey about the use of the communication tool related to their transitional care experience. Evaluation data to be collected include the number of urgent care visits, goals accomplished as stated by the patient, and incidents of re-admissions to the hospital.

Project Prospectus:

Patient Engagement in Transitional Care Improvement

By Sheeree C. Dela Pena, RN

Specific Aim: We aim to reduce hospital re-admissions of high-risk patients by supporting patient motivation and engagement in the Transitional Care Program by May 2015.

Background: The Transitional Care Program is a Public Health Program of Santa Clara County and was developed to operate within the community in partnership with Santa Clara Valley Medical Center and Ambulatory Care. This is a non-profit program and receives funding from Santa Clara County. The services are offered to patients free of charge and participation is voluntary. Patients from the hospital system are identified based on their risk for re-admissions by physicians and referred to the program for follow-up and support from Public Health Nurses (PHNs) during transitional care. Patients enrolled in the program receive individualized nursing care management and resources to help patients as they transition between hospital discharge and back into the home environment. The Transitional Care Program staff consists of a program manager, two PHNs, a program coordinator, and two public health assistants.

Supportive Data: Data was collected from interviews with staff and observations during home visits from February through March 2015. A Fishbone diagram developed (Appendix A) indicates multiple areas within the microsystem that contribute to patient re-admissions or emergency room visits. These areas include issues that are within the Transitional Care Program, the processes of the program, the barriers of the patient population, and the challenges with the discharge process from the hospital. The issues circled in red highlight the areas challenges are present within these areas. The Flowchart Map (Appendix B) is a focused assessment of the Transitional Care Program processes, beginning from when the patient is identified and referred to the program. The services provided by the TCP are indicated with reported challenges that the PHN faced, indicated in red text.

Microsystem Status Relative to the Project: The SWOT Analysis (Appendix C) indicated many issues to address, some of which will improve with the addition of new staff. A major strength are the multiple resources available to the population of interest. Therefore, the focus on this project is in motivating patients and providing resources to reduce re-admission. The Stake Holder Analysis (Appendix D) describes the patient as being under-involved and with varied levels of interest in the program.

Summary of Evidence: The key words "transitional care program" and "readmission prevention" were used to yield results with dates ranging from 2010-2015.

Databases Used: The search for evidence was completed using CINHAL, Google.com for national organizations, and on the Joint Commission's Transition of Care Portal

articles.

LaMantia et al (2010) argue that strategies related to communication to improve transitional care are lacking and discuss interventions that are effective in facilitating transitional care. Some interventions discussed include a standardized communication tool, pharmacist-led medication reconciliation, and discussion of warning signs for emergent care.

Li et al (2014) identifies models for best practices in transitional care that can be utilized as current interventions and provide support for improved outcomes. Evidence-based national models of best practices identified are Project BOOST, Project RED, The STAAR initiative, and The Care Transitions Program.

Shamji et al (2014) provide research that supports guidance on the development of an intake tool that can be used to enhance communication between the PCP and the urgent care center during transition of care.

Theoretical Direction: The Theory of Goal Attainment by Imogene King establishes that interpersonal relationship with patients are dynamic, and provide support to enable the patient to grow and develop to attain life goals. King's theory includes consideration of factors such as roles, stress, space, and time--all of which that impact the progress of goals in a transitional care setting. A communication tool used by the public health nurse and the patient will increase patient engagement and motivation. This will establish the nurse-patient relationship and goal attainment during transitional care.

Stakeholders: The Stakeholder Analysis (Appendix D) provides another view of the microsystem. The aspect of "interest" as indicated in the 3rd column reveals a difference from the patients as compared to all other groups involved in the Transitional Care Program. The patients have a varied level of interest in the program, which can be either low or high. This factor greatly affects outcomes of efforts of the public health nurses to assist the patients in transitions from the hospital after discharge, and ultimately affecting the risk of re-admission to the emergency room or re-admission into the hospital.

Business Case: According to the Alliance for Home Health Quality and Innovation, the estimated cost for one re-admission is $33,000. This cost is significant because nearly 1 in 5 Medicare patients are re-admitted within 30 days of discharge from the hospital (Rennke, et. al., 2012). Hospitals are also invested in transitional care interventions because the Centers for Medicare & Medicaid Services impose financial penalties of up to 1% of Medicare reimbursements for high re-admission rates (Rennke, et. al., 2013). The wage of the Public Health Nurse in Santa Clara County can range from $45.00 to $50.00 per hour. In 220 hours of time with the Transitional Care Program, the cost for a CNL working on the development and implementation of the communication tool is estimated to be about $9,900. The material cost of the project would require printing costs of the communication tool. It is estimated that the total number of open cases for the Transitional Care Program over the year estimated at 60-70 patients. To print a supply for one year, 100 colored sheets of the Communication Tool would cost about $200.00.

According to Public Health Department, for every four patients enrolled in the program, one hospitalization is avoided. If the intervention implemented can prevent another re-admission to the hospital, the benefit in hospital cost savings would be $21,000.

Methods: A communication tool was recommended to enhance communication between the nurse and client related to goals for transitional care. The goal of the tool is to increase patient engagement and motivation through a communication intervention. The communication tool will be used by the PHNs during home visits with the client. The client and the nurse will work together to fill out sections of the tool, such as the issues discussed, topic specific goals, and when to call for help (Appendix E). The tool will be kept by the client and updated each visit with the nurse to assist with the transition of care.

Steps for Implementation: The Timeline (Appendix F) indicates that the microsystem assessment and data collection began in January 2015. During February, data collection and research was reviewed and provided support for project direction. In March and April, a communication tool was developed to improve and coordinate nurse patient interaction. The communication tool will be presented to the program team members to be approved to implementation with current client cases.

Evaluation: Data will be collected in qualitative form, through the feedback from the public health nurse and the patients. A short questionnaire will be present and include questions about the ease of use of the tool, if it enhanced understanding of health care plan, and if communication was established. In terms of quantitative data, information about how many patients actually used the tool and continued tracking of emergency readmissions as compared to historical data.

Results: On April 23rd, the final presentation of the project and the communication tool was presented for the team to review and approve. Participants of the meeting were the program manager, my preceptor, the program coordinator, and three PHNs were present. PHNs whom worked in the field offered feedback for format and content, and the revisions were incorporated into a final approved version fro testing with a client. The program director provided enthusiastic feedback that the tool may be given to the client with a promotional magnet of the Transitional Care Program. The presentation was sent to the Public Health Department Nursing Director, and she requested to use some of the informational slides of the presentation to help train future PHNs. The communication tool was implemented with two client cases. The source file of the communication was provided to the Transitional Care Program at the request of the program director.

Outcomes: The two cases in which the communication tool was implemented were very different from one another. For the first case, the tool was better suited for use with the caregiver of the patient, because the patient was conserved and unable to make medical decisions for herself. This client case was dynamic and related to caregiver role stress and medical needs of the patient. The second patient was successfully received and utilized by the patient and his family. The patient filled out the communication tool with assistance and kept the tool for consecutive home visits for updates. The PHN of the

program have not been required or expected to utilize the communication tool at this time.

Recommendations: Continue to implement the communication tool with select client cases. At the close of each case, the patient can be asked to fill out a survey on about the use of the communication tool related to their transitional care. Additional data to collect include the number of urgent care visits, goals accomplished as stated by the patient, and incidents of re-admissions to the hospital. Following significant collection of data, the CNL can present the findings the Transitional Care Program staff to recommend implementation of the communication tool with all clients.

References:

King, C. R., & Gerard, S. O. (2013). Clinical Nurse Leader Certification Review. New
        York: Springer Publishing Company.

LaMantia, M.A., Scheunemann, L.P., Viera, A.J., Busby-Whitehead, J., and Hanson, J.C.
        (2010). *Interventions to Improve Transitional Care Between Nursing Homes and*
        Hospitals: A Systematic Review. Journal of the American Geriatrics Society.
        58:777–782.

Li, J., Young, R., Williams, M.V., (2014). *Optimizing transitions of care to reduce re-*
        hospitalizations. Cleveland Clinic Journal of Medicine. 18-5.

Nelson, E.C., Batalden, P.B., & Godfrey, M.M. (2007). *Quality by Design: A clinical*
        microsystems approach. San Francisco, CA: Jossey-Bass.

Nursing Theory – Goal Attainment. (2013). Retrieved from http://nursing-
        theory.org/theories-and-models/king-theory-of-goal-attainment.php

Rennke, S., Nguyen, O.K., Shoeb, M.H., Yimdriuska, M., Wachter, R.M., Ranji, S.R.,
        (2013). *Hospital-Initiated Transitional Care Interventions as a Patient Safety*
        Strategy: A Systematic Review. Annals of Internal Medicina. 158:5.

Shamji, H., Baier, R.R., Gravenstein, S., Gardner, R.L., (2014). *Improving the Quality of*
        Care and Communication During Patient Transitions: Best Practices for Urgent
        Care Centers. The Joint Commission Journal on Quality and Patient Safety. Vol.
        40-7.

Appendices

Appendix A

Fishbone Diagram of the Transitional Care Program
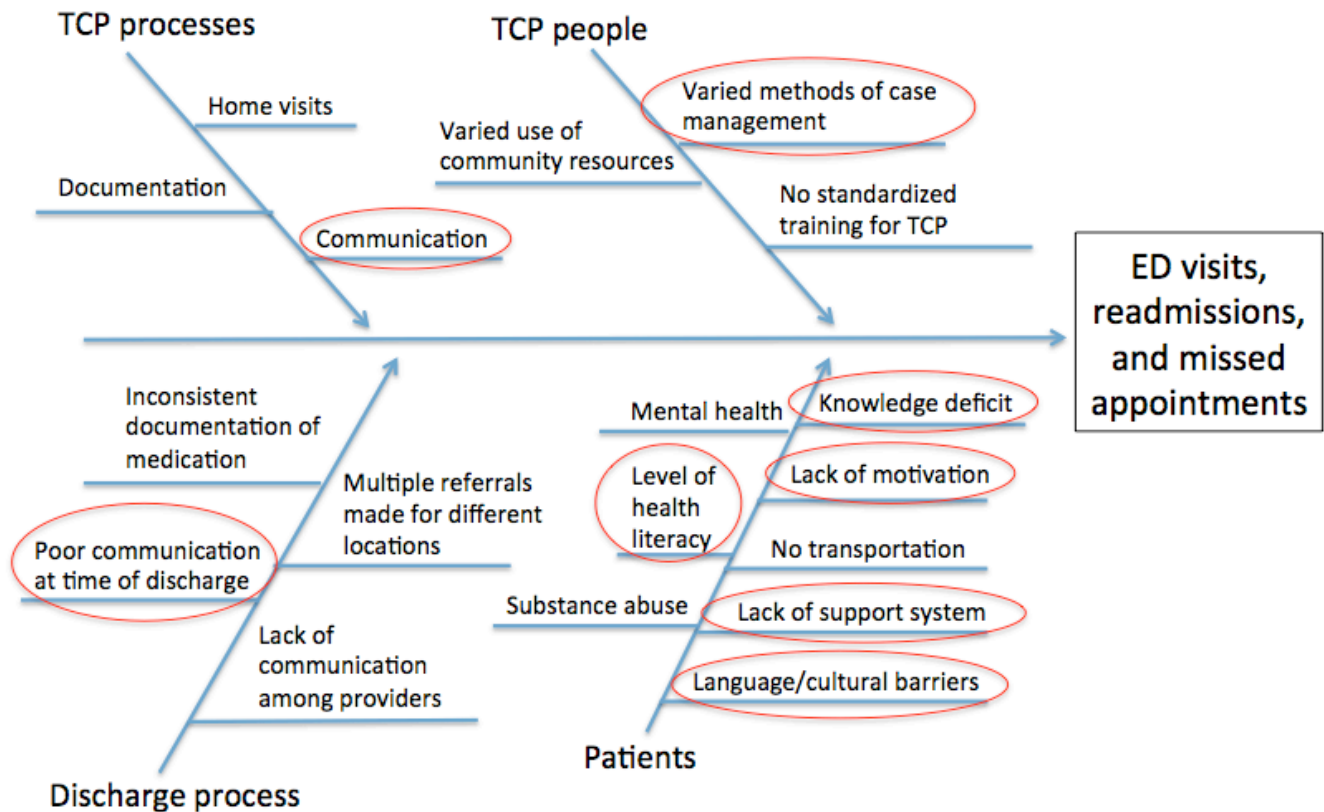
Appendix B

Transitional Care Program Process Flowchart

Referral of Patient to TCP → RN reviews patient charts and care needs → RN visits patient in home and completes assessment

Text indicated in red are problems that decrease the success of services.

Medication reconciliation
No PCP or multiple PCPs
Meds not reconciled at DC
Poor health literacy
Non-compliance
↓
Patient education
↓
Follow up on adherence to medications

Discharge referrals are coordinated
Multiple specialists
Missed appointments
Non-compliance
↓
Address barriers to health services
↓
Coordinate with other providers to ensure delivery of care

Patient barriers
Cultural and language barriers
Transportation
Non-compliance
Lack of motivation
Lack of support system
↓
Provide resources to address needs
↓
Evaluate outcome of resources used and additional needs

GOAL: Reduction of emergency room visits and increase in attendance of clinic appointments

Appendix C

SWOT Analysis of the Transitional Care Program

STRENGTHS	WEAKNESSES
• Collaborative efforts and communication among specialists, physicians, public health nurses, and case mangers • Shared vision and goals for patient and financial outcomes • Single shared EMR system between SCVMC, Ambulatory Care, and the Public Health Department • **Vast resources available to residents of Santa Clara County** • Physician support and referrals from SCVMC	• Small amount of staff to meet increase of incoming referrals • Limited structure in training for processes and public health nurses • Physical and mental health complexity of the patient • Varied approaches to case management
OPPORTUNITIES	THREATS
• Development of existing staff through training • Increased capacity to provide services by hiring of two more PHNs • Increased awareness of TCP among inpatient nursing staff	• Loss of funding • Loss of staffing • Loss of physician support • Poor communication among providers • Challenges with financial resources and insurance

Appendix D

Stake Holder Analysis of the Transitional Care Program

Stakeholder	Organization	Interest	Influence	Expectations	Problems/Constraints	Potential
Patients	The Community	Low or High	High	To receive support for health care	- Lack of motivation - Social and economical barriers - Perception about ones' own health - Poor health literacy - Complex health needs	To improve health outcomes and manage health needs successfully
Physicians	Santa Clara Valley Medical Center	High	High	To provide quality healthcare that will prevent readmissions	- Patient noncompliance - Discharge planning incomplete - Re-admissions has financial implication on hospital	To improve patient care and decrease the risk of complications with health
Public Health Nurses	Public Health Department	High	Low to Medium	To facilitate resources and support to patients	- Large caseload of patients - Inadequate discharge planning/process - Limited resources to provide support - Poor patient compliance	To enable patients to manage medications, appointments, and self-care
Specialists	Ambulatory Care	High	Medium	To provide treatment in outpatient clinics and follow up with patient	- Poor patient compliance - Complexity of patient care - Fragmented care with PCP	To provide patient care for complex health conditions

Appendix E

Sample of the Communication Tool Project

TRANSITIONAL CARE PROGRAM

Santa Clara County
PUBLIC HEALTH

My public health nurse is:	Sheeree RN, 408-123-4567

Plan for Transitional Care

Health concerns	Marie needs more care at home for rectal prolapse She needs a follow up appt with her PCP Status of nursing home placement
Goal for my medications	I will tell the staff if I am in pain (biopsy wound)
Goal for my appointments	I will attend my appointments
Goals for my safety	I will tell the staff if I fall I will call the staff if I need help
Goals for my diet	I will not drink soda or eat candy

When to go to Urgent Care:	Incision: increased redness, more drainage, more pain, fever

TRANSITIONAL CARE PROGRAM

Date of visit	Issues discussed	Next steps
4/14/15	Schedule appt w MD Request script for Tylenol Nursing home status	Schedule MD appt at 408-885-1234 PRN form for Tylenol to B&C PHN will call Kim about SNF
4/22/15	Nursing home status Pt not going to appts	PHN will call Kim re: nursing home and pt status

Appendix F

Timeline of the Transitional Care Program Project

Plan by week	February			March				April				May		
	W1	W2	W3	W1	W2	W3	W4	W1	W2	W3	W4	W1	W2	W3
Orientation	▇	▇												
Home visits, training			▇	▇	▇									
Interviews			▇	▇	▇									
Research and findings					▇	▇	▇							
Development of tools/training							▇	▇						
Presentation development								▇	▇					
Present presentation to Program Manager										▇				
Implement training and tool with patients											▇			
Surveys and evaluation											▇	▇	▇	▇