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Transitions in Care a Critical Review of Measurement

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Aim

The purpose of article is to explore how transitions in care have been operationalized and discuss how nurse managers can leverage their role in impacting care transitions.

Introduction

'Transitions in care' typically describes a change in health care as patients move between multiple care settings for example to and from the operating room or intensive care unit and most commonly refers to the time when patients are discharged from the hospital setting [1,2]. There is emerging evidence in the healthcare literature that demonstrates the existence of serious quality problems for patients undergoing transitions across multiple sites of care, especially upon discharge from acute care settings to home or other skilled care facilities [3]. Specifically, the current literature describes high rates of re-hospitalizations and ED visits as consequences of ineffective care transitions as patients are moving from the acute care environment to discharge to home or community based care [3,4].

Jencks et al. [5] review of claim data of patients discharged from the general medical service of a tertiary care hospital found that nearly 20% of Medicare beneficiaries were re-hospitalized within 30 days, and another 14% were re-hospitalized within 90 days. Furthermore, two thirds of patients who had been discharged with medical conditions were re-hospitalized or died within the first year after discharge. The necessity for re-hospitalization has been found to vary; Forster et al.'s [6] prospective study of untoward events upon discharge to home found that twenty percent of patients experienced an unexpected or adverse event in this phase of care. They describe injuries associated with laboratory abnormalities as well those that resulted in permanent disabilities. Most importantly however, they determined that many of these events could have been mitigated with simple strategic interventions.

Causation of adverse events during care transition can also tend to vary. For example, Tam et al. [7] found that two thirds of patients admitted to the hospital have unintended medication discrepancies. Furthermore many of these discrepancies remain common at discharge [4]. Compounding the presence of medication discrepancies upon discharge from hospital to home; it is rare for hospital physicians to directly communicate with community primary care physicians regarding the care trajectory and plan of care [8] which would present opportunities to reconcile such discrepancies.

Naylor's [2] research related to transitions in care upon discharge has identified that failure in communication between providers and across sites of care as well as inadequate patient and caregiver education frequently contributes to poor continuity of care and leads to unmet healthcare needs. In fact, communication failures have been noted to be at the root cause of up to 70% of sentinel events, half of which are the result of communication during a handoff or transition in care [9].

The Joint Commission [9] recognizes that ineffective transitions play a role in a majority of serious medical error and as such, implementing evidenced based strategies to facilitate effective transitions in care is a priority for acute care organizations. Greenwald's [10] analysis of hospital and patient characteristics related to untoward events and re-hospitalizations determined that, indeed, there are multiple dimensions of the hospital discharge process itself that can be improved upon and standardized. Nurse Managers are uniquely positioned to engage their staff in patient centered care strategies that measurably enhance care transitions upon admission as well as upon discharge to impact patient outcomes.

From an economic perspective, inadequate transitions in care can be quite costly. Under the Medicare Hospital Readmissions Reductions Program (HRRP) established in the Affordable Care Act, financial penalty will be imposed on hospitals with excess readmissions [11]. Nearly 13 percent of Medicare beneficiaries discharged from hospitals experience three or more provider transfers (readmission and then discharge again) often for the same health problem during a thirty- day period [12]. This movement of patients from hospitals to the community and back again accounts for an estimated $15 billion in annual Medicare spending [13]. Saleh et al. [14] determined that post discharge care transition programs not only enhanced older adults' self-management skills and abilities but also producing cost savings. Naylor [15,16] repeatedly demonstrated the economic benefits of a transitional care with implementation of the Transitional care Model (TCM), a nurse led intervention targeting older adults at risk for poor outcomes as they move across healthcare settings and between clinicians.

Transitions in care in today's healthcare environment are ubiquitous and should be viewed as high-risk endeavors in which nursing can play a major role in facilitating care. Nurses across all levels of care are ideally positioned to lead through innovation and execution of patient centered processes that enable effective transitions in care and impact health outcomes. Through scientific inquiry we can identify the salient dimensions of transitions in care that confront us. Furthermore, once identified, these dimensions can guide us as to the development of metrics that can assist managers with improving efficacy and improving patient outcomes. Careful operationalization of concepts by nursing leaders is imperative prior to engaging staff and implementing evidence based process changes.

The concept of 'transitions' has origins in the social sciences. Bridges [17] was among the first to introduce and describe the phenomena of transitions. Expanding on Bridges' work, Meleis developed Transitions

Theory [18,19], which was used to provide a framework for this review. Meleis asserts that, "Transition denotes a change in health status, or in role relationships, expectations, or abilities, it denotes changes in needs of all human systems" [19]. As changes in health status occur, Meleis urges us to consider the contextual or environmental elements that are impacting our patients during this period. "How human beings cope with transition, and how the environment affects that coping are fundamental questions for nursing" [19]. The transition itself provides the context in which the period of increased vulnerability to risk occurs [18]. As such, Meleis' perspective forces us to think more globally about our patients' vulnerabilities and the dimensions of these vulnerabilities as they intersect with the abundant complexities inherent in the health care environment. Meleis et al. [20] discuss properties of transition experiences in terms of 'process' and 'outcome indicators' that invokes a tangible phenomenon that can be measured in terms of quality [21]. Furthermore, Meleis [20] instructs us to measure the quality of the transition near 'the completion of the transition' as proficiency is unlikely to be seen early in a transition experience.

How others have operationalized and measured transitions in care

Transition in care has been operationalized and in many different ways. The American Geriatrics Society (AGS) consensus definition of transitions defines transitional care as "a set of actions designed to ensure the coordination and continuity of health care as patient's transfer between different locations or different levels of care in the same location" [12]. Coleman suggests that improving quality and safety during transitions in care are fundamentally different from improving quality or safety in a single setting [12]. He believes that the goal of transitional care is to facilitate a match between an individual's care needs and his or her care setting. Thus, instruments that measure the quality of transitions are needed.

Brock et al. [22] determined that implementation of improved care transitions for Medicare beneficiaries resulted in a positive correlation between quality improvement for care transitions in communities and re-hospitalizations. Shepperd et al. [23] analysis of data from 21 randomized control trials (RCTs) that compared individualized discharge plans with routine discharge care, determined that a structured discharge plan tailored to the individual patient resulted in a reduction in readmission rates and increase in patient satisfaction. Additionally, Allen et al. [24] systematic review of eight data bases for randomized control design studies on the quality of transitional care interventions found that transitional care interventions reported in most studies reduced re-hospitalizations. However, gaps were found in the evidence base related to patient and their family caregiver in transitional care interventions.

Moreover, existing instruments that measure the quality of care transitions are limited in their applicability to various care transitions as they tend to focus exclusively on transitions upon discharge [1,25-26].

The patient's perspective of the quality of the care transition is critical. The actual experiences of older patients and identified elements such as fear, anxiety, caregiver support, and preferences that perhaps providers may not have identified is critical. Accordingly, transitions theory through the lens of Meleis [18]; would urge us to inquire about the nature or quality of the transition in care related to the experience from the patient's perspective. Meleis would urge us to seek to qualify the patient's perception of the impact of the transition on their well-being rather than to seek to qualify the health care provider's perception of the transition in care. Meleis [18] informs us that this approach would more accurately elicit the meaning the situation has for the patient.

Meleis [18] informs us that if we are indeed to view transitions as a process, our goal should be focused on anticipating the likely points of peak vulnerability with respect to patient health needs. Meleis [18] contends that preventative interventions should occur before the transition occurs; thus discerning the dimensions of information and education, as well as coordination of care at time of discharge through measures provided by the PPE-15 is important.

Conclusion

A validated measure that captures the essential domains of successful transitions across care settings is the first step in improving transitions in care. Refining this measure for patients with specific needs and circumstances may assist with the innovation and development of interventions needed to ensure high quality care. Nursing's efforts in defining the process indicators from the patient's perspective as well as what patients care about, can identify the gaps that are present in existing measures of care transitions and bring clarity to the information that is actually required for a successful transition in care to occur. Evidenced based nurse led care interventions that bridge these gaps have demonstrated improvement in the quality of care transitions. Additionally, though not studied as extensively as transitions upon discharge, the current climate in healthcare urges us to consider our measurement of quality of care transitions upon admission to the acute care setting (or at time of change in health status) as well as upon discharge. Thus the challenge for nursing is to discern those metrics of transitions in care across settings.

Implications for Nursing

Measurement of transitions in care using a reliable and valid instrument can provide new insight for nurses and allow for the development of nurse led strategies can further bolster proven efforts to facilitate successful transitions in care and impact patient outcome. It is critical to identify the dimensions of transitions in care that are particularly salient and amenable to improvement. Such knowledge can influence and create further opportunity for innovative and advanced nursing interventions as well as influence organizational changes and environmental system factors that either contribute or confound the quality of transitions in care.

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