Nurse Led Care Transitions Interventions: A Strategy to Improve Health System Integration and Performance

CAHSPR Conference 2015
May 26, 2015

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St. Michael's
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INVESTIGATIVE TEAM

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- Ella Ferris
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Funded by the Ministry of Health and Long Term Care
Health Services Research Fund Targeted Research Competition (2014-2016)

BACKGROUND

- Patients with complex needs associated with their multiple diseases and conditions, frequently require care in multiple settings and are particularly vulnerable to poorly executed transitions in care.

- Poorly executed care transitions involving elder patients with complex care needs results in medication errors, care delays, avoidable re-admissions, and increased healthcare costs.

PATIENT AND CAREGIVERS PERSPECTIVES

- Family caregivers often perceive a lack of consistency in care provided and the absence of any organized system driving the preparation for the development of the discharge plan.
- Family caregivers tend not to be informed and/or involved in an impending discharge.
- They often experience difficulties knowing who to approach for information and advice.
- Patients' complex psychosocial needs and limited access to outpatient resources present barriers
  - Inadequate support system, unstable housing, caregiver burden, mental illness

(Bauer, Fitzgerald, Koch, 2011; Byrne et al., 2011)

HEALTHCARE PROFESSIONALS PERSPECTIVES

- Healthcare providers view poor transitions as one element of a broken healthcare system:
  - Inadequate compensation for care coordination
- Lack of standardized processes contribute to inefficiencies and chaos.
- Poor multidisciplinary communication within the hospital makes it difficult to effectively perform transitional care tasks.
- Communication across settings is fragmented, which can lead to poor patient outcomes and affect clinician job satisfaction.
- Providers experience poor quality transitions as painful and dissatisfying.

(Davis et al., 2012)

BACKGROUND

- Recent systematic reviews have identified that nurses are either leading or are an integral team member of care transition interventions.

- No comprehensive review of the literature exists on the role and impact of nurses in care transitions of complex elder patients whom are a vulnerable segment of our population.

RESEARCH QUESTION

Which care transition interventions involving nurses hold promise for improving health system integration and performance outcomes amongst complex elder patients and under what circumstances?

METHODS

Phase 1: REALIST LITERATURE REVIEW	• An iterative review that discerned what works for whom, in what circumstances, in what respects and how the intervention should be implemented
Phase 2: MODIFIED DELPHI PANEL	• A structured process that harnessed the expertise and knowledge from a group of individuals in a systematic manner through a series of questionnaires interspersed with open feedback
Phase 3: EMBEDDED CASE STUDY	• A mapping out the local contextual data to series of conclusive statements derived from literature review and Delphi panel using the following data sources: Alberta Context Tool, interviews, participant observation, and administrative data

REALIST LITERATURE REVIEW RESULTS

- **31,242** abstracts were located. After removing duplicates, **18,592** abstracts were identified.

- **379** abstracts met inclusion criteria and their full articles were located. Previously completed scoping and systematic reviews produced an additional **36** articles.

- **182** of the 415 articles were abstracted - of which 49 involved complex (two or more co-morbidities) elder patients.

MODIFIED DELPHI PANEL

ROUND 1

- Panel ranked a series of statements based on six items: 1) the theoretical underpinning of the interventions; 2) roles that nurses have; 3) components of the interventions; 4) measures; 5) contextual factors; and 6) outcomes associated with the implementation of nurse led care transition using a 9-point Likert scale.

- The scale required each statement for relevance, feasibility of assessment, and likely impact.

ROUND 2

- Face-to-face meeting with panel members where findings from the initial round presented and discussed.

- Opportunity provided to propose additional interventions and contextual factors.

ROUND 3

- Final review and ranking of statements that received an aggregate score of 7/9 or higher by panelists.

RANKED DELPHI PANEL STATEMENTS

Educate and coach about self management skills	• Educate and coach patients, their family members, and/or their care givers, where possible face-to-face, about self-management skills including how to: set clear goals for managing their complex health condition; learn to identify a change in worsening conditions and/or potential complications and how to respond; improve medication usage by ensuring they understand the medications purposes, instructions, side effects, and interactions; and navigate and make the best use of the health system for their care.
Understanding the importance of the discharge plan	• Ensure patients, their family members and/or caregivers are aware of follow-up medical appointments and understand the importance and implications of the post-discharge care plan; address physical, health related, and/or social barriers to attending follow-up appointments; and facilitate follow-up care for patients who are unable to make their own arrangements and may be at risk for deteriorating health conditions, non-adherence to care plan, and/or inability to attend their follow-up appointments.

RANKED DELPHI PANEL STATEMENTS

Standardized documentation tools and comprehensive communication strategies	• Use standardized documentation tools (e.g. discharge summaries and care plans) and comprehensive communication strategies (e.g. warm hand-offs) during care transitions with accepting health care providers (e.g. within health care organizations or family physicians or nurse practitioners) and whenever possible build in feedback systems that ensure receipt of reports.
Nurses create holistic plans that bridge settings	• Optimize nurses' roles in care transitions to allow them to: create evidence informed care transitions plans by facilitating comprehensive holistic assessments (physical, mental, cognitive, social support and economic status) with the interprofessional team and develop and implement within their scope of practice a comprehensive care transition plan spanning the care spectrum (pre-discharge, post-discharge and bridging) with clear interventions (e.g. pathways or discharge checklists) that are flexible and adaptable to patients' needs and preferences.

RANKED DELPHI PANEL STATEMENTS

Leadership, strategic alignment and accountability	• Have strong leadership, strategic alignment and accountability structures in organizations to enable quality care transitions for the complex elder patient population.
Timely communication and being present to maintain continuity	• Establish timely communication mechanisms with nurses and interprofessional team providing care to patients and being available at the time of transfer for collaboration with patients, their family members and/or caregivers and their primary care provider to coordinate and maintain continuity of the care across the care spectrum

RANKED DELPHI PANEL STATEMENTS

Nurse education quality transitions	• Educate all nurses on the key role they have in ensuring quality care transitions of complex elder patients.
Enhanced Clinical Information System	•Facilitate information transfer and decision support amongst the interprofessional health care team and patients, their family and/or caregivers through enhancement of clinical information systems including to: create an integrated patient-centred personal health record; provide options for patient or their family members and/or caregivers to maintain the primary health record; and explore mechanisms that ensure continuity of information for patients that are unable to (e.g. cognitively impaired, few social support and low economic status) or do not wish to maintain their own health record.

RANKED DELPHI PANEL STATEMENTS

System wide interventions for education and linking of interprofessional team	• Ensure the appropriate, timely linkage of patients, their family members and/or caregivers by establishing system wide interventions that provide education and link members of the interprofessional team to relevant community resources, services and programs.
Understand the Caregivers involvement and needs	• Caregivers determine preferred level of involvement, readiness and capabilities of patients, their family members, and/or caregivers in the formation and execution of their care transition plans and additional preparation or supports may be needed to optimize their strengths and coping capabilities to ensure quality care transitions.
Specialized Care Transition Nursing Roles	• Create more specialized care transition nursing roles that are provided with advanced level educational preparation (e.g. Master's level and/or specialized post-licensure education on geriatrics, care transition management, and case management through courses and/or clinical fellowships).

PANEL PARTICIPANTS

Andrea Bishop	Dalhousie University
Beverly Bulmer	St. Michael's Hospital
Sonya Canzion	St. Michael's Hospital
Winnie Chan	St. Michael's Hospital
Peter Cox	Patients for Patient Safety Canada
Susan Cymbaluk	OMNI Health Care Peterborough
Margaret Gehrs	Centre for Addictions and Mental Health
Nadine Janes	West Park Healthcare Centre
Emilia Krzyminski	London Health Sciences Centre
Agnes Kulinek	University Health Network
Andrea Lauzon	Holland Bloorview Kids Rehabilitation
Dianne Leclair	Ontario Nurses Association
Barbara Lui	Sunnybrook Health Sciences Centre

PANEL PARTICIPANTS

Dianne Martin	Registered Practical Nurses Association of Ontario
Marilyn McDonald	Dalhousie University
Janice McVeety	Accreditation Canada
Joan Park	St. Michael's Hospital
Rebecca Ramsden	Mount Sinai Hospital
Mila Ray-Daniels	Hamilton Niagara Haldimand Brant Community Care Access Centre
Gayle Seddon	Toronto Central Community Care Access Centre
Laura Shapiro	St. Michael's Hospital
Samir Sinha	Sinai Health System
Tricia Swartz	Canadian Patient Safety Institute
Stephanie Vandevenne	Erie St. Clair Community Access Centre
Natalie Warner	Long Term Care Coordinator

PHASE 3: EMBEDDED CASE STUDY

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- A mapping out the local contextual data to series of conclusive statements derived from literature review and Delphi panel using the following data sources: Alberta Context Tool, interviews, participant observation, and administrative data

IMPLICATIONS

- Our research is timely as the complex elder patient cohort will grow substantially in the next decade impacting health care costs and thus has the potential to influence a large proportion of the population globally.

- Using an integrated knowledge translation (IKT) approach will ensure the successful uptake of our results, improving the health of elder Canadians as they transition within and across health care settings and home, in addition to improving the well- being of their families and caregivers.


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