Nursing’s Role in Successful Transitions Across Settings

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Care transitions across settings (hospital, other institutional settings, and home) are vulnerable exchange points for patients and family caregivers that contribute to higher risk of poor health outcomes. The Institute of Medicine and National Quality Forum identified improving transitions across the continuum from acute care to home as a national priority. Despite this, care transitions for individuals with disabling conditions, such as stroke, remain inefficient, resulting in unmet patient and caregiver needs, increased safety risks, high rates of preventable readmissions, and increased healthcare costs. Nurses have an integral role in care coordination activities at various practice levels and settings, thus nurses can help transform healthcare delivery for stroke survivors through improving transitions.

Stroke is the leading cause of major disability. Annually, ≈800,000 people are hospitalized for stroke in the United States. In 2010, there were ≈6.6 million stroke survivors with a predicted increase in prevalence of >20% over the next 20 years. Despite medical advances resulting in reduced stroke mortality, disability after stroke remains a major concern and adds complexity to care transitions for this population. Given stroke prevalence, improving nurses’ engagement in optimizing care transitions for this population is essential.

Readmissions after discharge from institutional settings to the community are a closely monitored measurement of care transition effectiveness. Readmissions may indicate unresolved problems, discharge to an inappropriate level of care, quality of immediate posthospital care, or a combination of these factors. Thirty-day readmission rates after hospital discharge are reported at 14.4%, with 11.9% of these determined as preventable. Readmissions after discharge from inpatient rehabilitation facilities range from 9.0% to 16.7%, varying with the severity of stroke impairment. Patients discharged to skilled nursing facilities have the highest 30-day readmission rates. Readmissions are associated with substantial economic burden on the healthcare delivery system.

The impact of stroke on function and activities of daily living varies widely. The need for continued medical and nursing care management is based on patient need. Approximately 60% of stroke patients require postacute care (PAC) services after acute inpatient discharge. PAC includes inpatient rehabilitation facilities, skilled nursing facilities, and community-based services, including outpatient and home health.

Determining the appropriate level of PAC on hospital discharge is a key component in ensuring optimal outcomes for stroke survivors. Nurses contribute to this determination through a biopsychosocial and ecological assessment of the patient and family caregiver. Factors that must be considered include the individual’s medical needs, prestroke level of function, rehabilitation tolerance, and community supports.

The family caregiver’s capacity to care for the stroke survivor including preexisting health conditions, other responsibilities, previous caregiver experiences, and available social support must also be considered. Other important considerations include family dynamics, financial resources, and the community living setting. Systems factors include the components of care and services, intensity of services (eg, number of hours of nursing care or therapy), and structure of available programs.

Nurses interact with patients/families at their most vulnerable times and often learn information critical to successful transition planning. They play a key role in promoting successful transitions by developing and evaluating the transition plan and identifying and communicating barriers to the plan. Examples of barriers include limited finances to cover out-of-pocket costs of PAC and family members who do not have the capacity to provide care post discharge. Communicating this information to the interprofessional team early in the patient’s hospital stay is essential to assure that the transition plan is tailored to the needs of the patient and family, and that patients are transferred to the appropriate PAC setting. The intensity of medical, nursing, therapy, and other services varies significantly along the care continuum from inpatient rehabilitation facilities to skilled nursing facilities to community-based care. To be most efficient and effective, care settings must be matched to patients’ needs to ensure optimal function and participation in meaningful activities and avoid costly readmissions. Comprehensive rehabilitation with adequate resources, dose, and duration must be provided to achieve these outcomes. Providers can use the Determination of Probable Discharge to the Community Model (Figure) to identify important elements to ensure that the needs of patients with stroke can be met in the identified

Received June 22, 2016; final revision received June 22, 2016; accepted July 7, 2016.
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(Stroke. 2016;47:00-00. DOI: 10.1161/STROKEAHA.116.012095.)
© 2016 American Heart Association, Inc.
Stroke is available at http://stroke.ahajournals.org DOI: 10.1161/STROKEAHA.116.012095
setting. This model illustrates matching the discharge environment and support with the patient’s required needs based on functional prognosis.

Safe, timely, and efficient transitions across care settings are promoted through effective information transfer that contributes to optimal collaboration and coordination among the patient, family, and interprofessional team. The National Transitions of Care Coalitions recommends 7 best practices to improve care transitions (Table 1).16 Standardizing shift, unit, and interfacility handovers among providers and establishing procedures for effective transition communication and accountability are essential. Patients and families must be taught to leverage technology; to use electronic health records, where clinical information is readily available to facilitate communication with providers. In addition, nurses must ensure that patients have timely access to follow-up care and know how to communicate with providers in each setting.

Shorter lengths of stay in acute care17 and inpatient rehabilitation facilities18 have resulted in inadequate care coordination across the care continuum, especially during and after the transition home. Despite programs designed to train family members in caregiving skills, they often lack sufficient preparation and support to assume the caregiving role.12,19 Patients and families/caregivers must be knowledgeable about the patient’s condition and plan of care. Caregivers must be assessed for their capacity to provide the needed care and their readiness to assume the caregiving role at home.12,13 Nurses must support stroke survivors and their families through care transitions by providing training on care needs, information and resources on stroke prevention and recovery, and strategies to manage survivor and caregiver socioemotional needs, financial concerns, and family issues.13,20

Table 2 includes examples of internet-based resources. In a recent study, a nurse practitioner-led Transitional Stroke Clinic demonstrated a 48% reduction in 30-day readmissions in patients with stroke (n=510). The Transitional Stroke Clinic included 2-day telephone follow-up with a registered nurse and a clinic visit with the nurse practitioner within 7 to 14 days.

In a scientific statement on stroke family caregiver and dyad interventions, combining skill building (eg, problem solving) interventions with psychoeducational strategies is recommended to achieve optimal outcomes for stroke survivors and their caregivers.22 Specific interventions include medication management, patient and family education and training, information transfer, follow-up care, and healthcare provider engagement.19 In a review of transitional care models, evidence supports positive outcomes when including these types of interventions with patients/families following stroke.21 These types of family-centered interventions should be included in the discharge plan.

Medication management must be included in the overall transition plan and includes the assessment of patients’ medications and education and counseling about side effects.16 Using data from the AVAIL study (Adherence Evaluation of Acute Ischemic Stroke Longitudinal),24 researchers found at 3 months post discharge 98% of study participants (n=2219) understood how to take their medications and 95% knew why the medications were prescribed. However, patients who were older, black, or men were less likely to understand medication side effects.25 The Systematic, Accurate, Functional, Effective medication management program is designed to increase safety and decrease medication-related adverse events specifically for patients with stroke.36 The program includes evaluating the function and needs of patients with stroke to develop strategies to assist patients and caregivers in managing medications.

The Centers for Medicare and Medicaid recognize that the discharge planning process should ensure patients and caregivers are prepared to be active partners and advocates.

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**Table 1. Improving Care Transitions, The National Transitions of Care Coalitions,**16 p. 4

| 1. Improve communication among providers, patients, and caregivers |
| 2. Implement EHRs with standardized medication reconciliation elements |
| 3. Expand the role of pharmacists in transitional medication management |
| 4. Establish points of accountability for nurses and other providers involved in sending and receiving patient information |
| 5. Increase case management and care coordination |
| 6. Implement payment systems that align incentives |
| 7. Develop performance measures to encourage better transitions of care |

EHR indicates electronic health records.
for their healthcare and community support needs. To positively impact care transitions for stroke survivors and their families, nurses must reframe their views of their duty to patients and families beyond the limits of work shifts and settings. They can extend their scope of influence on longer term outcomes by identifying and documenting transition issues early, implementing strategies to address concerns, and communicating the transition plan to the next level of care. “Making their boundaries more fluid to create a more comprehensive continuum, …finding what connects them rather than what separates them…to ensure the health of people over their ever-increasing life spans (p 49).” This will contribute to attaining the National Quality Strategy Triple Aim to improve quality of care, improve health, and reduce healthcare system costs.

#### TAKE-HOME POINTS

- Nurses play a key role in promoting successful transitions by developing and evaluating the transition plan and identifying and communicating barriers to the plan.
- Nurses must engage patients and caregivers as active partners and advocates for their healthcare and community support needs.
- Nurses must extend their scope of influence on longer term outcomes by identifying and documenting transition issues early, implementing strategies to address concerns, and communicating the transition plan to the next level of care.

None.

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**Key Words:** electronic health records ■ medication therapy management ■ nursing ■ patients readmission ■ stroke
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Stroke. published online September 22, 2016;
Stroke is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2016 American Heart Association, Inc. All rights reserved.
Print ISSN: 0039-2499. Online ISSN: 1524-4628

The online version of this article, along with updated information and services, is located on the
World Wide Web at:
http://stroke.ahajournals.org/content/early/2016/09/22/STROKEAHA.116.012095.citation

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