ABSTRACT

Background: For nursing professionals to direct and influence the health care changes for implementing the Patient Protection and Affordable Care Act, emerging graduate nurses must be prepared as leaders and advocates for smooth patient care transitions for patients and caregivers. This article reports on how an undergraduate nursing program and its clinical partner created a course to allow students to step back from direct patient care and explore diverse nursing roles, team collaboration, communication, and processes that aim to collectively promote safe and effective quality care.

Method: Students completed online pre- and posttest surveys to rate their confidence levels with skills across seven measures. Results: Comparative analysis of the pre- and posttest surveys indicated a significant increase in students’ perception of their knowledge and skills across all areas. Conclusion: The instructional framework, using a care transitions model and clinical experiences, prepared students to work with health care teams and community partners for managing patient and family transitions in a variety of health care settings. [J Nurs Educ. 2015;54(9):479-484.]

The Centers for Medicare and Medicaid Services (CMS, n.d.) has adopted a definition for care transitions occurring when a patient moves from one health care provider or setting to another. The term care transitions refers to the movement that patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness. The imperative to successfully move patients in and out of complex health care systems, while maintaining continuity, requires that the ongoing short- and long-term care needs of patients must be understood by those who will manage the care when a patient leaves the acute care setting and transitions to ambulatory care, an extended care facility, or home. Keeping the patient centric in the process of providing patient-centered care has also been a thrust for more than a decade, as captured in the quality aims of the Institute of Medicine (IOM) report, Crossing the Quality Chasm: A New Health System for the 21st Century (2001).

Despite current practices, an ethnographic study of patient experiences after hospital discharge noted that the day of discharge may not be the best time to translate knowledge into safe, health-promoting actions at home (Cain, Neuwirth, Bellows, Zuber, & Green, 2012). Graham, Gallagher, and Bothe (2013) explored the dilemma between nurses’ attitudes and beliefs regarding the important role of nursing in discharge planning and the barriers to executing a quality discharge plan. In a review of the discharge literature, McBride and Andrews (2013) showed that educators often teach with little assessment of knowledge or individualization based on need and teach more on the diagnosis. Too often, the time needed for patient and family assessment and education is abbreviated. According to Coleman and Berenson (2004), challenges in care transitions include patient safety, with errors in medication being due to multiple providers and limited communication with each other, patient and caregiver unpreparedness for their roles in self-management, and a lack of knowledge about asking for guidance from other health care providers.

If a transition does not occur successfully, patient care can be delayed, misunderstood, or halted altogether, causing disease or illness progression, decreased quality of life and patient and family satisfaction, and, ultimately, a need for patients to return...
to the health system for costly readmissions. The National Transitions of Care Coalition (n.d.) was founded in 2006 to specifically address the challenges of patients transitioning between care settings and produces multiple tools and resources on assessment and interventions from national and world leaders. As health care increasingly extends beyond acute care settings and into the community, new health care delivery models advocate nurses’ roles in care transitions, such as the navigators used in ambulatory care settings.

The purpose of this article is to describe the method used to bring a new course on patient care transitions to the undergraduate nursing curriculum and to present course evaluation results. The intent of the clinical course was to prepare graduate nurses to develop a more focused awareness and knowledge base of the complexity of transitions and to build their practice and leadership skills in care transitions.

BACKGROUND AND SIGNIFICANCE

National Drivers

Health care has become increasingly challenging for both providers and recipients due to higher numbers of individuals having access to care, the ongoing economic demands to reduce health care costs, and the anticipated shortage of health care educators and clinicians. In 2008, the 9th Statement of Work was released to all quality improvement organizations to change the course of Medicare quality and safety (CMS, 2008). The three themes were Beneficiary Protection, Patient Safety, and Prevention. Each of the 14 participating states was asked to reduce unnecessary readmissions to hospitals while increasing quality at a lower cost.

At the same time, the Patient Protection and Affordable Care Act increased the number of Americans with health care coverage and provided funding for community-based public health and prevention programs, research, and evaluation on key health measures (Purcell & Webb, 2013).

Background information from CMS indicates that hospitals have historically been directly responsible for quality of care during patients’ hospitalization and the discharge planning process. With estimated readmission costs of more than $26 billion each year, identifying the key drivers for readmission is essential to identify target interventions to reduce the need for readmissions. CMS promotes strategies to achieve such interventions through the funding of innovations to improve quality of care and through the Community-Based Care Transitions Programs and Partnerships for Patients (CMS, n.d.).

Professional Nursing Recommendations

Reports from the Patient Protection and Affordable Care Act and CMS innovations indicate that the U.S. health care system is experiencing a major transition, with multiple changes that should be directed by nurses in leadership positions (Purcell & Webb, 2013). The latter is supported by the IOM report, The Future of Nursing: Leading Change, Advancing Health (2010), which follows the Patient Protection and Affordable Care Act principles, with recommendations to expand opportunities for nurses to lead and disseminate collaborative improvement efforts. Toward that end, the American Association of Colleges of Nursing’s (2008) Essentials of Baccalaureate Education for Professional Nursing Practice, Essential VII Clinical Prevention and Population Health, promotes higher level education preparation for nursing to improve patient care outcomes. Having the knowledge and skills at the point of entry into practice allows nurses to appropriately assess, educate, and work in partnership with patients, families, providers, and community resources. Planning for care needs may vary, as patient status, care requirements, and care settings change with the patient’s disease progression or healing.

Local Strategies

Health care organizations such as the University of Michigan Health System, with its educational partner, the University of Michigan School of Nursing, are expanding the opportunities for nurses to lead and manage collaborative efforts with physicians and other members of the health care team to redesign and improve practice environments around patient transitions, inclusive of both inpatient and ambulatory care settings.

In 2009, the University of Michigan School of Nursing embarked on discussions to redesign the existing undergraduate accelerated second-career program (ASCP) to improve the quality of teaching and learning. This redesign was launched so that ASCP graduates can more readily integrate into practice and fully inhabit new RN roles as easily as the traditional 4-year graduates. Throughout the curriculum redesign, patient and caregiver readiness emerged as a pivotal theme for the new Care Transitions course that would highlight the complexity of care across the continuum, while exposing students to patient and family transitional care needs. The clinical component centered on helping students to understand care delivery models that move patients and families from a microsystem to a macrosystem, the nuances of patient hand-offs, and the importance of clear communication and collaboration with health care partners. Course objectives also emphasized nurses’ roles in developing and implementing health policy, health financing, and access to health care.

COURSE DESIGN

The defining of course elements in the new ASCP proposal included direction provided by the American Association of Colleges of Nursing’s Baccalaureate Essentials (2008) and the IOM (2010) report, along with key concepts from the work of Benner, Surphren, Leonard, and Day (2010), Educating Nurses: A Call for Radical Transformation; the NCLEX-RN® study plan (National Council of State Boards of Nursing, 2013); and the Quality and Safety Education for Nurses, led by the Robert Woods Johnson Foundation (Cronewett et al., 2007). In addition, the ASCP would follow the newer clinical placement model found in the traditional undergraduate program of pairing students with RN clinical mentors in the units and with embedded faculty at the partner health system (Svejda, Goldberg, Belden, Potempa, & Calarco, 2012).

Theoretical Model

The Care Transitions course was designed to expose students to an array of tools to improve the assessment of patient and caregiver discharge readiness prior to discharge. The mid-
dle range theory by Meleis (who was influenced, in part, by Florence Nightingale’s focused work in environment, health and well-being concepts), Sawyer, Hilfinger Messias, and Schumacher (2010), was selected as the foundational theoretical model. The model introduced students to the framework of the assessment, which includes the following four main components: the nature of the transition, transition conditions, nursing therapeutics, and patterns of response.

Course Structure

The weekly lecture, seminars, webinars, and small-group interactive work were designed to elicit critical thinking and the application of transition concepts. Patient cases were analyzed for transitions from hospital to home, from provider care to patient self-managed care, and for working with families adapting to the new responsibilities of caregiving. Students were required to complete 44 clinical hours at the negotiated sites, which included inpatient units, ambulatory care clinics, palliative care consult services, visiting nurse and home medical divisions, as well as external community agencies. The clinical placements allowed students to experience the complex and necessary communication among health care team members and community resources in facilitating smooth transitions for patients and families.

Clinical Experience

To help students understand the methods and skills needed to bridge care and education between providers and patients and their caregivers, focused inpatient experiences centered less on direct patient care and more on unit-to-unit patient transfers, as well as the preparation with various health care team members to plan for discharge to home, to hospice, or to another care facility. Some students were assigned to ambulatory and procedural sites, where they could follow other types of care transitions through telephone triage, telehealth practices, and home or community visits.

Student Learning

The culmination of learning was evaluated through clinical assignments, including a short paper, clinical reflection logs, and a group presentation. The required paper assignment asked students to analyze a patient or family transition situation experienced during their clinical rotation. The paper must include the application of the Meleis model; an assessment and analysis of a client, family, or health system outcome, using any risk assessment tool from the literature; and evidence-based recommendations for interventions. Student group presentations centered on barriers to discharge teaching, long-term care clients moving to an acute care facility, or patients transitioning from home to long-term care. The group presentations further conveyed students’ understanding of key concepts and their developing skills in critical aspects of communication and coordination of care.

EVALUATION METHOD

To evaluate the effectiveness of the new course’s impact on improving students’ knowledge and skills to provide transitional care and quality care, a pre- and posttest assessment was conducted, with a specific focus on the perceptions of self-confidence in transition care. Students were asked to rate their confidence around the following seven topics: (a) medication reconciliation, (b) assessing barriers to transition, (c) developing a follow-up plan, (d) evaluating home safety, (e) evaluating functional abilities, (f) communicating with providers, and (g) identifying appropriate discharge settings (Krippalani, Jackson, Schnipper, & Coleman, 2007). The time between the pretest and posttest was 13 weeks. The data collected for course evaluation were anonymous, and the study was not considered human subject research requiring institutional review board approval.

RESULTS

Overall, the comparative analysis from the pre- and posttest surveys indicated a significant increase in students’ perceptions of their knowledge and skills across all areas (Table); however, 26 students did not respond to the posttest survey, resulting in loss of data. Because the pre- and posttests were administered in class as a voluntary activity, obligation to respond was not a course requirement, which is the probable cause for the posttest attrition. Sensitivity analysis was used to assess how the additional scores may have affected the evaluation results if the 26 nonresponders had completed the posttest.

Despite the response rate loss, using the method of sensitivity analysis of the nonresponders suggests that the original 30 posttest responses indicating increased confidence levels can be viewed as representative perspectives of all 56 students.

DISCUSSION

In the IOM’s Future of Nursing (2010) report, a key message on education indicated, “Nursing students need to have greater exposure to principles of community care, leadership, and care provision through changes in nursing school curricula and increased opportunities to gain experience in community care settings” (p. 319). Examining students’ confidence levels in facilitating patient care transitions was useful in determining the value and effectiveness of the selected teaching strategies for the new Care Transitions course. Positive results were obtained from the students’ exposure to nursing roles in the continuum of care areas, allowing the students to learn about skills and experiences that would enable them to think about and advocate for patient and family care through a broader holistic lens. The experiences prepared them with improved communication skills for working with health care teams and community partners when managing patient and family transitions throughout a variety of health care settings. Overall, the students recognized that readiness for discharge is an important measure of assessment, patient education, caregiver support, and successful transitions. Students were able to understand the multitude of transitions that occur within the hospital, as well as the complexity of discharging the patient to the best environment with appropriate community resources. The use of Meleis’ middle range theory (Meleis et al., 2010; Meleis & Trangenstein, 2010; Kralik, Visentin, & van Loon, 2010) provided a framework.
### TABLE
Pretest and Posttest Confidence Levels of Study Participants (N = 56)

<table>
<thead>
<tr>
<th>Skill Performance</th>
<th>Pretest (n = 51 [%])</th>
<th>Posttest (n = 30 [%])</th>
<th>Change From Pretest to Posttest</th>
<th>Sensitivity Analysis of Nonresponders[^a]</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ability to adequately communicate with my patient’s follow-up provider about the important issues managed during the inpatient stay</td>
<td>38</td>
<td>73</td>
<td>35% increase</td>
<td>48% increase 39% increase 20% increase 19% increase 1% increase</td>
</tr>
<tr>
<td>2. Ability to adequately communicate with my patient’s follow-up provider about the important issues requiring follow up after discharge from the hospital</td>
<td>38</td>
<td>66</td>
<td>28% increase</td>
<td>44% increase 35% increase 26% increase 16% increase 2% decrease</td>
</tr>
<tr>
<td>3. Ability to complete a medication reconciliation with a patient</td>
<td>18</td>
<td>73</td>
<td>55% increase</td>
<td>68% increase 59% increase 50% increase 39% increase 21% increase</td>
</tr>
<tr>
<td>4. Ability to complete an evaluation of a patient’s functional abilities at home</td>
<td>20</td>
<td>72</td>
<td>52% increase</td>
<td>66% increase 58% increase 48% increase 37% increase 19% increase</td>
</tr>
<tr>
<td>5. Ability to complete an evaluation of a patient’s safety at home</td>
<td>38</td>
<td>66</td>
<td>28% increase</td>
<td>44% increase 35% increase 26% increase 16% increase 2% decrease</td>
</tr>
<tr>
<td>6. Ability to develop an appropriate follow-up plan for my patient on discharge from the hospital</td>
<td>17</td>
<td>79</td>
<td>62% increase</td>
<td>72% increase 63% increase 54% increase 44% increase 43% increase</td>
</tr>
<tr>
<td>7. Ability to find the resources in the community for the patient to stay in his or her living situation</td>
<td>13</td>
<td>49</td>
<td>36% increase</td>
<td>60% increase 53% increase 42% increase 32% increase 14% increase</td>
</tr>
<tr>
<td>8. Ability to identify the appropriate discharge setting for my patient</td>
<td>21</td>
<td>53</td>
<td>32% increase</td>
<td>54% increase 45% increase 36% increase 25% increase 8% increase</td>
</tr>
<tr>
<td>9. Ability to identify the important barriers a patient faces when transitioning from the acute inpatient setting to the outpatient setting</td>
<td>32</td>
<td>93</td>
<td>61% increase</td>
<td>64% increase 56% increase 47% increase 36% increase 18% increase</td>
</tr>
</tbody>
</table>

[^a]: Sensitivity analysis results equal the percentage of confidence applied to 26 nonresponders, added to the percentage of confidence of the 30 posttest responders, minus the percentage of pretest responses for each of the nine items.

[^b]: Rated on a Likert scale of 1 = least confident, 2 = less confident, 3 = somewhat confident, 4 = confident, and 5 = most confident.

[^c]: Represents the percentage of students who responded with a 4 = confident or a 5 = most confident in performing the identified skill.
for understanding the complexity of transitions—in particular, nursing therapeutics and its effects on the nature and the outcome of transitions.

Strengths of the clinical placements included students spending time with nurses in case manager roles in a new institutional care management model. In this model, students were able to see how unit-based case managers and social workers interacted with nursing and other care team members each day. For some students, having the opportunity to attend interdisciplinary discussion groups was invaluable in helping them to more fully understand the plan of care originates within a health care team. Students who were placed with visiting nurses making patient home visits experienced the skills and expertise required of this type of specialty role and observed firsthand the nurses’ autonomy in decision making, balanced with the support of direct telephone communication with providers.

Despite several positive aspects of the clinical placements, areas for improvement were noted. Although some students had clinical placements that allowed for direct communication with patients, families, and providers, others were at locations where the experience of outpatient clinic telephone triage and telehealth practices, although informative, was limited more to observation. On the basis of student feedback, a targeted area for improvement in the future is to have both direct and observational experiences be available to every student over the course of the term as rotational opportunities at multiple clinical sites.

Regardless of the setting in which each student experienced clinical hours, an overarching strength of the model was their ability to have experiences beyond performing direct patient care only. The varied community placements added to all students’ understanding of nurses’ multiple roles in the community and the transitions occurring throughout the health care system. In addition, the Care Transitions course was designed to precede the Population Health course, which occurs sequentially in the curriculum and further explores community resources and evaluation of individual patient needs.

RECOMMENDATIONS

Using students’ responses, informal preceptor feedback, and faculty’s desire to level and broaden the experiences of all students, the following recommendations were suggested for the course redesign:

• Integrate clinical transitional concepts and experiences within other clinical courses to facilitate multiple exposures with all types of transitions. Expand student clinical rotations beyond acute care settings, even within medical–surgical clinical courses.
• Provide each student with diverse opportunities to be assigned with care managers, visiting nurses, clinic nurses, and other health care team members. Create opportunities for students to follow a patient’s health care journey through the continuum of care and multiple settings as a contributing member of the health care team.
• Meet with faculty lecturers at all levels of the curriculum to determine where key concepts related to care transitions, theoretical models, and community resources can be introduced and reinforced in didactic courses throughout the 4-year curriculum.

CONCLUSION

The redesigned ASCP program provided an opportunity to evaluate a new course design intended to prepare future nurses to be more fully aware of the positive impact that a successful care transition can have on (a) quality outcomes for patients and families, (b) decreased readmission rates, and (c) bringing effective leadership to the health care profession, as models of care are designed and implemented in health care organizations. The strength in having students step back from direct patient care to experience the diverse nursing roles in the continuum of care areas was invaluable in broadening their understanding of the full scope of health care teams and the communication necessary for smooth transitions between health and illness. Use of a theoretical model for the course design and to provide a structural framework for students to assess patient and caregiver readiness for transitions was instrumental in helping the students embrace key concepts in their evolving nursing practice. Overall, the richness that transitional care curricular topics bring to undergraduate nurses’ education in preparing them to engage in, and in some cases, lead the discussions and planning of health care delivery models across all settings aligns with the vision for the transformation of nursing.

REFERENCES

McBride, M., & Andrews, G.J. (2013). The transition from acute care to home: A review of issues in discharge teaching and a framework for...


