Transitions Nurse Program (TNP)

Funding: VA Office of Rural Health; VA Office of Nursing Services
Principal Investigator: Robert E. Burke MD, MS –Assistant Chief of Hospital Medicine, Denver VA Medical Center

Background and Significance

The Transitions Nurse Program (TNP) is a proactive, personalized, nurse-led and Veteran-centered intervention to improve access for rural Veterans to follow-up with their PACT teams following hospitalization. This program addresses risks rural Veterans often face when returning from hospitalization at tertiary care facilities, making care safer, more cost-efficient, and more Veteran-centered.

Prior to establishing the TNP, rural patients would likely face a long inpatient stay and an uncertain future following hospital discharge. These Veterans are vulnerable not just due to having a severe illness in need of advanced services, but also because of the barriers inherent with residing in rural areas. At times, PACT clinics do not receive the notification of admission or discharge of a veteran until 48 hours post-discharge. The PACT clinics are not always made aware of medication changes, and a poor-quality handoff from the tertiary site can result in poor coordination of follow-up appointments and other needs—from inpatient care, to PACT providers. These conditions all create potential for poor health outcomes in Veterans.

This program was piloted at the Denver VAMC and associated rural primary care sites from October 2014 - February 2016. When we compared outcomes of Veterans enrolled in the pilot TNP to local Veterans hospitalized during the first six months of the program, we found the TNP reduced unplanned, 30 day readmissions (−6.9%, 95% confidence interval = −14.2 to 0.31%, P = .06). We also found the Veterans enrolled in the TNP had increased follow-up rates with their PACT within 14 days of hospital discharge (10.43%, 95% confidence interval = 1.20 to 19.66).

The TNP intervention is carried out by a Transitions Nurse, who follows a 4-step process that compliments and supports PACT clinics. The Transitions Nurse ensures the patient has a follow up appointment, and collaborates with the PACT clinic, notifying them of the patient's hospitalization. This includes the coordination of the patient's post-discharge needs. An encrypted document is sent to the patient's PACT clinic, including a full discharge summary, and medication reconciliation for post discharge coordination with the PCP. Within 72 hours post discharge, the Transitions Nurse will call the patient to assess adverse events, reinforce medication reconciliation, and address any pending concerns. Lastly, the transitions nurse engages the patients PCP, and/or PACT clinic staff in the rural community, informing of any further patient needs, promoting interdisciplinary collegiality, and concluding a warm patient hand-off.

The Transitions Nurse Program can benefit any medical center or VISN that provides specialized services in a tertiary facility for rural Veterans referred or transferred for care. We have developed implementation materials, including almost 80 hours of nurse training modules, to help ensure success at new sites. The program can be adapted, depending on what enrollment criteria is best for your site. The TNP is currently implemented in Gainesville, FL; Iowa City, IA; Salt Lake City, UT; Seattle, WA; Denver, CO; and Pittsburgh, PA, with more than 600 Veterans enrolled in the program in the first year. We hope you find our Transitions Nurse Program to be as important as we do for the care coordination of our Veterans.