5.2 million Veterans live in rural communities across the United States. Research shows that our Veterans living in rural areas are often referred to distant tertiary VA hospitals when they need hospital care, but often struggle when they return home.

Hello. My name is Bob Burke, and I’m the Medical Director of the Rural Transitions Program at the Denver VA. I want you to imagine you’re one of the many rural Veterans living in your VISN, and you’re hospitalized and suspected of having a heart attack. Because the VA concentrates specialized services at tertiary VA’s, you’re transferred from your local VA to a tertiary VA for a cardiac catherization procedure. This procedure suggests you need bypass surgery which you undergo, and four weeks later you’re discharged from the hospital. However, when you return home, you find that the home health care that was supposed to be set up hasn’t been arranged. You need oxygen, but it hasn’t been delivered. No one at your local PACT site is aware you’ve been admitted, and you’re having trouble reaching your primary care physician. You may need specialized medications, but they aren’t available locally. The discharge instructions from the tertiary site say, “follow up with your cardiologist,” but the nearest one may be hundreds of miles away. You’re unsure whether you should be taking the medications that were prescribed in the hospital or the ones you had at home before. We interviewed rural physicians and patients and found that experiences like this were, unfortunately, quite common. This is why we designed the Rural Transitions Nurse Program and the role of the transitions nurse.

Hello. My name is Lynette Kelley, and I’m the transitions nurse here at the Denver VA. Our aim is to close the loop as Veterans are discharged from tertiary VA hospitals and support their rural PACT providers to provide needed follow-up care. This is necessary because reliable systems for notifying PACT providers that their patients were admitted are not often available. Conflicting medication lists between the hospital and the PACT clinic are the norm. Providers at the tertiary sites might not know what resources are available in the rural PACT setting leading to inappropriate follow-ups, and patients who undergo this transfer process are often quite ill, which is why they needed the tertiary services. They are among the most vulnerable Veterans to adverse outcomes after they leave the hospital and coordinating their care is a must. Our intervention follows a four-step process that’s carried out by the transitions nurse, and it complements and supports our PACT clinics.

[phone ringing]

The transitions nurse prepares the patient for discharge using teach-back to confirm their understanding of their medications, how to monitor their symptoms and whom to contact for help. The transitions nurse obtains a follow-up appointment for the Veteran with the rural PACT site, preferably within 14 days of discharge. At the time of discharge, the transitions nurse collaborates and notifies the PACT clinic. This contact provides the needed information to address the post-discharge needs of the patient. The transitions nurse sends an interfacility communication consult to the patient’s primary care provider with a full discharge summary and medication reconciliation for post-discharge coordination with the PCP. This document becomes available in the patient’s local CPRS system. The nurse calls the patient within 48 hours to assess symptoms, reinforce medication reconciliation and address any educational gaps the patient may have.

We have enrolled more than 350 Veterans in our program in Denver, and this program is making a difference for our Veterans through improved coordination, follow-up with the PACT clinic and reductions in hospital readmissions.

As you can see from the following quotes and feedback, the Veterans and providers that we have already worked with in this program have had positive experiences with it.

“Hello. My name is Mel Anderson, and I’m a hospitalist here at the Denver VA. We’re a referral center for our large Rocky Mountain network and historically have had challenges caring for patients from outside our local system. It’s proven difficult to contact PCPs and arrange important follow-up, even something as simple as ordering lab tests. It’s been generally frustrating to navigate the divide and coordinate effective care. The Transitions Nursing Program has really transformed this coordination by creating a reliable bridge to the other systems, promoting a safe discharge, and giving peace of mind to patients and providers alike.”

“Hello. I’m Lori Harvey. I’m the Clinical Nurse Specialist here at the Denver VA for Electrophysiology Department and before the creation of the TNP, I often found challenges in contacting and coordinating necessary procedural follow-up and appointments when managing the primary care discharge needs of our rural Veterans. I often hoped that somebody would be following up with the recommendations made at discharge, but was feeling unsure that they were ever completed. The transition nurse and I work together at discharge to ensure that the patient has his or her cardiology and primary care recommendations coordinated prior to discharge and the transition nurse alerts me of any complications or adverse events post-discharge, which allows me to appropriately follow-up with the patient and encourage rapid evaluation and management. With the TNP, I now feel confident that patients will have appropriate discharge follow-up according to the recommendations that are made, and somebody will be checking in with them after discharge to promote a safer transition home.”

Thank you for your attention. The program requires a full-time transitions nurse and a part-time physician. Training and support is available to help you implement the program successfully at your site. The VA Office of Rural Health is generously funding this program for three years and then it’s up to your site to sustain the program afterwards. We hope you find our Transitions Nurse Program to be as important as we do in coordinating the care of our rural Veterans, and I hope to work with you in the future implementing this program at your site.