APRNs in transitional
The patient is an 80-year-old African American woman who has lived in the area for 50 years. Her diabetes is worsening, she faces possible amputation, and she worries about how her transition from the hospital to a skilled care facility will be accomplished. … No, wait! The patient is a 20-year-old white man who was hit by a car just one month after moving into the area. He has no relatives nearby and has not yet considered all the different treatments he will need and how they will be communicated to him accurately. … No, wait! The patient is a Haitian woman who … No, wait! Patients who are in need of transitional care fit any one of these descriptions and thousands more.

With the shifting landscape of health care and various roles of health care providers, it can be difficult to get a clear picture of all the players and their functions. One such role that is coming into focus is that of the advanced practice registered nurse (APRN). Health care professionals would do well to cultivate a good understanding of the part APRNs can play in the various health care delivery settings.

Background of emerging roles
Historically, the role of nurse practitioners (NPs) developed as a way to provide primary care for the underserved. More recently, NPs have offered solutions to pressing concerns in the U.S. health care delivery system. In 2010 the Institute of Medicine (IOM) recommended that APRNs—a designation that includes NPs—be allowed to practice to the full scope of their abilities and that any barriers to doing so be removed. And, indeed, many states have removed such obstacles. Additionally, insurance companies now include NPs in their provider networks. The Patient Protection and Affordable Care Act (ACA) instituted health insurance reform, expanding coverage to 48 million uninsured Americans, adding further demands for effective health care delivery. The APRN has emerged to address these growing needs, particularly in the area of transitional care.
The NP: A historical perspective

Although nurses of the late 1800s showed definite similarities to nurse practitioners (NPs), the role was formally developed in 1965 by Loretta Ford, EdD, and Henry Silver, MD, of the University of Colorado. Since that time, the education and role of the NP has undergone further expansion:

1960⁵ The first NP program is created in 1965. The program has a pediatric focus and advances the clinical practice of students by teaching them to provide primary care and make medical diagnoses.

1970⁵ Federal funding helps establish many more NP programs to address a shortage of primary care physicians in underserved areas. Idaho becomes the first state to endorse NPs’ scope of practice to include diagnosis and treatment.

1980⁵ Nurse practitioner education begins to move into university settings as master’s-level programs.

1990⁵ The number of NP programs doubles between 1992 and 1997. By the turn of the century 321 institutions offer either a master’s- or a post-master’s-level NP program.

2000⁵ The National Council of State Boards of Nursing APRN Committee works with the APRN Consensus Work Group to develop the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education, which is endorsed by the NCSBN Board of Directors in 2008. In 2010 the Institute of Medicine (IOM) recommends that APRNs be allowed to practice to the full scope of their abilities.

Four roles, one umbrella

The initialism APRN widely refers to nurses who have earned a master’s degree or higher, provide direct clinical care, and are educated in one of four roles:

1. **Certified registered nurse anesthetist (CRNA).** The CRNA provides the full range of anesthesia and anesthesia-related care to patients of all ages and health statuses, including those with immediate, severe, or life-threatening injuries. This care takes place in multiple settings, including hospital surgical suites, obstetrical delivery rooms, critical access hospitals, ambulatory surgical centers, pain management centers, and dentists’ and podiatrists’ offices.²

2. **Certified nurse-midwife (CNM).** The CNM provides an array of primary care services to women, such as gynecologic care, family planning services, and prenatal and postpartum care. In addition, the CNM can treat the female patient’s partner for sexually transmitted diseases and reproductive health. Care locations may include the home, hospitals, birth centers, ambulatory care centers, and public and private clinics.³

3. **Clinical nurse specialist (CNS).** The CNS fulfills a unique role as an APRN by integrating care across the continuum and through the three overlapping and interrelated spheres of influence: patient, nurse, and system. The CNS handles diagnosis and treatment of health and illness states, disease management, and prevention of risk behaviors and illnesses among patients, families, and broader groups.³

4. **Certified nurse practitioner (CNP).** More commonly referred to as NPs, these professionals provide direct primary and acute care across different settings. These members of the health delivery system practice autonomously in family practice, pediatrics, internal medicine, women’s health, and geriatrics.²

Additionally, APRNs are educated in at least one of six population foci²:

1. Family and individual health across the life-span

2. Adult-gerontology

3. Pediatrics

4. Neonatal

5. Women’s and gender-related health

6. Psychological and mental health

Furthermore, APRN education is broad-based and includes three separate graduate-level courses in advanced physiology and pathophysiology, health assessment, and pharmacology, as well as appropriate clinical experiences.²

While all four roles share the broader initialism of APRN, no model of APRN regulation is shared across states. Each state independently determines the legal scope of practice, recognized roles, criteria for entry into advanced practice, and certification examinations accepted for entry-level competence assessment.²

However, several standards, as outlined by the APRN Consensus Work Group and the National Council of State Boards of Nursing APRN Advisory Committee, are inherent to the definition of an APRN, which includes the following²:

- Completed an accredited graduate-level education program in preparation for one of the four recognized APRN roles
- Passed a national certification examination and maintains continued competence through recertification via the national certification program
- Acquired advanced clinical knowledge and skills in preparation for providing direct care to patients, as well as a component of indirect care
- Builds on the competencies of RNs by demonstrating a greater depth and breadth of knowledge, a greater synthesis of data, increased complexity of skills and interventions, and greater role autonomy
- Educationally prepared to assume responsibility and accountability for health promotion and/or maintenance as well as the assessment, diagnosis,
and management of patient problems, which includes the use and prescription of pharmacologic and nonpharmacologic interventions.

- Has clinical experience of sufficient depth and breadth to reflect the intended license
- Has obtained a license to practice as an APRN in one of the four APRN roles, with some exceptions

The functions of the APRN are many, especially across the four roles and six population foci.

Skills for all settings
The APRN can provide care across a wide range of health care circumstances and patient conditions, with the emphasis, form of implementation, and possible work settings varying within and across each APRN role. What remains constant is the defining factor for all APRNs: their significant focus on direct patient care in their education and practice. Consequently, APRNs have the particular ability and opportunity to support patient and caregiver well-being by getting to know the patients and caregivers personally. One study found that a way in which this method was particularly effective was when APRNs uncovered obstacles related to missing essential information that may not have been evident to other health care providers.

Indeed, APRNs are personable and thorough, finds Milee Kunath Tapanes, CMA (AAMA), from Fox Valley Medical Center in Aurora, Illinois, who works with APRNs and is enthusiastic in her praise of them. As an example, to obtain a complete patient history, the APRNs interview patients on their level to build a bond, while the medical assistant assembles appropriate items from the office files.

That impression of thoroughness is echoed by Melissa Gilmore, CMA (AAMA), from Des Moines, Iowa, who speaks of one APRN who goes above and beyond in her care of patients. For example, Gilmore describes how this person works to educate teenage patients with diabetes and their parents at the same time.

Above-and-beyond care begins before the patient even walks through the door for Candice Crabb, DNP, from De Pere, Wisconsin, who holds her doctorate with a family nurse practitioner emphasis. Her specialty provides care to all ages in the form of routine wellness exams and health maintenance, chronic disease management, acute care or sick visits, and in-office procedures.

Certainly, the skills of open communication with patients and advanced education in management and patient care are essential and evident components of an APRN’s skill set.

Defining transitional care
Because of their skill sets, APRNs are uniquely positioned to manage transitions from one health care setting to another.

Lapses in health care quality and safety are particularly felt by patients—especially chronically ill patients—as they transition between care settings and providers. These vulnerable exchange points are marked by a rise in the following:

- Medication discrepancies
- Adverse clinical events
- Unmet patient needs
- Patients’ poor satisfaction with their care

For example, a patient may have been prescribed medication while in the hospital, but it was not accurately communicated to the nursing home to which the patient was discharged.

“Without serious attention to [the coordination of care], the patient is at risk for exacerbation of symptoms and visits to the emer-
TLC in TCM

An evaluation of transitional care interventions and examinations of case summaries from participating advanced practice registered nurses (APRNs) led to the creation and continued development of the Transitional Care Model’s nine core components:

1. **Screening.** Targets adults transitioning from hospital to home who are at high risk for poor outcomes.

2. **Staffing.** Deploys APRNs who assume primary responsibility for care management throughout episodes of acute illness.

3. **Maintaining relationships.** Establishes and manages trusting relationships with patients and family caregivers.

4. **Engaging patients and caregivers.** Engages older adults in designing and implementing a plan of care aligned with preferences, values, and goals.

5. **Assessing/managing risks and symptoms.** Deals with the identification and efforts to address patients’ priority risk factors and symptoms.

6. **Educating/promoting self-management.** Prepares both older adults and family caregivers to identify and respond quickly to worsening symptoms.

7. **Collaborating.** Promotes reaching consensus on a plan of care between older adults and members of the care team.

8. **Promoting continuity.** Involves the same clinician across sites to prevent breakdowns in care.

9. **Fostering coordination.** Promotes communication and connection between health care and community-based practitioners.

Although similar, transitional care is complementary to but not the same as discharge planning, care coordination, disease management, case management, or primary care.

To achieve the goals of transitional care, health care professionals need to get to the root cause of readmissions and then implement a solution, says Dr. McCauley. For example, a patient’s depression may be the very reason they are not taking their prescribed medication for depression. “Systems [then need to be] put in place to help the patient until they are able to participate as needed,” explains Dr. McCauley. Or perhaps a patient has minimal or ineffective support systems at home, then “family, neighbors, and community resources need to be established and coordinated to help the patient be successful,” she says. “The real barriers to and facilitators for effective self-management must be identified and addressed.” This is where an APRN’s skill set proves valuable.

A comprehensive familiarity with patients’ histories can help the APRN identify and overcome barriers to quality care, says Dr. Crabb. “I review as much of their medical record as I can or review what is essential and pertinent to their visit. If a patient is new and is seeking to establish care with me, I ask them to ensure that their previous medical records are sent to my office before their appointment, so I have time to review the information,” she explains. “I feel patients appreciate and respect the fact that I pride myself on having knowledge of their previous medical history.”

Yet Dr. Crabb is well aware of the limitations of this process. “Even the most complete and comprehensive medical records may not tell the entire story,” she says. For this reason, she makes a point of providing ample time for patients to tell her about themselves and their reasons for seeking care.

In regard to how much time she spends with patients, Dr. Crabb says “the time is quite variable. The length of visits can be dictated by an organization or a provider’s preferences. Typically, an annual physical exam, Medicare Annual Wellness Visit, or chronic disease management check require more time than an acute care visit for something like a sore throat. Frequency of patient appointments is also extremely variable and depends on the patient. All patients are encouraged to have an annual physical exam. This allows us to ensure they are current with preventive measures like age-appropriate screenings and immunizations. Patients with chronic diseases, such as diabetes or hypertension, require more frequent visits depending on how stable their diseases are. Well-controlled chronic diseases may require visits only every six months, whereas uncontrolled diseases may require visits every three months or more frequently depending on the situation.”

Dr. McCauley recalls one instance in which an APRN did everything she could to ensure that a patient received needed care: “One of our APRNs identified that a patient was not keeping her provider appointments because she could not get out of her house. This nurse was relentless in getting community agencies to work together—our nurse had a ramp built on her house, then the patient was able to keep her medical appointments, and also was able to be more mobile.”

While not every transition requires management by an APRN, and routine hospital-to-home transitions can and are handled safely and effectively by other health care professionals, many transitions would benefit from APRN management. Criteria
Indeed, APRNs have proven to be particularly effective in transitional care. A qualitative analysis found that APRNs successfully aligned necessary services for patient-caregiver pairings and increased the likelihood that patients’ health care providers had the information needed to make appropriate care decisions. Moreover, APRNs generally demonstrated a determination to facilitate well-coordinated and quality care by constant communications, such as numerous phone calls and meticulous follow-up.

Reducing readmissions
Of the possible adverse events that can occur during a transition, rehospitalization is a considerable concern—and too often a reality. Approximately 1 in 5 (or about 2.6 million) Medicare patients discharged from a hospital are readmitted within 30 days, at a cost of over $26 billion a year. Hence, the Community-Based Care Transitions Program (CCTP) was established in the ACA to test models for improving transitions between hospitals and other settings and reducing readmissions for high-risk Medicare beneficiaries.

Although improving the quality of care during hospitalization and the discharge planning process plays a hand in reducing readmissions, any factor along the care continuum could be the cause. Therefore, taking steps to identify the key drivers of readmissions is the first step in implementing interventions to reduce them. Fortunately, the education and experience of APRNs position them to work as transitionalists and focus on uncovering such drivers.

An APRN might find that a patient experiences multiple hospital admissions due to poor self-care, a medical plan not fine-tuned to the patient, or additional health problems that are yet to be addressed, says Dr. McCauley. “If these issues are managed and we can keep symptoms under control, then we can keep people safely at home.”

In a 2011 study concluded that APRNs are likely to assume expanded roles in the delivery of transitional care because of their effectiveness and value in aiding the ACA aim of reducing avoidable hospital admissions. “Across all of our randomized clinical trials...
we demonstrated a longer time to first readmission, reduced number of readmissions, and lower cost of overall care, mainly due to preventing rehospitalizations,” Dr. McCauley says. “These are the benefits of transitional care that are thoughtfully and carefully completed. “We have also worked with patients who identify that they no longer want to be in and out of the hospital so much, and their goals are more consistent with palliative care or even hospice. We work with everyone to help the new plan of care focus on managing... appropriate services in the home [that are] consistent with the patient’s end-of-life wishes,” says Dr. McCauley.

### Advanced practice makes perfect

A primary strategy APRNs employ to prevent drivers of hospital readmissions is providing thorough and accurate education to patients and caregivers.

Care continuity is the hallmark of this model. The APRNs look at the patient holistically, not only from the perspective of the illness prompting hospitalization. “We [are] most effective in managing the complexity of multiple chronic conditions and in stabilizing the patient’s support systems—family and community services—to ensure that the patient [has] what [is] needed. … Most people don’t have one accountable caregiver but have a network—several children or grandchildren or neighbors,” says Dr. McCauley.

### Settings for transitional care

Transitional care management services are furnished following the beneficiary’s discharge from one of the following inpatient hospital settings:

- Inpatient acute care hospital
- Inpatient psychiatric hospital
- Long-term care hospital
- Skilled nursing facility
- Inpatient rehabilitation facility
- Hospital outpatient observation or partial hospitalization
- Partial hospitalization at a community mental health center

Following discharge from one of the above settings, the beneficiary must be returned to his or her community setting, which may include the patient’s home, a rest home, or an assisted living setting.

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Requirements include HS diploma/GED; CMA (AAMA) (preferred) or RMA; and 2 years experience as a Medical Assistant. Clinical skills to include injections, EKG, phlebotomy and vitals, use of medical diagnostic equipment, familiarity with basic lab terminology and medication protocols also required. Technical Diploma in Medical Assisting preferred.
To accomplish this, the APRN will visit a patient daily while in the hospital and within 24 hours of returning home. “They focus on what is most important to the patient, as well as on implementing the plan of care related to all health problems and helping the patient and family overcome obstacles to managing their health issues,” Dr. McCauley states. The APRN’s regular check-ins with the patient and the patient’s support system ensure that the patient is receiving necessary care and that the contributions of everyone are being optimized.

“All of this is dependent on the APRN establishing a strong relationship with the patient and family so that trust is developed. We want the patient to freely discuss their needs and concerns,” says Dr. McCauley. If the patient trusts the APRN enough, they may share what the real source of the problem is. For example, they might not be able to afford their medication, so they take less than prescribed. Or perhaps the patient stops taking needed medication because of its adverse side effects. “Trust between a patient and an APRN is key,” stresses Dr. McCauley.

Prepped for palliative care

The APRN’s value extends beyond preventing rehospitalizations to improving a patient’s quality of life. This effect can be particularly seen in palliative care, in which transitions are inherent for patients with life-limiting illnesses, and the focus shifts from curative treatment to symptom management and pain relief to improve the quality of life for patients and their families.

Palliative care APRNs have specialized training in communication skills and treatment of complex symptom management. Such a skill set allows APRNs to take an assessment of a patient’s total pain, which includes physical, psychological, social, and spiritual domains. Based on the results, the APRN can then work toward optimal analgesia to control a patient’s complex symptom burden through medication and interventional management.

The close relationship between patients and APRNs has shown a twofold effect. First,
the APRN can identify patients who would benefit from admission to a hospital for symptom management. Second, once patients have been admitted, one study found that patients repeatedly reported feeling comforted when their APRN was part of their inpatient care team. The relationship of trust that built over time between the patient and APRN was partially responsible. Moreover, the APRN can assist other team members in better understanding the patient and their family. And when the palliative care physician and APRN are kept informed and work together with other health care providers, smoother transitions back into the community are possible.

Additional benefits include decreased emergency room visits, fewer hospitalizations, and decreased health care costs.

Good transitional care benefits patients by ensuring correct medications and other therapies are properly provided to them. Hospitals benefit too through reduced liability because of fewer errors.

“Physicians, nurses, social workers, mental health professionals, and other clinicians should have a conceptual and practical foundation in the provision of transitional care.” The APRN is well positioned through training and experience to handle such responsibilities.

References
5. Patient Protection and Affordable Care Act, HR 3590, 111th Cong, 2nd Sess (2010).