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Needs Assessment for a Nurse Practitioner-Led Transitional Care Program

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
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Abstract

The rising cost of health care and changes in healthcare delivery have prompted a need to improve continuity from the hospital to home. This scholarly project was initiated to assess the impact on patient outcomes related to initiation of a nurse practitioner-led transitional care program (TCP). Using the Diffusion of Innovations and Health Belief Models, the purpose of this study was to identify the impact of a TCP on improving the health of patients with congestive heart failure (CHF), diabetes mellitus Type II (DM II), and chronic obstructive pulmonary disorder (COPD). The impact of the TCP was evaluated by a review of patient satisfaction results, reduction in patient readmission rate, and emergency room consults. Two years of data from a community-based health care program were collated from a sample of 819 individuals with chronic disease between 65- and 85-years-old who had a 30-day hospital readmission after a nurse practitioner home visit either or related to an exacerbation of their CHF, DM II, or COPD. The secondary data were analyzed, using SPSS, to determine changes in rates of readmission. Descriptive statistics were used to represent and compare changes in rates. After implementation of the nurse practitioner home visit program, the 30-day readmission demonstrated an 81.07% reduction with the 30-day readmission for exacerbation of COPD, CHF, and DM II was reduced by 36.77%. The project findings contribute to social change by identifying how a reduction in the frequency of hospitalizations could contribute to decreased health care expenses and improved health outcomes. Advanced-practice nurses working in home care settings, may use the results of the study to establish effective community interventions that may reduce health care costs.

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Dedication

This dissertation is lovingly dedicated to my children: Rochelle, Raymond, Regine, and Rainz, and to my best friend Relyndo each of whom have encouraged and supported me throughout the course of my doctoral studies. I further dedicate this work to the memory of my parents Vicente and Gloria and to my aunt Valentina whose life examples, generosity, hard work, and confidence in me sustained and motivated me to always do my best. I am also pleased to dedicate my work to Dr. Deborah Lewis for her undying support and to Victoria Nelson, MA for editing assistance.

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Section 1: Nature of the Project

Introduction

The cost of health care in the United States has motivated program planners to develop new health care plans without compromising the delivery of quality health care. Using the transitional care model, a program was developed to achieve effective continuity of care from the hospital to home, the goal of this project was to improve patient outcomes as manifested by reduced hospital readmissions (Meleis, 2010). The transitional care program (TCP) for this study was designed as an intervention to enhance the outcomes of patients recently discharged from the hospital with chronic illnesses, such as congestive heart failure (CHF), diabetes mellitus type II (DM Type II), and chronic obstructive pulmonary disease (COPD) to improve health care economics through reducing health care costs.

Statement of the Problem

The quality of care and not the volume of service has been the primary focus of Centers for Medicare and Medicaid Services (CMS) in their care organization program. Feigle (2011) claimed that, in this proposed rule, CMS physicians are paid based on their quality of service and not their volume of service. Therefore, practice change has to take effect to address expected realignment in the system in order to underscore that the physicians are compensated for the quality of care or service they provide.

The incidence of morbidity remains significantly high, particularly on chronic diseases. According to the Agency for Health Care Research and Quality (AHRQ, 2013), there are more than 125 million people who have at least one chronic disease. In addition,

75 million have two or more of these illnesses, namely CHF, COPD, DM, HTN, asthma, and depression, which account for about 75% of total health care spending (AHRQ, 2013). In addition, a typical patient with multiple chronic disease cycles in and out of the hospital uses the emergency room (ER) often. There is a fragmented delivery of care for this target population (TP), which is supported by a fee for service payment system (AHQR, 2013). With the advent of the expected changes in health care management, health care organizations and individual providers now share responsibility for the effective management of chronic disease. In addition, many health care organizations and providers are in a quest for ground breaking and evidence-based processes to reduce avoidable readmission of patients with the chronic diseases as it has been proven to cause a financial burden in the health care system (Hines, Yu, & Randall, 2010). The high rates of incidence on these chronic diseases further expounds the need to ensure that services provided is not only given to address the specific need of the patient but also to improve the health in general. This will aid in reducing the readmissions or often visit in ER of the patients and could improve their quality of life.

Statement of the Need

I proposed a TCP as an intervention to improve the health outcomes of the TP, which also includes a reduction of health expenditures due to readmission. In this study, the TP were those patients who had chronic diseases, such as CHF, COPD, and DM II. These patients also had a history of frequent readmission to the hospital or ER consultations after a recent discharge from the hospital. In this study, I highlighted

hospital readmission of patients with CHF, COPD, and DM II as the primary problem that influences added health care cost. This problem can be prevented through effective nursing interventions, and this intervention was expounded on my TCP. The purpose of the program interventions was to reduce, if not eliminate, hospital readmissions and the ER consultations due to exacerbation of these chronic diseases.

In a nurse practitioner (NP)-led TCP, the area of concern is the gap between the patients' the primary care provider's (PCP) discharge and the follow-up visit. Succeeding NP visits, even after the PCP visit, should be conducted to reinforce the teachings and to recognize the weakness of the patient/caregiver in understanding how the patient's condition could be safely managed at home. In addition, these visits could be used to detect the early signs and symptoms of exacerbation so that treatment could begin early and thus avoid hospital readmission or ER consultation. Medication reconciliation and timely institution of ancillary procedures necessary for the effective transition would also be of prime importance. The intention of this program is to empower the patient, as well as the caregivers, in their health care management. Field NPs involved in the program would see the patient within 24-48 hours after discharge to institute the TCP. If this TCP were successful, it could be the answer to the financial burdens of the health care maintenance of this TP.

In order for the program to work, it is necessary to assess needs of the TP, including the study of the environmental make-up of the patient. For instance, the availability of willing and able caregivers who have working knowledge base and adequate skills to take care of the patients' needs must be determined. This may include

transportation to their primary MD or ordering and retrieving medications from the pharmacy or other supplies needed by the patient. Lee (as cited in Laureate Education, 2011a) also articulated that the needs assessment includes identification of the appropriate stakeholders influencing patients' outcomes, such as the primary care providers, ancillary support team (X-ray technician, phlebotomist, pharmacist), and home health agency personnel. It would also help to perform a "windshield survey" of the patient's environment by identifying the nearest urgent care, the nearest pharmacy, and the nearest grocery store to meet the patient's basic needs. Lee also reiterated that the most important resource is the people (as cited in Laureate Education, 2011a). For this project, the transitional care team would be taught how to recognize when to report significant changes in the condition of the patient to the patient care provider (PCP) or the nurse practitioner (NP) provider so an immediate intervention could be instituted and, thus, prevent complications or deterioration, which could return the patient back to the hospital. Understanding these needs assessment factors, identifying them, and integrating them in the proposed program would ensure a successful outcome (Laureate Education, 2011b)

Mission Statement

The mission of the TCP is to fill the gap in care from hospital or skilled nursing facility (SNF) to the homes of patients with chronic illnesses, such as CHF, COPD, and DMII, to reduce hospital readmissions and ER consultations with an exacerbation of these conditions. In this doctor of nursing practice (DNP) project, I sought to design a TCP that would ease the transfer of patients from hospital to home in a systematic

manner and with the patients' clear understanding of on how they would be cared for at home. It would decrease the confusion that usually besets most patients when discharged from the hospital. In this TCP, I also underscored the impact of improvement in nursing practice in terms of patients' satisfaction with respect to service and the continuity of care provided by the involved health care provider.

An effective program defines its TP in terms of both demographics and economics. To ensure its effectiveness, the demographics and economics must agree with each other, which imply that, a decreased prevalence or incidence rate of readmission or consultation in ER of patients with chronic diseases should result to an increased on the saved health care cost of the patient. This also implies that there is an effective transitional care manifested which allowed the demographics and economics to agree with each other. All of the stakeholders must be represented because their involvement could help the program to determine its desired outcome. To fulfill the goals and objectives of the program, and to implement it successfully, patients with chronic illnesses, caregivers, providers, program planners, and funding organizations (Health Maintenance Organization [HMO], Accountable Care Organizations [ACOs], Medicare/Medicaid) should also agree on the terms of condition of this program. The agreement enclosed specifically for this study was the one between JANP INC and me. This expounds what the organization allowed me to conduct for this program. In addition, it also observes the policies implemented by HIPAA. The input of all is essential to formulating an interventional program that would address each patient's needs.

Researchers have shown the cost-effectiveness of a TCP in promoting continuity of care for patients who are discharged from the hospital. Ornstein, Smith, Foer, Lopez-Cantor, and Soriano (2011) studied the effectiveness of an NP-led TCP in a home-based primary care program and demonstrated that the program improved the lines of communication among multidisciplinary home-based and inpatient providers across disciplines. Furthermore**,** the NP-led TCP also facilitated the accurate and timely transfer of vital patient information (Ornstein et al., 2011). These findings are profound evidences, which could aid patient with chronic diseases to improve their health and quality of life. Furthermore, it also emphasis on how it can help patients save from health care costs.

The idea of transitional care brings a new perspective on how patient care can be improved and will produce a longer long-term effect. According to Banning (2008), enhanced clinical reasoning on what concepts to use in the analysis of the needs assessment of transitional care is useful in determining the ideal TCP to be adopted by an organization. The new program would ultimately improve the decision-making process; this program would not only benefit the patient (as shown in the health outcome), but would also assist the other stakeholders (the organization, the ACOs, HMOs, government). The program would also prevent an increase in expenditures on unnecessary and avoidable rehospitalizations. The program's objectives coincide with the U. S. government's efforts in Healthy People 2020 to pursue a preventative path for all diseases and reduce the country's health care costs (National Prevention Council, 2011).

Project Goal

The project goal was to assess the needs of a TCP using data analysis from the dashboard of a current supportive homebound program.

Project Objectives

This project had three objectives:

1. To be able to advance the quality of health care delivery through the leadership of NPs in collaboration with the health care organization in promulgating its mission of providing quality health care via responsible nursing practice and adequate transition of care from hospital to home (Based on DNP essentials: organizational and systems leadership for quality improvement and systems thinking)
2. To be able to develop a health care policy or guideline for the proper management of chronic diseases (CHF, COPD, and DMII) that would be adopted by health care organization to ensure the smooth transition of care and to provide a positive approach to the management and treatment of this group of patients (Based on DNP essentials: health care policy for advocacy in health care)
3. To enhance the knowledge base and skills of NPs in transitioning patients recently discharged to home from a hospital or other facility and to allow the development of a health care program that addresses the social problems encountered in the delivery of care (Based on DNP essentials: health care policy for advocacy in health care).

Risk Factors

Risk factors are always apparent in every study, which has a great influence on its result. In this project, the risk factors identified were a lack of communication between the providers from the hospital and the provider receiving the patient in the field; inadequate instructions given by discharge planners or nurses from the hospital, particularly in medication reconciliation; and the potential lack of coordination between the involved health care providers of the hospital and health care providers who were involved with the patient care outside the hospital. Addressing these concerns were significant hurdles.

There are three essential factors that would assist nurses in conducting a successful program. These factors include the assessment of the needs of the TP, instilling professionalism, and owning responsibility for setting health priorities to benefit the transitioning patients. According to White and Dudley-Brown (2012), professionalism is cultivated through excellent informal and formal communication. This effective communication can also be facilitated through the provision of a culture conducive to innovative practice, which stimulates practitioners to offer more patient-centered care Also, providers must involve the patient and their family in the planning and decision making on how their care should be conducted to ease any tension, foster trust, and increase understanding among all stakeholders involved in the care.

Proposed Activities

The purpose of these activities were to collect data for the TCP and to evaluate the findings in order to determine the impact of the encapsulated interventions of the

program in the reduction of the readmission of patients with chronic diseases, particularly CHF, COPD, and DM II.

1. Collect and select literature that would benefit the program development (2 weeks)
2. Collect data from a dashboard of current supportive homebound program (2 weeks)
3. Analyze data (1 week)
4. Evaluation of the data analysis (1 week)
5. Present report to stakeholders (1 week)
6. Dissemination of results- (1 week)

Nurse Practitioner-Led Transitional Care Program Budget Proposal

In order for a program to function properly and for operations to move forward, an appropriate and feasible budget, which includes revenues and expenses for the year, should be put in place. A 6-month budget at start-up would enable stakeholders to analyze the situation. They can help make suggestions, as needed, on how to make the program more cost-effective, sustainable, and reliable. Developing a break-even analysis would add to the planning.

The total cost for a 6-month budget proposal for a startup program would be $143,000 (see Appendix D). Once the program is on a soft launch, and analysis shows a good outcome, then additional funds may be requested from different sectors. Government support may be pursued, which includes Medicare/ACO incentives and budget allocations for companies and organizations showing marked improvement in

their performance (i.e., increased patient satisfaction rates and readmission rates that save government expenditures on chronic patients). According to Naylor, Aiken, Kurtzman, Olds, and Hirschman (2011a), patients in the (TCM) group were found to be less likely to be rehospitalized at least once within 6 months (37.1% vs. 20.3%; $P<0.001$) as compared to the control group. Boutwell, Griffin, Hwu, and Shannon (2009) showed that there were significantly fewer rehospitalizations in 1 year among patients who received the intervention than patients who received standard care (104 vs. 162; $P = 0.047$). Patients in the TCM group earned about half of the average total health care costs in 6 months as compared to the patients in the control group ($3,630 vs. $6,661; $P <0.001$); the patients who received TCM-based care had total health care costs averaging $5,000 less than the patients in the control group ($7,636 vs. $12,481; $P = 0.002$) (Boutwell et al., 2009). The results of this study could be duplicated, and there would be a 50–66% savings that could be counted as revenue. Revenues from the program include moneys saved by the company through the prevention of readmission of the patient in a 30-day period, reduction in the use or duplication of ancillary procedures because early diagnosis prevented exacerbation or complications of the disease, and an increase in the number of patients referred for TCP due to increased rate of patient satisfaction.

The proposed TCP is not considered "budget neutral," a term used by the government to describe the effect—costing or saving the government money— of a new law on a budget. This intervention is not considered budget neutral because it is designed to save on government health care expenditures by saving money by reducing the number of avoidable ER visits and hospital readmissions (McMahon, 2013).

Financial Analysis

The process in which the significant operating and financial characteristics of an organization or firm based from the accounting data and financial statements, expounds on the idea of financial analysis. The primary objective of this process is to demarcate the effectiveness in which funds, both the investments and debts, are employed in the firm (Martin, 2002). Financial analysis also measures the efficiency, profitability, and liquidity of its operations to ensure that the business runs smoothly. Financial analysis is also concerned with the value as well as the safety of the debtor's claim against the assists of the firm (Sofat & Hiro, 2011).

An NP-led TCP is a new alternative to managing discharged patients from the hospital or health care facility. In order to provide stakeholders or investors with a cost-effective financial analysis, numbers and statements need to be cited that exemplify the profitability of choosing a NP-led TCP despite added expenditures on personnel salaries over increasing a patient's hospital stay, hospital readmission, and or ER consultations. Use of NPs to spearhead such program have proven effective and strengthen the daily operation of such intervention. A TCP would address post discharge issues like

1. Incomplete handoff of patients' health care to their primary care physician or provider
2. Lack of appropriate and timely monitoring to warn the patients' health care providers before issues exacerbate
3. Patients' difficulty in understanding their medications and instructions

4. Ongoing obstacles for implementation and coordination of care across the extended care team. (Transition Advantage, 2013)

Lapses in addressing each of these issues cost the organization revenue that may be turned into profit (either net earnings of the corporation when reimbursed by Medicare, financial wise or improvement in the health of the patient preventing readmission in the hospital, clinical wise). Financially, if problems are not addressed and identified earlier, the transition of a recently discharged patient from the facility may bring more financial burden to the CMS (Medicare) and state (medical) in terms of increased health care cost by posing a higher risk of readmission within 30 days post discharge (Innovation Team, 2013). A competent and knowledgeable NP leading the TCP would address this concern.. In accomplishing the goals of the program to reduce readmission, better coordination among primary care providers and NPs in the field and proper use of the support team as stipulated by program planners play a role in applying effective budgeting for program (Chrisinger, 2010; Martin, 2002). Short-term effects of not addressing the problem would be an increased readmission rate of the patient with a chronic illness that can also increase their complication, thus increasing hospital length of stay. It may also result in a consequential increase in morbidity and mortality rates that would further affect the organization financially through loss reimbursement from Medicare /Medical due to underuse of health care services and increased patient dissatisfaction. Long-term effects of not addressing the problem would result in increasing health care costs for the government tantamount to failure to address goals and objectives of the program to reduce the overall cost of health care.

The program planner can present the profitability and effectiveness of the program to the stakeholders and potential investors using cost-effective financial analysis. This would increase the interest in the operation of the program that is equated to improved support to the health care team for better delivery of quality health care to the TP. In addition, it would also eventually yield high impacts on the patients' satisfaction and their families. The increased satisfaction rates lead to a different health care network systems giving the NP-led TCP a positive mark leading to improved profitability (reimbursement) from Medicare/ Medical and other HMOs (see Appendix C).

Implications for Social Change in Practice

The implementation of this NP-led transitional care would have an impact on the care and outcomes of patients from discharge to adjustment to another level of care at home. This may lead to reduced avoidable ER visits and hospital readmission of the TP.

Definitions of Terms

Accountable care organizations (ACO): The organization's tap to manage care of the Medicare-Medicaid insured clients (McGinnis & Small, 2012).

Nurse practitioner (NP): Master or doctoral prepared nurse practitioner ("Nurse practitioner", 2015).

Primary care providers (PCP): The doctors primarily responsible for the care and management of the health of their patients ("Choosing a primary care provider", 2015).

Target population (TP): Recently discharged patients with CHF, COPD, and DM as a part of their diagnosis.

Transitional care program (TCP): The proposed program for recently discharged.

Assumptions, Limitations, and Strengths

The limitations of this study were the number in the sample population and the exclusion of qualitative input to the discussion.

The strength of this project included the increasing number of studies regarding the significant contribution that TCP has on the outcome of patient care.

In this study, I assumed that the TP's readmissions were based on exacerbation of the identified diseases.

Summary

TCP lead by NPs is a new program that appears to manifest promising results in the improvement of patient's health as well as quality of life. Traditional health management cannot shoulder all of the burden of health care delivery. This innovation would pave the way on how quality health care delivery can best be achieved. NPs are equipped with the knowledge and skills to spearhead this program because they have the clinical, psychological, and social charisma that would transcend the care of the patient to a new level of holistic care management. Effective collaboration with PCPs, and other stakeholders (e.g., the hospitalist, health care organizations, auxiliary support groups) should all work together in order for the program to be successful. The intention of the plan is to support the government program in alleviating of the high cost of health care delivery and provide an alternative solution to the problem without endangering the lives of the patients with minimally added cost compared to savings. Placing the right people in leadership positions, the NP, would result in better management of patients' care

because these individuals have the compassion and willingness to serve above and beyond for the sake of their patients' health and well-being. A well-planned budget would provide an effective guide to know how the program is doing and serve as an impediment on the expenditures that may be incurred in the implementation of the program.

Section 2: Review of Literature and Theoretical and Conceptual Framework

Introduction

In this section, various evidence-based NP studies, related to the described project question, were reviewed. The review of scholarly evidence was undertaken so that the related studies could be identified, discussed, and included in the study. Various sources were used for searching including the Internet and the Walden Library. From the sources, various peer-reviewed journals were identified for inclusion in this review. Keywords used included *assessment, nurse practitioner, transitional care,* and *best traditional care practices*. Journals included in the study were all peer-reviewed and published by authentic sources so that the results and conclusions derived from the discussion are reliable.

Theory and Model Relative to the Problem

Transitional care is a new concept; thus, the diffusion of innovations (DOI) theory was the most appropriate theory/model to use for the project. The proposed program involved the process of adopting the continuity of care as spearheaded by doctorally prepared NPs in the field. This program offers an alternative to costly long hospitalization and readmission to the hospital due to the same chronic illnesses (CHF, COPD, and DMII) in relapsed or exacerbation. According to Hodges and Videto (2011), DOI offers an explanation of how new ideas, practices and products spread through a population. Imprinted in this model is the knowledge or exposure to the plan and understanding of its function, persuasion or positive attitude towards the program, decision or commitment to adopt the plan, implementation or use of the plan, and the confirmation of the decision to

adopt a plan based on positive outcomes from the program. This theory collaborates well with the health belief model (HBM) by Stretcher and Rosenstock (1997). This model is based predominantly on an individual's perception of a particular health issue. By changing an individual's perception, the likelihood of an individual acting on the recommended health behavior increases. Glanz and Rimer (2005) stated that there are four important concepts in HBM: "(1) perceived susceptibility, (2) perceived severity, (3) perceived benefits, and (4) perceived barriers" (p. 13). Perceived susceptibility and perceived severity work together to create a sense of fear or threat. In applying these principles to the project, the patients' perceived fear of being not adequately prepared when discharged home and not receiving enough instructions at discharge may cause them to go back to the hospital. By changing such a belief/behavior through timely intervention/care given by NPs during their initial evaluation /assessment and the assurance of availability of immediate help or resources if needed, the patient and their family would benefit. Once innovations are implemented and have produced positive outcomes, they become vital in the planning application. Adopters can implement this plan and tailor it according to their needs (Orr, 2003).

DOI has been widely practiced in research, communications, and in a business. It originated from social science, education, communication, business, and economics (Furneaux, 2012). A typical example of the DOI theory includes the use of new technologies (cell phones, computers, weight products, etc.). Once the innovations are introduced in the market through advertisements (persuasion) and positive reviews from media, consumers (adopters) are attracted and have increased demands for the product

(outcome). It also triggers a decision to produce more products (implementation) by the company. The theory fits nursing informatics as well and provides a scaffold for planning informatics-related innovations (Kaminski, 2011).

Literature Review of Evidence-Based Best Practices to Support the Project

Health-related quality of life and wellbeing (HRQoL) is a new concept topic in the Healthy People 2020 program of the government. The definition of HRQoL varies among different authors, however, researchers agree that this concept is multifaceted and it highlights the influence of a disease and related treatment on the individual's overall well being (Fairclough, 2010). In a different definition of HRQoL, Cella and Bonomi (as cited in Fairclough, 2010) stated, "the extent to which one's usual or expected physical, emotional and social well-being are affected by a medical condition or its treatment" (p. 2). This explicates what the condition as well as the treatment affects the quality of life of an individual in various aspects. For instance, an operation had been successful, however, the financial cost of the hospital bills and the post-op care brings another burden to the patient and their family, which may have impact on their daily livings such as their budget for daily expenses or the education of their children. Such circumstance is also encapsulated in the concept of HRQoL.

HRQoL and well-being have been used by clinicians and public health officials to determine the impact of chronic illness, treatments, and short- and long-term disabilities. According to Centers for Disease Control and Prevention [CDC] (2008), chronic diseases have been recognized as a leading cause of death and disability in the United States. These chronic diseases have been attributed to 7 out of 10 deaths annually (CDC, 2008).

The common chronic diseases, which lead to more than 50 % of deaths in United States annually, are heart disease, cancer, and stroke (CDC, 2008). In 2008, about 107 million Americans had at least 1 of 6 reported chronic illnesses, which entails cardiovascular disease, asthma, COPD, arthritis, cancer, and diabetes (CDC, 2008). In addition, about 1 of every 2 adults aged 18 or older has cardiovascular disease, asthma, COPD, arthritis, cancer, and diabetes (CDC, 2008). The use of transitional care home is a new concept designed to help transition patients discharges from the hospital (TP) to their home without breaking the continuity of care to lessen incidence rate of patient rehospitalization.

The patient's quality of life can further be enhanced through effective management of nurses. Rich et al. (1995) found that a nurse-directed, multidisciplinary team intervention could help to improve the patient's quality of life, reduce hospitalizations, and reduce medical costs for elderly patients with CHF. This was identified through review of readmission rates within the span of 90 days following hospital discharge, indicators of quality of life, and costs of health care for these higher risk CHF patients. Rich et al. indicated that interventions that involve the education of the patient and their family, appropriate diet, a properly planned early discharge, medication reconciliation, and intensive follow-up are important factors in the care of a patient with a chronic disease to avoid hospital readmission and ER consultation. This highlights the significance and impact that an effective patient education, with their families on the discharge plan and instruction, can do in averting potential readmissions and increasing quality of life.

The impact of transitional care had also created a profound impact in terms of economic aspect. According to Ornstein et al. (2011), a transitional care pilot program was designed with the primary purpose of improving the coordination and continuity of care, diminish the rates of readmissions, confirm the financial benefits brought about by shorter length of stay, and improve the documentation of patient conditions. To demarcate the improvement after the intervention, Ornstein et al. compared data from admission-related financial costs, length of stay, and case-mix index. Feedback from the patient caregiver and the inpatient care providers were collected as to the satisfaction and usefulness with the program. It was documented that the program improved communication among the care providers, and it ensured the accurate and timely transfer of critical patient information. Nevertheless, the length of stay and prevention of hospital readmission failed to be reduced by this program. However fine-tuning of this NP-led program model may be a viable way to improve in hospital patient care management, as well as transitional care for older adults in a home-based primary care model.

Transitional care is significantly different from primary care. According to Naylor et al. (2011b), transitional care is described as a broad range of timely services intended to ensure positive health care outcomes and avoid preventable adverse consequences for at-risk populations. Transitional care is complementary, which is not synonymous with other health care services, such as those encapsulated in primary care or case management. The trademarks of transitional care are underscored on highly susceptible and critical chronically ill patients, the timely nature of the services, and a focus on teachings to the patient and caregiver during this transition.

A TCP created by the Visiting Nurse Service of New York was led by a nurse practitioner who provided services which facilitate supplementation of gaps in the care among recently discharged patients requiring home health care and awaiting follow-up appointments with their primary care physician. The nurse practitioner is responsibility in conducting an initial assessment in order for this provides baseline data to demarcate eligible at-risk patients, develop the transition plan before discharge, communicate the transition plan among involved or relevant providers, and supports both the home health patient and nurse during the transition period. Although the program improved the patient's adjustment to a different care setting and reduced waiting times for follow-up appointments, it still failed to reduce unplanned readmissions. These only demonstrated that TCP is still evolving and improving at a fast pace and designing a well-planned program for our organization can serve as a model for others to implement.

According to Long (2012), the transition from one care setting to another has been recognized as a danger-zone laden with factors that can adversely affect health care and may result in poor patient outcomes. In addition, change in the care setting brought about poor continuity of care. The gap between the patient discharge and PCP follow-up visit is where the typical "falling through the cracks" happens and supports the need for a DNP-led transitional, patient-centered, health care intervention that aims to empower the patient and the family/caregiver to address self-care/symptom management including but not limited to medication management and PCP follow-up. Through integration of the knowledge of DNP prepared NPs and the evidenced-based interventions which empowers

both the patients and their families with the appropriate knowledge and tools, TCP can significantly diminished incidence of hospitalization, as well as ER, use (Long, 2012).

I reviewed various studies that are directly associated with the DNP Scholarly Project question. From this section, I was able to identify the best suitable model for this study. In addition, the Diffusion of Innovations (DOI) theory is the most appropriate theory/model to use for the project. DOI offers an explanation of how new ideas, practices and products spread through a population (Rogers, 1995). The theory fits nursing informatics as well and provides a scaffold for planning informatics related innovations (Kaminski, 2011).

Summary

The study findings and relevant literature suggest that nurse-directed transitional care as a multidisciplinary intervention goes back several decades and has been shown as early as 1995 to effectively reduce hospital readmission rates (Rich et al., 1995). In addition, a pilot program by Ornstein et al. (2011) created to improve the coordination of team members; continuity of care, cost-effectiveness, and fewer readmissions has showed equally promising results. Moreover, the literature demonstrates a consistency in care in nurse-led transitional care settings. This circumstance was well illustrated by the NP-led Visiting Nurse Service of New York in which nurses were able to help overcome barriers to attending follow-up appointments after discharge. As stated by Long (2012), the period of transition is a critical time in which a number of factors need to be considered in terms of self-management and family participation. Of all the elements addressed by the literature, some of the most important points included transitional care intervention

thorough educating the patient and family, appropriate diet, proper discharge planning, medication reconciliation, and timely follow-up. Each of these elements becomes all the more crucial when working with patients suffering from chronic disease.

Section 3: Methodology

Introduction

In Section 3, the data collection, data analysis, population sampling, evaluation, and dissemination planning of the DNP scholarly project are discussed. It is a core section of the DNP scholarly project as the entire project is based on the effectiveness of this section.

Outcome Data Collection Process

Implementation of the program started with quantitative data collection and analysis using the statistical tool Statistical Package for Social Sciences (SPSS). Quantitative analysis was done through the collation of data from the company's dashboard. These data included demographics, ER diversions, hospital admission/readmission, and the number of hospital bed days before and after the implementation of the program proper.

For the NP-led TCP, 2 years of data from the organization dashboard were collected before and after they had been enrolled in the homebound program. For patients to be in the program, they had to have (a) CHF, COPD, and/or DMII; (b) a history of two or more admission after hospital/facility discharge related to CHF, COPD, and/or DMII, such as chest pain infection, shortness of breath (SOB), cough diabetic ketoacidosis (DKA), hypoglycemia; (c) recently discharged from hospital or facility to home, and (d) managed by well-qualified NPs.

Population Sampling

The sampling method used was a collection of data from the dashboard without any personal identifiers except age and gender. The TP included patients with chronic disease, particularly CHF, DMII, and COPD, who were recently discharged from the hospital, transitioned to their home, and seen by the NP in 24–48 hours from discharge. The sample population of data related to 1,173 patient visits that were evaluated and assessed by the field NP within the qualifying period

The institutional review board (IRB) is the formally designed committee to approve, monitor, and review all biomedical and behavior research involving humans. The board assures the ethical conduct of studies with respect to the protection of human subjects. For this project, de-identified data for patients who were recently discharged and who meet the above-described criteria were provided to me from the hospital records with permission of the hospital authority. The data were anonymized so that individual patients could not be identified. Permission was received from the Walden IRB prior to beginning the data collection and analysis (Approval No. 09-25-14-032413).

Methodology

The methodology included a secondary data analysis from the NP organization dashboard database for the past 2 years. Data were collected from the dashboard on patients as to (a) age (65-85 YO); (b) sex; (c) ethnicity; (d) with diagnosis (CHF, COPD, and DMII); (e) recently discharged from hospital or SNF (within 24-48 hours) with a diagnosis related to exacerbation of the either CHF, COPD, DMII, or all and were transitioned to their home; (f) had been evaluated and managed at home by an NP within

24-48 hours from discharge; (g) had been evaluated and managed at home by an NP after 48 hours; and (h) had been managed and cared for by a home visiting NP for 30 days from the most recent discharge from hospital/facility.

Prior to the collation of data, a data use agreement was secured between JANP Inc. and me. The agreement entailed a clear demarcation of what was allowed to be retrieved from their records, which would only be applicable for the research. The agreement was congruent with the rules and regulation from HIPAA. Aside from the organizational data use agreement, I also secured IRB approval, which guided this study in ensuring that it was completed appropriately and ethically.

Data Analysis

The secondary data were analyzed and evaluated. The analysis was represented using appropriate graphs, charts, and tables. The data collected were analyzed using the SPSS software.

Results

Below are the data collated from JANP Inc. from January 2013 to June 2014 (exactly 18 months). Table 1, Figure 1, Figure 2, Figure 3, Figure 4, and Figure 5 provide a summary of the data.

Table 1

Summary of Data

Period	1/13 to 1/14 (18 months)
Total new referrals seen at home	2016
No. of patients included in high-intensity care	1173
Patients Diagnosed with Congestive Heart Failure, Diabetes Mellitus II, Chronic Obstructive Pulmonary Disease, or All (Between ages 65 to 85 years old)	819
Readmission in a span of 30 days after nurse practitioner home visit program	155
Readmission in the span of 30 days which is brought about exacerbation of COPD, CHF, and DM Type II	98

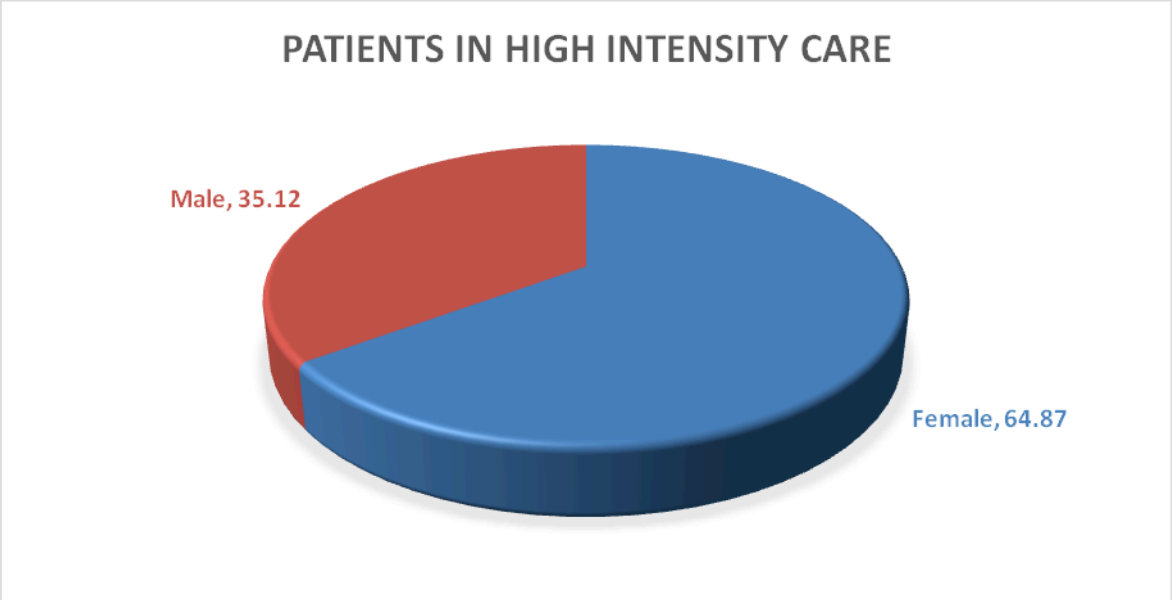

Figure 1. The rate of male and female patients in high-intensity care

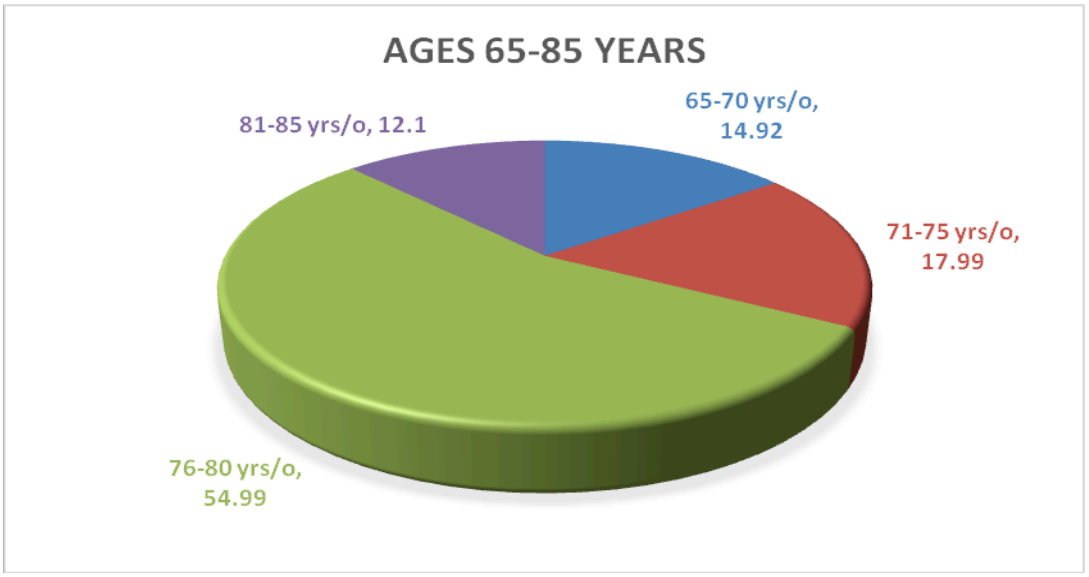

Figure 2: Rate of patient in high-intensity care according to age.

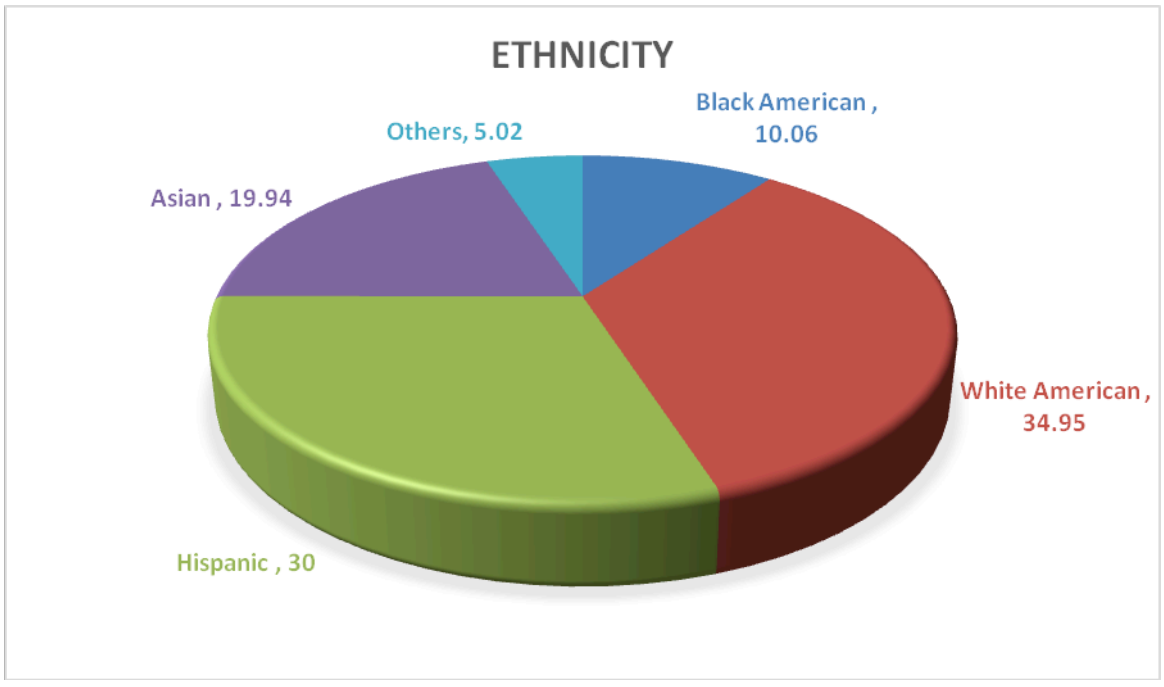

Figure 3: Rate of patient in high-intensity care according to race/ethnicity.

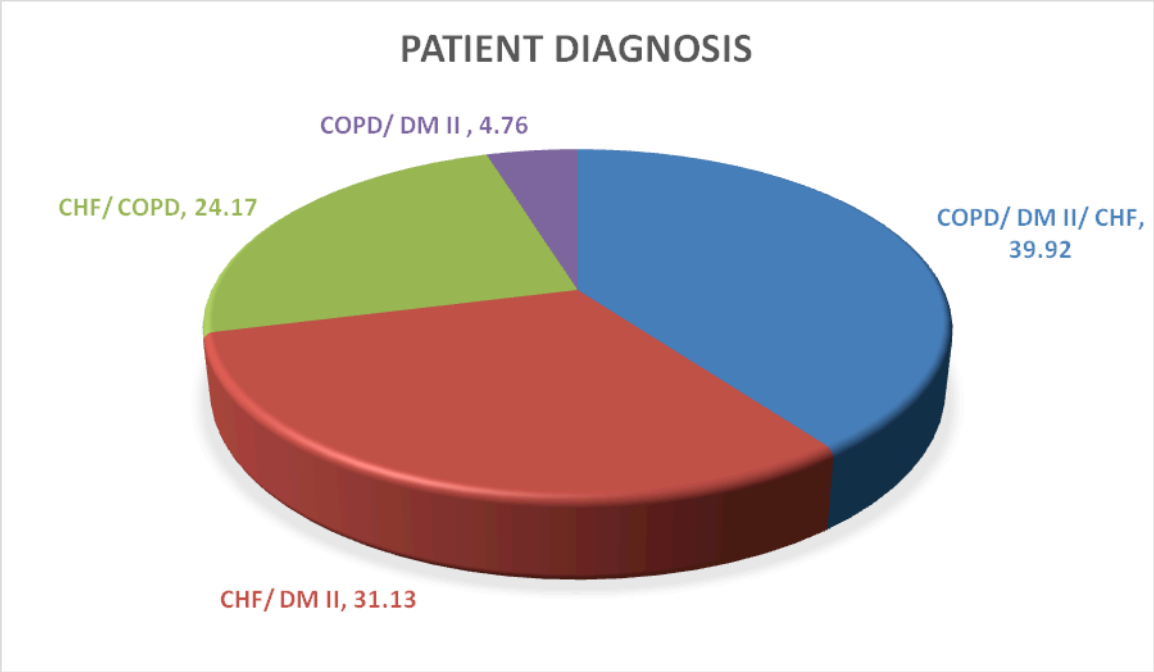

Figure 4: Rates of patients diagnosed with congestive heart failure, diabetes mellitus ii, chronic obstructive pulmonary disease, or all (between ages 65 to 85 years old).

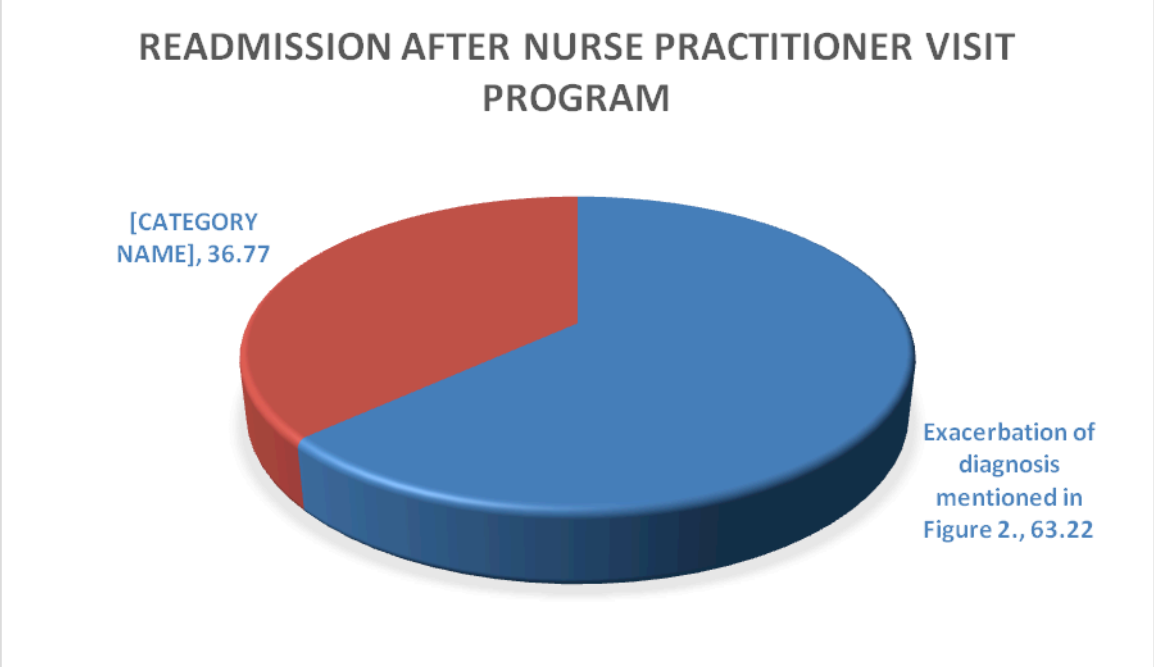

Figure 5. Rate of readmission in a span of 30 days after nurse practitioner home visit program.

The initial number of referrals who were seen at home was 2016. Patients who were not included in high-intensity care were removed from the participant group. To identify which among the patients would further fit the study; we identified patients who were diagnosed with CHF, DM Type II, COPD, or All. All of these patients were between 65 to 85 years old. From these criteria, the number of patients was further reduced from 1173 to 819. This implies that 30.18 percent of the participants or referrals were removed from the study. In addition to this, all remaining patient were all under high-intensity care, diagnosed with CHF, DM Type II, COPD, or All, and between 65 to 85 years old. They were all undergoing Transitional care, and due to the integration of this nursing intervention the patient who was readmitted in a span of 30 days after the nurse practitioner home visit program were reduced to 155 and shows 81.07 percent of the patients have likely improved their health. And in further evaluation, the readmission of patients in the span of 30 days that brought about exacerbation of COPD, CHF, and DM Type II diminished by 36.77 percent; thus resulting to 98 readmissions only. After filtering the data from JANP Inc. the 2016 number of new referrals was reduced by 95.14 percent, and 4.86 percent represents the older adult with readmission in the span of 30 days due exacerbation of COPD, CHF, and DM Type II.

Summary

The results of this study were collated from the data gathered from JANP, Inc. The organization allowed the researchers to utilize their existing record in order to appraise how effective NP-led TCP is in the reduction of readmission cases. In addition

to this, it helped further demarcate the impact of this program in reducing the hospital cost that the patient would usually spend with regards to their condition. Upon evaluation of results, the figures depict a diminishing number of patients being readmitted which can define the effectiveness of the program.

The study focused on the three most common chronic illnesses among older adults, which are CHF, COPD, and DM Type II. These are also the most common cause of readmission among the said population. Therefore, upon appraisal of the reasons for readmission after the program, we have defined the number of patients who were readmitted because of the three chronic illnesses and compared it to the number of patients with this illness prior to the implementation of the program. The figures presented above were the product of the organization's two years of data (18 months to be exact), which then expound that the patients were closely monitored during the homebound program.

Section 4: Findings, Discussion, and Implications

Introduction

This section provides an explanation of the significance and implications of the results collated from the study's evaluation. The reduction of the figures from the initial data were expounded to facilitate a better understanding on how the program affected the quality of life of the patient, the likelihood for readmission for the same chronic illnesses, and also the cost reduction it has on the patient's hospital bills. I also present the implications of this study, as well as the influence the program had in improving the patients' health and the need to have this strategy implemented in every health care setting. JANP Inc.'s 2 years of data provided information that defined how improvement and integration of new interventions with the conventional nursing care and discharge plan have helped the patients with long-term effect in terms of improvement of their health.

Discussion of Results

The results presented above are a summary of data collated from JNAP Inc. In this project, I discussed the number of patients qualified for this assessment of the program and the impact of implementation of the program. From the data presented above, in the span of 18 months, there were 2,016 newly referred patients seen at home. Among these figures, about 1,173 were considered to be under high-intensity care. In order to be considered for this care, a patient must have at least two or more hospital admissions or ER consultations in the span of 6 months.

The majority of patients under this care were females (761), and the remaining 412 patients were male. From 1,173 patients, data were further subdivided based on their diagnoses. All of the patients aged from 65- to 85-years-old. There were a total of 819 patients diagnosed with CHF, DM Type II, and COPD. All of these patients not only had one diagnosis, they had at least have two to three concomitant illnesses at one time. A majority of these patients were diagnosed with all of the diseases mentioned in Figure 2, such as CHF, DM Type II, and COPD. Then, patients with CHF and DM Type II followed this; then patients with CHF and COPD; and the least part of these patients have both DM Type II and COPD.

The 819 patients were further narrowed down to 155 who had at least one ER consultation or hospital readmission. The reduced number of readmissions was further categorized based on its cause of readmission. About 98 readmission or ER consultation were brought about by further aggravation of CHF, DM Type II, and COPD, while a smaller portion from this figure, 57, was due to falls, scheduled surgery, urosepsis, and other causes that were not brought about by the three main diseases mentioned above. The great reduction of readmission, as the figures were further filtered based on the qualifiers, narrow down to 98. These 98 patients were all under high-intensity care; aged 65- to 85-years-old; had diseases such as COPD, CHF, and DM Type II; had readmission 30 days after a NP home visit program from 24 to 48 hours after discharge, and were readmitted because of exacerbation of COPD, CHF, and DM Type II. Hence, transitional care provided by NPs was effective.

Patients aged 65- to 85-year- old may be perceived as population that would require assistance merely because they are old. However, this does not limit them on their capabilities such as making sound decisions and adapting to the changes and available resources in their surroundings. The population in this age range can still be assisted in a so that they can also help themselves manage their condition and improve the quality of their life. Although the program seems to provide a promising result, it is still imperative to consistently evaluate the NPs implementation in order to identify the needs and opportunities for further improvement. Furthermore, it is also important to demarcate the different settings of transitional care to further empower the nurses on how they could increase their competency level.

The competency and experience of the health care provider, particularly the nurse, is one of the limitations that could affect the impact of transitional care. According to Naylor and Keating (2008b), there are several factors that compromise the quality of transitional care. These factors include "Poor communication, incomplete transfer of information, inadequate education of older adults and their family caregivers, limited access to essential services, and the absence of a single point person to ensure continuity of care all contribute" (Naylor & Keating, 2008b. p. 58). These are modifiable factors that are dependent among nurses. Aside from these factors, the predicament of a compromised quality of transitional care is further aggravated by cultural differences as well as the language and health literacy.

In transitional care, it is imperative to consider the diversity of patients. Although the program is focused on the same goal, there are still varying interventions that must be

tailor fit to each patient. Naylor and Keating (2008a) mentioned three approaches evident among several studies on transitional care. This was found to be helpful in improving the quality of life of chronically ill adults. These three approaches are increasing the access of older adults among proven transitional care services, enhancing the transitions among acute hospitals settings, and enhancing the patient handoffs to and from the acute care hospitals (Naylor & Keating, 2008a). Each of these approaches was further explained in this current study, but the evidence also has limitations, which could influence its results.

The community-based case settings can be further divided into the hospital at-home and day-hospital settings. In the study articulated by Naylor and Keating (2008a), they expound that in the hospital at-home settings, the results of the study showed that older adults who would then be hospitalized due to further aggravation of their chronic condition achieved the same result obtained if they are in an acute care hospital. In fact, they manifested a shorter length of stay and significantly lesser overall cost (Naylor & Keating, 2008a). The older adults engaged in this program expressed a satisfaction with this program. The day hospital, on the other hand, is another form of transitional care. In this program, the participants have access to services such as rehabilitation and palliative care. However, these services are only available for a few days every week for 9 weeks (Naylor & Keating, 2008a). The outcome expound by Naylor and Keating on the study manifested the similar outcome on the program of this current study, the participants from JANP Inc. had an increase reduction readmission or hospital use and the participants also manifested an improvement in their function.

In relevance to transition within settings, there are two programs in this setting, Acute Care for Elders and Professional Patient Partnership. The Acute Care for Elders model is developed from University Hospitals of Cleveland in Ohio, which aim to help the patient increase their increase their discharge readiness and avert functional decline. This also means that this program helps the patients feel empowered regarding their health. The findings described in this study also showed a shortened length of stay in the hospital and diminished hospital cost as compared to conventional care. The professional –patient partnership model is developed to improve the discharge planning of the patients. This model not only focuses on molding the competency of the health care providers but also empowering and improving the patient's ability to manage their own health. After the implementation of this model, the findings of the study showed that both the patients and health care providers expressed their readiness and effectiveness in managing their health after discharge (Naylor & Keating, 2008b).

In terms of transitions to and from the acute hospitals, the settings are further divided into two models, care transition coaching, and APN transitional care model. Care transition coaching is an intervention in which health care providers encourage the patient and their family caregivers to increase their role during the transition. In this study, the result also manifested significant results such reduced readmission in the hospital 90 days after discharge. In addition, the results showed that patients save $500 less of mean hospital costs in the span of six months after discharge. The APN transitional care model, conversely, is an intervention, which is offered for older adults with higher risk and multiple medical and surgical conditions (Naylor & Keating, 2008b).

The result of this study was also the same as with the other mentioned above. The patient manifested improved physical function, satisfaction with care, and quality of care. In addition, patients have lesser numbers of readmissions and expenses in total health care cost (Naylor & Keating, 2008b).

In comparison to the result of the study, it is likely that the number of readmission sand ER consultations can be further diminished. The studies also revealed that regardless of what approaches used, all manifested positive results. The impact has increased the physical function of the patients and reduced the total health care cost brought about by readmission as well as exacerbation of their illnesses.

There have been a limited data collated from the JANP Inc., which hinders a more succinct impact of transitional care. One of the less underscored factors of transitional care is the competency level of nurses and the standard physical functions improved among the patients. In addition, the absence of readmission a month after discharge is something, which could be possible. A significant part of this intervention for this health conditions involved maintaining a healthy diet, healthy lifestyle, and discipline. This program must be able to underscore these factors because they are fundamental to all health conditions, and it can bring better physical function among patients who are chronically ill, as long as they can sustain the discipline to manage these diseases.

Another important aspect of this study is determining if there is a need to establish a plan of care for different genders because the number of admissions is significantly high among females. The number of female population is nearly twice the number of male population in terms of readmission, which may suggest that intervention needs may

be slightly different for male patients. Further research on this topic is imperative to provide further enlightenment on the degree of impact of transitional care considering the diversity of patients. In this study, the ethnicity/ race, different age range within 65 to 85 years old and patient care settings were not demarcated which may also have an influence on the quality and effect of transitional care.

Plan for Evaluation

Performance of the proposed program would be monitored as to their utility, feasibility, propriety and accuracy to reflect in the summative evaluation whether the program is effective in reaching its goal of improved patient outcome with concomitant cost reduction in their health care (see Appendix B).

Long-term effects of the impact of evaluation to the organization would be its ability to save on the cost health care maintenance of patients with CHF, COPD and, or DMII (TP) by virtue of improved patient outcome. Whereas the short and intermediate effects as a consequence of the implementation of the program are patient health care outcome would improve as evidenced by reduction of avoidable hospital readmission and ER visits of patient with chronic diseases like CHF, COPD and DMII (TP) if seen within 24-48 hour after discharge from a higher level of care to home.

NP-led TCP is a new alternative to patient care outside the hospital. It serves as an answer to one of the objectives of the Healthy People 2020 that is to “create social and physical environments that promote good health for all” (CDC: Healthy People 2020). Program effectiveness may be evaluated using both Outcome Base Evaluation (OBE) and Impact Base Evaluation (IBE). OBE examine the results of a program to determine if

there are differences between the outcomes and the program's stated goals and objectives. It shows what changes or benefits of the program affect the people through the outputs. IBE is a subset of an outcome evaluation that assesses causal links between program activities and outcomes (United States Environmental Protection Agency, 2012). It illustrates the impact of implementing the program for the people and is articulated as a statement of change or how the target population is compensated while OBE measures the scope of a project's activity such as products generated and delivered, persons served, events and services affected; they are the assets of a project and are usually expressed in numbers. OBE is means of determining whether a project or program has met its goals. This helps in establishing and measuring benefits and demarcating intended population to be benefited (Utah State Library, 2013). Hodges and Videto (2011) described this evaluation process as it focuses on the long-term goals. Ideally, thorough process, impact, and OBE would be conducted, but resources, as well as the needs and wants of the stakeholders, may come into play when evaluating a program and may affect the evaluation type. Questions to ask for this program include what is the purpose of the assessment? Who would use the evaluation results and how the results are going to be utilized? Nurse Practitioner led Transitional Care Plan’s cost-effectiveness would be judged according to the patient satisfaction results, reduction in patient readmission rate and ER consults, and increase communication between providers and primary care physicians that would ultimately be manifested in the reduction in cost spending for the health care maintenance of these chronically ill patients. The outcome evaluation program is not only useful in the nursing fields but also useful to the social service

agencies in assessing the problem of homelessness on how the housing program can mitigate the problem and in assessment of library services (Rubin, 2004).

Program evaluation is an important and valuable measure of the effectiveness of the program developed. To evaluate TCP outcome base evaluation would be utilized. Evaluators may use qualitative and quantitative methodologies used by other investigators in other fields but the vital qualification is that it should have organized data collection method to be able to relay the results to the concern groups (stakeholders) in a timely manner. Positive evaluation results would pave the way to sustain the support of the organization's financial leadership. This would demonstrate how robust the program is.

The evaluation plan includes goals, objectives, activities and data collected to attain the goals and objective intended. The evaluation plan also targets to demarcate if there are avenues for opportunities, which could affect the effectiveness of nurse practitioner. For instance, the issue touches on factors relevant to diversity such as race /ethnicity, age range within 65 to 85 years old, and other cultural differences. Although the data or results provided by JANP Inc. did not underscore and individually presented data based on patient differences, this program would try to appraise if such factors would have a significant impact on transitional care especially on the level of competency manifested by the nurse under this program.

Plan for Dissemination

Success in distribution may be influenced by the overall nature of the information that has been developed with stakeholders' cooperation because it should produce an

effect that would be useful to the targeted audience. To be effective in disseminating the program it should be oriented towards the need of the stakeholders (patients with CHF, COPD, and DMII, insurance companies, primary care providers, home health agencies, pharmacies, etc.) and should be in the language that they understand. It should include a variety of methods (1) written medium such as publications (2) electronic media such as social media, websites and links and (3) person to person contact by organizing project presentation using visual aids such PowerPoint, posters, and flyers to better relay the message of the program.

Publications are still considered one of the effective means of dissemination although such intervention is very conservative; the effectiveness can never be marginalized. The Urban Health Institute - Johns Hopkins University (Greensboro Health Disparities Collaborative, n.d.) articulated that academic publications are an integral form of knowledge dissemination. One rationale for this notion is because book per se is an essential means of bridging the gaps and disparities among stakeholders, which facilitate better communication on a particular circumstance. For instance, DM Type II is often associated with eating too much sugar. This perception is linked to diet, but the understanding of the disease per se is very limited because people think that once you take in food rich in sugar or anything sweet, it could lead to Diabetes. However, through the availability of written publications such as pamphlets or small and thin books, educators can integrate the fundamentals that every individual needs to know about the disease. For instance, people should be familiar with other symptoms of Diabetes including excessive thirst, excessive hunger, and frequent urination. In addition to this,

written publications allow an individual to expand their knowledge even on the technical health condition because they are equipped with the basics required for better understanding.

Electronic media should not be marginalized in terms of information dissemination because this is other means that can also have access to vast array of the population. For instance a simple social network media such as Facebook is not only limited to sharing personal thoughts, several companies and organizations had been using this means as a practical tool to promote their products or purpose. Therefore, dissemination of information through social network websites such as Facebook, Twitter, and other sites also implies that it could facilitate further expansion on how information can be disseminated, regardless of age, gender, geographic location, and other varying factors. Vyas and Trivedi (2014) expound that social networking is an invaluable tool capable of communicating information to a wide audience. In the study, they have conducted in determining the role of social networking tools in the sharing of information of Smt. Hansa Mehta Library; Vyas and Trivedi (2014) found that promoting and disseminating information through social networks such as Facebook, Twitter, Blogger, YouTube, RSS, Plus Share, Wikipedia, MySpace, Ning, Meebo, LinkedIn, Flickr, PBwiki, Footnote, Community Walk, Slide Share, and Digg, the library was able to interact with more users. In addition, social networking tools can help this study to promote collaboration among stakeholders because it may have a forum, comments, or discussion in which they can express what they think about the information. It is also a means of appraisal, which identifies the opportunities and other means of improvement.

Another advantage of this approach is that it requires less cost, less effort, less manpower, but greater impact. Social networking or websites have less cost because presentation or dissemination of information would be continuous but would only necessitate expenses for the Internet connection, computer to use for social networking or in creating an official website, and for site maintenance. As compared to continuously organizing a person to person presentation, the cost is quite high and the event would also require greater effort and certain number of workforce to ensure that the presentation would run smoothly; unlike in social networking or website a person or two would be enough to sustain and maintain that dissemination of information.

Facebook: a very popular social networking sites which allow people to comment, chat online, make friends, and also share resources (Vyas & Trivedi, 2014). Facebook also has a service in which organization, movies, or certain cause wanted to build an official page in which user can like to keep them posted of its updates.

Twitter: a microblogging application (Vyas &Trivedi, 2014), which provides consistent daily updates about an organization or account holder. Information dissemination is best for this application specifically for promoting and inviting audience for seminars or presentations.

Blogger: creating a blog gives an author a profound means of disseminating information because the organization or the author would be able to feature or disseminate wealth information at one time. This is best for presenting articles or pieces of evidence about NP-led TCP in the states or, in the same settings. This

can also serve as an update for the student nurses, novice and seasoned nurses. Vyas and Trivedi (2014) expound that blog can be maximized when used with RSS.

RSS: This stands for Really Simple Syndication, which was associated with web formats used in publishing information, which often utilized for blogging, live audios, news feeds, as well as video. Vyas and Trivedi (2014) expound that RSS helps the users be updated with the latest information.

YouTube: Another popular website in which presentation can be provided through videos. This is the best means of dissemination information because tutorials and presentation of shreds of evidence about NP-led TCP. Novice nurses can benefit from this means because they would be able to see how to conduct properly interventions encapsulated in this program.

Wikipedia: An online encyclopedia in which other users can share their inputs about the program. Wikipedia has an editing feature, which allows the user to share their pertinent and significant knowledge on a given topic.

Person to person contact is another means of information dissemination, which requires a great effort from the team. First, the team would first consider their audience. They have to determine for whom the materials would be applicable to and how many people can be catered by the presentation. Second, are the materials sufficient enough to address the audience's needs and level of understanding? Finally, this means of dissemination could be costly especially if it requires provision flyers or posters. There is also a possibility that the dissemination of information on this approach would be limited

because the presentation would only be limited to certain number of hours and the audience for the performance would also be limited based on the capacity of the venue where it would be held. However, such a strategy could be based applied when engaging with health care providers such as nurses because the audience would be able to raise their concern about the presentation per se and have their respective concerns addressed immediately. The means of dissemination of information would be based largely on the purpose, audience, and the content that we intend to present.

The most important thing that should be included to have a successful dissemination is to recognize and provide for the "natural flow" of the four levels of distribution that would lead to the ultimate goal of the DNP scholarly project, which is program utilization namely (a) spread, (b) exchange, (c) choice, and (d) implementation. It is also imperative that what would be disseminated is accurate, relevant, and representative.

Ten Elements of an Effective Dissemination Plan as Applied to TCP

1. Goal: To reduce avoidable hospital readmission and ER consultation thru improve patient outcome.
2. Objectives: Based on evidence-based best practice TP would be transitioned well from a different level of care to another in this case from facility to home. The effective change is believed to improve patient outcome thereby supporting the achievement of the goal.

3. Users: Potential users are the TP, health insurance companies be it Medicare, Medical or managed care, PCP and or the different disciplines involve in the patient care.
4. Content: Content of the medium for dissemination should be simple, informative, colorful, and attractive to catch the attention of the end users for the sole purpose of increasing "buy-ins."
5. Source(s): Coordination with public places such as hospitals, waiting sheds, convenience stores, radio stations,
6. Medium: TCP project propose to use the Poster, Flyers and PowerPoint presentation as the medium of dissemination.
7. Success: The increasing number of attendees on presentations and a widespread of knowledge about TCP would measure dissemination success.
8. Access: Poster, Flyers, and PowerPoint, Website that has links where the searcher can go deeper into the result and conclusion of the DNP academic project. The website would include a blog area where users are allowed to comment on the findings of the DNP academic project.
9. Availability: For the result of the DNP scholarly project is readily available to the end users, after fine-tuning, it is the investigators purpose to submit it for publication.
10. Barriers: As with other endeavors, dissemination of this DNP scholarly project is expected to encounter barriers thus they should be identified at

the beginning and address as it as soon as it arises. One barrier identified were the permits that may not be given to post the posters on strategically locations therefore communications would be sent out as soon as the

Aim for Sustainability

What good is a project if it is not sustainable? A project is called workable when there is a continued utilization after its completion. When a project delivers a relevant contribution the health care industry, sustainability is expected. Implementation of the TCP based on evidence-base best practices would determine the project's sustainability. To be assured of sustainability one should be able to identify the results, which should be implemented, have the commitment of the stakeholders, which in turn would foster financial support leading to increase visibility of the program (Guidelines Project, 1994) (see Appendix A).

The ultimate goal of this project is to improve TP health care outcome thereby reducing health care maintenance expenditures and finally, based on results; it is the hope of the author that the program be sustainable.

Implications

Policy Impact

The result of this study on the current health care system is emphasizing the need to implement an NP-led TCP in every institution. It was presented and well demarcated in the study, that the data were gathered from an estimated two years of TCP among hundreds of patients. The time allotted by JANP Inc. for this program has provided

valuable results, which led to several conclusions. First, the program has aided in reducing the number of readmissions. Second, the program has also substantially helped the patients reduce their hospital expenses. Given this outcome, it can be inferred that integrating such a program among all health care settings would significantly impact the industry as well as the nation's health expenses. Therefore, it is time for policymakers to ponder such of programs and help the hospitals and clinics and facilitating the strategies encapsulated in the program actually.

Clinical Practice

The interventions learned, and the impact of this program has an enormous impact on the quality of clinical practice because it allows nurses to become more competent. It could also increase the nurses' interest in furthering their knowledge and skills because it makes them a better nurse, but it also has an impact on reducing their workload in the hospital and allotting more time for other integral concerns. It has become evident that the number of people requiring medical attention has been increasing and this may also compromise the nurse's quality of work since they have to manage their time based on the census at a given period. It may be possible that nurses would not be able to ensure optimal level of service and quality care at every given time at every patient catered. Thus resulting in an inadequate care outcome. However, if readmissions would be substantially diminished, then nurses can allot more time to their patients, and they can also provide more attention to the needs of their patients.

Research

In terms of research, the study could serve as supplementary information on the impact of a TCP. In addition to this, it can also be a means to define the most applicable and useful TCPs that may be applied to the patients based on their need or in accordance with the availability of their resources. There is still a great need to consider factors that would have impact on the care program because regardless of how astounding the transitional care plan can be, the outcome may still be insignificant if the patient would not be able to adhere and sustain on was advised. This allows the nurses to create alternatives that would still increase the effectiveness of the program and at the same time increase the patient cooperation and quality of life.

Studies on TCP may also define as to when this strategy can be applicable or helpful. As mentioned earlier, the program was applied to the three most common diseases. This then allows the researchers to identify what has caused the patient's readmission. It may be possible that the patient have all the required resources for his or her care but they fail to understand how these can be utilized, or they simply do not comply with what was prescribed. This rationale then can be expounded on how a TCP creates social change.

Social Change

The best social change that could be cultivated by the TCP among patients is empowerment. The program seems to have a positive impact on the patients because it makes them more in control of their health and aware of the complication they may likely be encountered. Therefore, this can also be a great means of making patient education

more effective especially in chronic illness because the complications of their diseases are not only brought about by the disease process per se but it is also influenced by the individual's lifestyle and eating pattern. It also gives them wider knowledge about health as well as their conditions. In relevance to nurses, the social change that it could manifest it associating every nurse as a competent health care provider. This is because patients would sometimes associate nurses as health care providers who would merely follow orders for physicians. However, the roles and responsibility of a nurse is not only limited to this idea. Nurses are capable to make their own decisions and advised non-pharmacologic interventions that would make profound results or improvement in the body. In addition to this, it hastens the nurse's skill and the role of being an educator because the success of the patient reflects the effectiveness and competency of their nurse.

Summary

The quantitative data collection would be employed in the program to provide better analysis, and review of data gathered through the whole process of implementation and the author have chosen the use of SSPS as its statistical arm. It is my aim that this program be further improved by future investigators and for the program to be continued so that newer data and statistical analysis can be incorporated, which would enhance the evaluation of the program as to its viability and reliability of its use. It is essential that the data would be as accurate as possible so that the initial endeavors of this study can be reproduced in future studies. Information dissemination is crucial to the success of the program in order for stakeholders (primary care providers, hospitalist, health care

organizations, etc.) and potential investors to take ownership of the program and be a part of the changes that are coming in the health care world.

Section 5: Scholarly Product

Project Summary and Report

Introduction

The DNP project proposal was developed to identify the impact of transitional care among patients, particularly among older adults with chronic illnesses such as DM Type II, COPD, and CHF. In materializing this study, we have collated the data from JANP Inc., which included 30 patients with the above health condition and qualifies under these conditions:

- Age (65-85 y/o)
- With diagnosis (CHF, COPD and DM Type II)
- Recently discharged from hospital or SNF (within 24-48 hours) with a diagnosis related to exacerbation of the either CHF, COPD, DM Type II or all and were transitioned to their home
- Have been evaluated and managed at home by an NP within 24-48 hours from discharge
- Have been evaluated and managed at home by an NP after 48 hours
- Have been managed and cared for by a home visiting NP for 30 days from the most recent discharge from hospital/facility.

Provided with these qualifications, we have conducted a summative evaluation to identify the effectiveness of the program in reaching its goal of enhancing the patient cost with a concomitant cost reduction in their health care. The data collated entails the number of new referrals seen at home; patients included in the high-intensity care;

patients diagnosed with chronic diseases such as CHF, DM Type II, COPD, or all; patients who are readmitted in a span of 30 days after nurse practitioner home visit program; and readmission in the span of 30 days which is brought about exacerbation of COPD, CHF, and DM Type II. This would help identify the discrepancy of a patient outcome prior and after the interventions involved in the transitional care.

Background

Transitional care is not an overnight nursing intervention, which is expected to manifest significant outcomes. This was expressed as a, "broad range of time – limited services designed to ensure health care continuity, avoid preventable poor outcome among at-risk populations, and promote the safe and timely transfer of patients from one level care to another or from one type of setting to another" (Lubkin & Larsen, 2013 p. 524). This study identified the influence of transitional care and its association with increased rates of potentially avoidable hospitalizations. Lubkin and Larsen (2013) articulated that in a 2009 study, about 20 percent of Medicare beneficiaries discharged from the hospitals were re-hospitalized within 30 days after discharge, and nearly 34 percent were readmitted after 90 days. Chronic illnesses were the main factor for the patient's readmissions.

The results collated from JANP Inc., provided an overview of a need to integrated Transitional Care Program in Health Care Institutions for it underscored a meaningful reduction of patient readmission brought about chronic illnesses after the program. Transitional care interventions have been evaluated to provide profound benefits. Lubkin and Larsen (2013) have mentioned that among 18 studies appraised, the authors have

inferred that there is a robust body of evidence, which can support the benefits of transitional care. In addition to this, the studies of nine interventions showed positive outcome of transitional care such as demonstration improvement on at least one measure of readmission, while eight out of nine studies manifested diminished all –cause readmission through at least 30 days after hospital discharge. On the three studies evaluated, it demonstrated effective reduction on readmissions for at least 6 to 12 months after discharge, these three studies involves a focus on patient self- management.

The rationale, which has motivated the study to be developed, is the increasing number of patients with a lesser number of health care providers to assist them, especially nurses. The scarcity in number of nurses is not only a predicament of United States but also other parts of the world, and we can't blame the increasing number of patient because part of the nurse's responsibility is to promote health and prevent hospitalization or re-hospitalization. Therefore, nurses would still have a substantial part in ensuring that the patient would be provided a succinct discharge instruction or post discharge care if necessary, because the impact of transitional care is not only focused on the improvement of health but also in the reduction of health care costs which is one of the stressors during patient care.

The impact of transitional care from other recent studies can then provide a substantial support and explication of how it can aid patient with chorionic illnesses. Furthermore, it also supporting evidence that the result collated from JANP Inc. supported a care program that would help various patients, especially the older adults.

Proposal and Future Project Strengths

The strength of this proposal is underscored based on the recent studies which provide strong evidence supporting the profound benefit of transitional care, its main focus is on addressing the needs after discharge (Grove, Burns, & Gray, 2013) as to avert readmission Capezuti, Malone, Katz, and Mezey (2014) articulated that transitional care is at the core of health care issues such as overly complex and uncoordinated delivery of care, requiring steps and patient handoffs which brought about the slowdown of care as well as the reduction instead of enhancement of safety. They also added that about 90 percent of the readmissions are actually unplanned or preventable, which help Medicare save about $17 million of payments.

Recommendations for Future Project Study

Transitional care may vary from one institution to another, and this can be defined by the best practices of transitional care implemented in different hospitals. According to Capezuti et al. (2014), best practices of transitional care do not start upon discharge of the patient but as soon as the patient is admitted and sustained throughout this period up to 90 days after discharge. In addition to this, the care also entails interventions which go beyond the provide discharge instruction, which allows the patient to empower themselves in managing their health. It helps them reduce complete dependency and demarcate their capabilities in control and managing their health care needs with moderate to minimal health care assistance. Therefore, future project studies relevant to transitional care should also encapsulate variation among different institution to identify

which interventions are effective and what among these interventions needs further improvement.

Dissemination of Plan

The dissemination of plan would focus on utilization of World Wide Web because this would allow greater access to a wider audience. In addition to this, there are several social media settings, which would help this project be integrated with various ideas through communication with the audience. The presentation of succinct and updated information on transitional care helps the audience, such as health care providers together with the patient's and their family caregiver to be equipped with the fundamental information about management of chronic illness at home. In addition to this, Steiner (2012) also mentioned that it can be effectively used to post the ongoing activities and of the study with a presentation of the final results in a more formal forum. The dissemination of information would utilize Blog, Facebook, Twitter, and Wikipedia in order to have rapid access (Caroll, 2013) on the target audience.

Conclusion

This study demarcates not only the benefits of transitional care, but also how nurses can effectively reduce the likelihood of readmission upon the patient's admission. Capezuti et al. (2014) has mentioned that best practices of transitional care starts upon admission of the patient. This then helps nurses identify how they could increase the patient outcome in terms of enhancing the quality of care and helping patients reduce their readmission. In addition to this, this study would also define the need for every hospital to integrate effective transitional care in their institution.

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Appendix A: Transitional Care Program Budget Allocations for 6 Months

Revenues		Expenses		
			Per month	Per 6 months
Initial Investment of the Medical Group	$143,000.00	1. NP salary @ $10,000./month NP patient /day=6 x 5 =30 visits /week x 4 = 120 visit/month		$60,000.00
		2. Multidisciplinary team average expenses (X-ray, phlebotomist, Pharmacist, dieticians, Home Health nurse, PT) X 10 visit per patient in 60 days @ $ 100/visit 20 new patients/month	5 visit/patient /months x $ 100/visit= $ 500/patient /month 20 new patients /month x $ 500 month/patient= $10,000/month/patient x 6 months	$60,000 / 6 months
		3. Supplies (internet, software fees, Computers, etc.)		$10,000.00
		4. Contingency funds		$13,000.00
Total Revenues	$143,000.00	Total Expenses		$143,000.00

Appendix B: Input and Output in the Organization Plan

Elements	Input measurement	Output measurement	Cost
Human Resources: Personnel cost; training hours; FTE	1. No new hires 2. Existing DNP re-training on new program	1. No increase in work hours 2. Increase knowledge base/skills of DNP on transitional care	Minimal increase in the cost of re-training; Avg. Salaries of Field DNP ($60/hour)
Informational Resources: Computer/hardware; programs utilized; chart audits/review;	Educational programs/brochures/ Paraphernalia on transitional care benefits (pros and cons)	Printing of brochures/ Educational materials	The cost of printing the program materials, approx. $50
Monetary Resource: Funding	Program funding coming from the corporate	Detailed information (itemized) on fund allocation	Cost of program budgeting (prepared by program planners)
Managerial Resource: Program Manager (DNP level) Clinicians/providers Ancillary support groups	1. Leadership quality and education level of program leader 2. Good collaborative skills/attitude of qualified program leader	1. Adequate program manager and supervisors in the field 2. No additional managers anticipated to run and continue the program	1. 20-24 hours' time spent by program leader on the operation and management of personnel in the field; collaborating with providers and directing support groups

Appendix C: Performance Measurement, Monitoring, and Summative Evaluation

Performance Measurement Standard	Monitoring	Summative Evaluation
Utility	Monitor who needs the evaluation results and whether they get the relevant results on time.	Determine whether the program worked as visualized thru the outcomes.
Feasibility	Monitor whether time and resources are enough and properly utilized.	
Propriety	Monitor whether the rights and welfare of those directly impacted by the program are protected during the evaluation process.	
Accuracy	The evaluation process should produce valid, credible and usable information to all concern.	

Appendix D: Sustainability after the Program Implementation