



# Improving Transitions of Care With an Advanced Practice Nurse: A Pilot Study

Martha Tan-Fu Hsueh, DNP, RN-BC, and Kathleen Shannon Dorcy, RN, PhD

Gaps in complex oncology care coordination between inpatient and outpatient settings can result in treatment and monitoring delays and omissions, which can negatively affect patient outcomes. Gaps also exist for patients facing complex treatment modalities and collaborations between multiple care teams working at geographically distant sites. A pilot advanced practice nurse care coordinator (APNCC) role to coordinate these complex care transitions and implement processes for safer and more efficient care has shown promise.

## At a Glance

- Treatment and monitoring delays can negatively affect patient outcomes.
- The APNCC can minimize transition gaps, improve patient safety, and increase the quality of care delivery through effectiveness and efficiency.
- The APNCC pilot program reduced patient length of stay and infection rates.

Martha Tan-Fu Hsueh, DNP, RN-BC, is a nurse care coordinator at the University of Washington Medical Center and at the Seattle Cancer Care Alliance and Fred Hutchinson Cancer Research Center, and Kathleen Shannon Dorcy, RN, PhD, is the director of nursing research, education and practice at the Fred Hutchinson Cancer Research Center, both in Seattle, WA. The authors take full responsibility for the content of the article. The authors did not receive honoraria for this work. No financial relationships relevant to the content of this article have been disclosed by the authors or editorial staff. Hsueh can be reached at [thsueh@uw.edu](mailto:thsueh@uw.edu), with copy to editor at [CJONEditor@ons.org](mailto:CJONEditor@ons.org).

Key words: transitions in care; hospital quality outcomes; length of stay; central line-associated blood stream infection

Digital Object Identifier: 10.1188/16.CJON.240-243

Patients with cancer receive the majority of their treatment in outpatient settings (Walter, 2013). At the University of Washington Medical Center (UWMC), where Seattle Cancer Care Alliance (SCCA) inpatients are housed, the authors identified gaps in care transitions from inpatient to outpatient settings through quality improvement initiatives. The specific gaps were clustered in categories from patient safety goals provided by the Joint Commission (2015).

Gaps during transitions in care play a key role in healthcare quality and safety. Improvements in complex oncology care must be made at the patient, provider, and system levels. The intersection of inpatient and outpatient settings is where

care transitions are most crucial for ensuring both the quality and safety of care (Brez et al., 2009; Snow et al., 2009). Gaps during care transitions increase the health risks to patients as well as the liability risks for providers and care systems (Kelly, 2014). Medically complex patients with cancer have multiple treatment needs at discharge. Therefore, care transition gaps can pose serious risks, anxiety, and stress for these patients and their families if they are unable to access appropriate services and support. Case management can be effective in reducing care transition gaps but unable to show total cost efficiency (Stokes et al., 2015). The authors of the current article developed a pilot study with modifications from a case manage-

ment model and other small quality improvement projects in UWMC and SCCA.

## Methods

The aim of the pilot study was to reduce length of stay (LOS), lower readmission rates, and decrease delays and misses in treatment during transitions from inpatient to outpatient care. The pilot was initiated with three resident physician teams who care for about 50% of all inpatients with cancer in the hospital.

The advanced practice nurse care coordinator (APNCC) is a non-rotating member of the interprofessional team. When a patient is admitted to the hospital, the APNCC performs a comprehensive clinical, functional, social, and insurance assessment via chart audit to propose the best disposition plan. Throughout the stay, the APNCC coordinates and collaborates with other interprofessional staff to promote the most efficient transitions. The APNCC reassesses needs on a daily basis, adjusts the care plan accordingly, and communicates with team members to prepare the patient for the target discharge date and disposition.

During the pilot study, standardized communication mechanisms were developed between inpatient and outpatient teams to promote timely dialogue concerning patients' evolving needs. Standardized practice guides, computer-generated orders, and extensive referral lists also were developed. Standardized practice guides, developed by the APNCC, included a central line management guide, male/female fertility preservation guides, and a home infusion order guide to ensure efficient and effective care transitions. A computerized physician order entry (CPOE) system