The Hartford Impact on the Care of Older Adults in Transition

Health care delivery systems are changing at an unprecedented rate, fueled by increased prevalence of chronic disease, a growing older adult population, and high administrative costs (The Henry J. Kaiser Family Foundation, 2010) in an era of shrinking reimbursement. A major subset of these delivery changes involves addressing the problematic area of transitioning the care of older adults across settings and among providers.

The Institute of Medicine (2011) has called on nurses to be at the table leading initiatives toward an improved, more efficient, consumer-driven health care delivery system that improves health outcomes for patients at a reasonable cost. In 2000, the John A. Hartford Foundation, along with the American Academy of Nursing, launched the Building Academic Geriatric Nursing Capacity (BAGNC) program. Through transformative change in developing leaders as enlightened change agents, the program’s purpose is to produce expert nurse researchers, academicians, and practitioners to lead the field of gerontological nursing and change the landscape of care for older adults (BAGNC, n.d.). Nurses participating in both BAGNC predoctoral and postdoctoral fellowships have been influential in enhancing the role of nurses in closing the gaps between evidence-based best practices and current care delivery. While patient centeredness and team-based professionalism must become the renewed focus of all health professionals in health care delivery system redesign, these concepts form the practice fabric of nurses tasked with managing chronic conditions and coordinating care across transitions.

This special issue highlights the current work of present and past Midwest BAGNC scholars and Claire M. Fagin Fellows who have focused on strategies to improve the care of older adults in transition within and across levels of care. These articles describe work on a number of veritable core components of effective transitions, such as (a) screening to identify at-risk patients, (b) the centrality of patients’ and caregivers’ goals and preferences to the process, (c) enhanced communication among providers and across settings, and (d) education for patients and caregivers on prevention and early identification and response to worsening problems.

Critical discussions surrounding mechanisms to improve transitional care are far from over. Research is
needed that provides proven, accessible measures for improving the quality and efficiency of transitional care. The research described in this special issue highlights approaches that inform ways to improve care transitions that include the following:

- Correlates and risk factors of functional decline and new institutionalization among critically ill older adults.
- A chronic grief intervention for Alzheimer’s caregivers.
- Transitional rehabilitation for cardiac patients in post-acute care settings.
- The influence of polypharmacy, medication regimen complexity, and inappropriate medications on rehospitalization of older adults using home care.
- Barriers to medication reconciliation in nursing homes.

These articles highlight and address the needs of older adults as they and their loved ones face life-changing transitions across the continuum of care. Competent and enlightened nurse researchers, academicians, and practitioners with interest in care transitions will be crucial to energize practice and envision a new health care system where nurses come to the table prepared to take the lead in major policy changes. The contribution that nurses can make to the quality of transitional care may perhaps translate into one of the most significant contributions to the final solution to the crisis in our nation’s health care delivery.

REFERENCES

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