The Role of the Nurse Leader in Care Coordination and Transition Management Across the Healthcare Continuum

Session 090
The Role of the Nurse Leader in Care Coordination and Transition Management Across the Healthcare Continuum

A joint statement by the American Organization of Nurse Executives and the American Academy of Ambulatory Care Nursing
“Health care is characterized by fragmentation — among disciplines, among departments, among organizations, and among geographic locales — while those it serves depend on coordinated effort. The system propagates waste: waste of time, resources, and good will.”

The Institute of Medicine
Why Create a Joint Statement?

Care coordination and transition management (CCTM) are integral to health care delivery.

Both organizations produced seminal work related to care coordination/transition management:

- Workforce Roles in a Redesigned Primary Care Model (AONE)
- Nurse Executive Competencies in Population Health (AONE)
- Post-Acute Care Competencies (AONE)
- CCTM Core Curriculum (AAACN)
- RN Role Dimensions and Competencies for CCTM (AAACN)
- Scope and Standards for CCTM (AAACN)
- Online CCTM Course (AAACN and HealthStream)

Role of the nurse leader needs further clarification regarding CCTM.
Day of Dialogue

- February, 2015
- 5 AONE and 5 AAACN members participated
- Focus on nurse leader role in acute and post-acute settings
- Care coordination as key strategy now and future
- Draft statement approved by both Boards of Directors
- Joint Statement published in:  
  Nursing Economic$, Sept/Oct 2015  
  Nurse Leader, July, 2016
Six Strategies of the Joint Statement

1. Know how care is coordinated in your setting
2. Know who is providing care
3. Establish relationships with multiple entities and individuals who can work together to improve care coordination and transition management systems
4. Know the value of technology and its impact on workflow and the roles of the care coordination team members
5. Engage the patient and family
6. Engage all team members in care coordination
Strategy #1: Know How Care is Coordinated in Your Setting

• Know your patient population(s)
• Determine the needs, requirements, and resources of your population(s)
• Simulate the patient journey through the healthcare system
• Know your patient transition infrastructure and how the interprofessional team communicates
**Strategy 1: Know How Care is Coordinated in Your Setting**

Know your patient transition infrastructure and how the interprofessional team communicates

- Identify and become familiar with the organizational care transitions model
  - The model should be evidence-based and easily executed
  - If no model in place, investigate multitude of resources available
- Determine the communication method(s) the interprofessional team will use in executing care transitions, i.e., EMR, white board in the room, etc.
- Assess the effectiveness
Strategy 1: Know How Care is Coordinated in Your Setting

Know your patient population(s)

Become familiar with clinical and meaningful use demographics of patients you serve

– Allows for appropriate care planning
– Assists with population risk stratification
– Informs training on cultural sensitivity
– Anticipates translation service needs
– Determines multi-lingual staffing
– Predicts patient education/handout needs
Strategy 1: Know How Care is Coordinated in Your Setting

Determine the needs and required resources of the patient population(s)

- Become familiar with the community needs assessment conducted by our organization
- From the needs assessment data, identify the gap between “what is” and “what should be”
- Determine if services offered are sufficient enough to meet the “what should be” need with particular attention to disparities in care
- Fill the gap as needed
Strategy 1: Know How Care is Coordinated in Your Setting

Simulate the patient journey through the healthcare system

- Engage 2-3 members of the interdisciplinary team in simulating the patient journey from admission to discharge
- Consider wait times, physical barriers, technological support, communication strategies
- Identify barriers to eliminate and best practices to replicate
- Conduct focus groups with patients to glean their perspective on the process
Strategy #2: Know Who is Providing the Care

- Define the roles and key job responsibilities of those who serve as formal members of the interprofessional care coordination team across the continuum of care that are evidence-based and organization appropriate
  - Focus on eliminating role and cost redundancy
  - Ensure roles are well-defined and understood within the team and outside the team
  - Refer to standardized competencies from professional organizations
Strategy #3:
Establish relationships with multiple entities and individuals who can work together to improve care coordination and transition management systems

• Convene an interprofessional stakeholder group of team members involved with care coordination across the continuum of care
• Invite external stakeholders to join the group based on the needs of your particular hospital and post-acute care/outpatient settings
• Invite all stakeholders to provide input aligning communication and collaboration between current resources to improve care coordination and transition management.
Strategy #3
Exemplar

- History of strong academic-practice partnership supporting patients, nurses, students, faculty, and staff and always looking for opportunities
- Provide a model opportunity for the Thomas Jefferson University Hospital (TJUH) Department of Nursing to grow collaboration/partnership with the Jefferson College of Nursing
Strategy #3: Exemplar

• Communication Catalyst Program: Transforming Nurse-Patient Communication at Jefferson
• Focused intervention on care coordination and transition management
A 2013 Press Ganey study using national HCAHPS data showed that performance on the Communication with Nurses dimension strongly influences other Patient Experience of Care dimensions within the value-based purchasing (VBP) framework. Specifically, the study demonstrated that when hospitals improve nurse communications with patients, they see associated gains in other scores …
Strategy #3: Exemplar

300 Nurses
10 cohorts of 30 nurses each

12 Month Cohort Duration
Cohorts meet 2x a month
Each cohort completes one online unit and one in-person didactic learning session per month

12 Masters-Prepared Clinical Nurse Specialists
Online learning will be guided and in-person learning will be overseen by Clinical Nurse Specialist instructors who will specialize in one of each of the 12 units
Strategy #3: Exemplar

- Targeted Outcomes: Individual-Nurse-Organization
  - Improve quality of individual experience and outcomes
  - Increase nursing communication HCAHPS scores, resulting in an improved overall score for Jefferson
  - Provide unique and high-quality professional development opportunity for nurses that will result in higher nurse satisfaction scores
  - Contribute to the latest research in Patient Engagement and Nursing
**Strategy #4:**

Know the value of technology: impact on workflow and roles of team members

- Assess the current state of technology as it impacts care coordination and transition management
- Strategize and optimize potential technology
- Work closely with IT on data analytics to capture outcomes and identify high risk patients
Strategy #4:

Assess the current state of technology

1. Risk Identification
   What is in place to focus the care team on patients with the highest risk of poor outcomes?
   e.g. LACE, BOOST etc.

2. Plan of Care
   Is there a single place to find the full picture at panel and patient levels?
   Does the plan of care span the continuum?
   Are specific, measureable patient-identified goals easily incorporated?
Strategy #4: Assess the current state of technology (continued)

3. Communication
   Is communication among the care team, facilitated?
   How are patients and families engaged in communication and care?

4. Integration
   How do current or proposed tools/technology integrate with existing systems.
Strategy #4:
Electronic Health Record (EHR)

• What can your current EHR do?
• Are you using it to facilitate and optimize care coordination activities
• At Aurora Healthcare, made a conscious decision to leverage the functionality of existing system when possible
Strategy #4:
Strategize and Optimize Potential Technology

• “Flurry” of new technology on tap for care coordination
• Essential to success in VBC environment
• Ensure development of workflows and care team roles – utilize technology to support
• Engage team members and care coordinators
• Consumerism – what do patients want?
• Participate in overall coordinated strategy development for remote monitoring, telephonic visits
Strategy #4:  
Data Analytics

• Participate in designing point of care decision support tools that improve efficiency and link to clinical and strategic priorities
• Technology supporting value based care is essential
• Focus on tools that allow clinicians to see clinical trends and aggregate clinical data that support critical thinking
• Carefully select reporting tools that promote efficiency and provide direction

Examples – outcome measurement data and predictive analytics
Strategy #5: Engage the Patient and Family

• Patient engagement
  – Actions taken by individuals to obtain the greatest benefit from health care services

• Patient activation
  – Understanding one’s role in the care process and having the knowledge, skills and confidence to perform the role

• Relationship activation
  – Caregivers partnering with patients/families/caregivers, each other and communities to empower patients to manage their health
**Strategy #5: Engaging the Patient**

- Patient transformed from passive recipient of care to **ACTIVE PARTNER**
- Participation replaces paternalistic approach
- Patient/Provider relationship becomes Consumer/Healthcare Team relationship
- Nurses are empowered to lead the healthcare team in engaging patients/families
“When the relational aspects of care are attended to, people tend to feel less as though things are being done TO them and more like they are an equal participant in the decision making process”

Koloroutis, M & Trout, M

See Me As a Person, 2012
Strategy #6:
Engage all team members in care coordination

Team = patient
family
caregivers
care coordinator (RN)
providers
care team members
community resources
**Strategy #6:**

**Engaging the Team**

- Identify stakeholder champions
- Demonstrate value of care coordination
  - Promote role of RN coordinator and advocate for resources
- Longitudinal vs episodic care
  - One plan of care
  - Interprofessional collaboration
- COMMUNICATION IS CRUCIAL!
Strategies # 5 & 6

Outcomes of Engagement – Patient and Team

- Patient empowerment
- Increased patient/family satisfaction
- Improved staff and provider satisfaction
- Enhanced clinical quality
- Enhanced patient safety
- Improved staff recruitment/retention
Summary

Role of the Nurse Leader:

1. Develop expertise/knowledge regarding care coordination and transition management
2. Promote evidence-based care coordination and transition management practices for nursing
3. Engage key stakeholders to promote/implement care coordination/transition management
4. Identify/engage interprofessional “champions”
5. Utilize data/metrics to demonstrate value/quality
6. Promote use of technology to enhance care coordination/transition management collaboration and outcomes
7. Advocate the value of nursing in care coordination and transition management
Resources

**AONE**
- [www.aone.org](http://www.aone.org)
- Workforce Roles in a Redesigned Primary Care Model
- Nurse Executive Competencies
  - Chief Nurse Executive
  - Post-Acute Care Population Health
  - Population Health

**AAACN**
- [www.aaacn.org](http://www.aaacn.org)
- CCTM Core Curriculum
- RN Role Dimensions and Competencies
- Scope and Standards of Practice for Registered Nurses in CCTM
- Online CCTM Course with HealthStream


Thank you!
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