Care Coordination and the Essential Role of Nursing

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Director of Practice
OBJECTIVES

• Recognize that coordination of care is an integral part of nursing practice for registered nurses and APRNs across settings and roles.

• Identify strategies for integrating care coordination into nursing practice.

• Address common barriers to care coordination.
Which of the following best describes your nursing practice setting?
• PURPOSE

• Quality improvement and cost control rely on effective coordination of patient care.
• Registered Nurses across the continuum of care play an essential role in care coordination.
• Professional nursing links these approaches, promoting quality, safety, and efficiency in care, resulting in improved health care outcomes that are consistent with nursing’s holistic, patient-centered framework of care.
• This model for RN care coordination provides a guideline for nurses in direct care as well as those in highly specialized care coordination positions.
BACKGROUND

• Fragmentation of care within the United States has been attributed to a lack of Care Coordination.
• The Affordable Care Act of 2010 supports quality improvement and cost control.
• Health Care Reform emphasis the concept of the medical home, where care is coordinated.
• Nurses are central to organizing patient care needs.
WHAT IS IT??

DEFINING CARE COORDINATION
<table>
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<tr>
<th>National Quality Forum</th>
<th>AHRQ</th>
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<tr>
<td>“A function that helps ensure that the patient’s needs and preferences for health services and information sharing across people, functions, and sites are met over time” (National Quality Forum, 2006, p. 1).</td>
<td>“The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services” (McDonald et al., 2010, p. 4).</td>
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“Care coordination promotes greater quality, safety, and efficiency in care, resulting in improved healthcare outcomes and is consistent with nursing’s holistic, patient-centered framework of care.”
Care Coordinator
Role

• Value proposition
• Service design
• Service delivery

(Craig, Eby, & Whittington, 2011)
Care Coordination Across Settings:

- Emergency Department
- Inpatient Continuity of Care
- Inpatient Discharge Transitions to Community
- Primary Care Continuity of Care
Goals of Coordination of Care: Emergency Department

- Facilitate discharge plans
- Assure that prescriptions are filled
- Medication Reconciliation
- Arrange follow up appointments in primary care and specialty care if needed
- If uninsured, arrange appointments in FQHC or other charity clinics
- Refer to community resources
Goals of Coordination of Care: Inpatient

• Facilitate communication and integration of treatments when multiple teams and/or units are involved
• Facilitate evidence-based care such as core measures and other treatment protocols
• Medication Reconciliation
• Discharge Planning
• “Translate” information for patients/families
Goals of Coordination of Care: Inpatient to Home

<table>
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<tr>
<th>Effective Transition</th>
<th>Integration</th>
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<tr>
<td>• Prevent readmission</td>
<td>• Patient Understanding</td>
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<td>• Medication Reconciliation</td>
<td>• Patient Accountability</td>
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<td>• Connect to resources</td>
<td>• Maximize Self Management</td>
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<td>• Facilitate appointments &amp; follow up</td>
<td>• Know and manage “red flags”</td>
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<td>• Address barriers</td>
<td>• Initiate contacts as needed</td>
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<td>• “Translation” of information</td>
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Goals of Coordination of Care: Primary Care

- Continuity of care between primary care and specialty care
- Assure transfer of information
- Medication Reconciliation and Management
- Patient Understanding
- Maximize Self Management, Patient Accountability
- “Translation” of information
- Connect to Community Resources
CARE COORDINATION ACTIVITIES

SYSTEM
- Translate
- Facilitate
- Connect
- Medication Reconciliation
- Identify & Address Barriers
- Transition

PATIENT
- Connect
- Translate
- Facilitate
- Teach
- Transition
- Integrate
- Empower
- Medication Reconciliation
So **WHO** can fill that role?

*What caregiver is best adapted to organize care across the continuum?*
• Does your Institution Have a dedicated Nurse Care Coordinator?
• What does the Care Coordinator role require?

  – A qualified professional to implement a plan of care that is focused on each patient’s unique resource needs and preferences
  – An expert in cognitive decision making, as well as communication and counseling skills in order to adequately address the needs of the patient throughout the continuum of care.
### CORE COMPETENCIES AND FUNCTIONS

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<th>COMPETENCIES</th>
<th>FUNCTIONS</th>
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<tr>
<td>• Develops partnerships</td>
<td>• Provides care coordination interactions</td>
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<td>• Communicates proficiently</td>
<td>• Manages continuous communications</td>
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<td>• Uses assessments for intervention</td>
<td>• Completes/analyzes assessments</td>
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<td>• Is proficient in care planning skill</td>
<td>• Develops care plans with families</td>
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<td>• Integrates all resource knowledge</td>
<td>• Manages/tracks tests, referrals and outcomes</td>
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<td>• Possesses goal/outcome orientation</td>
<td>• Coaches patients/families</td>
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<td>• Takes an adaptable and flexible approach</td>
<td>• Integrates critical care information</td>
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<td>• Desires continuous learning</td>
<td>• Supports/facilitates care transitions</td>
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<td>• Applies team building skills</td>
<td>• Facilitates team meetings</td>
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<tr>
<td>• Is adept with information technology</td>
<td>• Uses health information technology</td>
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Antonelli, McAllister & Popp (2009)
That Sounds Like a Nurse!

It *SHOULD*! Care Coordination is at the heart of what nurses do best: Patient-Centered Care!
INHERENT IN THE ROLE OF THE NURSE

- Patient-centered care coordination is a core professional standard and competency for all nursing practice (American Nurses Association, 2010)

- The ability to evaluate and optimize available health care resources is a core competency of the Baccalaureate prepared nurse (American Association of the Colleges of Nursing, 2008)

- The nursing code of ethics guides nursing’s responsiveness to changing health care systems and the context in which health care is provided, further supporting the care coordination role of the nurse (American Nurses Association, 2001)
The American Nurses Association advocates for the vital role of nurses in the design and implementation of care coordination systems. The care coordination process is one part of professional practice through which nurses at every level influence patient care (American Nurses Association [ANA], May 31, 2011)
TNA’s Position

“The complexity of the patient population may require communication and collaboration across multiple health care teams and systems therefore coordination of care is an integral part of nursing practice for registered nurses across a variety of settings and roles. Complex patient populations may require a designated care coordinator prepared at the masters or higher level in nursing.”
Professional nursing is associated with many of the core competencies and functions described as unique to care coordination. The nurse assumes the role as partner with patients and families, using the patient and family needs and preferences as guiding factors in the provision of patient-centered, holistic care.

But now that we know this, how do we model our care?
What is the purpose of a model?

- A preliminary work or construction that serves as a plan from which a final product is to be made.
- A schematic description of a system, theory, or phenomenon that accounts for its known or inferred properties and may be used for further study of its characteristics.
Modeling the Nursing Role

In response to the changing health care environment with the increased emphasis on the medical home and coordinated care, as well as in recognition for the prominent role that nursing plays in patient-centered care, the Texas Nurses Association has developed the Coordination of Care Model.
The Nursing Role:  
Guidance for the Nurse in the Care Coordinator Role

- Each concentric circle within the model denotes thematic activity and nursing role.
- The patient and family are represented at the center of the model, supporting the concepts of patient-centered care.
- Seated behind and in support of the patient within the model is the Registered Nurse Care Coordinator.
The Light Green Ring

Represents the Nursing Role:
- In connecting with the patient, forming relationships that foster collaboration and partnership, promoting continuity of care and promoting optimal health outcomes.
- Within patient-centered care activities that occur between the nurse and the patient or family, consisting of translation, identification of barriers, teaching, facilitating, integrating and empowering.
The Light Blue Ring

Represents the Nursing Role:

• In establishing collaborative relationships with the care team with the intention of assuring continuity of care, maximizing self-management and preventing decline.

• Of translation using effective communication with the care team in the provision of care, facilitation of services, integration as conflicts are reconciled, patient advocacy, and addressing systemic barriers to the health optimization of the patient.
The Purple Ring

 Represents the Nursing Role Within:

• The health care environment (an aggregate of social, cultural, biological etc.) that create the context within which the patient transitions with the assistance of the registered nurse care coordinator.

• The entire interdisciplinary group (acute care, specialty care, etc.).

• Other resources (payors, support groups, national organizations etc.) represented within the ring as contributors to the health care environment.
Levels of Care Coordination

- 80% of general patients’ care coordination can be completed by an APRN, direct care nurse or typical case management programs.
- 15% of patients are moderate in complexity and need additional services or specialized attention.
- 5% of the most complex patients need intensive services by multiple providers in order to achieve optimal outcomes.
Moderate to Complex Care Coordination

• Medically complex patients (with 2 or more chronic conditions)
• Patients by age e.g. pediatrics, 65+
• Specific chronic conditions (DM, HTN, renal failure, transplants, CHF, mental health diagnoses)
• Patients with 3 or more ER visits per year
Nursing Care Coordinators......

Registered Nurse Care Coordinators can be utilized across many settings.

Inpatient Care Coordinators facilitate:
• Evidence-based, high quality care
• Communication and integration of treatments when multiple teams, providers and settings are involved in patient care

Inpatient Care Coordinators:
• Focus on discharge transitions to community settings
• Make home visits and attend appointments with patients utilizing a variety of communications technologies, with a focus on symptom management and avoidance of re-hospitalization.
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<th>Small Facilities</th>
<th>Medium Facilities</th>
<th>Large Facilities</th>
<th>All Facilities</th>
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<td>• Identify top 5-10 most common diagnosis for ED visits and admissions in the past year</td>
<td>• Analyze readmission data to select patient groups to target (such as CHF, Pneumonia etc)</td>
<td>• Analyze readmission data to identify top 10 diagnoses that lead to readmission within 30-60-90 days</td>
<td>• Begin discharge planning within 24 hours of admission</td>
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<td>• Identify top 10 patients in terms of expense in the past year</td>
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<td>• Improve discharge process, inclusive of education and discharge teaching</td>
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<td>• Enhance services at times of transition for patients with high risk of re-hospitalization</td>
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BARRIERS TO CARE COORDINATION

• Health literacy
• Direct to consumer drug marketing
• Cultural influences
• Ethical dilemmas
• Documentation across care providers
• Aging of the population
• Long term cases.
Which of these barriers would you identify as the most difficult or most likely faced barrier to care coordination at your institution?
THE FUTURE

As an advocacy function nurses must assume a leadership role in identifying and implementing care coordination activities, exploring options for nurse-led coordination models.


Thank You

Questions? Contact us at: practice@texasnurses.org