Coordinating Care and Managing Transitions for Individuals with Complex Care Needs Using the CCTM RN Model

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OBJECTIVES

- Disease demand for care transition management for individuals with complex care needs across the care continuum
- Developing care coordination and transition management (CCTM) dimensions and competencies
- Disease challenges, future directions, and outcomes of the CCTM RN Model in managing care transitions for individuals with complex care needs

BACKGROUND

- Chronic diseases responsible for 90% of all deaths each year, and treating people with chronic diseases accounts for 86% of nation’s health care costs
- 88% of U.S. healthcare dollars are spent on medical care that only accounts for approximately 16% of a person’s health
- Other determinants of health are: lifestyle and behavior choices, genetics, human biology, social determinants, and environmental determinants accounting for approximately 40% of health outcomes (Thorup et al., 2015) http://www.essentialpolicies.org/assets/pdfs/2015/11/15_SNAP_Center_for_Policy_Research.pdf
- Many studies with multiple factors, combining with social complexities such as, mental health and substance abuse, economic factors, and a host of social risks such as social isolation and homelessness (Berkowitz, Nilan & Whitcomb, 2009)
- Escalating problem of multiple chronic conditions (MCC) among Americans is a major challenge, associated with substantial health outcomes and rising healthcare expenses (Ford et al., 2015)
- Delivery of health services continues to employ “out of site” approaches that focus on individual chronic diseases (Ford et al., 2015)
- Average Medicare patient has seven providers across four care settings involved in their care, five specialty providers and two primary care providers (IOM, 2013)

SIGNIFICANCE

- The Joint Commission identified miscommunication as the main cause of serious, unexpected patient safety events and a common cause of sentinel events reported during the first six months of 2013 (Ellison, 2015)
- Managing care transitions for individuals with complex care needs
- Needs across the care continuum
- With advent of EHR, there are few documentation screens for nurse documentation
- There were no indicators to track the impact that care coordination and transition management had on outcomes
- The Escalating problem of multiple chronic conditions (MCC) among Americans is a major challenge, associated with substantial health outcomes and rising healthcare expenses
- Each dyad reviewed four to five articles and needed to reach consensus on items
- Communicated with major stakeholders at frequent intervals

Definitions of Care Coordination and Transition Management

- Effective care coordination and transition communication is an expectation of the patient
- Care coordination “is 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 care to that patient.”
- Coordinating care involvement of multiple healthcare providers can improve outcomes for the patient and increase efficiency of the healthcare system

Methods

- Search and appraisal of interprofessional evidence for best evidence-based practices on care coordination and transition management in all settings
- Use theory (Wagner’s Chronic Care Model, 1997) to guide development of dimensions, implementation, adoption, sustainability, and dissemination of Care Coordination and Transition Management (CCTM)
- Use Quality and Safety in Nursing (QSEN) format to specify competencies
- Use Logic Modeling to clarify assumptions and relationships between major constructs
- Use expert panel approaches to review but not care coordination as delineated in CCTM
- Developed a standardized tool for use with individuals with complex care needs
- Population health management became the new 8th dimension given the prominence

Table 1. Example of Dimension with Knowledge, Skills, and Attitudes

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<thead>
<tr>
<th>Dimension</th>
<th>Competencies</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education and Engagement of Individuals and Families</td>
<td>- Counseling of Individuals and Families</td>
<td>- Coaching and Counseling of Individuals and Families</td>
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<tr>
<td>Transition Manager</td>
<td>- Education Collaborative</td>
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Table 2. Nine Dimensions of Care Coordination and Transition Management

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<th>Dimension</th>
<th>Description</th>
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<tbody>
<tr>
<td>Support for Self Management</td>
<td>- Development and use of content centered Care Planning and Management Skills</td>
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<tr>
<td>Teamwork and Collaboration</td>
<td>- Communication of care plan is routinely prepared with “Ask Me” before &amp; after seeing physician</td>
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<tr>
<td>Person-Centered Care Planning</td>
<td>- Engaged, educated and supported the primary caregiver</td>
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<tr>
<td>Population Health Management</td>
<td>- Provides for long-term care and home care of multidisciplinary team including physician, dietician, psychologist, MD, pharmacist, social worker, nurse</td>
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Table 3. Cross Walk of Dimensions for CCTM with National Competencies

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<td>Quality and Safety in Nursing (QSEN)</td>
<td>- Evidence of nurse contribution to outcomes of care</td>
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<td>Evidence-based Practice</td>
<td>- Evidence of nurse contribution to outcomes of care</td>
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Use of Logic Model

- Depends on an e-mail report for a project
- Surface assumption, environmental issues and needed knowledge, skills, and attitudes
- Specific relationships among program goals, objectives, activities, outputs, and outcomes
- Challenges and concerns surrounding program components, activities involved, who carries out the activities and specification of short, medium and long-term outcomes
- Sets up evaluation by assessing with development of the measures used to determine if activities are meeting the objectives and if the program’s objectives are met (outcomes measures)

Figure 1. CCTM Logic Model

Challenges Using CCTM with Individuals with Complex Care Needs

- Developing and using a need to define what constitutes a patient with complex care needs
- Developing education and evaluation methods that foster CCTM involving QSEN tools and access to comprehensive care
- Developing data management to support the interprofessional team
- Building human resource systems to support CCTM
- Creating an environment (physical and cultural) to support CCTM

Advantages of Using CCTM With Individuals with Complex Care Needs

- Decrease in use of inpatient stays and avoid hospital readmissions
- Improved outcomes and satisfaction
- Improved quality of care and reduced hospital costs

Example of Using Standardized Tool During Care Transitions

- BOOST®: Better Outcomes by Optimizing Transitions
- Developed: By Hospital Medicine
- Assist in stratification of risk, as well as assessment of need

- EFFECTS®: Enhancing Patient Experience and傅undation of Transitions
- Developed by: Hospital Medicine
- Orientation for patients – what to expect during hospital stay

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