Patient Engagement: A Key to Quantify the Impact of Nursing in Care Coordination

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Background

❖ Need for Care Coordination
❖ RN Care Manager (RNCM) role
❖ How do we quantify the RNCM nursing practice?
❖ How do we standardize and track patient engagement?

(Google, 2018)
Benefits of Patient Engagement in Care Coordination

(Google, 2018)
Current State

(Google, 2018)
Whole Health Partnership

The Pathway
Partners with Veterans to discover their sense of meaning, aspiration, and purpose, and begins to create an overarching personal health plan

Wellbeing Programs
• Self-Care/Complementary & Integrative Health (CIH)
• Health Coaching & Health Partner Support

Integrative Clinical Care
• Outpatient & Inpatient
• Health & Disease Management within a Whole Health Paradigm (i.e., Personal Health Planning, CIH, Health Coaching)

(U.S. Department of Veterans Affairs, 2018)
Pilot Overview

❖ How to quantify RN Care Manager role in patient outcomes and provide standardization of patient engagement
  ❖ Huddle board ticket
  ❖ Evidence-Based: Ambulatory Care Nurse-Sensitive Indictors Series: Patient Engagement as a Nurse-Sensitive Indictor in Ambulatory Care (2016)
❖ Work group created
❖ Valid and reliable tool adapted from VA MOVE & Smoking Cessation
❖ CPRS Template created
❖ Three PACT RN Care Manager’s piloted 90 days
❖ Rolled out to all 15 PACT teams
### PATIENT ENGAGEMENT TEMPLATE PILOT

<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAN and/or % Probability Unchanged</td>
<td>1</td>
</tr>
<tr>
<td>CAN and/or % Probability Improved</td>
<td>21</td>
</tr>
<tr>
<td>CAN and/or % Probability Worsened</td>
<td>5</td>
</tr>
<tr>
<td>Patient Deceased</td>
<td>1</td>
</tr>
</tbody>
</table>

**91% Improvement**

![Chart](chart.png)
INITIAL PATIENT ENGAGEMENT

The Veteran has agreed to work on the following health concern:

How confident are you to make health changes?
[ ] Not at all confident [ ] Somewhat confident [ ] Very confident

What are your barriers to achieving your goal?
[ ] Time [ ] Money [ ] Motivation [ ] Other [ ] N/A

Current stage of change:
[ ] Precontemplative—No intention to change at present time
(f/u 6 mo- set PCAS reminder)
[ ] Contemplative—Considering a change
(f/u 30 days, set PCAS task reminder)
[ ] Preparation—Preparation following the decision to change the behavior
(f/u 2 weeks- set PCAS task reminder)
[ ] Action—Currently engaged in behavior change activities
(f/u 30 days, set PCAS task reminder)
[ ] Maintenance—Continuation of changed behavior beyond six months

Action Plan:
[ ] Nursing appointment
[ ] Defer to PCP for PharmD consult
[ ] DSME class
[ ] CDSMP class
[ ] Glucometer Education
[ ] Alc lab ordered
[ ] Smoking Cessation class
[ ] Other
[ ] Nutrition direct access
[ ] Nutrition consult
[ ] Home Telehealth (HT) consult
[ ] MOVE consult
[ ] SW consult
[ ] TH Pain School
[ ] N/A
[ ] Defer to PCP for MH consult

[ ] Teach Back Method used to verify patient understanding.
[ ] Patient agrees to the plan of care.

Motivational Interviewing principles are applied to empower patient, provide continuous support from the VA team and elicit behavior changes that contribute to positive health outcomes.
FOLLOW-UP PATIENT ENGAGEMENT

The following health concern was previously reviewed with the Veteran:

Previous stage of change:
- [ ] Precontemplative  [ ] Contemplative  [ ] Preparation  [ ] Action  [ ] Maintenance

Current stage of change:
- [ ] Precontemplative-No intention to change at present time
  (f/u 6 mo- set PCAS reminder)
- [ ] Contemplative-Considering a change
  (f/u 30 days, set PCAS task reminder)
- [ ] Preparation-Preparation following the decision to change the behavior
  (f/u 2 weeks- set PCAS task reminder)
- [ ] Action-Currently engaged in behavior change activities
  (f/u 30 days, set PCAS task reminder)
- [ ] Maintenance-Continuation of changed behavior beyond six months

What were your successful behaviors to achieving your goal?  [ ] N/A

What were the motivating factors that impacted the change:
- [ ] Information on resources
- [ ] Test or lab results
- [ ] Nurse education or follow-up
- [ ] Education provided by other health care professional
- [ ] Other

What were your barriers to achieving your goal?
- [ ] Time  [ ] Money  [ ] Motivation  [ ] Other  [ ] N/A

Additional Action Plan Identified:
- [ ] Nursing appointment
- [ ] Referral to PCP for PharmD consult
- [ ] DSM-5 class
- [ ] CDSMP class
- [ ] Glucosemeter Education
- [ ] Alc lab ordered
- [ ] Smoking Cessation class
- [ ] Other

- [ ] Nutrition direct access  [ ] Home Telehealth(HI) consult
- [ ] NOVE consult
- [ ] SW consult
- [ ] PT Pain School
- [ ] N/A
- [ ] Refer to PCP for MH consult

[ ] Teach Back Method used to verify patient understanding.
[ ] Patient agrees to the plan of care.

Motivational Interviewing principles are applied to empower patient,
provide continuous support from the VA team and elicit behavior changes that
contribute to positive health outcomes.
Progress Notes

04/27/2018 12:59

** CONTINUED FROM PREVIOUS PAGE **

- Glucometer Education
- Alc lab ordered
- Smoking Cessation class
- Other
  - SW consult
  - TH Pain School
  - N/A
  - Refer to PCP for MH consult

[ ] Teach Back Method used to verify patient understanding.
[ ] Patient agrees to the plan of care.

Motivational interviewing principles are applied to empower patient, provide continuous support from the VA team and elicit behavior changes that contribute to positive health outcomes.

PLAN/FOLLOW-UP:
  Forward note to Primary Care Physician for review

FUTURE APPOINTMENTS:
  No future appointments.

TIME SPENT: 11-20 Minutes

** THIS NOTE CONTINUED ON NEXT PAGE **
What were your barriers to achieving your goal? [ ] Time [ ] Money [ ] Motivation [ ] Other [ ] N/A

Additional Action Plan Identified:
[ ] Nutrition appointment
[ ] Nutrition consult
[ ] Referral to PCP for Pharmed consult
[ ] ISM consult
[ ] INO consult
[ ] Gastroenterology consult
[ ] Aleric lab ordered
[ ] Smoking cessation class
[ ] Other

[ ] Teach back Method used to verify patient understanding.
[ ] Patient agrees to the plan of care.

Motivational interviewing principles are applied to empower patient, provide continuous support from the VA team and elicit behavior changes that contribute to positive health outcomes.

PLAN/FOLLOW-UP:
Forward note to Primary Care Physician for review

FUTURE APPOINTMENTS:
No future appointments.

TIME SPENT: 11-20 Minutes
Sustainment Plan

(Google, 2018)
Summary

❖ Voice of the Veteran
❖ Whole Health practices
❖ Elicit positive health outcomes
❖ Decrease admissions
❖ Cost avoidance
❖ Standardize Care Coordination process & documentation
❖ Include Patient Engagement in Care Coordination
❖ Quantify the RNCM role in patient outcomes

(Google, 2018)
Questions/Comments

(Google, 2018)
References


