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# A Message from AAACN President

## The wait is over! The *Care Coordination and Transition Management (CCTM) Core Curriculum* Is Here

Health care reform and the Patient Protection and Affordable Care Act (2010) challenged the American health care system to find ways to manage the complex health needs of the population by increasing access to care and managing costs while providing the highest quality of care. Interprofessional patient-centered care models like the Patient-Centered Medical Home and Accountable Care Organizations are designed to provide personalized care management with "RNs ideally positioned to serve in the care coordinator/transition manager role" (Haas, Swan, & Haynes, 2013, p. 45). Safe, efficient, and effective transitions between providers, levels of care, and various care settings will be key factors to the success of these models.

The vision for this much anticipated text grew out of the need and desire for evidence-based registered nurse (RN) competencies to provide education for and demonstrate the effectiveness of the role of the RN in care coordination and transition management (CCTM). The American Academy of Ambulatory Care Nursing (AAACN) developed an action plan in 2011 to initiate this endeavor. The project included three phases for the core curriculum development and a fourth phase to include the development of an online education course (Haas et al., 2013).

Four separate interprofessional Expert Panels were convened. The first reviewed and analyzed the literature. The second defined the nine dimensions and the core competencies and associated activities related to RN care coordination and transition management. The third built upon the work of the first two panels and created the table of evidence which includes the competencies and the knowledge, skills, and attitudes necessary to fulfill this important role. A fourth panel of nurse leaders and experts from ambulatory and acute care was enlisted to develop and create this *Core Curriculum* and the online course corresponding to the content of the text.

For our three editors – Sheila A. Haas, PhD, RN, FAAN; Beth Ann Swan, PhD, CRNP, FAAN; and Traci S. Haynes, MSN, RN, BA, CEN – this project has been a labor of love! They have worked tirelessly to facilitate the work of the Expert Panels and to champion the publication of this cutting-edge text and educational course that will serve as a CCTM resource for all registered nurses. The AAACN Board of Directors and I thank our editors, the nurses and other professional colleagues who served on the Expert Panels, and the authors and reviewers who worked so diligently to bring the vision of this *Core Curriculum* to reality. We also acknowledge the Academy of Medical-Surgical Nurses (AMSN) for their collaboration in serving on the Expert Panels; for their assistance in developing the chapter "Care Coordination and Transition Management Between Acute Care and Ambulatory Care;" and for their endorsement of the *Core Curriculum*.

I hope that you find this outstanding publication to be a valuable resource in your nursing practice wherever you coordinate care or manage patient transitions.

**Susan M. Paschke, MSN, RN-BC, NEA-BC**
*AAACN President, 2013-2014*

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# Foreword

## A Competency Model to Improve Quality and Safety, Care Coordination, and Transitions

Health care has been in continual change over the past few decades, implementing multiple strategies to improve outcomes. Nurses are increasingly positioned to help lead these changes through advancements in nursing education and refocusing professional practice models. Competency models are one strategy for improving care by describing standardized care objectives that address the shortcomings identified in the Institute of Medicine report *To Err is Human* (IOM, 1999), and the quality goals described in the *Crossing the Quality Chasm* report (IOM, 2001). These reports revealed startling gaps in health care and proposed a quality framework, STEEEP, to improve care outcomes: all care should be Safe, Timely, Equitable, Efficient, Effective, and Patient-centered. These goals, in addition to changes from the 2012 Affordable Care Act, are changing health care access, delivery, and reimbursement dramatically. The 2010 IOM report *Future of Nursing* called for nurses to practice to their fullest preparation and also to seek advanced educational mobility to lead changes in improving care. Thus, nurses are uniquely positioned to provide key leadership in improving care management across the myriad care delivery settings, but need guidelines for specific settings and populations that help meet new regulations and reimbursement demands.

**A Competency-Based Resource**

This *Care Coordination and Transition Management Core Curriculum* is a just-in-time competency-based resource to guide nurses in the new delivery systems and payment directives. Increasing complexity of care, diverse practice settings, and payer requirements are key factors that position nurses to have a leading role in care management across providers and transitions in care. The *Core Curriculum* addresses competencies for improving care outcomes among the multiple dimensions of growing complexity of care in diverse settings, and, in particular, ambulatory populations. Most guidelines and evidence-based standards have been developed based on acute care inpatient experiences without addressing care needs across transitions in settings or multiple providers. The three editors of this text have carefully researched the competencies needed for new care management roles, both inpatient and outpatient, to coordinate and manage care effectively.

Edited by three experts in ambulatory care who have each served as president of the American Academy of Ambulatory Care Nursing, the *Core Curriculum* provides a futuristic perspective that integrates the award-winning and widely adopted Quality and Safety Education for Nurses (QSEN) competency model (American Association of Colleges of Nursing, 2012; Cronenwett et al., 2007). The goal of QSEN (www.QSEN.org) is the integration of the six competencies into all of nursing so that quality and safety are part of nurses' daily work: patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics. These competencies are now part of nursing education standards and other regulatory and certification guidelines.

The *Care Coordination and Transition Management Core Curriculum* provides a critical step in improving quality and safety of care and helps nurses understand better how to incorporate the QSEN competencies in practice. Patient-centered care is at the heart of safety; the Care Coordination and Transition Management standards describe specific evidence-based principles for accurate and personalized assessment as the basis for patient-centered care. Safety awareness is even more important in considering the unique practice settings that include advanced practice nurses who may be in independent or group practice, nurses who must communicate and share care goals among interprofessional colleagues, and those who manage small care teams or supervise unlicensed personnel. Recognizing breakdowns in processes is the first step to develop quality improvement initiatives that can close gaps between ideal and actual performance measures. Competency in informatics provides a key strategy for communication, decision support, and documentation.

**Making Care Standards Accessible**

The potential power of this *Core Curriculum* is in making care standards readily accessible to nurses. Standardization in care is a major component of safe care. Evidence-based standards share best practices based on the latest evidence gathered from the literature and documented experiences. Nurses are the constant patient care providers who spend the most time with patients, and as such, have key information for making care decisions. Knowing when and how to speak up is critical for improving care outcomes. Many errors occur during transitions in care, whether between providers, between settings, or unit-to-unit transfers; standardized handoff processes and communication can assure care management without interruption.

Competency objectives identifying the knowledge, skills, and attitudes for accomplishing work help to standardize care by specifying competencies for providers in a particular setting or population focus to successfully perform functions or tasks. Competencies are defined by the knowledge needed for achievement, the skills that enable

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application, and the attitudes that shape caregiver responses and influence decision making about care. Competency models can also provide measurement criteria for assessing competency achievement. Competency development includes developing clinical judgment, reflecting on improving one's work, and awareness of the context of practice (Tanner, 2006). Competency development is more than achieving skills or completing tasks. A competency-based practice model guides organization of tasks within a patient-centered perspective to address needs in a particular care delivery setting such as nursing in an ambulatory care center or a specific patient population. Competency statements identifying the knowledge, skills, and attitudes can be applied to developing educational curriculum or specific training, identifying licensure and certification requirements, writing position descriptions, recruiting and hiring personnel, and/or evaluating employee performance.

**Empowering Nurses and Patients**

Building on the six QSEN competencies, the *Care Coordination and Transition Management Core Curriculum* culminates in care guidelines across nine evidence-based dimensions: self-management, patient and family education and engagement, communication and transition, coaching and counseling patients and families, nursing process, teamwork and collaboration, patient-centered care planning, decision support and information systems, and advocacy. The comprehensive nature of the competencies can leverage improvements across all settings and providers and be applied in multiple ways from orientation to evaluation. These competencies are about empowering nurses and empowering patients applying the change model of *Will, Ideas, and Execution.* We know nurses have the *will* to improve care when they have the *ideas* and have the resources for *execution.* The *Care Coordination and Transition Management Core Curriculum* is a vital resource for all nurses that fits the current practice arena and has the capacity to improve care for all.

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# Preface

The passage of the Patient Protection and Affordable Care Act (ACA) in 2010 has provisions fostering movement from a focus on acute care to care across the continuum with wellness, health promotion, and disease prevention. Settings for care, again fostered by the ACA, are the Patient-Centered Medical Home (PCMH) and Accountable Care Organizations. ACA provisions offer many opportunities for access to primary care for patients and for contributions by ambulatory care nurses as well as for nurses working in acute, subacute, and home care. The ACA also has provisions that mirror the Institute of Medicine's (IOM, 2001) *Crossing the Quality Chasm* report recommendations for health care reform, including the need for care to be safe, effective, patient centered, timely, efficient, and equitable. Other ACA provisions are focused on use of evidence-based practice to guide care provided by interprofessional teams. Again, in PCMHs and other ambulatory care settings, these expectations spelled out in health care reform legislation offer opportunities for ambulatory and acute care nurses to be major contributors. Finally, another IOM report, *The Future of Nursing: Leading Change, Advancing Health* (2010), includes recommendations, two in particular, that speak directly to opportunities for all nurses in this era of health care reform: (a) Nurses should practice to the full extent of their education and training, and (b) Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States (IOM, 2010).

*The Care Coordination and Transition Management Core Curriculum for Ambulatory Care Nursing* is a comprehensive, evidence-based guide designed to support the American Academy of Ambulatory Care Nursing's (AAACN) mission: "To advance the art and science of ambulatory care nursing" and provide a valid and reliable care coordination and transition management model and practice resource for nurses (AAACN, 2014). Recognizing that demand for primary and specialty care would increase with enactment of the ACA and that the numbers of patients with complex chronic illnesses were increasing, the AAACN decided to invest in a translational research project to define the dimensions of care coordination and transition management (CCTM). This foundation could provide for development of CCTM competencies for nurses and evidence-based content for professional education and continuing development of ambulatory and acute care nurses working in new models of care delivery in PCMHs and other care settings.

This *Care Coordination and Transition Management Core Curriculum* is one outcome of the CCTM project. This *Core Curriculum* text is designed for registered nurses currently working in ambulatory care and acute care settings who aspire to move into the RN in CCTM role as well as for nurses who are considering transitioning into ambulatory or other settings where they desire to develop CCTM knowledge, skills, and attitudes that are essential to the CCTM role. The *Core Curriculum* is a rich, evidence-based resource that can enhance nursing student experiences in ambulatory, acute, subacute, and home care settings. This *Core Curriculum* uses the Quality and Safety in Nursing Education (QSEN) Competency framework (Cronenwett et al., 2007) that specifies knowledge, skills, and attitudes (KSA) for each of the nine Registered Nurse Care Coordination and Transition Management dimensions. The unique KSA tables included in each chapter provide a rich resource by summarizing chapter content and enhancing understanding of the breadth and depth of each dimension. The tables categorize requisite skills and attitudes that are needed in addition to knowledge of content for each Care Coordination and Transition Management dimension.

This undertaking could not have come to fruition without the commitment and expertise of the volunteer AAACN member expert contributors who participated in one or more expert panels and were authors of chapters in this *Core Curriculum*. The AAACN Board of Directors and membership, as well as its association management firm, Anthony J. Jannetti, Inc., are to be commended for their vision, leadership, and support of this translational research project and the publication of the *Care Coordination and Transition Management Core Curriculum*. We are proud to provide this text to RNs who want to grow as care coordinators and transition managers to better serve our most vulnerable patient populations.

**Sheila A. Haas, PhD, RN, FAAN**
*Lead Editor*
**Beth Ann Swan, PhD, CRNP, FAAN**
*Co-Editor*
**Traci S. Haynes, MSN, RN, CEN**
*Co-Editor and Project Manager*

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# CHAPTER 5

# Patient-Centered Care Planning

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## Learning Outcome Statement

The purpose of this chapter is to enable the reader to demonstrate the ability to develop, implement, and provide ongoing management of a comprehensive plan of care – based upon the individual patient's values, preferences, and needs – in partnership with the primary care provider and larger interdisciplinary care team.

## Learning Objectives

After reading this chapter, the registered nurse (RN) working in the Care Coordination and Transition Management (CCTM) role will be able to:

- Perform a comprehensive needs assessment on the patient focusing on the overall needs so interventions can be planned and implemented accurately.
- Identify gaps in care and individualize the plan focus through a pre-visit chart review and visit planning.
- Describe the process for identification of high-risk populations and determine appropriate risk.
- Utilize motivational interviewing as a communication style to guide the patient and family planning to make positive behavior changes to improve health.
- Develop a plan of care utilizing input from patient, family, and multidisciplinary team members.
- Design interventions founded in evidence-based clinical guidelines.
- Demonstrate the knowledge, skills, and attitudes required for the patient-centered care planning dimension (see Table 1).

## Competency Definition

"Patient- and family-centered care is an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families" (Institute for Patient- and Family-Centered Care, 2014, para. 1).

In designing the plan of care, the registered nurse (RN) engaged in Care Coordination and Transition Management (CCTM) recognizes the integral role patients, families, and caregivers have in ensuring the health and well-being of patients. Additionally, the RN in CCTM acknowledges that emotional, social, and developmental support are critical components in the delivery of health care (The Institute for Patient- and Family-Centered Care, 2014). Engaging patients and their designees in care plan development supports improved patient outcomes, increases patient and family satisfaction, restores dignity and control, and contributes to financial stewardship in the allocation of resources. Core concepts for patient-centered care planning include (a) respect and dignity: honor perspectives, choices, values, beliefs, and cultural backgrounds; (b) information sharing: timely, accurate, transparent, and complete communication; (c) participation: engagement and participation of patients and families in care and decision making; and (d) collaboration: inclusion of patients and families in program design, implementation, policy development, and professional education (The Institute for Patient- and Family-Centered Care, 2014). The degree of inclusion is determined by the patient and does not preclude the patient making care decisions independently if he or she is competent to do so (The Institute for Patient- and Family-Centered Care, 2014).

### I. Comprehensive Needs Assessment

A. Psychosocial Assessment Tool: this is a Patient Health Questionnaire with 2 or 9 questions (PHQ-2 or 9) that assesses patient for signs and symptoms of depression. According to Kroenke, Spitzer, and Williams (2003), "the purpose of the PHQ-2 is not to establish final diagnosis or to monitor depression severity, but rather to screen for depression in a first step approach" (p. 1). A score of 3 or more requires further inquiry using the PHQ-9 Questionnaire. Both

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questionnaires focus on the past 2 weeks. "The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression" (Kroenke, Spitzer, & Williams, 2001, p. 1).

1. PHQ-2 or 9 is handed to the patient to complete.
2. It is scored by the primary care provider or another member of the team.
3. A positive screen PHQ-9 is further assessed for presence and duration of suicide ideation.
4. The questionnaire can be repeated at each visit to reflect improvement or worsening of depression and response to treatment.
5. Notify primary care provider for worsening signs and symptoms.
6. Emergent suicidal intervention for any planned interventions with adequate means to carry out intervention.

B. Functional assessment: the Katz Index of Independence in Activities of Daily Living (IADL) is the most appropriate instrument to use in assessing functional status when measuring a patient's ability to perform activities of daily living independently (Katz, Down, Cash, & Grotz, 1970). "One of the best ways to evaluate the health status of older adults is through functional assessment which provides objective data that may further indicate decline or improvement in health status, allowing the nurse to plan and intervene appropriately" (Shelkey & Wallace, 2012, p. 1).

1. Tool is used to detect problems in performing ADLs.
2. The index ranks adequacy of performing bathing, dressing, toileting, transferring, continence, and feeding.
3. RN in CCTM should plan for increased services such as physical therapy, occupational therapy, and visiting nurse or aide services for patients who have difficulties with ADLs.

C. Cage and Cage-AID: the CAGE-AID is a questionnaire that focuses on both drug and alcohol abuse. The CAGE-AID is a conjoint questionnaire where the focus of each item of the CAGE questionnaire was expanded from alcohol alone to include other drugs (Brown & Rounds, 1995). Regard one or more yes responses to a positive screen. There are four questions to be completed by the patient.

1. Positive screen would follow-up with primary care provider about drug and alcohol rehabilitation.
2. Behavior medicine or behavioral health consult as needed.
3. Monitor at each visit to promote dialogue about the problem.
4. Recommend referral to Alcoholics Anonymous.
5. Recommend referral to other drug or alcohol treatment programs in the area.

D. The Mini-Cog – Mental Status Assessment of Older Adults: "Five and a third million Americans of all ages have Alzheimer's disease or other dementias. The increased availability of successful treatments for dementia and dementia-related illnesses means there is a substantial need for increased early identification of cognitive impairment, particularly in the geriatric population" (Doerflinger, 2013, p. 1).

1. The Mini-Cog is a simple screening tool that takes 3 minutes to administer.
2. Effective triage tool to identify patients in need of further evaluation by a neurologist.
3. Clock Drawing Test (CDT) is scored as normal or abnormal.
4. CDT is considered normal if all numbers are present in correct sequence and position; hands are readably displayed at the correct time. (Length of hands is not a factor.)
5. Instruct patient to remember three words such as table, pencil, and apple.
6. Next, ask him or her to draw a clock showing the time of 11:15.
7. Next, ask him of her to state the three recalled words.
8. Award 1 point for each recalled word and 2 points for correct CDT.
9. Score 0-2 is considered positive screen for dementia and requires prompt evaluation.
10. Early identification and intervention should lead to better outcomes.

E. Modified Caregiver Strain Index: "Caregivers may be prone to depression, grief, fatigue, financial hardship, and changes in social relationships. Screening tools are useful to identify families who would benefit from a more comprehensive assessment of the care giving experience" (Onega, 2013, p. 1).

1. Thirteen question tool that measures strain related to care provision.
2. Covers five domains: financial, physical, psychological, social, and personal.
3. Higher the score the higher the strain.
4. Self-administered instrument by the client/caregiver.
5. Appropriate interventions are needed to help the caregiver.
6. Further assessment of the caregiver by his or her primary care provider.
7. Early intervention could prevent further deterioration in the patient and caregiver.

F. Get Up and Go Test: "The timed Get Up and Go Test is a measurement of mobility. It includes a number of tasks such as standing from a seating position, walking, turning, stopping, and sitting down which are all important tasks needed for a person to be independently mobile" (Mathias, Nayak, & Issacs, 1986, p. 387).

1. Test is performed when patient is wearing regular footwear, using usual walking aid, and sitting in chair with an armrest.

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**Table 1.**
**Patient-Centered Care Planning: Knowledge, Skills, and Attitudes for Competency**

"Recognize the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values, and needs" (Cronenwett et al., 2007, p. 123).

| Knowledge | Skills | Attitudes | Sources |
|---|---|---|---|
| Integrate understanding of multiple dimensions of patient-centered care:<br>• patient/family/community preferences, values<br>• coordination and integration of care<br>• information, communication, and education<br>• physical comfort and emotional support<br>• involvement of family and friends<br>• transition and continuity.<br><br>Describe how diverse cultural, ethnic and social backgrounds function as sources of patient, family, and community values. | Elicit patient values, preferences, and expressed needs as part of clinical interview, implementation of care plan and evaluation of care.<br><br>Communicate patient values, preferences, and expressed needs to other members of health care team.<br><br>Provide patient-centered care with sensitivity and respect for the diversity of human experience. | Value seeing health care situations 'through patients' eyes.'<br><br>Respect and encourage individual expression of patient values, preferences, and expressed needs.<br><br>Value the patient's expertise with own health and symptoms.<br><br>Seek learning opportunities with patients who represent all aspects of human diversity.<br><br>Recognize personally held attitudes about working with patients from different ethnic, cultural, and social backgrounds.<br><br>Willingly support patient-centered care for individuals and groups whose values differ from own. | Cronenwett et al., 2007 |
| Demonstrate comprehensive understanding of the concepts of pain and suffering, including physiologic models of pain and comfort. | Assess presence and extent of pain and suffering.<br><br>Assess levels of physical and emotional comfort.<br><br>Elicit expectations of patient and family for relief of pain, discomfort, or suffering.<br><br>Initiate effective treatments to relieve pain and suffering in light of patient values, preferences, and expressed needs. | Recognize personally held values and beliefs about the management of pain or suffering.<br><br>Appreciate the role of the nurse in relief of all types and sources of pain or suffering.<br><br>Recognize that patient expectations influence outcomes in management of pain or suffering. | Cronenwett et al., 2007 |
| Examine how the safety, quality, and cost effectiveness of health care can be improved through the active involvement of patients and families.<br><br>Examine common barriers to active involvement of patients in their own health care processes.<br><br>Describe strategies to empower patients or families in all aspects of the health care process. | Remove barriers to presence of families and other designated surrogates based on patient preferences.<br><br>Assess level of patient's decisional conflict and provide access to resources.<br><br>Engage patients or designated surrogates in active partnerships that promote health, safety and well-being, and self-care management. | Value active partnership with patients or designated surrogates in planning, implementation, and evaluation of care.<br><br>Respect patient preferences for degree of active engagement in care process.<br><br>Respect patient's right to access to personal health records. | Cronenwett et al., 2007 |

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**Table 1. (continued)**
**Patient-Centered Care Planning: Knowledge, Skills, and Attitudes for Competency**

| Knowledge | Skills | Attitudes | Sources |
|---|---|---|---|
| Explore ethical and legal implications of patient-centered care.<br>Describe the limits and boundaries of therapeutic patient-centered care. | Recognize the boundaries of therapeutic relationships.<br>Facilitate informed patient consent for care. | Acknowledge the tension that may exist between patient rights and the organizational responsibility for professional, ethical care.<br>Appreciate shared decision making with empowered patients and families, even when conflicts occur. | Cronenwett et al., 2007 |
| Discuss principles of effective communication.<br>Describe basic principles of consensus building and conflict resolution.<br>Examine nursing roles in assuring coordination, integration, and continuity of care. | Assess own level of communication skill in encounters with patients and families.<br>Participate in building consensus or resolving conflict in the context of patient care.<br>Communicate care provided and needed at each transition in care. | Value continuous improvement of own communication and conflict resolution skills. | Cronenwett et al., 2007 |
| Describe strategies for learning about the outcomes of care in the setting in which one is engaged in clinical practice. | Seek information about outcomes of care for populations served in care setting. Seek information about quality improvement projects in the care setting. | Appreciate that continuous quality improvement is an essential part of the daily work of all health professionals. | Cronenwett et al., 2007 |
| Recognize that nursing and other health professions students are parts of systems of care and care processes that affect outcomes for patients and families. Give examples of the tension between professional autonomy and system functioning. | Use tools (such as flow charts, cause-effect diagrams) to make processes of care explicit. Participate in a root cause analysis of a sentinel event. | Value own and others' contributions to outcomes of care in local care settings. | Cronenwett et al., 2007 |
| Explain the importance of variation and measurement in assessing quality of care. | Use quality measures to understand performance.<br>Use tools (such as control charts and run charts) that are helpful for understanding variation.<br>Identify gaps between local and best practice. | Appreciate how unwanted variation affects care. Value measurement and its role in good patient care. | Cronenwett et al., 2007 |
| Describe approaches for changing processes of care. | Design a small test of change in daily work. | | Cronenwett et al., 2007 |

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# CHAPTER 11

# Care Coordination and Transition Management Between Acute Care and Ambulatory Care

*Janine Allbritton, MSN, RN*
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## Learning Outcome Statement

The purpose of this chapter is to enable the reader to understand the outcomes a mutually developed, implemented, and continuously evaluated transition of care plan has on quality of care, patient satisfaction, and patient outcomes. In addition, recognizing the financial impact and understanding the importance of integrating evidence-based practice guidelines into a transition of care plan are essential components of the role of the registered nurse (RN) in Care Coordination and Transition Management (CCTM).

## Learning Objectives

After reading this chapter, the RN in the CCTM role will be able to:

- Identify opportunities for transition management within the continuum of care.
- Identify key elements of successful transition planning including identification of vulnerable populations.
- Review the most common factors influencing poor transition of care.
- Describe components of an evidence-based transition plan.
- List examples of transition of care models.
- Apply an evidence-based format to coordinate information transfer between sites of care.
- Demonstrate the knowledge, skills, and attitudes required for transitions in care (see Table 1).

## Competency Definition

*Transition of care* is the movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another (Centers for Medicare & Medicaid Services [CMS], 2013a). "It comprises a range of time-limited services that complement primary care and are designed to ensure health care continuity and avoid preventable poor outcomes among at-risk populations as they move from one level of care to another, among multiple providers and across settings" (Naylor, Aiken, Kurtzman, Olds, & Hirschman, 2011, p. 747). Transitional care is "a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location" (Coleman & Boult, 2003, p. 555).

Until recently, much of the research conducted on transition of care events emphasized hospitals and the discharge planning process. It has become apparent there are numerous instances along the continuum of care during which the progress toward positive clinical outcomes has the potential to derail. It is also becoming apparent that responsibility for a person's care does not end when that person enters or exits another care setting. Through active involvement of the patient and caregiver and participation of providers of care from environments outside the hospital, in concert with discharge planning occurring during hospitalization, opportunities for preventing errors will be uncovered, preventable re-admissions will be decreased, and more conscientious use of the shrinking health care dollar will occur.

The coordination of patient care is an established standard of nursing practice, regardless of the practice environment. Engaging the patient and family to participate in determining the needs and preferences surrounding their care and providing education and securing essential equipment, supplies, and community resources to manage their care has long been part of the scope of the practicing registered nurse (RN). The American Nurses Association (ANA) released a position statement regarding the essential role of RNs in this endeavor. "Patient-centered care coordination is a core professional standard and competency for all registered nursing practice. Based on a partnership

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guided by the healthcare consumer's and family's needs and preferences, the registered nurse is integral to patient care quality, satisfaction, and the effective and efficient use of health care resources. Registered nurses are qualified and educated for the role of care coordination, especially with high risk and vulnerable populations" (ANA, 2012, para. 2). In October 2012, Medicare began linking hospital reimbursement to the quality of care. This increased focus on quality places more emphasis on better preparation of patients for managing their illness at home. The goal is to promote quality and cost savings through the reduction of after-hospital adverse events and prevent re-admissions. In particular, the ambulatory care RN plays a critical role in care coordination and transition management (CCTM) by focusing on prevention of illness, management of specific high-risk conditions, reduction or elimination of preventable complications, as well as promotion of healthy lifestyle changes and careful use of valuable health care resources. Management of a care transition generally begins when a patient is identified as having a status change (deterioration or improvement) that makes it appropriate to move to another setting or level of care (American Medical Directors Association [AMDA], 2010).

## I. Transition of Care Opportunities

A. Acute to ambulatory care which includes transition of care from hospital to primary care physician.
   1. This is one of the most common transitions of care to identify and one that has been researched the most.
   2. Provides an opportunity to have a major impact on quality of care with effective hand-off communication.
   3. Is the transition of care most likely to positively impact health care cost savings through implementation of strategies to reduce adverse events and hospital re-admission rates.
   4. Contains communication gaps between providers in the acute care and post-hospital care agencies which results in providers having an incomplete picture of the scope of the patient's needs.
   5. Requires collaboration between inpatient or acute care RN contact and the RN in CCTM in ambulatory care, Patient-Centered Medical Homes (PCMH), and outpatient settings, both having access to multidisciplinary health care teams.
   6. Provides opportunity for patients to further discuss and solidify goals discussed but not finalized in acute care settings.
   7. Home care agency must be made aware of pertinent care information and patient needs to maintain consistency in care and anticipate care needs.

B. Acute to sites within long-term care continuum requires RN points of contact to facilitate communication between health care team at different levels of care.
   1. Care transitions expose older adults to added risk for medical complications, decreased quality of life, and overuse of acute health care services (National Transitions of Care Coalition [NTOCC], 2011).
   2. Older adults now enter nursing homes with increasingly acute health conditions which means they are more vulnerable to poor health and quality-of-life outcomes.
   3. Nursing home residents are highly vulnerable to harm from poorly executed care transitions, including inadequate communication of critical information from the hospital, medication errors including omissions, delays in follow-up diagnostic tests, treatments, and repeated hospitalizations.
   4. The fundamental goal of those assisting older adults during transitions of care is to promote safe and person-centered transitions that are most likely to achieve patient and caregiver goals without complications (AMDA, 2010).

C. Ambulatory care and extended care to acute care.
   1. Acute care RNs are generally responsible for collecting data to establish a plan of care, but often have incomplete information regarding patient's prior health status, socioeconomic issues, support systems, and coping mechanisms. This is an opportunity for the RN in CCTM to facilitate the exchange of information.
   2. In current practice, information previously developed for a patient's ambulatory or extended care plan of care is seldom shared with the acute care medical team.
   3. The RN in CCTM can assist in facilitating the transfer of care to acute setting by ensuring and/or providing the following elements:
      a. The patient should have an accountable provider or a team of providers during all points of transition. This provider(s) should be clearly identified, will provide patient-centered care, and will serve as central coordinator across all settings and across other providers.
      b. The patient should have an up-to-date, proactive care plan that includes clearly defined goals, takes into consideration the patient's preferences, and is culturally appropriate.
      c. Whenever possible, the management and coordination of transitional care activities should be facilitated through the use of integrated electronic information systems that are interoperable and available to patients and providers.
      d. Information must be communicated to the acute care setting on current prescription and over-the-counter medications (including vitamins, herbs, laxatives, etc.) specifying name, dose, frequency, and duration.
      e. Strategies for appropriate communication with patients with limited English proficiency and health literacy must be defined.

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**Table 1.**
**CCTM Between Acute Care and Ambulatory Care: Knowledge, Skills, and Attitudes for Competency**

| Patient-Centered Care | | | |
|---|---|---|---|
| Recognize the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values, and needs (Cronenwett et al., 2007). | | | |
| **Knowledge** | **Skills** | **Attitudes** | **Sources** |
| Analyze multiple dimensions of patient-centered care including patient/family/community preferences and values, as well as social, cultural, psychological, and spiritual contexts.<br><br>*Types of transitions:*<br>• Acute to home<br>• Acute to subacute<br>• Home to acute<br>• Acute care to long-term acute care | Identify patient and caregiver main concerns regarding care after discharge, management of symptoms, attainable goals related to disease and prognosis.<br><br>Identify and create plans to address barriers in care settings that prevent fully integrating patient-centered care.<br><br>Engage patients or designated surrogates in active partnerships along the health-illness continuum. | Commit to the patient as the source of control and full partner in his/her care.<br><br>Commit to patient-centered, collaborative care planning.<br><br>Appreciate physical and other barriers to patient-centered care.<br><br>Value the involvement of patients and families in care decisions.<br><br>Respect preferences of patients related to their level of engagement in health care decision making. | Cronenwett et al., 2007 |
| Analyze patient-centered care in the context of care coordination, patient education, physical comfort, emotional support, and care transitions. | Work to address ethical and legal issues related to patients' rights to determine their care.<br><br>Work with patients to create plans of care that are defined by the patient. | Commit to respecting the rights of patients in determining their plan of care.<br><br>Recognize the need to work with family members to accept the patient's right for self-determination.<br><br>Value the decisions of patient and family in choosing best next level of care based on patient's goals. | Physician Orders for Life-Sustaining Treatment Paradigm (POLST), 2012 |
| Analyze strategies which empower patients and/or families involved in the health care process. | Engage patients and/or caregivers in developing active partnerships at all levels of care.<br><br>Eliminate barriers to family or other caregiver's presence during care discussions per patient's request. | Value the involvement of patients and families in care decisions.<br><br>Respect patient preferences for degree of active engagement in care process.<br><br>Honor active partnership with patients or their designated participants in planning, implementing, and evaluating care provided. | Cronenwett et al., 2007 |

*continued on next page*

**Source Note:** Cronenwett et al. (2007) reprinted form *Nursing Outlook, 55*(3), 122-131, with permission from Elsevier.


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