PERSPECTIVES IN Ambulatory Care Nursing

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To my sons, Charlie Morgan and David.
I'm so happy to see the adults you've become.
To my husband Charles for his unfailing,
unflagging, and unconditional love and support.

—Caroline Varner Coburn

To Susan Grant who gave me the opportunity
to step into the world of ambulatory nursing.
To Linda McCauley who had the foresight to see the
importance of adding ambulatory nursing to BSN curriculum.
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of the value of ambulatory nurses to the population and healthcare.
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—Deena Gilland

To my parents, Elizabeth and John H. Reck,
for raising me to believe that anything is possible.
To my daughters, Erica and E. Connor Swan,
for being impossible.
To my husband, Eric J. Swan, for making
everything possible, you're my inspiration.

—Beth Ann Swan

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Caroline Varner Coburn earned her BSN from Duke University, MS from Georgia State University, Adult Nurse Practitioner certification from Emory University, and DNP from the University of Alabama at Birmingham. She currently holds the position of clinical associate professor at Nell Hodgson Woodruff School of Nursing, Emory University, Atlanta, GA. Her academic focus is ambulatory nursing and interprofessional collaboration for education of undergraduate, graduate, and postgraduate nurses in a domestic and global context. In support of these academic interests, she is actively involved in a collaborative relationship between the Emory School of Nursing and a nongovernmental organization in The Bahamas. As part of a national taskforce for the American Academy of Ambulatory Care Nursing, she participated in the development of guidelines for academic–clinical collaboration in ambulatory care.

Deena Gilland, DNP, MSN, RN, NEA-BC, FAAN

Deena Gilland is the vice president of Patient Services and chief nursing officer of Emory Healthcare's Ambulatory Practice and an instructor at the Nell Hodgson Woodruff School of Nursing at Emory University. Prior to her current role she served as the director of Oncology Services for the National Cancer Institute (NCI)-designated Winship Cancer Institute of Emory University.

Gilland has dedicated the past decade to establishing a national model and structure for nursing practice in an ambulatory care setting. Her work centers on nursing optimization and illuminating the value of nursing. Gilland impacted nursing practice by developing an ambulatory nursing organizational structure with senior nursing options, optimizing the ability of nurses to impact the health of our population. Her innovative work to develop a prelicensure nursing student path into ambulatory nursing, along with creating methods to induct them through a nurse residency, has advanced the profession nationwide and forged a path for nurses in the ambulatory care.

Gilland received her Doctor of Nursing Practice in Health Systems Leadership and her MSN in Healthcare Leadership from the Emory School of Nursing, and her BSN was obtained from Georgia College. She completed the Managing Healthcare Delivery program at the Harvard Business School and is a fellow of the CNO Academy. She currently serves on the board of directors for the American Academy of Ambulatory Care Nursing (AAACN).

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Beth Ann Swan earned her BSN from Holy Family College, and her MSN and PhD from the University of Pennsylvania School of Nursing. She is a fellow of the American Academy of Nursing, past president of the American Academy of Ambulatory Care Nursing, and a 2007–2010 Robert Wood Johnson Executive Nurse Fellow. She is nationally and internationally known for her research and work in health care and nursing. As an expert clinician, she was an early leader in exploring the impact of changing health care delivery models on outcomes of care. Throughout her career, Dr. Swan has been an advocate for engaging consumers in their health care, promoting ambulatory and primary care, and creating innovative evidence-based practices to improve care. She was a member of the Veterans Health Administration Choice Act Blue Ribbon Panel and was a member of the Josiah Macy Jr. Foundation Planning Committee for Preparing Registered Nurses for New Roles in Primary Care. Her numerous publications cover a wide range of topics focused on ambulatory and primary care, innovations for practice and education, and health care policy.

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Preface

"The difficulty lies not so much in developing new ideas as in escaping from old ones."

John Maynard Keynes

Background

The impetus for *Perspectives in Ambulatory Care Nursing* came when we (Dr. Deena Gilland and Dr. Caroline Coburn) initiated a new course at the Nell Hodgson Woodruff School of Nursing at Emory University, titled "Ambulatory Care Nursing." In planning for this course, we found that existing textbooks on population or public health did not capture the perspectives of ambulatory care nursing. At every available nursing conference, we asked if publishing houses had any textbooks in progress on this subject, and when the answers were negative, we decided to submit our own book proposal.

The contributors to this book represent some of the outstanding leaders in ambulatory nursing. Among them is Dr. Beth Ann Swan, who agreed to join us as third editor and provided invaluable expertise and resources.

Why a separate ambulatory care course? Current courses in most prelicensure nursing programs generally include at least one course on population or public health, which is valuable content. However, it is our contention that both population health and public health generally view individual care from a larger perspective, whereas ambulatory care addresses care on an individual and family level.

We also found that the broad spectrum of ambulatory care more than provided enough content for a stand-alone course, without significantly overlapping with an existing course in population health. The different sites of ambulatory nursing offer a myriad of experiences, from primary care to same-day surgery to specialty clinics to infusion centers, dialysis, urgent care, and telehealth, to name a few.

Perhaps most important, over the time we have taught ambulatory care as a separate course, it has become increasingly apparent that many students have a persistently acute and episodic care focus. We believe it does them a disservice when we fail to immerse them fully in an understanding of healthcare delivery across the care continuum. Even if they know their interest lies within the acute care setting, it is essential for them to understand the full spectrum of an individual's and family's care and its impact on the success of not only inpatient treatment but also overall health. Students and registered nurses (RNs) need to be knowledgeable about and understand where an individual and family came from and where they are going, in order to holistically provide care across the continuum rather than in silos.

How to Use This Book

This book is intended to be useful in both academic and practice arenas. As the U.S. healthcare system turns toward preventive care and keeping individuals out of the hospital, schools of nursing also will turn to more content to prepare students for this shift. For these schools, this book can provide structure and substance for courses that address these topics. Certainly,

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it is our hope that courses focused specifically on ambulatory care nursing will find appropriate content in these chapters. But as care across settings comes into clearer focus across the entire nursing education curriculum—in courses on public and community health, population health, issues and trends, adult health, medical-surgical nursing, and fundamentals, to name a few—we believe the perspectives offered in this text will help all nurses become more practice-ready. In particular, Chapter 15 addresses the need for and incorporation of ambulatory care content into nursing curricula.

Additionally, this book can provide resources for nonacademic settings. Ambulatory care sites are hiring new graduates in increasing numbers and seeing acute care RNs shift to ambulatory settings. These RNs will need a full understanding of ambulatory care, and this text can serve as an orientation tool as well as a reference for nursing management in implementing practice change. Chapter 16 discusses professional development of the ambulatory care nurse within the perspective of the general healthcare system.

Whether used in stand-alone ambulatory care courses, across the nursing education curriculum, or as a further resource for practicing RNs, to support the different uses of this book, a table is located at the end of this introduction that maps the main content topics found in this book to the appropriate chapter. Also, each chapter contains a case study with accompanying questions for class discussion or individual responses.

A word about the use of *individual*: In the writing of this book, there was discussion about the best way to describe those who receive care in an ambulatory setting. We decided on the word *individual* rather than *patient* or *client* for several reasons. *Patient* is most often descriptive of someone in an acute setting or within a clinic. This leaves out those who are cared for in health fairs, homeless shelters, workplaces, schools, and the many other settings where individuals work, play, or worship.

Client often is used in the ambulatory setting in place of *patient*. However, this word can be rather impersonal and almost implies a delivery of service rather than a collaboration in care. For all of those reasons, we chose *individual*, both to remain as neutral as possible in the description and because, ultimately, care should be focused on individuals and their families.

COVID-19 Impact

As this introduction is being written, our world is going through an extraordinary time coping with the Coronavirus (COVID-19) or severe acute respiratory syndrome coronavirus 2 (SARS COV-2) pandemic. In 2020, the Year of the Nurse and the Midwife, the role of nurses in every country has never been more acknowledged and appreciated. The skill and commitment of RNs in acute care settings is undeniable and well documented; however, because this book is about RNs in nonacute settings, we would like to say a few words about the impact of COVID-19 on ambulatory care nursing.

Within this book, the impact of COVID-19 is discussed in the chapter on telehealth in respect to long-standing changes. However, because current information may quickly become outdated, we chose not to address this specific topic in other chapters.

The role of the ambulatory RN was thrust into the spotlight in this health crisis, and ambulatory RNs were positioned into roles that made a substantial impact in the response to COVID-19. For example, in at least one university system, ambulatory care RNs were deployed as the public-facing team on the COVID-19 hotline. These RNs ensured that individuals, employees, and community contacts were appropriately educated, triaged, and, as needed, scheduled into COVID-19 screening clinics. Other ambulatory RNs were utilized in nurse practitioner and RN-led virtual care clinics where COVID-19–positive individuals were cared for via telehealth visits through daily symptom management.

Ambulatory RN care coordinators assumed the role of managing all COVID-19–positive individuals discharged from inpatient units through transition management visits

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(Landor et al., 2020). This both enhanced individual outcomes and contributed to the financial sustainability of the health system. In addition, RNs and advanced practice registered nurses (APRNs) led drive-through and independent screening and testing sites, supporting the epidemiologic response to this crisis.

The need for home healthcare does not disappear in the face of quarantines, and ambulatory care RNs in that field faced the same issues related to personal and client protection as did their acute care counterparts. Like hospitals and ambulatory care settings, home health organizations also faced difficulties in retaining RNs who would work with COVID-19–positive patients and hurdles in acquiring sufficient personal protection equipment. Mental health support for these RNs was an ongoing challenge, as it was in other ambulatory and acute settings.

Arguably, the field of telehealth will be the one most profoundly changed because of this forced shift in care delivery. Even the darkest cloud can have a silver lining, and because of these changes, RNs and APRNs are finding and enhancing their skills in virtual care. Reimbursement models are being modified and it is to be hoped that these changes will continue and expand to allow for full RN compensation in this growing arena. Additionally, as both providers and individuals become comfortable with some form of remote care, true person-centered care may include adapting for problems with face-to-face encounters, whether the challenges be distance, transportation, or physical impairment.

In a final note, the following observation was made by Susan Mitchell Grant, who was chief nurse executive at Emory Healthcare during the Ebola crisis when those patients were being admitted to Emory University Hospital. Her comments at that time are equally relevant today:

> … People often ask why we would choose to care for such high-risk patients. For many of us, that is why we chose this occupation—to care for people in need.… We can either let our actions be guided by misunderstandings, fear and self-interest, or we can lead by knowledge, science and compassion. We can fear, or we can care. (from an op-ed in the *Washington Post*, August 11, 2014. http://news.emory.edu/stories/2014/08/community_responds_oped/campus.html)

Reference

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Content Map

Using this content map: some topics, such as roles of advanced practice nurses and nurse leaders, are woven throughout most chapters and are not specifically noted here. Also, care coordination is not listed here because it is a separate chapter and also is integrated into most chapters.

Key Content	Chapter(s)*
Accreditation	5*
Advocacy	4*, 7
Behavioral and mental health, integrated care	2, 3, 10, 12, 14
Care delivery and payment models	2*, 3, 6
Community and public health	1, 3, 10, 13, 14
Continuum of care	1, 8*, 10*, 13
Cultural and literacy considerations	3, 7, 14*
Education and self-care management	7*
Elements and history of ambulatory care nursing	1*, 2*, 8, 10, 15
Health Information Technology/informatics	2, 6, 8–10, 16
Healthcare delivery models	2*, 5
Home health	1, 11*
Nurse executives/nursing leadership	6, 16
Nurse navigation/case management	8*
Nurse residency/professional development	16*
Nurse-sensitive indicators/nursing economic impact	5*, 6, 10
Nursing workforce and education	15*, 16*
Payment models and care delivery methods	1, 2*, 5*, 10
Policy/regulation	3*, 4, 7–9, 11, 13, 14
Practical nurses and unlicensed personnel	4*, 5
Primary care/patient-centered medical homes	2*, 5, 6, 10*
Protocols and delegated orders	9, 10
Quality measurement/evidence-based practice	5*, 6*, 16
Scope of practice	4*, 7, 9, 11, 13
Social and economic influences on health	1, 2, 3*, 14*
Specialty and episodic care	1, 11*, 12*
Team-based/interprofessional care	6, 10*, 16
Telehealth and virtual care	1, 6, 9*
Veterans, women, school, prison, occupational health	3, 13*
Vulnerable populations	2, 3*, 13, 14*

*Content is primary in this chapter.

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8

Care Coordination

Mary Hines Vinson, Beth Ann Swan, and Caroline Varner Coburn

PERSPECTIVES

"Care coordination is needed today more than ever, especially for persons with chronic conditions and the families and significant others who assist with their care. Care coordination by nurses in all health care settings focuses on education, coaching and counseling to enhance understanding and execution of the plan of care. Nurses providing care coordination identify each person's values, goals and preferences for care, as well as, best evidence-base[d] practices for populations and advocate for them as needed within the interprofessional health care team and with those responsible for costs of care."

Sheila A. Haas, PhD, RN, FAAN, Dean and Professor Emeritus, Loyola University Chicago, Niehoff School of Nursing

LEARNING OBJECTIVES

Upon completion of this chapter, the reader will be able to:

1. Understand the context of care coordination within the current healthcare delivery system, the profession of nursing, and the practice of ambulatory care nursing.
2. Understand the differences among the following roles: case manager, care manager, transitional care nurse, nurse navigator, care coordinator, care coordination and transition management (CCTM) registered nurse (RN).
3. List specific knowledge, skills, and attitudes required for the practice of care coordination in ambulatory care nursing.
4. Identify sources of professional practice standards for RNs in care coordination roles.
5. Define and describe types of care coordination models.

KEY TERMS

Care continuum
Care coordination
Care management
Case management
Health information technology
Transition management
Transitional care

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Care Coordination in U.S. Healthcare

Care coordination has in recent years emerged as one of the most rapidly expanding areas of nursing practice. Seen as a foundational element of healthcare reform, much attention has been directed toward defining and measuring specific processes and quality outcomes related to care coordination (Bower, 2016; Swan et al., 2019b). Government agencies, health systems, insurers, and quality programs across the United States are focused on improving care and reducing costs, particularly for high-risk and vulnerable populations that consume healthcare resources. There is an urgency within the healthcare community to make progress in this rapidly evolving area of nursing care.

Healthcare services in the United States are among the most expensive in the world, yet the quality of care has been negatively impacted by increasing complexity, decentralization, fragmentation of services, and failure to engage individuals and families in their care. Individuals often see multiple providers and receive a variety of services with rapid turnover, leading to confusion and difficulty managing complex plans of care. These factors ultimately affect health outcomes. Care coordination has been recognized as a key strategy for addressing these issues, and registered nurses (RNs) are well positioned to lead this initiative.

Historical Perspective

Although the awareness of nursing's significant contributions to care coordination in healthcare may be recent, RNs have, in fact, been providing care coordination for decades with little recognition of the processes inherent in the provision and organization of these services. In recent history, this began with the advent of diagnosis-related groups (DRGs) in the 1980s and managed care in the 1990s. At that time, health plans began to require primary care "gatekeepers" to oversee access to expensive specialist care. **Care management** evolved as a way for hospitals to control cost and reduce length of stay. RNs were deployed as case managers, both by hospitals and in community settings, where they followed high-risk individuals in an effort to reduce costs and prevent readmission. Health plans created utilization management roles to audit hospital care and coordinate postdischarge services (Zazworsky & Bower, 2016).

These payer-driven changes in care delivery increased the visibility of and payment for specific treatments and interventions. One downstream effect of these changes was that care coordination activities that may be wide-ranging and difficult to ascribe to a single diagnosis became increasingly critical, yet often unrecognized and undervalued. This attention to cost and quality in healthcare provided the foundation for today's focus on RN care coordination. Readers are referred to Chapter 2 for a full discussion of national strategies and payment models driving the need for care coordination.

Nursing Perspective

In 2012, the American Academy of Nursing (AAN) put forth policy recommendations to the Centers for Medicare and Medicaid Services (CMS), urging them to move quickly to adopt clear and consistent definitions for care coordination and **transitional care** and to implement reimbursement models for these services at the community level. Further, the AAN recommended that such models be sustainable and replicable. The policy statement urged the government to allocate funding for the development of performance measures and information technology to ensure consistent outcome measurement. Finally, they recommended that the government invest in workforce development directly related to care coordination and transition services (Cipriano, 2012). In 2013, AAN published the American Nurses Association's (ANA's) white paper, *The Value of Nursing Care Coordination*, highlighting the numerous accomplishments of the profession of nursing in promoting, practicing, and leading care coordination in diverse settings and on behalf of a wide variety of individual populations.

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The authors illustrated the importance of care coordination in healthcare reform with its potential to support the goals of better quality, more efficient use of resources, and reduced cost (Camicia et al., 2013).

In 2014, ANA convened the Care Coordination Task Force (CCTF) to review evidence and seminal documents related to care coordination in nursing. This group put forth recommendations for federal policy priorities to address goals of healthcare reform and advance nursing's contributions to effective care coordination. An interprofessional, collaborative approach was recommended that would prioritize individual, family, and population-specific approaches to care. The task force outlined policy priorities to reduce barriers related to scope of practice. Specific recommendations included a call for an acceleration of the design and implementation of evidence-based care coordination measures, as well as consistent reimbursement for care coordination services across all qualified health professionals (Lamb et al., 2015).

The American Academy of Ambulatory Care Nursing (AAACN) was quick to recognize the need for competencies to guide ambulatory care RNs in the evolving area of practice of care coordination. Between 2011 and 2014, thought leaders within the organization organized members and stakeholders nationwide in a call to action to define the roles and competencies needed for care coordination and transitional care across the **care continuum** (Haas et al., 2013).

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Care Continuum, Care Coordination, and Proliferation of Terms

Within the framework of a longitudinal approach to chronic health issues, it is important for care coordinators to look beyond current or immediate needs of individuals and to incorporate past and anticipated future challenges. The continuum of care is a concept that describes a system that guides and tracks individuals over time through a comprehensive array of health services spanning all levels and intensity of care (Healthcare Information and Management Systems Society, 2018). The notion of a care continuum that includes care across time and place, between and during care delivery encounters and care providers, has existed for many decades. However, dramatic changes in healthcare service delivery, augmented by innovative technology advances, have resulted in a continuum of care today that is much more complex than in the past. Care is offered in a variety of settings and must address not only physical health but also psychosocial, environmental, and economic issues.

Today's care continuum includes assessment of healthcare services, social determinants of health, and community resources, all factors that impact the health and well-being of individuals and families. Care coordination is essential in navigating these and other influences on the continuum of care. A variety of terms and roles related to care coordination have proliferated over the last 15 years; their definitions and differentiation are described in what follows. It is essential for RNs in ambulatory care and all practice settings to understand the full scope of care coordination and comprehend the differences between care management/manager, **case management**/manager, nurse navigator, transitional care, and **transition management**.

Care Coordination

The most recent definition from the National Quality Forum's (NQF) Care Coordination Endorsement Maintenance Project 2016 to 2017 is "a multidimensional concept that includes effective communication among healthcare providers, patients, families, caregivers (regarding chronic conditions); safe care transitions; a longitudinal view of care that considers the past,

while monitoring present delivery of care and anticipating future needs; and the facilitation of linkages between communities and the healthcare system to address medical, social, educational and other support needs that align with patient goals" (National Quality Forum, 2017).

Care Management

Care management is "a process designed to assist patients and their support systems in managing their medical/social/mental health conditions more efficiently and effectively" (Agency for Healthcare Research and Quality, 2014). Care management at the individual practice level refers to team-based approaches to care whose purpose is to assist individuals and their caregivers in managing health-related conditions across providers and services (Tomoaia-Cotisel et al., 2018).

Care managers identify target groups within the practice along with the defined responsibilities of team members and activities performed. Care management is most successful when services are provided by high-functioning interprofessional teams characterized by shared values, clearly defined roles, and effective communication skills (Tomoaia-Cotisel et al., 2018). Care management differs from care coordination in that care management is a more episodic approach.

Case Management

The Case Management Society of America defines case management as "a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes" (2017). The primary focus in case management is to help the individual navigate from one level of care to another. For instance, the case manager may coordinate complicated home care needs for recovery after surgery until individuals resume their previous level of independence. Another focal area of case management is utilization review. Case management differs from care coordination in that case management is episodic, spanning only the time frame defined by a health service encounter, until an individual is transitioned from one level or site of service to another (Ahmed, 2016).

Nurse Navigation

One example of nurse navigation is an oncology nurse navigator (ONN), who is "a professional registered nurse with oncology-specific clinical knowledge who offers individualized assistance to patients, families, and caregivers to help overcome healthcare system barriers. Using the nursing process, an ONN provides education and resources to facilitate informed decision-making and timely access to quality health and psychosocial care throughout all phases of the cancer continuum" (Oncology Nursing Society, 2017, p. 6). The limited ONN role is focused on education and engagement, access, and standardized communication between providers and settings regarding individual needs and issues. Nurse navigation is different than care coordination in that nurse navigation is a singular intervention not encompassing all the dimensions and activities of care coordination (Haas et al., 2019).

Transitional Care

Transitional care is defined as "a broad range of time-limited services designed to ensure health care continuity, avoid preventable poor outcomes among at-risk populations, and promote the safe and timely transfer of individuals from one level of care to another or from

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one type of setting to another" (Naylor et al., 2011, p. 747). Transitional care is a short-term process as an individual moves from one level of care to another. An example of transitional care may be ensuring full communication and support for an individual who needs temporary care in a skilled nursing facility (SNF) and who will be returning home at a previous level of health. Transitional care differs from care coordination in that transitional care is time limited, involving a single transfer.

Transition Management

Transition management is defined "in the context of RN practice in multiple settings as the ongoing support of individuals and their families over time as they navigate care and relationships among more than one provider and/or more than one healthcare setting and/or more than one health care service. The need for transition management is not determined by age, time, place, or healthcare condition, but rather by individuals' and/or families' needs for support for ongoing, longitudinal individualized plans of care and follow-up plans of care within the context of healthcare delivery" (Swan et al., 2019a, p. 3). This concept of transition management is specific to the care coordination and transition management (CCTM) model developed by AAACN and described more fully next. Inherent in this model is the management of care on an ongoing basis across the continuum of care.

The Care Coordination and Transition Management Model

The CCTM model provides a blueprint for the RN practice of CCTM. Theoretical foundations of the CCTM model include the chronic care model (Wagner, 1998) and the quality and safety education for nurses (QSEN) framework that serve to further refine knowledge, skills, and attitudes related to each dimension (Cronenwett et al., 2007). The CCTM model includes nine dimensions with competencies for each dimension. This model is summarized in Box 8.1.

The work of AAACN in developing the CCTM model reflects the goals of the *Future of Nursing* report (Institute of Medicine, 2011) by advocating for RNs to serve in roles that allow them to practice to the full extent of their preparation and licensure and by challenging professional nurses to lead change in healthcare. In addition, the identification of unique roles as providers of care coordination services speaks to the Institute of Medicine's (IOM's) call for RNs to seek higher levels of education and to be full participating partners in healthcare redesign.

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BOX 8.1 Nine Dimensions/Competencies of Care Coordination and Transition Management (CCTM)

Advocacy
Education and engagement of individuals and families
Coaching and counseling of individuals and families
Person-centered care planning
Support for self-management
Nursing process
Teamwork and collaboration
Cross-setting communications and care transitions
Population health management

Note. American Academy of Ambulatory Care Nursing. (2017). In C. Murray (Ed.), *Scope and standards of practice for professional ambulatory care nursing* (9th ed). Author. Used with permission of American Academy of Ambulatory Care Nursing (AAACN), aaacn.org

Scope and Standards of Practice for Care Coordination and Transition Management

The ANA delineates expectations for all RNs in its *Scope and Standards of Practice*, and standard 5A is defined as coordination of care (ANA, 2015). As in any professional specialty, RNs in CCTM must be guided by universally accepted standards of practice. The knowledge, skills, and attitudes associated with CCTM must be defined and embraced by the profession and employed in measuring performance, as well as in determining payment for care coordination services (Lamb & Newhouse, 2018). In 2016, AAACN published standards that provide detailed authoritative statements describing the responsibilities that RNs specializing in CCTM are accountable for, including nurse executives, administrators, and managers. The domain of *Clinical Practice* includes six standards that address the nursing process, describing its application specifically in the practice of CCTM. The domain of *Professional Performance* includes 10 professional practice standards that describe professional behaviors associated with the practice of CCTM (AAACN, 2016). A summary of these standards is found in Box 8.2.

BOX 8.2 Scope of Practice for Registered Nurses in Care Coordination and Transition Management (CCTM) from the American Academy of Ambulatory Care Nursing

Clinical Practice Standards	Professional Performance Standards
Assessment: systematically collects data related to the involved patient or population as they move across the care continuum.	**Ethics:** applies the nursing code of ethics to all areas of practice.
Nursing Diagnosis: analyzes data to identify diagnosis or issues to facilitate the appropriate level of care.	**Education:** maintains ongoing knowledge and competence of current evidence-based practice.
Outcomes Identification: identifies expected outcomes for the patient, group, or population.	**Research and Evidence-Based Practice:** integrates relevant research to maintain and optimize best practices, promote improvement, and advance the profession.
Planning: develops patient- and/or population-centered plan of care that identifies and advocates for strategies and alternatives to achieve the expected outcomes.	**Performance Improvement:** enhances quality and effectiveness of practice, systems, and population health outcomes.
Implementation: implements the developed plan of care (including subsets of care coordination, health teaching or promotion, and consultation).	**Communication:** communicates effectively through a variety of formats to build relationships and deliver care.
Evaluation: evaluates the status and progress of the patient or population and communicates the status and progress to relevant professionals across the care continuum.	**Leadership:** acquires and utilizes leadership behaviors in all settings and across the care continuum.
	Collaboration: interacts with patient, family, caregivers, and other professionals to improve health outcomes.
	Professional Practice Evaluation: evaluates the nurse's own practice in relation to patient outcomes and relevant policies, standards, procedures, regulations, and statutes.

(*continued*)

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BOX 8.2 Scope of Practice for Registered Nurses in Care Coordination and Transition Management (CCTM) from the American Academy of Ambulatory Care Nursing (*continued*)

Clinical Practice Standards	Professional Performance Standards
	Resource Utilization: utilizes appropriate resources that are safe, effective, and fiscally responsible.
	Environment: engages in initiatives to maintain an environment that is safe, confidential, and comfortable for patients, visitors, and staff.

Note. Adapted with permission of American Academy of Ambulatory Care Nursing. (2016). *Scope and standards of practice for registered nurses in care coordination and transition management* (1st ed.). Author. Used with permission of American Academy of Ambulatory Care Nursing (AAACN), aaacn.org

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Roles of Registered Nurses in Care Coordination

The roles of RNs in care coordination continue to evolve. In 2012, AAN recommended guiding principles for implementation, evaluation, and payment for care coordination and transitional care (Cipriano, 2012). The principles suggested that successful models offer care tailored to individual and family needs and preferences provided by interprofessional teams. The teams are highly collaborative, allowing for leadership to shift between disciplines based on the individual situation. Shared decision-making is a core foundation, and the expertise of RNs is visible.

In 2015, representatives from the American Organization for Nursing Leadership (AONL) (formerly the American Organization of Nurse Executives) and AAACN came together to discuss the role of nurse leaders in CCTM across the healthcare continuum. This dialogue resulted in a joint statement, *The Role of the Nurse Leader in Care Coordination and Transition Management Across the Health Care Continuum* (AAACN, 2015). The statement included the following six major areas:

- Know how care is coordinated in your setting.
- Know who is providing care coordination in your organization.
- Establish relationships with multiple stakeholders to improve CCTM systems.
- Understand the value of technology and its impact on workflow and roles.
- Engage individuals and families.
- Engage all team members in care coordination.

Although the foregoing principles were addressed to nurse leaders, the concepts are applicable to any RN working in care coordination. The following section describes the application of care coordination in the clinical setting.

Nursing Process and Care Coordination

Care coordination begins with the nursing process, as reflected in the six standards of clinical practice for CCTM listed in Box 8.2. The nursing process represents the essential core that unites all nursing practice and serves as the common thread across the profession and the care continuum, providing a framework to guide practice in diverse practice settings and across populations and developmental stages (ANA, 2017). With its roots in the scientific process, these steps guide the nurse through an evidence-based process in providing care.

Person-centered and population-based assessment and care planning are the foundation of care coordination. RNs performing care coordination activities utilize a longitudinal care planning process that involves a deliberate and in-depth approach to assessment, planning for individual needs across time and place to achieve or maintain health and wellness. A variety

of assessment tools are employed to gather information and contribute to a comprehensive picture of individual and family needs, priorities, preferences, and desired outcomes. The RN analyzes information gathered during the assessment to determine care priorities. Using an interprofessional approach, the RN identifies goals that are realistic, measurable, time sensitive, and reportable (AAACN, 2016). Interventions in care coordination are based on current evidence and best practices. The RN explores opportunities for self-management support, involving the individual and family in choosing specific goals for improving health status and well-being. Collaborative and interprofessional contributions to care are an essential part of the longitudinal plan. Care coordination is based on shared decision-making with individuals and families, as well as involving them in evaluating the effectiveness of care and services. Goals are established through collaboration between the individual/family, RN, and other members of the healthcare team. An important aspect of internal communication includes documenting goals and expectations in the electronic health record to encourage individual/family and interprofessional participation in achieving and evaluating outcomes.

RN Care Coordination in Ambulatory and Primary Care

Public policy changes such as the Affordable Care Act (ACA) have resulted in millions of additional people seeking primary care, many with complex chronic healthcare needs. To respond to this increasing need, RNs are working in expanded and enhanced roles in ambulatory and primary care, coordinating care and managing chronic diseases, particularly for high-risk individuals and populations. High-quality primary care models, such as the Patient-Centered Medical Home (PCMH), have emerged with new opportunities for nurse leaders and RNs to advance care models supported by interprofessional care teams and preventive approaches to care (Bodenheimer & Mason, 2017). Most primary care practices today are incorporating principles of disease prevention and care coordination, with a concurrent increase in RNs providing care at their full scope of practice. This approach to primary care is discussed in more detail in Chapter 10.

RNs performing care coordination in primary care settings describe a variety of activities, including: (1) identifying individuals in need of care coordination, (2) performing outreach to individuals by telephone and/or electronically, (3) providing face-to-face nurse visits, (4) providing support for self-management and social support, (5) managing cross-setting communication, (6) coaching and counseling individuals and families, (7) triaging contacts by individuals, and (8) participating in group visits (Friedman et al., 2016). Most care coordination roles include medication management and going beyond simply determining whether an individual's medication list is current. In the context of care coordination, RNs review medications for appropriate use, situations that may have changed the need for a particular medication, unrecognized side effects, and other implications for care. Protocols and guidelines may be employed for medication adjustment and refills.

The most consistent use of RNs coordinating care is related to long-term management of chronic conditions. In one review of RN roles in primary care, the most prevalent chronic diseases reported were diabetes, hypertension, and asthma (Norful et al., 2017). The authors found that for all chronic diseases, RNs reported care coordination roles using standard clinical practice guidelines, under which they were able to perform risk assessment and care coordination by reviewing laboratory and diagnostic tests and identifying individuals with abnormal findings requiring follow-up. Under appropriate scope of practice, RNs performed these care coordination tasks for the purpose of coordinating next steps in the individual's care, rather than making treatment adjustments.

RNs providing care coordination to underserved populations in primary care face significant challenges. One study that exemplified the common challenges in this setting described efforts to improve outcomes for diabetic patients at a Federally Qualified Health Center (FQHC), where care coordinators at the FQHC contacted participants and offered appointments within 2 to 5 days of referral. They found that persistent efforts on the part of care coordinators contributed to improved outcomes for those patients who continued with care at

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the FQHC (Mehta et al., 2016). A more complete discussion of care for underserved populations is found in Chapter 12.

Roles of Registered Nurses During Care Transitions

A care transition occurs when an individual moves from one setting of care to another. This includes movement to and from a hospital, between ambulatory care practices or specialty care practices, short- or long-term care, home health, or rehabilitation facilities. Early research related to care transitions focused largely on the discharge processes from the acute care environment, but current evidence reveals a high level of vulnerability for errors in care transitions of all types at all points on the care continuum. This realization has led to calls for increased awareness and more research to define strategies for improved processes and enhanced communication at every transition of care (Rattray et al., 2017; Sheikh et al., 2018).

Transition: Leaving or Returning to Acute Care

Discharge from the acute care hospital environment to the ambulatory environment continues to be the most common transition, primarily because of the significant opportunity for improving quality of care and reducing costs (Adams et al., 2019). Acute care transitions focus on care that is transferred to the individual's primary or specialty care provider, an alternate care facility, supported home care, or home. This focus has, in part, been driven by penalties applied to hospitals for inappropriate readmission rates. However, a trend toward decrease in the length of hospital stay also means that individuals may be discharged without a full understanding of or having support for their required follow-up care.

A variety of innovations to address the challenges of care transition from the hospital continue to be explored. For example, an RN may serve as a transition manager in order to identify individuals at high risk for readmission and to provide specific interventions during both hospitalization and postdischarge follow-up. Clearly defined roles and improved linkages between RNs in these diverse care delivery environments would contribute greatly to creating more seamless care. The following are examples of transitions from acute or ambulatory care to different settings and their associated challenges.

Acute Care to Home

Arguably the most common care transition is from the hospital to an individual's home, with follow-up provided by the individual's care provider. For individuals with an uncomplicated hospital stay and few to no comorbidities, transition is likely to be seamless. For individuals who do not fall into that category, the skills of care transition outlined previously become more important. Effective communication between the acute care facility and the primary care provider is essential. The RN who provides discharge planning in the hospital is well positioned to ensure that the individual's primary care provider is notified of the individual's hospital admission and subsequent discharge.

Acute Care to Skilled Nursing Facilities

Transitions between acute care and long-term care environments are associated with significant risk, particularly for frail older adults with comorbidities and limited social support. It is estimated that two million older adults receive postacute care in SNFs annually in the United States (Toles et al., 2016). SNF residents are highly vulnerable, often because of age, cognitive impairment, and the presence of one or more chronic diseases. Adequate communication from the hospital is essential to avoid poorly executed care transitions and poor outcomes from medication errors and delays in treatments.

A retrospective medical record audit of 155 charts transferred from acute care hospitals to one SNF reported deficiencies that included missing transferring physician contact information and incomplete medication lists. Missing medication information included instructions

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for steroid tapering, as well as details related to administration of antiarrhythmic and anticoagulant medications, adding significant risk for adverse drug events (Jusela et al., 2017). In addition to SNFs that are intended for long-term stay, annually in the United States, 1.8 million older adults transfer from acute care hospitals to short-term postacute rehabilitative services following surgery. Expectations among payers to reduce inpatient hospital length of stay have led to a growing need for short-term SNF settings to provide care during the recovery period. This population is highly vulnerable, with one in seven readmitted after major surgery and one in five experiencing an adverse event within 30 days (Davidson et al., 2017).

In this setting, transitional care that is specific to postdischarge needs becomes especially important, especially related to postoperative infection. One study found that among Medicare patients undergoing vascular surgery who were transferred to an SNF, the most common reason for hospital readmission was postoperative infection (Fernandes-Taylor et al., 2018). These and other complications may be a factor of inappropriate transition referral to facilities that are not equipped to handle the patient's needs. Consequently, the authors suggested that there is a need for processes to match short-term SNF capabilities to individuals' postoperative care needs.

Ambulatory Care, Primary Care, or Skilled Nursing Facility to Acute Care

The responsibility of ambulatory care, primary care, or SNF teams to coordinate care during transitions to the acute care environment is often overlooked. Acute care RNs have responsibility for creating a plan of care at admission but often have incomplete information regarding the individual's prior health status, socioeconomic status, family support systems, cultural preferences, and coping mechanisms (Adams et al., 2019). RNs in ambulatory care, primary care, or SNF settings can improve care transitions by initiating a collaborative process of information exchange on behalf of the individual. Providing a complete list of medications, including over-the-counter medications and supplements, is important, especially if the hospital and ambulatory/primary care practice do not share a common electronic health record system. A designated member of the ambulatory/primary care team should be responsible for all care transitions, with RNs who have expertise in care coordination often being best suited for this role.

Transition: Between Nonacute Settings and Providers

The transitional care literature does not include transitions between nonacute care settings. However, this type of care transition is addressed by the CCTM model, described previously, with transition management working in tandem with care coordination. CCTM defines the ongoing support of individuals, families, and populations as they navigate multiple systems of care delivery over time. Unique to the CCTM model is the notion that CCTM are dynamic "integrated functions that may occur simultaneously or separately and are not time limited" (Swan et al., 2019a, p. 3). RNs performing CCTM activities follow individuals and families across time and place, reflecting various levels of care, for example, transitions between different ambulatory providers, changing developmental needs, and episodic needs requiring hospitalization. Especially in individuals most needing CCTM, it is common to find frequent movement between different nonacute facilities with varying skilled care levels. These individuals with complex care needs benefit from a system that ensures the communication and coordination principles inherent in quality care transitions.

Skilled Nursing Facilities to Home

The challenges of transition from hospital to SNF have been noted; however, challenges also are reported in the transition of frail older adults from the SNF to home. One systematic review reported poor outcomes within 90 days, including emergency department visits, hospital readmission, and increased risk of mortality. The authors reported promising but limited evidence of transitional care interventions associated with lower rates of rehospitalization and improved physical function (Toles et al., 2016). In a review of existing transitional care models, recommendations included that the discharge summary from the SNF to home should include identification and availability of a caregiver, a report of baseline cognitive status and

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cognitive status at discharge, and identification of the primary care provider to link with home care services for ongoing care (Sheikh et al., 2018). Another descriptive study added that SNF cultures that promote staff engagement with individuals and families appear to improve the ability of staff to deliver evidence-based transitional care services (Toles et al., 2016). Successful transition from the SNF to home includes the already identified themes of support for the individuals when they return home, involvement of family, and communication with primary care providers and may also include population-specific recommendations of cognitive evaluation and availability of a caregiver.

Ambulatory/Primary Care to Palliative Care or End-of-Life Services

Health systems frequently offer palliative care and end-of-life services in order to improve quality of care and continuity for individuals and families. Palliative care is described as "a medical subspecialty focused on providing relief from the symptoms, pain, and stress of serious illness. The goal is to improve quality of life for both the patient and the family. It is appropriate at any age and any stage of illness and can be provided along with curative treatment" (Spaulding et al., 2016, p. 189). Although, as noted, palliative care can be provided at any stage of illness, end-of-life or hospice care is provided when the individual's death is imminent.

In the U.S. healthcare system of today, individuals generally do not completely transition to a palliative care team; often their care continues to be overseen by their primary or specialty provider. However, when palliative care is initiated it may become the primary source of care coordination for that individual during the time that it is needed, and this is especially true for individuals who transition to end-of-life care.

Successful transition to palliative care providers includes the essential concepts of communication and support, but with the added focus on the highest possible quality of life, regardless of the expected outcome. Depending on those expected outcomes, transition to this care may require a higher level of emotional support from both the RN coordinating care and provider and the palliative care team. Attention to this emotional support is even more important in the transition to end-of-life care.

Ambulatory/Primary Care to Specialty Care

Referrals from primary care providers to specialists represent a high-volume care transition between and among ambulatory care practices. When there is a care transition between primary care and specialty care, both communication, including robust use of the electronic health record, and collaborative relationships between specialists and primary care providers are important in minimizing gaps in care because of silos created by multiple care providers. Consultative services provided by specialists may be episodic in nature with a focus on a single issue. However, the specialist who has long-term or permanent involvement in the individual's care may make decisions that would overlap with or affect those of the primary care provider. In these situations, it is especially important for the RN to be involved in coordinating care and managing the transition by assuring information flow and the integration of the specialist plan into the longitudinal plan of care. There may be a specific transitional care RN role in these practices.

Care Coordination and Care Transition Tools

The transition from one care setting to another is inherently vulnerable to breakdowns or errors in communication, and evidence has demonstrated that poor communication between service providers at times of transition has contributed to negative patient outcomes. Poorly executed care transitions often result in negative impacts for individuals and their families, as well as downstream effects, including increased costs and risk of rehospitalization (Sheikh et al., 2018). There is evidence that as many as 20% of individuals discharged from acute care hospital settings experience an adverse event within 3 weeks of discharge, 66% of which are medication related (Jusela et al., 2017).

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Some contributing factors to poor communication are easily identifiable, such as language barriers, cultural differences, and health literacy. Other factors, however, may be systematic and require the use of standardized tools to ensure that essential aspects of care transitions are not overlooked. It is imperative for healthcare organizations to place a priority on improving processes related to care transitions, particularly between acute care hospitals and the ambulatory care practice environment. Standardization of communication processes and discharge tools has been recognized as a strategy for improving care transitions between hospital and home or next level of care. Some examples are provided in the following section.

Better Outcomes for Older Adults Through Safe Transitions

The Better Outcomes for Older Adults Through Safe Transitions (BOOST) model is a nationally recognized quality improvement program for reducing hospital readmissions and includes use of the 8Ps screening tool and the universal patient discharge checklist and general assessment of preparedness (GAP) (Society of Hospital Medicine, n.d.). The tools assess social determinants of health, predict risk of adverse events postdischarge, and provide risk-specific evidence-based interventions. These tools are available online at https://www.hospitalmedicine.org/globalassets/clinical-topics/clinical-pdf/8ps_riskassess-1.pdf. Outcomes reported across participating organizations include reduced 30-day readmission rates and improved communication between hospital and primary care providers (Hansen et al., 2013; Robertson, 2017).

Project Reengineered Discharge

Project Reengineered Discharge (RED), an innovative discharge approach developed by the research group at Boston University Medical Center, is characterized by a standardized discharge process to ensure individuals are prepared when leaving the hospital. This model includes: (1) tailored education to meet literacy needs and postdischarge care, (2) an emergency plan for the individual and family/caregiver, and (3) an individualized discharge plan and follow-up telephone contact for reinforcement of instructions (Stubenrauch, 2015). The tool kit is available at https://www.bu.edu/fammed/projectred/toolkit.html. Project RED outcomes include improved experience of care, decreased emergency department utilization, decreased readmissions, and decreased costs (Cancino et al., 2017; Stubenrauch, 2015).

STate Action on Avoidable Rehospitalizations

The STate Action on Avoidable Rehospitalizations (STAAR) model was developed by a team at the Institute for Healthcare Improvement (IHI) with the goal of improving transitions from hospital to community settings and reducing avoidable readmissions. The key design elements of this model include individual and family engagement, cross-continuum team collaboration, health information exchange, and shared care plans (Boutwell et al., 2009). Key elements in the ideal transition from acute care hospital to office practice include the assurance of timely access to care following hospitalization, use of standardized communication processes, and adjustment of postdischarge care based on risk. Postdischarge calls focus on medications, self-care, symptom management, and confirmation of follow-up between hospitalist and primary care provider as well as an emphasis on structured elements of posthospital follow-up appointments (Bates et al., 2014). Supporting materials and tools may be found at http://www.ihi.org/Engage/Initiatives/Completed/STAAR/Pages/Materials.aspx.

Integrated Care Transitions Approach

Unlike the three tools described previously, the Integrated Care Transitions Approach (ICTA) is designed to improve transitions across the care continuum between and among ambulatory and primary care, home care, skilled care, and acute care. The seven components of the model

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are: (1) communicating effectively among provider teams, (2) discussing goals of care and advance directives, (3) assessing function, (4) reconciling medications, (5) implementing a coordinated plan of care, (6) providing timely and complete discharge summaries, and (7) developing person-centered instructions and risk-related education (Sheikh et al., 2018).

The Role of Health Information Technology in Care Coordination

The term "**health information technology (HIT)**" refers to the application of computers and technology in the provision of healthcare. HIT supports care coordination activities by enabling the transfer of information and enhancing communication between providers in different locations, as well as providing clinicians with tools for managing care using distance technology (Austin et al., 2019). The growing use of mobile devices allows on-demand access to health information and enhances communication with individuals through automated reminders.

Advancing the role and use of HIT in improving CCTM within and across settings, disciplines, and with individuals, families, and caregivers must be a priority (Swan et al., 2019b).

HIT is intended to support and complement the practice of CCTM by providing continuous access to information that improves efficiency of care. Information systems have considerable potential to make care coordination more effective, and further development is needed to create systems that reflect the team-based nature of care coordination. Progress is dependent on the creation of standard data formats (domains) related specifically to care coordination, as well as the ability of information systems to transmit this data within and across care settings (interoperability).

More work is needed to create tools that document important care coordination processes and interventions. Domains with the largest gaps include information transfer, monitoring systems, tools to track progress toward self-management goals, and direct links to community resources for individuals, families, and caregivers (Samal et al., 2016). These are significant areas of concern that will continue to hamper progress in accurately documenting, measuring, and reporting care coordination processes, outcomes, and effectiveness.

Care Coordination and Technology-Mediated Information Sharing

Legislation and initiatives related to healthcare reform have ensured that electronic health records are well embedded in the U.S. healthcare system. Electronic health records contain comprehensive, longitudinal information about individuals that supports care across settings and providers. The electronic health record supports documentation, reduces redundancy, and improves accessibility to information across the continuum. Electronic health records also enable individuals to access their health information by way of portals that provide a direct link to secure personal health information (PHI) such as test results and visit notes as well as to scheduling and billing activities. Although portals are an extension of the electronic health record, personal health records (PHRs) are more person-centric, controlled by the individual or family member, and information is shared at the discretion of the individual. Both of these technology-mediated resources provide valuable tools for safe and efficient CCTM.

Care Coordination and Technology-Supported Interventions

Care coordination is arguably the most valuable in the setting of chronic disease management. Technology supporting personal health devices has promise for improving care coordination

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and the management of outcomes for individuals with chronic diseases, especially those related to behavior choices. For example, populations considered to be at high risk for cardiovascular disease (CVD) include those who use tobacco, have low physical activity levels, are obese, and have type 2 diabetes. Technology-supported interventions have resulted in positive results in these groups (Linke et al., 2016).

Smoking Cessation

Telephone technology to address smoking cessation, commonly referred to as "Quitlines," provides evidence-based support for smokers and maintains high utilization. Many Quitlines offer access to additional information and services, such as personalized plans and counseling, as well as social support. Although more technologically advanced methods are available, these Quitlines have continued to thrive. Other technology-based approaches include smartphone applications (apps), text messaging, social media platforms, and text-based support from trained counselors (Linke et al., 2016).

Obesity

Obesity represents a prevalent risk factor for multiple chronic diseases. In recent years, technology-based interventions have emerged as a promising strategy for supporting weight loss. Interactive computer or Web-based interventions are most common, and mobile technology, including text messaging and mobile telephone applications, is gaining popularity. These technologies integrate behavioral change strategies, health coaching, and wireless scales to support weight management (Linke et al., 2016).

Low Physical Activity

Insufficient physical activity is another prevalent risk factor for CVD and contributes significantly to health issues such as diabetes and metabolic syndrome. Technology-based assessments provided by self-tracking devices have increased in popularity and have the advantage of providing objective and accurate tracking of data. The technology supporting these applications is developing rapidly. These wearable technologies enable those who use them to better understand their needs and take control of their lives (Linke et al., 2016).

HIT Conclusion

Developing and improving HIT applications to manage chronic health issues is a growing field that offers significant support for CCTM in nursing. Improvements in technology will contribute to understanding, describing, and measuring structures, processes, and outcomes of care coordination. A positive downstream effect of this work will be improved recognition of the contributions of nursing toward improving healthcare in the United States, particularly in the areas of CCTM.

Summary

The changing state of healthcare delivery in the United States offers exciting opportunities for RNs in the practice of CCTM. The interplay of complex individual needs, new models of ambulatory care delivery, and technologic advances in communication and self-care creates an environment that allows for optimal use of nursing skills, knowledge, and competencies. The educational preparation for RNs provides the knowledge and skills needed to navigate this changing landscape of care and offers an opportunity for RNs to fully demonstrate the value of their contributions to quality and safe care for individuals, families, and populations.

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Case Study

Tom Roberts is a 70-year-old White man, who receives primary care services at a practice near his home. Although Mr. Roberts has enjoyed good health for most of his adult life, he was diagnosed with hypertension at the age of 56 and hyperlipidemia at age 60. Mr. Roberts has become progressively less active since his retirement, steadily gaining weight. Last year he was told by his physician that he is "prediabetic," but he is unsure exactly what this means. At his annual visit last week, his body mass index (BMI) moved to 30.2, and annual lab results revealed a rise in A_{1c} levels to 6.8. Although Mr. Roberts' physician has mentioned the need for exercise, nutrition, and portion control, to date there has been no formalized plan for how to manage his health. The day after his annual visit, Mr. Roberts began to experience shortness of breath and mild chest pain. He presented to the emergency department, was admitted, and underwent an angioplasty, which he tolerated well.

Mr. Roberts has been married for 35 years. His wife is 65 years old and is limited by osteoarthritis in her hands, but otherwise in good health. They have two children, both of whom are married and live in another state. Mrs. Roberts is an active member of her church, but Mr. Roberts rarely attends. He does not have a strong support group of friends and does not socialize very often.

Jan has been an RN for 20 years, 17 of which she spent in an acute care setting, providing bedside nursing on a medical–surgical unit. Three years ago, Jan transitioned from acute care to a position in the primary care practice where Mr. Roberts is a patient. Jan attended an ambulatory nurse residency program to prepare her for her new role. She recently completed a year of study and successfully achieved professional certification as a CCTM-certified nurse. Jan has been appointed as an RN care coordinator with her practice and will now assume Mr. Roberts' care.

1. Use the nursing process to assess Mr. Roberts, and describe the steps, in order of priority, that Jan should take in managing Mr. Roberts' care.
2. What are the goals, immediate and long-term, for Mr. Roberts? How will Jan identify these goals, and who is involved in determining them?
3. What interventions will Jan use to accomplish the goals? Who will be involved in this implementation and how? What are the challenges to implementing her interventions?
4. What are examples of measurable outcomes for Mr. Roberts, and how will Jan evaluate those outcomes?

Key Points for Review

- The continuum of care is a concept that describes a system that guides and tracks individuals over time through a comprehensive array of health services spanning all levels and intensity of care. The continuum of care describes care across time and place, between and during care delivery encounters and care providers.
- The CCTM RN utilizes an evidence base to manage ongoing, longitudinal, individualized plans of care and follow-up plans of care for individuals, families, communities, and populations within the context of healthcare delivery across the care continuum.
- A care transition occurs when an individual moves from one setting of care to another. Transition management works in tandem with care coordination and describes the ongoing support of individuals, families, and populations as they navigate multiple systems of care delivery over time.
- Standardization of communication processes and discharge tools has been recognized as a key strategy for improvement of care transitions between hospital and home or next level of care.
- HIT supports care coordination activities by enabling the transfer of information and enhancing communication between individuals, families, and providers in different locations, as well as providing clinicians with tools for documenting and managing individual care using distance technology.

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