American Academy of Nursing on Policy

The imperative for patient-, family-, and population-centered interprofessional approaches to care coordination and transitional care: A policy brief by the American Academy of Nursing's Care Coordination Task Force

*Pamela Cipriano, PhD, RN, NEA-BC, FAAN**

Galloway Consulting, Charlottesville, VA

The American Academy of Nursing (AAN), representing nurse policy leaders, scientists, and clinicians, applauds the Centers for Medicare and Medicaid Services' (CMS) recognition and support of evidence-based care coordination and transitional care. As CMS moves forward with policies for care coordination under Medicare and Medicaid, the AAN urges the agency to consider the framework it uses for thinking about care coordination and the evidence to support that framework. The Academy seeks to share its perspectives on crucial elements of such a framework to support the integration of care coordination and transitional care into the U.S. health care system to meet the 3-part aim of better health, better care, and lower costs.

Care coordination and transitional care services are strategically important for achieving the priorities in the National Quality Strategy and the Partnership for Patients. Current models alone are not sufficient to meet these priorities. Swift recognition and payment for additional interprofessional models is needed to deliver on the promises of better care, better health, and reduced costs through improvement. To that end, the AAN recommends that CMS and the payer community:

1. ***Adopt clear definitions of care coordination and transitional care that are patient, family, caregiver, and population centered that can be used consistently among all stakeholders.***
2. ***Implement payment models expeditiously for evidenced-based care coordination and transitional care services delivered at the community level by teams led by the best professional to coordinate the care, including nurses and other professionals as well as physicians.***
3. ***Ensure replicability and sustainability of care coordination and transitional care models through improved performance analytics and workforce development:***
   a. ***Expedite funding to develop, implement, and evaluate performance measures that address gaps in effective and efficient care coordination and transitional care.***
   b. ***Invest in workforce development to better prepare all team members to deliver effective and efficient care coordination and transitional care services.***

AAN supports the need for expanding and accelerating implementation of effective care coordination and transitional care models. Care coordination as defined by Agency for Healthcare Research and Quality (McDonald et al., 2010) is the deliberate organization of patient care activities across time and settings to facilitate appropriate delivery of health care services. Transitional care, an important component of care coordination, is usually targeted to populations at high risk for poor and/or costly outcomes as they cross care settings. AAN supports the need for more interprofessional, team-based, and nurse-led or -managed models to increase access, improve care, and reduce costs for all in need (Marek, Adams, Stetzer, Popejoy, & Rantz, 2010). AAN urges CMS to recognize and pay for proven models and approaches including those that do not require physician stewardship.

Models that Work

Several care models exist that apply care coordination and transitional care led and/or carried out by nurses and other nonphysician providers with demonstrated positive impact on clinical and economic outcomes. Examples include:

Task Force members: Maureen Dailey, DNSc, RN, CWOCN; Tine Hansen-Turton, JD, MGA, FAAN; Harriet Kitzman, PhD, RN, FAAN; Gerri Lamb, PhD, RN, FAAN; Mary Naylor, PhD, RN, FAAN, and Sue Reinhard, PhD, RN, FAAN.

* *Corresponding author*: Dr. Pamela Cipriano, Galloway Consulting, 512 Rosemont Drive, Charlottesville, VA 22903.
E-mail address: Pcipriano93@gmail.com (P. Cipriano).

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- Programs to enable frail elders to remain in their communities, preserve function, decrease hospitalizations and emergency department visits, improve other clinical outcomes, and contain costs below that of nursing homes.
- The Nurse-Family Partnership model providing care coordination for impoverished, high-risk, first-time pregnant women has documented effective short-term and long-term outcomes for both mothers and babies through rigorous comparative evaluations (Olds et al., 2010).
- The primary care–based nurse-managed health clinic model, defined in the Affordable Care Act, has strong care coordination practice as its hallmark.
- Transitional care approaches to reduce avoidable emergent care and rehospitalization (Coleman, Parry, Chalmers, &Min, 2006; Naylor et al., 1999; Naylor et al., 2004; Naylor et al., 2009; Naylor et al., 2011; Parrish, O'Malley, Adams RI, Adams SR, &Coleman, 2009).

Guiding Principles

AAN recommends the following guiding principles for implementation, evaluation, and payment for care coordination and transitional care models:

- Models are patient and family caregiver–centered in concept and design that support shared decision-making.
- Interprofessional teams match services to patient and family needs to gain the highest value.
- Team leadership shifts according to patient and family needs, preferences, and expertise of team members.
- Existing and new payment mechanisms recognize evidence-based models led by any discipline that are associated with improved quality outcomes and cost reduction.
- Explicit and seamless links connect patients, providers, and caregivers to community resources.
- Teams have high reliance on the expertise, skills, and services of registered nurses.
- Care coordination and transitional care provide seamless transition experiences for patients and family caregivers.
- Ongoing quality measurement and comparative effectiveness research are needed to test these assumptions and define best practices.

Specific Recommendations

1. **Clear definitions of care coordination and transitional care:**

Adopt clear definitions of care coordination and transitional care that are patient, family caregiver, and population centered that can be used consistently among all stakeholders.

- Definitions should be patient, family, and population centric.
- Definitions should address services provided by any *qualified professional*[1] based on the risk status and needs of the patient, family, or population.
- Definitions should be easily used and understood by the public, providers, and payers.

2. **New payment and delivery models that recognize and incentivize teamwork:**

Implement payment models expeditiously for evidenced-based care coordination and transitional care services delivered at the community level by teams led by the best professional to coordinate the care, including nurses and other professionals as well as physicians.

- Recognize and pay for models that provide effective organization and management of care *across* providers and settings.
- Models must rely on effective communication and timely teamwork.
- Models, although team-oriented, typically highlight the central role of registered nurses.

3. **Replicability and sustainability of care coordination and transitional care models through improved performance analytics and workforce development:**

Invest in workforce development to better prepare all team members to deliver effective and efficient care coordination and transitional care services.

- Invest in research linking care coordination interventions to quality and cost outcomes with urgency to show the impact on complications and readmissions.
- Invest in workforce capacity–building and ongoing development.

Expedite funding to develop, implement, and evaluate performance measures that address gaps in effective and efficient care coordination and transitional care.

- Move beyond existing care coordination performance measures that are largely provider centered and condition specific.
- Create new shared accountability composite measures targeting process and outcomes that extend beyond minimalist checklists to address changing risk

[1] "Qualified professional" is defined as a health care professional who is educated and trained to coordinate the care of people at varying levels of risk. Although some professionals may be skilled at coordinating care for high-risk patients, others may qualify for managing only low-risk patients. Determining who is "qualified" should reflect the specific needs and health problems of the patient and family.

and patient complexity. The following key measures are recommended to be included.

Care Coordination: Priorities for Measurement

Cross-cutting Issues

- The need for examination of measure denominators and risk adjustment strategies that capture differences in care coordination and transitional care intensity across patient populations.
- The need for a common denominator to identify the general population for care coordination and transitional care across settings moving beyond diagnosis and condition-specific denominators.

Patient and Family Experience of Care Coordination

- Measures that address timeliness and responsiveness of care and services.
- Measures that capture patient and family goals and preferences for care and services.
- Measures that consider unique care coordination and transitional care needs of children and their families.
- Measures that consider the extent to which care coordination and transitional care are culturally appropriate.

Process Measures of Care Coordination

- Measures of the development, implementation, and regular review of an integrated plan of care incorporating patient and family preferences and goals.
- Measures of timely and accurate communication of the plan of care across providers and settings.

Outcome Measures of Care Coordination

- Standardized measures of preventable hospitalizations and emergency department visits.
- Measures of patient and family satisfaction with care coordination and transitional care.
- Measures of quality of life and functional status across the continuum of care.

Structural Measures

- Measures of staff and team competence in care coordination, particularly competence in complex care coordination and transitional care for seriously ill patients and their families.
- Measures addressing access to appropriate and competent care coordination and transitional care.

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Innovative Models of Care

A number of care models that apply care coordination and transitional care led and/or carried out by nurses and other nonphysician providers have demonstrated positive impact on clinical and economic outcomes. The nurses in the following examples have been designated as "Edge Runners" by the AAN for their innovative models of care that have improved clinical outcomes while containing or lowering costs (www.aannet.org/edgerunners). Examples include:

Programs to enable frail elders to remain in their communities, preserve function, decrease hospitalizations and emergency department visits, improve other clinical outcomes, and contain costs below that of nursing homes.

- University of Missouri School of Nursing's Aging In Place Project, a state-academic-private partnership (Rantz et al., 2011).
- University of Pennsylvania School of Nursing's Living Independently for Elders (LIFE), a PACE program (Sullivan-Marx, Bradway, & Barsteiner, 2010; Mukamel et al., 2007).

Care coordination for impoverished, high-risk, first-time pregnant women has documented effective short-term and long-term outcomes for both mothers and babies through rigorous comparative evaluations (Olds et al., 2010).

- The Nurse-Family Partnership model

The primary care–based, nurse-managed health clinic model, defined in the Affordable Care Act, has strong care coordination practice as its hallmark. Nurse practitioner–led interdisciplinary teams: (1) Build solid relationships with their patients, (2) facilitate the exchange of information between providers and patients, and (3) integrate the care provided by multiple professionals with outside resources and services (Coddington & Sands, 2008; Hansen-Turton, 2005; Barkauskas et al., 2011; Beaulieu & Humphreys, 2008; Anderko, Fisher Robinson, & Uscian, 2000).

- The Eleventh Street Family Health Service
- Family Practice and Counseling Network

Transitional care approaches to reduce avoidable emergent care and rehospitalization:

- Transitional Care Model (TCM) at the University of Pennsylvania School of Nursing (Naylor et al., 1999; Naylor et al., 2004; Naylor et al., 2009; Naylor et al., 2011).
- The Rush Enhanced Discharge Planning Project (Hospitals in Pursuit of Excellence, n.d.), which uses Master's-prepared social workers to help elders increase their understanding of prescribed medications; it decreases patient and caregiver stress.
- The Care Transition Program at the University of Colorado (Coleman, Parry, Chalmers, & Min, 2006) uses registered nurses, social workers, or community workers as transition coaches to promote self-management and greater family involvement to bridge transitions between hospital and community settings. "Care Transition Intervention" emphasizes medication self-management, patient-centered health records, appointment scheduling, and recognizing indicators of deteriorating condition.

The AAN urges rapid recognition, implementation, compensation, and evaluation of a broader range of evidence-based interprofessional care coordination and transitional care models. Escalating payment eligibility will not only promote greater access but will also promote earlier success achieving improved quality and efficiency.

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