Health Care Reform and Ambulatory Nursing Part II

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Session Objectives

At the conclusion of this session, attendees will be able to:

- Articulate the need to ensure pre-licensure nursing students have knowledge, skills and competencies (both QSEN and Interprofessional IPCP competencies) to work as ambulatory care nurses
  - Discuss QSEN and IPCP competencies and need for high levels of practice with them in ambulatory care nursing
  - Discuss nursing contributions to care and outcomes in ambulatory care
  - Discuss expected outcomes from providers with QSEN and IPCP competencies
Session Objectives (continued)

- Articulate the need to keep up-to-date with rapidly evolving ambulatory care environment, regulatory changes and demands for access, quality and safety in all ambulatory care patient encounters.
  - Discuss evolution of the RN-Care Coordination and Transition Management Role in Ambulatory care.
  - Discuss methods of keeping patients engaged in care and population health management

IOM Report:

*Crossing the Quality Chasm* (2001)

- Multiple factors have created a quality chasm.
  - Medical science and technology have advanced at an unprecedented rate
  - Growing complexity of health care
  - Rapid changes in science and technology
  - U. S. health care delivery system has *fallen far short in ability to translate knowledge into practice and to apply new technology safely and appropriately*
  - If the system cannot *consistently* deliver to-day’s science and technology, it is even less prepared to respond to advances during the coming decades.
- It takes an average of *17 years* for new knowledge generated to be incorporated into practice
**Crossing the Quality Chasm** (IOM, 1999)

1. *Care is based on continuous healing relationships.*
   a. health care system must be responsive at all times, and access to care should be provided over the Internet, by telephone, and by other means in addition to in-person visits.

2. *Care is customized according to patient needs and values.*

3. *The patient is the source of control.*

4. *Knowledge is shared and information flows freely.* Patients should have unfettered access to their own medical information and to clinical knowledge.

5. *Decision making is evidence-based.*

Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place.
6. **Safety is a system property.** Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.

7. **Transparency is necessary.** The system should make available to patients and their families information that enables them to make informed decisions when selecting a health plan, hospital, or clinical practice, or when choosing among alternative treatments. This should include information describing the system’s performance on safety, evidence-based practice, and patient satisfaction.

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8. **Needs are anticipated.** The system should anticipate patient needs, rather than simply react to events.

9. **Waste is continuously decreased.** The system should not waste re-sources or patient time.

10. **Cooperation among clinicians is a priority.** Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care.
Knowledge and Skills Needed by Nurse Leaders

- Quality and Safety Education in Nursing (QSEN)

- QSEN Competencies:
  
  **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

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Knowledge and Skills Needed by Nurse Leaders

- **QSEN Competencies (continued)**
  - **Quality** ~ Use data to monitor the outcomes of care processes and use improvement methods to design and test changes to continuously improve the quality and safety of health care systems.
  - **Teamwork and Collaboration** ~ Function effectively within nursing and inter-professional teams, fostering open communication, mutual respect and shared decision-making to achieve quality care.
Knowledge and Skills Needed by Nurse Leaders

QSEN Competencies (continued):

- **Safety** ~ Minimizes risk of harm to patients and providers through both system effectiveness and individual performance
- **Evidence-based Practice** ~ Integrate best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care
- **Informatics** ~ Use information and technology to communicate, manage knowledge, mitigate error, and support decision making.

QSEN Pre-Licensure Competencies

[http://qsen.org/competencies/pre-licensure-ksas/](http://qsen.org/competencies/pre-licensure-ksas/)

- Using the Institute of Medicine competencies, QSEN faculty and a National Advisory Board have defined quality and safety competencies for nursing and proposed targets for the knowledge, skills, and attitudes to be developed in nursing pre-licensure programs for each competency. These definitions are shared in the six tables below as a resource to serve as guides to curricular development for formal academic programs, transition to practice and continuing education programs.
QSEN Pre-Licensure Evidence-based Practice Competency

- **Definition:** Integrate best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care.


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QSEN Pre-Licensure EBP Competency: Knowledge

- Demonstrate knowledge of basic scientific methods and processes. Describe EBP to include the components of research evidence, clinical expertise and patient/family values.
- Differentiate clinical opinion from research and evidence summaries. Describe reliable sources for locating evidence reports and clinical practice guidelines.
- Explain the role of evidence in determining best clinical practice. Describe how the strength and relevance of available evidence influences the choice of interventions in provision of patient-centered care.
- Discriminate between valid and invalid reasons for modifying evidence-based clinical practice based on clinical expertise or patient/family preferences.
**QSEN Pre-Licensure EBP Competency: Skills**

- Participate effectively in appropriate data collection and other research activities. Adhere to Institutional Review Board (IRB) guidelines. Base individualized care plan on patient values, clinical expertise and evidence.
- Read original research and evidence reports related to area of practice. Locate evidence reports related to clinical practice topics and guidelines.
- Participate in structuring the work environment to facilitate integration of new evidence into standards of practice. Question rationale for routine approaches to care that result in less-than-desired outcomes or adverse events.
- Consult with clinical experts before deciding to deviate from evidence-based protocols.

**QSEN Pre-Licensure EBP Competency: Attitudes**

- Appreciate strengths and weaknesses of scientific bases for practice. Value the need for ethical conduct of research and quality improvement. Value the concept of EBP as integral to determining best clinical practice.
- Appreciate the importance of regularly reading relevant professional journals.
- Value the need for continuous improvement in clinical practice based on new knowledge.
- Acknowledge own limitations in knowledge and clinical expertise before determining when to deviate from evidence-based best practices.
Core Competencies (IPEC, 2010)

- Values/Ethics for Interprofessional Practice
  - Act with honesty and integrity in relationships with patients, families and other team members.
  - Respect the dignity and privacy of patients while maintaining confidentiality in the delivery of team-based care.

Core Competencies (IPEC, 2010)

- Roles/Responsibilities for Collaborative Practice
  - Communicate one’s role and responsibilities clearly to patients, families and other professions.
  - Explain the roles and responsibilities of other care providers and how the team works together to provide care.
Core Competencies (IPEC, 2010)

- **Interprofessional Communication**
  - Choose effective communication tools and techniques, including information systems and communication technologies, for facilitating discussions and interactions that enhance team function.
  - Give timely, sensitive, instructive feedback to others about their performance on the team and respond respectfully as a team member to feedback from others.

Core Competencies (IPEC, 2010)

- **Interprofessional Teamwork and Team-Based Care**
  - Engage other health professionals—appropriate to the specific care situation—in shared patient-centered problem solving.
  - Reflect on both individual and team performance improvement.
IPEC Reinforcing and Restraining Factors

- **Reinforcing:**
  - Emphasis on Quality of Care
  - Focus on the Patient
  - Promise of Health Care Reform
  - Aging society
  - Growth in Scientific Knowledge

- **Restraining:**
  - Absence of role models
  - Reimbursement
  - Resistance to change
  - Logistical barriers

Nursing Contributions to Care and Outcomes in Ambulatory Care

- As we move to PCMH and ACO organizations:
  - Nurses will be working in areas that have patient populations that require:
    - Teamwork within groups of interprofessional providers
    - Ongoing Patient Assessment
    - Planning including development of EBP protocols
    - Patient Engagement and Education
    - Sophisticated interventions
    - Care Coordination and Transition Management
    - Specification of metrics that demonstrate safe, quality care
    - Evaluation of outcomes

**Nursing Contributions to Care and Outcomes in Ambulatory Care**

Nurses in ambulatory care whose practice is guided by the Wagner (1998) model:

- Will engage patients and families
  - Develop patient-centered, evidence-based care plans that move with the patient throughout the HC system and are used by all of the interprofessional team
  - Enhance patient and family participation in wellness, health promotion and disease prevention
  - Document using indicators embedded with the electronic health record (EHR)
Nursing Contributions to Care and Outcomes in Ambulatory Care

Nurses in ambulatory care whose practice is guided by the Wagner (1998) model (continued):

- Will engage patients and families
  - Participate in development of decision support systems for use in population health management
  - Enhance patient and family access to timely care and evaluation via telehealth methods
    - Outcomes can be decreased use of ED and 28 day readmissions to hospital
    - Increased patient and family satisfaction

Ambulatory Care RN Care Coordination Competencies

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Traci Haynes, MSN, RN, BA, CEN
### AAACN CCTM Experts

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### Perspectives in Ambulatory Care

#### Developing Ambulatory Care Registered Nurse Competencies for Care Coordination and Transition Management

*Shelley Haas*

*Beth Anne Swain, Tracie Haynes*

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*The University of Health Care System is collaborating with the National Association of Ambulatory Care Providers (NAACP) and the Ambulatory Care Organization (ACO) to develop a new, comprehensive ambulatory care program (ACCP) to progressively prepare nurses for the ACPO's core competencies. The ACCP is designed to enhance nurses' knowledge and skills in ambulatory care, with a focus on improving patient outcomes, enhancing patient satisfaction, and reducing healthcare costs. The program is intended for nurses working in ambulatory care settings, including primary care, specialty care, and urgent care clinics.*
Methods

- To develop Registered Nurse competencies for Care Coordination and Transition Management, needed:
  - To tap into expertise of ambulatory care nurse leaders
  - A cost effective, expeditious approach to bring leaders together
  - Opportunities to dialogue and build on each individual leader's knowledge, skills and experience
  - Use data summary techniques to capture and share outcomes achieved by each Expert Panel

Methods (cont’d.)

- **Focus Group Method** defined:
  - Bringing together people from similar backgrounds or experiences to discuss a specific topic, guided by a facilitator who elicits responses from the group, but does not influence responses
Methods (cont’d.)

- For this project, Focus Group Method, **online time** was used to:
  - Clarify methods and outcome expectations
  - Discuss issues with evidence evaluation, ambiguities and contradictions in evidence, absence of sufficient description in evidence materials
  - Sharing of concerns
  - Sharing of insights and expertise

Methods (cont’d.)

- The search for dimensions of Care Coordination and Transition Management:
  - Definition of Dimensions:
    - In the literature on care coordination, often activities are listed that are part of care coordination such as:
      - Developing a plan of care or
      - Monitoring progression of established goals
    - Activities such as these fit together within a broader construct or dimension such as planning
Methods (cont’d.)

- When developing a role that reflects all of the major dimensions or constructs that make up the role, use of dimensions allows for:
  - Addition or subtraction of relevant activities under each dimension as the role evolves
  - Development of competencies requisite to each dimension
  - Helps specify education and evaluation needed for successful practice within each dimension of the role

Methods (cont’d.)

- The Quality and Safety in Education in Nursing (QSEN) format was used for each care coordination and transition management dimension identified (Cronenwett et al., 2007)
- Panelists were also asked to identify the knowledge, skills, and attitudes identified in the literature, and if absent to use expert opinion to specify each
First Expert Panelists

- were provided with results of a search in MEDLINE, CINAHL Plus, and PsycINFO that yielded 82 journal articles plus white papers available on line from major organizations
- The 26-member Panel worked in dyads and abstracted data to a table of evidence (TOE)
  - Each dyad reviewed four to five articles and needed to reach consensus on items for TOE
  - Then abstracted the information onto the template table of evidence

First Expert Panel (cont’d.)

- The members represented:
  - practice and education;
  - public, private, military, and veterans organizations;
  - and 15 states in east, west, north, south, and central
Second Expert Panel

- This 16 member panel was charged with:
  - Defining the dimensions, identifying core competencies
  - Describing the activities linked with each competency for care coordination and transition management in ambulatory settings
- Using focus group methods online, the expert panel identified nine patient-centered care dimensions and associated activities of care coordination and transition management
Outcomes of Second Expert Panel

The nine dimensions were:

1. Support for self-management
2. Education and engagement of patient and family
3. Cross setting communication and transition
4. Coaching and counseling of patients and families
5. Nursing process including assessment, plan, implementation/intervention, and evaluation; a proxy for monitoring and intervening
6. Teamwork and collaboration
7. Patient-centered care planning
8. Decision support and information systems
9. Advocacy

This panel also identified competencies needed for each dimension including knowledge, skills, and attitudes.

Table 1
Dimensions and Activities of Care Coordination and Transition Management

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<tr>
<td>Self-management (diabetes) patient folder with self-management tools; (diabetes) patient folders with self-management tools: pamphlets, medication sheets, medication adherence; top 10 reason list; access to primary RN; literacy screening; goal setting, no more than two per visit</td>
<td>Establish relationship with patient and family by explanations of care coordination and collaborative care to meet patient needs.</td>
<td>Task of facilitating transition from one facility to another (&quot;warm hand-off&quot;)</td>
<td>Developing the long-term relationship with patients and family</td>
<td>Use open-ended questions to assess knowledge, give examples to assess critical thinking</td>
<td>Health coach/provider huddle</td>
<td>Some element of face-to-face</td>
<td>New onset use of insulin (pediatrics and adults)</td>
<td>Provide preventive care</td>
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Evidence-based activity Evidence-based activity Evidence-based activity Practice-based activity Evidence-based activity Practice-based activity Evidence-based activity Practice-based activity Evidence-based activity Practice-based activity
Wagner Model

The Chronic Care Model

Community
- Resources and Policies
- Self-Management Support

Health Systems
- Organization of Health Care
- Delivery System Design
- Decision Support
- Clinical Information Systems

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Improved Outcomes

Third Expert Panel
- Reviewed, confirmed, and created a table of dimensions, activities, & competencies (including knowledge, skills, attitudes) for ambulatory care RN care coordination and transition management
- After much discussion, they determined the original 8th dimension of decision support and information systems, as well as, telehealth practice were technologies that support all dimensions.
### What Is Population Health Management?

- Accountable care organizations need to have a handle on frequency and type of use of all sources of health care. Data often resides in insurance claims.
  - Managed care organizations have a head start in this area

### What Is Population Health Management? (continued)

- The EHR can be used for much more than tracking encounters and results
- It can be used for trend analysis, in particular areas of concern for large groups of people i.e., both inside acute care and outside (use of ED and 28 day readmissions)
- It can provide alerts, guidelines and prompts for individuals in populations of concern to change behaviors of both patients and providers (Morrissey, 2013)
### Table 2.
Dimensions, Activities & Competencies for Care Coordination & Transition Management

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Activity(ies)</th>
<th>Competency(ies)</th>
<th>Evidence (List Citation/References)</th>
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<td>Education &amp; Engagement of Patient and Family</td>
<td>Assessment of readiness to learn Development and use of content that is age, education level, and culturally appropriate Evaluation of learner understanding of content taught Performance of eight clinical processes: “assessing the patient and primary caregiver at home, creating an evidence-based care plan, promoting patient self-management, monitoring the patient’s conditions monthly, coaching the patient to practice healthy behaviors, coordinating the patient’s transitions between sites and providers of care, educating and supporting the caregiver, and facilitating access to community resources”</td>
<td>Knowledge: Knows questions to ask and cues to look for regarding physical, psychological, and social readiness to learn. Skills: Uses techniques that involve patient and significant others in learning. Uses techniques to assess learning such as “teach back.” Attitude: Demonstrates creatively in planning appropriate learning experiences for patients and significant others. Knowledge: Identifies questions to ask to holistically design an integrated care plan that encompasses a variety of care methods to provide patients with complex care needs with the resources needed to maintain the highest level of function. Has awareness of known risk factors that place a patient at risk for re-hospitalization or exacerbation and utilizes knowledge and critical thinking to identify actions to mitigate risk. Skills: Identifies full range of medical, functional, social, and emotional problems that increase patient’s risk of adverse health events. Addresses identified needs through education, self-care, optimization of medical treatment, and integration of care fragmented by care setting and provider. Monitors patients for progress and early signs of problems. Utilizes data collection and analysis to design interventions to improve patient outcomes.</td>
<td>Boult, et al. (2008). Early effects of “guided care” on the quality of health care for multimorbid older persons: A cluster-randomized controlled trial. Coleman, et al. (2007). Effectiveness of team managed home-based primary care</td>
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**Third Expert Panel**

- This Panel also determined methods to be used to enhance teamwork and interprofessional collaboration in outpatient settings
- Nationally recognized core competencies for interprofessional collaborative practice, quality and safety in nursing education (QSEN) competencies and public health nursing competencies overlap with the dimensions and competencies needed for ambulatory care RN care coordination and transition management (see Table 3)
Third Expert Panel (cont’d.)

- Population health management became the new 8th dimension given:
  - The prominence it is assuming in outpatient care even though there was little discussion of it in the literature reviewed
  - It also fits well with dimensions of the Wagner Model

Next Steps

- The AAACN Board of Directors has developed a charter for next steps in this initiative
- AAACN is ready to develop education modules for each of the dimensions with requisite competencies and also for informatics and telehealth practice competencies that support the entire RN-CCTM model
Next Steps (cont’d.)

- A call has been issued for volunteer writers for what will be called the RN Care Coordination and Transition Management Competencies Core Curriculum
- AAACN envisions a 13 module Core Curriculum document that will support education in the form of face to face; or on-line that will be available to ambulatory nurses aspiring to this role.
- Successful completion of the education package will also be a way to obtain recognition or certification for successful completion

Lessons Learned

- It has been a privilege to serve as facilitators in this initiative
- We have worked with truly expert ambulatory care nurses who are committed to their patient populations and practicing at the cutting edge of ambulatory care nursing
- Their productivity was phenomenal, they consistently delivered an excellent product on time and raised salient issues and challenges that made the deliverables even better
Lessons Learned (cont’d.)

- We found that it is feasible to use focus group techniques online, even with only telephone connectivity.
- We successfully used webcasting technology on an as-needed basis and archived the virtual meeting.
- We saved lots of trees and postage with use of the AAACN web site to deliver and share materials.

References: