UNIVERSITY OF SOUTH FLORIDA

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Practice Impact of an Online Care Coordination and Transition Management Course in RN-BS Student Population

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Need for Care Coordination Course

- Literature shows that effective coordination of care and transition management (CCTM) improves patient outcomes and contributes to high value care.
- But where is it integrated in the nursing curriculum?
- Originally developed as part of the innovative pre-licensure curriculum revision as a 2 credit course
- Modified as variable credit (3 credits) to fit the RN-BS requirements and allow practicing nurses to draw on their experience with additional assignments

RN-BS Program
Clusters and Electives

- More than 500 students currently enrolled in the RN-BS program
- Fully online student centric curriculum to meet student professional goals
- Core and elective courses total 30 credits
- Self-selected clusters to focus learning to meet goals
  - Education
  - Clinical Excellence
  - Leadership
- Students could self-select Coordination of Care in Nursing course as an elective in any cluster starting Summer 2018
- Clinical practice partner input was instrumental in redesigning the curriculum to include the need for improved understanding of transitions of care in all levels of undergraduate nursing education

Framework for Development

- CCTM Core Curriculum from American Academy of Ambulatory Care Nursing
- CCTM Depicted Within a Logic Model (Haas & Swan, 2014)

CCTM Depicted within a Logic Model

Figure 1.

Situation: The Care Coordination and Transition Management (CCTM) Model evolved to standardize work of ambulatory care nurses using evidence from interdisciplinary literature on care coordination and transition management. The vision is the CCTM Model would specify dimensions of CCTM and competencies needed to perform CCTM and make possible development of knowledge, skills, and attitudes needed for each competency so the registered nurse (RN) will meet needs of patients with complex chronic illnesses (and their families) being cared for in Patient-Centered Medical Homes (PCMH), as well as traditional and nontraditional outpatient settings, and their preparation and work as an RN in CCTM would be recognized and reimbursed by the Centers for Medicare & Medicaid Services.

Inputs / Competencies	Outputs: Activities	Outputs: Participation	Outcomes: Short	Outcomes: Medium	Outcomes: Long
Support for self-management	Enhance health literacy	RN In CCTM, MD, APRN, pharmacist, social worker	Baseline comprehensive needs assessment reflects patient values, preferences, and goals	Solutions to most critical socio economic issues	Engaged, educated patient/ family, increased ability to "cope" with care interventions
Advocacy	Negotiate and secure patient services; coach patient in self advocacy	RN in CCTM, MD, APRN, pharmacist, social worker	Patient/family concerns and goals heard, able to access providers, community services, medications	Patient/family compliance with treatment plan, medications	Keep primary care appointments, appointments in community agencies
Education and engagement of patient and family	Assess readiness to learn/learning styles	RN in CCTM, MD, APRN, pharmacist social worker, dietician, psychologist	Patient/family can"teach back" info on care interventions	Increased engagement in preventative care and use of telehealth learning modalities	Engaged, educated patient/ family
Cross setting communication and transition	Coordintion/collaboration between specialty and primary providers who develop and share the Patient Care Plan across settings	RN in CCTM, MD, APRN, pharmacist, social worker, dietician, psychologist, MD specialists, acute care, longterm care, and home care RNs	Care Plan transmitted between setting, changes and updates communicated	Use of electronic Patient Care Plan for hand-offs	Decreased errors, duplication, decreased costs
Coaching and counseling of patients and families	Answer questions patients/-families have before and after provider visit	RN in CCTM	Patients/families come prepared with "Ask Me Three" questions	Enhanced understanding of health care resources in the community and need to seek consultation prior to increased severity	Decreased ED use, increased ability to "cope" with care interventions

Inputs / Competencies	Outputs: Activities	Outputs: Participation	Outcomes: Short	Outcomes: Medium	Outcomes: Long
Nursing process	Assess patient for knowledge understanding diagnosis,needs, treatment, expected outcomes of treatment	RN in CCTM	Best evidence used for interventions/outcomes; care plan is routinely updated	Electronic process indicators show compliance with EBP plan, short-term EBP outcomes achieved	Long-term EBP disease or health outcomes achieved at 80% level
Population health management	Expert use of population management tools (e.g., registries, analytics tools) to track and monitor select population characteristics	RN in CCTM, MD, APRN, pharmacist, social worker, dietician, MA, psychologist, MD specialists, acute care, long-term care and home care RNs	Maximize impact of visit or telehealth call regarding disease management, prevention, and Wellness through alerts	Enhanced process improvement; enhanced immunization rates, participation in Wellness programming	Enhanced quality of care, achievement of benchmarks for prevention and Wellness
Teamwork and collaboration	Inclusion of teamwork in orientation and continuing education	RN in CCTM, MD, APRN, pharmacist, social worker, dietician, MA, psychologist, MD specialists, acute care, long-term care and home care RNs	Enhanced understanding of interdisciplinary roles; communication techniques	Early collaboration when issue arises, team problem solving/planning	Less "siloed" care; engaged health care team; increased appreciation of team member contributions
Patient-centered care planning	Motivational interviewing; eliciting patient's goals and priorities	RN in CCTM, MD, APRN, pharmacist, social worker, dietician, MA, psychologist, MD specialists, acute care, long-term care and home care RNs	Individualized care plan; care planning activities transcend barriers/transitions keeping the patient at the focus	Plan of care transparent for patient/family and perceive team is listening to their preferences/goals	Enhanced patient/ family engagement and satisfaction with quality of care

Assumptions: Patients will use primary care settings; patients will access CCTM providers; patients will be engaged in care processes; providers will collaborate, work in teams, develop and use patient-centered care plans; organization will have EHRs that operate across settings; outcomes are shared by team, not discipline specific.

External Factors: Slow development of interdisciplinary team education and practice. Changes in reimbursement and penalties for "never events" are decreasing revenues, slow implementation of EMRs that are operable across settings, and slow development of model of care plan that moves between settings.

Course Resources and Layout

- Textbook: “Care Coordination: A Blueprint for Action for RNs” published by ANA
- Divided into 8 modules
- Each module includes readings and a short presentation reviewing the topics related to the objectives
- Presentations are designed with integrated knowledge checks and an unfolding case study across all modules

Course Topics and Assignments

- Module 1—Care Coordination Overview, Review of Payer Models, High Cost of Hospital Readmissions
  - Insurance Comparison Chart
- Module 2—Patient Centered Care Coordination, HCAHPS Survey, Patient Experience as a Measure of Quality
  - Clinical Site Evaluation Paper based on ratings on Hospital Compare website
  - Discussion of a clinical experience that utilized patient or family preference to tailor care

Course Topics and Assignments

- Module 3—Interprofessional Communication, Collaboration, and Teamwork, Overview of TeamSTEPPS
  - Discussion based on TeamSTEPPS case study
- Module 4—Nursing Process and Care Coordination, Evidence-Based Quality Improvement for Better Transitions in Care
  - Develop a plan of care using the nursing process based on a case study with focus on discharge planning and transition management

Course Topics and Assignments

- Module 5—Nurse as a Patient Advocate, Health Literacy, Patient's Bill of Rights
  - Develop a plan of care for a patient based on a case study utilizing an appropriate health literacy tool
- Module 6—Patient and Family Education, Patient and Family Engagement in Hospital Quality and Safety
  - Develop a video demonstrating the "teach-back" method for patient and family education

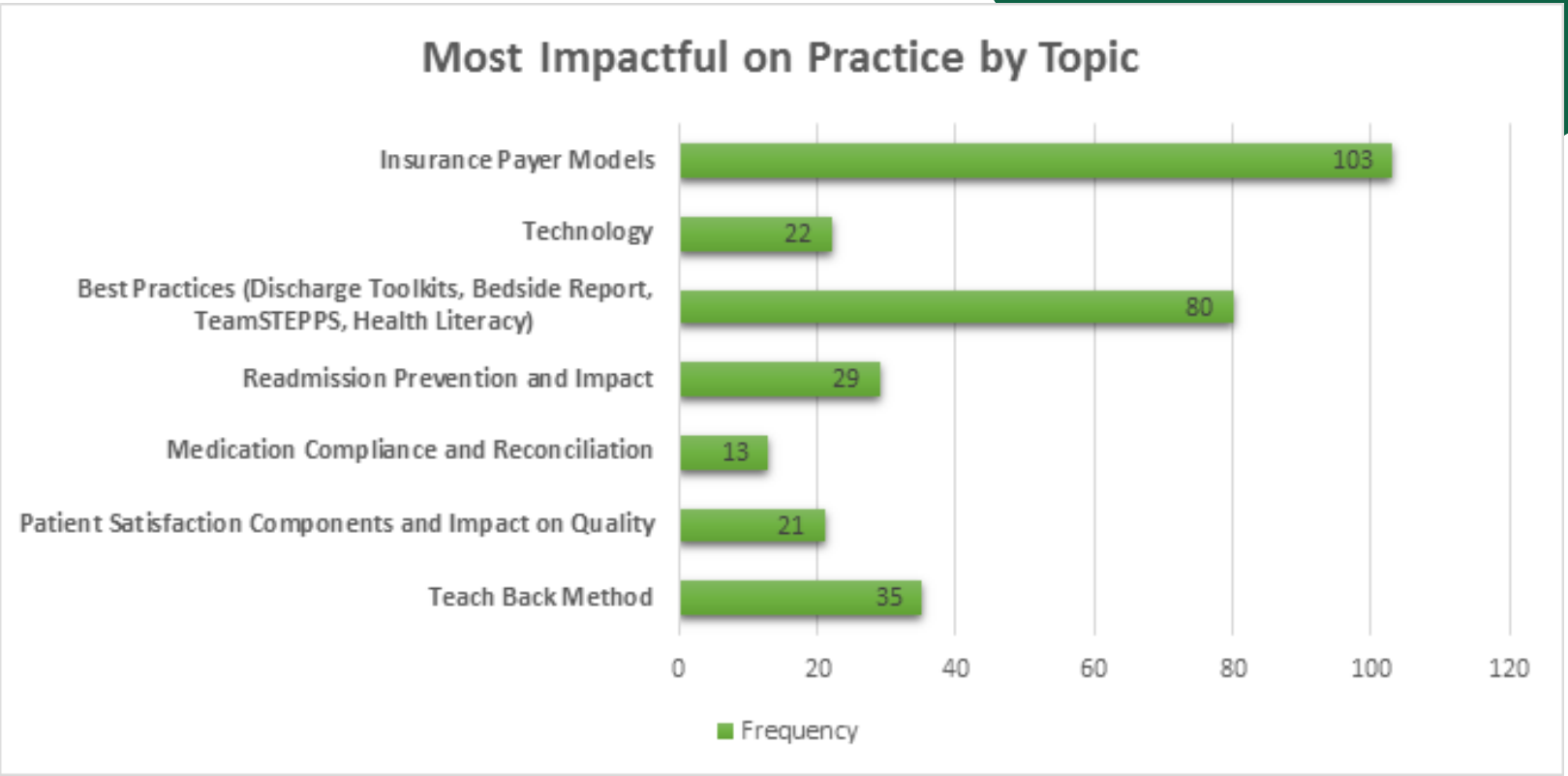
Course Topics and Assignments

- Module 7—Population Health Management, Informatics, Technology Application
  - Discussion reviewing a technology application that has potential to improve population health
- Module 8—Managing Care Transitions, Medication Reconciliation and Challenges in Medication Management
  - Case study completion with transitions with the acute care setting and from the acute care setting to home

Application to Practice—Student Feedback

- IRB approval through USF
- Students required to reply to the follow question and then reply to one of their peers
  - How will you utilize what you have learned from this course in your future practice? How will this knowledge improve your practice? What did you learn in this course that you thought was most useful? What was most surprising?
- Student responses from three semester were analyzed
  - Summer 2018—41 students
  - Fall 2018—14 students
  - Spring 2019—37 students
  - Total of 181 discussion board posting (initial postings and responses to peers)

Student Feedback



Powerful Quotes

- "The most useful tool was the teach back video assignment. Through practice and reviewing my recordings, I was able to visualize both my verbal and nonverbal communication."
- "I was unaware of everything the case managers on my unit did to ensure patient have the necessary resources. Now I am better equipped to help them in ensuring the patient has what they need to prevent readmission."
- "The insurance comparison assignment was the most interesting. That wasn't something that was taught in depth in my nursing program and it feels great to actually have the knowledge to help educate my patients."
- "After working on the insurance grid, I was able to put in action some of the information that I have learned. I advocated for my patient so once discharge time arrived, he qualified for rehab."
- "During this course, I have also been trained as a charge nurse at work and I have been able to put the concepts of care coordination into practice."
- "This class showed me that even if patients receive great care, they may wind up being readmitted due to lack of follow up or education. I have found myself now taking more time to ensure patients are able to continue their care once they leave me."
- "This course has improved my practice because I am a better patient advocate which has in turn made me a better nurse."

Next Steps

- Analysis of impact on pre-licensure students and their post-graduation practice
- Development of new RN-BS cluster to meet the community need for additional preparation for the specialty of ambulatory care

Ambulatory Care Cluster

- The new cluster focuses on knowledge and skills needed to care for patients across the lifespan in a variety of settings outside of the acute care environment
- The new cluster is made up of three courses and includes:
  - Introduction to Ambulatory Care Nursing
  - Digital Health
  - Coordination of Care in Nursing
- Clinical practice partners starting ambulatory care residency programs highlighted the gap in knowledge for new nurses in outpatient settings. This new cluster will introduce and prepare students for differences in practice between ambulatory and acute settings and the impact nurses can have on outcomes

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Questions?