Effective care coordination and transition management for older adults

As the number of older patients with chronic illnesses increases, so does the need for nurses to be knowledgeable and prepared to care for this often vulnerable population.

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Effective care coordination focuses on patient-centered care and patient care processes that are coordinated, reliable, and safe for older adults. The Agency for Healthcare Research and Quality states, "Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of healthcare services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among

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participants responsible for different aspects of care."

This article discusses how care coordination and transition management can have a positive influence on patient safety. Methods that foster communication and collaboration during care transitions have been shown to reduce exacerbations of chronic illnesses and readmission costs. When older adults and their families are knowledgeable about their care and have the needed resources available to make healthcare decisions, wellness can be maintained.

Impact areas: Nurses, patients, and families

Whether in an acute care or ambulatory setting, nurses must be prepared to engage with patients and families in care coordination and transition management to improve patient outcomes. Prepared nurses are able to assess and analyze the impact of multiple coexisting and chronic conditions that older adults face, many causing disruptions in their daily lives. Not only physical, but also emotional pressures can have a negative impact on the patient, including caregiver strain, financial concerns, and mental and cognitive issues that require social support and management.

When planning for care, the nursing assessment should encompass standardized assessment tools for older adults, including the patient's physical, medical, psychosocial, behavioral, socioeconomic, and spiritual needs. Additionally, having access to and utilizing electronic assessment tools that are appropriate for the individual patient will ensure portability of care.

Essential elements to support care coordination and transition management include evidence-based concepts focused on supporting self-management that reflects the patient's values, preferences, and goals. Nurses serve as patient advocates, helping patients and their families access preferred providers, community services, and medication. Patient and family education and engagement are keys to patient-centered care and teamwork. Coordination and collaboration of the healthcare team between and across healthcare boundaries are foundational in the planning, sharing, and implementation of the individualized care plan.

Barriers

Today's healthcare environment is more complex than ever, leading to multiple care providers across multiple care settings. Lack of coordination can lead to care that's fragmented and poorly planned, resulting in potential medication errors and avoidable hospitalizations. The absence of a designated care coordinator can lead to poor communication, incomplete transfer of information, lack of education for patients and caregivers, and limited or no access to needed services.

Communication is one of the most important aspects of patient teaching, and language barriers, cognitive impairments, and/or difficulty engaging in conversations can have negative impacts on patient care outcomes. Poor health literacy has also been identified as a barrier for patients navigating the healthcare system, especially during care transitions.

When examining specific patient populations, it's been determined that high-risk patients require more support and attention. This includes older adults prescribed five or more medications, patients with neurologic illnesses or multiple comorbidities, and those recovering from cardiac events. A particular challenge in caring for this population is making sure that timely referrals are in place to avoid unnecessary ED visits.

Sometimes additional barriers arise when patients are treated across networks, such as a hospital in one network and a primary care provider in another. In other situations, referrals may require continued requests across networks, particularly if there are bed shortages at nearby in-network hospitals.

Navigating complexity

Care coordination and transition management must start with guidelines for specific settings and populations. Knowledge of federal/state regulations and reimbursement demands is a must. The process must involve administrators, nurses, physicians, pharmacists, information technology partners, and case management colleagues and it must be tailored to the organization. Policies and procedures should be in place to identify at-risk patients through healthcare assessments that are integrated into the electronic health record and focus on evidence-based standards.

The Care Coordination and Transition Management Core Curriculum developed by the American Academy of Ambulatory Care Nursing is an excellent competency-based resource that can be utilized to guide nurses in new care coordination and transition management roles. The care guidelines are built on the Quality and Safety Education for Nurses competencies (see *Evidence-based dimensions of care*). A benefit of this curriculum is that it establishes evidence-based practices (EBP) and competencies for nurses in specific settings and can be focused on a particular patient population. Empowering nurses through competency certification can improve patient/family outcomes across all settings and providers.

Communication and collaboration are necessary for care coordinators to work across boundaries with community partners and expand those partnerships. Relational coordination among professionals improves patient care, so it's appropriate for managers/organizations to focus joint training or continuing-education initiatives on staff members getting to know each other's goals, resources, and constraints. Organizations with leaders who deliberately clarify common goals across agencies facilitate ongoing opportunities for ease of communication and relationship building, which will enhance effectiveness of care coordination and transition management.

Evidence-based dimensions of care

- Self-management
- Patient and family education and engagement
- Communication and transition
- Coaching and counseling patients and families
- Nursing process
- Teamwork and collaboration
- Patient-centered care planning
- Decision support and information systems
- Advocacy

Care models

Determining precise models or strategies of care for older adults with chronic conditions hasn't been a simple

consider this

To provide safe, evidence-based care for older adults transitioning from hospital to home, let's examine the key components of the TCM.

Screening: How are high-risk older adults identified?
Targeting specific populations of older adults is an important first step, especially those hospitalized with specific diagnoses, including heart failure, myocardial infarction, coronary bypass surgery, respiratory infection, and hip replacement, and/or a recent hospitalization or ED visit.

Staffing: Why utilize a transitional care nurse?
The transitional care nurse is prepared to conduct comprehensive assessments of health status, health behaviors, and social support needs. Additionally, expertise in developing an individualized care plan consistent with evidence-based guidelines, in collaboration with the patient and physician, sets the foundation for patient-centered care. Ideally, a master's-prepared RN who's trained in the care of older adults with chronic conditions will coordinate a comprehensive discharge plan and home follow-up.

Maintaining relationships: How are relationships built and maintained?
The nurse-patient relationship begins at the time of hospitalization and is reinforced with daily patient visits. After discharge, periodic home visits and/or scheduled phone/telehealth visits are conducted with an average of one nurse visit a week. Nurses are also available to patients via phone 7 days a week. Respecting patient values and preferences helps develop trust in building a collaborative team between the nurse, patient, and family.

Engaging patients and caregivers: Why's engagement necessary?
The level of engagement determines the readiness of the patient/caregiver to learn and enhances the level of satisfaction with quality of care. Keeping the patient and caregiver engaged through teaching and coordination/collaboration with providers enhances their ability to cope with care interventions and self-management.

Assessing/managing risks and symptoms: Why's the assessment so important?
Identifying a patient's individual needs starts with a comprehensive assessment of his or her health status using multiple assessment tools to define physical, psychological, emotional, social, and cultural dimensions. Through the assessment process, an evidence-based patient-centered care plan is developed that addresses individual risk factors, symptoms, and priorities.

Education/promoting self-management: What concepts are important to self-management?
Understanding symptoms of chronic conditions and self-management strategies are essential for patients/families to solve problems and improve quality of life. Understanding when and how to react to worsening symptoms builds confidence in decision-making, which promotes health maintenance and overall health outcomes.

Collaborating: Why's open communication necessary for self-management?
Collaboration and communication between the patient, family, and providers is essential to identify changes in patient health status and manage and/or prevent health complications, especially as the patient transfers between different levels of care and across healthcare boundaries.

Promoting continuity: What aspects of care improve continuity of care?
Involvement of the same clinician or team members improves communication and collaboration from admission to discharge or transition. Structured handoffs with clear instructions to the patient, family, and providers improve timely care processes, including medication reconciliation and polypharmacy, while promoting continuity of patient care.

Fostering coordination: Why are connections between hospital- and community-based practitioners necessary?
Promoting communication and connections between hospital and community settings facilitates timely and efficient sharing of patient information. Coordinated services, such as real-time accessibility to discharge medication lists and treatment protocols, build a culture of communication and promote patient/family re-engagement after hospital discharge.

straightforward process. However, new care delivery models and frameworks focusing on care coordination and transition management have been tested and proven effective. Understanding the key concepts of each of these frameworks and how they can be operationalized in the older adult population can have a positive impact on quality, safety, healthcare costs, and outcomes. Healthcare delivery models include the transitional care model (TCM), patient-centered medical home (PCMH), accountable care organization (ACO), and chronic care model (CCM).

did you know?

Care coordination and transition management aren't new for nurses, but many nurses feel challenged when understanding their role in the process. The Hospice and Palliative Nurses Association created a collaborative forum for nursing leaders from national specialty organizations to come together and discuss how to improve patient and family outcomes in the palliative care areas of pain and symptom management, communication and advance care planning, and coordination of care and transition management. Participants in one forum indicated that nurses were less conversant with issues related to setting an agenda for care coordination and found care coordination more "abstract" than other focal areas such as pain management. The nurses verbalized lack of familiarity with research, best practices, performance metrics, and regulatory and payment guidelines related to care coordination and transition management.

Transitional care model

One model that's consistently demonstrated effectiveness is the TCM—a nurse-led intervention focusing on older adults with five or more chronic conditions. This evidence-based approach has been rigorously tested and supports positive outcomes when used to treat older adults with chronic illnesses. Additionally, a reduction in rehospitalization costs and overall healthcare cost containment have been noted.

In a randomized clinical trial funded by the National Institute of Nursing Research, older adults hospitalized with heart failure who returned to their homes and received the TCM showed significant improvement (P = .026) compared with patients who received standard care. Additionally, fewer all-cause rehospitalizations (104 vs. 162, P = .047) were observed at 1-year post hospital discharge, contributing to lower mean total costs with an estimated patient savings of $4,845 ($P$ = .002).

In a report from the Centers for Medicare and Medicaid Services (CMS), more than 20 million Medicare beneficiaries were examined. Out of this group, 37% were found to have five or more chronic conditions. Compared with other Medicare beneficiaries, this group accounted for more episodes of acute illness and higher rates of healthcare encounters, including physician visits, ED visits, and hospitalizations. The TCM specifically looks at this population to improve outcomes through the lens of the "Triple Aim" to enhance patient experience, improve population health, and reduce costs.

The TCM provides a set of time-limited services during an episode of acute illness between clinicians and across settings. The core components of the TCM include:

- screening
- staffing
- maintaining relationships
- engaging patients and family caregivers
- assessing and managing risks and symptoms
- educating and promoting self-management
- collaborating
- promoting continuity
- fostering coordination.

Payment for the TCM is currently based in a fee-for-service payment system. In 2019, the CMS physician fee schedule introduced new billing codes for certain care coordination services. These codes were adopted to incentivize better care coordination but, unfortunately, nurses weren't added as an approved provider for these services. However, when further examining the fee-for service payment system, a nurse employed by a practitioner using the TCM may provide the care coordination portion under the general supervision provision (meaning the procedure or service is furnished under the physician's overall direction and control, but the physician's presence isn't required).

Patient-centered medical home

Another effective model is the PCMH framework in which a team-based approach to primary care is emphasized. In this model, a physician-leader coordinates care between providers across multiple sites and specialties. The PCMH model encourages increased access by expanding practice hours and facilitating

communication between providers and patients/families. The framework targets high-risk older adult patients with multiple comorbidities, using care planning interventions that support self-management, engaging patients through teaching and education, and conveying timely test results in a clear manner while coordinating transitions in care (specialist care) and follow-up. Identifying and preventing gaps in care promotes self-management and reduces costs by decreasing ED visits and inpatient admissions/readmissions.

Reimbursement is provided through a value-based care model. This means that providers are responsible for quality and costs, thus offering an incentive to implement care coordination activities as described in the quality payment program.

Accountable care organization

The ACO model offers financial incentives to provider groups for delivering lower-cost, high-quality care to a specific patient population through a framework that focuses on clinical care routines, boundary spanning, and team meetings.

Routines address the extent to which care delivery systems are coordinated through care management protocols, clinical pathways, and EBP guidelines. Routines provide a structure for beneficial activities and practices, such as disease or care management programs, standardized treatment guidelines, and care transition protocols.

Boundary spanning includes activities that integrate multiple people or departments, crossing over existing organizational boundaries between physicians and specialty providers or across settings.

Team meetings facilitate interactions among participants engaged in the same process, providing a forum for direct communication, which allows for more timely and interactive coordination of services.

This is another approach that receives payment through a value-based care model. The ACO has been developed to provide high-quality care through processes that drive down costs and produce positive patient outcomes. Providers include physicians, hospitals, and other healthcare organizations who voluntarily come together to coordinate care for Medicare patients.

Chronic care model

The CCM can be defined as an approach that focuses on delivering high-quality chronic disease management in a primary care setting. The key focus areas are:

- the community
- the healthcare system
- self-management support
- delivery system design
- decision support
- clinical information systems.

When examining these key areas, the CCM has developed "changes" that when applied to specific chronic illnesses, healthcare settings, and patient populations can improve patient satisfaction and clinical and system outcomes. It's important for organizations to have proactive teams to develop productive interactions between engaged patients and families. Providers should have the expertise to implement the redesigned processes and access necessary resources.

The CCM is based on a fee-for-service payment system under the general supervision provision of services for patients with two or more chronic conditions. Scope of practice allows nurses to provide care management services focused on clinical staff coordination activities that can be furnished remotely from where the physician or advanced practice nurse is practicing.

Significance of the nurse coordinator

In 2012, the American Nurses Association adopted a position statement that set the standard for nursing practice and addressed care coordination, including the nurse's role. The statement was developed and centered on the "Triple Aim," establishing patient-centered care

on the web

American Academy of Ambulatory Care Nursing:
www.aaacn.org/practice-resources/care-coordination-transition-management

Institute for Healthcare Improvement: www.ihi.org/resources/Pages/IHIWhitePapers/IHICareCoordinationModelWhitePaper.aspx

National Rural Health Resource Center:
www.ruralcenter.org/srht/rural-hospital-toolkit/community-care-coordination-and-chronic-disease-management

Society of Hospital Medicine:
www.hospitalmedicine.org/clinical-topics/care-transitions

University of Colorado School of Medicine Care Transitions Program:
https://caretransitions.org/all-tools-and-resources

University of Pennsylvania School of Nursing:
www.nursing.upenn.edu/ncth/resources

coordination as a core professional competency for nursing practice.

Nurses are recognized as playing an integral role in improving healthcare outcomes by leading team-based approaches and innovations in the design, implementation, and evaluation of care coordination processes and models. Additionally, nurses are recognized as advocates for healthcare consumers, families, and the public, using interprofessional collaboration and communication to reach shared patient-centered goals.

All organizations, whether acute care facilities or primary care settings, should be prepared to support care coordination functions and system development. This includes expanding the role of nurse coordinators through education and certification and preparing leaders who can act as full partners within an interprofessional team of healthcare providers to provide high-quality care to patients and families.

Better outcomes, less costs

Although there's great variation across settings and patient populations, care coordination and transition management for older adults requires attention to education and competency development, technology, communication, clinical decision support systems, and policy and regulatory changes. The nurse's care coordinator role must be defined and operationalized to enhance patient safety and decrease healthcare costs. ■

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