

THE NATIONAL QUALITY FORUM

Endorsing Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination

Table of Care Coordination Submitted Practices

NOTE: This information is for personal and noncommercial use only. You may not modify, reformat, copy, display, distribute, transmit, publish, license, create derivative works from, transfer or sell any information, products or services obtained from this document.

Practice Title	Practice Statement	Specifications	Submitting Organization
Heart Failure Nurse Advocate	Trained healthcare advocates should be recruited and utilized to ensure coordinated care for Chronic Heart Failure patients ¹ .	<ul style="list-style-type: none"> • Healthcare advocates should consist of specially trained nurses (RN, MSN, non-advanced practice) • Healthcare Nurse Advocates should be recruited, trained and deployed to appropriate settings as necessary. • Training should consist of: <ul style="list-style-type: none"> ○ Evidence-based approaches to medication adherence management, especially for angiotensin – converting enzyme (ACE) inhibitors/angiotensin receptor blockers (ARB) and beta-blockers; ○ Development of new and extensive patient-centered care coordination skills not currently part of traditional hospital case management, with special emphasis on post discharge telephonic follow-up, communication with physicians responsible for subsequent outpatient care post hospitalization, and doing “whatever it takes” to improve quality of life through self-management; and ○ special organizational skills, such as leadership, influence, effecting change, clinical and administrative credibility (especially with physicians and hospital CEO’s), creative problem solving, and conflict resolution. 	Atlantic Health

¹ Agency for Healthcare Research and Quality (AHRQ) and Catholic Healthcare Partners

THE NATIONAL QUALITY FORUM

Practice Title	Practice Statement	Specifications	Submitting Organization
Medicaid Care Management Services	Care management services should be provided for patient identified as high-cost and high-risk for medical and long-term care services. ²	<ul style="list-style-type: none"> • Comprehensive assessments of the client’s functional, cognitive and medical care needs should be performed. • Adopt protocols to enhance the client’s options to manage their care and services to achieve individual goals. <ul style="list-style-type: none"> ○ Incorporate individualized health action planning addressing client identified problems and goals. ○ Identify individual health goals the patient would like to achieve for self-management • Utilize the Insignia Patient Action Measure and motivational interviewing skills. • Nurse interventions should be a combination of in-home, telephonic and physician office visits. 	Washington State Aging and Disability Services Administration
Cardiac Rehabilitation Services	Healthcare organizations should utilize cardiac rehabilitation services to coordinate care for patients with a recent cardiovascular event. ³	<ul style="list-style-type: none"> • Cardiac rehabilitation services should begin at the hospital where patients are identified after they have had a cardiovascular event, including myocardial infarction (MI), percutaneous coronary intervention (PCI), coronary artery bypass graft (CABG) surgery, stable angina, heart valve surgery, and heart transplantation. • Eligible patients should be referred by the inpatient care team to an outpatient cardiac rehabilitation program and begin receiving those services approximately 1 - 2 weeks after hospital discharge. • At program entry, patients undergo an initial evaluation to identify cardiovascular and related comorbid conditions. An individualized treatment plan is then designed and implemented that includes a comprehensive program of lifestyle therapy, education, counseling, and medical treatments, all of which are done in coordination with the patient's primary medical care provider. • Patients participate in 60 minute rehabilitation sessions 3 days a week for up to 12 weeks. During that time program staff should monitor patients' clinical status, adherence to preventive therapies, and identify any concurrent symptoms or other concerns that may impact their cardiovascular recovery and health. • Programs should operate in a hospital or clinic setting, where patients report for their rehabilitation sessions. Programs may 	American Association of Cardiovascular and Pulmonary Rehabilitation

² Washington State Aging and Disability Services Administration

³ American Association of Cardiovascular and Pulmonary Rehabilitation

THE NATIONAL QUALITY FORUM

Practice Title	Practice Statement	Specifications	Submitting Organization
Care Partners	A Care Partners program should be utilized for supporting family and friends when caring for a hospitalized patient.	<p>also include home-based or other alternative approaches to service delivery, particularly for patients who live far away from the cardiac rehabilitation centers.</p> <ul style="list-style-type: none"> • The Care Partner should be a family member, friend, or volunteer, selected by the patient to participate at various times in educational, physical, psychological, and spiritual support of the patient. • Care Partners should be encouraged to be active participants in the care process and advised to speak up with questions, especially if something does not seem right, such as unexpected tests or procedures, unexplained medications, or adverse reactions. • Shortly after admission and with approval from the patient, the primary nurse discusses the routine care activities that are required and establishes the caregiver's interest. <ul style="list-style-type: none"> ○ The nurse is typically responsible for providing the necessary education about the care and monitors the caregiver's progress and comfort level with any new skills. It is important to state that care partnering is not to be seen as a replacement for nursing care, but rather as an adjunct or enhancement to care. • Routine care activities provided by Care Partners include, but are not limited to: <ul style="list-style-type: none"> ○ Personal care - bathing, backrubs, hair care; ○ Meal assistance - feeding, menu selection, encouraging, recording; ○ Ambulation assistance - wheelchair use, encouraging, monitoring; ○ Monitoring fluids and medications; ○ Diversional activities - reading, writing, companionship; ○ Treatments - mouth care, dressings, exercises; ○ Catheter/drain care; ○ Safety measures; ○ Suctioning. 	Planetree
Continuity Care Record	An electronic record system should be in place to allow the patient's health data to be accessible to the care giver at all	<ul style="list-style-type: none"> • The record system should be patient focused and demonstrate an emphasis on the data that is directly related to a patient's current medical problems. • The record system should be used to transmit timely 	American Academy of Family Physicians

THE NATIONAL QUALITY FORUM

Practice Title	Practice Statement	Specifications	Submitting Organization
	points of contact. ⁴	information to other physicians involved in the patient’s care. <ul style="list-style-type: none"> • The record system should include basic information about insurance, advance directives, care documentation, and care plan recommendations. 	
Care Transitions Intervention	Utilize systematic care transitions programs to engage patient and families in self-management after transferred home. ⁵	<ul style="list-style-type: none"> • The care transitions program should focus on four areas: medication self-management, use of a dynamic patient-centered record, timely primary care/specialty care follow-up and what to do when access is a problem and knowledge of red flags that indicate a worsening in their condition and how to respond. • The care transitions program should be a minimum of 4 weeks and incorporate skill building exercises and resource tools. • Key self-management skills should be identified. Skills needed to assert a more active role in the patient’s care. • A care transitions coach should be introduced to provide the additional support to the patient and family caregivers. <ul style="list-style-type: none"> ○ The transition coach assists in learning and developing care transition self-management skills. • Transition coach and patient simulate next steps care, including role play for upcoming encounters with other care givers. 	Care Transitions Program
Transitional Care Nurse	A Transitional Care Model should be deployed for chronically high-risk older adults. ⁶	<ul style="list-style-type: none"> • A Transitional Care Model should include the following elements: • A Transitional Care Nurse (TCN) should be utilized as the primary coordinator of care to assure continuity of care across the entire episode: <ul style="list-style-type: none"> ○ TCN should be used for in-hospital assessments, preparations, and development of an evidenced-based plan of care; ○ TCN should be used for regular home visits and ongoing telephone support through an average of two months post-discharge; • Continuity of medical care between the hospital and primary care physicians facilitated by the TCN accompanying patient at least first follow-up visits; • Comprehensive, holistic focus on each patient’s needs 	University of Pennsylvania, School of Nursing

⁴ American Academy of Family Physicians , ASTM-International

⁵ The Care Transitions Program

⁶ University of Pennsylvania, School of Nursing, NewCourtland Center for Transitions and Health.

THE NATIONAL QUALITY FORUM

Practice Title	Practice Statement	Specifications	Submitting Organization
		including the reason for the primary hospitalization as well as other complicating or coexisting events; <ul style="list-style-type: none"> • Active achievement in the patients and family care givers including education and support; • Emphasis on early identification and response to health care risks and symptoms to achieve longer term positive outcomes and avoid adverse and untoward events that lead to hospital readmissions; • Multidisciplinary approach that includes the patient, family, and formal caregivers as part of a team; • Physician-nurse collaboration; and • Communication to, between, and among the patient, family and informal caregivers, and health care providers and professionals. 	