Defining a Gap in Practice: Executive Summary

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MSN FP6614-Struc Process in Care Coord

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March 2021

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This summary will analyze clinical priorities for the Medicare-approved hip and knee replacement population to influence health outcomes utilizing care coordination processes with a PICOT question addressing a gap in practice for care coordination. Care coordination services and resources available for this population will be evaluated using evidence-based practice care coordination interventions to best care for this population. A selected nursing diagnosis will support collaborative care strategy with a discussion of intervention planning and expected outcomes for the care coordination process using the scope and standards of practice for care coordination.

Clinical Priorities for Lower Joint Replacement Population to Influence Outcomes

Many hospitals require their Medicare-approved lower joint replacement surgery patients to attend pre-surgical education with the care coordination team. This pre-surgery education's primary focus is to assess and address any social determinants of health(SDOH) patients may be experiencing before surgery in order to improve care quality, avoid discharge delays, control costs after hospital discharge, and prevent readmissions(Centers for Medicare & Medicaid Services, n.d.). Hospitals are penalized for less than 30-day readmissions, skilled nursing facility(SNF) spending, and how hospitals chose to reduce these costs is their decision (Zhu et al., 2018). Hospitals are moving more toward home-based care and are hiring dedicated care coordination staff such as community health workers(CHW) to continue to follow up patient care once skilled home health services are discontinued to ensure patients continue with their home care plan(Zhu et al., 2018). The guidance of CHWs helps patients keep follow-up appointments and assist with any needed resources, including monitoring and reporting of health outcomes to the primary physician or surgeon. CHWs are a part of a collaborative team such as nurse case

managers, social workers(SW), and dieticians who work behind the scenes from medical practices to assist patients with high risk or complex care needs to decrease high emergency department (ED) utilization and readmissions. Zhu et al., 2018 report there is much literature reporting on the benefits of home-based care utilizing CHWs, but there is a gap in knowing whether home discharges post-surgery without assistance from CHWs could increase hospital readmissions or harm patients with more complex needs(p.1286).

PICOT Question

In adult patients with total lower joint replacement surgery (**P**opulation), how effective is the use of CHWs in home-based care after surgery (**I**ntervention) compared to home discharges without the use of CHWs(**C**omparison) in improving quality of care and recovery (**O**utcome) during the postoperative and recovery time (**T**ime)?

Selected Gap Explanation

Once discharged from the hospital to home and when skilled services are completed, the real struggle is getting the patient to participate in their care for the long haul and maintain compliance with the healthcare plan and follow-up appointments(Kangovi et al. 2020). The assumption can not be made that all CHW's efforts will prevent unnecessary (ED) visits. There will always be behaviors that can not be changed, patients who refuse to participate in care coordination and remain non-compliant, and those who continually make poor healthcare choices(Zhu et al.,2018). Zhu et al., 2018 also report that they did not interview care coordinators or CHWs whose perspectives may differ from those of healthcare providers and surgeons regarding their views concerning the impact of utilizing CHWs or not in the homes for postsurgical patients(p.1284).

Available Care Coordination Services and Resources

Care coordination with the patient and family starts before surgery. The surgeon's office collaborates with hospital case managers, surgical unit nurses, home health liaisons, physical therapists, and pharmacists to provide weekly joint class education to scheduled joint replacement patients. The weekly education classes are arranged by the office surgery scheduler for the patients. Patients attend the class in the hospital, so they know exactly where to come on the day of surgery. A sit-down discussion is held, and each hospital discipline talks with the patients and any family who attend to discuss surgery, home-going expectations, medications, social determinants of health(SDOH), caregiver role, and durable medical equipment(DME). A question and answer session for the patients and families is offered at the end of the class. The goal is to meet face to face with patients and families, assess needs, prepare patients for home-going in an attempt to avoid unnecessary discharge delays and skilled nursing facility(SNF) referrals(Mendel et al., 2018). This pre-surgery education also helps patients plan pre-surgery interventions and educated them on expected outcomes after surgery. Patients and families receive education regarding transitions to a CHW once skilled services are complete. In this collaborative relationship with patients and families, a sense of trust develops with their provider, and patients meet a team member who will be caring for them in the hospital, which gives a sense of empowerment to patients and families(Zhu et al.,2018).

Evidence-based Care Coordination Intervention

The care coordination guidance provided to the Medicare-approved hip and knee replacement population is based on The Registered Nurse- Care Coordination Transition Management Model (RN CCTM). The American Academy of Ambulatory Care Nursing (2016) states this model focuses on individualized patient-centered assessment and care planning and

evolved to standardize all registered nurses' work using evidence from nursing and interprofessional literature on care coordination and transition management(p.8). The RN CCTM model focuses on care coordination and collaboration with the entire multidisciplinary team and offers a person-centered approach to patient care to empower and encourage patients to collaborate with their health care providers. A critical element of care coordination is preparing for the transition management of care, and this is where the use of CHWs plays a role. Transition management provides ongoing support to patients and families as they navigate their longitudinal healthcare journey(The American Academy of Ambulatory Care Nursing, 2016). Care coordination is about assessing individual care needs, tailoring care to that patient, identifying patient risks, and based on those risks or needs continue care services best suited for the transition management care.

Nursing Diagnosis

Readiness for Enhanced Individual Coping as evidenced by verbalization of desire to information from community health coach that will enhance optimal health outcomes and improve healing(Phelps et al., 2017).

Issue Assessment

The patient will display a readiness for enhanced individual coping by collaborating with the care coordination team by expressing a willingness to accept further assistance from the CHW to achieve optimal health outcomes and improved healing by maintaining follow-up appointments and accepting community resources and guidance from the CHW.

Planning Interventions and Expected Outcomes

First, a multidisciplinary collaboration needs to begin at the start of care, not just before the transition, including the patient and family(American Academy of Ambulatory Care Nursing,

2016). Next, care coordination needs to identify patients at risk for unnecessary readmission or ED utilization by assessing health literacy, SDOH, confidence in self-care, the complexity of any comorbidities, and their discharge condition(American Academy of Ambulatory Care Nursing, 2016). Lastly, transitional planning is more than the patient's discharge instructions; it involves coordination with all of the appropriate care providers necessary to ensure that the patient is effectively transitioned home with understandable discharge instructions, home health services, and determining the need for a CHW once skilled services are complete(American Academy of Ambulatory Care Nursing, 2016).

To achieve outcomes for patients and families, the goals need to be achievable based on their preferences and values, and it is essential to include them in decision making(American Academy of Ambulatory Care Nursing, 2016).

Expected outcomes will be evidenced by patients and families verbalizing understanding of referred community resources and maintaining follow-up appointments arranged by CHW(American Academy of Ambulatory Care Nursing, 2016).

The family and patient will accurately describe the disease process, feelings about self-management of their healthcare, and healthcare follow-up(American Academy of Ambulatory Care Nursing, 2016).

Outcomes will guide care across the healthcare continuum using a holistic, person-centered, evidence-based approach in attaining those patient goals(American Academy of Ambulatory Care Nursing, 2016).

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