INSPIREd Healthcare

A Value-Based Care Coordination Model

BILLIE LYNN ALLARD

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GLOBAL NURSING EXCELLENCE

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ABOUT THE AUTHOR

Billie Lynn Allard, MS, RN, FAAN, is the Administrative Director of Population Health and Transitions of Care at Southwestern Vermont Health Care, a four-time ANCC Magnet-designated health system. As an exceptional nursing leader for the past 35 years, Allard has spent her career leading innovation in community hospital settings, serving as Director of Cardiopulmonary Nursing, Director of the Emergency Department, and Chief Nursing Officer. Her visionary leadership style inspired nurses to function at the height of their capabilities, achieving 100% certification, implementing cutting-edge evidence-based practice, transforming care delivery, and improving patient satisfaction and clinical outcomes. In the past decade, Allard has led the implementation of an Accountable Community of Health as part of an all-payer model in Vermont. Redeploying nurses from the inpatient setting and using Mary Naylor's Transitional Care Model as a foundation, her program has resulted in a 50% reduction in hospitalizations for patients. Expert nurses navigating across the continuum of care could clearly identify gaps in care coordination and communication as well as opportunities to improve quality and safety. Allard and her team have partnered with physicians, associate providers, inpatient and outpatient clinical teams, and community agencies to implement 10 innovative programs to meet the quadruple aim. Together they have successfully created an Accountable Community of Health that is laying the groundwork for a successful value-based payment model in the state of Vermont.

Allard received her undergraduate degree from the University of Massachusetts, Amherst, and her master's degree from Russell Sage College in Troy, New York. She completed the Wharton Fellows Program for Nurse Executives at the University of Pennsylvania and Leonard Davis Institute of Health Economics. She also completed the Johns Hopkins Patient Safety Practitioner Certificate Program. Allard has given 11 podium presentations at national conferences—including the American Organization of Nurse Leaders, ANCC Magnet Conference, American Hospital Association Rural Health Conference, American Association of Healthcare Improvement Conference, and Pathways to Excellence—and has led two regional conferences showcasing successful population health strategies. She and her team have published numerous articles in professional nursing journals about their work and are presently involved in a research project to be published soon. In October 2017, they were awarded the ANCC Magnet Prize for Innovation supported by the Cerner Corporation. This recognition afforded them the opportunity to partner with health systems across the country to support the implementation of the Accountable Community of Health

model utilizing the SVMC Tool-Kit. Allard has served as a consultant for multiple health systems seeking assistance with population health strategies. Barbara Richardson, one of the transitional care nurses, was nominated by Allard and received the 2016 Magnet Nurse of the Year Award for Structural Empowerment. Her expert team also designed and implemented a nursing curriculum focused on transitions of care, which is now a part of the BSN curriculum at a nursing school. Allard has been adjunct faculty for multiple nursing schools, including the University of Massachusetts, Berkshire Community College, and Southern Vermont College.

In June 2019, Allard received the Elaine K. Sherwood Award for outstanding commitment for her dedicated work with the Organization of Nurse Leaders for Massachusetts, Rhode Island, New Hampshire, Connecticut, Vermont (ONL) Leadership Academy. She has served as faculty for the program for the past five years, providing education, coaching, and mentoring of nurses across New England. She presently serves on the AONE Continuum of Care Committee, working on a pre-conference related to the creation of a toolkit for population health and value-based care for the American Association of Nurse Leaders Conference in 2020.

In the past year, Allard was designated as an Edge Runner (recognition for nurse-designed models of care that impact cost, improve healthcare quality, and enhance consumer confidence and satisfaction) by the American Academy of Nursing and was recently inducted as a Fellow in the American Academy of Nursing.

Allard is married to her high school sweetheart, Eddie, and has three children: Scott, Kate, and Jennifer. Their family has been blessed with 11 beautiful grandchildren to keep them busy!

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GAIL BALCH, RN

Gail Balch is the Director of Information Systems and Clinical Informatics for Southwestern Vermont Health Care. A registered nurse with 25 years of critical care experience, she transitioned to Information Systems 20 years ago and is currently responsible for the implementation, support, and maintenance of clinical and business IT operations, including telecommunications.

Balch has worked with multiple electronic healthcare vendors to optimize clinical workflow, standardize data entry, and improve the value of electronic data across care settings. She is trained in Six Sigma and project management processes and uses these strengths to develop innovative solutions to complex interoperability problems.

When not working, Balch enjoys training for Spartan obstacle course races and spending time with her family in Vermont.

KAREN COPPIN, MSN, RN, CCRN-K

Karen Coppin is a Clinical Nurse Specialist in Transitional Care at Southwestern Vermont Medical Center (SVMC). She received her undergraduate degree from Bradley University in Peoria, Illinois, and her master's degree from Loyola University in Chicago, Illinois. Coppin has over 35 years of experience as a registered nurse in acute care settings, including medical-surgical and critical care. She served as SVMC's representative to the Capital District Region Critical Care Education Consortium, where she regularly taught a variety of classes and contributed to curriculum development. She was the proud recipient of an internal award that recognizes employees who exemplify the core values of the organization. She is a founding member of the transitional care team, for which SVMC won the 2017 ANCC National Magnet Award. She was an adjunct professor for nursing at Vermont Technical College, where she and her colleagues developed and taught an online BSN-level course on transitions of care and healthcare reform. She has published in the field of evidence-based practice and has presented at several national conferences on transforming the role of the CNS to improve patient outcomes during care transitions.

JENNIFER FELS, MS, RN

Jennifer Fels is a registered nurse with a master's degree from the State University of New York at Buffalo. She was most recently Director for the Bennington (Vermont) Blueprint for Health, a public-private statewide healthcare reform program. The Bennington Blueprint for Health includes 13 patient-centered medical home practices, six treatment sites for opioid substance use disorder, and a Women's Health Initiative.

Fels was chairperson of the Bennington Accountable Community for Health, a team of diverse community leaders and partners with the aim of "Building a Healthy Bennington." She has been on the nursing faculty at a local college.

Prior to her role with Vermont Blueprint for Health, Fels had clinical experience in critical care and held leadership roles in case management and performance improvement. She is known for her systems approach to program design.

Fels served as a Malcolm Baldrige National Examiner for five years. She is currently a trustee on several organizations' boards of directors.

Fels is engaged in the book arts, photography, art history, and puppetry. She has been a docent at the Albright-Knox Art Gallery in Buffalo, New York, and the Clark Art Institute in Williamstown, Massachusetts.

KATHARINE H. GREEN, BSN, RN

Katharine H. Green is the Director of Clinical Services for the DH Putnam Medical Group at Southwestern Vermont Medical Center, a four-time Magnet-designated facility that provides primary, specialty, and dental care services to patients residing in Vermont, New York, and Massachusetts. She has nine years of experience in nursing as a registered nurse in medical-surgical, telemetry, quality improvement, transitional, and ambulatory care roles. She graduated from Simmons College in Boston, Massachusetts, in 2010 with her bachelor's degree in nursing and joined Southwestern Vermont Medical Center. Green is currently enrolled in a master's program pursuing a Clinical Nurse Leader degree. Her responsibilities include process improvement, application of evidence-based best practices, collaboration with provider leadership, patient safety, and regulatory readiness for the organization. She is passionate about the delivery of high-quality patient care, the professional development of nurses, and advocacy for the profession of nursing.

SUSAN PURCELL MONTIEL, JD, CHC, CHPC, CPHRM

Susan Purcell Montiel is a practicing attorney, licensed in Virginia and Massachusetts. In her first career, she was a principal in a general practice firm in northern Virginia, specializing in civil litigation. After relocating to New England, she was the Risk Manager, Compliance Officer, and Administrative Director of Corporate Compliance and Legal Services for Southwestern Vermont Health Care. Montiel currently serves as General Counsel to Clinical Providers Staffing, PC, a gap-staffing agency meeting the needs of healthcare organizations throughout New England and New York State. She is certified in healthcare compliance and privacy compliance as well as healthcare risk management. She is also a trained mediator with a special interest in performance improvement. Montiel believes that her experiences in healthcare leadership give her keen insight into the challenges faced by healthcare organizations. She feels fortunate to bring this insight into her practice and is committed to assisting the providers of healthcare services in a concrete and easy-to-understand fashion.

BARBARA RICHARDSON, MS, RN-BC, CCRN-K

Barbara Richardson is a Clinical Nurse Specialist in Transitional Care at Southwestern Vermont Medical Center (SVMC). She received her undergraduate degree from the State University of New York at the Institute of Technology in Utica/Rome and her master's degree from Sage Graduate School in Troy, New York. Her clinical focus both at the bedside and as a CNS was in adult medical cardiology. She developed a course and taught new nurses about care of the cardiac patient, including rhythm identification and ACLS. She was an adjunct professor of nursing at Vermont Technical College, where she and her colleagues designed and taught a BSN-level course on transitions of care and healthcare reform. She is the winner of the 2016 ANCC Magnet Nurse of the Year Award for Structural Empowerment for her work in the development of the transitional care program at SVMC. She is a member of the transitional care team, for which her organization won the ANCC National Magnet Award for 2017. She has spoken widely on the topic of nurses and their impact on healthcare delivery change. She is published in the field of evidence-based practice, quality improvement, and care transitions.

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PREFACE: A NOTE FROM THE CHIEF FINANCIAL OFFICER

When I was first approached about the transitional care nursing (TCN) program, my response was, "Are you crazy?" What I heard was, "Invest in a program that spends money and reduces our revenue." At the time I had been a chief financial officer (CFO) for about 25 years and in healthcare finance for nearly 35 years. The goal for many of those years in healthcare finance was to control costs, spend less, and increase patient volume. I heard this program as "Spend more and decrease patient volume."

Healthcare costs have been increasing at a significantly greater rate than the rest of the economy, and over the past few years we've heard a lot about the Triple Aim: improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of healthcare. Well, the TCN program was going to improve the patient experience, sure. But it was also going to increase cost and decrease revenues for my hospital.

Around the same time this program was presented, the state of Vermont was in discussion to develop a single-payer or an all-payer model. The goal of the state and the hospital association in the dialogue was to *bend the cost curve* (i.e., slow the long-term growth of healthcare costs). The state also established the Green Mountain Care Board (GMCB) to help achieve this aim as well as other objectives.

Hearing about the transitional care program brought to mind a talk I had attended earlier in my career during which the speaker showed a picture of a smiling hospital chief executive officer (CEO), sometime in the late 1980s, surrounded by hospital beds filled with patients. As the discussion progressed, the speaker showed a picture of the same hospital but in the then-present day—the hospital beds were empty. The speaker asked what we thought the CEO's mood might be now. Well, my first thought was that the CEO found another job. My second thought was that the CFO had pulled out all her hair or found another job. Not a great picture either way.

The speaker then put up the picture with the empty beds, but with the CEO smiling. The speaker said that this is the CEO of the future, where the healthcare delivery system keeps patients out of the hospital. Instead of managing beds and occupancy, the CEO will manage the health of the community. My thoughts? *This speaker was nuts.* When the TCN program was presented to me, that talk I had attended, and those images, immediately came to the forefront of my mind.

The TCN program seemed as though it might help overall healthcare objectives but in the short term would negatively affect the hospital's operating performance. As I reviewed the merits of the program and the targeted population that we serve, and I focused on the community rather than the hospital, I could justify the program. But I would wake at night wondering how I would meet the hospital's financial commitments—including payroll, vendor payments, debt payments, and other expenses—if this program were extremely successful. Remember, this program was introduced when the hospital was being paid in a fee-for-service model, and we were only just beginning to talk about population health and bending the cost curve. I believe that had we not started this program in those years before the hospital entered the Accountable Care Organizations (ACO) model in Vermont, the hospital would have seen $3 to $5 million more in its revenues.

During the early years of the TCN program, it was in my "cross hairs" each budget cycle. In Vermont, the hospitals are given revenue targets each budget year. The annual increases have historically been around 3%–3.5%. With each budget cycle, the hospital was challenged to meet the target. But as we saw outpatient services increasing, the TCN program staff was managing patients in the home who were considered high risk and high utilizers of services, and the TCN team was keeping these patients out of the hospital. The program became an effective tool in the organization's toolbox to manage the overall hospital revenues—and we were able to meet the GMCB targets.

With each passing year, the state and Southwestern Vermont Medical Center (SVMC), along with a potential affiliation partner, kept talking of population health and fixed payment models. The transitional care program became a cornerstone whenever the population health and fixed payment models were discussed. I felt I had something to contribute.

It is important to let the reader know that at every opportunity I pointed out that I was spending hospital resources on the TCN program, an investment that was reducing the hospital's revenues and profitability. The hospital cannot even calculate a return on investment on the program accurately since the two negatives would equal a positive, which makes no sense.

Today, SVMC is an ACO model for certain attributable lives for Medicaid, Medicare, and certain insurance exchange programs. Our hospital is ahead of many of the other hospitals in the program. Because the transitional care program is mature, it is

an effective tool in SVMC's toolbox in the management of population health—especially for high-risk, high-cost individuals. It is worth noting this is only one tool in our toolbox today.

So how does the transitional care program benefit the hospital? I believe it is better to ask how this program benefits the community. The community benefits from this program more than the hospital, but the hospital is a community asset—we are here to serve the community, and the community members who receive services from the TCN program in many cases have a better quality of life than if the TCN program did not exist. I am making a value judgment in my comments—the judgment is that the high-risk, high-utilizing patients who receive services within the TCN program would rather be in the program instead of in and out of the hospital more frequently than they are. And that is a better quality of life.

The healthcare system as a whole benefits from a program like this. Though lower-cost episodes or elimination of episodes reduces a hospital's revenues, hospital admissions are typically the highest-cost episodes. If successful, the TCN program is one asset in reducing the overall cost of care in the healthcare delivery system.

A program like this goes against most of the principles many CFOs have grown up with. Many of those principles are built on the assurance that the hospital or medical center will generate revenues and thus be able to reinvest in itself for the future. I believe the future demands that we recognize that healthcare costs are growing at a greater rate than the economy can support and that our communities may not be able to afford the increases. A switch in focus from the hospital to the community is the first step.

If the hospital efficiently uses the community healthcare dollars, the hospital *and* the community will benefit. Healthcare premiums in the community will be reduced, and that money can be reinvested in the community.

CFOs need to be open-minded. Traditional financial principles are imperative—they must be kept and built upon—but hospital leaders now more than ever need to view the hospital as a community asset. And we must remember that we are the stewards of the community's health.

–Stephen Majetich, CPA
Chief Financial Officer
Southwestern Vermont Medical Center

FOREWORD

The future of healthcare in the United States is being profoundly impacted by innovation. Care delivery models, policies, scopes of practice, and leveraged technology are some of the aspects of healthcare where new knowledge and innovation are resulting in improvements in the quality of patient care. As innovators, all nursing professionals act as agents of change.

The recently updated American Nurses Association scope and standards of practice document calls for all RNs to "contribute to nursing knowledge by conducting or synthesizing research and other evidence that discovers, examines, and evaluates current practice, knowledge, theories, criteria, and creative approaches to improve healthcare outcomes" (ANA, 2015).

Innovative efforts in the healthcare system are often focused on furthering what is described as the Institute for Healthcare Improvement Triple Aim: improving the health of populations, enhancing the experience of care for individuals, and reducing the per capita cost of healthcare (Berwick, Nolan, & Whittington, 2008). In addition, some organizations have added a fourth aim: focusing on improving the experience of the healthcare provider. Or, more simply stated, helping healthcare workers attain joy at work.

In a keynote address at the Institute for Healthcare Improvement's (IHI's) 24th Annual National Forum on Quality Improvement in Healthcare, then IHI president and CEO Maureen Bisognano, MS, RN, presented a checklist for spreading innovations and evidence-based practices in healthcare. The checklist included five main points:

1. Set a vision to build will.
2. Find or create the best ideas.
3. Create the infrastructure to scale up.
4. Move beyond the walls of healthcare institutions.
5. Leverage teamwork to effect change.

This book tells the story of how the principles of this checklist inspired healthcare innovation and change in a small rural Vermont community.

INSPIREd Healthcare: A Value-Based Care Coordination Model is a fascinating look into how one transformational nurse leader and a team of heroic clinical nurse specialists embarked on a successful journey to create a new model of nursing care delivery. This new model, an Accountable Community of Health, came to fruition as a result of the successful application of the checklist for spreading innovations by my esteemed colleague, "Edge Runner" Billie Lynn Allard, MS, RN, FAAN. Allard formulated a vision for change by making the case for innovation based on the evolving landscape of healthcare payment and reward models and the shifting of the locus of patient care from the inpatient setting to outpatient and community care.

This book tells the story of how Allard and her courageous band of change agents found and created new ideas focused on the social determinants of health and transitions in care for improving the health of communities. By embracing community agencies and partners, they created an infrastructure for healthcare sustainability by looking beyond the inpatient world in which they had all spent their careers. They created partnerships and coalitions, sometimes with unlikely stakeholders, and the program thrived from the wisdom and the energy of these multidisciplinary teams. As scientists and innovators, Allard and her team also identified measures of success that could be captured, tracked, and trended in order to demonstrate that the implementation of the innovation actually resulted in significant improvements in healthcare transitions.

In addressing the "Quadruple" Aim of healthcare improvement, this team found great joy and satisfaction in their work. They describe how after long-standing career frustration with the healthcare system, they now feel empowered to influence and change it. Allard and her team present the evidence that their innovative program is teachable and replicable and results in improved outcomes of care for patients with chronic and complex needs.

This book offers a patient- and family-centered approach to the myriad problems surrounding care transitions in healthcare. The authors offer practical suggestions and tools for nursing services as well as recommendations for curriculum adaptation for academia. They have crisscrossed the country presenting this breakthrough work and have been featured in local media, including television and print, to disseminate their innovations. They have presented at the American Organization of Nurse Executives (AONE) and Magnet conferences, and they have been published in *The Journal of Nursing Administration*, *Home Health Care Now*, and *American Nurse Today*.

Their innovations have resulted in an initial 56.1% reduction in inpatient readmissions and 24.9% decrease in emergency department (ED) utilization at Southwestern Vermont Medical Center. The program has now expanded, with sustained results in transitional care nurse visits, reduced readmissions and ED utilization, and reduced hemoglobin A1c levels in diabetic patients. Southwestern Vermont Medical Center received the 2017 Magnet Prize for these nursing innovations, which have significantly improved the lives and health of patients in a small, rural, and economically challenged Vermont community.

I highly commend the authors for this healthcare innovation. I am proud of all of them and personally gratified to have helped them initiate and carry out this transformative change in our approach to transitional nursing care. May the model they have developed flourish and spread across the country—patients and healthcare systems will all benefit from following their lead.

–Carol A. Conroy, DNP, RN, CENP, FAAN
Principal and Founder of Healthcare Excellence Unlimited
ANCC Magnet Appraiser
Past Chief Nursing Officer, Southwestern Vermont Medical Center

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INTRODUCTION

This book was written to demonstrate the pivotal role of nursing in the transformation of care delivery as our many healthcare systems shift from a fee-for-service model to a value-based payment model. Imagine having the opportunity to make meaningful change in care delivery that better meets the needs of our patients and their families. This book takes you on the journey of a group of clinical nurse specialists in a Magnet®-designated community hospital setting who have successfully transformed care delivery while meeting the Triple Aim (Berwick, Nolan, & Whittington, 2008):

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of healthcare

BACKGROUND

As care shifts from inpatient hospital settings to outpatient locations in a Magnet community hospital setting, the inpatient role of the clinical nurse specialist (CNS) is jeopardized. In our story, the chief nursing officer delegated one nurse leader to find a way to use this talented clinical team in the future, safeguarding this valuable resource for healthcare delivery in the community.

A literature review revealed the innovative work of Mary Naylor from the University of Pennsylvania. Naylor initiated a research project in 1989 to study the effects of a comprehensive discharge planning protocol, designed specifically for the care of the elderly and implemented by nurse specialists (Naylor et al., 1994). Naylor's study concluded that this intervention delayed or prevented rehospitalization during the six weeks following hospitalization. In a fee-for-service model incentivizing high rates of hospitalization, this study did not transform care delivery at that time.

Using Naylor's model as a starting point, our team implemented a transitional care program to meet the needs of our community with the goal of achieving the Triple Aim.

Transitional care covers "a range of time limited services and environments that complement primary care and are designed to ensure care continuity and avoid

preventable poor outcomes among at risk populations as they move from one level of care to another, among multiple providers and across settings" (National Association of Clinical Nurse Specialists, 2019, para. 6).

The state of Vermont was simultaneously focused on finding a way to provide excellent healthcare at a reasonable cost to its communities. This provided a backdrop supporting our CNS team in their opportunity to transform care to achieve this mutually beneficial goal.

Expert clinical nurses navigating with high-risk patients from one setting to another clearly identified gaps in care coordination and communication while identifying opportunities for improvement. One by one, we have implemented successful programs. Lessons learned include:

- Community partners play a pivotal role in achieving success.
- Social determinants of health must be addressed to achieve successful management of chronic diseases.
- Resources to support primary care providers are central to improving community health.
- It's critical to maximize nursing and ancillary care partners practicing at the height of their license.
- The power of decision-making rests with each individual.
- Success is achieved by engaging individuals to make informed decisions based on their goals for the future.
- Longitudinal care delivery = each care provider considering what happened before and what will happen after each "patient touch."

PRESENT AND FUTURE

As one door closed for CNSs, another door opened. Without a doubt, this important work has been the highlight of our careers! We have successfully transformed care delivery to better meet the needs of our neighbors and friends. We have addressed what was not working and implemented strategies that are centered on empowering

patients (although we prefer the term "individual," which is reflective of a wellness-centered model rather than the traditional medical model) to engage.

In 2016, one of our nurses was recognized as the Magnet Nurse of the Year for Structural Empowerment. In 2017, we received the ANCC Magnet Prize for innovation. In 2018, I was designated as an Edge Runner by the American Academy of Nurses for the INSPIRE Model for population health. Collectively we have had opportunities to publish articles and participate in web conferences, blogs, podium presentations, panel discussions, and media events. We hosted a regional conference with Mary Naylor as our keynote speaker and co-authored a BSN curriculum, which debuted at a local nursing program. Now, Sigma is publishing this book. Two days ago, while cleaning off my desk on a Saturday night at work, I discovered a letter that had arrived six days before but got lost in the piles of work on my desk. It was from the American Academy of Nursing inviting me to be a Fellow at its next annual meeting in October. Dreams do come true!

Healthcare reform provides a unique opportunity for nurses across this country to use their voices and take a lead role in transforming care delivery. Now is the time! This book will show you a road map to follow, wherever you work.

HOW THIS BOOK IS ORGANIZED

Part 1: The Road to INSPIRE includes chapters 1–11 and is an account of our personal and professional journeys as we painstakingly made our way along the path to building a transitional care nursing program from the ground up.

Part 2: INSPIRE Across the Care Continuum includes chapters 12–20 and illustrates how the INSPIRE Model can be applied to almost any gap in care delivery, in almost any clinical setting, using examples from our own work.

Each chapter ends with "INSPIRE: Step by Step," a snapshot summary of key information that will make program replication a success. You will also find "INSPIRE in Action" sidebars laced throughout the book. These are case studies and anecdotes that help illustrate the numerous challenges we have overcome—and the successful outcomes that we've had the privilege to witness.

Take the reins and lead the change . . . nurses know what needs to be done! Be INSPIREd!

ANCILLARY MATERIALS, FREE DOWNLOADS, AND ADDITIONAL BOOK MATERIALS

Find more information about ancillary materials, free downloads, and any additional book-related materials for this book at Sigma's Repository via http://hdl.handle.net/10755/18280.

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CHAPTER

3

LAYING THE GROUNDWORK FOR A TRANSITIONAL CARE NURSE PROGRAM

–Billie Lynn Allard, MS, RN, FAAN

OBJECTIVES

- Identify the key partners needed to ensure success of care transition
- Learn what should be covered during introductory meetings with partnering agencies
- Understand the need for transitional care team meetings

ENGAGING PARTNERS

Most of our clinical nurse specialist (CNS) team members had spent the majority of their careers in acute care, hospital-based settings. During the transitional care education program the CNSs took, it was clear that dismantling the *medical silo* (piecemeal structure of healthcare delivery) was going to be necessary in order to achieve success.

As we began to think of ways to solve for gaps in the transition of care process, we identified which outside partners we felt would be most integral to making the shift toward a more cohesive and effective care plan once the patient left the hospital. Initially, they included:

- Primary care physicians (PCPs)
- Home care agencies
- Skilled nursing facilities (SNFs)
- Blueprint for Health team (medical home)
- Community agencies

THE PRIMARY CARE PHYSICIAN

The future of healthcare is predicated on the idea that patients have a PCP whom they will see regularly. The PCP will coordinate their care with other partners across the continuum and will function as the lead care provider, except for special circumstances (e.g., long-term cancer therapy, complex cardiology, urology, gynecologic diagnoses) (Primary Care Development Corporation, 2019). The foundation of primary care in the Dartmouth Hitchcock Primary Care Practices/Southwestern Vermont Medical Center (SVMC) Independent PCP practices is founded on the Vermont Blueprint for Health, as discussed in Chapter 1. The chief medical officer (CMO) of our health system met with the team to hear about the program and strategize a structure and function that would optimize results. He suggested that we partner with PCPs across our community. This concept differed from the Naylor Model because they received referrals from the hospital and partnered with home care agencies to deliver care. This proposed concept by the CMO made sense to our team but would require a close partnership with PCPs across the community. What if they were not interested? Would they recognize the value? How would their office

staff embrace this concept? In the past 10 years, the majority of PCPs no longer see their patients in the hospital. Eighty percent of patients are managed by hospitalists, while another 15% are overseen by specialists. About 3%–5% of PCPs still make rounds in the hospital (SVMC data, 2013). Having spent time learning about the Blueprint for Health and recognizing the need for each patient to have a PCP, we realized this model made sense. Patients would be in the hospital for a brief time while the majority of their care was led by the PCP. We could be an extension of the PCP by helping patients more successfully manage at home while bridging gaps in care coordination with care providers across other settings. We would also need to work closely with providers to get orders as we identified changes that required adjustment in the treatment plan.

The transitional care nurse (TCN) team had worked closely with the majority of PCPs prior to implementation of the hospitalist model and had collegial relationships with them. We expected this experience would be a bonus to successful implementation of this project. We also discussed the challenges faced by PCPs expected to see larger panels of patients with limited time for office appointments. The TCN program could help support primary care being the foundation of care delivery in our community. Our goal would be to have access to the PCP office records to be able to share pertinent information with the emergency department (ED) providers, hospitalists, and specialists at the hospital. Nurses had expressed concerns about hospitalists not having access to primary care patient information, and we thought this might be an opportunity to bridge that gap. The CMO agreed to champion our plan and help us in our search for potential partners.

Another physician partner who needed to be involved was the chief hospitalist. Due to a recent change in leadership, we met with the new hospitalist leader. He listened intently and agreed that this plan could represent potential improvement in care coordination across all settings. Developing collegial relationships with key physician leaders was a key to our future success with this program. We were beginning to recognize that this was going to be a marathon, not a sprint.

HOME CARE AGENCIES

The team determined that most instances of care overlap, duplication, or competition would occur between the home care agencies and the TCN program, and we sought to avoid those overlaps. Since we wanted to visit people in their homes, we

wanted to have a discrete role that did not overlap with existing services like home care. As we looked at patients discharged from the hospital daily, many did not have a need for skilled nursing, which prevented them access to coverage for home care services despite potentially benefiting from assistance. We also observed that some readmissions had been receiving home care services for a few weeks, no longer met criteria to continue the services, and were unable to care for themselves, resulting in readmission to the hospital. Our goal was to meet with the home care agencies and find where the transitional care program could fit without cutting into their niche.

Once we had a solid proposal for what we planned to do, we scheduled a meeting, inviting the two main home care agencies in our community. Our plan was to start with them and then schedule meetings with other home care partners from neighboring states (Massachusetts, New York, New Hampshire) that we would also want to work closely with. From the onset, there was tension in the room. We had provided a brief summary of why we wanted to meet, and their body language betrayed suspicion and concern about what was being proposed. We had surmised they may feel like we were invading their territory and looking to shift referrals away from them. Our goal was to fill gaps, not compete or overlap. Tactically, we started the meeting with a description of what our intentions were:

- To seek a way to provide navigation/education/support services to patients who do not meet criteria for home care services
- To coordinate with PCPs to share pertinent, important information from the PCP office with other care partners across the continuum
- To identify opportunities in which hospital-based services could coordinate more effectively with healthcare partners outside of the acute care setting
- To find strategies to create coordinated care delivery from the hospital, to SNFs, to rehabilitation centers, to home
- To avoid duplication of any other services now available in our community
- To learn about how care is being delivered by other care partners and find ways to work as a team

As the meeting continued, those present appeared more comfortable and open to the conversation. We shared data showing our 12%–14% overall readmission rates, with disease-specific rates for COPD at 25%–30% (SVMC, 2013). Data also demonstrated the large percentage of patients refusing any services offered by case

managers in the hospital (SVMC, 2013). We also reassured them that patients would still be referred to home care agencies for services they provided, such as wound management, skilled nursing, and ancillary services. We weren't looking to reduce their patient volume; rather, we were hoping to *increase* appropriate referrals.

Once their concerns were eased, the meeting attendees began sharing challenges that impacted the success of home care nurses' care delivery, including:

- Difficulty making contact with providers for urgent issues, causing delays in care and causing potentially avoidable ED visits or hospitalizations
- Lack of access to primary care patient information
- Lack of timely access to pertinent patient information post-hospitalization
- Challenges with seeing patients in a timely manner post-hospitalization due to peaks and valleys of referrals
- Frustrations that home care services covered do not always allow what would be beneficial to patients
- Issues with scheduling consistent nurse coverage for patients

This meeting was also an opportunity to ask if they would be willing to let the CNS team shadow them in their roles. This was an important part of the onboarding plan for the TCNs. Our home care partners agreed that we could shadow their nurses and appeared slightly less anxious about our intentions going forward. A plan was made to schedule a second meeting to discuss next steps. We also reassured them that we would seek ways to assist them with the identified issues they shared with us, including leveraging improved access for home care nurses with PCPs.

CONSIDERATIONS FOR URBAN AND ACADEMIC MEDICAL CENTERS

When health systems reach out to community partners to become proactively involved in the transitional care process, the partners may be surprised by the invitation. The perception that hospitals are behemoths that make decisions in isolation is real—and something we encountered even in our rural community setting. Listening to the barriers that partners encounter and then finding ways to assist them can lay the groundwork for successful partnerships.

SKILLED NURSING FACILITIES

The next meeting scheduled was with representatives from each of the SNFs in our community. Seldom did this group of competitors vying for patients sit in the same room to meet. Concerned about attendance, we reached out individually to each facility, connecting with the nursing leaders and administrators, encouraging them to come and participate. We also served lunch at the meeting to make it more convenient and appealing. Many shared later that they came reluctantly to find out what it was all about but had little hope that it would make a positive difference for their operation or patient care. We could feel that reluctance as the meeting began.

We began the meeting with introductions, followed by a brief description of how we hoped to support the SNFs with assistance from advanced practice nurses, soon to be TCNs. We spoke about healthcare reform, the potential impact of value-based payment, and the future challenges for SNFs across the country.

When we asked them to talk about the challenges they faced, participation increased dramatically. Many SNF leaders shared obstacles such as:

- Recruiting and retaining high-quality staff and nursing leaders
- Poor reimbursement that does not cover the cost of care delivery
- Frequent regulatory visits with unrealistic expectations, taxing their resources, time, and energy
- Challenges when transfers from the hospital happen late in the day, impacting access to medications, missed physical therapy treatments, and workflow challenges for second shift
- Incomplete handover communication from facilities sending patients for admission
- Unrealistic expectations of families concerning what services SNFs could provide

This meeting was pivotal to our ability to broaden our hospital-centric perspective and hear about the lived experience of our nursing colleagues across our community.

We began to feel a sense of camaraderie with one another. Even competing administrators and nursing leaders were having conversations, sharing frustrations, and feeling energized to be surrounded with colleagues sharing the same daily struggles. At the end of the meeting, everyone commented that it had been time well spent, and the SNF leaders expressed a willingness to work with us on this new journey. Could this be the beginning of changing the relationship between hospitals and SNFs across our community? We also hoped it offered an opportunity for nursing leaders from all SNFs to form relationships with each other that could prove to be beneficial in the future.

THE MEDICAL HOME: THE BLUEPRINT FOR HEALTH TEAM

Another critical partner in our community was the Patient-Centered Medical Home (PCMH), which had been preparing for healthcare reform and laying a strong foundation in our community for four years. This program was led by a seasoned nurse leader who had made great strides with improving healthcare access and delivery.

Most primary care and pediatric practices had medical home nurse case managers stationed in their practices 8–16 hours per week, depending on the size of the patient panel. Their role was to partner with the care team in the office, identifying high-risk patients, doing outreach post-hospitalization, and ensuring that patients were receiving appropriate screening, immunizations, and medication reconciliation. Practices were designated as meeting medical home standards and had to maintain quality and safety standards to receive ongoing payment per member per month. In our community, this program seemed to be unknown to most of the care community despite the value it offered for improving access to healthcare delivery. We were impressed by the work that the Blueprint team was doing, and we recognized that they would need to be a key partner with us moving forward.

We requested a meeting with the medical home care team as we had done with other care partners in our community. The medical home executive director preferred to have a one-on-one meeting with our project leader, which was scheduled. This felt rather foreboding . . . and it was.

Using a similar approach, the meeting began with a description of what we were hoping to accomplish. I started our meeting with the same questions we had posed at our previous meetings: How might TCNs help the medical home deliver high-quality care? Where are the gaps, potential opportunities for collaboration, and challenges you face?

But the executive director firmly stated partnering would be unnecessary, as the organization already successfully coordinated care. She warned that duplicating services would be a waste of resources and healthcare dollars. Trying a different tactic, scheduling a meeting with the medical home RN case managers was requested, but that was refused as well. Still not deterred, I made a request for the TCNs to shadow the nurse case managers as part of our onboarding program. As you might expect, this request was met with concerns that it would interfere with their workflow and was probably not possible.

We realized that some potential partners may prove more challenging than others.

COMMUNITY AGENCIES

Other meetings and visits with other community agencies and partners continued to be scheduled, including:

- Meals on Wheels
- Council on Aging
- Department of Health
- Adult day care programs
- Medicaid case managers
- Designated agencies for care of patients with mental health issues and substance abuse disorders

Our intention was to help each community partner that we met with design how best to create care coordination in our community. Prior to the meetings, despite having a plan in mind, we encouraged them to share what they believed would work best. Relationships previously were cordial and collegial, but care was being

delivered in silos with limited understanding of how becoming a team might impact outcomes. We also requested the opportunity for our TCNs to spend time shadowing their nurses, leaders, and team members so we could truly gain a better understanding of how care was delivered across all settings and strategize how we might be able to help—without interference, duplication, or judgment.

We soon recognized there was a whole new world of resources available that we should have known about in our role as hospital-based nurses. Almost everywhere we went, we were welcomed and embraced enthusiastically. Our goal was to learn from them and figure out what they do, how we would refer to them appropriately, and how we would help others to do the same. Our hope was also that our program might be able to support the work that these agencies were doing to safeguard and better care for our community.

As we look back on this exploration across our community, we recognize that the hospital was seen as the dominant, influential leader of healthcare in our community, wielding power and control. Our healthcare partners across the community have much to offer and were appreciative and surprised that we were seeking out their advice and assistance as we developed this program. Each meeting that we had and each partner that we built relationships with would prove to be pivotal to the creation of an Accountable Community of Health.

GETTING STARTED: CREATING THE TCN TEAM

DETERMINING FINAL STAFF SIZE

The new budget cycle was upon us, and the decision was made that one CNS (now TCN) would be full time in her new role, and two other CNSs/TCNs would work part time in each role. The rationale was to wean the CNS role away from the medical, surgical, intensive care, and ED setting. One CNS/TCN had accepted a position out of town due to relocation of her husband's role. One part-time CNS would remain in surgical services, and one full-time CNS would eventually cover all other locations.

CREATION OF AN ONBOARDING PLAN

We created a formal plan for onboarding, including an orientation plan (see Appendix D).

Each of the three TCNs would spend one to two weeks shadowing staff in skilled nursing/rehabilitation facilities—partnering with home care and hospice nurses, hospital-based case managers, and eventually in primary care practices with medical home case managers and/or nursing staff. Our hope was this experience would bridge the gaps of knowledge and understanding about the pathway of care delivery for our population and help us further assess how best to support our patients in this new world of healthcare reform.

TCNS BEGIN TO SHADOW OTHER NURSE ROLES

The TCNs began shadowing nurses in settings outside the hospital. The schedule was arranged so that each nurse could spend concentrated time in each setting. The nurses rotated through the sites, with weekly check-ins for the team to share observations, thoughts, and ideas for future planning. From the first day of observation, TCNs were able to identify opportunities for improved care coordination and communication, including improvements in hospital processes that were not supporting coordinated care delivery. Efforts were made to seek feedback from nurses in each setting about how the TCNs could best help without interfering or duplicating efforts. Again, our goal was to make this a collaborative process with nurses and other partners across the continuum of care.

THE FIRST OBSTACLES

CHALLENGES IN SKILLED NURSING FACILITIES

In the SNFs, it was evident how little time the RNs had to provide hands-on care. Much of the nurse's time was dedicated to medication administration and documentation, while nursing assistants provided the majority of the care. The new admission process (from hospital to SNF) was in need of improvement. Systems were cumbersome and difficult to navigate, and they did not support nurses having access to updated information about a patient's clinical status in a timely manner. We

also discovered that essential paperwork for receiving nurses in the SNFs was being kept by ambulance services and not handed over to the clinical team. Communication with inpatient and ED nursing leaders facilitated positive change and improved communication between the hospital and SNFs. Other challenges included:

- Difficulty making contact with patient providers
- A lack of onsite physician and associate provider coverage
- High staff turnover
- Challenges with release of staff to attend staff development and education
- Disrespect from hospital-based nurses during admissions and transfers from one setting to another

Suddenly our list of gaps and opportunities was growing exponentially. How could we make a dent in all that we had uncovered? In spite of it all, we witnessed excellent skilled care being delivered by compassionate clinical staff who cared deeply for the residents in their facility. SNF nurses wished they had more time to provide direct care to patients. Reimbursement challenges required nursing assistants, rather than RNs, to provide much of the direct care to patients.

CHALLENGES IN HOME CARE

None of our team had ever worked as a home care nurse, yet home visits to help coordinate care would be a major component of the TCN role. TCNs accompanied home care nurses traveling into homes of patients, witnessing the realities of delivering nursing care outside the walls of the hospital. Often there was minimal equipment and supplies available and no backup—no code team, no expertise and support of coworkers, and no physician "at your elbow" to provide orders.

TCN team members struggled with this major work change, many of them having reached the final phase of their career. In their previous roles, they were expert nurses well-respected for their knowledge and clinical expertise. Now they were filled with fear and anxiety to be working so far outside of their comfort zones. TCNs were awed by the work of the home care nurses and their confidence and ease in building relationships quickly and people they had never met before. Due

to our rural community location, the travel time was often excessive, the road conditions were poor, and it was challenging to find the right house. At times, the patients refused to answer the door or were not home. The TCNs witnessed the time constraints of the home care nurses, who had appointments booked all day and needed to stay on schedule. Hours of documentation were required, often at the end of their day. Suddenly, the referral forms and hand-off communication from the hospital to home care could be seen with new eyes, with many ideas of how to make it better. One important lesson learned was how much critical information can be gathered in the home. Many patients shared bottles of medications, unsure which ones to take. Most were confused about how to manage their symptoms. The most important observation was the large number of patients who were struggling to meet their basic needs for food, clean water, and safe housing. All of this had a major impact on their recovery post-hospitalization. Many were struggling to heat their homes and were unable to afford food with all of their prescribed medications. Some were living in unsafe and unsanitary conditions, without clear pathways to navigate safely from one room to the next. Our team was overwhelmed at the enormity of the issues many families faced. We had opened a door into the lives of the people in our community that represented a whole new world. As hospital-based nurses, we never realized the circumstances we were discharging patients to. Suddenly, it made sense why so many patients were readmitted. The needs were great . . . and now we knew why. How are we going to be able to make this better?

UNDERSTANDING THE ROLE OF HOSPITAL-BASED CASE MANAGERS

In addition to becoming acquainted with our outside healthcare partners, we knew we had an incomplete understanding of and appreciation for the role of hospital-based case managers. We knew they made discharge arrangements for patients in the hospital, ordered equipment needed, and made referrals. As we shadowed them, we came to appreciate the challenges of discharge planning paired with healthcare reimbursement and how this often limits safe and effective discharge planning. These challenges included:

- Patients' refusal of home care nursing services despite their critical need for help

- Struggle of families who have promised never to send loved ones to nursing homes faced with no other choice and making wrenching, heartbreaking decisions
- Broad and in-depth knowledge required regarding healthcare reimbursement, documentation, and coding
- Skilled navigation of services requiring complex choreography to align delivery with discharge
- Challenges to admit patients under correct status of observation versus inpatient status (requiring crucial, often difficult conversations with providers, patients, and family members)
- Ease of use of resource called InterQual requiring concrete justification for length of stay in acute care setting
- Drivers of financial health of the organization in turbulent times of healthcare reform

The TCNs immediately recognized the important role that case managers played, using the limited information they had about a patient to make the best discharge plan. It was clear that many patients refuse a safe discharge plan. Patients may benefit from time spent in a SNF but refuse and often can be seen back at the hospital soon after, requiring more intense resources, a longer hospital stay, and more pain and suffering that might have been prevented. There is pressure on hospitalists and case managers to move patients to discharge as soon as their condition is stabilized because they no longer "meet criteria" to remain in the hospital. The TCNs started to be "observers" of nurses attempting to educate patients about their diagnosis, medications, and discharge instructions "on the fly" the day of discharge. Frequently, discharge orders are written shortly before discharge occurs, and it requires a hurried, rushed approach. Observing patients during the process, it is clear that many are not absorbing the information and just want to go home. Could this be another gap that causes patients to require readmission to the hospital?

FURTHER SOLIDIFYING THE TRANSITIONAL CARE TEAM

WEEKLY MEETINGS

We held weekly meetings for the transitional care team. It was critical to capture the information being collected and begin to make a list of gaps, challenges, and opportunities. It also served as a support group where we could vent frustrations, worries, and concerns. The CNSs were starting to "let go" of some of the duties and responsibilities they had within the clinical units of the hospital. Nursing leaders were mourning the loss of this role for their clinical team and struggling to find alternative plans to bridge the gap. Looming was the huge responsibility of creating a successful program that would make a positive difference for care coordination and be a fulfilling and meaningful role for this talented team.

Sometimes the meetings would be brainstorming sessions of potential ideas for the future. I was witnessing the growth, development, and evolution of this team. With "fresh eyes," they were witnessing care delivery across the continuum through the perspective of patients and their families. How we wished we had gone on this journey at the beginning of our career; it would have changed so much: decisions we made, leadership we provided, tools we created.

GAP ANALYSIS CHART

At one of our weekly TCN meetings, we realized it was time to make a chart that included all of the gaps we were identifying. Table 3.1 outlines the gaps in transitional care and the actions we took to address them.

TABLE 3.1 TCN GAP ANALYSIS CHART

GAP	ACTIONS
Comprehensive care patients need more/different resources (behavioral health and substance use disorders [SUD])	Meeting with ED physician and nursing director United Counseling Service engagement Community Care Team based on Middlesex program
Lack of communication with nursing home	TCNs participate in care plan meetings Education support Consistent discharge plan Meeting scheduled in January Individual meetings scheduled for fall 2015
SNF staff facing challenges including high turnover rate = lack of training, difficulties with interdisciplinary communication, and insufficient MD/NP support	Interactive education program Encourage implementation (onsite educational presentation scheduled) Crisis management education needed Grant-funded position to support interactive program development
COPD readmissions Lack of education, time, inconsistent management	Interdisciplinary task force Standardization of treatment Magnet for refrigerators Medication education TCN visits Pharmacy visits Engage primary care offices Pulmonary rehab program
Many patients could benefit from one TCN visit post-discharge Medication management Safety Symptom management Primary care connection	In huddles identifying patient, offering visit (gathering data) Finding many potential issues: wrong meds, lack of understanding discharge plan, symptom management, need for other referrals, meals, heat, safety (need for social work, pharmacy, etc.)

continues

TABLE 3.1 TCN GAP ANALYSIS CHART (CONT.)

GAP	ACTIONS
Surgical discharge instructions handwritten and missing from chart	Referred to quality and CMO for resolution Need to create new system, group working on it
Need for more physician/nurse/case manager communication and collaboration	Implementation of interdisciplinary rounds Routine meetings with hospitalist leader Rounding on hospitalists Universal bed implementation Unit-based case manager/social worker assignment Bed management plan
Discharge summaries/crucial info not flowing from tertiary centers	Meetings scheduled with Albany Medical Center, Dartmouth, and others
Lack of home care services available for New York practices	Contact Rutland Visiting Nurses Association (VNA) Network with NY hospitals to identify options Grant-funded ambulance reassurance program Meeting scheduled with EDDY VNA program
Patients discharged from multiple PCP offices (nowhere to go)	Referral to ED community care team Express care option: PCPs share difficult patients (spread out the list) Meet with CMO and lead of Putnam Medical Group
No access to outpatient dietician services except medical home office (long wait time, not enough hours available)	Explore reimbursement model with Director of Revenue Cycle Group meeting with providers to strategize SWOT (strengths, weaknesses, opportunities, threats) analysis ofcommunity need and deploy resources

Limited access to diabetes education and coordination of care	Pilot project with certified diabetes educator at three practices PCMH-certified diabetes dietician covers all practices (limited availability) Team meeting held with SWOT analysis complete Meeting with BRG (consultant), HR, and CNO to explore redeployment of certified diabetes educator to diabetes education in PCP offices
Primary care office unaware of ED visits	TCN provides info Referral process for ED providers to consult TCNs for high-risk discharges Share success stories ED case manager referring patients
Community agencies/hospitals/primary care are working in silos	Combine meeting: medical homes/nursing homes/agencies/hospital/VNA Invite to huddle Involve in ED community care team
Lack of ongoing access to social work and closing loops Need for food, water, shelter before education and self-management	Hospital social workers lack resources to help patients long term Post .5 FTE TCN social worker position as extension to SVMC team (CNO to advocate for .5 FTE with EMT)
Support and Services at Home program identifying need for qualified people to assist with medication pouring in home settings	Explore volunteers with medical background Explore grant funding
Transportation issues for patients (physician appointment, lab, X-ray, groceries, medication)	One service requires 24 hr. notice. Need other options Contract with Village Ambulance for chair car service Donation of SUV, hospital-sponsored transportation for TCN and Spoke patients, explore project development

continues

TABLE 3.1 TCN GAP ANALYSIS CHART (CONT.)

GAP	ACTIONS
Challenges with medication reconciliation/best possible medication list	TCNs uncovering patient medication adherence in home setting different than reported to providers Challenge = how to share updated information with hospital/PCP TCN and medical home rep. added to medication reconciliation team Explore need for two lists (medications ordered by physician/medications being taken by patient)
Access to PCP information by ED physician and hospitalist to inform care before orders written	Meet with ED and hospitalist lead, ED nurse director. Identify crucial information needed by providers Triage nurse to pull info and place in front of provider
Provider documentation tool notes from TCN, pharmacist available but not being used	Time constraints in ED, hospital, PCP office TCNs communicating crucial information directly to physician TCNs sharing tips for PCP office visit Evaluate improved realistic communication plan
Lack of psychiatric resources in hospital and community	Community care advocate stymied by lack of resources to assist needy population Patient satisfaction survey results indicate some high-risk patients receiving narcotics prescriptions in ED
Difficulty with implementation of transitional care CPT codes in PCP offices	SVMC Internal Medicine pilot project not progressing due to competing demands PCP office wanting TCNs to document… would this be sustainable?
Some PCP offices not allowing TCN access to EMR causing delays in getting info	Explore issues and resolve

We recognized that all of these observations we were making with fresh eyes as hospital-based nurses were important. It would be impossible to tackle them all simultaneously, so we needed some system that would help us determine which ones should be the top priorities.

We were also recognizing that we needed more than just our team to make progress in some key areas. When visiting patients in their homes, it was clear that many had needs requiring a social worker, not a clinical nurse. We had our hospital-based social workers on "speed dial," and they had been very accommodating and helpful. Recognizing they had a huge patient load in the hospital and ED, we knew this was a critical gap that needed attention. We planned to discuss this with our CNO and look for a strategy to help resolve this important gap.

INSPIRE STEP BY STEP

- Contact and network with community partners, including home care/hospice and assisted living/SNF providers, community case managers, Council on Aging, Meals on Wheels, and mental health and addiction providers.
- Develop collegial relationships with key physician leaders—this step is key to the success of a transitional care program.
- Conduct meetings with open and direct communication, understanding there may be hesitance or concern initially.
- Plan for TCN team to shadow workflow in the various partner settings (as well as hospital-based case managers) to allow for in-depth understanding of needs and challenges in each role.
- Once TCN team begins, schedule weekly meetings to discuss:
  - Gaps in transitions of care (prioritize and make a plan to bridge)
  - Challenges and how to mitigate

- Strategies to increase support from senior leaders and set goals for further engagement
- A plan for onboarding the TCN team, including an orientation checklist and shadowing schedule

- Exercise patience and understanding when encountering resistance.

REFERENCE

Primary Care Development Corporation. (2019). *Policy & advocacy*. Retrieved from https://www.pcdc.org/policy-advocacy

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NOTE: *Page references noted with an* f *are figures; page references noted with a* t *are tables.*

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