Care Coordination Clinical Reasoning Model

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Objectives

- Describe the role of the Advanced Practice Nurse in care coordination.
- Describe the development of CCCR system model with authentic cases and advanced practice nurses.
- Use the nursing process to work through an unfolding case study.
Significance

- Major shortage of primary care physicians in the U.S.

- Uncoordinated care can cost up to 75% more than coordinated care.

- 3 nurse practitioner students to every 1 primary care physician student.

- The advanced practice nurse as the care coordinator (Owens, 2010).
Care Coordination Clinical Reasoning

• “As an Acute Care Nurse Practitioner, I start my critical thinking from the nurses point view and the nursing diagnosis and then work my way toward a medical diagnosis”.

• “I really like how this model lays out a very complex case in a simple, easy to understand way for students”.
Filtering, Framing and Focus

- **Filtering**
  - Discipline specific patient centered-systems thinking and reasoning about assessment of the case.

- **Framing**
  - Discipline specific patient centered-systems thinking as the provider considers care coordination needs.
  - Discipline specific team centered-systems thinking as the team considers care coordination needs.

- **Focus**
  - The organizational centered-systems thinking used by the interprofessional health care team to coordinate care.
  - Patient-centered care needs, expectations, and outcomes.
Diagnosis codes

- Pairing up medical diagnostic codes (ICD 10) along with nursing domains promotes the alignment of thinking and flow of terminology between the disciplines.
  - Nurse Practitioners are positioned to understand and utilize both domains of thinking and languages.

- Practitioners may start with an existing ICD 10 diagnostic code or a nursing diagnosis to work through a case.
Case study
CCCR Systems Model Web

- The **CCCR systems model web** worksheet builds on the foundation of the OPT model.

- Helps to visually represent and determine relationships between and among essential patient care problems, needs, and issues through concurrent consideration of all the needs and issues to appreciate complexity of challenges.

- Interaction of system dynamics and manages the cross-setting communication and care transitions for team interaction and systems thinking.
Risk for Injury, falls, other-directed violence

60 Year Old African American female Patient

History of cerebrovascular accident co-morbidities

Risk for Injury, falls, other-directed violence

Nutrition

Elimination & Exchange

Sexuality

Activity Rest

Perception Cognition

Self-Perception

Role Relationships

Comfort

ICD 10 Codes

Growth Development

ICD 10 Codes

Coping Stress Tolerance

ICD 10 Codes

Physical Abuse T76.11 Cellulitis L03.115

Health Promotion

Safety Protection

Life Principles

Hypertension I10 GERD K21.9

Nicotine dependence F17.203 Depression F33.0

Obesity E66.91 Hyperlipidemia E78.5 Vitamin D Deficiency E55.9

Hemiplegia I69.35

Mild cognitive impairment G31.84
Nursing Domain Priority Table

<table>
<thead>
<tr>
<th>Nursing Domain</th>
<th>Medical Diagnoses*</th>
<th>Web Connections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety / Protection</td>
<td>Physical abuse T76.11</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Cellulitis L03.115</td>
<td></td>
</tr>
<tr>
<td>Nutrition</td>
<td>Morbid Obesity E66.9</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Vitamin D Deficiency E55.9</td>
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<tr>
<td></td>
<td>Hyperlipidemia E78.5</td>
<td></td>
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<tr>
<td>Coping / Stress Tolerance</td>
<td>Depression F33.0</td>
<td>8</td>
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<tr>
<td></td>
<td>Nicotine Dependence F17.203</td>
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<tr>
<td>Health Promotion</td>
<td>GERD K21.9</td>
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<tr>
<td></td>
<td>Hypertension I10</td>
<td></td>
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<tr>
<td>Activity / Rest</td>
<td>Hemiplegia I69.35</td>
<td>7</td>
</tr>
<tr>
<td>Perception / Cognition</td>
<td>Mild cognitive impairment G31.84</td>
<td>7</td>
</tr>
</tbody>
</table>

Connect the ICD 10 codes with arrows on the OPT Clinical Reasoning web and come up with a priority nursing domain
Framing: Obese female in wheelchair, calm, claiming care provider abuse

Outcome State
1. Care giver support.
2. Cellulitis healed within 14 days.
3. Hamilton anxiety score <30 at next visit.
4. BP normal limits – compliant with medications.
5. Engages in physical activity for mobility level.
6. Adheres to cardiac diet.

Present State
1. Reports verbal, physical, financial abuse by care givers.
2. Cellulitis right lower leg.
3. Insomnia, anxiety and fearful.
4. Non-adherence to medical regimen.
5. Sedentary lifestyle.
6. Non-adherence to cardiac diet.

Testing
1. Elder Mistreatment Assessment Tool
2. Braden Scale
3. Hamilton Anxiety Scale
4. Vital Signs
5. Laboratory testing (CBC, Vitamin D, Lipid Profile)

Diagnostic Cluster
Cue Logic:
1. Hemiplegia I69.35
2. Cellulitis L03.115
3. Obesity E.66.9
4. Hyperlipidemia E78.5
5. Nicotine Dependence F17.203
6. Mild Cognitive Impairment G31.84
7. GERD K21.9
8. Hypertension I10
9. Vitamin D Deficiency E55.9
10. Depression F33.0

Keystone Issue:
Adult Physical Abuse T76.11
Cellulitis L03.115

Reflection on Clinical Reasoning

Plan of care
On-going to provide appropriate skilled care giving

Safety
Safe when out of current situation

Needs
On-going monitoring for co-morbidities

Capacity
New facility, home and care givers identified

Skills
Medication adherence assistance available

Resources
Transportation and meal preparation available

Self-management
Functioning at full capacity thus far


Ht: 5’6”, Wt: 244.8 lbs., BMI 39.5, BP: 132/84, HR: 84 bpm, RR: 20, O2 sat 94% at rest.
Needs Assessment
- Physical & Verbal abuse including financial exploitation

Individualized Plan of Care
- PACE participant without a primary care giver

Monitoring and Safety
- Safety concerns because of co-morbidities requires monitoring

Medical Care Services and Testing
- Cellulitis to right lower leg and status of co-morbidities

Evaluation of Capacity, Resources, Skills
- Dependency requires a skilled level of care for some activities of daily living

Coaching and Educating
- Education regarding medications and available resources

Self-management
- Knowledge of resources available and identification of health relationships with primary care giver

Team Collaboration
- Collaboration and communication between providers regarding reported abuse

History of cerebrovascular accident and co-morbidities

60-year old African American female patient

Safety Protection
- Adult Physical Abuse T76.11
- Cellulitis L03.115

CCCR Systems Model Web
The CCCR systems model worksheet provides a visual representation or map of the structure of the model to serve as a guide to help make explicit the value exchanges in team work and the perspectives that emerge when thinking at the level of the team.

Writing each element on the worksheet shows how the parts of the model relate to each other.
60 year old African American female patient history of cerebrovascular accident co-morbidities

Adult physical abuse T76.11 Cellulitis L03.115

*Practice Issues could be from any discipline; nursing, medicine, pharmacy, social work etc.

**Basic Needs Assessment**
- Practice Issues: physical and verbal abuse and financial exploitation
- Interventions: Remove from home and place in a SNF, Contact APS
- Outcomes: Investigate reported abuse. Safety
- Value: Explicit Knowledge

**Medical Care Services and Testing**
- Practice Issues: cellulitis on the lower leg
- Interventions: diagnosis made on P.E. start antibiotics
- Outcomes: prevent further injury
- Value: Deliverable in Value Network

**Coaching and Educating**
- Practice Issues: knowledge of medications and resources available
- Interventions: educate on medications and resources
- Outcomes: understanding & agreement on POC
- Value: Exchange in Value Network

**Activity Plan from Interprofessional Team**

**Team Centered-Systems Thinking**

**Organizational Centered-Systems Thinking**

**CCCR Systems Model**

**Individualized Plan of Care**
- Practice Issues: PACE participant without a primary care giver
- Interventions: placed in SNF for treatment of medical & psychological conditions
- Outcomes: prevent further decline and abuse, maintain safety and functioning, return to home
- Value: Structural Capital

**Monitoring Safety, Needs Assessment, and Plan of Care**
- Practice Issues: patient safety
- Interventions: close monitoring
- Outcomes: if safe, return home, if not, identify another care giver facility
- Value: Feedback/Resilience in a network

**Evaluation of Capacity, Resources, Skills**
- Practice Issues: dependent & requires skilled care
- Interventions: empower patient to be own advocate
- Outcomes: prevent injury, give support
- Value: Human Capital/Competence

**Promoting Self-Management**
- Practice Issues: knowledge or resources available and identification of health relationships for care giving
- Interventions: educate and empower
- Outcomes: secure and capable of being advocate for self and accessing support
- Value: Perceived value analysis and realization

*Practice Issues could be from any discipline; nursing, medicine, pharmacy, social work etc.*
Evaluation of Care Coordination Outcomes

- Did the organization or services provide resources and achieve care coordination outcomes for the case?
- Did the organizational dynamics support behaviors for the purposes of fulfilling the needs for this case?
- Did the feedback loop promote communication among and between the health care providers, and patient/family?
- Did the complexity of the system hinder or enhance the achievement of outcomes?
Summary

Educators can start with a simple case and have the students use their nursing lens to frame the case first. This will help the APRN student understand their role and start to appreciate and respect the frame from other disciplines. This is the beginning of successful care coordination.
Questions