INSPIRED Healthcare
A Value-Based Care Coordination Model

BILLIE LYNN ALLARD
In today’s environment where healthcare costs are outpacing the economy, healthcare systems are shifting from fee-for-service to value-based payment to deliver high-quality care while reducing costs. This shift presents nurses with the opportunity to take the lead in transforming care delivery and achieve the Triple Aim goals: improving patient experience of care, improving health of populations, and reducing per capita healthcare costs.

**INSPIREd Healthcare** follows author Billie Lynn Allard and her team of nurses as they successfully implement an accountable community of health in pursuit of the Triple Aim. The INSPIRE Model they follow provides an evidence-based blueprint for other healthcare systems hoping to solve the complicated problems surrounding care transitions and health promotion.

Through case studies, anecdotes, and step-by-step summaries, **INSPIREd Healthcare** examines:

- The seven-step INSPIRE Population Health Strategy Model
- The role of nurses and other clinical disciplines functioning at height of licensure to improve patient outcomes
- Practical solutions and lessons learned in engaging partners across care continuum
- Creation of community networks and care teams to achieve results
- Application of the model to pediatrics, mental health and addiction, pulmonary rehabilitation, diabetes management, and other services

"**INSPIREd Healthcare** is a brilliant case study in hope for the American healthcare system. Allard and her team have creatively hacked through the thicket of financial reimbursement, bureaucracy, and culture to forge a clear path to value-based, quality care. Follow them!"

- Kathleen Bartholomew, MN, RN
  Nurse Leader, Author, and Speaker

**Billie Lynn Allard, MS, RN, FAAN**, is the Administrative Director of Population Health and Transitions of Care at Southwestern Vermont Health Care. During her 35-year career, Allard has been an innovative, visionary leader in community hospital settings—inspiring nurses to achieve their potential, implementing evidence-based practice, transforming care delivery, and improving patient satisfaction and clinical outcomes.

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ABOUT THE AUTHORS

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.

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

Welcome to the Facilitator’s Guide for INSPIREd Healthcare: A Value-Based Care Coordination Model. This guide is designed to be a valuable resource for educators in education and practice as an adjunct to using the book as a resource for your class or study. In this guide you will find three sections for each chapter:

- Key questions will provide options for assignments, discussion groups, and research projects that can be used to foster students expanding their scope, perspective, and thinking while fostering learning.

- Additional Learning Activities will offer proposed assignments, delving deeper into one of the key concepts covered in the chapter. They may involve researching a subject, performing a literature review, or interviewing a patient, provider, or legislator. Some of the activities may involve using students’ clinical role to investigate a concept, encouraging them to explore innovative solutions and ideas to improve care coordination and delivery. This guide will provide opportunities to expand students’ frame of reference and perspective as nursing’s role evolves to better meet the needs of patients, families, and the community and focuses on improving the health of the population.

- Learning opportunities will provide potential suggestions for maximizing the learning, thinking, and practicing of the concepts in the book. Potential internship opportunities, observation, and partnership opportunities will elevate immersion into a full exploration of the concepts included in the book. Because the book aims to inspire readers to be creative and innovative and come up with their own ideas to improve care delivery, you will notice that some of the proposed clinical placement suggestions and projects will provide that opportunity for the student or the faculty.

THE INSPIRE MODEL

Development of the INSPIRE Population Health Strategy Model by the transitional care team happened following the successful implementation of many of the programs highlighted in the book. Through trial and error, the nurses and other team members learned what steps are important and need to be included in successful and thoughtful development of programs. This model can also serve as a blueprint to guide students on a journey into places nurses may have not been before, partnering with strangers they may never imagined would need to be included as the evolution of care delivery and payment models continues. Embracing the need for nursing to understand the intricacies of fee-for-service, all-payer, single-payer, and value-based payment is essential to prepare for the changes ahead. This guide can amplify the role of the patient or what the author prefers to call person in decision-making and to exemplify what person-centered care looks like.
ABOUT THE GUIDE

This guide is written as an adjunct tool for introducing and exploring the evolution of healthcare reform and the role of the nurse in taking a lead role. It follows the journey of clinical nurse specialists unexpectedly transferred from the clinical setting of the hospital to a new role as a transitional care nurse. They witness with expert nursing eyes the realities of the patient’s journey across the care continuum and identify what is interfering with improved patient outcomes, patient and family satisfaction, medication compliance, the critical role of social determinants of health, and the impact of management of chronic disease and successful recovery from illness.

The Facilitator’s Guide directs faculty providing education on healthcare reform, including the transition from a fee-for-service model to a value-based-payment model. Using the real-life example outlined in the book of one community hospital’s experience during this journey, students are given an opportunity to imagine playing a role in this evolution of healthcare in America. Much of the cutting-edge work highlighted in the book is not happening in places across the country. Nurses need to take a lead role because they are at the sharp edge of care delivery and are closest to the patients in most settings. Truly delivering patient-centered care requires an adjustment of thinking, learning, and executing away from the traditional medical model of healthcare delivery in our country. In nursing schools across the country, opportunities abound for nursing students to partner with patients across the care continuum, seeing firsthand the experience of care delivery in communities. Those opportunities can be pivotal to laying the foundation for their increased understanding and appreciation for gaps in care coordination, communication, and education. Experienced clinical nurse specialists who spent their careers in acute care hospital settings witnessed why patients were not successfully managing their chronic disease and being readmitted as they embarked on this journey. Nursing students across America need to understand this concept and be part of the solution for nurses helping to bridge the gaps, improve outcomes, and decrease costs while improving the patient and family experience. The Facilitator’s Guide supports faculty who are potentially unfamiliar with healthcare reform efforts as they help their students embrace new ways of delivering care with a foundation on Maslow’s hierarchy of needs, the critical role of social determinants of health. Decision-making lies in each person’s hands. Healthcare providers are most successful when meeting patients where they are without judgment, supporting them to make informed decisions, predicated on what matters to them.

This guide provides a chapter-by-chapter exploration of the book, building on the knowledge base and concepts. While telling a story, it offers insight into the lived experience of nurses, learning as they go and charting a course for successful outcomes for their patients. The nurses come to better understand the necessary reliance on other care partners across the health system and community. Facing them are the realities of poverty and the inability to receive care, afford medications and treatments, and be successful. Each chapter is highlighted with objectives, summaries of key points, explanations of new terms, and key questions to be explored. Suggestions for potential assignments and exercises to engage learners in expanding their perspectives are identified. Potential research questions assist the learner in expanding their understanding of the content to better apply it to their practice.

In selected chapters, suggestions for potential clinical placements and project assignments are shared to expand the traditional hospital-based nursing education model. As care delivery in hospitals shifts to the ambulatory setting, future challenges to prepare nurses for entry into practice can be more difficult.
This guide also encourages faculty to challenge students to expand their thinking, take risks, leave their comfort zone in their thinking, and grow and develop professionally. Just as the nurses highlighted in the book, nurses have the expertise, ability, intellect, and imagination to make positive outcomes in care delivery. They are encouraged to consider writing an article or letter to the editor, running for public office, or serving on a board. Consider nominating someone for an award or writing an abstract for a poster and podium presentation at a conference. In the appendixes of the book, examples guiding students may be helpful because they take the first step in adding to the nursing body of knowledge and representing the profession.

In Part 1 of this guide, objectives highlighted at the beginning of each chapter are included to help the instructor or facilitator align the learning assignments. In Part 2 of this guide, the INSPIRE Model is highlighted with a summary of the programs without objectives.
CHAPTER

HEALTHCARE REFORM IN THE U.S.

OBJECTIVES

- Discuss barriers to achieving desirable health outcomes
- Explore initiatives that address gaps in transitional care
- Introduce the Vermont Blueprint for Health
KEY QUESTIONS

In 2011, the Institute of Medicine (IOM) published a report titled *The Future of Nursing: Leading Change, Advancing Health*. Included were three charges to the nursing profession:

1. Nurses should assume a leadership role in changing the existing healthcare delivery system.
2. Nurses should practice at the height of their licensure.
3. Educational systems should prepare nurses for a focus on wellness, prevention, population health, diversity, and improvements in healthcare outcomes.

The IOM report offered the nursing profession an unprecedented opportunity to take a lead role in the evolution of healthcare delivery. Here are some questions to generate exploring next steps in this journey:

- How best can nursing as a profession transform care delivery and improve the health of our population?
- What are the key factors in some patients not having access to healthcare in a timely manner?
- What efforts have been made to improve this situation in the US?
- What is the purpose of the Vermont Blueprint for Health, and how will success be measured?
- How is the NCQA patient-centered medical home model of care delivery different from traditional primary care delivery? Describe how this might positively affect care delivery.

The prevalence of addiction to opioids and other illegal substances across our nation is an epidemic that requires new tactics to achieve success:

- What are the potential benefits for the hub and spoke model implemented in this community setting as a strategy to support patients with addictive disorders?
- Using the women’s health initiative model, what outcomes should be measured to demonstrate success? How could this program evolve to better meet the needs of this population?
- What benefits are derived from the SASH program implemented in this community? What outcomes can be measured to demonstrate success? List other potential ideas to improve this strategy to improve health and wellness.
- What is an ACO, and why is this a potential strategy for population health?
- What are the advantages and disadvantages of having a regulatory body like the Green Mountain Care Board provide regulation, innovation, and evaluation of Vermont’s healthcare system?
- What alternative approaches could be successful in transforming the healthcare system in America?
What are the ramifications of transforming from a fee-for-service to an ACO (value-based) payment plan?

Investigate other countries that appear to have lower cost and better healthcare outcomes than the United States. Why are they successful? What changes does our country need to make to achieve success?

ADDITIONAL LEARNING ACTIVITIES

1. Investigate the payment model in a healthcare organization, and interview a clinical leader regarding challenges and opportunities encountered.

2. Explore bills being entertained at the national level dealing with healthcare reform legislation. Who are the proponents and opponents? What are their platforms?

3. Research communities across America that have successfully implemented ACOs, and share lessons learned.

4. Examining the NCQA model for medical homes, what suggestions do you propose to increase their success and adoption across the country?

5. Partner with health system and community programs targeting mental health and addiction and assess efficacy. How would you design a program that best meets the needs of this population?

6. Partner with providers caring for pregnant women and evaluate the success of care coordination and community engagement. Evaluate community statistics for babies born to addicted mothers, surrendered at birth to foster care.

7. Research the resources available post discharge to patients in your community. Is there access for patients who lack financial means? Is there a SASH-like program? If not, propose an implementation plan for your community.

8. Interview a legislator involved in healthcare reform legislation and hear the legislator’s viewpoints regarding the future of healthcare reform.

CLINICAL PLACEMENT/PROJECT OPPORTUNITIES

- Healthcare executives involved in healthcare reform challenges (nursing, finance, pharmacy, laboratory services, physical therapy, C-suite)
- Legislators or advocates stationed in statehouses navigating these challenging waters
- Medical home team members across the care continuum
- Addiction services team members
- Hospital-based and ambulatory providers of healthcare for women, including conveners of task forces working on challenges
- Shadow opportunities for nonclinical community health workers providing support services in a home setting
CHAPTER 2

ANSWERING THE CALL FOR CHANGE

OBJECTIVES

■ Describe challenges facing a community hospital setting
■ Explore how the clinical nurse specialist can drive meaningful change
■ Introduce Naylor’s Transitional Care Model
■ Introduce the INSPIRE Model

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KEY QUESTIONS

1. Community hospitals across America are struggling to stay financially viable. Discuss contributing factors that affect viability of rural hospitals in today’s healthcare climate.

2. How does care for a chronically ill person differ in a value-based model than in the traditional fee-for-service model?

3. What leadership skills does nursing bring to the development and design of a new care delivery model within a value-based care environment?

4. Identify an opportunity in your community for improving care coordination. How would you design and implement a plan to meet the Triple Aim? (The Institute for Healthcare Improvement [n.d.] coined the term *Triple Aim* to describe an approach to optimize health system performance, including improving the patient experience of care [quality satisfaction], improving the health of the population, and reducing the per capita cost of healthcare.)

5. How did the Naylor Model initially achieve success, and why was it not supported as a standard of care delivery at that time?

The transitional care model focuses on highly vulnerable chronically ill patients throughout critical transitions in health and healthcare. Please answer the following questions related to the transitional care model:

- What is the intervention?
- Who provides the intervention?
- How long does the intervention last?
- What outcomes has the model demonstrated?
- Based on the following case study, how might the discharge plan change if the transitional care model is implemented in Dorothy’s case?

Dorothy is a 76-year-old independent female with an eighth-grade education who resides alone in a rural community. She has been admitted for a COPD exacerbation and received a new diagnosis of lung cancer during this hospitalization. She is a current smoker and has a high anxiety level. She has responded well to antibiotics and steroids and is now ready for discharge. She will be prescribed two new inhalers: an oral antibiotic and a steroid taper.

ADDITIONAL LEARNING ACTIVITIES

1. Choose a healthcare system leader and explore the present payment system in place. Are steps underway to introduce at-risk contracts in the future? What steps have been taken to prepare for healthcare payment reform?

2. Imagine if your role was in danger of being eliminated as part of the evolution of healthcare reform. How difficult would it be to embrace an entirely new role? What strategies would you use to find a pathway to success? What skill sets would be essential to embrace the change?
3. Examine the evolution of nursing roles over the past three decades. If all nurses function at the height of their licensure, what would that look like? How would nurses feel about it? How would that affect relationships with other team members such as providers, ancillary services, and administration? If the trend continued, what could the nursing profession be doing in 2030?

4. What suggestions in terms of clinical rotations, curriculum, nursing board content, and so on do you have for expanding the clinical preparation of nurses to be better prepared for the potential changes ahead?

5. Using the definition of “transitional care” in your text, identify a high-risk patient you have cared for who could have benefitted from improved care coordination. Design a care coordination plan to maximize positive outcomes and improve the patient's health.

6. Looking at the nine components of the Naylor Model, how many of those are achieved by you in your current role? (Alternatively, choose a potential future role.)

7. After reviewing the INSPIRE Model, identify why each step may be necessary to achieve success. What are the ramifications if you skip a step?

CLINICAL PLACEMENTS/LEARNING OPPORTUNITIES

1. Identify potential “transitional care” roles that exist in the care delivery system in your community. Partner with a care provider or patient to observe the impact of having or not having a resource focused on this.

2. Partnering with area clinical partners, pair one student with one patient able to navigate with the patient from one setting to another. (This could be a family member.) Log observations of what went well, what could have gone better, and any opportunities for improved communication and collaboration.

3. As healthcare reform continues to evolve, identify a nursing role that may need to change. Spend time with a nurse imagining how the role could evolve in the future. Interview the nurse to explore her thoughts about the evolution of care delivery in her specialty.
REFERENCE

CHAPTER 3

LAYING THE GROUNDWORK FOR A TRANSITIONAL CARE PROGRAM

OBJECTIVES

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

1. If you were designing a transitional care program in a specific clinical site, what partners would you need to engage? Would you anticipate getting support or pushback? Why?

2. What are some of the first steps you would need to take before feeling prepared and ready to implement your program?

3. Many primary care providers no longer round in the hospital. What would be your strategy to engage them in partnership to establish a transitional care program? Who might be able to help you if you ran into roadblocks?

4. If another discipline or nursing group was approaching you to discuss care transitions, what would make you develop trust and agree to work collaboratively with them? What would interfere with developing a collegial relationship?

5. Have you witnessed or potentially participated in the “caste” system of nursing where some nurses feel superior to other nurses working in other settings and clinical units? How could this program help to break down these impediments to care coordination? What preparation could you take to improve outcomes?

6. Are you aware of resources in the community that can potentially assist patients post-discharge? Do you routinely refer to them?

7. Are there some nursing roles you are unfamiliar with? Would you consider it beneficial to shadow a nurse in one of those roles to better understand their reality and challenges? Would it be beneficial for the profession of nursing to increase mutual understanding and respect?

8. Can you recall a time when you treated a fellow colleague with disrespect? Examine the reasons why, and plan to never let that happen again. What alternative approaches could you use?

9. Explore all levels of nurses and the relationships they have with each other (executives, academia, advanced practice). What are the key challenges in each setting, and how might you prepare yourself to successfully navigate?

10. As a leader, what strategies would you employ to build a strong transitional care team during the birth of this new program?

11. Reviewing the gap analysis included in Chapter 3, were you surprised by any of the gaps? Have you witnessed or experienced similar gaps in your career or personal experience? Pick three that you may have a creative solution for.

12. What was the benefit of transitional care nurses cataloguing their list of gaps from the beginning of the program? What might have happened if they did not do that?

13. What does the term fresh eyes mean? Do you have fresh eyes in the work that you do right now? What is the potential risk when you no longer have fresh eyes?
LEARNING ACTIVITIES AND CLINICAL PLACEMENTS

1. Introduce the term *longitudinal care delivery* focused on care delivery founded on what happened before your interaction with a patient and what will happen after being paramount to success. In each clinical rotation or observation, what would improved care coordination look like? How would it affect the outcomes, and what would change? Who would need to be involved and supportive?

2. Ask students to consider orientation for roles in the past. What ideas do they have for improvement? Share opportunities of excellent onboarding programs and why they worked.

3. Assess whether hospital-based nurses are familiar with available community resources. If so, are they appropriately referring to them? Are there up-to-date resource lists available? Could that be a future project assignment?

4. Assign each nurse to choose a high-risk patient being discharged. Evaluate what discharge plan was made and if it maximized referrals that may have been useful. Assign students to strategize how to engage hospital nurses in embracing the importance of this.

5. Explore students’ experience with cultivating collegial relationships with key physicians and executive team members. Discuss gaining skills, confidence, and competence with this important and necessary tactic. (You may want to use the Myers-Briggs survey and conversations about strategies and challenges.)
CHAPTER 4

PILOTING THE TRANSITIONAL CARE NURSE PROGRAM

OBJECTIVES

- Describe the first steps taken in initiating a program with a partner
- Describe the transitional care nurse workflow in the hospital and at home
- Present a model for transitional care nurse pathways
- Report early data showing success of the pilot program
KEY QUESTIONS

Communication is an essential element in healthcare. With the separation of primary care from hospital care, communication is even more vital to coordinate care effectively with a goal of reducing unnecessary hospitalizations.

1. Discuss the consequences of lack of care coordination and poor communication when a patient is discharged from acute care.

2. If this were an ideal world, what interventions would you employ to overcome number 1?

3. Explain why a transitional care program was successful in filling these care coordination and communication gaps.

4. How would you prepare for a meeting with a primary care provider or primary care office team? What tools, information, or data may be helpful to share?

5. Why would a contract be required to partner with this PCP group? What is nursing’s role if you are being contracted in a primary care practice office? Who could provide support for you in this unfamiliar territory?

6. What challenges present themselves when state borders intersect in your geographic service areas?

7. Why do many patients refuse home care services post-discharge? Identify strategies to bridge that gap to keep patients safe who are receiving appropriate services.

8. Infographics are highlighted in this chapter. Why are these useful tools for program development?

LEARNING ACTIVITIES AND CLINICAL PLACEMENTS

1. You are in the process of developing a new transitional care program. Your next step is to design a documentation tool that will be included in the primary care record. What elements would you include? How would it differ from an acute care documentation tool?

2. Many chronically ill older hospitalized patients are discharged with only a request to contact their PCP for an office visit as follow-up. Using the following case study, discuss why any nursing intervention after discharge would be beneficial. Given the option of a phone call or a home visit, support and explain which option you choose.
CASE STUDY

Mr. Grady is a 68-year-old male hospitalized for community-acquired pneumonia. He has a 10th grade education and a 40-pack-per-year history of smoking, and he has been given a new diagnosis of COPD. He will be discharged on a taper dose of steroids, two new inhalers, and an antibiotic. His oxygen saturation is 86% on room air with activity, so he will be going home with oxygen. He was given an appointment to see a pulmonologist in 2 weeks. Mr. Grady lives in a mobile home with his wife and son, both of whom are smokers. He is a recently retired mechanic and is on a limited income despite the fact that his wife and son are employed. His hobby is working on old cars, and he enjoys dirt bike races.

1. Write a brief elevator pitch explaining a transitional care program to one of the following:
   - A patient
   - A community peer
   - Your manager

2. You are in the process of developing a new transitional care program. Your next step is to design a documentation tool that will be included in the primary care record.

3. What elements would you include?

4. How would it differ from an acute care documentation tool?

5. You are implementing a new program in your clinical specialty. Design an infographic to provide a clear representation to share with others describing your program.

6. In fee-for-service traditional care delivery led by providers, what potential opportunities exist for improvement based on Maslow’s Hierarchy of Needs?

7. Evaluate whether screening for social determinants of health is happening where care delivery is happening. What impact can this have on patient outcomes? Design a plan to bridge this gap for a specific setting, and speak with leadership regarding implementation.
CHAPTER

5

CHALLENGES AND ROADBLOCKS

OBJECTIVES

■ Explore challenges related to information sharing
■ Identify potential areas of resistance from interdisciplinary teams
■ Describe the development of four clinical initiatives that addressed the needs of a primary care practice
KEY QUESTIONS

1. Why is change sometimes difficult for healthcare team members to embrace? Identify a project you may have tried to implement and strategies for success you have used. Are there other strategies the TCNs could have used to be successful?

2. Are you surprised that providers were not more interested in hearing information about patients from the primary care practices in the ED and admitted to the hospital? What ideas do you have that could bridge that gap? Are there missed opportunities related to this lack of support and interest?

3. Considering the hospitalist model of hospital-based care delivery, what strategies bridge the gaps between primary care and the hospital?

4. Change is difficult. In this chapter, you have learned about the challenges the TCNs faced. Discuss key concepts that were pivotal in the success of overcoming resistance and building a successful new program.

5. What role did senior leaders play in the success of the TCN program?

6. Have you ever been in a meeting where you felt attacked and unsupported? What strategies can you use to “go the higher ground,” resist reacting and getting emotional, and remain steadfast in your goals to improve patient care coordination?

LEARNING ACTIVITIES AND CLINICAL PLACEMENTS

1. Identify a new innovative program that could improve care delivery in a clinical setting. Design a plan to gain support from key partners to allow successful implementation. Imagine where resistance will come from, and identify potential strategies to overcome the barriers.

2. Choose an opportunity to improve care coordination in your community. Who would you invite to be on your interdisciplinary team? Who would lead the process? What issues and problems would you anticipate would arise? How would you partner with others to work through them? Explore how to run an effective meeting and role-play with a partner. How can you improve your skills in this area?

3. Based on the team you assembled, what potential value would all team members gain from working closely together to solve gaps in care delivery and coordination in the community? Seek opportunities in your practice to deploy this technique to improve population health and quality outcomes.
EVALUATING AND ADDRESSING HIGHEST-PRIORITY CARE TRANSITION NEEDS

OBJECTIVES

- Present a method for identifying healthcare delivery areas in need of improvement
- Describe how we created teams to address each area
- Delineate steps to formulate strategies for intervention
KEY QUESTIONS

1. From the patient and society’s perspective, why does a hospital readmission matter? What about the perspective of the C-suite (CEO, CFO, CNO)?

2. A collaborative team of caregivers comes together to strategize how best to decrease readmission rates, reduce healthcare costs, and improve outcomes. What is the advantage of a group of representatives from across the care continuum working together on improvement projects designed to better population health? Make a list of who will be invited to be on your team.

3. Which key members of your care team may benefit from working on a project together to improve teamwork, increase mutual respect and understanding, while potentially increasing quality outcomes and patient satisfaction?

4. Why is it important to use a Six Sigma improvement methodology to make processes more efficient and effective?

5. What is the value of a team charter for a project? Think about unsuccessful projects that you have participated in. Was there a charter, and might that have made a difference in the outcome?

6. Whether you are in a rural, urban, or community setting, strategies for population health can be effective. What accommodation would be required in an urban setting to achieve success with interdisciplinary teams? Would timelines need to be adjusted?

7. Have you ever been involved in a SWOT analysis? A new concept called SOAR seeks a more positive way to evaluate future opportunities for improvement. Research this concept and use it the next time you have an opportunity.

LEARNING ACTIVITIES AND CLINICAL PLACEMENTS

1. Choose an opportunity for improved clinical coordination and collaboration. Complete a literature review to identify evidence-based strategies potentially working in other settings. Summarize the findings in a one-page document to share with team members as a springboard to gain support for creation of an interdisciplinary team.

2. Create a draft charter to review with your team, and ask for feedback. This is the first step to kick off a project and can be instrumental in success. Look for key partners with succinct, clear writing skills as well as data experts who can assist with proposed measures for the project. (Literature review will also be instrumental to see what others are measuring across the country.)

3. Based on this chapter, how did this affect the success of the TCN team and lay the foundation for population health in their community? How would you replicate this in your setting?

4. Informatics and data analysts are key players in project management. Take the opportunity to network with them and recognize the value they bring. Involve them from the beginning to save time and frustration down the road. Always remember to collect baseline data before you make changes. Identify a potential project you will lead to test your strengths in this area.
CHAPTER 7

GETTING THE CHIEF FINANCIAL OFFICER TO BUY IN

OBJECTIVES

- Discuss the financial challenges facing community hospitals across the country
- Illustrate the need for an open, trusting relationship with the chief financial officer
- Define the Centers for Medicare and Medicaid Services transitional care current procedural terminology codes
- Highlight the importance of the chief financial officer’s support and championship of a transitional care program

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KEY QUESTIONS

1. As one article claims, the American healthcare system has a new model transforming the delivery system from hospital-centric to outpatient-centric that emphasizes community-based care (York, Kaufman, & Grube, 2014). How should we prepare for this? Are your health system and care delivery partners focused on this? What should the first steps be? How might nurses take a lead role?

2. Have you been at an administrative or staff meeting hearing an update regarding the financial status of the organization? What resonates with you and helps you understand? Do nurses have a role and responsibility in understanding the financial health of the organization? Why or why not? What strategies would help you understand?

3. Is healthcare finance an important element of nursing education that nursing curriculum should include? Describe your rationale for your response.

4. What disruption and challenges will be encountered as the US moves toward an all-payer value-based model of care delivery and payment reform? Imagine that you have a crystal ball, and predict the future. How can the nursing professional make a positive impact?

5. As a nurse executive, what steps could you take to better understand payment reform? How might you partner with the CFO to maximize success in your health system?

LEARNING ACTIVITIES AND CLINICAL PLACEMENTS

1. Arrange observation experiences with finance department personnel including billers, coders, clinical documentation specialists, accounts payable, and those in the revenue cycle. Assign each student to summarize the role of each department, considering why nursing could benefit from an improved understanding of the role and its contribution to a financially stable healthcare organization. Consider having a panel discussion for all students to learn about each role.

2. Invite the CFO or designee to be a guest speaker at your class sharing the crucial information that nurses across the country should better understand.

3. Design an innovative program for population health for your community. Create a summary document of the program and role-play meeting with the CFO or finance department representative to gain support for your pilot project to go forward.

4. Health systems across the country have dashboards that they review to assess the status of the organization’s financial health. Invite a healthcare executive to demonstrate how this information is used in daily operations, including what each line item represents.

5. Imagine that healthcare systems across the country do embrace the all-payer model. What ramifications will occur? What industries will be most affected? What disciplines may support or not support this transformation?

REFERENCE

CHAPTER 8

CREATING SUCCESSFUL PARTNERSHIPS

OBJECTIVES

- Identify elements of an effective partnership
- Explore two models that provide a framework for developing partnerships
- Describe techniques that build and maintain healthy partnerships with common goals
KEY QUESTIONS

1. This chapter recommends replacing the term patient with person, individual, or families. Describe why this may be important going forward and what benefits can be derived from this change.

2. What strategies by a leader encourage high-performing teams to come together for a common goal? Have you ever been on a team when this was successful or unsuccessful? Identify what influenced the outcomes.

3. The essential skill of having crucial conversation is a critical competency for leaders. Are you comfortable having crucial conversations? Assess how to improve your skills in this competency, and map out a plan for improvement.

4. The Accountable Communities of Health concept is one population health concept being implemented across the country. Why might this be an effective strategy, and what could potentially derail its success? What could you do to help it succeed?

5. Demonstrating success requires measurement of outcomes. As a nursing leader, how would you identify measurements for projects implemented under your leadership? What tools could support your decisions? Identify five projects with metrics to demonstrate success.

6. An essential element of creating successful partnerships is using the tactics outlined in this chapter. Consider situations in your experience in which you or another leader may not have been successful. What could have improved the outcome? What other complications derail successful partnerships, and what can you do to avoid this in the future?

LEARNING ACTIVITIES AND CLINICAL PLACEMENTS

1. Using the Collective Impact or Accountable Community of Health program, choose a population health project you want to implement and create a charter including a list of team member titles, specific goals, and timelines.

2. Based on a previous assignment, map out a sample workflow that could assist the project team to better understand opportunities for increased collaboration to improve care coordination and meet project goals.

3. Think about a recent interaction you had with a patient. Describing in detail how the conversation went using the exact words you said and the responses from the patient, evaluate whether you used motivational interviewing during your conversation. How would you modify your questions using that technique? What information might you have gained with this approach? Make a plan for how you will implement this in interactions with clients you work with in the future.
4. Quality measures identified can be process or outcome measures. Choosing a project you have or would like to implement in the future, identify some process and outcome measures that would be applicable. Consider completing a literature review to assist with this assignment.

5. Evaluate your understanding of community resources available in your community or clinical setting. In a recent clinical rotation, did you observe nurses and other care team members referring to appropriate community resources to support patients? Are there accurate lists of resources readily available to clinical staff? How might you advocate for the value of community partnerships to achieve population health? (Consider this assignment to include researching and creating a resource directory applicable for a clinical specialty location.)

6. Assign each student to observe meetings of an interdisciplinary team. Send them with a checklist to evaluate the elements of a successful project team, and assign them to construct a plan for improvement.

7. Partner a student with a nursing leader to review a project team led by this leader. Interview the leader on what worked, what didn’t work, and what the outcomes of the project were. The student must identify the root causes of issues and opportunities for improvement that may have made a positive impact for the team.
CHAPTER 9

COMPLIANCE AND REGULATORY CONCERNS ASSOCIATED WITH TRANSITIONAL CARE NURSING PROGRAMS

OBJECTIVES

- Review healthcare regulations currently in place (see Appendix Z in the book for a summary table)
- Identify and explain related regulatory requirements, including privacy rules and licensure
- Understand tools to maintain regulatory compliance
KEY QUESTIONS

1. What was the goal of the Affordable Care Act, and what actions have been taken since it was enacted to undo some of the impact?

2. CPT codes were introduced to support reimbursement of care coordination in 2012. How does this affect primary care delivery to improve care coordination and positively affect patient care outcomes? Investigate whether providers in your community are using these codes. What systems have been in place to support them?

3. Why was it essential for the transitional care team to involve the compliance officer and hospital attorney as they embarked on this road to transitional care?

4. Why is it imperative to have patient and partner-selection criteria that are revenue- and referral-neutral? Evaluate whether there are some agreements in your health system now. Were some programs negatively affected by this regulation?

5. Is there an ACO in your state or in your community? Evaluate how the ACO has navigated the pathway of patient enrollment to meet regulations (alternative plan, research, and ACO).

6. As the Accountable Community of Health model expands across the country, will lawmakers reconsider regulations that may inhibit care coordination and meeting the needs of high-risk populations? Research efforts are underway in this legislative agenda.

LEARNING ACTIVITIES AND CLINICAL PLACEMENTS

1. Consider inviting a compliance officer as a guest speaker to discuss the challenges and pathways to care coordination within the boundaries imposed by federal regulations.

2. Investigate programs underway in your community, and review patient consents that ensure patient confidentiality. If possible, attend one of the meetings and observe the many benefits of care coordination when shared information is allowed per patient consent. Compare and contrast what would have happened without this teamwork and collaboration.

3. Choose a critical need in your community that could benefit from increased care coordination. Construct a work plan of how you would proceed to implement the program after exploring with a compliance officer and attorney.

4. Interview a legislator and discuss challenges facing healthcare reform legislation. Determine bills in consideration presently that could affect payment reform and care coordination.

5. Invite a representative from a nursing professional organization involved in advocating at the state level for nursing. What bills are pending or being worked on for the future that could affect our profession?

6. Explore if there is a nursing lobbyist for your professional nursing organization. Spend a day with this person at the state house and share observations with the class. Would you be interested in that role? Why is it important?
CHAPTER 10

DOCUMENTATION AND DATA MANAGEMENT

OBJECTIVES

- Review meaningful use and its impact on care delivery
- Present workflow mapping as an integral tool in program design
- Illustrate how optimal documentation and data abstraction can create a sustainable transitional care program
KEY QUESTIONS

1. What is the purpose of documentation?

2. Discuss the value that data provides when designing or defending a new program.

3. As a TCN, you have agreed to be on the documentation tool development team. Answer the following questions:
   ■ Where should your documented information reside in the record?
   ■ How is information that you chart different from inpatient documentation?
   ■ Who should have access to your information?
   ■ What steps will you take to ensure documentation is standardized?

4. It’s now one year later. You are asked to present a report on your program to nursing administration. What data elements from your documentation tool would you extract to demonstrate program success?

5. Why it is critical to involve informatics as you develop new care delivery positions and programs? What are the potential risks if this is not done?

6. Healthcare has been incentivized to integrate medical records systems across communities to improve care coordination and access to important information. Evaluate if that has been effective in your healthcare community or system. What positive or negative impacts do you and other colleagues experience? What future strategies can help with this?
   ■ Is it possible to measure outcomes if you do not collect baseline data? Think of projects you have been involved in, and list examples of successful and unsuccessful data collection methods.

7. In your workplace, are third-party vendors behind dashboards that auto-populate results? Investigate who the informatics partners are who assisted with development of documentation and data collection in your clinical area of specialization.

8. When workflows are modified, does your clinical team also confer with informatics to redesign documentation simultaneously? This could be a missed opportunity for saving clinical time on documentation and up-to-date data collection and analysis.

LEARNING ACTIVITIES AND CLINICAL PLACEMENTS

1. Mapping workflow can be advantageous when setting up documentation screens and designing documentation fields that flow for a care provider. Choose a function, program, or care map in your department or area of concentration, and evaluate documentation and data management opportunities. Confer with an informatics partner to build synergistic systems to maximize efficiency and data collection.
2. Review dashboards available in your health system or clinical site, and interview leaders and staff to explore how dashboards are being used. Is this information helpful in your practice? How could it be more helpful? Create a dashboard that allows both administrators and staff to see results in a clear, one-page summary.

3. Assign staff to partner with informatics staff to better understand their expertise and knowledge. Assign a writing assignment exploring what they have observed and how that translates into increased teamwork, mutual respect, and understanding for this valuable partner on the care team.

4. Can students identify some system in their work life that is cumbersome and does not demonstrate potential results that would maximize success? Partner with an informatics team member and uncover the possibilities.

5. It is critical to embrace the value of data management, analysis, and utility of a well-designed dashboard. Choose one critical program, evaluate the data and how it is communicated and reported, and create an improvement plan to be shared with a supervisor. (Feel free to partner with appropriate team members and experts.)
CHAPTER 11

SPREADING THE TRANSITIONAL NURSING PROGRAM AND THE INSPIRE MODEL ACROSS THE PROFESSION

OBJECTIVES

■ Explore the ways in which the nursing curriculum must adapt to the realities of a new value-based payment healthcare model

■ Describe the transitional care nursing curriculum, and identify challenges

■ Detail the journey taken as we spread the transitional care nursing program and the INSPIRE Model across the nursing profession
KEY QUESTIONS

1. What is the benefit of including a care coordination course into a traditional clinical nursing curriculum?

2. With an emphasis on care coordination and understanding social determinants of health;
   - How would you use the new information to prepare your patients differently for discharge after an acute hospital stay?
   - What other types of coursework might be beneficial to help you broaden your understanding of clinical and nonclinical aspects of care coordination?

3. Vacancies in recruiting enough qualified candidates for nursing academic programs across the country are high. Why are joint appointments between nursing schools and health systems a good solution for the problem? Have you experienced faculty in one of these positions? What are the pros and cons?

4. Across the country, there is often competition between nursing programs. What steps were taken to maximize the chance for success in this partnership?

5. The transitional care nurses had never worked in academia and certainly found it challenging. Imagine how you would make that transition and what preparation may be helpful if you choose to accept a joint appointment.

6. The steering team that worked on setting up this course discussed what level of nursing program should include education regarding transitional care and healthcare payment reform. Based on your knowledge and expertise, propose how best to introduce the appropriate training and education at the appropriate level of nursing education for population health, care coordination, and designing and implementing an Accountable Community of Health.

7. Have you ever dreamed of doing a poster or podium presentation at a national conference? Search opportunities at national conferences, and write an abstract to submit. Seek a mentor who has successfully accomplished this to help you.

8. Professional nurses should join professional nursing organizations. This provides education and expands your knowledge base and mentoring opportunities; furthermore, attending national conferences is exciting, energizing, and fun. Search the website and look for opportunities to nominate a colleague for recognition. Even if they do not win, it is a wonderful compliment to them and lifts up your peers and your health system.
LEARNING ACTIVITIES AND CLINICAL PLACEMENTS

1. Assign students to evaluate the course description, objectives, credit hours, and grading system for this college course. Imagine that you are designing a new curriculum, and draft a proposal including all this information. Imagine the intricacies involved in designing a joint program shared by two schools.

2. Nursing faculty are challenged by the broad age range and experience of students in nursing programs across the country. What strategies could faculty deploy to challenge all students to maximize their learning, growth, and development in a class like the one highlighted in this chapter?

3. Identify a class you have taken where your lack of experience affected your depth of learning and the benefit derived. What might be some solutions considering the variety of students in classes for nursing degrees? What value is derived by having highly experienced nurses in your class as a part of discussion, class participation, and project work?

4. The book depicts the story of the development of a transitional care program in a community hospital setting. Imagine that you are working in an urban setting and wanted to get started in your clinical specialty. How would you begin? Who would be your partners? What specific goals would your program have, and how would you measure success?

5. Have you ever considered providing education at your workplace for other nurses? Identify a topic that you could research and present that may meet an identified need in your workplace. Meet with the education department, your manager, and others to propose the idea. You may find that you love it and want to do it more! Many educators did it the first time as a favor to someone and then found a lifelong passion for making education their profession and building future leaders. A picture says a thousand words. Try using this medium to engage the audience instead of using verbose slides.

6. Using the INSPIRE Model, develop a proposal for a population health program that would coordinate care in your community and meet the Triple Aim. Consider bringing it forward to your supervisor to be considered. Who knows where it may lead you?
PART 2

INSPIRE ACROSS THE CARE CONTINUUM
CHAPTER 12

INSPIRE: MENTAL HEALTH AND SUBSTANCE ABUSE
KEY QUESTIONS

1. Mental health issues and addiction is an epidemic across our country. Efforts to funnel resources in this direction are starting to happen in some communities. Are you aware of successful programs in your area? Is nursing using every opportunity to refer patients from acute care settings who have issues in this area?

2. Have you witnessed healthcare providers exhibiting disinterest and lack of compassion and caring when patients present with mental health or substance abuse disorders? What are some potential explanations for this response? What can you do to make this better?

3. Think of clinical assignments that you have participated in. Have you witnessed unnecessary medical care being delivered to patients who may not require them? Are some patients presenting with medical complaints when the underlying reason is something else? How does the community care team eliminate this from happening as often? What other ideas do you have that may be effective? Are there other locations and settings that could benefit from a program like this?

4. Why would the credentials for the patient advocate not be directly related to educational level and medical expertise?

5. Why is it important to obtain a patient consent and manage patient confidentiality? What other safeguards would you suggest to ensure that a breach does not happen?

6. What financial impact could occur if health systems across the country could implement similar programs? Explain how this could meet the Triple Aim and the Quadruple Aim.

7. Why would community partners embrace the value of the community care team if some partners refuse to engage? How might you convince them to participate?

LEARNING ACTIVITIES AND CLINICAL PLACEMENTS

1. Choose a community that you are familiar with. Who would you invite to be a part of the community care team? Who might be an effective leader of the program? Can you identify potential candidates for the patient advocate position? How would you engage community partners? Design a charter for your project and consider sharing it with an interested colleague who could potentially move it forward.

2. Assign students to observe in the emergency department (ED), and witness the population of patients who present there with medical problems but end up with negative work-ups. Are there potential other reasons they presented there? Consider other diagnoses, including mental health and substance abuse disorders. Are patients referred appropriately at discharge? Is any follow-up with other disciplines (social work, mental health workers, addiction, counselors) planned to support the patient? Are staff in ED aware of services to refer to with accurate information readily available?
3. Assign students to partner with social workers, addiction counselors, or mental health screening staff in an ED or clinic. Are patients screened for social determinants of health? Is there effective handover communication prior to discharge or transfer? Is there a separate space for patients with these diagnoses who may need to remain in the setting for prolonged periods of time awaiting placement or improvement in mental health?

4. Often there will be insufficient access to timely mental health and addiction support services as well as issues with food, housing, transportation, and a safe discharge plan. What actions do you observe care providers doing to ensure safe discharges? What gaps are evident in your community that need to be addressed? Consider volunteer opportunities in your community to assist with support of this needy population.

5. Partner students with community agencies involved in the community care team, including homeless shelters, housing, economic services, workforce training, addiction programs, home care agencies, and agencies of human services. Explore the important work they do and the necessity of working closely with healthcare partner organizations. Identify opportunities for enhanced teamwork, and consider ways to influence this moving forward.

6. Partner with peer counselors working with patients who have substance abuse disorders. Explore how they came to perform this role and how it helps them. Learn about the strategies they use to support patients and how that can be translated into your practice.

7. Research the term *unconditional positive regard*. Why is this important when dealing with this population of high-risk patients? Identify your personal biases, and work on them to improve your success as a nurse.

8. Consider how to implement one program in an urban setting that would address a patient population. How would it need to be different in a rural versus an urban setting?
CHAPTER 13

INSPIRE: PULMONARY REHABILITATION FOR PATIENTS WITH COPD
KEY QUESTIONS

1. Why is chronic lung disease pervasive in our country? What strategies are used to stem the growth of this chronic health problem? In a population health plan, what would you propose as an initiative that might be successful?

2. Funds for smoking cessation have limited availability in communities across this country. How would you advocate with legislators, insurance companies, and healthcare systems the importance of education?

3. Do you understand the physiology of addiction? Research how nicotine affects individuals. Children across our country are choosing to vape and causing damage to their lungs. What can the nursing profession do to stem this epidemic across our country?

4. Have you ever observed a pulmonary rehabilitation program? Identify why readmission rates dramatically decrease for patients who engage in the program and successfully complete it.

5. SVMC supported a “maintenance” program for patients following completion of the PR program. Why would this program be helpful? Are there alternative ideas for similar programs that could have the same impact?

6. COPD represents one of the major reasons patients are readmitted to hospitals across America. What creative strategies would you propose that may positively affect this population?

7. Many patients quit smoking for the duration of their hospitalization. How can we best bridge the gap to continue “no smoking” post-discharge? Many patients return to homes filled with smokers. How can we engage families and loved ones to support our patients?

8. One finding of the transitional care nurses was that COPD patients are often nervous, scared, and self-conscious about leaving their homes, especially if they require oxygen. What creative solutions can you suggest to educate and support these patients who may refuse to attend a pulmonary rehabilitation program?

9. Some patients have health plans that do not cover pulmonary rehabilitation or have expensive co-payments they cannot afford. How can we convince insurers this program is a successful population health strategy that should be covered?

10. Should a healthcare system in an all-payer, value-based payment system allow all patients who meet criteria to attend pulmonary rehabilitation as an investment in lower cost healthcare delivery for them?
LEARNING ACTIVITIES AND CLINICAL PLACEMENTS

1. Include pulmonary rehabilitation as a clinical site for student observation. Assign one patient for them to partner with and interview. Review medical records and trace the development of lung disease and trajectory. Use motivational interviewing to encourage the patient to complete the program and give up smoking permanently.

2. Have students review discharge instructions for a patient with COPD or lung disease. Observe the education provided by inpatient nurses and, if possible, partner students to make home visits with a home care or transitional care nurse. How prepared was the patient for discharge? What gaps existed in understanding of symptom management, medications, oxygen/nebulizer management? Were discharge instructions sent home helpful to the patient? What would work better? Design a more effective care plan for this patient.

3. Consider creating a COPD task force to decrease readmissions. Who would you invite to join the team? Who would lead the team? What data would need to be captured? If you could choose five areas to focus on, what would they be based on your observations?

4. Partner students with a respiratory therapist. Observe their interaction with patients who have chronic lung disease. Can nurses benefit from more education for this population to maximize education and support provided in inpatient setting? Is there a strategy across all clinical partners to support patients in quitting smoking?

5. Research smoking cessation programs in the literature. Design a program for your clinical setting to maximize success. Consider writing a grant proposal to obtain funding.

6. Meet with nurses in pulmonology outpatient offices to determine access to same-day appointments for patients calling with COPD exacerbations. Could this cause unnecessary hospitalizations and ED visits? What might be an innovative strategy as primary care and specialist access is a problem across our country?

7. Patients often listen to what their providers tell them to do. How might we get more providers to advise their patients to attend pulmonary rehab classes and quit smoking? What other incentives could increase patients following through with these initiatives?
CHAPTER 14

INSPIRE: DECREASING HOSPITAL READMISSIONS FROM SKILLED NURSING FACILITIES

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Skilled nursing facilities (SNFs) perform an important role in healthcare delivery. Seek an opportunity to visit and observe one and experience firsthand how it functions, and then explore the answers to these questions.

**KEY QUESTIONS**

1. Why is it important to understand SNFs even if that is not the clinical site you intend to work in?
2. Why is it important to connect with SNFs in your community to improve care coordination?
3. What challenges does the nursing home industry across the country face in these economic times?
4. What does the future hold as baby boomers begin to require skilled nursing home support?
5. Have you witnessed an elitist disrespectful attitude from hospital-based nurses toward nurses from SNFs? How did that make you feel? How can you ensure that you will never do that? Role-play crucial conversations with colleagues exhibiting disrespect.
6. Have you visited loved ones in an SNF? Are you aware of the number of patients each nurse cares for and each nursing assistant is assigned to? SNFs across the country struggle to be financially viable. Complete a literature review and determine why this is the case.
7. As baby boomers age, there are predictions that resources will not be available to absorb the need. How did this program lay a foundation for improved care delivery in the SNFs? Explore whether there is teamwork and collaboration happening between your health system and SNFs. What ideas do you have to improve this?
8. Nursing assistants are key members of the care team in SNFs. Many nurses begin their careers in this type of setting. What can the profession of nursing do to demonstrate more respect for this level of care provider?
9. How would you be successful implementing this program in SNFs? What key actions did Katharine take that helped achieve success with this project?
10. Are you a change agent or an impediment to new programs in your clinical site? Do a self-assessment and commit to a plan for self-improvement.
11. Evaluate the rate of readmissions for SNF patients in your community. What ideas could you implement that may improve this?
12. What population health strategies would you suggest in a value-based payment model to better serve residents of SNFs? What information should be provided to families and significant others?
13. Are you aware of partnerships between health systems and SNFs? How have they worked? What kinds of successful projects were they able to achieve?
14. Why are patients in SNFs more apt to be readmitted than other patients? List some actions that could be taken in your clinical arena to decrease that trend.

15. What is the value of STOP and WATCH in a nursing home? Imagine you are a nurse in that setting. How would things be different? Would quality outcomes be affected? Why?

16. Do you have an adequate understanding of the roles, responsibilities, and challenges of staff in SNFs? Why is it important that you gain an understanding to be a successful team player on the care team? (Plan to fill this void in your experience.)

17. What is shared governance? How did Katharine embed this in the culture change she was seeking to make?

LEARNING ACTIVITIES AND CLINICAL PLACEMENTS

1. Identify a readmission from an SNF. Perform a chart review, and trace the clinical pathway of the patient and potential opportunities for improvement along the way. Research literature regarding the impact on the elderly when moving from one unfamiliar setting to another. What ideas do you have to decrease this need? Are there innovative programs to consider?

2. Hand-off communication from each care provider can be a game changer. Observe the process in your clinical setting. Are there improved ways to accomplish this? Review the literature to find successful strategies.

3. The Interact program has been implemented in many locations successfully. Identify why this program works. Review the origin of the program and the physician who founded it. How did he come up with this innovation? Do you have ideas for other innovations?

4. As we face a shortage of potential beds for baby boomers, what other options might the healthcare system develop?

5. In Chapter 14 is a list of five factors that contribute to causing preventable readmissions. You are the unit manager in an SNF and have received grant funding to reduce readmissions. Create a work plan addressing each of these factors.

6. As a novice nurse with medical-surgical experience, imagine that you have accepted the position to implement Interact across community SNFs. What ideas beyond those presented in this chapter might be successful?

7. Part of the success of this project was empowering the licensed nursing assistants to function at the height of their training and education. Evaluate whether this is happening in a clinical unit you are working or training in. Develop a project that would accomplish this goal and transform care delivery. Include how you will measure it and how it may affect the rest of the staff in the SNF.

8. Imagine that you are a catalyst for change regarding an identified opportunity for improvement on your clinical unit. Develop a charter, and create a team with goals, objectives, and a timeline.
9. The foundation of success for this project was changing the culture and improving relationships, reigniting passion, and developing mutual respect and improved teamwork. Create a work plan for a real or potential workplace that could benefit from your leadership accomplishing these goals.

10. Develop a plan for SNF leadership to sustain and maintain the gains made in attitude, teamwork, appreciation, and respect by implementation of this project.
KEY QUESTIONS

1. Medication management is a key component to safe healthcare delivery. How can health systems across the country find more effective ways to manage medication delivery and patient compliance and tackle affordability for all patients and families?

2. The challenges of navigating with patients across the healthcare system and having sufficient knowledge to assist them with safe medication management and administration are huge. What are the critical components to success? Have you seen systems that are working in clinical settings?

3. Polypharmacy is a growing problem in our country. Many patients are discharged with prescriptions they are unable or unwilling to fill due to cost, lack of transportation, or fear of side effects. When asked if they are taking the medications via phone call or office visit, they often do not tell the truth. What impact could this have on their care?

4. Deprescribing is a relatively new term in healthcare delivery yet a critical component to decreasing the cost of care in our country. Have you observed this to be a routine part of medical management of care? Evaluate how this could be a standard procedure for patients across our country. Is there a potential for harm caused to patients if we do not have such a program?

5. Pharmacists are required to have a vast knowledge base for thousands of medications that are changing daily. How could nurses and pharmacists collaborate, demonstrating potential value to both parties?

6. The government allows hospitals and health systems to enroll in a 340B reimbursement program. Research this program and determine what impact it has on healthcare costs in our country. Interview a CFO or pharmacy director to explore their perspective about this program. What is the future of 340B? How would it affect your hospital? Other hospitals?

7. What data could be collected to support the role of a clinical pharmacist as a key partner for successful care coordination and population health? What clinical data should be collected to demonstrate success?

8. As thousands of people in our country struggle with addiction, what role could clinical pharmacists play in providing support for this population? Would it be possible for them to help with deprescribing high-risk addictive medications?
LEARNING ACTIVITIES AND CLINICAL PLACEMENTS

1. It is critical for nurses to embrace the value of the clinical pharmacist for effective care coordination. Partner students with the clinical pharmacists in nontraditional and traditional roles and evaluate how the profession has evolved based on a literature search.

2. Find a family member, neighbor, or friend who may benefit from your help in establishing a system to better manage their medications. Research available systems and partner with your “patient” to implement the best system to support their success going forward. Do not be alarmed if you are overwhelmed with the responsibilities and complications you will encounter.

3. Research the potential role of clinical pharmacists if they were supported to work at the height of their licensure. Complete an analysis of the pros and cons and potential roadblocks that could sabotage support for this initiative in our country.

4. Observe and evaluate the system for educating patients on new medications and discharge planning and education provided prior to discharge. What is working? What is not? Make suggestions for improvement using a literature search of cutting-edge research across the country.

5. Observe patient care in an ambulatory primary care practice. Trace the process for medication management and assess the efficacy. List your concerns and then propose a new system to decrease potential harm to patients and unsuccessful treatment of diseases and illness.

6. Attend a daily interdisciplinary round in your healthcare setting. Who attends the rounds, and what is their role? Who is missing and should be there?

7. Trace the process of medication education for patients in your setting. Ideally follow the patient from home to hospital, to rehab/SNF, doctor’s office, and then back home. How many medication lists were created, and how many discrepancies did you find? Could this have caused patient harm? Design a system that could remedy this healthcare delivery nightmare.

8. Determine if placing clinical pharmacists in PCP practices could ever be a cost-effective strategy in our country as we attempt to shift the payment system and decrease waste, duplication, and non-value-added meds, treatments, and supplies.

9. Research new techniques for retail pharmacies to deliver and improve medication management for the population of people we serve. Are there other opportunities for nurses and pharmacists to work more closely together to benefit patient care?
CHAPTER 16

INSPIRE: PEDIATRIC COMMUNITY CARE TEAM
KEY QUESTIONS

1. Are you aware of the statistics in your community regarding health status, access to social determinant of health, and issues facing high-risk families? Why is it critical that nurses across the country embrace the critical nature of this information?

2. Families across our country spend little time in the hospital setting. A focus on pediatric primary care practices is essential for the improved health of our children, yet many children are receiving care in urgent and express care locations with no primary care provider connection. What impact could this have on the health, wellness, growth, and development of our population?

3. What supports are available in the school system for at-risk children with mental health and behavioral issues in your community? What systems are in place to keep them and all the other children and staff safe? Have a conversation with an elementary or middle school faculty member and hear their perspective.

4. Is there a current, complete resource list for children’s services in your community? Are nurses in schools, the ED, pediatric practices, home care, and day care settings aware of them and referring to them appropriately? Do these partners work closely with each other?

5. As we try to improve care coordination across our country with the advent of value-based payment models, how do we maintain patient privacy and patient rights yet still find ways to access appropriate timely care for children with critical needs?

6. What strategies may be effective when trying to get agencies to work more collaboratively? How do we demonstrate that it can save time, resources, overlap, and duplication and be more effective? What is your strategy if they continue to refuse to engage?

7. In our rural community setting, families with special needs must travel for evaluations, treatment, and appointments with specialists required for their child’s care. This is financially impossible for many of them, which is delaying diagnosis and treatment and negatively affecting outcomes. As a nurse advocating for their patients, how can we influence this issue to maximize successful outcomes?

8. Pediatric care providers across the country are overwhelmed with how to meet the basic needs of high-risk families and still provide appropriate, timely medical care. What support systems should be available to support this need, and how can the cost be covered?

9. Our health system did not have a thorough understanding of the large number of at-risk families living in our community. Evaluate whether your health system has that same issue. What strategies may work to enlighten administrators, public service, government workers, legislators, and select boards to partner with you to make a difference?

10. Our community struggled to make headway with creation of a PCCT for 7- to 19-year-olds because many of the partners worked in silos and were reticent to share information. What agencies would need to come together for this age group, and what tactics could we use to improve outcomes? What critical partners would play a huge role in our success? What outcomes could we measure?
LEARNING ACTIVITIES AND CLINICAL PLACEMENTS

1. Partner students with a high-risk family in the community. Use a screening tool to determine social determinants of health as well as social and safety issues. Determine community partners engaged with family now and potential and appropriate future referrals. Involve pediatricians and charge nurses to assist with a plan for interdisciplinary meetings to coordinate care. (If this is not feasible, create an imaginary plan to better meet the needs, including improved outcomes as a result.)

2. Melissa (PCCT family advocate) works closely with school counselors and nurses to support high-risk families. Perform a literature review to find evidence of creative, successful programs across the country that could be considered for the future.

3. Assign students to prepare a presentation to the select board advocating that future decisions made be focused on improving the health and wellness of the community. What kinds of data would you need? What examples would you share of decisions that would make a difference? Review the literature to support your evidence available during the presentation.

4. Assign students to evaluate the care of children with behavioral health issues in the ED. Are there alternative places to safety transport children and families? Interview staff from various agencies to determine if they have potential ideas for the future. Perhaps you can be the catalyst for change.

5. Recently, evidence demonstrated that social media and screen time are causing increased depression and anxiety for children. How could nursing as a profession take a lead role in educating the public and mobilizing a plan to stop this “epidemic” in our country?

6. Partner students with a patient advocate in your health system. Observe the issues that arise and the wisdom of experienced patient advocates. How could this be translated into a PCCT at your setting?

7. In some cases, no matter what steps we take and partnerships we make, we are not successful in making a positive impact. How can nursing chart a course for the team while not losing faith in the process and moving on to other needy families?

8. Research what bills are being considered in Congress that support children in our country. Write a letter of support for one of the bills that you believe in, and mail it to a legislator. Consider posting it on social media or publishing a letter to the editor.

9. Parent education, advocacy, money management, healthy cooking, and parenting classes are critical needs in many communities with low income, needy families. Seek a grant that might support funding, and consider submitting it in partnership with other agencies.

10. Find a professional nursing organization in your state and become a member. Explore if they have a legislative advocate or lobbyist to support bills that promote health and wellness to support families. What bills are pending, and how might you get involved? Interview the lobbyist, and observe for a day the lobbyist’s role at the statehouse.
11. This is the Year of the Nurse and Midwife (2020). What can the profession of nursing do to better care for high-risk families and children in our country?

12. Research what other developed nations do to care for their children that results in improved health, wellness, and quality of life. If they can do it, why can’t we? Develop a plan for the future, and look for opportunities to make it happen.
KEY QUESTIONS

1. This program started when a registered nurse in an outpatient primary care practice saw a need and found a way to trial a solution to improve outcomes. She used the preliminary evidence to secure funding to expand to three offices and prove that it worked. What problem do you witness every day that needs a solution led by a nurse? Identify one issue and make an innovative plan that just might work. Extra credit if you actually pitch your idea to an administrator who may be able to support you moving forward.

2. The rate of pre-diabetes continues to escalate across our country. Reviewing the data and literature, what is the reason for this? What strategies can be deployed to stop this alarming trend?

3. The pre-diabetes program highlighted in this chapter is one year in length. What is the reason for that? Is it reasonable? Do you have other suggestions? Who should be educated about avoiding diabetes diagnoses? Who should provide the education? Would you commit to a one-year program? How could we get more people to agree to participate?

4. Can diabetes education be provided by nonclinical staff? At what point would a CDE nurse or CDE dietitian be preferred?

5. The treatment options for diabetes management and treatment are continually expanding with new testing, treatment, and monitoring equipment available. This presents a challenge for a busy primary care provider trying to juggle multiple, competing demands. How do the diabetes TCNs support primary care to improve management of diabetes?

6. Access to endocrinologists across community hospital settings is a challenge. How would you propose providing access to specialty care while maintaining fiscal economy? Research what other communities are doing to support diabetes management.

7. Type 1 diabetes patients tend to be frustrated and angry with their chronic disease and its ramifications on their life. What strategies could assist them to embrace the reality and keep a positive attitude to maintain their health?

8. Research on diabetes management continues to evolve and grow. Research the latest advancements and see how they are working in the literature. Are insulin pumps improving long-term management and resulting in fewer life-altering complications? What is the potential downside of using pumps?
LEARNING ACTIVITIES AND CLINICAL PLACEMENTS

1. Assign students to patients with diabetes or pre-diabetes. Interview them to find out their depth of knowledge and understanding and how they received that information. Review their serial AIC reading. Are they aware of the results, and do they understand what to do to help them improve over time?

2. A new program called Food Farmacy was successfully implemented in some communities across the country. Patients with diabetes who also have food insecurity can join a support group that provides 10 meals per week for a family of 4. This group process has demonstrated improved management of diabetes, including assisting family members in making healthy choices, decreasing their chances of developing diabetes. Research this program and determine what makes it successful. Find a way for us to hardwire this into care delivery for other diabetes patients with an innovative solution.

3. The diabetes educators highlighted in this chapter build relationships with their patients, meeting them where they are without judgement. They become the “coach” to assist them in taking charge of their health. Why is this different from traditional chronic disease education? If possible, assign your students to observe a diabetes/health educator and witness firsthand why motivational interviewing is different from what healthcare workers traditionally do.

4. Access to healthy food is a key component to diabetes management. Consider creative strategies in your community to maximize access to fruits and vegetables, cooking classes, and positive reinforcement for the progress they make.

5. One creative strategy being considered for deployment is called “Messages for Me,” which are auto-generated inspirational texts sent to patients three times a week once the patients consent to receiving them. The texts provide gentle reminders, key educational tips, reassurance, and caring. Research this program and consider what kinds of messages could be a part of the diabetes management “Messages for Me” program. Consider implementing it in your community.

6. Research the success of pre-diabetes education programs to decrease the conversion of participants developing diabetes Type 2. Design a marketing plan to get more participants to commit to the program.

7. In community hospital settings, access to endocrinologists is challenging. What creative strategies with telemedicine have been successful across the country? How do patients like using telemedicine instead of onsite, in-person appointments?
**KEY QUESTIONS**

1. Consider a muscular-skeletal injury you or a friend or family member experienced. Was your pathway to treatment efficient, maximizing your return to work and functioning, minimizing the need for narcotics to deal with pain management? Were you prescribed physical therapy? Would the trajectory have been different if PT saw you immediately after the injury?

2. Physical therapists are trained to assess and treat many injuries and problems yet often are not used when they can maximize recovery. Review articles highlighted at the end of Chapter 18 to hear the stories of successful programs across the country. What compelling information do you find? Perform a literature search to see what new studies may be published.

3. Access to primary care is at a premium across the country. Many patients seen in the ED are told to follow up with their PCP in 7 to 10 days. Data demonstrates that this can be non-value-added and occupy PCP appointments that could serve patients with exacerbations of chronic disease who are unable to be seen (and often end up in ED or admitted to the hospital). Evaluate PCP access in your service area, and discuss with practice managers what constitute non-value-added visits that decrease access for acute patients.

4. Physical therapists also have training in wound management and vertigo assessment and treatment. How might outcomes be different based on the presence and availability of that resource in the ED?

5. Frail, elderly patients are often discharged from the ED to home without adequate assessment of safety. Physical therapists can be instrumental in avoiding unsafe discharges that could result in falls and readmissions. What value do they bring?

6. Patient surveys for patients with access to PT in the ED were excellent. Why would that be the case? What is different from the traditional management to this additional team member?

7. According to most sources, patients should be receiving home exercise programs when they are discharged after an injury. This ensures the opportunity for patients to begin making therapeutic gains immediately and avoid immobilization that could result in long-term problems and chronic conditions. Have you received information on exercises from the ED or primary care provider?

8. Chronic back pain is an ailment afflicting millions of people across the country. Tracing the usual trajectory of traditional treatment included prescribing muscle relaxants, narcotics, and bedrest. This would be contrary to evidence-based practice for physical therapists. Could referrals made sooner to PT have an impact on chronic back pain, opioid addiction, and immobility?
LEARNING ACTIVITIES AND CLINICAL PLACEMENTS

1. Interview three patients with a history of muscular-skeletal injuries who believed their treatment took much longer than necessary. Map out the time of injury and each step of the diagnosis and treatment program. Do you see trends? Were there substantive changes in treatment at each step that caused improvement?

2. Review the education completed by doctoral-prepared physical therapists. Is it possible that their depth of expertise might be value-added in locations where multiple patients are seen with injuries? Using average cost for various treatment, appointments, and modalities, would overall cost savings be achieved by this change? Would improved patient satisfaction scores, decreased absenteeism from work, and decreased prescribing of narcotics be additional benefits (evidence of all disciplines working at the height of their licensure)?

3. Partner nursing students with physical therapists in any location. Observe the level of knowledge and expertise, including appropriate exercises to maintain strength and mobility, use of assistive devices to maintain safety, and concrete assessment for safety of patients discharged to home. How could other disciplines affect population health by practicing at the height of licensure and ability?

4. Do ED physicians and associate providers give exercise instructions to patients discharged from ED with muscular-skeletal injuries? Observe and compare what an experienced PT will do to ensure patients do not lose function and negatively affect outcome.

5. Review the data of patients with chronic pain who have been treated with narcotics for decades. Consider how the use of this resource might short-circuit the development of reliance and addiction to narcotics. Exercises, stretches, ambulation, flexion, heat, ice, and meditation can be effective strategies that avoid confrontation with providers demanding narcotics. Map out two different management strategies of patients, and evaluate the differences in cost, satisfaction, and long-term effects.

6. Complete a chart review in an orthopedic practice and trace the trajectory of care provided prior to referral to an orthopedist. What percentage were referred to physical therapy? How often was PT the discipline recognizing the need for a higher level of care? How many other visits, medications, missed work time, and immobility could have been potentially avoided?

7. In a fee-for-service model, many contracts required evaluations by PCP prior to physical therapy/orthopedist referrals. As we evolve to value-based payment models, does that make sense? As we face PCP shortages and lack of access for new patients, we need a new plan. Construct a plan to hardwire this in the care delivery system in your “new” integrated healthcare system.
KEY QUESTIONS

1. Healthcare workers across the country do not understand the difference between palliative and hospice care. What strategy would bridge this gap and expand appropriate referral and utilization? What was the strategy used in this program at SVMC?

2. The all-payer model focused on value instead of volume incentivizes supporting patients to make informed decisions about their healthcare based on their goals for the future, not based on a medical model of care delivery. Are there outcome measures that could help providers break previous habits of making decisions for patients without a thorough explanation of all options? Would this matter if provider pay is still based on RVUs and volume and not outcomes or quality?

3. Vermont had one of the lowest referral rates for hospice in the country. Recently, it had the highest rate of growth. Could this be connected with the evolution of the payment model in the green mountain state?

4. End-of-life conversations when treatment options are limited are always challenging. Certainly, as providers are forced to juggle more patients in less time, and PCPs do not round in the hospital with hospitalists taking over care, opportunities for timely conversation can be postponed. Some health systems conduct daily interdisciplinary rounds where care team members discuss how best to meet the needs of the patient/family. This can be an ideal time to explore options like palliative care. What impact could the addition of a palliative care nurse bring to PCP offices and SNFs? Map out why this would be a good investment in a value-based payment model.

5. Strong connections between palliative care and hospice care are essential because many patients eventually may require that service. Consider ideas that have the potential to create strong partnerships to support patients across the community.

6. Southwestern Vermont Medical Center’s readmission data demonstrated that 25–30% of patients readmitted had chronic disease that was no longer responding to treatment. What strategy would help providers to appreciate the benefit of palliative care referrals for these diagnoses? Design a presentation to help leverage this successful strategy to improve patient and family quality of life.

7. Many patients choosing palliative care live longer than they ever expected. Review the evidence about this phenomenon and consider interviewing a patient who experienced this to inquire what they attribute it to.

8. Palliative care can be emotionally exhausting for the staff involved. What strategies would assist nurses in palliative care to rejuvenate and stay refreshed in their specialty? Review the literature to see if there have been studies to demonstrate success.

9. Sometimes seeing is believing. How can we help care providers not embracing the value of palliative care to witness the difference it makes? Should we share special stories we have witnessed or participated in?

10. How can the nursing profession affect crucial conversations happening across the country with loved ones to avoid decisions made in a crisis without guidance from those loved ones? Explore successful programs nationwide and consider implementing one in your health system or community.
LEARNING ACTIVITIES AND CLINICAL PLACEMENTS

1. One of our biggest challenges is limited access to hospice inpatient care and hospice house for patients not able to be cared for at home. Consider the tenets of value-based payment reform and make a case for a hospice house to serve patients nearing end of life.

2. Partner student nurses with a palliative care or hospice nurse to witness the journey they travel with patients and families. What techniques work for conversations with families who do not agree on the best decision? Who ultimately should make the decision? How does the nurse support that happening?

3. Review palliative care literature and evaluate data and outcomes measures used in their analysis. Would sharing this data be compelling to providers and care team members you are trying to convince? Is that something that patients and family members would want to see to assist with decision-making?

4. Palliative care nurses need a certain skill set that some do not possess. Make a list of questions you would ask to assess their fit for the position. What questions might you include that demonstrate the skills they have with crucial conversations, dealing with difficult patients and families, and patient advocacy with physicians or other care providers?

5. Have you witnessed an ideal palliative care/end-of-life experience for a patient or loved one? Describe what made it work and why it was special. How can we support other families to be able to experience that? What questions should we ask to help it happen and meet the person and family needs?

6. Practice what you preach. Are you aware of your family and loved ones’ wishes? Do you feel comfortable having those discussions? What support material would be helpful? Have you shared your wishes with appropriate parties?

7. Do you have a completed healthcare proxy? If not, complete one at your earliest convenience. It is a labor of love for your family.
KEY QUESTIONS

1. An Accountable Community of Health requires considering the impact of social determinants of health on outcomes of care delivery. Have you witnessed an increased focus on collecting this information across healthcare and community settings? Are there systems in place to correct the problems identified? Are there additional resources available to connect families with assistance?

2. The RiseVT program highlighted in Chapter 20 is based on a program called EPODE focused on decreasing childhood obesity. How long would it take to see the results of a program such as this? In our country, who will continue to fund such a program? Does it fit in with the ACO and ACH model, and will it be essential to our success being achieved?

3. Why would amplify grants be a good strategy to get the word out about RiseVT and gain support from the community? If you were to identify a program to benefit from such a grant, what would it be? What outcome could be measured? How might your idea be sustained after grant money was done?

4. Prior to the RiseVT project and other population health initiatives, many of us were unaware of the large number of patients and families with food insecurity, housing issues, transportation issues, and no heat or hot water. Think about your own community. Are you aware of the status of children and families, housing, food, transportation, access to medical care, childcare, and safety? This is critical information to build an Accountable Community of Health.

5. Every year, people are hungry in our country, yet we waste food all the time without consideration for the families in need. Communities across the country are beginning to work together to find strategies to glean food and make it available to those in need. Imagine if retired people from across our country took charge of this critical need and volunteered some of their time to make it right. What is your community doing? Find out the facts and start a movement.

6. Do you have community health workers as part of the workforce on your team? What is their role? How is it supervised? What new ideas could be created to maximize their benefit? What training programs are available? What training should they have?

7. Innovative programs require innovative solutions. Would you reach out to an existing company and request they expand the scope of their product to meet your needs? Consider information you would need for the call and your strategy to convince them they should do it.

8. Screening programs are being trialed across the country to establish the efficacy of connecting patients with assistance immediately and potentially building relationships. The SBIRT and YSBIRT programs appear to be effective in our pilot projects. Why is this working? Do patients often not follow up if they are provided with information on who to call for an appointment following an ED or PCP visit? Why and how can we make it better?

9. In communities across America, why are healthcare systems choosing to get involved with downtown redevelopment and revitalization projects? See if you can find data on whether this is a good investment.
10. What are your hopes and dreams for healthcare and care coordination in the future? Dare to dream and then do! It just may become a reality some day!

LEARNING ACTIVITIES AND CLINICAL PLACEMENTS

1. Connect students with community partners involved in care coordination or social determinants of health. Have students explore how we can work more closely together to meet a need in the community that would be mutually beneficial. Create a project with deliverables and data that would demonstrate success.

2. Evaluate the waste of food in your community. Consider convening a group of stakeholders willing to help you make an improvement plan. Where would you find stakeholders? Who would you invite to the meeting? Where would the funding come from? How would you measure success?

3. Go to the RiseVT web page in Colchester, Vermont (Northwestern Hospital) and complete the health quiz. Witness how their program works and what success they have experienced to date. Is this something your community could benefit from?

4. Think of patients presenting to the ED, urgent care, or pediatric practice. Might they be open to being helped at that moment if it were available? If they are feeling worried, vulnerable, and in need of help, isn’t it a good strategy? How many patients receive referral information in the ED, urgent care, or doctor’s office and never follow through? Isn’t it worth a try? Review the literature and published results.

5. Explore literature regarding the Medically Tailored meals project. Evaluate whether this should be a model implemented across the country. Why or why not?

6. Remote monitoring for COPD patients was not a successful program in Bennington. Review the literature and see if this is a trend across other states. Is there data regarding use of spirometry? Is there any new data from the US about remote monitoring for pregnant women for hypertension and diabetes?
FINAL THOUGHTS

The author sincerely hopes that this guide offers faculty an opportunity to engage students across the country in the transformation of healthcare and payment reform in the US. Nursing is the most trusted profession with the education, knowledge, expertise, and compassion to chart the course for our future to meet the Triple and Quadruple Aim. This responsibility rests with the next generation of nurses to lead change and advance health as charged by the IOM in 2011. This guide sets the stage for:

- Nurses assuming a leadership role in changing the existing healthcare delivery system
- Nurses practicing at the height of their licensure
- Educational systems preparing nurses for a focus on wellness, prevention, population health, diversity, and improvements in healthcare outcomes