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Optimizing Strategies for Care Coordination and Transition Management: Recommendations for Nursing Education

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The purpose of this descriptive qualitative study was to explore nurse and healthcare leaders' experiences and perceptions of care coordination and transition management (CCTM®). Four barriers emerged that added insight into the lack of adopting and integrating CCTM knowledge, skills, and attitudes in nursing education in the following categories: curriculum redesign, silos of care settings and care providers, knowledge gap, and faculty development/resistance. Recommendations and implications for education, for both nursing students and practicing nurses, are described.

In the United States, individuals with multiple chronic conditions often require care from numerous healthcare providers and in a variety of settings. Chronic diseases are responsible for 7 of 10 deaths each year and treating people with chronic diseases accounts for 86% of our nation's healthcare costs (Centers for Disease Control and Prevention, n.d.) Eighty-eight percent of U.S. healthcare dollars are spent on medical care that only accounts for approximately 10% of a person's health. Other determinants of health are lifestyle and behavior choices, genetics, human biology, social determinants, and environmental determinants, accounting for approximately 90% of health outcomes (Lobelo, Trotter, & Heather, 2016).

Many individuals struggle with multiple illnesses combined with social complexities such as mental health and substance abuse, extreme medical frailty, and a host of social needs such as social isolation and

homelessness (Humowiecki et al., 2018). Delivery of healthcare services continues to employ outmoded "siloed" approaches that focus on individual chronic diseases (Parekh, Goodman, Gordon, Koh, & The HHS Interagency Workgroup on Multiple Chronic Conditions, 2011). However, individuals with multiple chronic conditions present to the healthcare system with unique needs, functional limitations, and/or disabilities. The evidence on how to best support self-management efforts in those with chronic disease is in early stages of development (Grady & Gough, 2014).

As persons with multiple chronic conditions transition between healthcare providers and settings, there are many gaps and errors that can and do occur. Incomplete transfer of information is a major factor in such gaps and errors. Effective care coordination and transition communication is an expectation of quality patient care. Adverse events and risk exposures occur due to

ineffective care coordination and/or poor communication during care transitions. Poor communication among healthcare providers and lack of shared information about patients result in under-treatment, suboptimal therapy, adverse drug events, and hospital admissions or readmissions (Levit, Balogh, Nass, & Ganz, 2013). Up to 49% of patients experience at least one medical error after discharge, and one in five patients discharged from the hospital suffers an adverse event. Improved communication among providers could prevent up to half or more of these events (Society of Hospital Medicine, 2019). One in five Medicare patients discharged from hospitals are readmitted within 30 days, and 34% within 90 days (Brown, 2018; Robert Wood Johnson Foundation, 2013a, 2013b).

Recognizing the potential for registered nurses (RNs) to contribute to enhanced quality and cost effectiveness through care coordination and transition management (CCTM[®]), a translational research project was completed. The project identified evidence-based dimensions and competencies of CCTM that guided development of a care model provided by RNs. The development of the CCTM RN model and role are described in an article by Haas, Swan, and Haynes (2013). The nine dimensions of CCTM are:

1. Support for self-management
2. Education and engagement of individuals and families
3. Coaching and counseling of

- individuals and families
4. Advocacy
5. Population health management
6. Teamwork and collaboration
7. Cross-setting communication and transition
8. Person-centered care planning
9. Nursing process (Haas, Swan, & Haynes, 2014).

CCTM practiced by RNs in all settings across the healthcare continuum has the potential to guide acute care practice and discharge teaching/planning, facilitate care transitions between different providers and settings of care, provide surveillance, and support persons with multiple chronic conditions as they live at home or in assisted living, or receive home care within the community and cope with self-management of their health and health care.

The question was raised: How are nursing students and practicing nurses educated for a variety of positions in coordinating care and managing transitions in all care settings across the healthcare continuum? Belief that CCTM education needs to be a major part of pre-licensure education and continuing education of practicing RNs led to initiating the Care Coordination and Transition Management Invitational Summit in spring 2018. The focus of the summit was to identify ways to enhance diffusion and adoption of the CCTM RN model. The development and conduct of the summit are described in the January/February 2019 issue of *Nursing Economic\$* (Haas &

Swan, 2019), this article describes recommendations for nursing education, and a third will describe recommendations for practice and policy.

Methods

Design

A descriptive qualitative design utilizing focus groups was used to assist in creating a strategic, collaborative agenda intended to facilitate adoption of the CCTM role for RNs in all practice settings across the healthcare continuum. The summit objectives included: (a) convening focus groups to identify strategies to increase the understanding of the sophistication of the practice of CCTM and its adoption by healthcare organizations, (b) providing a forum for individuals and organizations to share successful outcomes following CCTM implementation, and (c) developing actionable recommendations related to integrating CCTM in education, practice, policy, and research. In this article, pre-licensure nursing education recommendations that evolved in the analysis of the first round of focus group data will be examined, as well as recommendations for continuing education for currently practicing nurses.

Sample and Setting

To explore nurse and healthcare leaders' experiences and perceptions of CCTM, 41 individuals participated in focus groups on May 12, 2018, in

Lake Buena Vista, FL. Three rounds of focus group sessions were held; there were five groups with six to seven participants in each group resulting in transcripts from 15 sessions. Rotation schedules for each session assured participants interacted with different attendees in each session. Attendees represented a variety of organizational perspectives including hospitals, ambulatory care settings, professional nursing associations, academic institutions, action coalitions, and other healthcare and consumer organizations.

Data Collection

Focus group questions were developed by the co-investigators and informed by the literature and a pre-summit survey as described previously (Haas & Swan, 2019). The questions were designed to inform a collaborative and strategic agenda to enhance adoption and integration of CCTM into nursing education (BSN and continuing education for RNs preparing for CCTM roles). Research questions were:

- What are the major barriers to adoption and integration of CCTM in nursing education?
- What strategies could be used to overcome such barriers?
- Who would be the major stakeholders who would need to collaborate on enhanced adoption and integration of CCTM in nursing education?
- What strategies could be used to bring these stakeholders in as collaborators?

- What could be used as perceived incentives/benefits of adoption and integration of CCTM in nursing education?

Each focus group was convened by a facilitator, recorded using digital recorders, and augmented by notes taken by flip chart recorders. At the conclusion of the focus groups, all participants were given four colored index cards and asked to write actionable recommendations for education (pink), practice (blue), research (green), and policy (yellow).

Ethical Considerations

This study was approved by the Thomas Jefferson University Institutional Review Board. One of the investigators read the consent as a paper consent was distributed to all participants describing the study, its risks and benefits, and instructed participants the content of the focus groups should remain confidential. All participants were asked to provide verbal consent.

Data Management and Analysis

All sessions were digitally recorded and transcribed verbatim. Transcripts were de-identified and stored in a password-protected computer, and all recordings were deleted after transcripts were checked for accuracy. The two co-investigators plus two researchers with qualitative analysis expertise completed a line-by-line reading of the transcripts from the five groups. Following this reading, all four researchers identified categories,

sub-categories, and associated quotes independently. Saturation was achieved after reading the content from three of the five groups. Analysis of transcripts was facilitated by NVivo12 software (QSR International, Doncaster, Australia). Following procedures outlined by Creswell and Poth (2017), inter-coder agreement was established between the four researchers. Code comparison results from NVivo revealed 87.2% to 100% agreement among coders.

Results

Barriers to Adopting CCTM RN

Focus group participants identified 57 barriers, which were further categorized into four key barriers with sub-categories. The four barriers were curriculum redesign, silos of care settings and care providers, knowledge gap, and faculty development/resistance.

Barriers to curriculum redesign. In addressing curriculum redesign, several participants pointed out the issue of full curricula resulting in schools having to decide what parts of the curriculum to cut in order to add new content “sort of full curriculum. I know, just even a few of our partner universities, it’s really been discussed that they had to cut down the number of credit hours, and what did they end up cutting? They cut ... community, value-based, and ... the very things that are up and coming.”

Participants also identified multiple sub-categories of barriers to curriculum design, such as accreditation, certification, external regulators, education, and culture. One participant stated, “So what do we need for accreditation? And when you think of the baccalaureate essentials, I would argue that, yes, they’re in there, but do we need it more defined? And so that comes into how you manage your curriculum and what you put in there because, really, your curriculum should loop back to, obviously, meeting those essentials.”

Another participant added, “I also think there’s potential barriers with the Board of Registered Nursing in your states ... any time we have a perceived curriculum revision or change, there’s often, or at least in our state ... it’s a huge barrier.” Education barriers were further categorized into pre-licensure, post-licensure and on-the-job residency programs including continuing education requirements. Participants also discussed the need for a cultural shift among faculty away from silos of care to a broader approach incorporating care across the continuum.

Silos of care and care providers. One participant stated, “I would add the silos of care as a barrier,” another added, “Because the educational needs or the goals of the different silos are different and disparate. So that creates a problem from an educational perspective.”

Participants reported concerns with focusing

curriculum to meet the needs of the specialty areas of care, for example, “Not enough time in the curriculum, too many things to stuff into the space ...” Some participants also tended to limit CCTM to ambulatory care and did not appear to see that CCTM can and should be used in all care and settings across the continuum.

Knowledge gap. Participants identified different dimensions of the knowledge gap barrier. This barrier was characterized as a general lack of awareness about the CCTM RN model and lack of knowledge and understanding. One participant stated, “I think one barrier is lack of knowledge from the academic side ... do faculty really understand the importance of this [CCTM] and the impactfulness of this [CCTM] on patient care? So, if they’re not invested, then it’s not going to get into the curriculum.” In addition, a similar knowledge gap exists among currently practicing RNs.

Faculty development/resistance. One participant summarized the resistance among faculty in pre-licensure settings, “Not enough time in the curriculum, too many things to stuff into the space; this concept of integrating through. They were extremely resistant to that. Just let me teach another three-credit course, which is not how Quality and Safety Education for Nurses (QSEN) was meant to be because it’s nursing safety, nursing community owns that as a core responsibility.” QSEN was developed in 2005 to address

the challenge of preparing future nurses with the knowledge, skills, and attitudes necessary to continuously improve the quality and safety of the healthcare systems in which they work (Cronenwett et al., 2007). This participant also indicated that overcoming the lack of time and resources were important contributors to faculty resistance. Participants indicated that faculty will require additional training, “...and I would add faculty to that because they have not practiced, therefore, they don’t know how to prepare the next generation of nurses” and “I was thinking that these are harder skills to teach because a lot of these things are much more dynamic processes than just let me teach you a specific skill or how to do a particular thing.”

Strategies for Overcoming Barriers

Many of the strategies to overcome the barriers centered on the four key barriers, as well as the sub-categories identified in the previous section. For example, strategies to overcome curriculum design, education, faculty development, and silos of care were posited in areas of collaboration, incorporating strategies across curricula, role clarification/adaptation to culture change, and dissemination of knowledge.

Incorporating across the curriculum. Strategies to address the curriculum redesign barriers included suggestions to integrate CCTM into the curriculum across all areas. One participant mentioned that faculty should

be given well-organized exemplars to help them integrate CCTM into the curriculum and understand its importance in nursing, “For helping faculty or for educators ... you have looked at the competencies needed for this ... to help faculty integrate it, there need to be very good exemplars.” Another strategy, according to the focus groups, is to standardize education within health care for nurses who are already employed in order to ensure they become familiar with CCTM and the role of nursing in facilitating a smooth transition. As stated by a participant, “We have to figure out a way to standardize education for our employees.”

Collaboration. Participants within all groups reported that collaboration across the silos of nursing practice and providers may have a major impact on overcoming barriers to implementing CCTM into nursing education. According to the focus group members, collaboration needs to be part of all levels of nursing, including the various academic nursing roles such as the deans and faculty who teach at universities and colleges in undergraduate and graduate schools, “...when we talk about the faculty, faculty at all levels. So, you’ve got your undergraduate faculty, your graduate faculty, and then the DNP (doctor of nursing practice) faculty.” Health care also needs to enhance collaboration and standardize care coordination at all levels: from chief nursing officers to nursing educators and

nursing staff. “At the local level ... you get all this education done ... in the colleges and universities, we have to figure out a way to standardize education for our employees. So, at the employer level, what do they do for each and every RN and each and every – I would even say MA and LPN ... and our care managers, and social workers, what do we do at our institution that standardizes it across.”

Dissemination of knowledge. Participants from all groups discussed the importance of disseminating knowledge about CCTM at various levels in nursing. One participant, while acknowledging lack of funding, suggested a branding campaign to disseminate knowledge, “... because you’re so far ahead of everybody. And I just don’t know how deep the knowledge is that people know.” A second participant stated, Dissemination ... can’t just be by academics ... it really should have a strong influence from clinical and from all various different disciplines and different types of service lines.” In addition, providing “... data from the outcomes measures ... you’ve got to show the data because everybody lives and dies by those readmission data, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) data, and even the military and the VA get reimbursed by Medicare ... and so, you have to show the value of this through the data as part of the strategy.”

Role clarification and changing the culture. A fourth

strategy mentioned during the focus groups to address barriers is to clarify the role of nursing in CCTM and to change the culture within nursing education. A participant stated, “this is in all settings ... all RNs really own a piece of this. So somehow a strategy to get that messaging out. Everybody’s going to do this, here’s your stuff you need to get done, here’s your learning modules.” The participant went on to say that a majority of their nurses were more inclined to say, “... that’s not my job” when in fact, “... you educate, you talk to that patient all the time, you’re constantly offering suggestions for their care.”

According to the focus groups, clarifying the role of the nurse includes articulating the impact nursing will have on the CCTM implementation process. This role clarification must be combined with efforts to change the culture of health care. Clarifying the role of nursing and changing healthcare providers’ perceptions of this role providing CCTM will represent a major leap in helping facilitate care coordination. It is important nurses see their impact in all levels of care coordination across multiple settings of health care, such as inpatient and outpatient care. “First of all ... with a loss of primary care providers, nurses are the ones that are really going to be doing the care coordination.” Nursing attitudes were also mentioned as a barrier.

Participants stated that clarifying roles and promoting

culture change will make a key impact on the role CCTM will have in health care. Practice and policy change were also discussed during the focus groups as a form of changing culture within health care. Participants mentioned that practice and policy updates will allow health care to move forward from outdated practices and policies and will promote CCTM, which in turn will promote positive outcomes for patients. One participant stated, “Our practice needs to change the policy because that’s dated now. The movement is such that we need to hire new grads in an outpatient setting. So, I think we need to go back to nurse execs and look at what is our policy right now for hiring new grads? And can we reach out to these schools and say, hey, listen, we are hiring new grads.” Yet another spoke to the changing policy and collaborating with clinical practice coordinators to allow students to work in various practice settings previously denied to students and new graduates, “I mean moving people into intensive care units right out of school ... But the other issue that we have that I’ve experienced is clinical placement coordinators not allowing nurses to be placed in ambulatory.”

Stakeholders

Focus group participants identified over 40 stakeholders, 18 internal to nursing and 23 external to nursing, who may be part of the solution addressing

barriers to adopting CCTM roles for RNs. Selected stakeholders and associated barriers are included in Table 1 and Table 2.

Strategies to Bring Stakeholders in as Collaborators

Strategies to implement collaboration between provider and academic stakeholders would allow for stronger partnerships that will benefit all stakeholders in the long run. Improved collaboration will allow for both sides to have a better understanding of each other’s contributions, improve outcomes, and allow wider opportunities for new graduates who are CCTM prepared. In addition, healthcare systems need to strengthen academic-practice partnerships to support faculty and provide incentives to teach differently in a way that caters to the current needs of healthcare and patients. “... A strategy or a way to address this, and that would be the stronger academic-practice partnerships. You know, we’ve been pushing that, but we need to make it more evident, more upfront, and not just agreements but real partnerships.”

To publicize the importance of CCTM, participants expressed it would be extremely helpful to integrate it into all conferences ranging from practice to academia. “This should be brought up at every national meeting. A lot of national partners in this room here today from different associations ... there has to be a way to disseminate this at a broader

level ... there should be a strategy about getting the message from the top elements even down to, as we’re talking about, the faculty elements, which require somewhat of a different strategy at the different levels ... if the dean’s not supportive of something, it’s not going to happen ... and it needs to seem important at that meeting.” This integration would help spread awareness of the need for CCTM in nursing education, as well as the role and impact it will have on patients across all aspects of health care. Exposing various professional nursing organizations, including student organizations, professional conferences, and national meetings, to the need for care coordination will disseminate this knowledge at a broader level.

Incentives and Benefits to Adopting CCTM RN Model

Participants identified two main incentives to adopting CCTM. One was through the American Academy of Ambulatory Care Nursing replicating Sigma Theta Tau International’s “academies model” for faculty “... the purpose of this one would be a recognition that you’re such an excellent educator in CCTM, and we’re identifying you. You applied, and we’re bringing you here to help us figure this curriculum thing out. And then they go back to their school ... so that would be a way of incentivizing faculty and schools ... perhaps there’s an incentive

Table 1.
Selected Stakeholders Internal to Nursing and Associated Barriers

Stakeholders	Barriers
Nursing Deans	"I don't think enough Deans and Associate Deans in the schools even know about CCTM and understand it."
Nursing Faculty	"You know, I think one barrier is just of lack of knowledge from the academic side of it." "The other barrier is not having a focus on anything other than inpatient ... how do we get the word out that we really do need to pay attention to what's happening in healthcare delivery."
American Association of Colleges of Nursing (AACN)	"I think the other one is the accreditors, NLN and AACN. I think if they had content or conversation in the accreditation standards about this work [CCTM], it would be another voice."
National League for Nursing (NLN)	
Chief Nurse Executives/Chief Nursing Officers	"... the nurse leaders, the chief nurse executives, the CNOs, the VPs in nursing, most of them, it is a lack of knowledge, but they learn like on the spot. Like ... we've got to do something about all these readmissions. Like, we're losing money."
Vice Presidents Education and Research	"So, there's a problem from a bridge perspective of not only are we just educating to NCLEX, and we're missing a lot of aspects of what a nurse's role is; once they get over here into the real world, we further corrupt that because now on the hospital level or whatever saying, 'Really, your job is this. You're going to do it this way.' So, we take away critical thinking, we take away a lot of the activities that we were educated on that need to have more activity to be educated on."
Nurse Educators/Professional Development Specialists	"... but aren't we trying to say that this [CCTM] does not live in the ambulatory world? This work crosses over. And so, it just prepares a better RN no matter what setting they're in ... I also think incorporation of the [CCTM] curriculum into the nurse residency would be key to that."
Pre-licensure RNs and Practicing RNs	"Perception that CCTM is only for outpatient, ambulatory, primary care" "... already employed nurses, they were never taught that [CCTM]. And so, if they don't receive that curriculum or that content or education in their current job, it's a problem."
Tri-Council for Nursing: AACN, NLN, American Nurses Association, American Organization of Nurse Executives	"So how do the Tri-Council ... We have to make sure that we're all aligned, from the nursing agencies as well as the testing of what new graduates need now to be competent. This is part of competencies of nursing. How do we ensure that all of the nursing professional organizations are aligned?"

for the actual school for the number of scholars who completed the program." A second incentive is to fund small grants for academic-practice partners to create professional development opportunities for faculty and practicing RNs to champion the CCTM RN model. "So, having

some of those grant dollars out there from a variety of places; infusing some bucks into the situation ... if you can get the money to do it, then all of a sudden it takes on a new meaning."

The key benefit of adopting the CCTM RN model focused on impacting the care experience

and improving quality of care. "Well, I think you had mentioned it right away with me speaking to the nurse execs about how the benefits would improve HCAHP scores, improve perception from patients regarding your organization. So, if you use this tool or if you use CCTM, you're

Table 2.
Selected Stakeholders External to Nursing and Associated Barriers

Stakeholders	Barriers
Employers of RNs	“And this may be more related to it crosses over into integrating into practice, but for education, if it’s not valued by the employer or those that are supervising, or overseeing the care, then the nurses aren’t going to value it, and it’s not going to be part of their education, ongoing expectations.”
Practice Partners	“So, to piggyback on that, I think that industry has to kind of demand the change. And there are so many competing priorities that until leaders in industry, healthcare industry determine that this [CCTM] is a priority, I think that’s where it has to start.”
C-Suite Executives: CEO, COO, CFO	“I think they’re healthcare leaders that are responsible for resource allocation. And I think until we demonstrate the value in making this change [CCTM], I’m not sure they’re going to see that that needs to actually happen. I mean I think they need to demand it. And until we demonstrate that they need to demand it, I don’t think they will because they’re pulled in 50 directions.”

going to have outcomes. I think that’s the biggest outcome.” By educating both pre-licensure nursing students and practicing RNs “... the benefit then would be for both sides to have a better understanding, to have better outcomes, to have more opportunities for employment by your graduates. I mean it could go on down the list by strengthening those partners, making sure they’re current for care, prepared.”

A second benefit of adopting the CCTM RN is a better-prepared workforce. As one participant stated, “It’s just a better-prepared workforce, I mean from the educator. I know that’s not easy to translate sometimes, but we need to move beyond where we are a lot of times in nursing education because it is still so acute care focused and it’s yesterday. It’s not today, it’s not the future. And we’re the future now, and

people aren’t adapting so quickly ... as they should, but I think there’s got to be a way to make it relevant to them.” Another highlighted, “This work crosses over. And so, it just prepares a better RN no matter what setting they’re in.” Lastly, several participants suggested the CCTM RN spanned across the healthcare continuum, thus assuring care coordination across all settings. “But if the bedside nurse had education [CCTM], I believe it would really help close the gap between ambulatory and inpatient. They would be more prepared and prepare their patients better for the outpatient.” In summary, new pre-licensure nurses, RNs in all practice settings, practice partners, and stakeholders benefit with a better-prepared workforce resulting in better outcomes for individuals, families, and communities.

Recommendations and Implications

One major barrier that influences nursing education is faculty and nurse perceptions that their practice is limited to their specialty “silo” of care such as acute, intensive care, emergency, or surgical nursing. Siloed thinking makes it hard to recognize and envision care beyond the silo and across the continuum. Dialogue among nursing leaders, faculty, students, and other healthcare providers is essential for curriculum redesign, so that we move beyond concern for care for the encounter or stay to care provision and coordination across the continuum.

Other recommendations to overcome barriers include enhancing academic/practice partnerships. Such partnerships need to move beyond agreements between academe

and practice to provide sites for student clinical experience, to collaboration between academic and service leaders regarding preparation of new graduates to meet demands for care across the healthcare continuum. This is essential if nursing education is to move beyond silos of care, such as student clinical experiences focused on acute care. Collaboration between service, academic, and regulatory leaders is essential to decrease faculty resistance to change and foster nursing curriculum redesign. Licensure tests, such as NCLEX-RN, must be testing current nursing knowledge and skills. Accreditation criteria, such as the *Baccalaureate Essentials*, should be specifying current, necessary knowledge, skills, and competencies for both students and faculty.

Ongoing faculty education and development is recommended to deal with knowledge gaps. This recommendation is supported by the American Association of Colleges of Nursing (2018) *Vision for Nursing Education*: “Entry-level professional nursing education prepare a generalist for practice across the life span and continuum of care ... including disease prevention/promotion of health ... chronic disease care ... regenerative or restorative care and hospice/palliative/supportive care” (p. 12). A final recommendation is that a branding campaign be initiated to assist with recognition the CCTM RN model should be a part of every nurse’s practice repertoire

no matter what population he or she serves and no matter where the practice setting. \$

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