Nurses take the lead on care coordination

Advancing nurses' roles in care coordination

By Elizabeth Moore

Traditionally, care coordination has been a central role for nurses, who are key to ensuring patients' multidimensional needs are being met at the bedside, as they transition from one care setting to the next, and as they live their lives in the community. Opportunities for nurses to lead and innovate within care coordination are flourishing—although challenges remain.

That said, in declaring 2018 as a Year of Advocacy, the American Nurses Association (ANA) and nurse experts are committed to promoting nurses' roles in care coordination and have developed new resources that will help them gain recognition for their efforts.

A guide to action

With the January 2018 publication, *Care Coordination: A Blueprint for Action for RNs*, authors Gerri Lamb, PhD, RN, FAAN, and Robin Newhouse, PhD, RN, NEA-BC, FAAN, provide nurses with a plan to advance care coordination practice and advocacy.

"We believe there is a pressing need for a short, to-the-point book that educates nurses about key issues in nurse care coordination and recommends specific actions that can make a difference," said Lamb, an Arizona Nurses Association member and center director and research professor at the college of nursing and health innovation at Arizona State University. She noted that in addition to offering opportunities for advancing nurse care coordination, the current healthcare environment also presents many challenges.

Gerri Lamb

Robin Newhouse

"It is critical to understand the issues and take meaningful action now," said Lamb, who edited and coauthored an earlier book, *Care Coordination: The Game Changer—How Nursing is Revolutionizing Quality Care*.

"The high cost of chronic diseases and the fragmented nature of care have created an exponential increase in the need for care coordination," said Newhouse, dean and distinguished professor of the Indiana University School of Nursing and an Indiana State Nurses Association member. She noted that most patient care transitions are best done by RNs or advanced practice registered nurses (APRNs), particularly when a patient requires assessment of complex physical, mental, and social needs.

Care Coordination: A Blueprint for Action for RNs was designed to prompt nurses to lead and deliver effective care coordination and influence policy toward meeting healthcare needs for people, families, and caregivers in all settings.

The blueprint's action issues

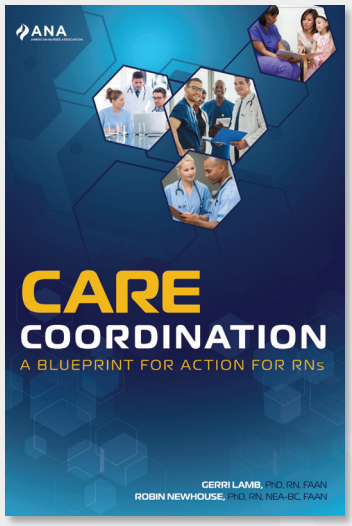
The core of the publication is its six action issues for nurses who want to advance nurse care coordination. Each of these is, according to the book, "pivotal to advancing nurse care coordination" and "practical, strategic, and actionable." The issues are:

- engaging patients, families, and caregivers
- demonstrating competency and readiness
- optimizing teams and teamwork
- using documentation and health IT
- measuring performance
- understanding payment.

Framing each action issue with three topics—what we know, what's trending, and what RNs can do—the authors offer practical suggestions and specific actions and resources for RNs to influence the future of nurse care coordination. For instance, measuring what nurses do to contribute to care coordination

outcomes is a critical issue in advancing care coordination practice and payment policy, and one that has been examined in great detail by workgroups convened by ANA and the American Academy of Nursing. One action recommended in *Care Coordination: A Blueprint for Action for RNs* is for all nurses to identify and share measures they are using to fill important gaps about specific care coordination activities and demonstrate nursing's impact on health and system outcomes. In addition, Newhouse said, "We need to make sure these measures are part of the patient care record."

The authors write, "Nurses must make the compelling case that they are essential to advancing care coordination. Nurses and the nursing profession have the knowledge, experience, and data to make this case—we must act."



ANA and the path to payment

When constraints on time and communication limit coordination of care, patients suffer.

"That's where we see medication errors and patients not seeing the value of a follow-up visit," said Cheri Lattimer, BSN, RN, executive director of the National Transitions of Care Coalition and a member of the 2017 ANA Care Coordination Panel. Nurses have the knowledge and experience to be the best agents of care coordination, she added, noting that while every care provider has some responsibility for coordinating care, "in reality, it is the nurse, the nurse case manager, and the advanced practice nurse who spend the most time with the patient throughout."

Lattimer expressed concern that unqualified individuals without proper training are working as care managers. "It's important to have performance measures and qualifications and to define the scope of work that's necessary," she said.

ANA has long advanced nurses' role in care coordination and developed comprehensive resources to support them. ANA panels convened in 2010, 2013, and 2017 have corroborated the essential role of RNs in care coordination, built guiding principles, identified structural components, and crafted definitions and competencies that have helped steer the movement toward payment and recognition.

Additionally, the passage of the Patient Protection and Affordable Care Act (ACA) in 2010 put a spotlight on care coordination.

"With ACA, [care coordination] became part of the language," explained Barbara Lutz, PhD, RN, CRRN, PHNA-BC, FAAN, FAHA, FNAP, McNeill Distinguished Professor at the University of North Carolina-Wilmington School of Nursing and a member of the ANA Care Coordination Panel. Now that Medicare pays for some types of care coordination, the healthcare system has embraced the practice, according to nurse experts.

A new white paper from ANA, "Medicare Payment for Registered Nurse Services and Care Coordination," examines the current ways Medicare pays for nursing services and patient care coordination, and how legislative or regulatory actions would allow care coordination programs to compensate nursing services. The paper discusses payment for APRNs, including nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives, and certified registered nurse anesthetists, as well as registered nurses (RNs and other degree-credentialed nurses) through another benefit category.

The ANA white paper outlines three statutory or regulatory changes that would facilitate access to nursing services and an opportunity through a Centers for Medicare and Medicaid Services section 1115A waiver to study direct payment to RNs to show Medicare cost savings and quality improvement goals. These statutory or regulatory proposals include recommendations for paying NPs and CNSs at the same rate as physicians, suggest using consistent and more expansive definitions of "physician," and propose changes to the statute to allow direct payment to RNs for performing care coordination activities.

In this Year of Advocacy, RNs are encouraged to explore the new resources and make a commitment to act. Lamb and Newhouse emphasized that "taking action on even one issue—even a small action—will create a ripple of changes. There is much we can accomplish together."

ANA resources for care coordination can be found at nursingworld.org.

— Elizabeth Moore is a writer at ANA.

Is your job a risk to your health?

By Susan M. Priano, PhD, RN

Nurses employed in U.S. hospitals are at risk for poor health outcomes due to unhealthy lifestyles and their work environment. Ranked by the public as the most trusted professionals and numbering 3.6 million nationwide, RNs have the power to effect behavior change as role models by practicing healthy lifestyles while improving their own health. Yet, a study of 2,730 hospital nurses from the American Nurses Association (ANA) Health Risk Appraisal (HRA), surveyed from October 2013 to December 2015, found serious deficits in diet, sleep, and physical activity that may jeopardize nurses' health and negatively impact the healing strength of the profession. Here are some key findings from the survey related to health, lifestyle, and work environment.

About the survey

The ANA HRA surveyed nurse demographics, health, lifestyles, and the workplace environment. The online survey was voluntary and provided nurses the opportunity to evaluate their lifestyles and health risks and offered suggestions for improvement with comparisons to national health databases.

This sample of U.S. hospital nurses, representing 12 hospital subspecialties, was 75% White and 92% female, with a mean age of 40 years. In all, 42% had fewer than 5 years of nursing experience. More baccalaureate-educated nurses (45%) than associate degree nurses (31%) responded. Compared to national nurse data, this sample was younger and less experienced, possibly because as nurses age, they move away from the bedside, according to the U.S. Health and Human Services Administration in 2010.

Health

Self-rated health was very good or excellent in 48% of nurses versus 65% of adult women. Nurses reported fatigue an average of 5 out of 14 days, while 70% of the nurses reported enough emotional support. Top health diagnoses were allergies (29%), low back pain (22%), migraines (18%), and depression (18%); more than half (56%) were overweight/obese with a body mass index > 25 kg/m^2.

Lifestyles

Nurses' lifestyles were often far from ideal in several areas, as these findings reflect:

- **Diet.** A mere 14% of the nurses were eating at least five servings of fruits and vegetables per day (2.5 cups).
- **Physical activity.** Just 45% of the respondents were engaged in aerobic activity of at least moderate intensity for 2.5 or more hours per week, while 47% performed muscle-strengthening activities twice a week.
- **Sleep.** Nearly half of the nurses (47%) slept fewer than 7 hours per day.
- **Smoking.** Most (94%) survey participants were not currently smoking cigarettes.
- **Alcohol consumption.** Over 90% of the nurses in the sample were within the recommended limit of 0 to 7 alcohol servings per week.

Lifestyle, by choice or consequence, exerts a great influence on one's health. Nurses unable to adopt and maintain healthy lifestyle behaviors are at risk for chronic diseases and early mortality. On the other hand, nurses who make healthy lifestyle choices have positive effects in caring for patient populations. They're more apt to discuss and recommend preventive behaviors such as smoking cessation, more physical activity, and eating a healthier diet to the people under their care.

Nurses who practice healthy lifestyles of daily physical activity, diet, and sleep habits may be better able to prevent workplace injury and avoid errors related to fatigue. Thus, improving the health and healthy lifestyles of nurses may improve patient care.

Nurses' health risk factors may be attributed to hospital workplace conditions that counter their efforts to maintain a healthy lifestyle and contribute to poor self-rated health.

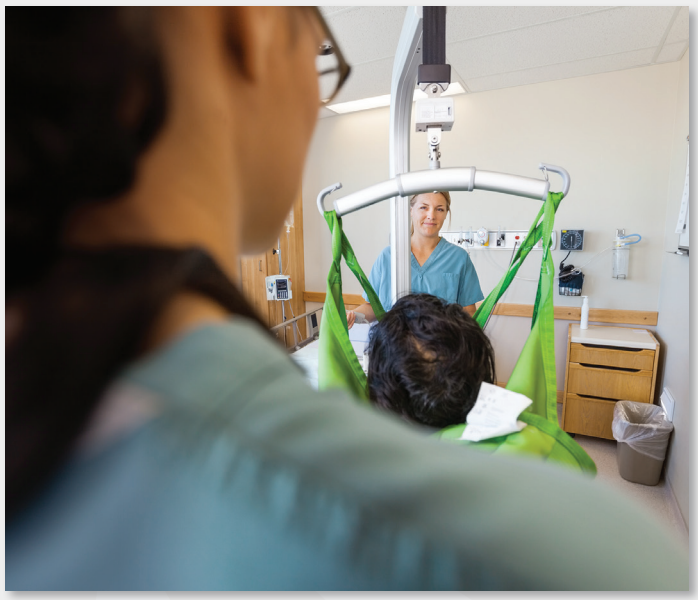
Work environment

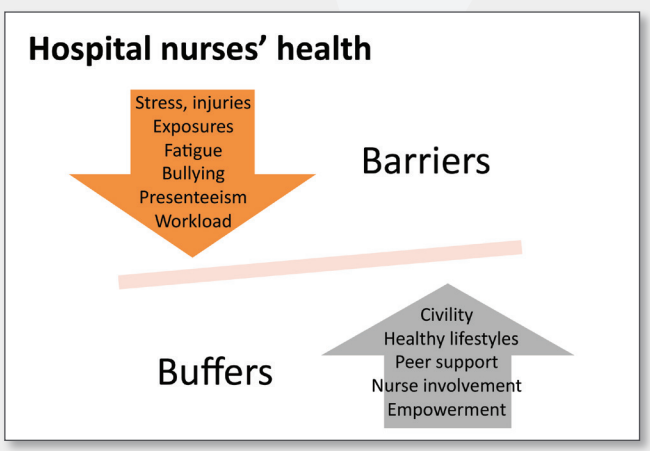
ANA defines a healthy work environment as "one that is safe, empowering, and satisfying." Yet, 63% of RNs in the United States are employed in hospitals, which are considered among the most hazardous

workplaces in this country, according to reports from the U.S. Bureau of Labor Statistics and Occupational Safety and Health Administration. Hospital workers suffer work-related injuries at a rate of 6.8 for every 100 full-time employees, almost twice the rate in industry. Nurses, who constitute the largest segment of hospital employees, collectively, are the most vulnerable for multiple workplace safety hazards due to the hospital environment.

The HRA assessed eight areas of known work environment concerns: workplace climate, health and safety risks, safe patient handling and mobility, sharps, bullying/violence, fatigue, wellness, and absent/present. Highlights of the survey include the following:

- **Climate.** In total, 75%-80% of nurses had positive perceptions of their employer, and 84% felt they were treated with dignity and respect.
- **Risks.** Of 21 potential risks, workplace stress was felt by 80% of nurses, followed by 61% reporting musculoskeletal disability; 40%-48% were at risk for hospital-acquired infections of respiratory or blood borne pathogens.
- **Sharps and safe patient handling.** Programs were in 75%-90% of the facilities, but only 26%-35% of nurses were involved in the planning and selection of safety equipment, and only 47% of nurses routinely used lift assistance devices.
- **Bullying/violence.** Nurses often (56%) experienced verbal or physical abuse from patients, families, and peers, while 42% of nurses felt aggression from persons in a higher level of authority.
- **Fatigue.** Slightly more than half (52%) of nurses worked 12-hour shifts, 41% worked overtime (>40 hours/week), with 67% reporting unplanned overtime, and more than 50% felt obligated to work when ill. Many nurses (61%) were unable to complete their assignments unless they worked through their breaks.
- **Wellness.** Services such as weight loss and smoking cessation were accessible to 55% of nurses with 49% participation. Healthy foods were available for 57% of nurses but were more expensive than other food choices.
- **Absent/present.** Nurses (55%) reported to work when sick, and 67% felt present when at work.





Need for a healthy workforce

While nurses' chief duty is to protect and promote health, hospital work exposes nurses to high levels of stress and physical and emotional injury. The ANA HRA has identified the barriers and buffers of a healthy nurse workforce and workplace. (See *Hospital nurses' health*.)

A healthy nursing workforce functions as a team working together, supporting the health of their patients and each other. Healthy workplaces can minimize workplace stress, reduce injuries and medical errors, and improve patient outcomes. Alternative healthcare models offer solutions for flexible staffing, rest, and healthy food to benefit health for all. Collective efforts and visionary leadership are essential to achieving worker protections.

Visit americannursetoday.com/?p=37828 for a list of selected references.

— Susan M. Priano is a staff nurse for the city and county of San Francisco, department of public health.

ANA resources

- **Healthy Nurse, Healthy Nation™.** Connect with RNs and join nurses leading the way to better health at hnhn.org.
- **Healthy Work Environment.** For ANA's position statement, tools, and resources, visit nursingworld.org/healthyworkenvironment.

Right to try

Q: My patient is terminally ill. There may be a treatment, but it isn't FDA approved. Do patients have a right to try investigational treatments, and what are the ethical implications of administering potentially harmful medications?

A: There are multiple pathways for terminally ill patients to obtain investigational medications. The intent is to enable dying patients to receive investigational treatments outside of clinical trials and before approval by the U.S. Food and Drug Administration (FDA). Right-to-try legislation and compassionate use are the common routes. *Right-to-try legislation* empowers patients to bypass the FDA approval process and go directly to drug manufacturers, but it doesn't exist in every state. *Compassionate use* regulations were established by the FDA to provide dying patients with faster access to experimental treatments. Compassionate use is available in all states and is physician initiated.

Right-to-try laws and compassionate use regulations enable patients to obtain treatments that have completed phase 1 clinical trials, which evaluate safety but not efficacy. Patients using the right-to-try or compassionate use loopholes subvert the clinical trials process.

Drug developers and manufacturers are reluctant to provide access to investigational treatments. Concerns include negative publicity and impact on future FDA approval from treatment failures and patient harm, effect on supply of investigational agents for clinical trials, and decreased availability of appropriate patients to participate in clinical trials. The FDA has developed a stringent approval process to protect the public from treatments that do more harm than good.

Ethically, the challenge is to balance a patient's desire for hope and potential for benefit with the obligation to do no harm. Multiple provisions in the American Nurses Association *Code of Ethics for Nurses with Interpretive Statements* (nursingworld.org/codeofethics) inform this issue.

Provision 1 states: "The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person." Establishing a trusting relationship, considering patients' needs, and respecting their values and right to self-determination would seem to require nurses to advocate for, and assist patients to obtain investigational treatments.

Provision 2 states: "The nurse's primary commitment is to the patient..." This would also indicate the nurse should advocate for access to investigational treatments above concerns for the clinical trials process. However, this is somewhat conflicting, as Provision 2 also identifies the patient as a population and community. There is a risk to the population of patients in need of safe and effective treatments when the clinical trials process is subverted for individual, unapproved use.

Provision 3 states: "The nurse promotes, advocates for, and protects the rights, health, and safety of the patient." This provision addresses the importance of informed consent for participation in research. It would apply for access to investigational treatments outside the research process. Special concern for vulnerable patients is also adressed in Provision 3. It describes the ethical obligation to protect health and safety, which seems to indicate that investigational treatments should not be provided.

Provision 4 states: "The nurse has authority, accountability, and responsibility for nursing practice; makes decisions; and takes action consistent with the obligation to promote health and to provide optimal care." Nurses bearing primary responsibility for the nursing care, their judgments, decisions, and actions need to reflect on the provision of investigational treatments because the harms that can result are unknown. Creating false hope for terminally ill patients and families can be harmful when it prevents preparation for the dying process.

Ultimately, it's a delicate balance between patient autonomy and informed consent, on the one hand, and the requirement to promote safety and prevent harm on the other, which must be considered in right to try and compassionate use of investigational medications. Nurses, supported by their code of ethics, should evaluate each situation individually and determine the ethically appropriate course of action.

Response by Donna Casey, DNP, MA, RN, NE-BC, FABC, chair of the ANA Ethics Advisory Board, and Danielle Sawyer, BS, paralegal and second-year student at Delaware Law School.

Visit americannursetoday.com/?p=37826 for a list of selected references.

Nurse uses grant funding to explore preterm delivery and cardiovascular health risks

February often brings to mind images of valentines and hearts. At the American Nurses Foundation, we took the opportunity to seek an update from one of our past Nursing Research Grant recipients, whose work focuses on heart and vascular functioning.

Margo B. Minissian, PhD, ACNP, is a nurse scientist, cardiology nurse practitioner, and clinical lipid specialist at the Barbra Streisand Women's Heart Center, Heart Institute, Cedars-Sinai Medical Center in Los Angeles. The center is designed to help women reduce their chances of heart disease through a preventive approach, including state-of-the-art screening and diagnostic testing.

In her previous role as an acute care nurse practitioner and clinical lipid specialist in the Barbra Streisand Women's Heart Center, Minissian developed a passion for clinical research evaluating women and worked on projects investigating the pathophysiology of heart disease in women. Her years engaged in investigator-led research propelled her to return to school to seek a PhD at the University of California, Los Angeles School of Nursing with an emphasis in biological research, which then springboarded into a primary research interest in cardiovascular disease prevention.

Margo B. Minissian

Minissian was awarded funding in 2015 from the Foundation through grants from the Preventive Cardiovascular Nurses Association and the American Nurses Credentialing Center Clinical Research Grant Fund for her doctoral research, titled "Is spontaneous preterm delivery associated with clustering of maternal cardiovascular risk markers and impaired vascular function? The SPACE study."

Women with a history of preterm delivery have up to a 3-fold increased risk of heart disease later in life. Also funded by the National Insitutes of Health, this study hypothesized that compared to women with term delivery, women with spontaneous preterm delivery would demonstrate greater vascular dysfunction postpartum. Her study findings suggested that these women have decreased vascular stiffness compared to women who deliver at term, suggesting physiological differences between the two groups. Minissian's findings were presented at the 2017 American Heart Association Scientific Sessions in Anaheim, California, where she was a finalist for the Martha Hill Young Investigator Award.

Minissian is grateful for the support from the Foundation as she launched her research career. "Support for nurse-led research available from the American Nurses Foundation helped make my research possible. My hope is that my research will help us understand who might be at risk for heart disease later in life and help prevent future cardiovascular events," Minissian said.

About nursing research grants

The American Nurses Foundation is grateful for the generosity of supporters over the last 62 years who have made it possible to award more than $5 million to more than 1,100 beginning and experienced nurse researchers like Minissian.

The Foundation's nursing research grant program review committee is led this year by Chair Gordon L. Gillespie, PhD, DNP, RN, CEN, CNE, CPEN, PHCNS-BC, FAEN, FAAN, associate professor, deputy director of the occupational health nursing program, interim associate dean for research and translation, at the University of Cincinnati; and Vice Chair Joan I. Warren, PhD, RN-BC, NEA-BC, FAAN, associate professor, University of Maryland, and project director for the Maryland Nurse Residency Collaborative.

Research projects focus on a variety of nursing science topics, including educational intervention for emergency department nurses responding to opioid overdoses, infant and maternal stress and attachment in the cardiac intensive care unit, a cognitive behavior skills-building intervention for asthma patients, and improving cardiac recovery with training in emotion regulation.

Visit givetonursing.org/nursingresearchgrant for more information and to learn how to apply for a grant award. Proposals are accepted between February 1 and May 1.

Nurses maintain #1 ranking as most honest and ethical profession

For the 16th consecutive year, the American public has ranked nurses as the professionals with the highest honesty and ethical standards, according to a Gallup poll released in December 2017. The annual poll has ranked nurses as the most honest and ethical out of a wide spectrum of professions, including pharmacists and grade school teachers.

"Nurses provide much more than bedside care. We advocate for patients, deliver primary care, meet the complex needs of patients with chronic conditions, volunteer for disaster relief efforts, and are a trusted voice in boardrooms across the country," said Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN, president of the American Nurses Association (ANA).

According to the poll, 82% of Americans rated nurses' honesty and ethical standards as "very high" or "high." The next closest profession, military officers, was rated 11 percentage points behind nursing.

"One of our greatest accomplishments this year has been the role nurses have played in fighting against any legislation to repeal the Affordable Care Act," said Cipriano. "Advocacy efforts have always been a core function and priority for our organization, but there is still work to be done, which is why we recently announced 2018 as the Year of Advocacy. ANA is committed to supporting and encouraging nurses to be advocates at all levels and to be influencers of positive change for our patients, our colleagues, and our nation."

To share an infographic highlighting the "Top 6 reasons nurses are ranked #1," visit ANA's Facebook page (goo.gl/5fDRDF).

NY nursing education bill signed into law

New York (NY) Gov. Andrew Cuomo signed into law a landmark measure requiring future RNs to obtain a baccalaureate degree in nursing within 10 years after initial licensure, but it maintains current multiple entry points into the profession.

The ANA-NY supported legislation, often called the "BS in 10," also exempts those currently licensed and enrolled in nursing programs. The legislation passed both the state senate and assembly earlier in 2017 before being signed by the governor in December.

The bill continues all current paths to licensure, including diploma and associate degree education, according to Barbara Zittel, PhD, RN, an ANA-NY member and ardent proponent of the measure since the New York State Board for Nursing helped craft it in 2003.

ANA-NY Executive Director Jeanine Santelli, PhD, RN, AGPCNP-BC, FAAN, said, "This bill acknowledges the value of associate degree–prepared RNs and gives them the time they need to advance their education. It also elevates the profession of nursing and will improve patient outcomes, as shown by research."

"ANA congratulates ANA-New York and all who worked to make the law a reality," said ANA President Pamela Cipriano, PhD, RN, NEA-BC, FAAN.

Volunteering during disasters

The American Nurses Association (ANA) encourages RNs who are interested in volunteering clinically during disasters to prepare and be ready before hurricanes, wildfires, and other catastrophic events strike. Nurses can pre-register with one of the many disaster registries and response organizations, such as these:

- Medical Reserve Corps—mrc.hhs.gov/HomePage
- National Disaster Medical System—phe.gov/Preparedness/responders/ndms/Pages/default.aspx
- American Red Cross—redcross.org/volunteer/become-a-volunteer#step1

Through these registries, nurses' licensure can be pre-verified and validated, they will have access to disaster training and drilling, and during a disaster, they will be deployed through a recognized system that's been incorporated into the local, state, and national response plans.

Nurses also may want to consider making a donation or volunteering in nonclinical capacities through their communities and with other organizations.

Additionally, the American Nurses Foundation supports nurses in disaster response and recovery. Visit www.givetonursing.org to support the profession and those in need.