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How does care coordination provided by registered nurses ''fit'' within the organisational processes and professional relationships in the general practice context?

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Summary
Aim: The aim of this study was to develop understanding about how a registered nurse-provided care coordination model can ''fit'' within organisational processes and professional relationships in general practice.
Background: In this project, registered nurses were involved in implementation of registered nurse-provided care coordination, which aimed to improve quality of care and support patients with chronic conditions to maintain their care and manage their lifestyle.
Method: Focus group interviews were conducted with nurses using a semi-structured interview protocol. Interpretive analysis of interview data was conducted using Normalization Process Theory to structure data analysis and interpretation.
Results: Three core themes emerged: (1) pre-requisites for care coordination, (2) the intervention in context, and (3) achieving outcomes. Pre-requisites were adequate funding mechanisms, engaging organisational power-brokers, leadership roles, and utilising and valuing registered nurses' broad skill base. To ensure registered nurse-provided care coordination processes were sustainable and embedded, mentoring and support as well as allocated time were required. Finally, when registered nurse-provided care coordination was supported, positive client outcomes were achievable, and transformation of professional practice and development of advanced nursing roles was possible.
Conclusion: Registered nurse-provided care coordination could ''fit'' within the context of general practice if it was adequately resourced. However, the heterogeneity of general practice can create an impasse that could be addressed through close attention to shared and agreed understandings. Successful development and implementation of registered nurse roles in care

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coordination requires attention to educational preparation, support of the individual nurse, and attention to organisational structures, financial implications and team member relationships.

Introduction

Increasingly, interventions to improve population health and wellbeing need to be sustainable beyond the implementation period. Thus, it is important to develop evidence about the sustainability of complex interventions within established contexts and ways of working (Campbell et al., 2000). In this study, we explored how registered nurse (RN)-provided care coordination could move beyond implementation to become embedded and integrated within the organisational processes and professional relationships of the general practice context.

Background

The health care system in Australia, like other industrialised countries, is confronting an ageing population with an increasing incidence of chronic conditions, combined with workforce shortages and cost escalation (Dunbar & Reddy, 2009). Furthermore, health care is provided within constantly changing complex and multi-layered systems. Unsurprisingly, service users frequently experience health care systems as cumbersome, unwieldy, unfriendly and opaque (Barach & Johnson, 2006). Care coordination is often promoted as an appropriate mechanism for supporting and maintaining strong partnerships within complex and seemingly fragmented systems (Chen, Brown, Archibald, Aliotta, & Fox, 2000; Powell Davies et al., 2006). In Australia, general practice is considered the vanguard of the health care system (Department of Health & Ageing, 2008). Consequently, general practice is increasingly being identified as a context that can provide continuous, comprehensive and coordinated care (Kidd et al., 2006; Rothman & Wagner, 2003). However, the mechanisms for embedding care coordination within this context are not clear and require further study.

Some authors believe that it is inevitable that RNs will have an increasingly important role in chronic condition care provision in general practice (Halcomb, Patterson, & Davidson, 2006). Moreover, general practice RNs themselves believe they have an important role in coordinating care, and that they are eminently capable of contributing in a meaningful way by connecting key people and facilitating information sharing processes and management (Patterson, Muenchberger, & Kendall, 2007). Indeed, RNs are appropriately skilled to assess the health, social and emotional well-being of older people and are well positioned to develop care relationships with patients (Siegloff, St. John, Keleher, & Patterson, 2007), which are all essential components of care coordination (Ehrlich, Kendall, Muenchberger, & Armstrong, 2009). Therefore, one method of decreasing care fragmentation and improving system navigation is to involve RNs in care coordination.

Despite the appropriateness of involving RNs in care coordination, new initiatives will not become embedded unless an intervention 'fits' within the existing environment (May, 2006; May & Finch, 2009). In response to a perceived need for improved understanding and explanatory capability in situations where new ways of organising health care were not routinely embedded in clinical practice, May and his colleagues developed the Normalization Process Theory (NPT) (May, 2006; May & Finch, 2009). According to NPT, the extent to which any new practice or innovation becomes embedded depends on the extent to which its components are workable in actual contexts and are capable of being integrated into existing contexts, that is fit.

To better understand the 'fit' of RN-provided care coordination within existing general practice contexts, we undertook a series of five studies, which used NPT as an overarching framework to guide data interpretations, discussion of the findings and implications of the research (May et al., 2010). The first four studies sought to better understand care coordination in existing general practice contexts prior to piloting a structured and supported care coordination role for RNs. The studies included: (a) a literature review (for further detail, see Ehrlich et al., 2009), (b) mapping usual chronic condition care, (c) a qualitative study of established care coordination practices, and (d) a qualitative study to investigate how RN-provided care coordination would be implemented (for further detail, see Ehrlich, Kendall, & Muenchberger, 2011). At the completion of these studies, a pilot project was conducted that involved general practice RNs and Divisions of General Practice (currently being restructured as Medicare Locals in Australia) support staff known as General Practice Liaison Officers (GPLOs)[1] in implementing a structured care coordination process within optimal locally responsive and supportive networks. This paper presents the final study, which investigated the 'fit' of RN-provided care coordination within the general practice context by exploring the experiences of general practice RNs and GPLOs. This project was approved by the University Human Ethics Committee and all participating organisations.

Methodology

A qualitative interpretive research design, which used focus groups to collect data, was used in this study. NPT, particularly the earlier Normalization Process Model (NPM) (May, 2006) which is one component of NPT, was used as a theoretical framework to structure data collection and interpretations (May et al., 2010) because of its explanatory capability in situations when the desired outcome was

[1] General Practice Liaison Officers (GPLOs) are employed by Divisions of General Practices to work with individual general practices. They focus on education and implementation of new initiatives within general practices. Divisions of General Practice are organisations who represent their General Practice membership at both State and National levels within Australia.