The Development of a Care Transition Model

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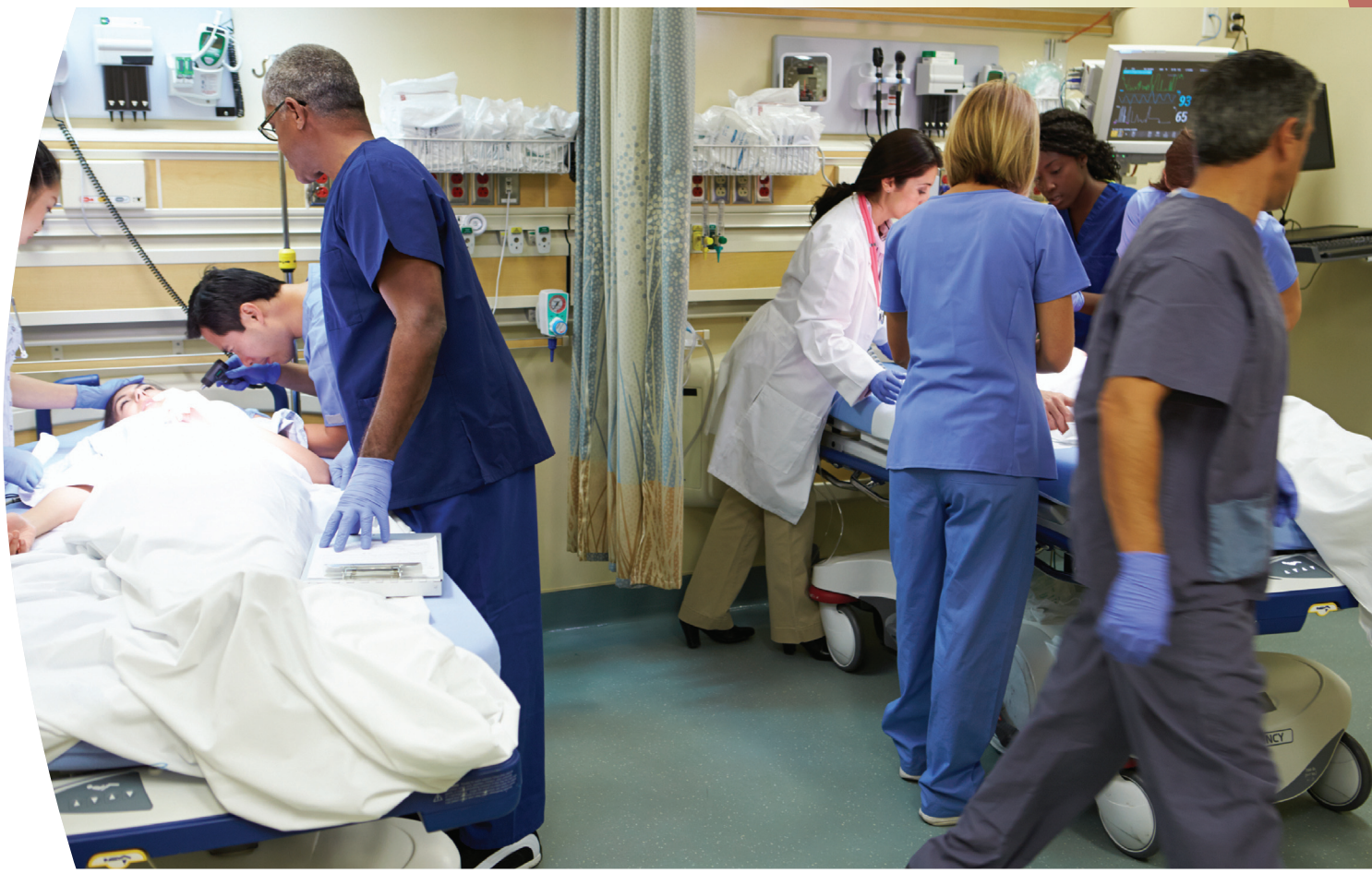

Improving population health, providing accessible, high-quality services, and lowering costs are goals that all of us in healthcare share today.[1] With the emphasis of healthcare reform on quality, efficiency, and outcomes with the goal to decrease the fragmentation of care, the Care Transition Coalition was developed. This is a patient-centered initiative designed to improve the patient's transition across settings. During an episode of illness, patients may receive care in multiple settings, often resulting in fragmented and poorly executed transitions. With our collaborative focus and enhanced continuity of care across health settings, the Care Transition Coalition addresses the deficiencies that occur during transitions by minimizing unnecessary hospitalizations and overutilization of the emergency department (ED). "With declining reimbursement and rising health care expenses, nursing leadership must look to new models for leading their patient care staff and achieve exceptional outcomes."[2] As a system of care was being developed, several leadership models were utilized.

LEADERSHIP MODEL

The principles of resonant leadership that Laschinger and colleagues[3] applied to workplace incivility were adopted to develop a new model of care. This was accomplished through the utilization and integration of the tenants of resonant leadership, specifically creating a vision, coaching of the staff, and maintaining a collegial approach alongside the foundation of Goleman's model of emotional intelligence (EI). Goleman's 4-domain model of EI was utilized as a framework with an initial emphasis on self-awareness.[3] "A primary task of leadership is to direct attention. To do so, leaders must learn to focus their own attention."[4] The majority of our careers have been in the acute care hospital setting; therefore, self-awareness was essential to make better decisions and to pay careful attention to "our voices" in order to move forward on a model that was somewhat foreign to us.[4] The model evolved from coordination of care in the acute setting to the start of a robust care transition model throughout the continuum. This was accomplished through the collaborative effort of the Care Transition Coalition.

CARE COORDINATION

The program originally deployed 2 critical care registered nurses (RNs) from the bedside to coordinate complex care for heart failure (HF) patients. Our 2 RNs managed a population of 70 chronic HF patients as inpatients and in the community setting. Education was provided on disease management and medications, as well as collaboration with the physicians to clarify or revise the care regime. The nurses interacted with these patients throughout their hospitalization and post-hospitalization with follow-up telephone calls and referrals to the home health agencies and primary care providers (PCPs). The results are impressive, specifically when we compared readmissions from 2012 to 2013 (*Figure 1*) and the comparison to the US National average (*Figure 2*).

LAUNCHING OF THE CARE TRANSITION COALITION

Based on the above results and the rapidly changing healthcare climate, as the chief nurse executive, McGuirk was charged with creating a coalition that expanded across community settings. It was also recognized that working with providers throughout the continuum to better coordinate care was emerging as standard best practice, with the emphasis on creating new working partnerships.[5] The Care Transition Coalition was launched in July of 2012, with 8 healthcare agencies. Over the next 24 months, the momentum built, and an additional 14 agencies joined the Coalition. There are now 22 partners with which we are collaborating (*Table 1*). Goleman's model of EI was critical because social skills in managing relationships and building networks was essential along with the ability to find common ground and build rapport.[6] Recognizing the fact that we all came to the table with a somewhat different vantage point of handling the care of the patient, the importance of managing relationships was critical.

The initial work of the Coalition targeted structure and processes to seamlessly transition the patient to post-acute healthcare and needed community resources, and removing the barriers to ultimately meet the needs of the patient. In keeping with national efforts to improve outcomes and integrate sustainable healthcare delivery models, the Coalition focused on enhanced communication and cost containment through decreasing preventable hospitalizations, readmissions, and unnecessary ED utilization. The use of the Veterans Health Administration innovation competencies/behaviors were used as a guide, specifically encouraging the voice of diverse groups and talents to optimize our outcomes. Due to the fact that the coordination of care across settings is complex, linear thinking and the traditional leadership model of commanding control would not work because of the changing dynamics of our collective environments. Mobility and agility were required to create a successful care model.[7] Below are our combined initiatives that resulted in the initial step at local transformation of our delivery system.

EDUCATION AND STANDARDIZATION

An early emphasis of the Coalition was aimed at educational efforts and enhancing communication with the goal of decreasing readmissions. There was a lack of standardized

Figure 1. Number of HF Readmissions by Quarter: 2012-2014 YTD