

# Using a Parent Coordinator to Support the Role of the Pediatric Nurse Practitioner in Care Coordination

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## ABSTRACT

The role of the pediatric nurse practitioner is becoming more complex with time. Both patients and the health care system are becoming more intricate. Effective support of the PNP can consist of a nonclinical professional who is a parent of a chronically ill child. Support including data entry, preclinic planning, self-management support, appointment scheduling, research, and between-visit follow-up can be provided from the perspective of a parent. This article will describe the role of a parent coordinator who was hired in part to provide support for a pediatric nurse practitioner in a primary care clinic for patients with asthma. *J Pediatr Health Care.* (2017) ■, ■-■.

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## KEY WORDS

Non-clinical professional, care coordination, chronic illness, pediatric nurse practitioner

## INTRODUCTION

The role of the pediatric nurse practitioner is becoming more complex with time. Both patients and the health care system are becoming more intricate. Effective support of the pediatric nurse practitioner (PNP) has mostly consisted of nurses in the past. Although nursing care is vital, there are tasks that a nonclinical professional could do to assist with the care of patients without overstepping the role of a nurse or nurse practitioner. This is vital when caring for patients with chronic conditions who frequently have comorbidities and socially complex needs, for whom more support is necessary. This article will describe the role of a parent coordinator who was hired as a nonclinical professional to provide support, from a parent's perspective, for a primary care clinic for patients with asthma that includes a PNP.

## LITERATURE REVIEW

Team-based care is becoming the norm for children with a chronic illness based on the medical home model, and this is effective at reducing disparities (Chin et al., 2012). Care coordination is imperative in this model. Tracking of patients and their encounters in medical facilities, tests, specialty care visits, and between-visit follow-up are important (Homer, Cooley, & Strickland, 2009). Care coordinators facilitate

communication with the medical team and are essential to medical homes (McAllister, Presler, & Cooley, 2007). Nurse practitioners are trained and frequently act as care coordinators for specific patient populations. The literature regarding health care navigation contains limited studies of nurse practitioners paired with nonclinical professionals (Yun et al., 2015). The purpose of this article is to show a novel partnership program of nonphysician members of the care team, such as a nonclinical professional, assisting a nurse practitioner in providing better care coordination and improving the experiences of care for children with a chronic illness.

It has been found that people with chronic medical conditions often have comorbidities combined with social complexity (Craig, Eby, & Whittington, 2011). Care of teens brings unique challenges because the team includes the adolescent and the parents. The care of a chronic illness is influenced greatly by parental motivation and attitudes and by the home environment. Children's hospitals have attempted to involve parents in the training of staff to educate them from a parent's perspective (AHC Media, 2009). However, concerns exist about whether this perspective is lost after orientation is over because the interaction is brief and not maintained over time. Nurses have been shown to misunderstand the parent perspective as well. Nurses and parents frequently do not agree about the prioritization of goals for children and their families who are seen in the hospital. In an article about children with chronic conditions, more nurses identified parents as having support needs and information needs than the parents did. Parents, on the other hand, identified more community service needs than the nurses did (Graves & Hayes, 1996). Because of these issues, we chose a parent of a child with a chronic illness for this nonclinical role. Early and consistent parental involvement is necessary to identify and prioritize goals for patients and their families.

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Research and implementation of the role of the nonclinical professional (specifically a patient navigator) in adult chronic disease, especially cancer, has been increasing. Patient navigation was initially created for cancer programs in New York to help with a defined episode of cancer-related care and included tracking patients over time with a defined set of services, identifying barriers to care so that delays in care could be reduced. Patient navigators have various backgrounds, from nurses and social workers to registration

personnel and cancer survivors. A meta-analysis showed that patient navigators improve cancer screening, reduce disparities, increase patient satisfaction, and improve emotional quality of life (Paskett, Harrop, & Wells, 2011). A systematic review found 17 studies of lay workers in pediatric chronic disease and concluded that lay workers may provide an important innovation for health care improvement (Raphael, Rueda, Lion, & Giordano, 2013). Additionally, another study in pediatrics more recently found that trained patient navigators could affect obesity outcomes for preschool-age children (Yun et al., 2015). Another recent article reports multiple ongoing studies with sickle cell disease using community health workers in pediatrics (Hsu et al., 2016). Patient navigators have also been used to help reduce health disparities (Natale-Pereira, Enard, Nevarez, & Jones, 2011). The literature shows that nonclinical professionals are influencing the outcomes of patients.

## DESCRIPTION OF PRACTICE

Cincinnati Children's Hospital Medical Center is a large, urban pediatric academic medical center. The Teen Health Center at Cincinnati Children's Hospital Medical Center provides primary care to over 8,000 primarily underserved (77% Medicaid) and African American (52%) youths 12 to 22 years of age. Approximately 15% have a diagnosis of asthma. The Asthma Innovation Laboratory, located in the Teen Health Center, is a primary care clinic focusing on patients with asthma. The purpose of the laboratory is to create and test innovative ideas, care methods, and self-management coaching techniques to improve care.

The care team is co-led by a physician and a pediatric nurse practitioner and includes an adult medicine- and pediatric-trained physician; a self-management coach; experts in quality improvement, data analysis, access services, and research; and a parent of a child with special needs. This parent is a vital member of the team; she aids in the care coordination of patients, participates in team decisions about improvement projects, and gives a parent voice to all that the team does.

## PARENT COORDINATOR ROLE

### Parent Voice

Originally hired in April 2007, the Parent Coordinator position was under the Patient Services division of the hospital. An initial task of the role was to give the parent's voice to team decisions about process improvement work. One example of this was when we were deciding whether to ask asthma symptom questions to just the patient or the patient and the parent. The parent coordinator believed strongly that the parent or guardian should be asked the same questions and that the lowest score (more severe symptoms) should be counted. This led to many fruitful conversations with patients and families about why they reported

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