



Leading Change throughout the Continuum of Care

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Introduction

Healthcare organizations are under pressure to produce high quality outcomes while in turn, decrease costs. Because leaders within healthcare, direct care providers and policy makers are instrumental in transforming the way patient care is delivered, they must remodel care delivery to advocate on behalf of patients. Both formal and informal leaders are in a position to streamline care delivery across healthcare settings. The establishment of collaborative partnerships throughout the community to address practice differences can be effective in developing educational programs for patients and caregivers, establishing standards and guidelines in caring for multiple patient populations, and creating formal care paths to enhance care delivery. Developments in regards to transitional care practices have the potential to enhance quality outcomes and optimize healthcare spending.

To effectively establish collaborative partnerships to transform transitional care practices, the implementation of population coordinators assigned to care for specified patient populations may be beneficial to organizations. Population coordinators can be utilized to provide community outreach, identify patients that need navigation and assistance, encourage patient self-management, provide emotional support, and coordinate processes and protocols. In describing care coordination practices that have been applied within the development of a comprehensive spine surgery program, healthcare organizations are able to better care for patient populations served.

Rationale for Change

Poorly managed transitional care can lead to increased readmissions, patient dissatisfaction, and inappropriate utilization of healthcare services. In the United States health system, patients experience transitions in their care, meaning they leave one setting and move to another. The settings included within these transitions are acute care facilities, nursing facilities, and assisted living facilities. Because the United States fragmented health delivery system may result in provider inability to achieve optimal health for the patients they serve, there is strong need to transform the environment of care.

As noted in previous work, a comprehensive population-based spine surgery program was developed at a community hospital located in Aurora, Illinois. The spine surgery population health coordinator assumes a leadership role in the areas of professional practice, staff development, education, program development, and quality management [1]. Population health coordinator roles focus on the promotion of safe and effective care delivery by 1) serving as liaisons

across various healthcare settings throughout the organizations primary service area, 2) developing patient care paths to streamline education and direct care provided, and 3) developing, implementing, and evaluating transitional care practices for the spine surgery patient population.

Initiating change is a highly complex process within organizations, therefore following a theoretical framework can provide stakeholders with a basis for making decisions, establishing control, and obtaining desired outcomes. Transitional care practices within highly complex organizations will require both change theory to advance the organizations way of thinking, along with a transitional care model to guide program development. Models of care that were used to facilitate the adoption of new processes include Kotter's Change Management Model and Naylor's Transitional Care Model [2,3].

Transitional care models focus on maintaining high quality care across healthcare settings. Unique features include care coordination by the same advanced practice nurse or health professional and utilizing evidenced-based protocols with the focus on long-term outcomes. The core components of the Transitional Care Model (TCM) provide a holistic, person/family centered approach to care, along with strong communication systems that spread across settings [4].

The guiding principles surrounding John Kotter's Change Theory can be successful in guiding change within complex organizations. Each stage acknowledges a key principle relating to people's response and approach to change, and in which people see, feel, and then change. In organizations, stakeholders must support the change in order for it to be successful. A key early task is to create a sense of urgency around the need for change [5]. Leaders can accomplish this through extensive competitor and market analysis, performing a SWOT analysis, and thorough interpretation of results. Effective communication of results is essential for stakeholders to understand the need for change.

Coordinating Care Delivery

The spine surgery population health coordinator is hospital-based and responsible for program development, implementation and evaluation. With hospital administration support, the population health coordinator role was autonomous in building the program based on Joint Commission standards for disease-specific certification. To meet program standards, committee members organized a tactical plan that served as a template for meeting program outcomes. (Table 1). It is also crucial for organizations to understand how care coordination was managed to better maneuver patients throughout the continuum of care. Referred from the primary health setting, three surgeons were identified as performing spine surgery at the community hospital in which this program was developed. The

surgeons were active participants in outlining care delivery practices. Surgeon offices coordinate preoperative testing and refer the patients to the preoperative spine class that was performed by the hospital-based coordinator. It is important to note that the relationships that were developed allowed for open communication during the preoperative phase for patients served. The hospital-based coordinator

worked with both the preadmission department at the hospital and surgeon office staff to make sure all patients received essential laboratory testing and preoperative education as outlined within the American Association of Neuroscience Nursing's (AANN) clinical practices guidelines for the care of the cervical and thoracolumbar spine surgery patient [6,7].

Tactic	Outcomes
Program Development	Develop committee membership
	Develop program vision/mission statement/scope of service/target population
	Develop performance improvement (PI) plan for the spine program and identify quality measures
	Develop staff education and competency plan.
Community Education	Annual community event and health fair for patients
	Annual community event for home health, long term care, and acute rehabilitation facilities
	Physician CME (schedule set, topics, invitations, speakers)
	Physician outreach and awareness building (Medical Staff Matters newsletter, program brochure development, population coordinator to serve as a liaison for physician offices and inpatient care)
	Patient Education (quarterly seminar, Stay Informed column, Call Center information, MD office brochure, Information Technology trending for preoperative class participants)
	Website development (call to action, calendar of events spine program outcomes)
Primary Care Physicians	Physician office staff relationship building with inpatient team (yearly breakfast)
	Surgeon offices
Pre-operative Care	Pre-operative education class development (handout materials, mandatory attendance, equipment lists, pre-operative checklist for patients and coach, fall prevention, vaccine, MRSA screening, role of coach, Spanish-speaking class, 1:1)
	Pre-admission testing (anesthesia evaluation, pre-emptive pain management, pre-operative checklist, history and physical, medication reconciliation)
	Pre-operative skin cleansing
Operative Care	Data evaluation for efficiency models (on time start times, cancellations, use of double rooms, turnover of rooms, block time for physicians, dedicated Operating Room team)
	Schedule distribution and care coordination conference development
Hospital Care	Environment of care (dedicated space, staff, wellness model, identity in the organization,
	Care standards (use of order sets, pain control).
	Involvement of discharge planners,
	Plan for self-care, management of disease progression, and health promotion
	Anesthesia involvement in post- operative care
	Define the role of the Population Health Coordinator

Table 1: Disease specific program tactical plan.

During the intraoperative and postoperative phases of care, the population health coordinator continued to follow patients throughout their stay. For patients going home following surgery, designated nurse practitioners would perform education prior to discharge. The population health coordinator would then follow-up via phone call within three days post discharge home. For those staying inpatient, the health coordinator rounded daily to assess needs and further work with nursing staff to educate and prepare the patient for discharge.

Following discharge home, the inpatient population would also receive a follow-up phone call to verify all needs were met and questions have been addressed.

Though preoperative, intraoperative and postoperative care for patients being discharged home was addressed, a gap was identified for spine surgery patients who required home health services or acute rehabilitation. Program leadership found it essential to build

relationships with various home health agencies and rehabilitation facilities in which our spine surgery patients utilized. Meetings were held with leaders throughout home health and acute rehabilitation to discuss the benefits in developing relationships to support ongoing education and patient follow-up for the patient undergoing spine surgery. It was decided that the population health coordinator would educate these facilities on the management of spine surgery patients following discectomy, laminectomy, and/or spinal fusion. Agencies were aware of the follow-up care that was educated to patients within the inpatient setting so that it could be translated the same way by home health care and acute rehabilitation providers. Further education was provided to these agencies on an annual basis with a focus on mobility following surgery, application and care of the cervical collar, and medication management. Comprehensive coordination of care throughout the continuum allowed for success of the program and enhanced outcomes for patients served.

Along with the delivery of education to clinical staff throughout the continuum, the population health coordinator planned annual community health fairs whose topics focused on increasing knowledge

on minimally invasive spine surgery and stabilization of the spine. The community was educated on ways to maintain a healthy spine, stroke prevention, diabetes prevention, preventing falls, smoking cessation and had opportunities to meet with physical therapy and chiropractors practicing throughout the community. Community health fairs were well attended and allowed our community members the opportunity to learn about maintaining a healthy lifestyle and inquire on questions pertaining to spine health.

As this article describes the benefits of developing a comprehensive spine surgery program with an emphasis on coordinating care delivery, it is crucial for organizations to understand both the pros and cons to disease specific program development. The development of a program that is not sustainable, can negatively impact the care of patient populations served (Table 2). The benefits to comprehensive programs focus on streamlined care delivery and coordination with an emphasis on quality, while the cons are related to time and cost of care. Organizations seeking to develop comprehensive programs can perform a thorough gap analysis to compare actual versus desired performance.

Pros	Cons
<ol style="list-style-type: none"> 1. Enhanced Care Coordination 2. Increased Communication Across Care Settings 3. Focused Patient Education <ul style="list-style-type: none"> • Increased preparedness • Decreased anxiety 4. Continuous Quality Improvement <ul style="list-style-type: none"> • Disease-specific populations 5. Physician Engagement 6. Ongoing Nursing Professional Development <ul style="list-style-type: none"> • Education • Competency 7. Antimicrobial Stewardship <ul style="list-style-type: none"> • Increasing patient education on the use of antibiotics during preoperative education course 	<ol style="list-style-type: none"> 1. 1.0 FTE Dedicated to Disease Specific Care <ul style="list-style-type: none"> • Population Health Coordinator: Spine 2. Costs Associated: <ul style="list-style-type: none"> • Preoperative Antimicrobial Bathing Supplies • Community Events 1x/year • Community Healthcare Event 1x/year Home Health Long Term Care Acute Rehabilitation 3. One on one education for patients not able to attend formal preoperative course. 4. Increased number of physician stakeholders impacts standardization compliance

Table 2: Comprehensive spine program development: Pros and cons.

Conclusion

The implementation of a structured comprehensive program has the potential to decrease readmissions. Readmission rates are being scrutinized by payer sources because they have an impact on reimbursement. Preventable readmissions or re-hospitalizations directly affect patient safety, patient outcomes, hospital reimbursement, and hospital accreditation. Preventable readmissions can be controlled by comprehensive discharge planning and closing the loop [8]. Because population health coordinators are directly involved in preparing the patient for discharge, they will have a strong role in redefining transitional care practices across the continuum.

To successfully develop a comprehensive program that is population-based, all aspects of care delivery must be analyzed. Organizations can utilize population coordinators as liaisons to help develop a plan of care to meet the needs of the patient. Population coordinators currently exist across healthcare settings for stroke, spine, congestive heart failure, chest pain, diabetes, and hip/knee patient populations. The population health coordinator role is instrumental in

performing community education, inpatient education, preoperative preparedness, and follow-up phone calls post discharge. If organizations decide to develop a comprehensive program that is population-based, health coordinators can develop collaborative partnerships with facilities their patient population may be discharged. These relationships with allow for enhanced communication and care delivery that extends throughout the continuum.

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