Beth Ann Swan, Madridge J Nurs. 2016
http://dx.doi.org/10.18689/2638-1605.a1.002

Coordinating care and managing transitions in community health nursing: The value proposition

Beth Ann Swan
Thomas Jefferson University, USA

Healthcare changes over the past few years have challenged the health care system to find ways to manage the complex health needs of individuals and the population by increasing access to care and managing costs while providing the highest quality of care. Safe, efficient and effective transitions between providers, levels of care, and various care settings will be key factors for success. The Affordable Care Act (2010) established provisions for Patient-Centered Medical Homes and Accountable Care Organizations where care coordination and transition management are methods to provide safe, high quality care to at-risk populations, such as patients with complex chronic conditions. In an era where cutting costs and registered nurses from community health settings is prevalent; three areas for development are: 1) a model for registered nurse care coordination and transition management (RN in CCTM) with high risk patients; 2) measures to track the impact of the RN in CCTM and; 3) methods to explicate the value proposition for deployment of community health RNs.

The work of registered nurses has been invisible due to insufficient documentation and absence of process and outcome performance measures. A logic model, was developed to delineate, dimensions of the RN in CCTM role; activities, short, medium, and long term outcomes of each dimension and to specify measures and the value proposition for the RN-CCTM as part of an interprofessional team in the community. Uses of the logic model for the RN in CCTM and their contributions to individual, family, and community outcomes will be presented. Use of the logic model for the RN in CCTM in development of a business case for investment in registered nurses doing CCTM will also be delineated.

As much of the needed care and services are delivered beyond the hospital walls in the community, community health nurses are well-positioned to advocate for and provide care coordination and transition management.

This presentation will discuss: 1) processes of developing and using a logic model to capture impact and value of care coordination and transition management in community health nursing, and 2) use of the logic model in developing a business case for investment in registered nurses doing care coordination and transition management in community health nursing.

Biography:

Dr. Beth Ann Swan is Dean at the Jefferson College of Nursing at Thomas Jefferson University. Dr. Swan is a Fellow of the American Academy of Nursing. She is past president of the American Academy of Ambulatory Care Nursing and a 2007-2010 Robert Wood Johnson Executive Nurse Fellow. Dr. Swan was a member of the Veterans Health Administration Choice Act Blue Ribbon Panel and is a member of the Josiah Macy Jr. Planning Committee for Preparing Registered Nurses for New Roles in Primary Care. She also served as an Honorary Visiting Expert, Health Manpower Development Plan (HMDP) for the Ministry of Health, Singapore.Dr. Swan has a distinguished record of extramural funding, publications, and presentations nationally and internationally.