Emerging Roles & RNCM Practice

Kelly Kruse Nelles MS RN APRN-BC
Lead Faculty

1

Learning Outcomes:

1. Describe the impact of the passage of the Affordable Care Act, release of the Future of Nursing Report 2010 and the Triple Aim on the emergence of RNCM roles.
2. Recognize the history/evolution of CM roles including nursing, social work and psychology.
3. Identify the professional documents defining RN and RNCM Practice.
4. Define case management, care management and care coordination as it relates to RNCM practice.

2

The Affordable Care Act, Future of Nursing Report and Triple Aim

Shaping the Emergence of Contemporary RNCM Roles

3

Passage of the Affordable Care Act (2010)

- Increase in call for RNs to practice in case manager, care manager and care coordination roles
- Across all practice settings
- Specifically highlights care coordination via case management as:
  "an essential component of high-quality care"
- Is a requirement of:
  - Accountable Care Organizations
  - Patient Centered Medical Homes

4

Looking Back to Look Ahead: Evolution of the Role

1860s response to new immigrant and poor
- Recognition that there was a lack of coordination of health and human services
- Settlement Houses emerged – Henry Street Settlement New York City (Nursing) /Hull House Chicago (Social Work)

1863 Massachusetts established the first Board of Charities
- Coordinate and conserve public funds to care for the sick and poor

1890 American Public Health Nursing founded by Lillian Wald
- CM services emphasized client as participant in choosing their healthcare

Early 1900s first US Public Health case management system
- By 1909 all States had organized some form of Public Health

1909 Wald convinced Metropolitan Life Insurance to provide visiting nurse services for its customers during periods of illness to forestall paying death benefits
- By the 1920s Metropolitan Life had saved $43 million as a result of implementing a nurse case management system

5

1935 Passage of the Social Security Act
- allowed for funding to support activities directed toward individualized health care

1940s WWI Veterans returned home with many physical and mental health problems
- The first VA medical center was established in Los Angeles
- Increased coordination of services by insurance companies for veterans

1960s Legislated deinstitutionalization of the mentally ill
- Large numbers of mentally ill discharged into the community
- Government funded CM programs to assist these patients with the transition
- Behavioral health workers expanded their use of CM tools and strategies

1970s Workers' Compensation insurers implemented CM programs
- focused on "return to work"

1970s & 1980s Multiple federally funded demonstration projects
- focused on LTC and community-based CM programs

6

1980s healthcare costs escalating due to fee for service structure
- Prospective payment system with diagnosis related groups (DRGs)
- Managed care and HMOs
- Hospital-based CM focused on cost management with development of discharge planning, utilization review, insurance coordination and authorization

1990s federal government again looking for new care delivery models
- The public now viewed healthcare as having been taken over by corporations resulting in restrictions of access to providers and services
- Health outcomes were not improving
- New models that emphasized quality and safety were being sought

2010 Passage of the Patient Protection and Affordable Care Act

Release of the Institute of Medicine's Future of Nursing Report
- Case management, Care Management, Care Coordination identified as key
- Nurses in these roles identified as essential

National Registered Nurse Case Manager Certificate Program

7

The Future of Nursing Report

"… begins with the assumption that nursing can fill new and expanded roles in a redesigned health care system."

"The report calls on nurses, individually and as a profession, to embrace changes needed to promote health, prevent illness, and care for all people in all settings across their lifespan."

National Registered Nurse Case Manager Certificate Program

8

Traditional nursing competencies will dominant a reformed healthcare system:
- care management
- care coordination
- patient education
- public health interventions
- transitional care

"Given their education, experience and unique perspectives and centrality of their role in providing care, Nurses will play a significant role in the transformation of the U.S. healthcare system." – Future of Nursing 2010

National Registered Nurse Case Manager Certificate Program

9

Since the Passage of the ACA

- Triple Aim
  - Improving the individual experience of care
  - Improving the health of populations
  - Reducing the per capita costs of care for populations
- Case Management, Care Management, Care Coordination
- RNCMS now present in all care setting patients move through

IHI Triple Aim

National Registered Nurse Case Manager Certificate Program

10

Emergence of Patient-Centered RNCM Roles

- Different from the acute care model
- Focuses on the nurses effectively partnering with groups of high need patients, including their family caregiver, to:
  - Manage chronic conditions more successfully
  - Access healthcare resources more appropriately
  - Improve health outcomes
- This Patient-Centered Pathway
  - Patient engagement
  - Population health
  - Safe care transitions
  - Care coordination across the healthcare continuum

National Registered Nurse Case Manager Certificate Program

11

Titles:
- RN Case Manager
- RN Care Manager
- Nurse Care Coordinator
- Transitional Care Nurse
- Discharge Planner
- Nurse Coach/Health Coach
- Nurse Navigator/Care Navigator
- Complex Care Manager

All work in "front line" positions partnering with patients and their family caregivers to ensure they receive the right care at the right time

Settings:
- Primary Care
- Acute Care Transitions
- Ambulatory and Community-based Clinics, FQHCs
- Home Health Services
- Hospice
- Long Term Care/Skilled Nursing/Rehab
- Occupational Health
- Retail Clinics
- Public Health Settings

National Registered Nurse Case Manager Certificate Program

12

Professional RNCM Practice

The Nursing Framework that Supports Practice Development

National Registered Nurse Case Manager Certificate Program

13

RNCM Roles & Full Scope Practice

"Practicing to the Top of Your License":

Nurses practicing to the full extent of their competencies, knowledge, and skills that they are educated, competent and authorized to perform

- Nursing Education
- State Nurse Practice Act
  - Multi-State Licensure/Nurse Licensure Compact: https://www.ncsbn.org/nurse-licensure-compact.htm
- Standards of Practice
  - Nursing Profession
  - Specialty Practice Area

National Registered Nurse Case Manager Certificate Program

14

Nursing Scope & Standards of Practice

Who: Registered Nurses and Advanced Practice Registered Nurses comprise the "who" constituency and have been educated, titled, and maintain active licensure to practice nursing.

What: Nursing is the protection, promotion, and optimization of health and abilities; prevention of illness and injury; facilitation of healing; alleviation of suffering through the diagnosis and treatment of human response; and advocacy in the care of individuals, families, groups, communities, and populations.

Where: Wherever there is a patient in need of care.

When: Whenever there is a need for nursing knowledge, compassion, and expertise.

Why: The profession exists to achieve the most positive patient outcomes in keeping with nursing's social contract and obligation to society
https://www.nursingworld.org/practice-policy/scope-of-practice/

Innovation Award Recipient Center for Championing Nursing in America

15

Case Manager Standards of Practice

- Case Management Society of America (CMSA)
  - *Standards of Practice for Case Management*
  - https://cmsa.org/sop22/
  - ANCC recognizes CMSA Standards of Practice

- Others:
  - American Case Management Association (ACMA)
  - National Association of Social Work (NASW)
  - American Board for Occupational Health Nurses (ABOHN)
  - Association of Rehabilitation Nurses (ARN)

National Registered Nurse Case Manager Certificate Program

16

Comparison of the Nursing Process & the Case Management Process (Nursing Case Management, 4th Ed., ANA)

CORE FUNCTIONS OF THE NURSING PROCESS	CORE FUNCTIONS OF THE CASE MANAGEMENT PROCESS
Assessment	Assessment
Diagnosis	n/a
Planning	Planning
Implementation	Implementation
n/a	Coordination and Interaction
Monitoring and Evaluation	Monitoring and Evaluation
n/a	Outcomes

National Registered Nurse Case Manager Certificate Program

17

Components of the Case Management Process (CMSA Standards of Case Management, 2022)

Client Identification, Selection & Engagement
Assessment and Opportunity Identification
Development of the Case Management Plan of Care
Implementation and Coordination of the Case Management Plan of Care
Monitoring and Evaluation of the Case Management Plan of Care
Closure of the Professional Case Management Services

National Registered Nurse Case Manager Certificate Program

18

Critical Functions Required throughout the CM Process

- Communication
- Facilitation
- Coordination
- Collaboration
- Advocacy

19

Case Management, Care Management, Care Coordination and RNCM Practice

20

Defining Nursing Case Management

ANCC Approved Definition:

"Nursing Case Management is a dynamic and systematic collaborative approach to providing and coordinating healthcare services to a defined population. It is a participative process to identify and facilitate options and services for meeting individual's health needs, while decreasing fragmentation and duplication of care, and enhancing quality, cost-effective clinical outcomes. The framework for nursing case management includes five components: assessment, planning, implementation, evaluation and interaction."

21

CMSA Approved Definition:

"Case Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost-effective outcomes."

22

Defining Nursing Care Management

Care Management Evolving Definition:

Comprehensive coordination that integrates medical and systems knowledge into care specific to the needs of the patient with multiple chronic conditions and their family caregivers. Focuses on population monitoring and interventions to improve patient outcomes as they negotiate their own complex medical issues. -

(Luther, et al. (2019). Essential nursing care management and coordination roles and responsibilities: A Content analysis. *Prof Case Mgt*, Vol. 24, No. 5; p 249-258.)

23

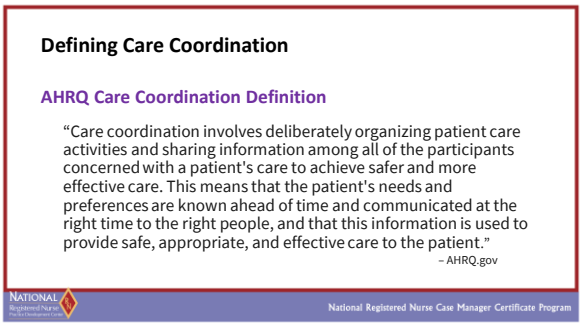
Care Managers

Use a range of strategies focused on helping chronically ill populations optimally care for themselves as they negotiate care across systems and settings. Care management focuses on providing effective disease management that includes accurate assessment. Care managers continually use their knowledge of treatment, medications, and tests, and proactively prepare patients for expected points of transition or destabilization. Highlights of the role also include self-management support, advocacy and non-judgmental relationship focused on partnership.

(Luther, et al. (2019). Essential nursing care management and coordination roles and responsibilities: A Content analysis. *Prof Case Mgt*, Vol. 24, No. 5; p 249-258.)

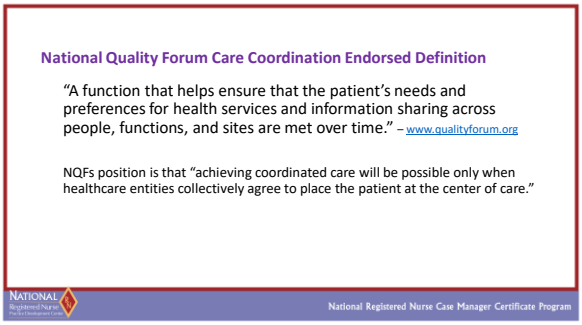
24

25

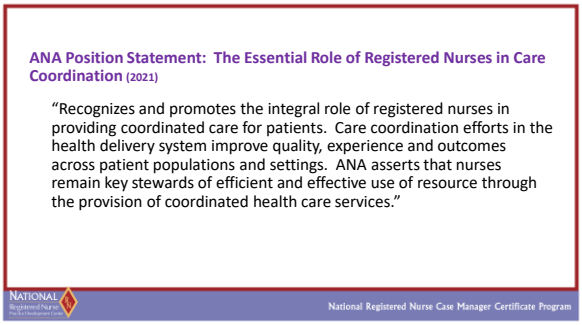


26

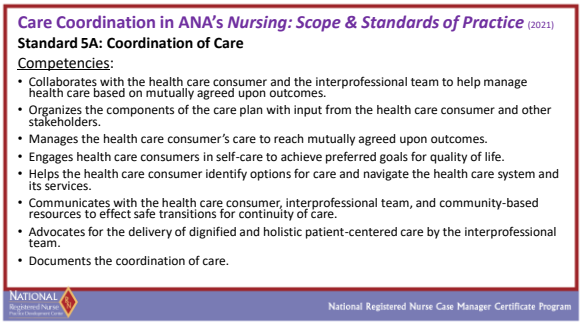
27



28



29



30

ANA Code of Ethics for Nurses

- Supports the central role of the RN in care coordination by:
  - Emphasizing the RNs role in collaborating with patients and caregivers
  - Elevating patient self-determination
- Explains that the patient, family or caregiver is at the center of care coordination needs and that registered nurses are advocates for these individuals' role in self-management and shared decision making

31

Care Coordination:

- The expectation is that all patients, regardless of their diagnosis, the severity of their illnesses or their social situation, need to have their care coordinated
- All patients require that their providers address their needs and preferences communicate pertinent information with other providers and across settings and assure that needed treatments and services are implemented in a timely and effective way.

32

Transitional Care:

The processes involved in linking care across settings, is an important component of care coordination for all patients.

Practices related to care transitions may require more intensive or extensive care coordination in the form of case management.

33

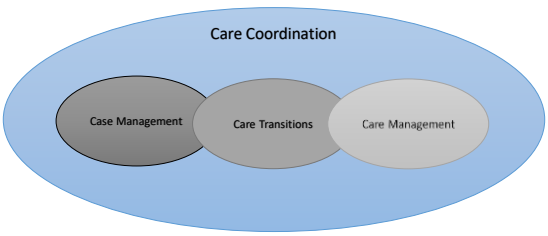
Case Management:

- Usually reserved for individuals with complex array of physical, emotional and social health needs at risk of significant adverse outcomes and very expensive care.

Care Management:

- Expands on elements of case management and care coordination in the primary care setting to proactively address the complexity of health care needs of individuals and populations.

34



35

Next Steps

- Review the posted Resources. Download any you would like to keep.
- Complete the Practice Development Activity
- Take the Test Your Knowledge Self-Assessment Quiz
- When you're ready move onto the next topic

- Questions? Let me know:
  - Kelly.kruse@nationalrn.com
  - (608) 437-6035 CST

36