

**RNCM Networking & Resources:
Advancing Care Coordination**

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KEYWORDS

- Internal Networking
- External Networking
- Service Planning
- Resource Allocation
- Assessment
- Community Resources
- Community Health Workers



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Professional Networking

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Professional Networking

- Gain Information
- Increase visibility in your role
- Establish personal connections



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Networking is about:

- creating opportunities
- establishing case management/care coordination contacts
- Important strategy to ensure success in your role

Your network should never be static

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Look for Contacts Everywhere

- your network should have lots of variety
- includes both internal and external contacts
- represent the needs of your patient population

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Internal – Be visible within your organization & community

- Be informed
- Make key contacts
- Share your commitment
- Be prepared
- Contribute/Share
- Stay in Touch



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External – Expand your contacts to support your professional role development and making connections to benefit patient care

- Professional organizations, meetings, community service
- Network by attending regularly, meeting new people
- Be prepared to describe what you do
- Business cards ready
- Follow up with contacts that you make



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Build a Reputation

- Be seen as someone who is knowledgeable, skilled, helpful, valuable
- Maintain regular and consistent contact with people that you want to stay in touch with
- Follow up
- Become known as a powerful resource to others



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Build Relationships

- Start and maintain a data base of the contacts in your network
- Keep in touch by sharing
- Be yourself



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A strong network :

- get advice from trusted sources
- keep your professional knowledge current
- better engage in service planning
- connect with community resources



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RNCM Service Planning & Resource Allocation



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Service Planning & Resource Allocation

- Requires knowledge of public & private services and resources
- Insurance companies – medical necessity
- Charitable services
- Informal sources: patient's family and friends
- Community-based agencies including affiliated religious groups
 - (e.g., Faith Community Nurses)

The unique features of each patient's case will determine the service planning & coordination details

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Flexibility & Creativity



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Identifying Community Resources

- Advancing Care Coordination requires the RNCM to know:
 - What services are available
 - Who is eligible
 - Cost
 - How to access including hours of operation
 - Referral requirements
 - Request pamphlets, brochures, business cards

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Community Resources & the Medical Neighborhood

RNCMs need to expand their thinking to look at care coordination from a population health approach

Look at the Medical Neighborhood

- What resources are available
- Where are the resource gaps

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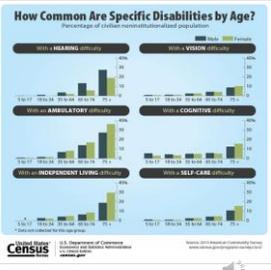
RNCM Resources

Aging & Disability

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Disabilities

- 61 million (1:4) adults live with a disability
- 2:5 adults over age 65 have a disability
- 1:4 women have a disability
- 2:5 Non-Hispanic American Indian/Alaska Natives have a disability
- More likely to also be obese, smoke, have heart disease and diabetes



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ADRCs – Aging & Disability Resource Centers



- U.S. Administration for Community Living
- Centers for Medicare & Medicaid Services
- Veterans Health Administration
- States developed local community centers that make it easier for older adults and individuals with disabilities to learn about and quickly access services and supports
- Eldercare Locator: <https://eldercare.acl.gov/Public/Index.aspx>

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Durable Medical Equipment (DME)



- Equipment & supplies ordered by a health care provider for everyday or extended use
- Medicare Part B approved list
 - Can include oxygen, wheelchairs, crutches, blood testing supplies for diabetics
- DME Criteria
 - Durable (can withstand repeated use)
 - Used for a medical reason
 - Used in your home
- Generally, has an expected lifetime of at least 3 years
- <https://www.medicare.gov/coverage/durable-medical-equipment-dme-coverage>

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STEADI

Stopping Elderly Accidents, Deaths & Injuries

- Standardized process for screening patients for fall risk
- CDC Toolkit provides:
 - A framework for implementing a fall prevention program
 - Strategies for assessing at risk patients for modifiable risk factors
 - Risk factor specific interventions to reduce falls
- A match for any RNCM practice that is focused on chronic care management of high need populations



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What Matters to Older Adults: Age Friendly Systems

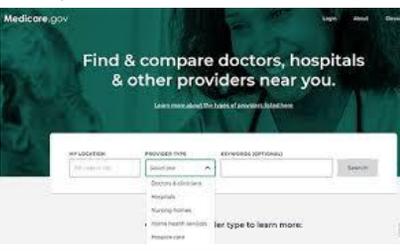
- A toolkit for health systems to design better care with older adults
- Age Friendly Systems initiative of The John A. Hartford Foundation & the Institute for Healthcare Improvement (IHI)
- Actionable steps to:
 - Ensure that every older adult's health outcome goals and care preferences are understood, documented, and integrated into their care

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CMS Care Compare

<https://www.medicare.gov/care-compare/>



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RNCM Resources

Screening & Assessment Tools

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Screening Tools

Process for evaluating the possible presence of a particular problem using a simple yes or no



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Screening Tools that Capture Social Needs

- Addressing SDoH includes screening for social needs
 - Identifying an individual or family's social needs (e.g., food insecurity)
 - Connecting to resources to address
- Social needs and risk factors are different for each patient

RNCMs are well positioned to screen for and identify social risk factors and unmet social needs of individuals and tailor interventions to address

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Screening Tools Can Help

What to Consider When Choosing a Screening Tool:

- Capacity to address specific needs
- Ease of completing tool in clinical setting
- Ability of the tool to capture specific needs that the organization can address
- Practice Tip:** check your EHR

Food <ul style="list-style-type: none"> Hunger Access to grocery stores Affordability of food Access to quality health, food 	Community and Social Environment <ul style="list-style-type: none"> Social integration Support systems Racism and discrimination Community engagement 	Health Care System <ul style="list-style-type: none"> Health insurance Provider availability Linguistic and cultural competency Quality of Care
Economic Stability <ul style="list-style-type: none"> Employment Income Habit Medical bills Support 	Neighborhood and Physical Environment <ul style="list-style-type: none"> Stable Housing Transportation Safety Walks Parks Midwalks Community Center/Recreation 	Education <ul style="list-style-type: none"> Literacy Early childhood education High school graduation Higher education Vocational training

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Accountable Health Communities Core Health Related Social Needs Screening Tool

- CMS Innovation Center
- 10-item HRSN Screening Tool
- Assesses 5 core domains:
 - Housing instability
 - Food insecurity
 - Transportation problems
 - Utility help needs
- Nurses can use the results to inform patients' treatment plans and make referrals to community services
- Is meant to be self-admin



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The EveryONE Project - Social Needs Screening Tool

- American Academy of Family Physicians
- Available in Spanish and English
- 11 Questions
- Can be self-administered or administered by clinical staff



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PRAPARE – Protocol for Responding to and Assessing Patients’ Assets, Risks and Experiences Tool

- National Association of Community Health Centers
- Action Toolkit used by FQHCs
- 15 Core Questions and 5 Supplemental
- Data can be directly uploaded to most EHRs
- Generally administered by clinical staff at the time of the visit
- Paper version can be given to the patient to self-administer



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Assessment Tools

Evidence informed tools to learn more about the patient's overall health & symptoms

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Katz Index of Independence in Activities of Daily Living

- Assesses functional status
- Ability to perform ADLs independently
- Detects problems performing ADLs
- 6 functional areas
- Scoring:
 - 6 = full function
 - 4 = moderate impairment
 - 2 or < = severe functional impairment

ACTIVITIES (Items 1 to 6)	INDEPENDENCE: (0 POINTS)	DEPENDENCE: (6 POINTS)
RATHING: Patient: _____	1) Patient bathes with complete or partial help or transfers only a single part of the body such as the back, genital area or distal extremity.	0) Patient bathes with help, using one part of the tub/shower. Requires total bathing.
DRESSING: Patient: _____	1) Patient can dress from chest and legs and can do the complex and difficult garments or shoes with fasteners. May have help for shoes.	0) Patient needs help with dressing or needs to be completely dressed.
TOILETING: Patient: _____	1) Patient can toilet, get on or off of toilet/shower, clean genital area without help.	0) Patient needs help transferring to the toilet, sitting on it or using toilet or shower.
TRANSFERRING: Patient: _____	1) Patient moves in and out of bed or chair unassisted. Requires transfer-aid and/or assistance.	0) Patient needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE: Patient: _____	1) Patient functions completely without any incontinence or defecation.	0) Patient is unable to totally control bowel or bladder.
FEEDING: Patient: _____	1) Patient can feed three solid meals without help. Preparation of food may be done by another person.	0) Patient needs general or total help with feeding or requires assisted feeding.

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The Lawton Instrumental Activities of Daily Living Scale

- Measures more complex skills than the basic ADLs measured by the Katz
- Identifies how a person is functioning at present & overtime
- Scoring:
 - 0 = low function, dependent
 - 8 = high function, independent

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Mini-Mental State Examination (MMSE)

- Validated assessment tool
- Tests 5 areas of cognitive function
- 5-10 min to administer
- Used repeatedly & routinely
- Scoring:
 - Maximum = 30
 - 23 or < = cognitive impairment

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Preparedness for Caregiving Scale

- Caregiver self-rated instrument
- 8 items that asks caregivers how well prepared they believe they are
- Assesses multiple domains of caregiving
- Scoring:
 - 0 = not at all prepared
 - 4 = very well prepared

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Burden Scale for Family Caregivers

- Assesses caregiver related variables
- Specific to home care of chronically ill persons
- Assesses the way the family caregiver deals with the care recipient
- Can determine time of institutionalization

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Assessment Tool Tips



- Allow data collection during your assessment to become conversational
- Listen deeply to your patient's stories
- Ask questions to better understand your patient's distinct perspective
- Avoid assumptions

The quality and depth of your assessment informs services and resources that will be needed

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RNCM Resources

Working with Community Health Workers

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Community Partnerships
Community Health Workers



- Frontline health workers who are trusted members of and/or have an unusually close understanding of the community served
- Public Health Model that began in the 1970s
- CHWs to serve as a liaison, link, or intermediary between health/social services and the community
- Role includes providing outreach, community education, informal counseling, social support, and advocacy

Community Health Worker Toolkit (CDC)
<https://www.cdc.gov/dhds/pubs/toolkits/chw-toolkit.htm>

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Joint Statement Tri-Council for Nursing (2017)
American Association of Colleges of Nursing, American Nurses Association, American Organization of Nurse Executives, National League for Nursing

"The Essential Role of the Registered Nurse and Integration of Community Health Workers into Community Team-Based Care"

- Describes the relationship of RNs and CHWs
- Role in achieving individual and population health outcomes
- Acknowledges new and modified roles for clinicians and other caregivers
- High impact teams

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Next Steps

- Review Resources, Assessment Tools & Practice Toolkits
- Use this time to organize yourself
- No videos or quiz

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