RNCM Networking & Resources:
Advancing Care Coordination

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Lead Faculty

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- 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 by 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

RNMCs 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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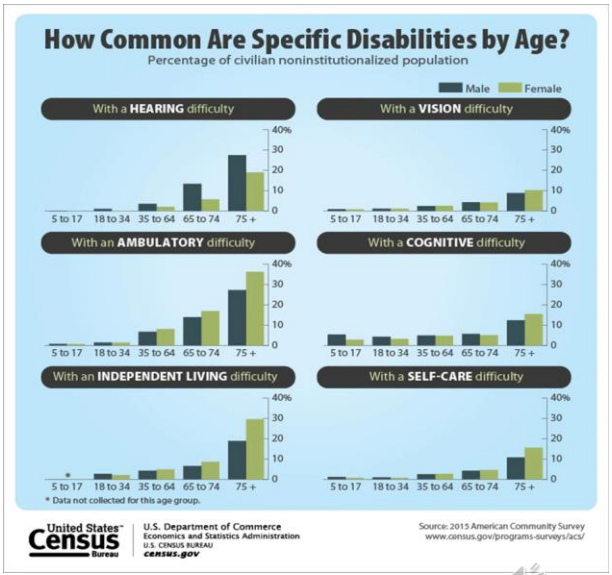
Disabilities

- 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

se this checklist to find and fix hazards in your home.

STAIRS & STEPS (INDOORS & OUTDOORS)

Are there papers, shoes, books, or other objects on the stairs?
- ☐ Always keep objects off the stairs.

Are some steps broken or uneven?
- ☐ Fix loose or uneven steps.

Is there a light and light switch at the top and bottom of the stairs?
- ☐ Have an electrician put in an overhead light and light switch at the top and bottom of the stairs. You can get light switches that glow.

Has a stairway light bulb burned out?
- ☐ Have a friend or family member change the light bulb.

Is the carpet on the steps loose or torn?
- ☐ Make sure the carpet is firmly attached to every step, or remove the carpet and attach non-slip rubber treads to the stairs.

Are the handrails loose or broken? Is there a handrail on only one side of the stairs?
- ☐ Fix loose handrails, or put in new ones. Make sure handrails are on both sides of the stairs, and are as long as the stairs.

FLOORS

When you walk through a room, do you have to walk around furniture?
- ☐ Ask someone to move the furniture so your path is clear.

Do you have throw rugs on the floor?
- ☐ Remove the rugs, or use double-sided tape or a non-slip backing so the rugs won't slip.

Are there papers, shoes, books, or other objects on the floor?
- ☐ Pick up things that are on the floor. Always keep objects off the floor.

Do you have to walk over or around wires or cords (like lamp, telephone, or extension cords)?
- ☐ Coil or tape cords and wires next to the wall so you can't trip over them. If needed, have an electrician put in another outlet.

KITCHEN

Are the things you use often on high shelves?
- ☐ Keep things you use often on the lower shelves (about waist high).

Is your step stool sturdy?
- ☐ If you must use a step stool, get one with a bar to hold on to. Never use a chair as a step stool.

BEDROOMS

Is the light near the bed hard to reach?
- ☐ Place a lamp close to the bed where it's easy to reach.

Is the path from your bed to the bathroom dark?
- ☐ Put in a nightlight so you can see where you're walking. Some nightlights go on by themselves after dark.

BATHROOMS

Is the tub or shower floor slippery?
- ☐ Put a non-slip rubber mat or self-stick strips on the floor of the tub or shower.

Do you need some support when you get in and out of the tub, or up from the toilet?
- ☐ Have grab bars put in next to and inside the tub, and next to the toilet.

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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

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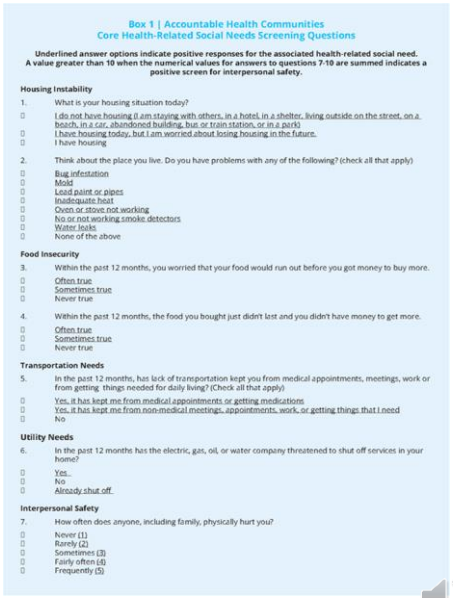
Accountable Health Communities Core Health Related Social Needs Screening Tool

- 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



Box 1 | Accountable Health Communities
Core Health-Related Social Needs Screening Questions

Underlined answer options indicate positive responses for the associated health-related social need. A value greater than 10 when the numerical values for answers to questions 7-10 are summed indicates a positive screen for interpersonal safety.

Housing Instability

1. What is your housing situation today?
   - ☐ I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
   - ☐ I have housing today, but I am worried about losing housing in the future.
   - ☐ I have housing
2. Think about the place you live. Do you have problems with any of the following? (check all that apply)
   - ☐ Bug infestation
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Inadequate heat
   - ☐ Oven or stove not working
   - ☐ No or not working smoke detectors
   - ☐ Water leaks
   - ☐ None of the above

Food Insecurity

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true
4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

Transportation Needs

5. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? (Check all that apply)
   - ☐ Yes, it has kept me from medical appointments or getting medications
   - ☐ Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need
   - ☐ No

Utility Needs

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
   - ☐ Yes
   - ☐ No
   - ☐ Already shut off

Interpersonal Safety

7. How often does anyone, including family, physically hurt you?
   - ☐ Never (1)
   - ☐ Rarely (2)
   - ☐ Sometimes (3)
   - ☐ Fairly often (4)
   - ☐ Frequently (5)

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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

Katz Index of Independence in Activities of Daily Living

ACTIVITIES Points (1 or 0)	INDEPENDENCE: (1 POINT) **NO** supervision, direction or personal assistance	DEPENDENCE: (0 POINTS) **WITH** supervision, direction, personal assistance or total care
BATHING Points: _____	(1 POINT) Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	(0 POINTS) Needs help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing.
DRESSING Points: _____	(1 POINT) Gets clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	(0 POINTS) Needs help with dressing self or needs to be completely dressed.
TOILETING Points: _____	(1 POINT) Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	(0 POINTS) Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
TRANSFERRING Points: _____	(1 POINT) Moves in and out of bed or chair unassisted. Mechanical transferring aides are acceptable.	(0 POINTS) Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE Points: _____	(1 POINT) Exercises complete self control over urination and defecation.	(0 POINTS) Is partially or totally incontinent of bowel or bladder.
FEEDING Points: _____	(1 POINT) Gets food from plate into mouth without help. Preparation of food may be done by another person.	(0 POINTS) Needs partial or total help with feeding or requires parenteral feeding.

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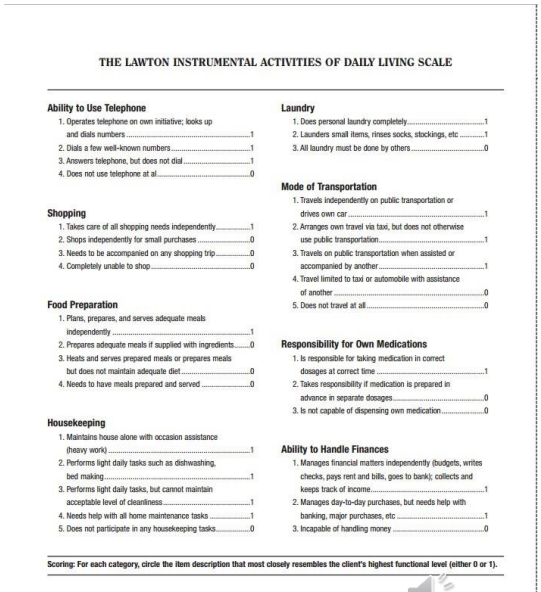
The Lawton Instrumental Activities of Daily Living Scale

- 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



THE LAWTON INSTRUMENTAL ACTIVITIES OF DAILY LIVING SCALE

Ability to Use Telephone
1. Operates telephone on own initiative; looks up and dials numbers 1
2. Dials a few well-known numbers 1
3. Answers telephone, but does not dial 1
4. Does not use telephone at all 0

Shopping
1. Takes care of all shopping needs independently 1
2. Shops independently for small purchases 0
3. Needs to be accompanied on any shopping trip 0
4. Completely unable to shop 0

Food Preparation
1. Plans, prepares, and serves adequate meals independently 1
2. Prepares adequate meals if supplied with ingredients 0
3. Heats and serves prepared meals or prepares meals but does not maintain adequate diet 0
4. Needs to have meals prepared and served 0

Housekeeping
1. Maintains house alone with occasion assistance (heavy work) 1
2. Performs light daily tasks such as dishwashing, bed making 1
3. Performs light daily tasks, but cannot maintain acceptable level of cleanliness 1
4. Needs help with all home maintenance tasks 1
5. Does not participate in any housekeeping tasks 0

Laundry
1. Does personal laundry completely 1
2. Launders small items, rinses socks, stockings, etc 1
3. All laundry must be done by others 0

Mode of Transportation
1. Travels independently on public transportation or drives own car 1
2. Arranges own travel via taxi, but does not otherwise use public transportation 1
3. Travels on public transportation when assisted or accompanied by another 1
4. Travel limited to taxi or automobile with assistance of another 0
5. Does not travel at all 0

Responsibility for Own Medications
1. Is responsible for taking medication in correct dosages at correct time 1
2. Takes responsibility if medication is prepared in advance in separate dosages 0
3. Is not capable of dispensing own medication 0

Ability to Handle Finances
1. Manages financial matters independently (budgets, writes checks, pays rent and bills, goes to bank); collects and keeps track of income 1
2. Manages day-to-day purchases, but needs help with banking, major purchases, etc 1
3. Incapable of handling money 0

Scoring: For each category, circle the item description that most closely resembles the client's highest functional level (either 0 or 1).

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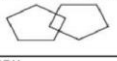
Mini-Mental State Examination (MMSE)

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

Mini-Mental State Examination (MMSE)

Patient's Name: _____ Date: _____

Instructions: Score one point for each correct response within each question or activity.

Maximum Score	Patient's Score	Questions
5		"What is the year? Season? Date? Day? Month?"
5		"Where are we now? State? County? Town/city? Hospital? Floor?"
3		The examiner names three unrelated objects clearly and slowly, then the instructor asks the patient to name all three of them. The patient's response is used for scoring. The examiner repeats them until patient learns all of them, if possible.
5		"I would like you to count backward from 100 by sevens." (93, 86, 79, 72, 65, ...) Alternative: "Spell WORLD backwards." (D-L-R-O-W)
3		"Earlier I told you the names of three things. Can you tell me what those were?"
2		Show the patient two simple objects, such as a wristwatch and a pencil, and ask the patient to name them.
1		"Repeat the phrase: 'No ifs, ands, or buts.'"
3		"Take the paper in your right hand, fold it in half, and put it on the floor." (The examiner gives the patient a piece of blank paper.)
1		"Please read this and do what it says." (Written instruction is "Close your eyes.")
1		"Make up and write a sentence about anything." (This sentence must contain a noun and a verb.)
1		"Please copy this picture." (The examiner gives the patient a blank piece of paper and asks him/her to draw the symbol below. All 10 angles must be present and two must intersect.) 
30		TOTAL

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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


try this:

Preparedness for Caregiving Scale

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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

	never	rarely	sometimes	frequently	nearly always
	0	1	2	3	4
1. Do you feel that your relative asks for more help than he or she needs?					
2. Do you feel that because of the time you spend with your relative, you do not have enough time for yourself?					
3. Do you feel stressed between caring for your relative and trying to meet other responsibilities for your family or work?					
4. Do you feel embarrassed over your relative's behaviour?					
5. Do you feel angry when you are around your relative?					
6. Do you feel that your relative currently affects your relationship with other family members or friends in a negative way?					
7. Are you afraid about what the future holds for your relative?					

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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/dhdsp/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

Questions:

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Advancing Care Coordination