Chronic Conditions and the Role of the Clinical Nurse Specialist

NACNS CHRONIC CARE TASK FORCE

NACNS Chronic Care Task Force Members

Julia N. Senn-Reeves (Co-chair), MSN, APRN, ACNS-BC, CCNS, CCRN, Chair, Bellarmine University, Kentucky
Mary P. Hansen (Co-chair), RN, MN, CCNS, CCRN, PCCN, CNS, Chair, Legacy Health, Oregon
Lori A. Dambaugh, DNP, CNS, RN, St. John Fisher College, New York
Judy K. Dusek, DNP, M.Ed., MSN, APRN-CNS, CMSRN, ACNS-BC, Via Christi Health, Kansas
Cynthia R. Kollauf, MS, RN, ACNS-BC, Aurora Health Care, Wisconsin
Renee A. Martin, MN, RN, PHCNS-BC, CGRN, Veterans Administration Portland Health Care System, Washington
Renada Rochon, MSN, RN, ACNS-BC, South Texas Veterans Healthcare System, Texas
Ludmila Maria Santiago-Rotchford, MSN, APRN, ACNS-BC, PCCN, Bayhealth Medical Center, Delaware
Mitzi M. Saunders, RN, PhD, ACNS-BC, University of Detroit Mercy, Michigan
Maureen Shekleton, PhD, FAAN, (Staff Advisor) NACNS Consultant, Illinois
M. Jane Swartz, DNP, RN, ACNS-BC, University of Southern Indiana, Indiana

BACKGROUND

- CHRONIC CONDITIONS TASK FORCE DEVELOPMENT
  - Charge from NACNS:
    - Identify activities/resources
    - Wellness to acute care
    - Across care transitions
    - Lifespan approach
  - Steps
    - Define "Chronic Conditions"
    - Relevant concepts/key words
    - Robust literature review
    - Identification of best practices r/t CNS competencies

DEFINITIONS OF CHRONIC CONDITIONS

- Uncertain etiology
- Multiple risk factors
- Prolonged course of care
- Functional impairment and disability
- Long latency period
- Noncontagious origin
- Incurability
- No physical outward signs
- Impairment in ADLs and community experiences

STATE OF CHRONIC CONDITIONS

- Most common, costly, preventable health issue (Ward, 2014)
- Leading cause of death and disability (Ward, 2014)
- 50% of all health care (Ward et. al., 2013 2014, Senate Committee on Finance, 2015)
- 86% of all healthcare costs (Geretis et. al., 2014)

STATE OF CHRONIC CONDITIONS

- Management of single chronic condition
  - pathophysiology
  - pharmacology
  - support/therapies
  - interdisciplinary
  - self care practices
- 1 in 4 adults = 2 or more chronic conditions (CDC, 2013, Ward, 2014)
- Reasons: aging population, poor nutrition, increase obesity, etc.

LEGISLATION AFFECTING CHRONIC CONDITIONS MANAGEMENT

- Affordable Care Act
  - avoidance of hospital readmissions
  - cost savings (improved coordination/management)
  - funding (education)
- Chronic Care Billing Codes
  - Care Coordination
  - Patient Communication
  - Medication Refills
  - Remote Care by Telephone
  - High Severity Chronic Care (Bipartisan Chronic Care Working Group)

PRACTICE SETTINGS

- TRANSITIONAL
  - hospital to home
- AMBULATORY
  - clinic
  - community
- HOME CARE
  - patient's home
  - home care agency

Exemplars in Practice:

The Clinical Nurse Specialist role in chronic conditions

Community Based COPD screening program

- A screening program to identify undiagnosed individuals with chronic obstructive pulmonary disease.
- Clinical Nurse Specialist directed program which helped to demonstrate how a CNS can lead and direct a community initiative which influenced behavioral change in relation to chronic disease

(Dejong & Veltman, 2004)

Expansion of Practice from Hospital to Ambulatory setting

- Described the use of a CNS provider for a population of patients and deployment of the CNS in ambulatory care settings as a case manger or care coordinator
- Identification of the important role of care coordination from the hospital to the ambulatory setting .
- Recognized the importance of the need to support nursing practice in the care of patients with complex conditions in ambulatory settings.

(Negley et al, 2016)

Clinical Nurse Specialist as Community-Based Care Manger

- Described an intensive approach for complex chronic illness management in the community
- Community Based Care Management Program developed to reduce costs of chronically ill Medicare enrollees by establishing links between the healthcare system and the community.
- Collaborative partnerships developed between Social Work and CNS case managers

(Ulch & Schmidt, 2013)

Evidence Based Continuing Education on Asthma to Nurses in Community Health

- Study demonstrates how CNS in community health can effectively respond to nurse's needs in the community
- High rates of asthma identified in a community with community health nurses identifying a need for increased asthma information related to care and management.
- Evidenced expert role the CNS may play in community needs assessment, and the identification , planning, implementation and assessment of appropriate interventions.

(Policicchio , et al., 2011)

Nurse Partners in Chronic Illness Care

- Study conducted at a family medicine outpatient practice which had initiated Wagner's chronic care model
- Practice incorporated the use of "Nurse Partners" (CNS) as chronic illness care managers
- Study purpose was to examine how patients with multiple conditions perceive the role of nurses who function in a care management role in a primary healthcare setting

(Shigaki, et al., 2010)

NEXT STEPS

"White Paper" Recommendations

- NACNS should actively advocate for the formulation of policies that impact the population of patient's with chronic conditions and their families
- Resources to ensure licensure, independent practice (prescriptive authority), reimbursable services (billing/coding)
- Promote role in chronic conditions (cost reduction, better patient outcomes)
- Additional research on role of CNS in chronic condition management

- For more information, contact info@NACNS.org

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