Chronic Conditions and the Role of the Clinical Nurse Specialist

NACNS CHRONIC CARE TASK FORCE
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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
DIRECT CARE COMPETENCY

- Home visits to develop in-depth comprehensive needs assessment and early identification of problems (Ulch & Schmidt, 2013; Adams, 2015)
- Early Screening and Identification of patients at risk for chronic conditions in the community (DeJong & Veltman, 2004)
- Management of transitions from acute to ambulatory care with nurses and other health care team members (Adams, 2015; Negley et al., 2016)
CONSULTATION COMPETENCY

- Translation of patient needs to nurses and other health care professionals (Ulch & Schmidt, 2013)
- Leading health care team members to integrate patient needs in plans of care (Ulch & Schmidt, 2013)
Development of policies and standardization of care among high cost diagnostic groups (Negley et al., 2016)
Collaboration Competency

- Leads collaborative efforts among health team members (Dejong & Veltman, 2004; Negley et al., 2016)
Use of motivational interviewing techniques (Ulch & Schmidt, 2013)

Provides formal education for community based nurses in the management of chronic conditions, (Policicchio, Nelson, Duffy, 2011).
RESEARCH COMPETENCY

- Conducts research on early identification of chronic conditions in the community setting (Dejong & Veltman, 2004).
- Uses data to assess the quality and effectiveness of CNS led clinical programs (Dejong & Veltman, 2004; Negley et al., 2016)
ETHICAL DECISION MAKING, MORAL AGENCY, ADVOCACY COMPETENCY

- Facilitation of patient/family understanding of the risks, benefits and outcomes of the proposed healthcare regimen
- Advocates for the CNS/APRN role in chronic care in the community setting. (DeJong & Veltman, 2004, Negley et al., 2016)
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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