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Nursing Executive Center

Achieving Care Continuity

Best Practices for Building a System That Never Discharges the Patient

Nursing Executive Center

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Available With Nursing Executive Center Membership

In recent years, the Nursing Executive Center has developed many resources to assist nurse leaders in coordinating care across the continuum. Select resources are shown here. All resources are available in unlimited quantities through the Nursing Executive Center.

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- Preempting Unnecessary Hospital Utilization

AVAILABLE ONLINE

To access these resources or order hard copies of the publications, please visit the Nursing Executive Center's website: advisory.com/nec.

Advisors to Our Work

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Executive Summary

The Mandate to Provide Seamless, Cross-Continuum Care

All too often, patients receive fragmented, episodic care—which leads to suboptimal clinical outcomes, avoidable health care utilization, and unnecessary spending.

Fragmented care is costly to both the nation and individual health care providers. Researchers estimate inadequate care coordination leads the US to waste between $25 and $45 billion each year. And individual providers are increasingly accountable for the total cost of care for their patients. Neither the country, nor providers, can afford to continue to deliver fragmented and episodic care.

Building a Health System That "Never Discharges" the Patient

To break down silos and deliver continuous care, health care providers need to fundamentally rethink how patients transition between settings. Currently, the central element of any transition is a patient being "discharged" from one setting and "admitted" to the next. But by definition, "discharging" a patient implies clinicians are relieved of the burden of responsibility for a patient's care.

Health systems must broaden their aspiration to include building a health system that "never discharges" the patient. The goal is for clinicians in any setting to feel responsible for a patient's care across the full continuum. For example, nurses on an inpatient medical unit feel responsible for the care and outcomes of their patients both on the medical unit as well as all other care settings the patients go to across the continuum—including primary care clinics, ambulatory clinics, post-acute care facilities, and patients' homes.

Avoiding the Trap of Perfecting One Transition at a Time

When it comes to building a health system that "never discharges" the patient, the Nursing Executive Center recommends against a one-off approach in which leaders perfect one individual transition before moving to the next. This effort can be compared to assembling a puzzle—and piecing together each care setting one by one.

The challenge with this approach is perfecting each transition is time consuming and resource intensive. There are simply too many "puzzle pieces" for it to be feasible. In addition, this approach can lead to a piecemeal end result, rather than a cohesive system that seamlessly supports patients as they move through the care continuum.

To build a system that "never discharges" the patient, the Nursing Executive Center strongly recommends leaders address underlying, systematic issues that affect all patient transitions. The goal is to implement strategies that improve transitions across multiple care settings at once—rather than working setting by setting.

Read the Study in Full to Learn More

Achieving Care Continuity equips nurse leaders with four imperatives to build a system that "never discharges" the patient. The four imperatives to achieve care continuity are:

1. Equip clinicians to provide continuous care.
2. Promote clinician ownership for cross-continuum care.
3. Promote patient and family ownership for self-care.
4. Scale up support for vulnerable patients.

Read the complete study for detailed guidance and best practices to act on each imperative.

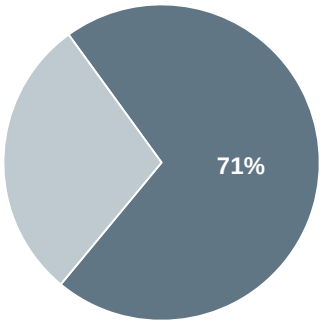
Nursing Executive Center Essay

Why We Need to Stop Thinking About “Care Transitions”

Despite health care leaders' best efforts to improve care coordination, patients continue to receive fragmented, episodic care. This manifests as care delivered in one-off visits in high acuity settings, or as avoidable utilization. According to recent studies, more than 70% of ED visits are avoidable, 4.4 million hospital trips are preventable, and 18% of hospitalized patients are readmitted within 30 days.

Huge Opportunity for Improvement

Percentage of ED Visits That Are Avoidable in the US[1]



4.4M

Estimated number of preventable trips to US hospitals each year

18%

30-day all-cause readmission rate[2]

1) Based on Truven Health Analytics analysis of 6,135,002 ED visits in 2010; "Avoidable" includes all ED visits except those for which medical care was required within 12 hours in the ED setting.
2) CMS, 2012.

Source: Truven Health Analytics, "Avoidable Emergency Department Usage Analysis," 2013, http://img.en25.com/Web/TruvenHealthAnalytics/EMP_12260_0113_AvoidableERAdmissionsRB_WEB_2868.pdf; Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project, "Nationwide Frequency and Costs of Potentially Preventable Hospitalizations, 2006," http://www.hcup-us.ahrq.gov/reports/statbriefs/sb72.jsp; CMS's 2012 Inpatient Standard Analytical File (SAF); Nursing Executive Center interviews and analysis.

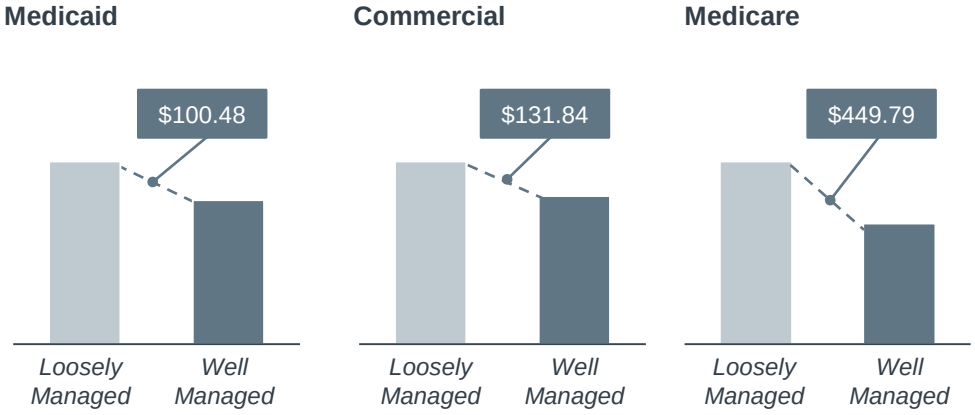
Not only does siloed care delivery lead to sub-optimal outcomes, it is also costly. Researchers estimate the US wastes between $25 and $45 billion annually from inadequate care coordination.

The benchmarks shown here provide a closer look at the cost of poorly coordinated care. They show the difference in per-member per-month costs for patients whose care is "loosely managed" versus "well managed." According to this data, patients with loosely managed care cost at least $100 per month more than those with well-managed care.

Health care providers are keenly aware of the high cost and sub-optimal outcomes that result from siloed care delivery. Accordingly, there is strong work already underway to improve care transitions.

Poor Coordination Costing Billions Nationally

Difference Between "Loosely Managed" and "Well-Managed" PMPM[1] Spending[2]



$25B-$45B

Estimated annual amount of wasteful spending resulting from inadequate coordination[3]

1) Per member per month.
2) 2011 data from Milliman.
3) 2011.

Source: Milliman; Health Affairs, "Health Policy Brief: Improving Care Transitions," 2012, www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=76; Nursing Executive Center interviews and analysis.

A common starting point for improving care transitions is preventing readmissions. And new policies—including Medicare's Hospital Readmissions Reduction Program—have created financial incentives that make readmissions a logical place for health care leaders to start.

For organizations tackling readmissions, the Nursing Executive Center recommends reviewing our publication *Nurse-Led Strategies for Preventing Avoidable Readmissions*. As shown here, it offers a strategic framework and best practices for improving two specific transitions in care: the transition from acute care to post-acute care, and from acute care to home.

Access *Nurse-Led Strategies for Preventing Avoidable Readmissions* on advisory.com/nec.

A Common Starting Point for Improving Transitions

Nurse-Led Strategies for Preventing Avoidable Readmissions

Leveraging the Inpatient Stay to Equip Patients for Long-Term Self-Management

1
Scale Interventions to Level of Risk

2
Identify and Activate Key Learners

3
Equip Patients with Accurate and Easily Actionable Post-Discharge Instructions

Facilitating Seamless Transfer to the Post-Acute Care Setting

4
Ensure Patients Are Discharged to the Appropriate Care Setting

5
Elevate PAC Quality to Ensure Safe Care for Complex Patients

6
Enable a Safe Transition Home with Immediate Follow-Up Care for Most Vulnerable Patients

Source: Nursing Executive Center, *Nurse-Led Strategies for Preventing Avoidable Readmissions*, 2011; Nursing Executive Center interviews and analysis.

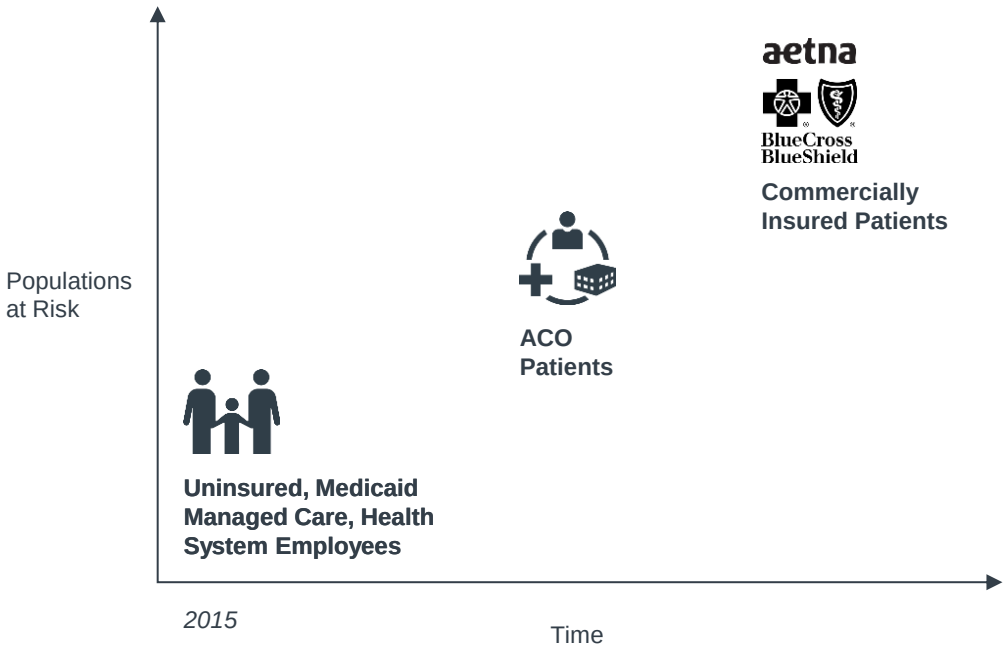
While preventing readmissions is a strong starting point for improving care transitions, providers need to expand their efforts. This is because providers are increasingly accountable for the total cost of care for patients.

As illustrated here, providers already assume full risk for uninsured patients, Medicaid Managed Care patients, and health system employees. Over time, many health care providers will assume full risk for additional patient populations, such as patients within an Accountable Care Organization (ACO) and commercially insured patients.

Being accountable for total cost of care means organizations must focus on all care transitions—not just the two transitions that are part of typical readmission efforts—because unnecessary health care spending occurs at many points along the care continuum. While preventable readmissions costs Medicare about $12 billion annually, this is only a portion of the estimated $25 to $45 billion annual cost of inadequate care coordination in the US.

Providers Increasingly Accountable for Total Cost of Care

Populations for Which Health Care Providers Assume Full Risk



$12B

Estimated annual cost of preventable 30-day hospital readmissions[1]

$25B-$45B

Estimated annual amount of wasteful spending resulting from inadequate coordination[2]

1) Medicare.
2) 2011.

Source: Health Affairs, "Health Policy Brief: Improving Care Transitions," 2012, www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=76; Nursing Executive Center interviews and analysis.

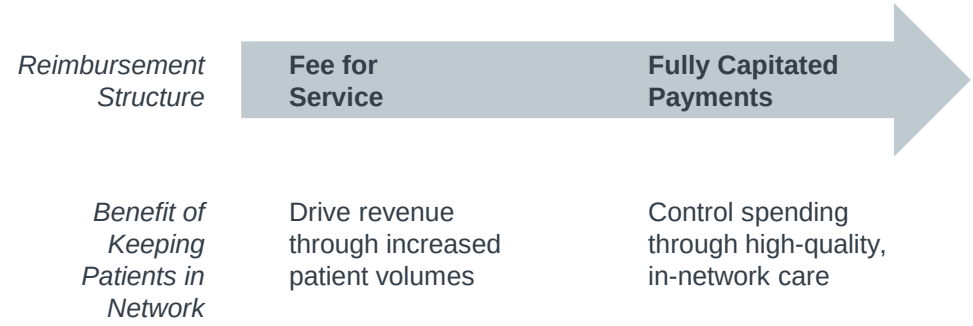
There is an additional benefit to better coordinating care and improving transitions between all settings: it keeps patients within your network.

This benefits all health care providers regardless of their payment environment. For providers in a fee-for-service environment, higher patient volumes drive revenue. For providers in capitated contracts, keeping patients in network means they can control spending by providing care in the lowest-cost, clinically appropriate setting within the network.

Keeping Patients in Network Through Care Coordination

Coordination Benefits All Organizations, Regardless of Payment Environment

Benefits of Keeping Patients in Network by Reimbursement Structure



Source: Nursing Executive Center interviews and analysis.

In sum, health care providers' future success will hinge on improving transitions between all care settings. But before taking action, it is important to clarify what it means to "improve transitions."

Currently, the central element of any transition is a patient being "discharged" from one setting and "admitted" to the next. But this concept of "discharging" a patient contributes to siloed care delivery. By definition, "discharging" a patient implies clinicians are no longer responsible for the patient's care.

In order to improve care transitions between all settings and deliver seamless care across the continuum, health systems must broaden their aspiration beyond "discharging" patients from one setting to the next. Instead, health system leaders must build a health system that "never discharges" the patient. The goal is for clinicians in any setting to feel responsible for a patient's care across the full continuum. For example, nurses on an inpatient medical unit feel responsible for the care and outcomes of their patients both on the medical unit as well as all other care settings the patients go to across the continuum—including primary care clinics, ambulatory clinics, post-acute care facilities, and patients' homes.

Clarifying Our Aspiration

Building a System That "Never Discharges" the Patient

Definition of "Discharge"

- "To relieve of a charge, load, or burden"
- "To release from an obligation"

Merriam-Webster Dictionary

Source: Merriam-Webster, http://www.merriam-webster.com/dictionary/discharge; Nursing Executive Center interviews and analysis.

When it comes to building a health system that "never discharges" the patient, the Nursing Executive Center recommends against a one-off approach in which leaders perfect one individual transition before moving to the next. This effort can be compared to assembling a puzzle—and piecing together each care setting one by one.

The challenge with this approach is that perfecting each transition is time consuming and resource intensive. There are simply too many "puzzle pieces" for it to be feasible. In addition, this approach can lead to a piecemeal end result, rather than a cohesive system that seamlessly supports patients as they move through the care continuum.

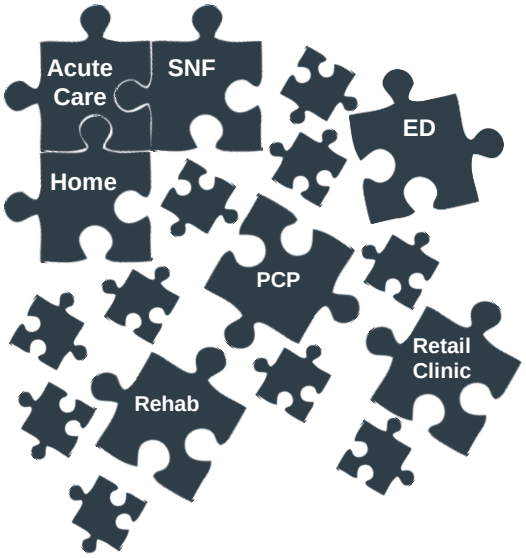
To build a system that "never discharges" the patient, the Nursing Executive Center strongly recommends the second approach shown on this page, in which leaders address underlying, systematic issues that affect all patient transitions. The goal is to implement strategies that improve transitions across multiple care settings at once—rather than working setting by setting.

The following pages describe how this systems approach has been applied to a select patient population.

Building a System That "Never Discharges" the Patient

Evolution of Patient Care Perspective

Perfecting Individual Transitions



Achieving Care Continuity

Source: Nursing Executive Center interviews and analysis.

Some progressive organizations have already begun implementing a systems approach to improving care continuity for select patients. An example comes from Premier Health in Dayton, Ohio.

Premier has designed a program to improve cross-continuum care for their 1% most costly patients, regardless of condition. A key component of the program is a navigator[1] who serves as patients' primary entry point to the health system and collaborates with inter-professional team members to ensure all of their patients' health and social needs are met. An excerpt of Premier's "Top 1% Navigator" job description is shown here.

The following pages describe key elements of Premier's Top 1% Navigator Program.

A complete version of Premier's Top 1% Navigator job description can be accessed through an online version of this publication on advisory.com/nec.

Care Navigator Role Gaining Momentum

Excerpt of Top 1% Navigator Job Description at Premier Health

Premier Health

Job Description: Advanced Illness Management Navigator, RN or MSW

Position Summary: The Navigator will be an integral member of the Advanced Illness multidisciplinary team. Together with nurses, social workers and community health coaches, the Navigator will oversee the enrollment of new patients into the project; assess health care needs and oversee care plan implementation; help develop care management strategies; and work with team members to provide linkages for the various health and social needs of patients with cost effective solutions.

Nature and Scope: Must have available phone to communicate and transportation, with appropriate licensure and insurance, to visit homes and other sites. Interacts with physicians, nurses, social workers and other disciplines, administrative personnel, and community resources.

Qualifications: Ability to effectively provide clinical care to socially and medically complex patients in a variety of nontraditional settings; ability to work collaboratively in a team and manage multiple priorities, utilize effective time management skills, and exercise sound administrative and clinical judgment; demonstrated ability to work well with people of various ages, backgrounds, ethnicities, and life experiences.

Collaborates with RN or MSW to serve medical and non-medical needs

One navigator on call to be available to patient 24/7 by phone

Case in Brief: Premier Health

- Five-hospital health system headquartered in Dayton, Ohio; includes over 100 sites of service
- In March 2014, piloted community-based navigator program for 25 patients generating greatest number of readmissions and ED visits at one Premier hospital; staffed by one RN and one MSW
- Navigators serve as single point of contact for all patient medical and community resource needs; coordinate with patient's primary care clinician, home health
- Navigators are available to patient 24/7 by phone; conduct community-based patient visits, call patient on regular basis (frequency based on patient needs); timeframe of care is 10 months
- By January 2015, expanded program to include 175 patients across multiple Premier hospitals; new model includes two RNs, two MSWs, one LPN, one health coach
- Expanded program serves patients with the greatest number of admissions, and patients 64 and older with a large number of admissions by CMS hospital penalty diagnosis
- CHF, COPD, and select high-risk patients are monitored by the RN navigator via remote telemonitoring; monitoring units include ancillary tools for weight, pulse oximetry, blood pressure; parameter triggers directly alert navigator of any abnormality, navigator then contacts patient
- 180 days post-implementation of Top 1% Navigator pilot, reduced readmission rate of patient group by 52%, reduced monthly costs for patient group by 50%

1) A navigator team of an RN and an MSW share a panel of 50 patients.

Source: Premier Health, Dayton, OH; Nursing Executive Center interviews and analysis.

First, Premier selects patients for the program by analyzing ED encounters and admissions. Second, a navigator team of an RN and an MSW share a panel of 50 patients. Third, one of the two navigators is on call 24 hours per day, seven days per week. This enables the team to collectively serve as the single point of contact for the patient. Fourth, navigators coordinate with a multidisciplinary care team to meet patients' medical and psychosocial needs. Fifth, navigators use remote telemonitoring for select[1] patients. Sixth, navigators adjust the intensity of their support to each patient's risk level. Additional details on how this is done are on the following page.

Establishing a First Line of Defense for the Top 1%

Key Elements of Premier's Top 1% Navigator Program

Patients selected for program **based on number of ED encounters and admissions**

RN and MSW navigator team shares panel of 50 patients

Navigators available 24/7; serve as **primary point of contact** for patient

Navigators **coordinate multidisciplinary care team** to meet medical and psychosocial needs

Navigators **track patient health via remote telemonitoring**[1] (including patients with CHF and COPD)

Navigators **interact with patient minimum of twice per month**; can be as often as 21 times per month

1) Remote telemonitoring used primarily for CHF, COPD, and other selected high-risk (high-touch) group patients as deemed appropriate.

Source: Premier Health, Dayton, OH; Nursing Executive Center interviews and analysis.

Even within the top 1% of most costly patients, leaders should further stratify patients within the navigator program to provide adequate support to those who need it most.

As shown here, Premier stratifies patients in their Top 1% Navigator Program into three different groups, based on how much support they need.

Low-touch patients meet monthly with the RN navigator. To make sure they stay on track, an LPN or health coach calls them every other week to check in.

Medium-touch patients meet weekly with the RN navigator, twice per month with the MSW navigator, and three times per month with an LPN. An LPN or health coach also calls medium-touch patients every other week.

High-touch patients receive the most hands-on support. In addition to multiple visits with the two navigators each month, they have several in-person and telephone check-ins with other members of the care team. Finally, the RN navigator observes select[3] high-touch patients through remote telemonitoring.

Scaling Support to Level of Patient Risk

Elements of Navigator Support Based on Risk Stratification Level

Risk Stratification Level[1]	Low Touch	Medium Touch	High Touch
Classification Criteria	Patients without hospital encounter in last 30 days, OR minimal number of medications, controlled disease symptoms	Patients with 1-2 ED visits in last 30 days without admission, OR multiple/advanced illness, multiple medications, uncontrolled symptoms, psychosocial barriers	Patients with observation, admission, or two or more ED visits in last 30 days, OR multiple advanced illnesses, multiple medications, uncontrolled symptoms, psychosocial barriers
Time in Category[2]	2-4 months	Minimum 4 months	Minimum 30 days
Care Team-Patient Contact per Month	Minimum 3 per month x 2 months, OR 2 per month x 4 months	Minimum 10 per month	Minimum 20 per month
Care Team Interactions with Patient	• **RN Navigator visit** once a month • **MSW Navigator support** as needed • **LPN or health coach phone call** every other week	• **RN Navigator visit** once a month • **MSW Navigator visit** twice a month • **LPN visit** three times per month • **LPN or health coach phone call** every other week	• **RN Navigator visit** twice a month • **MSW Navigator visit** twice a month • **Health coach visit** twice a month • **LPN visit** twice a month • **LPN or health coach phone call** three times a week • RN Navigator tracks patient metrics with **remote telemonitoring[3]**

1) Premier refers to the three risk stratification levels within the program as "low risk," "rising risk," and "high risk," respectively.
2) Time spent by patient in risk category before reevaluated and moved to new category (e.g., from rising-risk to low-risk).
3) Remote telemonitoring used primarily for CHF, COPD, and other selected high-risk group patients as deemed appropriate.

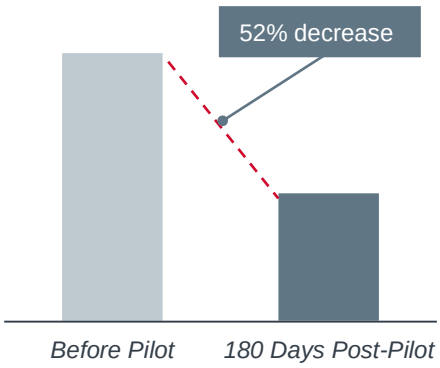
Source: Premier Health, Dayton, OH; Nursing Executive Center interviews and analysis.

Even though Premier's Top 1% Navigator Program is resource intensive, it allows Premier to reduce net costs because it is focused on only the 1% most costly patients.

Leaders at Premier report over a 50% decrease in hospital utilization by program participants and a net cost reduction of over $300,000 in the first six months of the program.

Benefiting from a Focus on the Top 1%

Hospital Utilization of Patients in Top 1% Navigator Program at Premier Health



$307,942

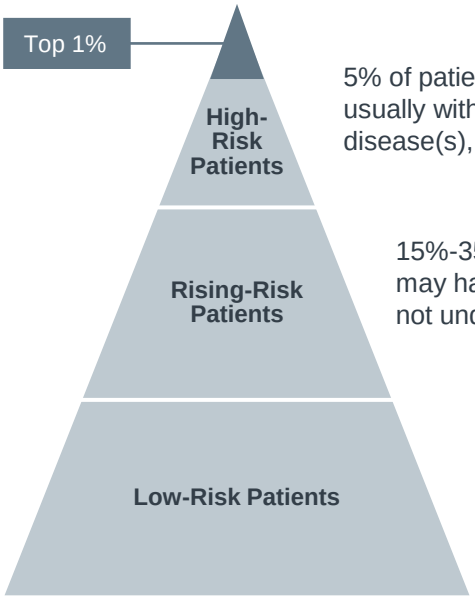
Total net cost reduction in first six months of Top 1% Navigator program at Premier

Deploying patient navigators is a highly effective way to improve care continuity for the highest-risk patients. But they are also too expensive to provide for every patient. And health care providers need to not only improve care continuity for the most acute patients—but for all three patient populations shown here: high risk[1], rising risk, and low risk.

To build a system that "never discharges" the patient (and not just the 1% most costly), leaders must pursue a systematic approach for improving care transitions that can be applied to all patients.

Looking Beyond the Top 1%

Managing Three Distinct Patient Populations



5% of patients; usually with complex disease(s), comorbidities

15%-35% of patients; may have conditions not under control

60%-80% of patients; any minor conditions are easily managed

1) High-risk patients include the top 5% highest-cost patients (including the top 1%).

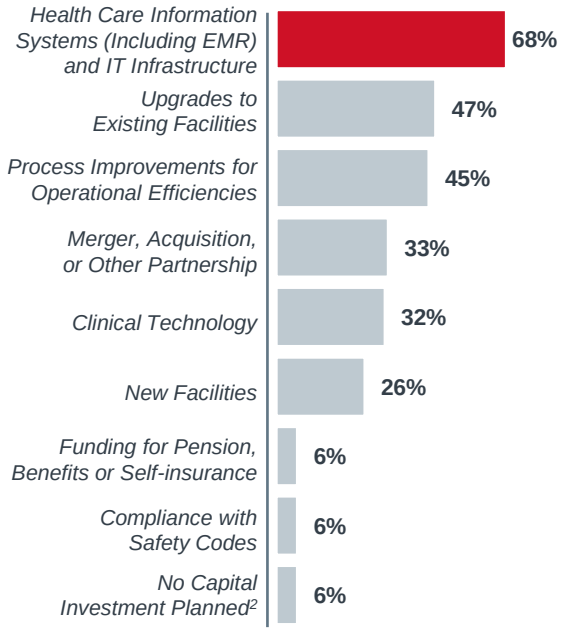
Source: Premier Health, Dayton, OH; Nursing Executive Center interviews and analysis.

Many organizations hope their EMR and IT infrastructure will be the systematic solution that improves care transitions for all patients. The aspiration is that IT can bridge silos between settings by improving the flow of information.

However, IT systems have not yet realized their promise. For example, 100% of accountable care organizations surveyed in 2014 reported interoperability issues.

CFOs Betting on the EMR to Achieve Care Continuity

Health Care Leaders' Priorities for Capital Investment[1]



ACOs Struggling with Lack of EMR Compatibility

100%

Percentage of ACOs in 2014 reporting interoperability issues[3]

"There may be a gap between the needs of the health care sector and the readiness of vendors in the health IT market to meet those needs."

Robinson C, et al., October 2014 Report prepared for ONC[4]

More importantly, even if IT infrastructure is perfected, it won't sufficiently improve care continuity. There are at least two reasons why.

First, the output of an IT system is only as good as the information clinicians enter into the system. Put another way, a perfect IT system cannot overcome the challenge of clinicians entering incomplete or inaccurate information into the EMR.

EMR Alone Not a Silver Bullet

Records Only as Good as the Information Entered

Representative Scenario

"Garbage In"

Clinician enters incomplete or inaccurate information into the EMR

→

A+

"Perfect IT System"

Top-of-the-line EMR and supporting IT infrastructure; all technical aspects of system working as intended

→ ?

1) Responses to the survey question, "What are your organization's top three priorities for capital investment in the next 12 to 18 months?"; n=125.
2) Indicates leader has no capital investment planned in the next 12 to 18 months.
3) Based on an online survey of 62 ACOs conducted by eHealth Initiative and Premier.
4) The Office of the National Coordinator for Health Information Technology.

Source: Robinson C, et al., "Health Information Technology Infrastructure to Support Accountable Care Agreements," Robinson & Associates Consulting, Prepared for The Office of the National Coordinator for Health Information Technology, October 2014, http://healthit.gov/sites/default/files/Report-ITtoSupportAccountableCareArrangements.pdf; HealthLeaders Media, 2013, "Investing Capital in EMR," http://www.healthleadersmedia.com/page-1/MAG-291958/Investing-Capital-in-EMR; HealthLeaders Media, Capital Funding Buzz Survey, November 2012, http://www.healthleadersmedia.com/content/HOM-288262/Capital-Funding-Buzz-Survey.html; HealthData Management, 2014, "IT Interoperability, Cost Huge Burdens for ACOs," http://www.healthdatamanagement.com/news/IT-Interoperability-Cost-Huge-Burdens-for-ACOs-48864-1.htm; Nursing Executive Center interviews and analysis.

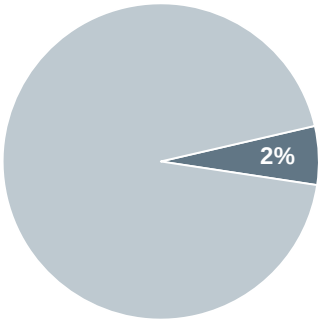
The second reason the EMR alone will not sufficiently improve care continuity is the EMR doesn't solve the underlying clinician workflows that result in episodic care. Many episodes of care are focused only on the patient's specific complaint—not on the patient's broader health needs. For example, only 2% of primary care visits include a depression screening, and 85% of medication order errors at admission are caused by inaccurate medication histories. To improve care continuity, leaders need to identify and address underlying workflow issues. Otherwise, leaders run the risk of automating workflows that perpetuate episodic care.

And existing clinical workflows are just one of the challenges leaders will need to overcome to build a health system that "never discharges" the patient. Additional challenges are shown on the following page.

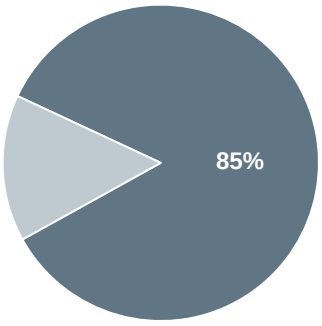
Form Follows Function

Providers Must Address Underlying Clinician Workflows

Percentage of Primary Care Physician Office Visits That Include Depression Screening[1]



Percentage of Medication Order Errors at Admission Caused by Inaccurate Medication Histories



Source: Centers for Disease Control and Prevention, National Ambulatory Medical Care Survey, 2010, https://healthmeasures.aspe.hhs.gov/measure/26; Gleason GM, et al, "Results of the Medications at Transitions and Clinical Handoffs (MATCH) Study: an Analysis of Medication Reconciliation Errors and Risk Factors at Hospital Admission," *Journal of General Internal Medicine,* 25 (2010): 441-447; Nursing Executive Center interviews and analysis.

1) 2010.

To help leaders deliver continuous care for all patients, the Nursing Executive Center identified the most significant root causes of why patients currently receive fragmented, episodic care.

The first root cause is clinicians are not equipped to provide continuous care. The underlying reasons include the following: clinicians lack necessary information, they aren't sure how to provide continuous care, and they don't have the time.

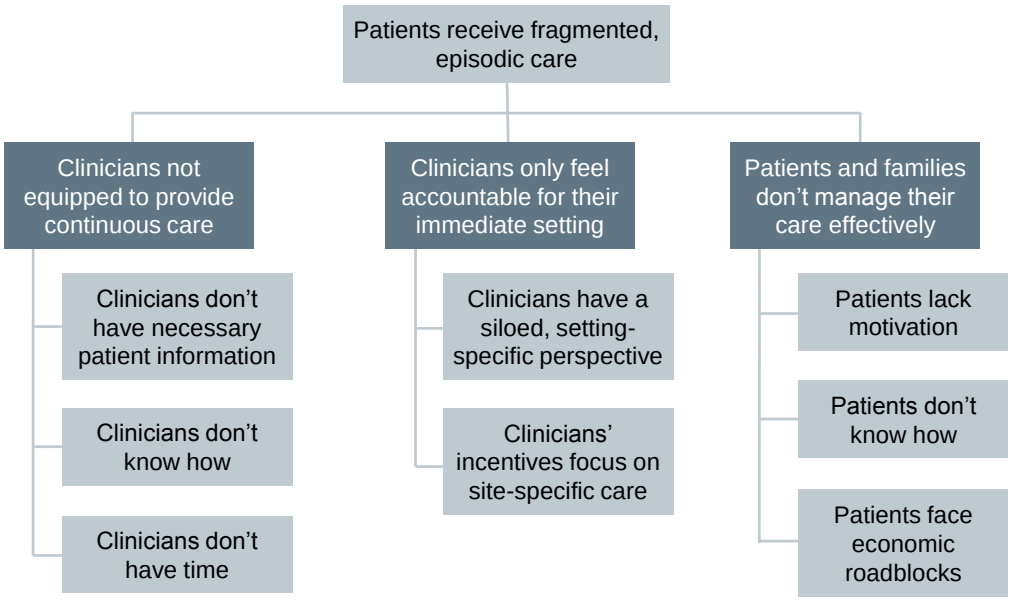
The second root cause of fragmented, episodic care is clinicians only feel accountable for care in their immediate setting. The underlying reasons include the following: clinicians have a setting-specific perspective, and they don't feel responsible for patients' needs beyond their immediate care setting.

The third root cause of fragmented, episodic care is patients and families don't manage their care effectively. The underlying reasons include the following: patients aren't motivated to manage their care, they don't know how to manage their care, and they face economic roadblocks to managing their care.

By systemically addressing these root causes, leaders can build a health system that "never discharges" a patient. The following page provides a framework for doing so.

Finding the 80/20

Key Root Causes of Patients Receiving Fragmented, Episodic Care



A complete version of the root cause analysis can be accessed through an online version of this publication on advisory.com/nec.

Source: Nursing Executive Center interviews and analysis.

Achieving Care Continuity

Best Practices for Building a System That Never Discharges the Patient

To help nurse leaders overcome the key root causes of why patients receive fragmented, episodic care, the Nursing Executive Center identified four imperatives to build a system that "never discharges" the patient. The imperatives are shown in bold on this page. Each imperative has at least one underlying strategy, shown in italics. The numbered best practices are the building blocks for achieving a strategy.

The first imperative is to equip clinicians to provide continuous care by ensuring they have easy access to "need-to-know" information and enabling them to connect the care plan across settings. The second imperative is to promote clinician ownership for cross-continuum care by broadening the front line's perspective beyond their own setting and incentivizing continuous care. The third imperative is to instill patient and family ownership for self-care by appealing to patients' personal motivators for involvement and equipping patients and families with tools for self-management. The fourth and final imperative is to scale up support for vulnerable patients by investing in targeted services for select populations, such as medically complex patients, patients with mental health and substance abuse issues, homeless patients, and frail elderly patients.

To achieve care continuity for all patients, leaders must implement at least one practice for each imperative. For optimal impact, the Nursing Executive Center recommends implementing one practice per strategy.

The remainder of this publication describes each imperative in turn, with details on the associated strategies and key components to implement each of the practices.

1 Equip Clinicians to Provide Continuous Care

Ensure Easy Access to "Need-to-Know" Information

1. The Critical Patient Information Summary
2. Motivational Interviewing
3. Patient Preference Discussion Guide

Connect the Care Plan Across Settings

4. Shared Cross-Setting APN
5. Cross-Continuum Care Agreement
6. Cross-Continuum Care Pathway

2 Promote Clinician Ownership for Cross-Continuum Care

Broaden the Front Line's Perspective Beyond Their Own Setting

7. Cross-Continuum Shared Governance
8. Alternative Care Setting Experience
9. Community-Focused Nursing School Rotations

Incentivize Continuous Care

10. Continuum-Focused Leader Incentive Plan
11. Frontline Organizational Alignment Bonus

3 Instill Patient and Family Ownership for Self-Care

Appeal to Patients' Personal Motivators for Involvement

12. Personally Motivating Goal Incorporation
13. Nonclinical Peer Advisor

Equip Patients and Families with Tools for Self-Management

14. Inpatient-Based Key Caregiver Skill Building
15. Recorded Transition Instructions
16. Personalized Patient Support Line
17. Daily Text Reminders

4 Scale Up Support for Vulnerable Patients

Invest in Targeted Services for Select Populations

18. NP-Led Clinic for the Medically Complex
19. Justice Department Partnership for Behavioral Health
20. ED Alternatives for Homeless Patients
21. Remote Telemonitoring for the Frail Elderly

Source: Nursing Executive Center.