American Nurses Association
Care Coordination Quality Measures Panel – Steering Committee
Member Bios

Angela Baxter, RN, BSN, BS

My strongest area of expertise relates to my current role as RN Care Coordinator/Case Manager at the Kansas City VA. I have been in this department four years, called appropriately “Transition Team, teamed 1:1 with SW. Provide coordination and discharge planning for a medical hospitalist team as well as specialties which have included ENT, Urology, Cardiology and General Surgery. Am an integrated team member for all aspects of patients care while inpatient as well as for discharge - coordinating testing, evaluations, nursing care, follow-up appointments, DME, home health and myriad of other. As VA provides both inpatient and outpatient care, I also coordinate care for team of outpatient providers and their patients as well. This involves linking to specialty care and other needs as well as transitioning from outside hospitals, nursing homes to home and vice versa, to hospice care and other transitions - creating a unique perspective across care settings. On Discharge planning/Care Coordination Quality Improvement System Redesign Team which reduced patient unmet extended stay days related to UM social issues by 64% from 2011 to present. Evaluated the existing processes and outcomes. Lead the design of new care coordination tool for admission and designed and implemented staff nurse education regarding evaluation for care coordination, tool automatically triggers consult. Updated computerized consult to Transition Team to assist providers. I have also experienced care coordination at multiple facilities on multiple occasions, both positive and negatively.

Mary Ann Christopher, MSN, RN, FAAN

Mary Ann Christopher has served as President and CEO of the Visiting Nurse Service of New York (VNSNY), the nation's largest not-for-profit home-and community-based health care organization, since January 2012. Prior to joining VNSNY, Ms. Christopher was President and CEO of VNA Health Group in New Jersey. She is a leading voice on a wide range of health care issues, particularly delivering patient-centered community-based care to diverse, changing populations across a continuum of needs. She has spent her career educating fellow nurses in best practices for coordinating care, and enhancing the patient/caregiver experience through new care delivery models. Throughout her career and most recently at VNSNY, she has developed, implemented and evaluated a broad and diverse set of care coordination models aimed at decreasing cost, increasing quality, and increasing access. Programs currently under her leadership include transitional care, complex care management for the dually eligible, falls prevention, CMS-designated health home, and a nurse practitioner-led palliative care program. The VNSNY Managed Long Term Care model for care coordination served as the model for Medicaid Redesign in New York State. Recognized this year as ANA’s Honorary Human Rights Award recipient, Ms. Christopher's distinguished career includes service as an appraiser for the Magnet Program and work with an academic medical center in New Jersey which resulted in an Institute of Healthcare Improvement (IHI) award for care coordination impact in first thirty all cause readmission of patients with CHF, and a subsequent RWJ Foundation grant award for replication. She also helped to spearhead a care coordination model in New Jersey that focused on collaboration among four urban hospitals, the VNA Health Group, City Government and the State Department of Health. A member of the Board of Directors of the Visiting Nurse Associations of America, she has presented these and other innovative models nationally.
Maureen Dailey, DNSc, RN, CWOCN (Co-CHAIR)

Maureen Dailey DNSc, RN, CWOCN is a Senior Policy Fellow in Nursing Practice and Policy at the American Nurses Association (ANA). She has thirty years of nursing leadership and direct care experience across healthcare settings. In multiple roles, she has led patient care enhancement programs to reduce avoidable readmissions, healthcare associated conditions, and excessive cost across settings. Dr. Dailey has led the development, implementation, and evaluation of programs to improve nursing care, team-based care coordination, and patient/caregiver engagement. These programs included advanced practice nurse telehealth consultation, population risk stratification and management, targeted transitional care for complex care, and electronic health record innovations such as clinical decision support. Dr. Dailey has participated on the National Quality Forum-convened Readmissions Action Team and the Critical Paths for Creating Data Platforms: Care Coordination and the American Academy of Nursing’s Care Coordination Task Force. Dr. Dailey was appointed to the American Medical Association Physician Consortium on Performance Improvement’s Quality Improvement Advisory Panel in 2011.

Ingrid Duva, RN, PhD

I am a currently a Veteran’s Health Administration Quality Scholar (VAQS), which is a post-doctoral fellowship emphasizing quality improvement in healthcare. In this fellowship, I work with RNs in VA primary cares that have recently transitioned to a Nurse Care Manager position. This new position is intended to improve coordination of care for the patient and amongst the patient care team. Additionally, I will be conducting a mixed methods research study examining the Nurse Care Manager’s role in primary care coordinating care for chronically ill patients with the use of electronic health data contrasted to RNs guided by protocols and algorithms as well as electronic health data. My previous work experience and research both led to the development of my interest and expertise in the work of nurses and specifically nurse care coordination. As a nursing administrator and operations consultant, I spent 10 years leading and participating on work redesign teams in the acute care environment. In 2007/2008, as a beginning researcher, I served on Dr. Gerri Lamb’s team who developed the staff nurse care coordination inventory (SNCC), the first of its’ kind. I used that instrument in my dissertation study, funded by AHRQ, which examined the relationship between staff nurse care coordination and factors in the work environment believed to influence this work. My findings illuminated practical concerns with the instrument as it was originally developed and opportunities to adapt and enhance the instrument for future use and/ or testing as well as translation to other care settings.

Sheila Haas, PhD, RN, FAAN

Dr. Haas is the AAACN Organization-level nominee: Sheila A. Haas, PhD, RN, FAAN, is a Professor and former Dean of the Marcella Niehoff School of Nursing at Loyola University Chicago. Dr. Haas research, done with Loyola colleagues in the 1990s, on the role of the nurse professional in ambulatory care has been used to delineate dimensions (including care coordination), competencies and to help conceptualize the American Academy of Ambulatory Care Nursing (AAACN) conceptual framework and core curriculum. Most recently, AAACN convened three expert panels to develop the dimensions, competencies and a model of RN Care Coordination and Transition Management for use in ambulatory care settings. Dr. Haas co-facilitated AAACN volunteer members who met online using focus group methods. The first expert panel completed a comprehensive interdisciplinary literature analysis of care coordination and transition management. The second panel identified nine dimensions and associated activities of care coordination and transition management, and competencies required for each dimension. The third expert panel used the dimensions to build a Registered Nurse Care Coordination
and Transition Management Model (RN-CCTM) and defined methods for interprofessional collaboration and teamwork in ambulatory care. This research has been accepted for poster, podium and publication. Dr. Haas has served on the Research Committees of AAACN and the American Organization of Nurse Executives. She also served as an AAACN Board member and President. She is past President of the National Federation of Specialty Nursing Organizations. Dr. Haas also serves on the American Nurses Credentialing Center Board of Directors.

**Susan Hinck, PhD, APRN, GCNS-BS**

My expertise applies to several of the Care Coordination Quality Measures Panel criteria. I am a practicing clinical nurse in a small home health agency, as well as the Administrator and director of the quality improvement program for the organization. As a nurse making home visits to clients, I see firsthand the challenges and benefits of communication in care transition and coordination, including benefits to patients who receive excellent care coordination. As the Administrator of the proprietary, free-standing, Joint Commission accredited home health agency, I have put in place an internal quality measure program incorporating federal CMS rules, home health care industry standards, and best practices recommended by organizations such as Home Health Quality Initiative. I collect, analyze, and report the quality measures for the organization. My clinical, academic, and research background is firmly founded in the conduct of qualitative and quantitative research, centering on measurement of care quality. Further, I serve on committees in several state-wide initiatives such as the Missouri Health Connection health information infrastructure to exchange electronic health information for care coordination across organizations, Missouri Medical Home Collaborative Steering Committee planning and implementing a multi-payer health home/medical home concept among primary care practices in Missouri, Missouri Action Coalition Strategic Advisory Committee and Leadership Council that have the goal of implementing the recommendations of the IOM 2011 Future of Nursing report, and Missouri Nurses Foundation (President) that recently received a RWJF grant of $150,000 to carry out the activities of the Missouri Action Coalition.

**Ellen Kurtzman, MPH, RN, FAAN (Co-CHAIR)**

Ellen Kurtzman, MPH, RN, FAAN, assistant research professor at The George Washington University School of Nursing, has been working in the fields of health care quality for more than two decades. Her own research focuses on the influence of public policy on quality and nursing practice. In this capacity, she has served as lead investigator on projects evaluating the impact of reform on health care including nursing. Previously, she was the architect of NQF-endorsed national voluntary consensus standards for nursing-sensitive care. While at NQF, Ms. Kurtzman also led national efforts to establish hospital and home health care performance standards. She has published and presented extensively on performance measurement and public reporting. Ms. Kurtzman has also enjoyed a productive collaboration with colleagues at the University of Pennsylvania, School of Nursing (Penn) to advance a model of care referred to as the Transitional Care Model (TCM). In this capacity, she has supported efforts to reduce hospital readmission rates and decrease spending, promoted care coordination, and built policy support for TCMs adoption. Ms. Kurtzman holds a bachelor’s degree in nursing from Penn and a master’s in public health from The Johns Hopkins University. She is currently pursuing a doctorate in health policy from GW Trachtenberg School. In 2009, she was inducted as a Fellow of the American Academy of Nursing and is a founding member of the Phi Epsilon Chapter of Sigma Theta Tau International.
Cheri Lattimer, RN, BSN

I currently serve as the Executive Director for the National Transitions of Care Coalition (NTOCC) and the Case Management Society of America (CMSA). In my role with these two national organizations, I provide oversight and leadership for programs and strategic imperatives addressing the issues and concerns of care coordination, transitions of care, patient and family caregiver engagement, development of tools, resources and educational training to assist health care professional (physicians, pharmacists, nurses, social workers & allied health) in implementing and delivering collaborative care models, and addressing the concerns of system-wide data collection and transfer of information. Nurses must be able to define their role in care coordination and be partners with the clinical team in developing performance measures related to the nursing role, patient engagement and that of the collaborative team. Then we can align the payment incentives for nursing between performance and value add to improving health outcomes for patients. Over the last two years I have been working with hospitals and health plans to align these various components of care delivery and believe I can bring that experience and lessons learned to the panel. The role of nursing is so imperative to achieving success for many of the provisions within the Affordable Care Act we cannot afford not to be at the table addressing the issues of care coordination, transitions of care, quality measurement, patient/ caregiver advocacy and professional education.

Linda Lindeke, PhD, PNP

Linda Lindeke PhD RN CNP is a fellow in the American Academy of Nursing and associate professor, School of Nursing, University of Minnesota where she oversees the PhD program. Linda practices as a pediatric nurse practitioner weekly, caring infants and families after discharge from the neonatal intensive care unit. She serves on the national advisory panel for the National Healthcare Transition Center called "Got Transition?" that develops resources for adolescents, young adults, families, providers and systems regarding transition from pediatric to adult health care services. Dr. Lindeke serves on the Project Advisory Committee for the Pediatric Medical Home Project of the American Academy of Pediatrics (AAP) that videotaped her in three YouTube videos about care delivery. She co-chairs the Pediatric Health Care Home (PHCH) Special Interest Group (SIG) in NAPNAP that supports nurse practitioners in evolving models of pediatric care delivery and coordination. She serves on the advisory board for a federally-funded project developing care coordination measures within state Medicaid and SCHIP data. Linda serves on the Institute of Medicine (IOM) Best Practices Innovation Collaborative regarding team-based care quality and measurement. While serving on the American Nurses Association (ANA) Congress on Nursing Practice and Economics, Dr. Lindeke was very involved in creating an ANA Position Statement as well as a White Paper on nurses' roles in care coordination.

Barbara Lutz, PhD, RN, CRRN, APHN-BC, FAHA, FNAP, FAAN

I am a certified rehabilitation and advanced public health nurse with 30 years of combined experience in practice, research, education, and service. My research focuses on understanding the needs of family caregivers and stroke patients as they transition through the care continuum from acute care to rehabilitation to home. I was a co-investigator on a home telehealth care coordination intervention pilot study for stroke patients and caregivers, and am currently exploring innovative ways to assess and address patients and caregivers needs as they are discharged from inpatient rehabilitation. I am also a member of a research team exploring community-based transitional care / care coordination interventions for persons with chronic illnesses who seek treatment in the emergency department (ED). Our goal is to reduce ED use and unnecessary hospitalizations by coordinating care and linking patients
to community providers. I am a board member of the Association of Rehabilitation Nurses (ARN). ARN is committed to providing guidance and support to patients with chronic illnesses and disabling conditions and their caregivers to help them better understand their treatment options so they can be active participants in decision-making about their care. We advocate for nurse-led care coordination models that bridge care settings from acute care to the community to improve the quality of care. My public health, rehabilitation, and research expertise will provide the ANA Care Coordination Quality Measures Panel with a unique combination of skills and experience to advance care coordination measurement across the continuum.

**Mary Morin, RN, MSN, RN-BC, NEA-BC**

As a Nurse Executive, I have developed and implemented both ambulatory and inpatient care coordination/case management models. In 2011, developed and implemented an ambulatory-based "intense" care coordination population management program focused on patients within primary care practices with chronic diseases (i.e. CHF, Diabetes, COPD, Renal) and/or conditions (e.g. chronic pain, autoimmune, behavioral health) - these patients were also high cost and high utilizers across my health system and health plan. Quality metrics/goals were developed and tracked (e.g. reduce ED visits, admissions, readmission, and increase quality of life, use of primary care, advanced care planning)-benchmarking on a national level was not available. As the chair of our system's Magnet Steering Committee and Executive Sponsor for our system's Care Coordination Practice Council, I am very interested in metrics to demonstrate the value of care coordination across all venues.

**Lauren Mulrooney, RN, BSN**

The vast experience I have in all levels of care in multiple provider environments gives me an understanding of the issues and concerns that occur to jeopardize patient care, safety and medication reconciliation. I have been involved in initiatives to develop tools and address areas of communication needed to assist with appropriate transitions of care. The experience I have in long term care facilities, homecare, hospice, rehab and acute care gives me the experience and knowledge to be an active member. Thank you.

**Terri Ann Parnell, DNP, RN**

Health literacy is a cross cutting priority and has been identified as a vital area for national action in both private and public sectors. It has previously been looked upon as an individual trait; however it is now evident that it must also encompass the health literacy related needs and complexities of the professionals and the health care system providing the care. The health literacy knowledge and experience of nurses engaged in care coordination is a critical component of successful outcomes. Dr. Parnell has over 30 years nursing experience including expertise in health literacy, cultural awareness, patient and family education, nursing education, marketing and the development of brand identities for service lines. She is currently Vice President for Health Literacy and Patient Education for the North Shore-LIJ Health System and has established an integrated, operationalized and sustainable approach to health literacy across the 16 hospital health system. She has integrated concepts of health literacy, cultural awareness and patient-centered care into core activities and also provides health literacy leadership and consultation.
Janet Tomcavage, MSN, RN

Janet Tomcavage is the chief administrative officer for Geisinger Insurance Operations (GIO). In this role, she co-leads the insurance company’s health services department with the chief medical officer. Ms. Tomcavage has administrative responsibility for quality improvement, ProvenHealth Navigator® (Geisinger’s medical home model), disease/case management, medical management, pharmacy, wellness, clinical informatics, clinical systems development, provider network management, and GIO consulting. Ms. Tomcavage also provides clinical and executive leadership for GIOs multi-state operations. Ms. Tomcavage earned her bachelor of science in nursing from Bloomsburg State University and her master of science in nursing from College Misericordia. Ms. Tomcavage has co-authored articles on patient-centered primary care, diabetes, disease management and the expanded role of nursing in health care. Ms. Tomcavage has lectured nationally on those and many other topics.