RNCM Role in Primary Care

Kelly Kruse Nelles MS RN APRN-BC
Lead Faculty

1

KEYWORDS

- Primary Care
- Patient Centered Medical Home
- Usual Source of Care
- Medical Neighborhood
- Culture of Health
- Social Determinants of Health
- Social Needs
- LEAP
- Federally Qualified Health Centers
- IHS Care Model
- VA PACT
- Nurse Family Partnership

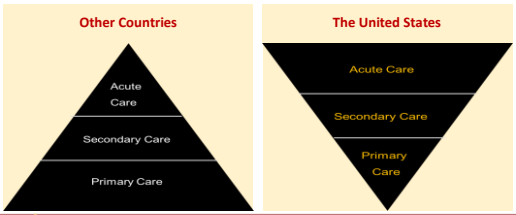
2

The Shift to Primary Care

Population Health Public Health & Primary Care

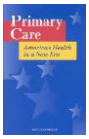
3

Flip the Pyramid



4

- 1967 American Academy of Pediatrics introduces term "medical home"
- 1978 Declaration of Alma-Ata introduced at the International Conference on Primary Care (First international declaration of primary care's key role in promoting the health of all people)
- 1996 Institute of Medicine releases Primary Care: America's Health in a New Era - Redefines Primary Care



"The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health needs, developing a sustained partnership with patients, and practicing in the context of family and community." - Institute of Medicine, 1996

5

- 1996-2009 Work continues to move primary care forward
  - Developing new models: reimbursement, chronic care, medical homes
- 2008 National Medical Home Accreditation Programs
  - National Committee for Quality Assurance (NCQA)
  - Utilization Review Accreditation Commission (URAC)
  - Joint Commission
  - Accreditation Association for Ambulatory Health Care (AAAHC)
- 2010 Passage of Patient Protection and Affordable Care Act

6

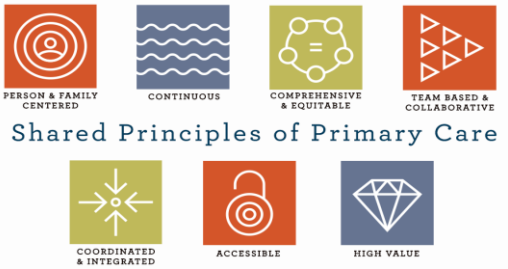
Patient Centered Medical Home

- Each PCHM is tailored to the population and community served
- Not a place but a partnership
- Features:
  - Patient & Centered Care
  - Comprehensive
  - Coordinated
  - Accessible
  - Committed to Quality & Safety

7

- **Patient Centered**
  - Supporting patient and families to manage care
  - Patients participate as fully informed partners
- **Comprehensive**
  - Team-based, holistic care
  - Prevention, screening, episodic acute care, chronic care
- **Coordinated**
  - Care is organized across all systems patients move through
  - Partner with community and public health
- **Accessible**
  - Shorter wait times, extended hours, 24/7 electronic/telephone access
  - Health IT
- **Commitment to Quality & Safety**
  - Quality Improvement processes

8



9

Primary Care

"High quality primary care is the provision of whole person, integrated, accessible, and equitable health care by interprofessional teams that are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families and communities."

- National Academies of Sciences, Engineering & Medicine (NASEM)

10

Primary Care

- Build trust and relationship to address social needs & structural drivers of inequities
- Connect patients to available sources of health insurance
- Use telehealth and other digital health interventions to enhance access
- Provide culturally & linguistically appropriate care
- Utilize an expanded care team and community assets to address unmet social needs
- Engage in the community in practice and system level decision making

11

Usual Source of Care

- Foundational Relationship that allows the patient to be proactive in helping to prevent & manage common chronic conditions before they become more severe & costly
  - Chronic disease management
  - Vaccinations
  - Preventive services and screenings

Usual Care demonstrates greater participation in high value services and more positive health care experience

12

CMS Primary Care Test Models

- Comprehensive Primary Care Plus (CPC+) began 2021
- Global & Professional Direct Contracting (GPDC) began 2021
  - Will be rebranded The Accountable Care Organization Realizing Equity Access and Community Health Model or ACO REACH effective January 1, 2023
- Independence at Home
- Primary Care First

CMS CCMI Goal: Identify models that offer greater flexibility to primary care providers and payment models that value primary care

13

PCMHs vs ACOs

- Both are widely adapted Innovation Models
- ACOs
  - Increased number of covered lives from 2.6 million in 2011 to 23.5 million in 2015 with 150 million by 2025
  - CMS and private payor sponsored contracts
- PCMH
  - Currently 13,000 primary care practices housing almost 70,000 clinicians deliver care to 21 million patient in PCMH certified facilities
  - Patients receiving care at PCMH certified facilities have improved health outcomes and costs compared to standard care
  - CMS currently testing models for alternative payment methods

14

Similar Goals – Different Approaches

ACOs	PCMHs
• Primarily **value-based reimbursement model** that incorporates "voluntary" collaboration among providers • Incentive-based payment model that holds providers accountable for outcomes while giving them a share of the earned savings	• **Care delivery models** involving significant collaboration as part of the certification process • System-based approach in which structures & processes are established to ensure holistic, coordinated care is delivered to the patient

15

Primary Care & the Medical Neighborhood

- Clinical-community partnership
- Serves as the patient's primary "hub" and coordinator of health care
- Goals:
  - Collaboration with "medical neighbors" to encourage the flow of information across and between clinicians and patients
    - Clinical: specialists, hospitals, home health, LTC, etc.
    - Non-clinical: community centers, faith-based organizations, schools, employers, public health agencies, etc.
  - Actively promote care coordination, fitness, healthy behaviors, proper nutrition, healthy environments and workplaces

Successful medical neighborhoods focus on meeting the needs of patients incorporating population health and community health needs (AHRQ)

16

Culture of Health Action Framework

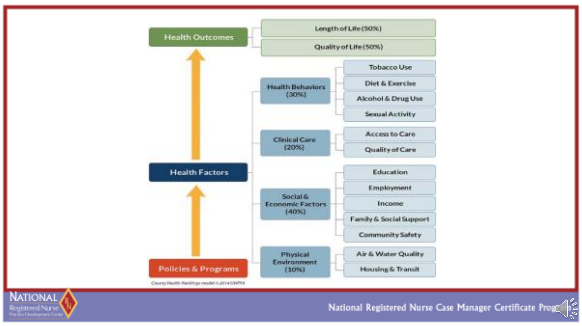
- Launched in 2014 by RWJF
- National agenda to improve health, well-being and equity in America
- Where everyone in a community has a fair and just opportunity for health and well-being, not limited to traditional health indicators
- https://www.rwjf.org/en/cultureofhealth/about.html

17

Primary Care - More Than Medical Care

Social Determinants, Social Factors and Health Equity

18



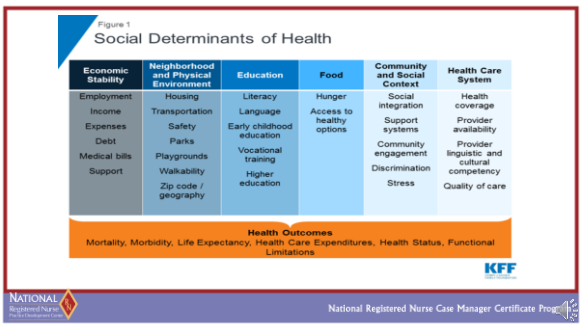
19

Redefining Health

Social Determinants of Health

- SDoH have been described as "the causes of the causes"
- Provide a framework for understanding root causes that contribute to an individual's health, the reasons health disparities exist and how health equity is achieved by all people regardless of socioeconomic status
- Moves beyond defining health in terms of medical care

20



21

Social Needs (NASEM, 2019)

"Individual level nonmedical acute resource needs related to SDoH such as housing, reliable transportation, strong support system at home, that must be met for individuals to achieve good health outcomes and for communities to achieve better health."

"Person centered concept that incorporates each person's perceptions of his or her own health-related needs, which therefore vary among individuals."

Unmet social needs describe factors that prevent people from experiencing positive health outcomes

22

Race and Racism

Racism

"an organized social system in which the dominant racial group based on an ideology of inferiority, categorizes and ranks people into social groups called "races" and uses its power to devalue, disempower, and differently allocate valued societal resources and opportunities to groups defined as "inferior". – Future of Nursing Report 2020-2030, Ch. 2

- Structural
- Cultural
- Discrimination

23

Income & Wealth

- Level of Wealth is associated with health outcomes
- Higher wealth associated with lower mortality, higher life expectancy, slower declines in physical functions
- Significant health differences between income levels below 100% and above 200% Federal Poverty Level
- Low income correlates with higher rates chronic disease, obesity and smoking
- Income impacts safety and quality of neighborhoods and schools
- This disadvantage accumulates over a person's lifetime; can persist for generations

2021 Federal Poverty Guidelines

Household Size	100%	138%	150%	200%	400%
1	$12,880	$17,774	$19,320	$25,760	$51,520
2	$17,420	$24,040	$26,130	$34,840	$69,680
3	$21,960	$30,305	$32,940	$43,920	$87,840
4	$26,500	$36,570	$39,750	$53,000	$106,000
5	$31,040	$42,835	$46,560	$62,080	$124,160
6	$35,580	$49,100	$53,370	$71,160	$142,320
7	$40,120	$55,366	$60,180	$80,240	$160,480
8	$44,660	$61,631	$66,990	$89,320	$178,640

*For households with more than 8 persons, add $4,540 for each additional person.

The Federal Poverty Guidelines are issued each year by the U.S. Department of Health and Human Services. They are used to determine the financial eligibility for certain federal programs. Federal Poverty Guidelines are also referred to as the federal poverty level (FPL). 200% FPL is commonly considered the level of income needed for self-sufficiency.

24

Access to Health Care

Needed:
- Promoting and maintaining health
- Preventing and managing disease
- Reducing unnecessary disability and premature death

Includes:
- Health Insurance Coverage
- Availability of health care providers and services

25

Access to Education

- Lower income families often live in school districts that are resource poor
- Strong correlation between education and morbidity/mortality
- Lower education attainment = higher rates of chronic disease
- Less than high school education impacts life expectancy

26

Housing Instability & Homelessness

- Stability
  - Residential instability increases risk of teen pregnancy, early drug use and depression in youth
- Quality & Safety
  - Lead exposure
  - Substandard conditions
    - i.e., water leaks, poor ventilation, air quality
- Affordability
  - Lack of affordable housing = difficulty paying rent/utilities
  - More likely to have a usual source of health care, postpone needed treatment
- Neighborhood
  - Availability of resources = better health
    - i.e., Public transportation, transportation to one's job, grocery stores with nutritious foods, safe spaces to exercise

27

Food Insecurity

- Lack of resources to purchase adequate food to maintain health
- Low-income neighborhoods have limited sources of health food
  - ie., lack of supermarkets, food deserts
- Most research on effects of food security focused on children
  - Birth defects, cognitive & behavioral problems, higher hospitalization rates, poorer general health, poor oral health

28

Environment & Climate Change

Environmental conditions affect the health of everyone
- Low income & People of Color at greater health risk

Hazards
- air pollution, chemical exposure, poor water quality

Natural Disasters/Climate Change
- More likely to live in a high-risk area for natural disasters
- Less resilient housing
- Less capacity to move

29

Future of Nursing Report 2020-2030

This model provides a framework to describe the social needs & strategies needed to address SDoH and improve health for individuals and communities
- Upstream
- Midstream
- Downstream

30

RNCMs in Primary Care

31

RN Primary Care Practice Domains

- Preventive care
- Chronic illness management
- Care management
- Transition care
- Practice operations

32

LEAP project

Primary Care Team: Learning from Effective Ambulatory Practices

The Primary Care Team leap

A national program funded by the Robert Wood Johnson Foundation

- Examined Role of RNs in 30 high performing, innovative primary care practices
- FQHCs, nurse managed center, private practices,
  - 24 were certified PCMHs
  - Mix of single and multiple organization practice sites
- 2 practice groups emerged
  - Team RNs
  - RN Care Managers
  - Multiple titles
    - Nurse, charge nurse, care team RN, nurse care manager, care coordinator, complex care manager, health coach

33

High Value Activities of RNs in Primary Care

- Telephonic & Face to Face Transition Management
- Daily Routine Visits Scheduled Only with the RN for preventive, acute and chronic care (Independent Nurse Visits)
- Specialized clinics within the Primary Care practice for high volume needs (i.e, prenatal care, warfarin management)
- Home & Hospital Visits for selected patients requiring intensive management
- Collaborative joint primary care provider clinic visits (PCP/RN)

34

Federally Qualified Health Centers (FQHCs) **Community Health Centers**

- Facilities that meet the requirements of the federal Community Health Center Program
- Intended to increase access to comprehensive primary care, dental, and mental health care for underserved populations.
- Requirements:
  - Public or nonprofit health care organization
  - Located in or serve a designated Medically Underserved Area or Population
  - Governed by a community board where at least 51% of board members are health center patients
  - Provide services to low-income Medicaid, Medicare and un/underinsured populations (using a sliding fee schedule).

AMERICA'S HEALTH CENTERS

AUGUST 2022

Community health centers are nonprofit, patient-governed organizations that provide high-quality, comprehensive primary health care to America's medically underserved communities, serving all patients regardless of income or insurance status.

In 2021, for the first time in a single year, health centers served over **30 million patients**

Over 1,400 Community Health Centers and Look-alike organizations provided care at more than 14,000 locations across the country in 2021.

1 in 11 Americans are health center patients, of whom:

- 20% are uninsured
- 59% are publicly insured
- 90% are low-income
- 65% are members of racial and/or ethnic minority groups
- 42% live in rural communities

35

Community Health Center Outcomes

- 22 million vaccines
  - 77% have gone to patients of racial/ethnic backgrounds
- 20 million screening tests
  - 61% have gone to patients of racial/ethnic backgrounds
- 7.2 million N95 masks & 7.9 million at home test kits
- Expanded access to care and services

RNCMS integral to care delivery

- Telehealth
  - 29 million virtual visits
- Dental Services
  - 5.7 million patients
- Mental Health Services
  - 2.7 million patients
- Substance Use Treatment
  - 285,000 patients
- Medication-assisted Treatment for Opioid Disorder
  - 184,000 patients

36

IHS Care Model

Consistent with the PCMH

- Anytime Access to the Care Team
- Well Care & Sick Care (Preventive & Chronic Care)
- High quality Reliable Care
- Coordinated Team-based Care

- Outcome: Culturally Sensitive Care
  - Engages the Indigenous community in developing strategies the improve overall health
  - Recognizes cultural and spiritual respect as crucial components of healing

RNs practice as RN Team Members or Care Managers

37

VA PACT

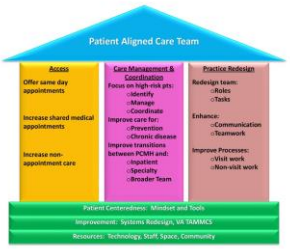
Patient Aligned Care Teams

- Follow PCMH Model
- Veterans assigned to a PACT
- **Focus**
  - Partnerships with Veterans
  - Access to care using diverse methods
  - Coordinated Care among team members
  - Team-based Care with Veteran at the Center

PACT Team

- Veteran Patient
- Primary Care Provider
- Nurse Case Manager
- Clinical Staff/Administrative Clerk
- Pharmacist
- Social Worker
- Dietician
- Mental Health Provider

38



39

Nurse Family Partnership

- First Time Moms and their children affected by social and economic equality
- Specially educated RNs regularly visits first time moms starting in early pregnancy and continuing until the child's second birthday
- Model interfaces with public health

40

NFP Outcomes

- 48% Less likely to suffer child abuse and neglect
- 56% reduction in ED visits for accidents & poisoning
- 67% less likely to experience behavioral & intellectual problems at age 6
- 72% convictions of mothers (measured when the child is 15)
- 35% fewer hypertensive disorders of pregnancy
- 82% increase in months employed

41

Health Quality Partners

Advanced Preventive Care

- RN Care Managers & health care team work together to reduce risk for vulnerable populations
  - Chronically Ill Older Adults
- Specially trained RNs provide clinic visits, home visits and community health promotion
- Care Coordination
- Chronic Disease Management
- Personalized Preventive Interventions

42

HQP Outcomes (RCT):
- Saves lives
- Reduces hospitalizations
- Decreases health care costs for higher risk Medicare beneficiaries
- High patient satisfaction

43

Home Based Primary Care

Frail elders and people with disabilities who have multiple chronic conditions, functional impairments, and/or social needs that make office or hospital visits difficult
- 2 million homebound adults and the nation's older adult population

- Multiple Team-based Care Models:
- Identify & address social needs
- Comprehensive care coordination
- Innovative technology to share information

44

HBC Outcomes:
- More person-centered care to underserved populations
- Reduced health care disparities
- Curb costs associated with unnecessary hospital visits or nursing home admissions

45

The Vision

46

The Vision

Imagine you have a team of trusted health care providers who think about and monitor your health all year round. They connect with you via phone, text or email in between clinic visits at your convenience to remind you about important preventive screenings or vaccines. They coach you through shared decision making in reaching health goals that are important to you, including physical, mental and oral health. They coordinate your care and medications. If you end up in a hospital, they help you transition safely back home. And, because they know your health outcomes depends on social determinants of health such as housing and employment, they help you navigate community resources to support your social needs.

47

Next Steps
- Watch the Videos
- Review Resources
- Complete Practice Development Activity
- Take the Test Your Knowledge self-assessment quiz

Questions:

Kelly.kruse@nationarn.com
(608) 437-6035 CST

- Better Care
- Healthier Communities

48