Curriculum Innovations to Support Population Health Management by RNs

DISCLOSURES

- I have no conflicts of interest to report.

- This project was funded through a 2 Year Grant funded by Health Resources Services Administration (HRSA) as part of the NEPQR-BPCS program to expand educational capabilities to prepare nurses for practice in ambulatory care settings.

SESSION LEARNING OUTCOME

At the end of this session, the participant will be able to:

- Identify innovative educational opportunities to support preparation of BSN prepared RNs for practice in community and primary care settings and to to promote population health in these settings.

OVERVIEW OF PRESENTATION

- Emerging roles for RNs in primary care settings
- Description of the initial program curricular innovations
- Results/Outcomes/Next Steps

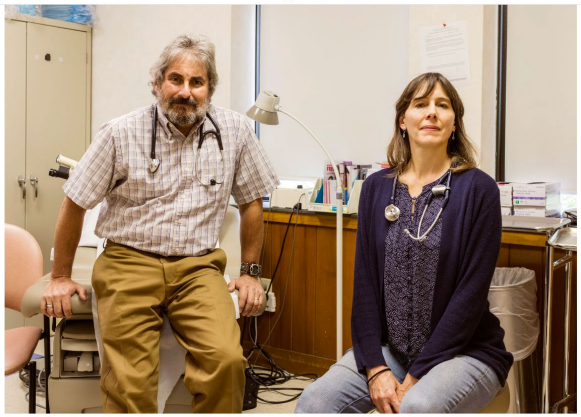
CHANGING LANDSCAPE OF PRIMARY CARE

- Patient Complexity- PCP's estimate 25% of patients in their panels are "complex"
- Need to coordinate care across partners and systems
- Maximizing use of health care information technology - *Effective access, use and analysis of data, telehealth*
- Payment models- *Shift to "value" and "risk" based models*

Powell, JA et al; Emerging Primary Care Trends and Implications for Practice Support Programs; Aligning Forces for Quality Primer, RWJ Foundation, Jan, 2015.

EMERGING ROLES FOR RNS IN PRIMARY CARE

The New York Times



North Carolina is offering payment incentives for doctors like Robert Rosen and Amy Sapp, at Admore Family Practice in Winston-Salem, to play a larger role in managing care.
Jeremy M. Lange for The New York Times

By Steve Lohr

Aug. 26, 2019

RALEIGH, N.C. — North Carolina seems like an unlikely laboratory for health care reform. It refused to expand Medicaid coverage under the Affordable Care Act, and ranks in the bottom third among states in measures of overall health.

JOSIAH MACY JR FOUNDATION

PUBLICATIONS

Registered Nurses: Partners in Transforming Primary Care

Thomas Bodenheimer, MD, MPH and Diana Mason, PhD, RN, FAAN co-chaired the June 2016 conference whose proceedings are recorded in this report, Registered Nurses: Partners in Transforming Primary Care.

50 1969 2019

American Association of Colleges of Nursing

Celebrating 50 Years as the Voice of Academic Nursing

Essentials Revision

A NEW WORKFORCE IS NEEDED

The NEW ENGLAND JOURNAL of MEDICINE

Rethinking the Primary Care Workforce

THE JOURNAL OF AMBULATORY CARE MANAGEMENT

Registered Nurses in Primary Care: Emerging New Roles and Contributions to Team-Based Care in High-Performing Practices

HealthAffairs

Confronting The Growing Burden Of Chronic Disease: Can The U.S. Health Care Workforce Do The Job?

OPPORTUNITIES EXIST BUT….

WE ABSOLUTELY MUST:

- **Make the value proposition** for these positions
- Better articulate how nursing skills and knowledge are worth the investment when working with complex patient populations

Results

Indicators

Performance Measures

Population Measures

Turning Curves

Content on the business of healthcare and these concepts is absent in undergraduate nursing curricula

What would success look like?

BSN PRACTICUMS IN POPULATION HEALTH (BSNPOP) PROGRAM GOALS

- Prepare a minimum of 17 unduplicated baccalaureate nursing students to assume a community based position upon graduation.

- Develop RN capacity in the region by educating ten (10) RNs through our Primary Care Certificate Program

- Educate a minimum of fifty (50) healthcare providers in the region about benefits of having a BSN prepared RN in community/primary care settings

CURRICULAR INTEGRATION STRATEGIES

Practicums are embedded in existing courses:

RIBN	**Community (fall)** **2 credit (60 hr.) practicum**	**RIBN Essentials Capstone Practicum (spring)** **3 credit (120hr) practicum**
Traditional BSN	**Community (fall or spring)- 4 credit hour course- 52-60 hours of 168 total practicum hours**	**Synthesis Course Practicum 60-84 hours of 120 total practicum hours (same semester as community course)**
ABSN	**Community (fall or spring)- 4 credit hour course- 52-60 hours of 168 total practicum hours (summer)**	**Synthesis Course Practicum 60-84 hours of 120 total practicum hours (fall)**

PARTNERSHIPS

- Partners include:
  - regional federally qualified community health centers (FQHCs) (2)
  - regional hospital systems (3), and
  - a low income senior housing community.
  - Tribal/IHS hospital
- Grant supported BSN-RN at each partner agency who serves as full time preceptor for students and care manager for clients served by the agency.
- Hospital partners provide placements with RNs in their care coordination/discharge planning programs to support student learning related to transitions of care between acute and primary care settings.

CAPACITY BUILDING EFFORTS

- Embedding RN Care Managers in sites into roles that previously did not exist
- Working with agencies/RNs to develop metrics for ROI of this role
- Training preceptors/RNs New to the CCTM role
- Strategic “loading” of advisory board- key influencers in primary care in the region

LEARNER RECRUITMENT STRATEGIES

RIBN (ADN articulation program)- in year 4 of the program

Traditional BSN- final semester of 2 year program

Accelerated BSN- 18 month program- last 6 months of program

ADVISING DAY RECRUITMENT

EVALUATION OF STUDENT LEARNING

Students are evaluated on:

- outcomes for the course in which the experience is embedded
- additional learning outcomes for the practicums based on CCTM activities.

Evaluations are conducted by Faculty Liaison and Preceptor

FINE TUNING ALONG THE WAY

- Redesigned from one continuous practicum assignment to two “sessions,” each with different foci
- Session 1 (during community/mental health course) learners rotate across partner agencies to see varied roles of RNs
- Session 2 (during capstone) immersion with RN in care management role.

LEARNERS BY PROGRAM TYPE

Nursing Program	Percentage Make Up of PoP Program
Traditional BSN	8 (16%)
RIBN	21 (42%)
ABSN (Accelerated)	19 (58%)
RN-BSN	2 (4%)

HELP AGENCIES JUSTIFY RN POSITIONS

- Community Nurse in Senior Independent Living Apartment Community
- Population health outcomes for Medicare Advantage Program Enrollees

IMPACT OF AN INTEGRATED COMMUNITY NURSE IN SENIOR HOUSING COMMUNITIES

Background

The rapidly aging population is faced with a multitude of chronic health conditions. These challenges are increased for many seniors trying to piece together services necessary to maintain their independence, many of which will become high users of costly healthcare services.

Through a platform of housing with supportive services, this model supports older adults' ability to safely age in place. The team includes the Resident Service Coordinators (RSC) and the CN that :

- Addresses geriatric population health issues
- Engages and empowers residents to self manage multiple chronic diseases and/or behavioral health issues
- Connect residents to community services
- Support positive outcomes when transitioning between care settings
- Helping cope with life and health events

Community Nurse Model

Since, 2016, the Community Nurse is onsite at the property during the regular workweek, and provides a range of services for residents to augment programs and services provided by the RSC, as required by the Department of Housing and Urban Development for subsidized housing.

The model is supported through a joint commitment between Givens Affordable Communities, the housing provider and Givens Life Ministries, a separate LLC that provides community outreach, and education to he broader community.

Additionally, with support from a federal grant, the Community Nurse, serves as a one on one preceptor for undergraduate nursing students:

- Nursing students work within the resident's community and learn to identify where barriers and challenges to healthcare are experienced.
- Students provide assessments, develop plans of care, reinforce education and follow-up visits within the financial and social boundaries of resident community.

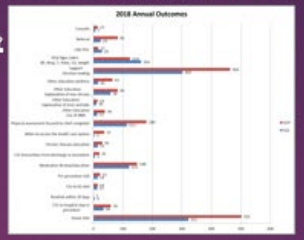
Setting

- Phase One (120 apartments) and Phase Three (60 apartments) serve persons with incomes approximately less than $24,000 per year.
- Phase Two (82 apartments) serves persons with incomes of $24,000 to $45,000 a year.
- RN also serves a 100 unit HUD tax credit senior housing in a rural setting

Results

Program evaluation is guided using the Results Based Accountability (RBA)™ framework, which is a disciplined way of thinking to support an outcome orientation by addressing three basic questions:

How Much did we do?



44% (n=41) of residents completing a 2018 survey had utilized services of the Community Nurse within the first 18 months of the program.

How Well did we do it?

In relation to providing supportive wellness services, residents ranked these services from the Community Nurse as highly valuable.

Residents indicated the Community Nurse helped them to:

- Stay well and live independently (n=34, M=4.85, SD .359)
- Have more confidence in making decisions about their health (n=30, M=4.76, SD .504)
- Better manage a chronic condition (n=24, M=4.54, SD .977)
- Understand discharge instructions post medical procedure, or hospital admission (n=21, M=4.38, SD 1.07)
- Understand how their medications work and proper administration (n=20, M=4.38, SD 1.02)
- Be prepared to talk with their healthcare providers and family (n=22, M=4.45, SD .857)

Is Anyone Better Off?

87% of residents answering the survey felt their quality of life was improved as a result of support services provided by the Community Nurse.

Residents perceived that the Community Nurse had a positive impact on them by providing:

- Emotional support and resources during a stressful time
- Education on prevention and self-care behaviors
- Creative ways to actively engage in their community
- Clear communication/answering questions in a understandable way

Services Provided

- Health promotion
- Education on medications
- Education to support self-management of chronic diseases,
- Healthcare system navigation support
- Care transitions support
- Counseling services
- Advocacy
- Connections to community resources
- Advanced Directives Guidance
- Precepting BSN students to support skills in community based nursing and geriatric care

Impact

Residents overwhelmingly embraced the integration of a Community Nurse into their housing community... To better address the healthcare needs of vulnerable populations through timely preventive care and coordination of services. Finding ways to help seniors age well in community settings will reduce hospital admissions and re-admissions, lower healthcare costs, and reduce the amount of time spent in expensive skilled care.

Combining housing with supportive services is a common sense approach to using available resources, to create a thriving community where seniors can feel more secure and enjoy life knowing there is help in place if and when they need it. Partnerships between organizations with a common goal are critical to the success of this model.

Next Steps

Beginning in April, 2019, as a result of a partnership with a local Federally Qualified Health Center, which was brokered with assistance of the School of Nursing, will be opening a nurse led primary clinic onsite at Givens Gerber Park.

Future opportunities to support sustainability of the Community Nurse program include exploring possibility of contracting with the FQHC for the Community Nurse to provide billable services, such as transition care management and chronic care management, as well as expansion of the model to other affordable housing communities in the area.

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number D77HP29898, Nurse Education Practice Quality and Retention, in the amount of $499,372. The information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

IMPROVED OUTCOMES AND REVENUE!

TCPi Transforming Clinical Practice Initiative

RN SUPPORTING REVENUE IN PRIMARY CARE

Lessons Learned

Integration of RN-led interventions to support population health and resolution of documentation issues for Medicare Advantage populations can result in positive return on investment for primary care practices

Performance Challenge

- Quality measures for the practice were below targets to be able to realize financial incentives through Medicare Advantage Plans
- Demonstrating value of a newly embedded BSN-RN in the practice and improve metrics to realize revenue from incentive programs.
- Capture money being "left on the table."

Practice Solution

Examine the impact of RN-led interventions to address quality measures to support Medicare Advantage plan incentive programs at a regional Federally Qualified Health Center.

Enhance the star rating of the practice, realize revenue from resolution of 'suspect conditions' and improve 7-day and 14-day medication reconciliation (post-hospital discharge).

Change Steps

Practices can integrated a dedicated RN to address population health metrics and resolve "suspect conditions" for clients with Medicare Advantage Plan health coverage.

RN-provided telephone follow up, chart investigation, collaboration with medical providers, and client outreach to address medication reconciliation post hospitalization targets as outlined through the health plan's incentive program.

Capture metrics through primary and secondary data sources to quantify RN effort and revenue as well as trends for targeted UDS/ HEDIS measures.

Practice Spotlight

Opened in 1963, Blue Ridge Community Health Services (BRCHS) is the nation's oldest migrant health center, and today provides medical, dental, behavioral health, pharmacy, and outreach services at twenty one locations in rural western North Carolina. BRCHS is a federally qualified health center that serves approximately 618 clients with Medicare Advantage insurance coverage. Quality measures, especially related to percentage of patients receiving colorectal screening and diabetic management measures, were below desired benchmarks.

BRCHS initiated the integration of dedicated effort by a Registered Nurse (RN) to address these issues. Partnership with a local university helped to capture return on investment of RN effort, which was monetized over the course of one year. During this time, the practice's star rating increased from 2.74 to 4.25, triggering a financial bonus of $70 per member per year.

Other practice revenue included medication reconciliation for post hospital discharge, a bonus ($75 per member per year) for resolving suspect conditions as well as $20 per condition resolved. A bonus for statin use for clients with diabetes resulted in an additional $600 for the year. In total, BRCHS's RN-led population health interventions cost $54,734, but returned $88,185 in additional revenue.

Challenge: Approximately 52% of the clients served are uninsured. Quality measures, especially related to percentage of patients receiving colorectal screening and diabetic management measures, were below desired benchmarks. The practice faced a triple challenge: 1) improving quality measures to enhance patient outcomes and revenue, 2) carving out a new role for the RN serving as a preceptor for learners under the grant funded program, and 3) justifying the value of an RN.

Actions: Through a partnership with a local university school of nursing who had received a federal grant to embed preceptor-led primary care practicum experiences in the baccalaureate nursing curriculum, BRCHS placed an RN in the practice with salary support from the grant. Interventions included RN-provided telephone follow up, chart investigation, collaboration with medical providers, and client outreach to address medication reconciliation post hospitalization targets as outlined through the health plan's incentive program.

Results: RN-led interventions resulted in revenue which far exceeded the cost of the RN effort expended.

Next Steps: BRCHS has identified need for additional RN effort has to expand these interventions to other payer sources. The practice has also identified other roles for RNs in the practice to support sustainable operations, improve provider satisfaction and enhance patient outcomes.

APM

Authors: National Nurse-Led Care Consortium, Kae Rivers Livsey MPH, PhD, RN, Western Carolina University School of Nursing and Jennifer Styles, RN, BSN, Blue Ridge Health.

TCPi Transforming Clinical Practice Initiative

Lessons Learned

Change Tactics

Successful practice transformation tactics fall under person- and family-centered care, sustainable business operations, and quality improvement:

- Person- and family-centered care: Specific client outreach including holistic nursing assessment and client centric education by the RN to enhance collaboration with patients and families.
- Sustainable business operations: Capturing effort for RN interventions required development of a specific "dummy code" as current requirements for "nursing services' effort does not distinguish RN-led interventions from those performed by other clinical staff. Another goal of the project was to document value to justify continued employment of the RN beyond grant funded period.
- Quality improvement: University and practice partners developed a plan to capture impact and to prepare the next generation of RNs for practice in primary care settings. This partnership reflects an alignment of strategies to capitalize on environmental opportunities.

Resources

Results Based Accountability was used as the framework to support this project. To learn more visit.

For more information on incentive plans under United HealthCare Medicare Advantage plans.

Practice Spotlight

Table 1. Revenue through Medicare Advantage incentive programs

Incentive program	Revenue
Star Rating -$70 per member per year	$43,260
MCAIP-suspect condition resolution - $75/member/year +$20/code resolved	$35,115
Medication reconciliation post discharge	$9,210
Statin use with persons with diabetes	$600
	$88,185

Figure 1. Monthly Star Rating -2018

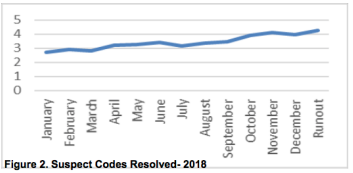


Figure 2. Suspect Codes Resolved- 2018

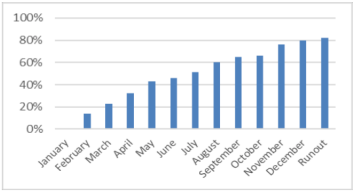
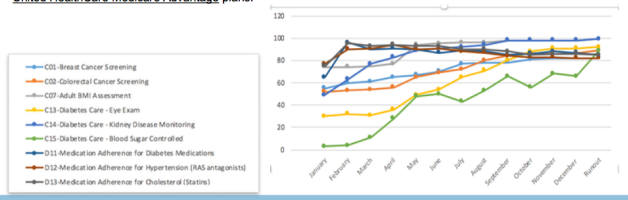


Figure 3. Quality Measures -2018



APM

Authors: National Nurse-Led Care Consortium, Kae Rivers Livsey MPH, PhD, RN, Western Carolina University School of Nursing and Jennifer Styles, RN, BSN, Blue Ridge Health

SPEED BUMPS IN THE ROAD

Primary Care Certificate tuition for preceptors – deemed unallowable cost in grant-

Plan B:

- CCTM modules for preceptors and students
- Preceptor training sessions
- Need for Results Based Accountability training

OTHER LESSONS LEARNED

- All funded programs (n=9) reported experiencing the prevailing notion conveyed from nurses, faculty and peers that they need to have med surg experience before going into primary care as practice setting.

- Where is the evidence????

ADDITIONAL ACTIVITIES

Developed multimedia materials to share information on the program and educate primary care providers on how RNs in primary care can impact patient outcomes

Introduce students in the nursing 101 classes to community/ primary care nursing

Held regional conference in 2018 to educate providers on the role of BSN RN Care Manager

Expand sites- VA, Cherokee Health System, Medicaid Case Management program

GRANT RESULTS

How Much	How Well
• 50 students • 35 completed both sessions • 4 partner agencies • 4 BSN prepared RN preceptors hired • New telephone triage and IPE sim developed	Attrition Rate (30%) (37%) of those completing have accepted roles in community/primary care post graduation >2000 hours completed practicum hours by students Partner Agencies have embraced RN role- committed to RN position Integration of primary adopted by faculty in other courses

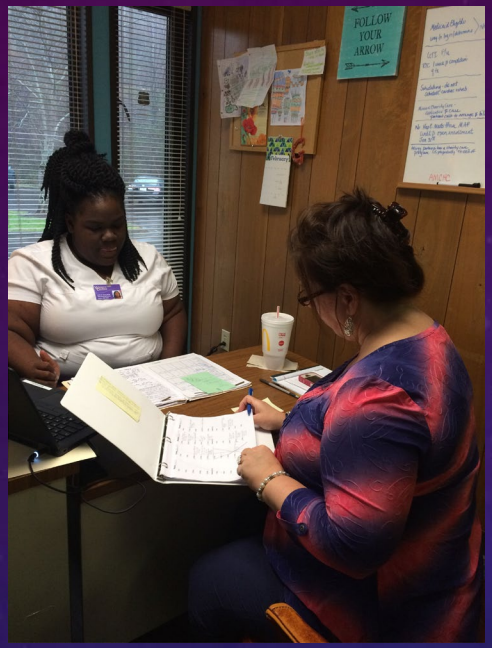
Is anyone better off?

Benefits to learners:

- Better understanding of social determinants of health
- Knowledgeable of available resources for patients
- Know how to advocate for available resources
- Development of holistic view of patient/client
- Developed motivational interviewing skills
- Developed skills in goal setting
- Worked as part of an interprofessional team
- Aware of opportunities that exist in primary care for RNs

- **Benefits to agencies:**
- RN sensitive indicators helping demonstrate value of RN in practice
- Improvement seen in quality metrics
- Revenue generated from resolved suspect conditions
- Better capacity to “address the whole person”
- Out of the thirteen (13) students that attained jobs in primary care post-graduation, five (5) are employed within the partner agencies

NEXT STEPS- RESIDENCY FELLOWSHIP



Western Carolina University | RNs in Primary Care

1 of 42 programs funded across the country
4 year cooperative agreement with HRSA
Year one Planning Year (YEAH!)

- https://www.wcu.edu/learn/departments-schools-colleges/HHS/nursing/undergrad-programs/bsn/rnpcgrantprogram.aspx

RNPC Project Goals

- Goal 1: Develop capacity of faculty and preceptors to support competency development for expanded nursing roles in primary care.

- Goal 2- Enhance capacity of BSN-RNs prepared to work to their full scope of practice in community based primary care settings.

- Goal 3- Articulate the value proposition of the expanded RN role in community based primary care settings.

Simulations

- Virtual Reality Simulations
- IPE using Mursion
- Telephone Triage
- Preceptor Training

Virtual Reality Simulation

https://wlos.com/news/local/western-carolina-nurses-take-learning-to-new-level-with-vr-equipment

IPE Simulation

https://www.dropbox.com/s/m7e8rd14j5z2x9c/Holly%20-%20Leyla.mp4?dl=0

Supply Side Capacity Building

- Providing technical assistance to primary care practices to consider service delivery redesign to support use of the RN working at their full scope.

- Sharing Sessions w/Consortium Members
- One-on-One Consultation
- Assistance with Pro Forma and ROI Analysis

REFERENCES

- Bodenheimer, T., Chen, E., & Bennett, H. D. (2009). Confronting the growing burden of chronic disease: Can the US health care workplace do the job? Health Affairs (Millwood), 28, 64e74
- Bodenheimer, T., & Bauer, L. (2016). Rethinking the primary care workforce — an expanded role for nurses. *The New England Journal of Medicine, 375*(11), 1015-1017. doi:10.1056/NEJMp1606869
- Bodenheimer, T & Mason, D. Registered Nurses: Partners in Transforming Primary Care. Proceedings of a conference sponsored by the Josiah Macy Jr. Foundation in June 2016; New York: Josiah Macy Jr. Foundation; 2017
- Flinter, M., Hsu, C., Cromp, D., Ladden, M. D., & Wagner, E. H. (2017). Registered Nurses in Primary Care: Emerging New Roles and Contributions to Team-Based Care in High-Performing Practices. *The Journal of ambulatory care management*, *40*(4), 287–296. doi:10.1097/JAC.0000000000000193
- Lohr, S. (2019). *Inside north Carolina's big effort to transform health care*. New York: New York Times Company.
- Powell, JA et al; Emerging Primary Care Trends and Implications for Practice Support Programs; Aligning Forces for Quality Primer, RWJ Foundation, Jan, 2015.

Kae Rivers Livsey, MPH, PhD, RN
Associate Director, Associate Professor, Western Carolina University School Of Nursing
klivsey@wcu.edu

J. Danielle Martin, MSN, RN
WCU RNPC Residency/Fellowship Director
jmartin@wcu.edu