# Implementing a Nurse-Led Community Care Team in Primary Care

Vanderboom, CE, PhD, RN & Holland, DE, PhD, RN
Division of Nursing Research, Department of Nursing
**Mayo Clinic, Rochester, MN, USA**

## Background

The prevalence of adults living with multiple chronic conditions (MCCs) is widespread, and there are significant obstacles to providing appropriate healthcare.

A central problem is that disease-based approaches have proven inadequate both in terms of outcomes and quality of life for patients, and in terms of efficacy and cost.

An alternative approach is the Patient-Centered Medical Home in primary care, of which the Community Care Team (CCT) is an evolving component.

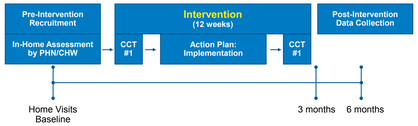
It is increasingly recognized that to achieve health, the healthcare system must first consider the person within the context of their family and community and minimize barriers to health by addressing the social determinants of health such as the ability to meet one's basic needs for nutrition support, transportation, and social conditions. Meeting these needs is foundational for self-managing MCCs.

Although numerous community services are available to support primary care, there is minimal integration of healthcare and community services, leading to under-utilization of community services and fragmentation of healthcare

A Community Care Team (CCT) is an interdisciplinary group consisting of the patient/family, nurse care coordinators from primary care, public health nurses, community services designed to address the integration gap by coordinating primary care, public health and community services.

CCTs offer an effective way to minimize barriers and address the social determinants that influence health outcomes. support, transportation, and social connectedness; meeting such needs is foundational for managing MCCs

CCT Intervention




## Purpose

The purpose of this project is to actively partner primary care with community services via a CCT, to intentionally bring together health and community services to enhance patient-centered care for individuals with MCCs

The CCT partnership leverages the strengths of primary care and optimizes the strengths of community services to offer accessible, cost-effective services tailored to meet the needs of individuals and families

The CCT is foundational for extending primary care redesign efforts toward building Accountable Communities for Health sometimes call "medical neighborhoods" to improve care and reduce costs for individuals with MCCs.

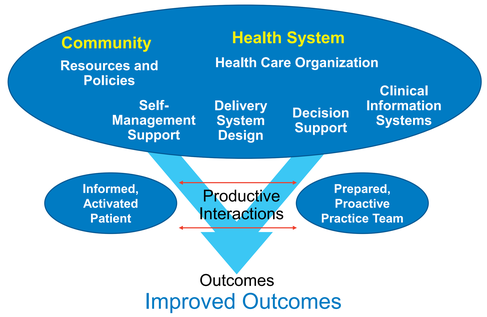
## Methods

- Design: a naturalistic, descriptive, implementation project
- Sample: Older adults with MCCs experiencing difficulties in managing their MCCs; receiving nurse care coordination through PCMH in primary care; with a special focus on "dual-eligible" individuals who qualify for both Medicare and Medicaid.
- Setting; 2 primary care practices in the upper Midwest of the U.S.
- Procedures: CCT implementation involves partnering with community organization including 2 medical centers, the county public health department, an intercultural assistance program and senior services. An existing community health collaborative group serves as the governing body for the CCT
- The CCT Intervention: an intensive, 12 week program that includes 2 meetings with the patient/family and involves action and crisis prevention planning, strengthening an informal circle of support, and providing ongoing health and community follow-up
- CCT members include: nurse care coordinators from primary care, public health nurses, social workers, community health workers

## Community Care Team

## Conceptual Framework

Chronic Care Model




## Outcome Measures

- The CCT project goal is to provide patient-centered care that is effective, efficient and timely as measured by:
- Patient-focused measures:
  - Patient Assessment of Chronic Illness Care
  - Physical, mental and social health (Global Health Scale)
  - Resilience (CD-RISC)
  - Confidence to manage MCCs (Self-Efficacy Scale)
  - Knowledge, Behavior, Status (Omaha System)
  - Use of health services (hospital, ED, nursing home)
- Community-focused measures:
  - Community services recommended by CCT and used by patients
- Implementation measures:
  - Extent of participation
  - Effectiveness – perceptions of patients/families/ clinicians
  - Adoption of the CCT by nurse care coordinators
  - Consistent delivery of the CCT
  - Maintenance of the CCT – the extent to which the CCT becomes a routine part of practice

## Acknowledgements

The CCT project is part of a $45 million State Innovation Model (SIM) cooperative agreement, awarded to the Minnesota Departments of Health and Human Services in 2013 by The Center for Medicare and Medicaid Innovation (CMMI) to help implement the Minnesota Accountable Health Model.

The Community Care Team is a partnership between Mayo Clinic, Rochester, MN, Olmsted Medical Center, and Olmsted County Public Health.

## Preliminary Results

***Accomplishments to date:***

- Subcontracts with community providers are in place
- All team members received education about strengths-based care using the Wraparound process
- CCT systems and processes are in place
- 22 patients referred to CCT – 2 non-English speaking
- The inclusion of public health nurses and community health workers is invaluable
- An informational brochure and website have been developed; a secure data repository is in development

***Challenges:***

- Developing team facilitation skills is challenging
- Extensive need for community health worker services

## Nursing Implications

- Most care providers are unaware of the impact of social factors on patient's ability to manage MCCs. The CCT integrates primary care and community services to address social barriers as well as health-related factors that impact health
- We anticipate that the CCT will change clinical nursing paradigms through partnerships between health and community services to provide more holistic nursing
- Results of the CCT project will increase our understanding of comprehensive, strengths-based primary nursing care