Implementing a Nurse-Led Community Care Team in Primary Care

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**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 (PCMH) 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 and shelter, and optimize 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 called “medical neighborhoods” to improve care and reduce costs for individuals with MCCs.

**Purpose**

The purpose of this project is to actively partner primary care with community services via a CCT to effectively 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.

**Community Care Team**

- **Pre-Intervention**
  - **Home Visits**
  - **Recruitment**
  - **Pre-Intervention**

- **Intervention**
  - **Conception Framework**
  - **Chronic Care Model**

- **Post-Intervention**
  - **Implementation**
  - **Outcome Measures**

**Conception Framework**

- **Chronic Care Model**

**Chronic Care Model**

- **Community Resources and Policies**
- **Health System**
- **Health Care Organization**
- **Clinical Information System**

**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)**
    - **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
  - **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**

**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**

**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 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.

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