

Transforming the Workforce to Provide Better Chronic Care: The Role of Nurse Care Managers in Rhode Island

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This is the first in a series of case studies exploring the evolving role of nurses in new delivery system models designed to better meet the needs of consumers with chronic health conditions. Each case study provides policy recommendations and showcases the work of a nurse in a new initiative.

This study looks at improving chronic care at the Rhode Island Chronic Care Sustainability Initiative that involves 36 primary care practices serving over 220,000 consumers. It also provides readers with an opportunity to see how the policy decisions that created this initiative influence practice through a “Day in the Life” of the nurse care manager beginning on page 3.

Chronic illnesses are responsible for more than three-quarters of health care spending and 7 out of 10 deaths in the United States—and nearly half of all Americans have at least one chronic illness—according to the Centers for Disease Control and Prevention.¹

To improve health outcomes, especially for those with chronic illnesses, and help contain health care costs, commercial and public payers broadly support patient-centered medical homes (PCMHs) for delivery of primary care. The PCMH care model emphasizes

quality, comprehensive, coordinated, and patient- and family-centered care.

Many PCMH initiatives have found professional care management to be an effective component of a strategy to improve health outcomes by assisting consumers in accessing the medical, behavioral health, social service, and educational resources they need to best manage their care.

The shift to a PCMH model requires that practice staff improve the way they function individually and collectively as a team; the Rhode Island Chronic Care Sustainability Initiative (CSI-RI) is illustrative of how nurse care managers (NCMs) can function in a PCMH model of care. CSI-RI is a multipayer PCMH program that supports 36 practices with 303 providers, including nurse practitioners and physician assistants who serve over 220,000 Rhode Islanders.²

Virtually all payers in the state are participating in this initiative to fund improvements in the care delivery system by providing monthly payments to PCMH practices based on the number of covered lives. These payments help primary practices pay for additional staff, including a required nurse care manager, and implement an electronic health record system, and may include the development of a patient advisory committee.³

About This Series

Transforming the Workforce to Provide Better Chronic Care: The Role of Registered Nurses

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This series explores the evolution of primary care systems to better meet the needs of consumers with complex health conditions. It demonstrates that changes in the workforce are required to empower consumers to better manage their health.

The series is a collaboration of the National Academy for State Health Policy and the AARP Public Policy Institute. We recognize that it takes a team of skilled professionals to deliver improved chronic care. In this series, we focus on how registered nurses—who make up the largest segment of the health care workforce—are being deployed in ambulatory delivery systems to take on new roles. Future series will focus on other members of the health care team.

We selected six initiatives that offer replicable policy strategies to develop, implement, and sustain patient-centered approaches to care. Each case study highlights one of these initiatives and provides policy recommendations and an “on-the-ground” look at the work of its nurses.

We conducted site visits to:

- **Rhode Island’s Chronic Care Sustainability Initiative:** a multipayer medical home initiative that supports an embedded nurse care manager in each primary care practice.
- **North Carolina’s Pregnancy Medical Home Program:** a medical home program for high-risk pregnant Medicaid beneficiaries where obstetric nurse coordinators oversee program operation and quality improvement.
- **Minnesota’s Health Care Homes:** a multipayer medical home initiative where nurses play a crucial role ensuring that primary care practices meet state standards.
- **Hennepin Health (MN):** an accountable care organization where a behavioral health nurse care coordinator orchestrates care among primary care, behavioral health, and social service agencies.
- **Yamhill (OR) Community Care Organization’s Community HUB:** an accountable care organization where a nurse leads a program to improve care for super-utilizer patients.
- **CareFirst’s (MD) Patient-Centered Medical Home Program:** a commercial medical home program using nurse care coordinators to help consumers better manage their chronic conditions. CareFirst is also piloting this program with Medicare consumers through an Affordable Care Act “Health Care Innovation Award.”

These six initiatives offer replicable opportunities and lessons for other states and/or payers that are developing or considering patient-centered models of primary care delivery. All of these initiatives support consumer navigation of complex care systems, understanding of illnesses, and learning self-management skills.

Additionally, all of these initiatives have policies in place that facilitate roles where nurses are supporting practices to be more responsive to consumer needs. The final paper of this series will synthesize lessons learned across all cases studies and offer recommendations for states, policy makers, and educators.

For more information please visit our websites: <http://www.aarp.org/health/health-insurance/role-of-nurse-care-managers-ri-AARP-ppi-health.html> or <http://www.NASHP.org>.

CSI-RI has found that embedding a nurse care manager in a primary care practice is a critical component of its strategy to improve care and health outcomes for patients with chronic illnesses and/or complex conditions. According to codirector Deb Hurwitz, payers were willing to make the investment in registered nurses (RNs), despite being more costly than other staff (e.g., licensed practical nurses [LPNs]), because they believe RNs add a “balance of clinical knowledge and direct patient experience” that is necessary for effective chronic care management that uses metrics to inform patient care.

CSI-RI practices regularly use a number of metrics to report on quality, cost of care, and patient satisfaction. These metrics include clinical measures for chronic conditions and utilization measures, such as emergency room use and hospital readmissions. The measures are designed to capture the “medical home effect”—how well the PCMH model is working to shift health care utilization away from acute hospital-based treatment to high-quality, patient-centered

preventive primary care. Reporting from participating practices shows that at CSI-RI, the embedded nurse care manager is central to the ability of practices to meet PCMH expectations.

Lessons Learned and Remaining Challenges at CSI-RI

Five years after launching the initiative, participants in the CSI-RI initiative offer the following recommendations for developing a PCMH initiative.

Lessons Learned

- ***Set realistic expectations.*** A nurse care manager’s responsibilities are likely to evolve over time depending on the needs of the practice and the goals of the initiative. For example, time spent by the nurse care manager helping a practice develop a medical home model of care will likely compete with the time that nurse can devote to working with patients.
- ***Provide adequate resources and support to maximize RN capacity.*** Training should be offered to nurse care managers and to providers and

A Day in the Life of Nurse Care Manager Dawn Buckley from the Rhode Island Chronic Care Sustainability Initiative

When South County Internal Medicine joined the Rhode Island Chronic Care Sustainability Initiative (CSI-RI) in 2010, the practice hired a nurse care manager, Dawn Buckley, RN, who has played a key role facilitating significant transformation inspired by the initiative.

“Our entire practice has changed. We’ve gone from a physician-centric to team-centric model. Our focus on tracking quality measures and setting goals is improving,” stated one physician at the six primary care physician (PCP) practices located in southern Rhode Island. “Physician time is better spent, and patients are better prepared for visits.”

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Nurse care manager Dawn Buckley discusses patient care with Dr. Letitia Horrigan at South County Internal Medicine.

A Day in the Life...

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The Day Begins

Each day quickly brings new challenges for Buckley as she works to best meet the needs of her patients and their family caregivers.

At 8:00 a.m., she logs on to her computer and reviews the list of scheduled appointments to identify patients at risk for complications. The practice recently adopted a risk stratification care management tool that classifies patients into four categories, from no risk to high risk, using color codes.⁸ Many patients have not yet been coded, so Buckley works to identify patients with the highest risk for complications. Those patients meet with Buckley for a 15-minute visit before their scheduled PCP visits. She asks questions to understand their situation, reviews medications, and talks with family members and other caregivers. This pre-visit planning helps the physicians better allocate their time with patients.

Buckley then reviews the daily Admission, Discharge, Transfer (ADT) report that South County Hospital emails to the practice each morning. This report lists all patients from South County Internal Medicine who were admitted, discharged, or transferred from the hospital. Because about 70 percent of the practice's patients receive care in this hospital, this report contains a gold mine of data to help Buckley identify patients in need of care management. She also checks CurrentCare—Rhode Island's health information exchange—for ADT activity at other hospitals.

Regardless of their need for care management, all patients discharged from the hospital are contacted within two business days to review medications and discharge orders—an evidence-based standard adopted by this practice.

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staff to better integrate nurse care managers into practice workflow.

- **Engage consumers in the decision-making processes.** To ensure that care management and other core elements of the medical home model are continually responsive to consumer needs, CSI-RI has established a Patient Advisory Group to advise CSI-RI leadership.⁴

Overcoming Remaining Challenges

- **Offer behavioral health resources.** South County Hospital recently hired a behavioral health nurse care manager to serve as a resource for nurse care managers and practices to better address the behavioral health needs of patients.
- **Revamp education curricula for RNs.** CSI-RI has recognized the growing need for RNs be trained in emerging delivery system models and is working with the Rhode Island College School of Nursing to develop a graduate certificate program in nurse care management geared for RNs with a BS in nursing. The program aims to provide RNs with the necessary education and skills to function in care management roles in PCMHs.⁵ RNs will learn from providers and nurse care managers participating in the CSI-RI. The program will be offered starting in the fall 2014 semester.

Role of State Policy

Rhode Island has adopted a number of state policies designed to facilitate not only the capacity of RNs to serve as nurse care managers, but also the integration of the RNs onto the primary care team. The table below highlights these policies and notes a number of persisting challenges.

Table 1
Rhode Island Chronic Care Sustainability Initiative (CSI-RI) Nurse Care Manager (NCM) Model—
State Policy Facilitators and Challenges

	Facilitators	Challenges
Model	NCMs embedded into primary care practices (or multiple practices if each does not have enough patients) to work with high-risk and chronically ill patients; ⁶ approximately 1:150 nurse-to-patient ratio.	NCMs working with multiple practices may face challenges integrating into different workflows and navigating multiple electronic medical record systems.
Education & Qualifications	Bachelor's degree in nursing; licensed RN in RI and at least 3–5 years' experience coordinating care for patients with complex illnesses and with primary care providers.	Limited educational opportunities for care management and care coordination training currently in Rhode Island and generally in nursing curricula.
Training & Resource Supports	Training workshops for providers and NCMs; CSI-RI facilitates monthly nurse care manager meetings to share best practices.	Time and resources to provide in-person training workshops are limited; virtual workshops and calls are more widely used.
Physician Acceptance	CSI-RI offers coaching to assist with NCM assimilation into primary care practice office operations; CSI-RI facilitates monthly NCM meetings to share strategies.	When practices join CSI-RI, providers are often not experienced with having an NCM on staff; setting boundaries about job role is needed.
Financing & Payment	All payers in RI participate in financing the cost of NCMs as well as other costs associated with operating as a PCMH; ⁷ payers also partly finance training opportunities for NCMs.	Payers recognize the role of the NCM but need to recognize that improved care outcomes for those with chronic illnesses will require adding others to the practice team such as behavioral health specialists, pharmacists, and others; CSI-RI will be piloting “shared teams” of these kinds of providers in 2014.
Access to Data	Electronic health information exchange—enabling health care providers to access and share patients' medical information electronically—between local hospitals and individual practices in certain areas of RI.	CurrentCare, the state health information exchange, has just 25 percent of patients enrolled.
Consumer Input in Model Development	Establishing a Patient Advisory Group to provide input on model.	Progress toward establishing Patient Advisory Groups is slow due to logistical challenges in convening patients for meetings.

A Day in the Life...

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She fires off emails to some of the PCPs, sharing information about a recent patient admission. Next, she flags electronic health records to alert physicians who have scheduled office visits today about recent concerns raised by families, caregivers, the Visiting Nurse Services (VNS), and others. She shares her assessments and recommendations regarding some of these concerns with each physician.

The Morning Rush

Patients begin to flow into the practice when the doors open at 9:00 a.m. Buckley starts with several scheduled appointments for “wellness visits”⁹—an annual voluntary checkup for Medicare patients. These patients, often accompanied by their caregivers, bring a completed Health Risk Assessment to the 30-minute appointment.

During the appointments, Buckley reviews changes to the patients’ medical health, cognitive and functional status, and social history. She then makes referrals to appropriate patient education resources, including Stanford Chronic Disease Self Management Classes that she conducts,¹⁰ and other community resources, such as transportation and social services. Buckley has trained the practice’s two LPNs to also perform these “wellness visits.”

After her early appointments, a physician pulls Buckley into an appointment with a patient who has high cholesterol and needs dietary education. Certified as a cardiovascular outpatient educator by the Rhode Island Department of Health, Buckley provides the patient with immediate counseling.

Next, Buckley meets with a diabetic patient. As a certified diabetic outpatient educator, Buckley helps her diabetic patients understand and manage their condition. At this appointment, the patient brings his glucometer and Buckley downloads and discusses his readings—something that rarely happened before South County Internal Medicine became a PCMH.

“We didn’t have time to deal with meters before Dawn came,” one physician notes. Now, more than 100 patients are actively engaged in this aspect of care.

Buckley uses motivational interviewing techniques that she learned while taking a Guided Care training¹¹ offered by CSI-RI to help the patient set new goals. After the visit, Buckley speaks briefly with the physician to relay the patient’s progress. This information allows the physician to better focus time spent with the patient. Buckley has also trained the front office staff to remind patients during appointment scheduling to bring in their glucometers, blood pressure logs, and complete Health Risk Assessments, if applicable, so patients are better prepared for their appointments.

Before lunch, Buckley pulls reports for each physician showing the number of patients receiving smoking cessation interventions. South County Internal Medicine is eligible for performance payments from all the payers participating in CSI-RI if the practice meets certain quality targets, including one for tobacco cessation interventions.

The Afternoon Rush

After lunch, Buckley reviews hospital discharge summaries online and begins contacting patients in need of follow-up. She places a call to a recently discharged patient to assess his physical, mental, and functional status. She then places a call to a patient found to have a very high blood glucose level after recently being admitted to the hospital for cancer. Buckley attempts to track down the patient and schedule a follow-up appointment with his PCP.

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A Day in the Life...

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Buckley moves on to send a mass email notifying male diabetics about a “Men’s Night Out”—a chronic disease self-management class that she is facilitating later in the month. Then she answers a call from the VNS asking her advice about managing a patient at home.

She consults with a physician regarding this patient. Because of her licensure as an RN, she is able to take verbal orders from the physician to change the patient’s medications; enter the orders into the chart; and call the patient, pharmacy, and the VNS about the changed orders. Buckley has developed a strong working relationship with the VNS and keeps them on speed dial as a valuable resource for many of her patients.

Next, a physician pulls her into an exam room to counsel a patient and his family. The patient’s health is declining and he has lost 15 pounds since the last visit. “In these moments, patients and families are often the most open to interventions. This opportunity might be lost if the counseling is done days later, over the phone, or by someone not connected with the practice,” says Buckley.

At the end of the day, Buckley meets with the front office staff to help her conduct outreach to a list of patients who have not had a primary care visit in over a year. Buckley will be back tomorrow at 7:30 a.m. to meet with practice staff and PCMH practice transformation experts from the CSI-RI project. They will discuss how to improve patient satisfaction and establish a patient advisory group. Buckley is responsible for helping the practice maintain its recognition as a PCMH.

It’s been another long day, but Buckley could not imagine a better job. “This is an incredible position and so professionally rewarding. It surpasses my prior experiences working in a hospital,” she says. “The opportunity to develop one-on-one relationships with patients, their families, and caregivers has resulted in long-term, meaningful connections that have led to improved health care.”

Endnotes

¹ National Center for Chronic Disease Prevention and Health Promotion, “Chronic Diseases: The Power to Prevent, The Call to Control,” 2009. Accessed at <http://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/chronic.pdf>.

² The Rhode Island Chronic Care Sustainability Initiative, “Annual Report 2013.” Accessed at https://www.pcmhri.org/files/uploads/CSI-RI%202013%20Annual%20Report_FINAL.pdf.

³ The National Academy for State Health Policy, “Medical Home & Patient-Centered Care – Rhode Island.” Accessed on June 13, 2014, at <http://www.nashp.org/med-home-states/rhode-island>; and Rhode Island Chronic Care Sustainability Initiative and the Rhode Island Quality Institute, “Patient-Centered Medical Home – Rhode Island.” Accessed on June 13, 2014, at <http://www.pcmhri.org/>.

⁴ American Academy of Family Physicians, “Risk-Stratified Care Management and Coordination.” Accessed at http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/RSCM.pdf.

⁵ “CSI-RI: Strategic Planning Final Plan,” PowerPoint presentation, February 21, 2013. Accessed at http://www.pcmhri.org/files/uploads/CSI_Strategic_Plan_Summary%20March%202013.pdf (slide 22).

⁶ Rhode Island College, “Rhode Island College School of Nursing Announces Graduate Certificate in Nurse Care Management,” June 5, 2014 (news release). Accessed at http://www.ric.edu/news/details.php?News_ID=2544.

⁷ The term “high-risk patients” refers to patients who have chronic diseases and/or are at elevated risk for hospital readmission and frequent emergency room utilization.

⁸ The Rhode Island All-Payer Patient Centered Medical Home Act (<http://webserver.rilin.state.ri.us/BillText11/SenateText11/S0770Aaa.pdf>) enacted in July 2011 requires all state-regulated health insurers to participate in a PCMH collaborative—CSI-RI.

⁹ Centers for Medicare and Medicaid Services, “Medicare Learning Network Matters®: Annual Wellness Visit (AWV), Including Personalized Prevention Plan Services (PPPS),” 2011. Accessed at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm7079.pdf>.

¹⁰ Stanford School of Medicine, “Chronic Disease Self Management Program (Better Choices, Better Health® Workshop).” Accessed on June 5, 2014, at <http://patienteducation.stanford.edu/programs/cdsmp.html>.

¹¹ Johns Hopkins University, “Guided Care®: Comprehensive Primary Care for Complex Patients.” Accessed on June 5, 2014, at <http://www.guidedcare.org/>.

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