



Charting Nursing's Future

Reports on Policies That Can Transform Patient Care

Implementing the IOM *Future of Nursing* Report—Part III: How Nurses Are Solving Some of Primary Care's Most Pressing Challenges

2012

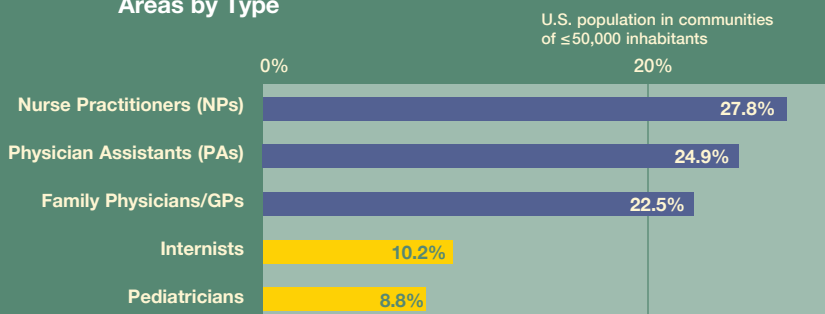
JULY

As pressure mounts on primary care providers to improve patient health and lower health care costs, delivery systems are looking to nurses to solve many of primary care's most pressing challenges. Nurse practitioners (NPs) and certified nurse-midwives (CNMs) are providing primary care alongside physicians and physician assistants. NPs and RNs are leading the way in managing chronic conditions and coordinating care transitions. RNs and licensed

practical nurses are tracking patients to make sure they get the care they need, and nurses at all levels are educating patients to better care for themselves.

This brief explores policies that support this evolution in primary care delivery and looks at several innovative models that provide patient-centered, coordinated, and cost-effective care by taking advantage of nursing's strengths.

Figure 1 Percentage of Primary Care Providers Working in Rural or Remote Areas by Type



Uneven geographic distribution of the health care workforce limits access to primary care. Primary care NPs, PAs, and family physicians are much more likely to work in rural and remote areas than are other primary care providers.

Source: AHRQ Publication No. 12-P001-4-EF. Data derived from analysis of National Provider Identifier file, November, 2010; U.S. Census Bureau Population Estimate, 2008.

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The Value of Nursing

A master's-prepared nurse case manager from The Nebraska Medical Center visits with a patient served by Senior ASSIST, a comprehensive, long-term care management and home-visiting program for chronically ill elderly people. Case managers develop care plans, reconcile medications, and teach patients how to care for themselves. They also coordinate care transitions and connect patients with community resources to strengthen the support system at home.

In 1998, The Nebraska Medical Center hired Diane McGee, RN, MSN (right), and others to develop and implement the program for their high-risk patients who did not qualify for the Medicare home health care benefit. McGee attributes the program's success to the continuity of care it provides and the close collaboration between the case managers, physicians, and other care providers.

A study comparing participants' hospitalization rates and health care costs during the six months prior to and after admission to the program showed decreases of 62 percent and 63 percent, respectively. A retrospective chart review showed a 30-day rehospitalization rate for program participants of only 11 percent, more than 6 points below the national average.



Photo: Taylor Wilson, courtesy of The Nebraska Medical Center, Omaha

Nursing Roles Evolve to Extend and Improve Primary Care Delivery

In 2010, the Robert Wood Johnson Foundation brought together thought leaders under the auspices of the Institute of Medicine (IOM) to answer this question: “What roles can nursing assume to address the increasing demand for safe, high-quality, and effective health care services?” The resulting report, *The Future of Nursing: Leading Change, Advancing Health*, notes that nurses—the largest and most flexible component of the health care workforce—are “poised to help bridge the gap between coverage and access, to coordinate increasingly complex care for a wide range of patients, to fulfill their potential as primary care providers to the full extent of their education and training, and to enable the full economic value of their contributions across practice settings to be realized.”

Nursing Roles for an Evolving Primary Care System

Glossary

APRN: advanced practice registered nurse*

NP: nurse practitioner*

CNM: certified nurse-midwife*

RN: registered nurse

LPN, LVN: licensed practical or vocational nurse**

*These nurses hold advanced degrees.

**These nurses work under the supervision of an RN.

• Primary care provider

NPs care for people of all ages, diagnosing and treating acute and chronic conditions, prescribing medications, ordering tests, and promoting health through prevention and patient education. CNMs manage low-risk pregnancies and deliveries and provide routine gynecological and primary care to women of childbearing age.

• Clinical nurse leader

Master’s-prepared nurses provide evidence-based leadership within the care setting to redesign and improve care.

• Case manager/care manager/care coordinator

These titles denote NPs and RNs who develop care plans, teach self-management, and coordinate care for chronically ill patients in clinical settings, in the home, and via telephone or telehealth devices.

• Provider of transitional care

NPs and RNs design and implement care plans for patients transitioning between acute care, home, long-term care, and other settings.

• Provider of care according to standard protocols

NPs in convenient care clinics conduct physical exams, offer preventive services, and diagnose and treat common acute and chronic conditions. In some primary care practices, RNs handle simple acute and preventive care.

• Manager of population health

RNs and LPNs review patient registries to monitor patient health and ensure timely laboratory studies and other screenings.

“Given the current trends in physician-based primary care, the development of a robust cadre of advanced-practice primary care nurses (and physician’s assistants) should become a major priority. ... [It] can be achieved at lower cost and in a shorter timeframe than a comparable increase in the number of primary care physicians. ... [Such an increase] might actually contribute to bending the health care inflation curve.”

The Heritage Foundation, *Not Enough Doctors? Too Many? Why States, Not Washington, Must Solve the Problem*, by Roger E. Meyer, MD, 2010. The author is a former vice president for medical affairs at George Washington University.

Nurses are well positioned to assume greater responsibility for primary care as millions of newly insured Americans enter the health care system through the Affordable Care Act, recently upheld by the Supreme Court. Nurses are already leading the way in keeping patients healthy, managing their diseases, and reducing their use of costly hospital care by increasing the availability and scope of primary care services.

NPs are the fastest-growing group of primary care providers, with NP students who plan to enter primary care graduating at three times the rate of their medical student counterparts. They are also more likely to practice in remote and rural areas where physicians are scarce (see Figure 1, p. 1), and research has shown that health outcomes are comparable for patients whether they receive primary care from an NP or a physician.

The innovative models featured in this brief redefine nursing roles to extend access, improve care, and contain costs. These models emphasize the care coordination at which nurses excel. They employ interprofessional teams that share responsibility for health outcomes. They exploit information technology to enhance patient communication, track care, and improve clinical decision-making. They change the way care is paid for, and they allow nurses, physicians, and others to practice to the full extent of their knowledge and skills.

Despite these trends, many barriers inhibit the growth and improvement of the primary care sector. Traditional reimbursement mechanisms discourage providing the prevention, care coordination, and disease management services that characterize the best primary care. This brief considers payment reforms that offer promising ways to support the use of nurses to deliver these services. In some states, nurses face additional regulatory, policy, and financial barriers that make it difficult for them to practice to the full extent of their education and training. These barriers, and their implications for interprofessional collaboration, will be explored in *Charting Nursing’s Future* 19.

For More Information

- www.thefutureofnursing.org/iom-report
- See *Charting Nursing’s Future* 9 for more on how nursing expands access and issue 17 for more on interprofessional collaborative care.

HealthPartners
Empowering Primary Care
Nurses to Serve Patient Needs

Primary care nurses at HealthPartners, a large nonprofit health care organization based in Minnesota, once defined their roles as supporting particular physicians. Today their roles have been redefined. RNs and licensed practical nurses (LPNs) share responsibility with HealthPartners primary care providers for anticipating patient needs and making sure they have the supports in place to successfully implement care plans. They also treat some acute conditions by following standard protocols. HealthPartners hires NPs, physicians, and physician assistants to work as primary care providers (PCPs). It also hires NPs to diagnose and treat common conditions via the Internet.

This transformation of nursing roles grew out of a larger initiative to reduce unwarranted variation in the quality of care by standardizing best practices and implementing them across the system. For primary care, this meant replacing a reactive, visit-focused approach with what HealthPartners calls the Care Model Process, an adaptation of the highly respected Wagner Chronic Care Model, which emphasizes the delivery of evidence-based care to an informed and activated patient by a team of prepared and proactive practitioners.

In practice, the Care Model Process means HealthPartners nurses review electronic health records and order lab work prior to patient visits. They also coordinate postvisit and between-visit care, including transitional care following hospitalization. The most high-risk patients receive comprehensive, hour-

Who Provides Primary Care?

“Primary care is the provision of *integrated, accessible health care services* by clinicians who are *accountable* for addressing a large *majority of personal health care needs*, developing a *sustained partnership with patients*, and practicing in the *context of family and community*.”

Source of definition: National Research Council. Primary Care: America's Health in a New Era. Washington: National Academies Press, 1996.

Primary Care Providers Physicians (pediatrics, internal medicine, family medicine, and general practice) Physician assistants Nurse practitioners Certified nurse-midwives	Clinical Team Members Registered nurses Licensed practical nurses RN and APRN specialists in mental health, diabetes education, HIV care, etc. Medical assistants Social workers Psychologists Dentists Clinical pharmacists Dental hygienists Nutritionists
	Other Team Members Clerical assistants Translators Health educators Coaches and consultants (birth, lactation, fitness, etc.) Receptionists

long office visits. RNs assess ongoing concerns prior to the encounter with the PCP and follow up to ensure that patients understand and implement their care plans.

This collaborative approach extends to pharmacists, diabetes educators, and other team members, who meet with or phone patients to address diet, medications, and other concerns. Professional roles are clearly defined, and all clinicians are empowered to provide the full scope of services allowed under their licenses.

In recent years, a new role has emerged for HealthPartners NPs. They provide easily accessible diagnosis and treatment for many of the same conditions commonly handled in convenient care clinics through an online service called virtuwell. Patients have embraced this low-cost alternative to traditional office visits. Virtuwell logged nearly 30,000 completed visits

in its first 20 months and continues to attract new visitors.

Model Policies and Practices:

- Creating collaborative care teams;
- Using standing orders to empower nurses and other clinicians to provide the full scope of services allowed under their licenses;
- Providing access to routine care via the Internet;
- Standardizing best practices.

Outcomes: HealthPartners scored above the state average on 10 of 12 quality measures in 2011. The share of patients receiving optimal diabetes care rose from 10 percent to 42.5 percent in five years.

Cost Savings: Total cost of care was 10 percent below the statewide average in 2010. Avoided ER visits for patients with diabetes saved \$900,000 in one year alone.

For More Information

To learn more about the Wagner Chronic Care Model, visit www.improvingchroniccare.org.



“Empowering nurses to coordinate what goes on before, after, and in between patient visits has transformed our ability to provide high-quality primary care.”

Beth Waterman, RN, vice president, Health Improvement and Care Innovation, HealthPartners

Recent Reforms Affirm Pioneer's Vision



Charting Nursing's Future salutes Donna L. Torrasi, RN, MSN, executive director, Family Practice and Counseling Network

When Donna Torrasi became one of Pennsylvania's first NPs in 1976, few people knew what an NP was. Not so today, thanks in part to Torrasi's efforts to expand the profession's role in providing primary care. She helped found one of the nation's first federally qualified nurse-managed health centers, and later, as a Robert Wood Johnson Executive Nurse Fellow, she co-authored a book with Tine Hansen-Turton, *Nurse-Managed Health Centers: Getting Them Started and Keeping Them Going*.

Today the type of integrated, interprofessional care Torrasi and her colleagues provide to inner-city Philadelphia residents has gained wide respect. The Family Practice and Counseling Network addresses the social and emotional as well as the physical dimensions of health, and key features of the network's approach have been institutionalized in the patient-centered medical home model.

Looking back, Torrasi recalls that having a great care model was only a first step. "I realized my dream of having a nurse-managed practice," she says, "but I quickly saw that we had to change state policies in order for the center to function properly."

To do that, Torrasi became a founder and board member of the National Nursing Centers Consortium (NNCC) and testified on behalf of prescribing authority for Pennsylvania's NPs. She also worked with NNCC to champion broader reforms that culminated in the Prescription for Pennsylvania.

Innovative Primary Care Models That Take Advantage of Nursing's Strengths, continued

Prescription for Pennsylvania Leveraging Nursing's Contributions to Primary Care

Five years ago, charges for avoidable hospitalizations for Pennsylvanians with chronic conditions totaled \$4 billion, and researchers estimated that only 56 percent of patients were receiving evidence-based care to keep those conditions in check. In response, the office of then-Governor Edward Rendell launched the Prescription for Pennsylvania, a series of reforms to address the quality, affordability, and accessibility of health care.

Two of these reforms leveraged the nursing workforce to improve the delivery of primary care. The first tackled the state's restrictive practice acts to allow NPs (and later other health professionals) to practice to the full extent of their training. This paved the way for the opening of dozens of convenient care clinics staffed by NPs (see "The Value of Nursing," p. 7).

Pennsylvania also turned to nurses as a way to get a handle on chronic conditions. The state's Chronic Care Initiative (CCI) offers financial incentives to primary care practices to implement the Wagner Chronic Care Model within the context of a patient-centered medical home (PCMH). This team-based approach to primary care emphasizes data collection and patient engagement, and it relies on nurses to provide care management, which has proven effective in keeping chronic conditions under control.

To support CCI, Pennsylvania provided a Web-based patient registry, administered medical home payments on behalf of private payers, offered care management training for nurses, and coordinated regional meetings where providers could share best practices. Within these learning collaboratives, nurse-managed health centers, which provide primary care to underserved communities, emerged as leaders in sharing innovations. These included group visits, same-day appointments, and engaging patients in self-management.

"At the time, small primary care practices felt they were in chaos," says Ann S. Torregrossa, Esq., who directed the Governor's Office of Health Care Reform. "Everything fell on the shoulders of the physician, and changing that—helping them learn how to use their staff more effectively, organize workflow, and introduce open access scheduling—was very welcome."

In 2012, the administration of Governor Tom Corbett introduced a comprehensive accountability tool to ensure that the investment in CCI is paying off. The tool looks at each practice's engagement in transformation initiatives, its use of best practices, and its improvement in meeting individually set clinical targets.

Model Policies and Practices:

- Removing legal and political barriers to practice for all health professionals;
- Assisting practices in meeting nationally recognized standards for PCMHs;
- Promoting care management by supplementing fee-for-service payments with financial incentives for new infrastructure, payments for performance, and revenue gain sharing;
- Forming learning collaboratives to support primary care transformation;
- Funding a patient registry to track quality improvement;
- Working toward standardizing outcome measures among all payers and practices.

Outcomes: Blood sugar, blood pressure, and cholesterol measures improved, as did the use of evidence-based care related to asthma and diabetes. Medicare now participates in CCI through the federal Multi-Payer Advanced Primary Care Practice Demonstration.

Cost Savings: ER utilization and costs are down for some practices. In 2010, a major payer, Independence Blue Cross, introduced incentive payments similar to those developed by CCI for all of its primary care practices.

Vermont Blueprint for Health Supporting Primary Care With Community-Based Nurse Care Coordination

Situating nurse care coordinators in the community to work within clinics and private practices is a central strategy of Vermont's Blueprint for Health. This landmark legislation created regional Community Health Teams that deploy nurses, social workers, behavioral health counselors, and others to transform the delivery of primary care. Nurses often lead the teams, whose members divide their time among each region's participating practices. They meet with patients in person and follow up by phone to make sure they receive the preventive and coordinated care that the state is banking on to keep its citizens healthy.

This strategy emerged as Vermont instituted a series of pilot projects to address the increasing costs of caring for people with chronic illnesses. The Community Health Teams, developed with public and private support, make it possible for primary care providers who participate in the Blueprint to create advanced primary care practices (APCPs), Vermont's version of the medical home.

"The teams are allowing people to take care of patients the way they have always wanted to, or in some cases, allowing them to do what they've always done without losing their shirts," says Blueprint Associate Director Lisa Dulsky Watkins, MD.

To participate in the Blueprint, practices must meet national standards for medical home accreditation and make use of the Community Health Teams. Vermont supports its APCPs with enhanced monthly per-member

The Value of Nursing



A certified nurse-midwife (left) talks with a child as she examines her mother at the Family Health and Birth Center (FHBC) in Washington, D.C. The center was founded to improve the health of D.C. families, which have some of the nation's worst birth outcomes. FHBC's rates of cesarean section and preterm birth are less than half the national average, and in 2011, FHBC had

a low-birthweight rate of only 2.8 percent, far superior to D.C.'s rate of 10.3 percent.

Birth center costs reflect their high-touch, low-tech approach. In 2010 facility fees averaged \$2,277 per birth versus \$8,920 for comparable vaginal births in hospitals.

payments tied to the quality of care and with a Web-based clinical tracking system, DocSite, which facilitates population management and evidence-based clinical decision-making. The state's major payers must contribute to funding Blueprint initiatives. Since Vermont's acceptance in the federal Multi-Payer Advanced Primary Care Practice Demonstration in 2011, Medicare has also participated.

Model Policies and Practices:

- Funding community health teams, which serve all state residents and allow for variation in implementation at the practice and regional levels;
- Helping primary care practices meet national standards for PCMHs;
- Supplementing fee-for-service payments with monthly per-patient payments based on quality;
- Engaging major state payers in the design of health care reform;
- Changing the state's nurse practice act to mitigate physician shortages

by allowing experienced APRNs to engage in solo practice.

Outcomes: Community Health Teams are connecting patients with mental health providers, self-management resources, and other services. Vermont Medicaid is taking advantage of the teams to scale back its use of contracted disease management programs.

As of January 2012, APCPs were serving more than 353,000 of the state's 637,000 residents. State officials anticipate that at least 90 percent of the state's primary care practices will choose to become APCPs by October 2013.

Cost Savings: Early data trends suggest that the Blueprint may put Vermont on a path to cost containment. Patients in Blueprint practices tended to be older, have more chronic conditions, and have higher medical costs than the state average in 2007. Nevertheless, by 2010, the growth in their use of health care was slowing down at a rate similar to or higher than the state's as a whole, according to an evaluation by Onpoint Health Systems, which manages Vermont's multipayer claims database. Attendant costs had also begun to decline.

"I used to feel that I spent my day putting out fires. I was sometimes afraid to ask patients questions because it would be opening a can of worms I couldn't cope with. Now that I work with a team, I ask the question."

Jennifer P. Gilwee, MD, interim vice chair for primary care internal medicine, Fletcher Allen Health Care

Many barriers inhibit the growth and improvement of the primary care sector. Chief among these is a payment system that undervalues primary care providers relative to specialists and fails to pay for many of the services considered essential to the best primary care delivery.

In response, public and private payers have experimented with a flurry of new payment mechanisms in the past few years. These include bundled payments, global payments, shared savings, care coordination and management fees, and schemes designed to encourage integration among service providers. The goal is to create financial incentives that will lure clinicians to primary care practice and reimburse them for delivering the prevention, care coordination, and disease management services that keep people healthy.

Practice barriers also inhibit the development of the nation’s primary care capacity. The IOM *Future of Nursing* report notes that while workforce shortages “would be expected to engender greater demand for all primary care providers including NPs, barriers to practice interfere with their full employment in ambulatory care.” Even in states that allow NPs to practice to the full extent of their education and ability, health plan practices and reimbursement policies can constrain the use of NPs. (*Charting Nursing’s Future* 19 will explore these topics.)

As lawmakers and insurers sort through these challenges, business innovators and government agencies are capitalizing on the availability of

highly educated NPs to increase access to primary care (see p. 7).

Payment Mechanisms That Support Primary Care Transformation

Global and bundled payments have emerged as promising ways to incentivize providers to improve the quality of care while keeping an eye on the bottom line. Whether paying a single provider for a bundle of services or paying multiple providers a lump sum to cover care for a specific condition, global and bundled payments place an upper limit on costs and make it affordable for providers to hire more nurses to coordinate care and improve delivery in other ways. Reimbursement can be applied to services delivered outside the office or via telephone or the Internet before, after, and between visits. Because these payments do not reward volume, they create an incentive to focus on prevention, manage chronic conditions well, and coordinate care among all of a patient’s providers, activities that are poorly reimbursed—if at all—by most fee-for-service plans.

Some skeptics question how global and bundled payments will be distributed and hold providers accountable for care. Yet early adopters report that these payments are yielding positive results. In Massachusetts, the majority of primary care practices affiliated with BlueCross BlueShield, the state’s largest insurer, now receive global payments. A recent study by the Harvard Medical School found that after one year, the quality of care was

significantly higher in these practices than in the company’s fee-for-service network, especially for adults with chronic illnesses and for children. What is more, costs were down.

The Case For Nurse Care Management

The use of nurses to manage care appears to be paying off. Nurse care management is proving effective in controlling the progression of chronic conditions, reducing ER visits and hospitalizations, and preventing hospital readmissions. In some cases, such as transitional care from hospital to home, care management programs can save more money than they cost (see *Charting Nursing’s Future* 9, p. 8).

Aetna, one of the nation’s leading health care benefits companies, has employed dedicated nurse care management with its Medicare Advantage members since 2003. Even with most care management delivered over the telephone, this population had 31 percent fewer acute-care days than a comparable population with traditional Medicare coverage. In 2007, Aetna sought to improve the program by embedding the care managers in primary care practices and some multispecialty groups. This produced an additional 12 percent reduction in acute-care days, which translates to a 3 percent to 4 percent reduction in overall costs per member.

These cost savings, and the attendant health benefits, justify Aetna’s investment from a business perspective, but company officials acknowledge that transitioning the model to a fee-for-service environment poses challenges. Some insurers in multi-payer pilots, including Aetna, have addressed this by paying providers a supplemental care management fee (see *Charting Nursing’s Future* 17, p. 8). This typically varies according to the inherent risk associated with the health status of the patients being managed and on the provider’s ability to meet agreed-upon goals to enhance the quality of care.

Nurse Care Management Leads to Lower Hospital Utilization for Aetna Medicare Advantage Members

Acute-Care Utilization by Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) Medicare Advantage Members Compared With Those in Traditional Medicare Fee-for-Service Plans (7/1/2008–6/30/2009)

Plan	Acute Admissions	Acute Inpatient Days	ER Visits
HMO	-20%	-34%	-15%
PPO	-19%	-31%	-24%

Source: Aetna, Inc., 2011

Business Innovations

“Regulations and reimbursement systems currently trap in high-cost venues much care that could be provided in lower-cost, more convenient business models.” This argument, put forth by Clayton M. Christensen, Kim B. Clark Professor of Business Administration at the Harvard Business School, and his co-authors, Jerome H. Grossman, MD, and Jason Hwang, MD, in *The Innovator’s Prescription*, supports their contention that health care is unaffordable because of a lack of business-model innovation in the health care industry.

The authors note that health conditions fall along a spectrum—from those that are well understood and easily treated to those that require the expertise of specialists to diagnose and treat. They divide the work of the typical primary care office into four categories:

1. straightforward diagnosis and treatment of generally acute disorders such as earache;
2. ongoing oversight of chronic diseases such as diabetes;
3. wellness examinations and disease prevention;

“Nurses, nurse practitioners, and physician assistants are assuming increasing levels of responsibility for primary care. In the future these professionals will become the principal caregivers for patients with the growing number of diseases that have precise diagnosis and treatment protocols.”

Clayton M. Christensen, Kim B. Clark Professor of Business Administration, Harvard Business School



4. preliminary identification of disorders such as osteoporosis, asthma, and cancer that may require referral to specialists.

They foresee NPs, physician assistants, and in some cases RNs handling the work of the first two categories, with physicians focusing their attention on identifying disorders and conducting the wellness exams that often reveal undiagnosed conditions. The emergence and rapid proliferation of convenient care clinics (see “The Value of Nursing,” below) supports this view, as does the growing use of telemedicine, which allows providers to access the expertise of specialists via the Internet.

Christensen and his co-authors also advocate moving toward a consumer-driven health care system where individuals armed with high-deductible insurance plans and health savings accounts purchase their care

directly. They contend that this will give consumers a greater stake in keeping costs down and stimulate downward market pressures.

Enrollment in such plans increased from 4 percent of all employer-sponsored insurance in 2006 to 13 percent in 2010. If this trend reaches 50 percent, overall health care spending for the nonelderly population could decrease by about 4 percent and save \$57 billion annually, according to projections in a 2012 study by the RAND Corporation. The study was funded by the California HealthCare Foundation and the Robert Wood Johnson Foundation.

“Consumer-directed health plans can clearly have a significant impact on costs, at least in the short term,” says study leader Amelia M. Haviland, PhD, a statistician at Carnegie Mellon University and RAND. “What we don’t yet know is whether the cutbacks in care they trigger could result in poorer health or health emergencies down the road.”

The study notes that families enrolled in consumer-directed plans slightly reduced their use of highly recommended preventive care such as cervical cancer screenings and routine blood sugar testing in the first year. Another recent study followed several hundred Massachusetts families with chronic conditions and found that those with employer-sponsored high-deductible health plans were three to four times more likely to delay or forgo care because of cost than were families with traditional plans.

The Value of Nursing



A nurse practitioner engages a patient while her mother fills out forms at one of the nation’s increasingly popular retail clinics. The convenient care industry has grown from three clinics in 2000 to more than 1,350 clinics today, and saw a 10-fold increase in consumer use from 2007 to 2009. Patients express high levels of

satisfaction with the clinics’ convenient locations, transparent pricing, extended hours, and providers, most of whom are NPs.

Convenient care clinics offer a focused menu of services with established treatment protocols. Nearly 90 percent of retail clinic visits concern simple acute conditions such as sore throats and respiratory infections or preventive services such as immunizations. Studies show that these clinics provide care within the range of services offered that is equal or superior to that provided in more traditional settings and at significantly lower cost.

When convenient care clinics began expanding, some physicians expressed concern that they would compete with primary care providers, but the majority of clinic patients report that they do not have a regular source of care. Today the clinics are viewed as a welcome adjunct by many health systems and as a conduit into primary care.

For More Information

- www.rand.org/pubs/external_publications/EP201200104.html
- www.springerlink.com/content/k884422j8t75p076/?MUD=MP
- www.cca-clinics.org and www.nncc.us/site

Patient-Aligned Care Team Connecting Nurses With Patients to Strengthen Continuity of Care

The U.S. Department of Veterans Affairs (VA) draws on the equivalent of 8,500 full-time nurses to deliver continuous, coordinated primary care to veterans. Working in areas as diverse as patient education and system improvement, VA nurses play multiple roles in the delivery of interprofessional primary care through the Patient-Aligned Care Team (PACT).

The PACT is the latest iteration of the VA's 16-year transformation from a hospital network to a health system focused on primary care. Each five-person PACT includes a primary care provider (an NP, physician, or physician assistant), a nurse care manager (an RN), a clinical associate (an LPN or nursing assistant), and a clerical associate. The fifth member of the team is the veteran, who is encouraged to take an active part in making decisions about his or her health.

"We want patients to understand their health conditions and their options," says Cathy Rick, RN, FAAN, FACHE, the VA's chief nursing officer. "That way patient preferences can guide the PACTs in providing care that meets individual goals."

Each veteran has a PACT RN who is responsible for coordinating his or her care. When distance or disability makes regular clinic visits difficult, this connection is sustained via telehealth technology (see "The Value of Nursing," above). This continuity of care, often a challenge for time-stressed primary care providers, creates strong bonds between nurses, patients, and their families.

In a major support capacity, master's-prepared nurses serve in the relatively new role of clinical

The Value of Nursing

Every morning, the veteran (left) inputs his vital signs into a monitoring device, answers basic health questions, and sends the information to the Martinsburg VA Medical Center, some two hours away in Martinsburg, W.Va. There his assigned home telehealth nurse reviews the data on a secure website. Telehealth nurses function as case managers and care coordinators



Photo: Barry Kornacki, courtesy of Martinsburg VA Medical Center, Martinsburg, W.Va.

for patients who have difficulty coming in for appointments. They help veterans manage their chronic conditions and allow many to remain in their homes. Nurses often work with the same patients for years, creating strong bonds. "They feel comfortable calling," says Debbie Jolliff, BSN, RN-BC, CCM (right). "They know they can depend on us."

Home telehealth services also free up outpatient appointments for other patients. Despite its potential to catch symptoms early and avert expensive emergency care, telehealth is not reimbursed by Medicare or most private insurers.

nurse leader (CNL). CNLs provide evidence-based leadership within the care setting regarding issues such as quality and safety, interprofessional collaboration, patient satisfaction, and system redesign to promote efficient and effective care.

Model Policies and Practices:

- Promoting a collaborative team culture, with all members working at their highest level of competency;
- Developing electronic health records;
- Employing telehealth technology.

Outcomes: In one year, 120,000 patients opted into secure messaging, phone utilization in primary care

rose from 4 percent to 23 percent, and two-day postdischarge contact increased from 6 percent to 35 percent.

Cost Savings: In 2009, the VA invested \$1 billion in primary care transformation initiatives. The VA's highest-performing PACTs have seen reductions in their patients' rates of ER/urgent-care visits and acute-care hospital admissions by 43 percent and 47 percent, respectively. The VA anticipates significant savings as more enrollees move into PACTs and as PACTs improve their performance.

For More Information

See *Charting Nursing's Future* 11 for more on telehealth.



"The sustained relationships nurse care managers develop with veterans are central to the success of the PACT model."

Cathy Rick, RN, FAAN, FACHE, chief nursing officer, Department of Veterans Affairs

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