

The Tri-Council for Nursing

The Essential Role of the Registered Nurse and Integration of Community Health Workers into Community Team-Based Care

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American Association of Colleges of Nursing

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Purpose

This document describes the position of the Tri-Council for Nursing with regard to the essential role of the registered nurse (RN) in community team-based care, and describes the relationship of RNs and community health workers (CHW) who assist teams in achieving individual and population health outcomes. The evolution of community team-based care acknowledges new and modified roles for clinicians and other care givers, their relationships and customized interactions with patients and families. The Tri-Council position will inform consumers, providers, and policy makers about the changing nature of care in the community and the importance of high impact teams, highlighting the roles of registered nurses and community health workers.

Introduction to Community Team-Based Care

Interprofessional team-based care is widely accepted as an effective model of care for complex patients in hospital and ambulatory settings. The increasing complexities of health care and persistent demand for information have been primary factors driving the need for high-performing teams. These teams bring individuals together in the community to provide the best possible care as well as achieve all three aims of the National Quality Strategy (U.S. Department of Health and Human Services, 2011) — better care and experience, improved population health and lower costs. Mitchell and colleagues (2012) articulated the values and principles for successful teams as well as the urgent need for high-quality teamwork leading to shared responsibility and more effective patient-centered and coordinated care. However, simply having different professionals work together has not provided the full range of skill sets and other attributes that are needed for the delivery of person-centered care, nor the comprehensive forms of population-based services needed to promote health and optimize partnerships for health (Pittman & Forrest, 2015). Movement of care to the community and the emerging focus on population health has shifted emphasis to health, wellness, disease prevention and more effective chronic disease management. The result has been higher demand for patient-centered care that is more easily accessible, coordinated and culturally congruent. Care models have been evolving to meet this demand, driven in part by the Affordable Care Act mandate to remove barriers to people's access to affordable care in their communities. Community team-based care incorporates the concepts of home and community-based services that aim to keep people living in their homes, but is not limited to serving those with some type of functional limitation.

Successful Community Team-Based Care Models

Changes in health care policy have fueled a renewed recognition that healthy people are an essential ingredient for a healthy nation, and have reignited an interest in community health. Given that, there is a growing focus on community team-based care models as a solution to improving population health. Patients and family members are active members of the team that collaborates to work toward the common aim of helping the individual (patient) and family together with other caregivers to achieve their goals. The team actively integrates different perspectives, knowledge, experience, expertise, and cultural awareness to address a health, illness or wellness need.

Disease and population-specific models have existed within community care settings for many years and were a catalyst in the movement toward patient-centered medical homes (PCMH)¹. Management of conditions, such as pediatric asthma, diabetes, obesity, and hypertension has been the focus of team-based care, particularly in underserved populations in order to provide cost-effective solutions to problems that often result in health disparities.

Faith-based organizations have had a long-standing role to improve the health status of Americans. Their work in health promotion and elimination of disparities in underserved communities represents strong partnerships between communities and health care organizations. Similar roles to CHWs have existed for some time in faith-based organizations, focused on improving individual and community wellness.

Employers have also found success in offering a team approach to helping employees and their families improve their health, manage chronic conditions and reap the benefits of a more productive workforce while at the same time improving the health of their communities. Community health centers, a long-standing linchpin in delivering care to the underserved, also represent a model of community team-based care. These publicly funded health care organizations serve as a health care home providing primary and preventive care in communities with unique cultural and health care needs (National Association of Community Health Centers, 2009).

The Patient-Centered Medical Home

Patient-centered medical/health homes represent one approach to comprehensive team-based care that has been widely studied and included as a valuable strategy in the Affordable Care Act. PCMHs are team-based by definition (Bodenheimer, et al., 2014), and encourage a more comprehensive approach to care. While most are led by physicians, some are also led jointly by advanced practice registered nurses (APRNs) and physicians, and a small number are led solely by APRNs who have their own panel of patients in states with full practice authority. Increasingly, these models are evaluating the advantages of including CHWs as part of the team (Herman, 2011). The more developed aspects of the PCMH are those that reflect the provision of services by primary care providers (physicians, APRNs or physician assistants), specialists and organizations within the formal health care system, such as acute care, post-acute care and ambulatory care facilities. The interactions with state and local public health

¹ The term PCMH may be used to represent Patient-Centered Medical Home, or Primary Care Medical Home, or Patient Centered Health Home

departments, and diagnostic, pharmaceutical and community and social services are less well-established and will vary by location. As a result, there is greater emphasis on management of illness, both acute and chronic, with less time and fewer resources dedicated to health, wellness, and maintaining or restoring functional status, all critical for quality of life and the health of the population. The integration of CHWs into PCMH teams taps into the strong community link of these individuals and helps strengthen transitions between clinical care and advice and self-management. CHWs provide valuable support and education to patients and help identify those who would benefit most from care coordination (Matiz, Peretz, Jacotin, et al., 2014). Through their understanding of local needs and issues, CHWs may help reduce the gaps created by social determinants of health that may lead to health disparities in the health care system.

Care Coordination-Centric Models

While the individual patient's needs and preferences will determine the degree of involvement by various members of the health care team, the RN brings a core competency to the team of coordinating care across a continuum of health care services such as acute and post-acute care, including in-patient and out-patient; specialty care (such as physical and occupational therapy); diagnostic services; pharmacy; and community and social services (such as transportation and meal preparation and ensuring proper referrals are made). These complex care needs require registered nurses and APRNs to provide advanced assessments, coordinated care planning, evidence-based interventions and evaluations that are within the registered nurse's scope of practice.

Examples of nurse-led models that focus on care coordination across a care continuum include the Nurse-Family Partnership Model for new parents (Olds, Kitzman, Cole, et al., 2010) and Naylor's Transitional Care Model for older adults with co-morbid chronic health conditions (Naylor, 2012). These models use nurses either at the generalist level (Olds et al., 2010) or at the advanced practice level (Naylor, 2012) to lead care teams that focus on goal-setting, problem-solving, and behavioral change. The level of clinical decision-making and use of evidence-based behavior change models (Kitzman, Olds, Sidora, et al., 2000) differentiate this level of care coordination from the encouragement provided by community health workers for patients to seek care and follow basic health guidelines. They exemplify research-based models that have been shown to be cost-effective and have been widely tested across the U.S., and may be included in broadly based approaches, such as PCMHs.

A significant challenge for all teams, including those in PCMHs, is providing seamless communication flow among all team members, including an investment by all to participate in information-gathering and -sharing (Taylor, Lake, Nysenbaum, et al., 2011). Communication plays a major role in determining the success of team collaboration and effectiveness. Effective communication among and between team members is viewed by many as one of the most important factors in promoting team-based care and achieving desired outcomes. Taylor, et al. (2011) also identified a number of barriers in the creation of a medical neighborhood, including few financial incentives, lack of personnel needed for care coordination and fragmented diversity of services. These barriers must be addressed to achieve a successful patient-centered medical home or other comprehensive community team-based care model.

Team Members

New models of care that emphasize collaboration across disciplines, settings, organizations, communities

and families call for a broader, more comprehensive team of professionals, lay workers and support disciplines to meet the changing needs and preferences of people. A community-based team requires a cohesive approach to prevention, wellness, recovery from illness, health maintenance, and advanced illness care, including palliative and end-of-life care. Being able to keep people healthy in their homes, decrease reliance on complicated, high-tech, high-cost facilities and maintain person-centered care requires a broadly based team that can work together with a high degree of trust, a low reliance on hierarchy and a spirit of innovation to solve complex problems. As health status fluctuates, the patient’s needs and preferences will dictate who leads the team. Many of the team roles are well-known, but in the community setting they may take on less traditional functions and push the boundaries of conventional care.

The spectrum of team members, professional and lay, paid and volunteer, in community team-based care is broad, and includes, but is not limited to, the following:

Team Member Categories	Roles/Job Titles
Patient and Family	
Patient	Essential core of team
Family and family caregivers, and other informal caregivers	Essential support and caregivers to patient and family unit
Health care providers	
Nurses and assistants to nurses	Registered Nurses Advanced Practice Registered Nurses Clinical Nurse Leaders Care Coordinator, Case Manager, Navigator Licensed practical nurses Nursing assistants, technicians Community paramedic Parish nurses
Nutritionists	Nutritionists
Pharmacists	Pharmacists
Social Workers	Social workers
Physicians, physician assistants and allied medical professionals	Medical doctors (primary care and specialty care) Physician assistants Medical assistants Podiatrists
Dentists	Dentists Dental Hygienists

Allied health professionals and public health providers	
	Community health workers Health educators Case managers Program facilitators Advocates Physical and occupational therapists Translators School liaisons Clergy members

Less well-known in many parts of the U.S. is the CHW. Nurses, too, have varying degrees of knowledge and experience with CHWs. The American Public Health Association (2009, npg) defines CHWs as “frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served.” This person takes on many different functions and serves as a cultural liaison, often bridging cultural and language barriers. In the U.S. and more so in developing countries, communities frequently rely on CHWs to fill in for shortages of health care workers or view them as a less expensive alternative to other providers. The focus on CHWs in the United States, however, is to help transform the health care system by embedding care in communities in order to focus not only on illness care, but more on health and wellness with individuals who are ethnically, culturally and linguistically adept at working within their neighborhoods. The CHW builds a peer-peer relationship with an individual rather than a provider, thus establishing a foundation as a trusted advocate. (Rosenthal, Brownstein, Rush, et al., 2010) They perform valuable services that address care needs that connect patients and families to community resources, inform culturally appropriate care, and identify sociodemographic conditions that may predispose individuals to health disparities. Brooks and colleagues (2012) describe some of the roles and guidelines for setting up a CHW program through their tool kit, *Building a Community Health Worker Program: The Key to Better Care, Better Outcomes, & Lower Costs*. They advocate for the more versatile “polyvalent or multipurpose community health worker” (pg. 5-6).

The benefits of the CHW are being realized with increased access to a range of services, particularly those addressing social determinants of health and those aimed at reducing the ethnic and racial disparities of care (Phalen, & Paradis, 2015). Many states and organizations have developed training curricula targeted for specific chronic disease conditions or specific foci for using CHW roles such as addressing homelessness (Centers for Disease Control and Prevention, 2015). A national curriculum and standards have yet to emerge, but will need to engage the experience and wisdom of the community health workforce in the process.

CHWs have been found to be cost-effective team members with patients who are high risk or have limited support systems, or who may live in underserved urban or rural areas. In some cases, community health workers may be key cultural brokers who are able to help patients and families understand and use health care recommendations. We endorse comprehensive team-based approaches that incorporate CHWs to address complex health issues using the best science available.

Further, we support and encourage research to determine the most effective team-based approaches and interventions that meet the clinical needs and evaluate the appropriateness and impact of team member roles.

Adequate training, supervision and assimilation within the health care team are key to successful incorporation of community health workers in primary care teams. Vital to the discussion of training and roles is an emphasis on serving as a communication and cultural link between patients, families, and health care professionals, rather than assuming clinical roles in assessment, diagnosis and treatment. Discussions of training requirements recognize the potential costs of lengthy training programs, while also emphasizing the importance of appropriate preparation for the roles these team members can play in improving the link between people and the health care they need (Kangovi, Grande, & Trinh-Shevrin, 2015). Weil (2014) characterizes the tension between two models of the CHW workforce. One, unique to the U.S., professionalizes the role within the health care system and the second maintains the CHW embedded in the community where community engagement defines the role. Weil advocates for recognizing the wisdom CHWs bring to the process of defining their future.

Registered Nurse Leadership Roles in Community Team-Based Care

The interaction between the RN and the CHW can produce a powerful set of interventions that optimize patient outcomes. RNs, fulfilling a key role in care coordination, are able to identify opportunities where the complementary role of the CHW, a team member who is sensitized to communicate a variety of needs and who is attuned to the pulse of the community and its services, strengthens the care team's ability to meet a wide range of individual needs and preferences. The RN is uniquely positioned to coordinate care, managing multidirectional communication with the patient, family, team members and other service providers. Further, the RN helps the team evaluate the effectiveness of their actions and redirect services as needed. The core competencies, including knowledge and skills needed for team leadership, understanding of community-based care and care coordination, and outcomes evaluation across sites of care, are provided in baccalaureate degree nursing programs.

The American Nurses Association (ANA) has defined the value of nursing care coordination as “a function that helps ensure that the patient's needs and preferences are met over time with respect to health services and information sharing across people, functions and sites” (ANA, 2012, p. 1). Working as care coordinator, the RN is instrumental in decreasing the fragmentation occurring in health care and serves as that vital connection between the person (patient) as the primary core team member, the CHW, and the primary care clinician, specialists and other team members. RN care coordination leads to positive patient outcomes, effective collaborative practice and a decrease in health care costs. Research has shown that nurses' (APRNs and RNs) delivery and coordination of care decreases the financial burden of providing appropriate health care services both in the in-patient and community settings (Atherly & Thorpe, 2011; Robles, et al., 2011).

APRNs have a long history of providing care in teams leading to improved outcomes, increased access, enhanced patient safety and greater cost savings. As leaders of team-based care, they have an integral role managing and coordinating care for patients, especially those socially disadvantaged, and with chronic, multiple co-morbid conditions and other complexities requiring close longitudinal monitoring.

The roles and responsibilities of each team member must be defined, and guiding principles, protocols and standard procedures for communicating care results and referrals among specific health care members of the team must be specified. The RN is the linchpin to bridge the communication gap between health care professionals, the patient and the lay community health workers in order to coordinate appropriate care.

CHWs may not be the sole cultural brokers in the future. The team relies on these individuals, who advocate on behalf of an individual or a group of a different cultural background, with the aim of producing change or reducing conflict (National Center for Cultural Competence, 2004). The cultural broker is careful to incorporate an individual's or group's cultural perspectives and differences into a person's plan of care creating an environment of mutual understanding and respect. APRNs, RNs and physicians can all be formally educated to incorporate these responsibilities into their practice if a CHW is not available to the team, or the role may be fulfilled by a patient's relative, clergy member or friend. The intent is that through the knowledge and understanding of cultures, this individual can serve as a mediator between the patient and health care providers.

Implications of Current and Emerging Models

Successful models of team-based care across settings are still evolving with varying degrees of success and sustainability. Pioneer accountable care organizations reported use of registered nurses to supervise licensed practical nurses and unlicensed community health workers, collaborate with transitional care service providers, coordinate care across settings and provide direct ambulatory care and community-based health education (Pittman & Forrest, 2015). There is an urgency to address team-based models of community-based care, including improved integration of community-based workers, as individuals are increasingly taking on more responsibility for their care, recovery and health status in a rapidly changing health system. Just as collaboration is without walls, so is community-based health care. Whereas teams and traditional models of care are more readily apparent in care delivery settings such as hospitals and outpatient clinics, there are fewer established and rigorously tested models scaled up for such care in the community.

Community team-based care models take variable approaches in keeping with patient or family needs. Some individuals may not require a full team approach at all times, and others may not find a team approach most conducive to manage their own health and health care. Each team might have a unique configuration based on patient-driven goals, with potential involvement by a variety of health and social service providers, to yield the best outcomes for patients, particularly those with the highest risk for poor health based on social and physical factors. Teams can add costs to the provision of care, including financial, time and opportunity costs for patients and families, and risks associated with diffusing the relationship between patients and primary clinicians (Bodenheimer, Ghorab, Willard-Grace, et al., 2014). For example, the cost of employing a full range of health professionals can be daunting for private offices or small clinics. Because of the variable nature of patient and family health needs, team structures and the costs of and access to health care providers, it is important to acknowledge that team-based solutions to health care coordination, quality and promotion of partnerships with patients and families may vary and require evaluation (Driessen, Bellon, Stevans, et al., 2015). More comparative effectiveness studies of team-based models are needed to determine what types of teams are optimal in different situations (Cooper & Hernandez, 2015).

Conclusion

The Tri-Council supports the further development, implementation and evaluation of community team-based models of care delivery to promote the goals of comprehensive, equitable and prevention-oriented care delivery that optimally engages individuals, families and their communities. We support delineation of roles and responsibilities of team members that are consistent with scopes of practice and that encourage collaboration and full partnership with individuals, families and communities. Given that, we underscore the critical leadership role of RNs in the delivery and coordination of care, as well as the importance of CHWs, who bring unique knowledge and skills to assist teams and act as a bridge between community resources and patients and families. Finally, we recommend assessment of the type and nature of education, training and continued competence for those holding or aspiring to hold new roles on health care teams.

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