RUSH

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National Academy of Medicine

Future of Nursing 2020-2030

Site Visit

Thursday, June 6, 2019

- Welcome letter
- Agenda
- Presentation and visit descriptions
- Publications

Welcome

National Academy of Medicine Future of Nursing Committee,

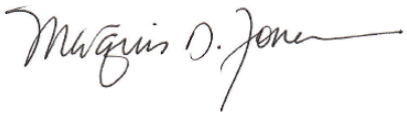
On behalf of our entire Rush nursing community, welcome to Rush University Medical Center and Rush University. We are honored to be hosting the Future of Nursing Committee for a site visit and town hall meeting.

Addressing the social determinants of health is crucial to Rush's mission and we applaud your efforts as you begin to chart a path for the nursing profession to help our nation create a culture of health, reduce health disparities, and improve the health and well-being of the U.S. population.

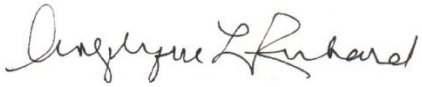
At Rush, improving the health of the individuals and diverse communities we serve is essential to all that we do. Additionally, this mission is also the foundation on which we educate our student body who will deliver exceptional health care, generate innovative knowledge, and provide transformative leadership to improve health outcomes for all populations.

Our strong academic and practice partnerships, both within and outside the system, enable nursing at Rush to leverage a wide array of expertise and resources when addressing the needs of those we serve, particularly around the social determinants of health and health equity.

We are pleased at the opportunity to highlight some of Rush's efforts in this direction and look forward to discussing how to further support and advance nursing's contributions in this area.



Marquis D. Foreman, PhD, RN, FAAN
John L. and Helen Kellogg Dean of Nursing, Rush University
Associate Chief Nursing Officer, Rush University Medical Center



Angelique L. Richard, PhD, RN, CENP
Chief Nursing Executive, Rush System for Health
Vice President Clinical Nursing and Chief Nursing Officer, Rush University Medical Center
Associate Dean for Nursing Practice, Rush University

Site Visit Descriptions and Presenters

State of the Health of Chicago

Presenter: Julie Morita, MD, Commissioner, Chicago Department of Public Health

Dr. Morita will provide an overview of the health of the city, including the major health challenges faced by Chicago, and the development, implementation and outcomes of the city's Health Chicago 2.0 plan.

Rush University Medical Center and West Side United: An Initiative to Collaborate Across Sectors to Improve Health

Presenter: Ayesha Jaco, MA, Senior Director of Programs for West Side United

West Side United seeks to improve neighborhood health by addressing inequality in healthcare, education, economic vitality and the physical environment using a cross-sector, place-based strategy. West Side United works across major anchor institutions in 10 of Chicago's West Side neighborhoods to address the social determinants of health by connecting low-wage healthcare workers to in-demand, well-paying career pathways in hospitals that lead to financial security. West Side United supports local entrepreneurs and helps them take advantage of procurement opportunities at anchor institutions, such as hospitals or large businesses with a long history in Chicagoland, in order to grow their enterprises and create local jobs

The Surplus Project: Food as Medicine

Presenters: Jennifer Grenier, DNP and Nicole Wynn, DNP

Population served: West Side of Chicago, Patients at Rush University Medical Center

Committee Visit: The Committee will be given an actual tour or virtual tour of the entire process regarding the Food Surplus and Food as Medicine Program, related staff education as well as staff engagement in screening for the SDoH on 4 inpatient units.

Current roles of nurses (how nurses are being utilized to address health equity and SDOH): Nurses who complete certification in food handling package food to be donated to shelters and screen patients for the SDoH on 4 targeted pilot units upon patient admission. Nurses Grenier and Wynn also provide education to help prepare staff to interact with patients around the SDoH.

Partners involved (other organizations, sectors, professions, students): Greater Chicago Food Depository, Franciscan Outreach House, and internal interdisciplinary health professions including social work, nutrition, and population health.

Financial structure and sustainability: Budgeted into Nursing and Population Health annually

Replicability: The Rush Surplus Project was initiated at Rush Oak Park by Jen Grenier in 2015; it then was expanded to RUMC and collectively has served over 40,000 meals. Since it was initiated, 9 hospitals/universities and organizations across the country have adopted this model. Lastly, the program has extended under the leadership of Nikki Wynn and Jennifer Grenier to the Food is Medicine program coupling nurses' assessment of SDOH upon admission to the provision of social services as well as the delivery of a month's worth of food to the patient's room before discharge. This program resulted in Rush becoming a Chicago Food Depository site.

Metrics or outcomes used to evaluate the program and describe impact (what is success and how is it measured?) Some outcomes include a reduction in landfill by approximately 8400 pounds per year and 700 meals per month since 2015.

What could nurses be doing that they are not doing now? (Expanded roles, additional responsibilities, broadened scope, leadership activities) Nurses are at the frontline providing the care to the patients and building the relationships. They are the ones who build the trust. They are the true partners with these patients and are well positioned to screen for the SDoH and work with an interdisciplinary team to ensure that patients are connected to essential resources.

Challenges and opportunities: Continued funding, house wide expansion

Thresholds Community Mental Health Center

Rush Faculty Practice Nursing in the Community: Impacting the Social Determinants of Health at Thresholds

Presenters: William Reedy, RN, BSN; Regina Shasha, PMHNP, FNP; Megan Burrows, RN, BSN

Population served: Thresholds is a community mental health service provider who serves a population of persons with serious mental illnesses (SMI). A person with SMI is at risk for dying an average of 25 years earlier than a person without SMI and from preventable causes. Additionally, a person with SMI is often housed in long term care settings which are far more restrictive than needed to provide necessary supports for health and wellness.

Current roles of nurses: With a few exceptions, nurses at Thresholds work in two distinct roles. **ACT** nurses work at the highest level of care Thresholds offers; Assertive Community Treatment or ACT. This evidence based practice is a team approach. An ACT team has its own psychiatrist, nurse and outreach staff who are credentialed as social workers, licensed clinical counselors and other practitioners of the healing arts. The team meets every day to discuss each of its clients or *members*. An ACT team will serve 30 to 50 members, depending on the size of the team. **Nurse Care Coordinators, or NCCs** are in place specifically to serve people who are transitioning from long term care into independent living. NCCs assess and prepare members for safe transition from LTC to community by providing education and advocacy for linkage to necessary services and evaluations prior to discharge. These positions are mandated

by the Williams Consent Decree and the Colbert Consent Decree. These are adjudications stemming from class action lawsuits filed by plaintiffs who sued for their right, under the Americans with Disabilities Act, to be housed in the least possible restrictive setting.

Partners involved: Thresholds partners with Federally Qualified Healthcare Centers or FQHCs to provide integrated care for its members. That is, psychiatric and primary care services can be obtained in the same setting with better coordination of care and better outcomes. Currently, FQHC partners with Thresholds include Heartland Health Centers, Howard Brown Health and Aunt Martha's. Thresholds also partners with Rush College of Nursing to provide well prepared nurses with an opportunity to serve in the community.

Financial structure and sustainability of the initiative: ACT services are funded as specified in the Definition of Community Mental Health Service reimbursement guide, a document released by the Illinois Department of Human Services (DHS). NCC services are funded through grants from DHS stemming from the Williams and Colbert Consent Decrees.

Replicability of this initiative: ACT is an evidence based practice which is in place in communities across the country. The Williams and Colbert Consent Decrees are paralleled in other class action lawsuits nationwide, including Gary Alexander et.al vs United Behavioral Health, David Witt, et.al. vs United Behavioral Health (United States District Court, Northern District of California) and Disability Advocates, inc. vs. David A Paterson, et.al. (United States District Court, Eastern District of New York).

Metrics or outcomes used to evaluate the program and describe impact: Desired outcomes are clinical homeostasis and progress towards goals identified in the Integrated Care Plan. Success is measured by length of stay in the community uninterrupted by hospitalization, incarceration or other institutionalization.

What could nurses be doing that they are not doing now? Continue to engage every member and focus on wellness in addition to management of unstable chronic diseases. Nurses could also participate to a greater degree in public policy discussions related to Social Determinants of Health (SDOH).

Challenges and opportunities: Nurses have the opportunity to strengthen outcomes by promoting policies and programs to improve physical environments such as housing and transportation, impact social and economic barriers to wellness, to improve access to quality healthcare and to model and teach health behaviors which sustain wellness.

Sue Gin Health Center

Presenters: Theresa Gallagher, DNP, APRN; Angela Moss, PhD, APRN

Nurse-managed primary care health and wellness clinic in a low-income housing development

Population served: Residents are primarily from racial and ethnic minority groups and many were previously uninsured and without access to quality healthcare services.

Current roles of nurses (how nurses are being utilized to address health equity and SDOH): Two, soon to be three, nurse practitioners provide care at the clinic. Nurse practitioners see patients for acute visits, as well as managing chronic conditions. The nurse practitioners also assist patients in signing up for health insurance, schedule transportation for hospital visits, and connect patients to local resources to address food insecurity, child care needs, and job placement.

The nurse practitioners, along with graduate nursing students from Rush University, lead health promotion programming to improve the overall health of the community. A weekly after school science program teaches school-aged children the importance of STEM with fun and engaging curriculum from the Museum of Science and Industry. A weekly wellness program for adults educates adults about common health conditions, nutrition, and concludes with an exercise program every week. The Adolescent Empowerment Program aims to improve decision-making skills in adolescents and reduce their risk-taking behavior.

Partners involved (other organizations, sectors, professions, students):
Rush University nursing students
Rush University medical students
Rush University audiology students
University of Illinois at Chicago optometry students
DePaul University nursing students
Museum of Science & Industry
Chicago School of Psychology
The American Lung Association
Chicago Police Department
Chicago Cares
Chicago Department of Public Health
Illinois Eye Institute
Illinois Heart Rescue

Financial structure and sustainability of the initiative; Replicability of this initiative: The financial structure of the clinic initially was a gift from the Exelon Corp in the name of Sue Gin, but the clinic is now billing Medicaid and Medicare for services. This model has been replicated and will continue to be replicated by the Office of Faculty Practice in the College of Nursing at Rush University.

Metrics or outcomes used to evaluate the program and describe impact (what is success and how is it measured?) Success was first focused on utilization of the clinic, but now we are looking at vaccination rates, hemoglobin A1C trends and blood pressure trends over time. Connecting residents to cancer screenings such as mammograms and colonoscopies at local medical centers will be next.

What could nurses be doing that they are not doing now? (Expanded roles, additional responsibilities, broadened scope, leadership activities) A dedicated nurse case manager would be the most helpful. Many people seek help at the clinic who would be best served by an RN who can connect people to services and follow-up. A wellness RN who can perform more home visits and give patients education in their homes would be a great use of the RN role.

Challenges and opportunities: The challenges were first establishing trust in the community. This was accomplished by a nurse practitioner attending community meetings and events to get to know the residents. While the clinic was being established, an open door policy was adopted so residents could ask questions and receive consultations.

The opportunities have been connecting with many community organizations, which offer much-needed social services. These organizations have been connected to other clinics which need their help. This network of social organizations has been invaluable in improving the health and quality of life of the residents.

Simpson School Based Health Center

Presenters: Sally Lemke, DNP, WHNP-BC, Director of Community Based Practices;

Instructor, Rush University College of Nursing and Kate Orlin, RN, Clinic Manager

Rush School Based Health Center (SBHC) at Simpson Academy for Young Women; one of three SBHCs operated by Rush.

Population served: The Rush SBHCs serve children and adolescents ages birth through 20 for preventive, primary, and behavioral health services in a school-based clinic setting and families of school age children for behavioral health services. The students at Simpson Academy for Young Women are all pregnant and/or parenting and in grades 6-12.

Current roles of nurses (how nurses are being utilized to address health equity and SDOH): Rush SBHCs are nurse-managed health centers with care provided by an interprofessional team. One RN Clinic Manager oversees day to day clinical operations and an RN Program Coordinator leads school outreach, programming, and RUCON nursing student clinical experiences and onsite scholarly project work. The primary provider of each site is an FNP who also serves as a preceptor for APRN students. A PMHNP provides care at each SBHC once a week, who is involved in a training fellowship for future PMHNPs. Other onsite staff include LCSWs, a Child Psychologist, physicians, CMAs, and front desk staff. In addition to providing evidenced-based care to patients, nurses (APRNs and RNs) are involved addressing SDoH through systems built into daily workflow to assess need and link patients to resources. Examples of this include standardized templates to assess need, integrated NP/LCSW workflow for quick access to behavioral health and case management services, use of NowPow for external referral, and onsite resources. (*see below)

Partners involved (other organizations, sectors, professions, students): Rush partners: Depts. of Pediatrics, Med/Peds, and Psychiatry; CON; Rush Woman's Board; Rush Associates Board. External partners: Chicago Public Schools; Greater Chicago Food Depository; CBOs working in the school; CBOs located in neighborhoods where students live.

Financial structure and sustainability of the initiative: Funding derives from a combination of public, corporate, and foundation grants; Medicaid reimbursements; and in-kind support from Rush. Sustainability of programming and services is supported by partnerships with Rush and external partners and CON student scholarly projects.

Replicability of this initiative: The SBHC model is an established, nationally recognized model that is highly-replicable.

Metrics or outcomes used to evaluate the program and describe impact (what is success and how is it measured?) Outcomes are driven by population health foundations and include benchmarked percentages of appropriate students having 1) annual wellness check; 2) depression screening; 3) up-to-date immunization; 4) STI screening; 5) adequate asthma management; 6) use of effective contraception; 7) adequate prenatal care; 8) linkage to mental health services; 9) improvement on mental health metrics.

What could nurses be doing that they are not doing now? (Expanded roles, additional responsibilities, broadened scope, leadership activities)

Our staff: additional nursing care coordination opportunities; expanded use of RN patient visits for preventive and follow up care; additional onsite procedures so patients do not need to go to urgent care or ED for certain services; expansion of collaborative care model for psychiatric and mental health care.

Nursing students: students in our sites are often surprised to learn of the broad scope of nursing practice outside of hospital settings. Their understanding of future practice opportunities is broadened, and they learn there is a niche for nurses everywhere. Unfortunately, students continue to receive messaging from the nursing profession and educators that recent graduates need to complete a minimum amount of hospital-based work before moving to community- or ambulatory-based roles, thus limiting the reach and impact nurses and the nursing profession have outside of traditional settings.

Challenges and opportunities

Challenges: financial sustainability; financial constraints limiting time spent on programmatic activities; unpredictable stability of host-school relationships and staffing. Opportunities: focus on trauma-informed practices and cultures of care; expanded mental health programming and staff; increased opportunity for school integration; opportunity for nursing student involvement in nurse-driven care/programs that address health equity and SDoH.

* Onsite resources for selected SDoHs include: 1) transportation: Ventra card program; 2) food security: onsite stock of healthy snacks and donated baby formula and food; twice monthly healthy food market in partnership with the Greater Chicago Food Depository; onsite breastfeeding station; and linkage to WIC; 3) housing: linkage to community based housing programs for pregnant and parenting teens; 4) employment: referral to Rush's youth workforce development programs and community based resources; and 5) provision of daily necessities: donated formula/baby food; breastfeeding supplies; diapers/wipes; clothing; toiletries and hygiene products.*

Posters

- **"Caregiving Grandparents' Social Determinants of Health and Health Outcomes"**

  Jen'nea Sumo, PhD, RN; JoEllen Wilbur PhD, APN, FAAN; Michael Schoeny, PhD; Peter Cummings, MPH; Wrenetha Julion, PhD, RN, FAAN

- **"The Design of a Sequential Multiple Assignment Randomized Trial (SMART) to Improve Physical Activity for Sedentary Working Women"**

  Susan Buchholz, PhD, RN, FAANP; JoEllen Wilbur, PhD, RN, FAAN; Shannon Halloway, PhD, RN; Michael Schoeny, PhD; Spyros Kitsiou, PhD; Tricia Johnson, PhD

- **"Determinants of Physical Activity during pregnancy: An integrated review"**

  Meghan Garland, MS, RN; Jo Ellen Wilbur, PhD, RN, FAAN; Pamela Semanik, PhD, APN; Louis Fogg, PhD

- **"The OpEd Project"**

  Rebecca Darmoc, MS

- **"Legislative and Patient Advocacy Committee"**

  Kelsey Schmidt BSN, RN, CPN

Student Posters

- **"Adverse Childhood Experiences"**

  Rachel Farnes; Erin Haberman; Kareem Syed Shah; Brianna Wiggins

- **"The Incarcerated Population: A Health Disparity."**

  Taylor Dabish; Samantha Davidson; Carolyn Grant; Cameron White

Nursing Models Addressing the SDoH

Heart Failure Care Coordination: Reducing 30 day readmissions

Presenter: Barbara Hinch, DNP, ACNP-BC

Population served: Patients with Heart Failure (HF) that are coming to Rush for medical treatment

Current roles of nurses: Initial screening for SDOH is done if patient admitted to hospital by bedside nurse, ongoing education on living with HF, care management RN team addresses SDOH issues in MDRs, APRN follow up call from ambulatory clinic to confirm patient has meds, all home health needs are addressed, and patient is aware of follow up appoint and transportation. APRN sees HF patients on initial 7 day F/U post-hospital visit.

Partners involved: Social workers (SW) from care management and outreach SW team, pharmacists, RN staff nurses, DNP students working on DNP projects related to HF transitions, Physicians- hospitalists, primary care , cardiologist and advanced HF team, Preferred Provider Home Health agencies with RN liaisons at Rush.

Financial structure and sustainability of the initiative: Currently increasing the dedicated team members to focus on HF transitions and care coordination. We are working towards our end goal of having a multi-disciplinary dedicated HF team that follows patients in the hospital and out in community.

Replicability of this initiative: Other institutions could replicate the HF transition dedicated team and learn from our strategies for care coordination.

Metrics or outcomes used to evaluate the program and describe impact: Overall metric for hospital performance that is tracked is 30 day HF readmission rate. We are also using the AHA Get with the Guideline quality metrics to ensure we are consistent with evidence based guidelines for quality outcomes.

What could nurses be doing that they are not doing now? Bedside/ambulatory RN need more time to spend on educating patients with HF using self-care management strategies, provide additional community outreach opportunities to work with HF patients, lead classes for HF patients in ambulatory settings, create nurse dedicated visits in clinic, lead the development and implementation of an infusion clinic for HF patients, lead initiative for phase 1 cardiac rehab

Challenges and opportunities: Opportunity- Billing for nursing services that are not part of bedside RN typical responsibilities; develop a dedicated HF interdisciplinary team that follows HF patients in hospital and community. Challenges are ability to carve out time in follow up clinic visit to address SDOH. In addition, financial challenge to support dedicated HF transition team funding from hospital.

ACT Model and Population Health:
RN, SW and CHW model of care coordination

Presenters: Angela Allen, RN; Arlene Miller, PhD, APRN-BC, FAAN; Kathryn Swartwout, PhD, APRN-BC

Population served: The populations that will be served are the patients who receive County Care Insurance (Medicaid), as well as our Value Based patients; these are patients who receive Cigna or Blue Cross Blue Shield Insurance. The patient will be assessed for needs, by completing a Health Risk Assessment (HRA) with either a nurse, social worker, or Patient Care Navigator within our triad model, this model consists of a nurse, social worker, and patient care navigator (PCN). Depending on those identified needs either a social worker or a nurse will continue to work with the patient by, assisting with health management, connection to resources, setting goals, and reducing identified barriers. If the patient has been identified as having low to minimal needs according to the ACT Model, the patient will be placed in quadrant 1. The patients that are categorized as quadrant 1 do not have care management services. If the patients have been identified as having more psychosocial needs, it would be more feasible for the social worker to be the lead on the case, and the patient will be placed in quadrant 2. If the patient is more medically complex then the nurse will take the lead, and the patient will be placed in quadrant 3. If the patients display both psychosocial as well as medical needs, both disciplines will work congruently to assist with the patient's needs, and the patient will be placed in quadrant 4.

Current roles of nurses (how nurses are being utilized to address health equity and SDOH). Currently the Population Health Nurses are assessing for SDOH, by completing an HRA for our patient population. The HRAs are initially completed by either the Patient Care Navigator annually, or the nurse for any health needs/changes or utilization. The following 3 questions are pertinent to out patient population and will weigh heavily on the patient's risk stratification, which will be high, medium, or low depending on the patient's answers. (1) Do you lack transportation to make it to appointments or pick up medications, (2) Do you have difficulty paying for your medication, and (3) Do you need help with food, clothing, or housing. Although, the Population Health Nurses utilize this screening tool, the nurses that work inpatient have a set of criteria to follow that will also assess SDOH.

Partners involved (other organizations, sectors, professions, students): the current approach to assessing as well as meeting the needs of the patients who have been identified through SDOH screeners is a multidisciplinary approach. Each clinician that has an interaction with the patient has a responsibility to assist with any identified needs. As the patient moves through the continuum of care, each discipline connects to develop a feasible care plan to decrease barriers and connect the patient to resources.

Financial structure and sustainability: Funded by Medical Home Network. The idea of assessing for SDOH as well as assigning a specific discipline to work with the patient longitudinal is extremely sustainable, because our patients will continue to display complex needs. The implementation of an identified discipline within the patients care team will provide a more streamlined structured plan and may eliminate the barrier of provider mistrust.

Replicability: Replicable in primary care settings. Metrics or outcomes used to evaluate the program and describe impact (what is success and how is it measured?): Patient-centered outcomes, satisfaction, utilization (care management contacts, ED visits, re-hospitalization).

From a Population Health Nurses perspective, success can come in several different forms, which include, but are not limited to: (1) decrease in utilization, (2) increased patient engagement with Care Managers, (3) physician/clinicians buy in to care management, (4) increase in prevention management related to behavior health as well as medical, (5) increase in patients connected to resources needed from identified SDOH screeners, (6) patient buy in to better health initiatives as well as insight regarding conditions, (7) increase in provider accessibility, (8) increase in patient to nurse outreach (patient reaching out to the nurses with question and to discuss needs), and (9) decrease in patient no show rates.

What could nurses be doing that they are not doing now? (Expanded roles, additional responsibilities, broadened scope, and leadership activities). Although nurses are connecting with patients on a broader level within healthcare the idea of digging deeper with SDOH may require more buy in. The day-to-day required task that nurses complete of caring for patients that present with an identified condition remains the priority, while the patient as a whole must be considered more. Nursing is a task driven profession and the need to accomplished identified goals of better health outcomes does not stop at the bedside. As nurses continue to acquire higher education and have an opportunity for a plethora of different positions to choose from, the holistic and more longitudinal approach to patient care is moving more to the forefront. As nursing continues to evolve, we have an opportunity to incorporate curriculum that focus more on environmental health barriers, population health needs, SDOH needs, and how to address them, the critical thinking aspect that goes along with assessing for these needs, and the approach of meeting the patient were they are not only physically, but mentally, socially, and idea wise.

Challenges and opportunities: Some of the challenges that nurses face are patient engagement, identified patient population with providers, and some education barriers. Nurses have an opportunity to provide education that encompasses a gamete of learning opportunities for students to dig deeper into the intended holistic approach to nursing.

Improving care for those with intellectual and developmental disabilities

Presenters: Sarah Ailey, PhD, RN, CDDN; Beth Marks, PhD, RN, FAAN

Population served: Current roles of nurses (how nurses are being utilized to address health equity & SDOH): People with intellectual and developmental disabilities (IDD) experience a “cascade of health disparities” and have ongoing difficulties accessing culturally relevant care. Their support staff often face similar issues related to access to care. A social justice framework guides nurse researchers in scaling-up evidence-based programs such as Steps to Effective Problem-Solving (STEPS; an NIH funded clinical trial) and HealthMattersTM Program; and, implementing quality improvement projects by Doctor of Nursing Practice and Generalist Entry Masters students to improve health promotion and management of health conditions for people with IDD.

Partners involved include: University Centers on Excellence for Developmental Disabilities, community based organizations, non-governmental organizations, professional organizations, regulatory organizations and federally-funded organizations for developmental disabilities.

Financial structure and sustainability of the initiative: HealthMattersTM Program “costs” are estimated to be ~$300/participant including staff training and time. STEPS is being tested with an NIH clinical trial for efficacy of STEPS to improve social problem-solving and

reduce problematic behaviors for people with IDD living in community homes. The clinical trial gives people with IDD and their staff in community homes the STEPS intervention, while an attention-control of people with IDD and their staff in community-based homes receive a Food for Life intervention. Healthcare economist, Tricia Johnson, study Co-I, is evaluating STEPS' societal cost-effectiveness (e.g., CBO costs, health care system, public services, participant, family) and costs of behaviors between participants receiving STEPS compared to usual care (control group behavior costs, excluding costs of the nutrition intervention).

Replicability of this initiative: HealthMattersTM State Research Scale-Up (2013-19) and Community-Academic Partnerships (2008-2019) has reached over 10,000 people with IDD and have certified 2,650 instructors in 210 community-based organizations across 35 states and 8 countries. STEPS is being implemented in 9 CBOs. STEPS has been disseminated through 5 professional organizations with plans to publish STEPS at the completion of clinical trial with a non-profit publisher. A Generalist Entry Masters student is working with one CBO to develop an implementation protocol for the CBO to adopt and sustain STEPS. Generalist Entry Masters students implemented the Food for Life program last year at a CBO serving people with IDD and visual impairments last within their public health clinical rotation; and, STEPS will be implemented in their day program in 2019.

Metrics or outcomes used to evaluate the program and describe impact (what is success and how is it measured?): The HealthMatters Assessment of Organizational Need and Capacity evaluates organizational need and capacity for health promotion among CBOs in relation to organizational culture, internal and external resources, employee knowledge, and employee self-confidence.

STEPS uses an algorithm to determine agency and societal costs of behaviors in community-benefits with STEPS. Dr. Ailey has advised or been second reader on seven DNP projects related to improving health promotion and managing health in CBOs. Two DNP projects related to nurse/non-licensed direct support personnel cooperation focused on detecting new or emerging health conditions with plans for Health System Management student to evaluate costs and potential cost savings next year. Dr. Ailey has been the content expert of advisor for 18 Generalist Entry Masters student capstones related to improving acute care services at Rush University Medical Center for patients with IDD. A recent Health Systems Management student evaluated costs of care for patients with IDD treated at two academic medical centers with specific programs targeted at improving acute care of patients with IDD versus three medical centers without specific programs. Controlling for several factors, costs at the two institutions with programs were statistically better. A manuscript is currently in review.

What could nurses be doing that they are not doing now? Evidence suggests people with IDD experience substantial health disparities and that nurses do not receive adequate education to provide them culturally relevant care. CBOs, primary care, urgent, acute care, and long-term care settings need expanded roles. For this, improved partnerships between nursing research, education and practice are needed.

Challenges and opportunities: Innovative strategies can be addressed through the new Golisano Institute for Developmental Disability Nursing' post-graduate certificate in healthcare of people with IDD, working with CBOs as clinical sites for prelicensure and DNP students, implementing policy initiatives to enhance the nursing roles within CBOs, and developing service learning initiatives with CBOs as clinical sites for prelicensure and DNP students. Additionally, the nursing role in CBOs needs to explicitly include managing health (in the context of aging population who often have multiple chronic conditions) in the community. Nurses should be actively involved in what should be competencies of non-licensed direct support staff, as collaboration with this group is needed in order to manage the health of people

with IDD. Service-learning models can be used to work with non-licensed frontline workers to improve health promotion.

Chicago Public Schools: An Academic Practice Partnership

Presenters: Jennifer Rousseau, DNP, APRN-BC; Heide Cygan, DNP, PHNA-BC

Population Served: Chicago Public Schools (CPS) is the third largest school district in the country, and serves 370,000 students across 659 schools. Nearly eighty percent of CPS students live at or below the poverty level. The student population is diverse: 46.8% Hispanic, 37% African American, 10.2% Caucasian, 4.1% Asian, 1.1% multiracial, 0.2% Hawaiian/Pacific Islander, and 0.3% Native American/Alaskan.

Current Roles of the Nurse: Understanding that healthy students are better learners, nurses play an important role in academic, health, and life outcomes of Chicago youth. Rush College of Nursing faculty work with the Office of Student Health and Wellness (OSHW) to guide implementation and evaluation of district-wide health and wellness policies. These efforts align with target areas identified as health priorities in the Healthy Chicago 2.0 initiative, a city-wide program to reduce health disparities among the diverse neighborhoods of Chicago. By improving health outcomes of Chicago youth, we positively impact their ability to learn and succeed in life. Recent projects include:

- Conducting qualitative research to understand facilitators of and challenges to health and wellness policy implementation within individual schools.
- Convening a panel of 20 nationwide experts for a Delphi study to develop the *Healthy CPS Survey*, the first school health and wellness policy implementation measurement tool of its kind.
- Developing a learning experience for Rush Graduate Entry Masters (GEM) students to teach sexual health education in CPS schools, assisting with policy implementation at target schools, teaching sexual health education to CPS students in grades 5 – 12.
- Directing secondary data analysis of Youth Risk Behavior Survey data to examine teen pregnancy and adverse childhood experiences for CPS students
- Seeking grant funding for a project that will analyze school nurse sensitive health outcomes, moderate focus groups and make policy recommendations for district wide utilization of school nurses.

Financial Structure, Sustainability and Replicability: This partnership is an exemplar of the Academic Practice Partnership model. Since 1996, the Rush University College of Nursing and CPS have worked together to provide opportunities for nursing education and scholarship while improving adolescent health. It was intentionally formed to be mutually beneficial to each partner and their stakeholders and is supported by leaders in both organizations. Sustainability is built upon a foundation of respect for organizational missions, shared values, shared knowledge, and trust. Through standing meetings, task forces, and committee work by partner members at all levels, the partnership has not only been sustained but has grown stronger. This is evidenced by increased students clinical placements, shared data, joint grant writing, and co-authored project dissemination. This academic practice partnership is replicable to other community partners and colleges.

Outcomes

- Sexual Health Education (https://onlinelibrary.wiley.com/doi/abs/10.1111/phn.12527)
    - CPS students reached: 2,200+
    - GEM student participation: 95
    - Pre- and post-test scores: 19 – 32% increase

    - Dissemination products: three oral presentations, one poster presentation, and one journal article
- Health and Wellness Policy
    - Qualitative research: https://journals.sagepub.com/doi/abs/10.1177/1059840519846089
    - Development of the *Healthy CPS Survey*, completed by all 659 CPS schools in April 2019
    - Environmental audits of individual schools are currently being conducted to validate the survey. Once complete, revisions will be made to the survey and the survey will be offered to other large urban school districts nationwide.
    - Dissemination products: six poster presentations, one journal article, one journal article in preparation

What could nurses be doing that they are not doing now? The CPS OSHW functions as a public health department within the school district. Currently, nurses are utilized within CPS in roles that allow for reimbursement (Individual Education Plans, direct care services for students with high medial needs, etc.) and direct funding (vaccine compliance, state health requirements, etc.). Other than the Rush partnership, nurses are minimally involved in health promotion activities or research. By including more nurses in this partnership, we would able to implement and evaluate evidence based health promotion interventions based on the research Rush nurses have conducted. Nurses could teach and evaluate outcomes of sexual health education in schools. Nurses could guide policy for district-wide health and wellness efforts. Nurses could work with individual schools and unique communities to assist them in the implementation of health and wellness policies. Nurses could examine school specific data and adapt programs to meet the specific needs of student population. Nurses could implement health promotion activities that include families and the surrounding school community.

Challenges and Opportunities

- Building sincere trust
- Balancing two different academic calendars and administrative policies
- Opportunity for a faculty practice agreement

Community partnerships to educate APRNs and improve quality care for vulnerable populations

Presenter: Kathleen Delaney, PhD, PMHNP, FAAN

Current partnerships include a range of sites (FQHCs, Free Standing Clinics); the nurses are primary care providers who focus care within the context of the lives the clients' live.

Partners include urban FQHCs, Free and Charitable Clinics, Nurse Managed Clinics (top down relationships- organization to CON) and bottom up seed partnerships with community agencies that are developing or refining their care to vulnerable populations.

Our commitment to the partnership drives us to seek financial support from both grants and the College of Nursing. We are at the point where both partners look for any potential funding stream. The top down partnerships have proliferated throughout academia so I assume they are being replicated.

At Rush we track our success at sustaining and growing partnerships; at developing select competencies in our students, and our use of the partnership to cultivate innovative educational models.

Moving Forward

The last Future of Nursing recommendations eloquently combined a sense of how to improve health care (with a better prepared workforce) with actionable items that nursing could control and do (e.g. create residencies, BSN preparation). Are we going to follow that same structure that lines up health care issues-with action items within nurses' grasp?

We could recommend education that increases the sensitivity of the nursing workforce to SDOH and the intersection of health and the lives of the underserved. The Competencies to Address Needs of the Urban Underserved (used at Rush CON) accomplish that.

Or we could line up what is occurring in the service sector, what advances in the science of treatment and what can we can do as a workforce to potentiate the necessary interface of individual, family, community (a modified Bronfenbrenner scheme). This would seem best done at the population level since you are integrating massive amounts of data around science, service structure trends, and population needs.

Top down academic partnerships are beneficial because they draw upon nursing expertise at many levels (knowledge base, practice base, translational science acumen). They help us with training needs and set up avenues to enrich the practice environment.

Bottom up partnerships are beneficial because it is front line staff and at times a faulty member trying to carve out better health for a population in real time. They are slower but the yield greater mutual insights.

Addressing the SDoH in Ambulatory Care/Meaningful Ambulatory Care Nurse-Sensitive Indicators

Presenter: Rachel Start, MSN, RN, NE-BC, Director of Ambulatory Nursing and Nursing Practice, Rush Oak Park Hospital

Leveraging Top of Scope Nursing Practice in Ambulatory to Lead Transformation: Benchmarking, Leadership and Care Delivery Redesign

Population: Initiatives aimed at the nursing population in the ambulatory/outpatient/ community setting with outcomes related to their patient populations (emphasis on chronic, vulnerable and primary care) as reflectors of top of scope practice.

Nursing Roles: Emerging roles reflect care coordination, social determinant assessment and intervention, transitions management, and population health. Nurse Executive roles also being defined and supported for strategic leverage at system level for nurses across continuum.

Partners: AAACN; AONE; AACN; ANCC; AMGA; Collaborative Alliance for Nursing Outcomes; Press Ganey

Financing: Organizations, due to change in payment structures and the influx of volume into the setting, are increasingly transforming care delivery models to meet the quadruple aim. Leveraging the role of nurse at top of scope to lead this redesign, manage data specific to role as well as the interdisciplinary team and create better opportunities for patient health and access is in every organization's top of mind return on investment at this moment.

Replication: Benchmarking nursing quality data in the ambulatory sphere and creation of structures that empower nursing leadership are being underscored by such notable endeavors as designation by the ANCC Magnet program. Organizations are replicating the elements needed to create leadership in any area where nursing is practiced through this model whether they are pursuing application or not. Replicability depends on the strength of nursing leadership across the continuum and the ability of nurses to be at strategic decision making tables, given significant influence to guide care delivery model redesign and excellent clinical practice.

Measuring Outcomes: Benchmarking is now available through this work at the national level. Emphasis is now on participation in benchmarking, mentorship of organizations to support top of scope practice and performance improvement and dissemination of organizational best practices to grow the science of ambulatory nursing into the future. A growing number of organizations are revising structure to include nursing discipline voice in influential roles such as that of the CNO, which supports professional governance throughout any structure beneath. Increased engagement and a move towards higher education and specialty certification in exams such as the AAACN CCTM specialty exam, support the fact that empowerment and leadership can lead to an autonomous nursing workforce in this setting.

Nursing Roles and Opportunities: Nurses need to publish the great work they are doing. The base of literature in this setting is still new and growing- many are doing progressive models and displaying top of scope practice but have not entered into the scientific literature as of yet.

Nurses are vastly needed to oversee, especially from a patient safety perspective, populations and the workforce seeing them in the community. Greater acumen in care coordination and population health activities from the pipeline of new nurses entering particularly primary care is important. As organizations deploy community health workers, conduct social determinant screening and create virtual health options for prevention and disease management, nurses must be leveraged in this oversight role, managing both patient safety and care coordination.

Challenges and Opportunities: Current challenges stem from the fact that the ambulatory environment has not traditionally leveraged any discipline but that of the physician. As payment models have shifted to a values focus, however, all disciplines, and particularly that of nursing has started to play a more prominent role. Particularly in the Patient Centered Medical Home model and any replications, strategies and tactics for addressing high value care in new care delivery models that leverage the team have started to transform the consciousness of systems and allow for a fuller compliment of disciplines to engage in patient care. Quality departments, education and even professional governance within nursing and/or support from a CNO office such as has been long traditioned in the inpatient setting is not a forgone conclusion for nurses in ambulatory. They often very much lack structural empowerment, leadership that is visionary/

strategic and understanding from administration or physicians on the vital role that nursing can and needs to play in partnering to provide higher value care that offers greater access to a more diverse array of patient populations.

RN Medicare Wellness visits

Presenter: Susan Hurley, MPH, RN, Director Of Clinical Operations, Rush Oak Park Physicians Group

RN Medicare Wellness Visits and Social Determinant of Health Screening

Target Population: Adults over age 65 or those eligible for Medicare benefits due to disability

Role of the Nurse: Nurses are conducting Medicare wellness visits for eligible pts. These visits are preventive/screening visits that incorporate a health risk assessment. (HRA) The HRA screens for food, housing and meeting health care needs along with other items.

Partnerships: These visits involve the ambulatory team: MDs, RNs and CMAs. We then partner with Now Pow for an extensive network of resources to access for our ambulatory pts.

EPIC and Billing team (templates build into EPIC for easy documentation.

Rush Health for Data Analytics

Financing: Visits are charged at $260. Reimburse at $192.00. Approximately 40 minutes per visit. If an RN performs 6 visits/5 days/week, RN salary will be covered and a (+) profit margin will exist.

Replicability: Easily reproducible with RN resources. 12 hours training provided and resource manual created.

Measureable Outcomes: Program just began April 2019. Metrics: Number of visits performed, (+) screens identified and appropriate resources secured. Pt reported improved outcomes, Completion of annual health measures and reduction in risk

Future Nursing Roles: This expands nursing's role and allows direct patient contact, opportunity for educating pts and connecting to needed resources. Positions for leadership in partnering for improved patient outcomes, obtaining Advance Directives

Needed to Expand: Training RN's, Educating pts on value of yearly Medicare wellness visit, Buy in from key stake holders and MD partners

Food Matters Project

Presenter: Laurie Ouiding, RN

Population served: Diverse neighborhood with underserved population, Bronzeville neighborhood

Current roles of nurses: Program developed by Rush Pediatric Nurse to address issue of inequitable access to affordable healthy food. Member of Rush Nursing Health Equity Council, working on pediatrics unit which was a pilot unit to roll out the SDOH assessment. Currently looking into having pediatric community wellness clinics staffed by PNP and RNs, as well as introduce the Culinary Medicine program to Rush University Medical School and the Nursing program.

Partners involved: Rush dietary, students to teach community nutrition classes. Advocates for Urban Agriculture (board member), Bronzeville Urban Development, Quad Communities Development Corporation, Ward 3 Alderman, Chicago Trend, World Business Chicago, The Plant/Plant Chicago.

Financial structure and sustainability: Funded by Chicago Community Loan Fund, Chicago Trend and Illinois Opportunity Zone Collaborative. Project includes mixed development including residential component and commercial/event space resulting in numerous different revenue streams.

Replicability: Business model replicable and being looked at for Detroit, New Orleans and Puerto Rico sites.

Metrics or outcomes used to evaluate the program and describe impact (what is success and how is it measured?): Demographics/health assessment at beginning and end of Culinary Medicine/Nutrition series of classes.

What could nurses be doing that they are not doing now? Offer regularly scheduled wellness clinics (in the plans to do so)

Challenges and opportunities: City land acquisition for unique project. Many opportunities to replicate this project throughout the city in areas that need equitable access to healthy, affordable, locally grown foods.

RNs assessing and addressing the SDoH in acute care settings

Presenter: Janice Phillips, PhD, RN, FAAN

Population served: Nursing staff

Current roles of nurses (how nurses are being utilized to address health equity and SDOH): The discussion will highlight findings assessing nursing knowledge and level of comfort when addressing the determinants of health with patients and will highlight how findings were used to inform staff education on 4 pilot units.

Partners involved (other organizations, sectors, professions, students): Nurses from Rush Oak Park and Copley completed the survey as well.

Financial structure and sustainability: NA

Replicability: Absolutely

Metrics or outcomes used to evaluate the program and describe impact (what is success and how is it measured?) A post assessment survey will be conducted with the 4 units who are already doing SDoH screening as part of a pilot project. Staff completed the SDoH survey prior to the pilot roll out and have received education in concert with the initial findings. A post survey is scheduled to assess any difference in knowledge or self-efficacy surrounding the SDoH.

What could nurses be doing that they are not doing now? (Expanded roles, additional responsibilities, broadened scope, leadership activities) Nurses would be a nice addition to Boards, Commissions and other entities that are addressing the determinants of health. We should expand our influence beyond medically oriented boards and commissions.

Challenges and opportunities: We need more visibility on how we can be make meaningful contributions to the health related decision making process especially in non-medically oriented circles.

Relevant Publications

- 2018 Rush Health Equity Report
- We can't afford not to supply school-based healthcare
- A Nurse-Led Intervention to Address Food Insecurity in Chicago
- An academic practice partnership: Building capacity to meet sexual health education policy requirements of a public school system
- Building mental health and caring for vulnerable children: Increasing prevention, access, and equity
- Improving Mental Health Care: What Nurses Can Do
- Critical workforce issues for registered and advanced practice nurses in integrated care models
- Improved Utilization of Preventive Services Among Patients Following Team-Based Annual Wellness Visits
- American Academy of Ambulatory Care Nursing Position Paper: The Role of the Registered Nurse in Ambulatory Care
- The Role of the Registered Nurse in Ambulatory Care Position Statement
- The American Academy of Ambulatory Care Nursing's Invitational Summit on Care Coordination and Transition Management: An Overview
- Ambulatory Care Nurse-Sensitive Indicator Industry Report
- AAACN CCTM Invitational Summit Briefing
- Evolution of a Conceptual Model: Ambulatory Care Nursing
- Realizing Momentum and Synergy: Benchmarking Meaningful Ambulatory Care Nurse-Sensitive Indicators
- Developing the Value Proposition For the Role of the Registered Nurse In Care Coordination and Transition Management in Ambulatory Care Settings
- Educating nursing students in clinical leadership
- Efficacy of the HealthMatters Program Train-the-Trainer Model

Additional Publications Available for Download