The Pivotal Role of Registered Nurses (RNs) in Improving Health Outcomes

Wednesday April 30th, 2025

1:00-2:00pm Eastern / 10:00-11:00am Pacific

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $550,000 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

Continuing Education Credits (CEUs)

Through MWHS, the Weitzman Institute can award continuing education credit (CEUs) to physicians, nurse practitioners, pharmacists, nurses, physician associates/assistants, dentists, psychologists, social workers, and dietitians. Please note that continuing education credit requirements differ by state, jurisdiction, and licensing agency. It is your responsibility to confirm if your licensing/credentialing agency will accept the credits offered by Weitzman Education activities.

To learn more, please visit:
https://education.weitzmaninstitute.org/content/about-us

JOINTLY ACCREDITED PROVIDER™
INTERPROFESSIONAL CONTINUING EDUCATION

Disclosures

- With respect to the following presentation, there has been no relevant (direct or indirect) financial relationship between the party listed above (or spouse/partner) and any for-profit company in the past 12 months which would be considered a conflict of interest.
- The views expressed in this presentation are those of the presenters and may not reflect official policy of Community Health Center, Inc. and its Weitzman Institute.
- We strive to create a respectful and welcoming learning environment. If anything in today's session makes you feel uncomfortable, please let us know via email at nca@chc1.com.
- We are obligated to disclose any products which are off-label, unlabeled, experimental, and/or under investigation (not FDA approved) and any limitations on the information hat we present, such as data that are preliminary or that represent ongoing research, interim analyses, and/or unsupported opinion.
- This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $550,000 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

MOSES/WEITZMAN Health System

Always groundbreaking. Always grounded.

Community Health Center, Inc.

A leading Federally Qualified Health Center based in Connecticut.

ConferMED

A national eConsult platform improving patient access to specialty care.

The Consortium for Advanced Practice Providers

A membership, education, advocacy, and accreditation organization for APP postgraduate training.

National Institute for Medical Assistant Advancement

An accredited educational institution that trains medical assistants for a career in team-based care environments.

The Weitzman Institute

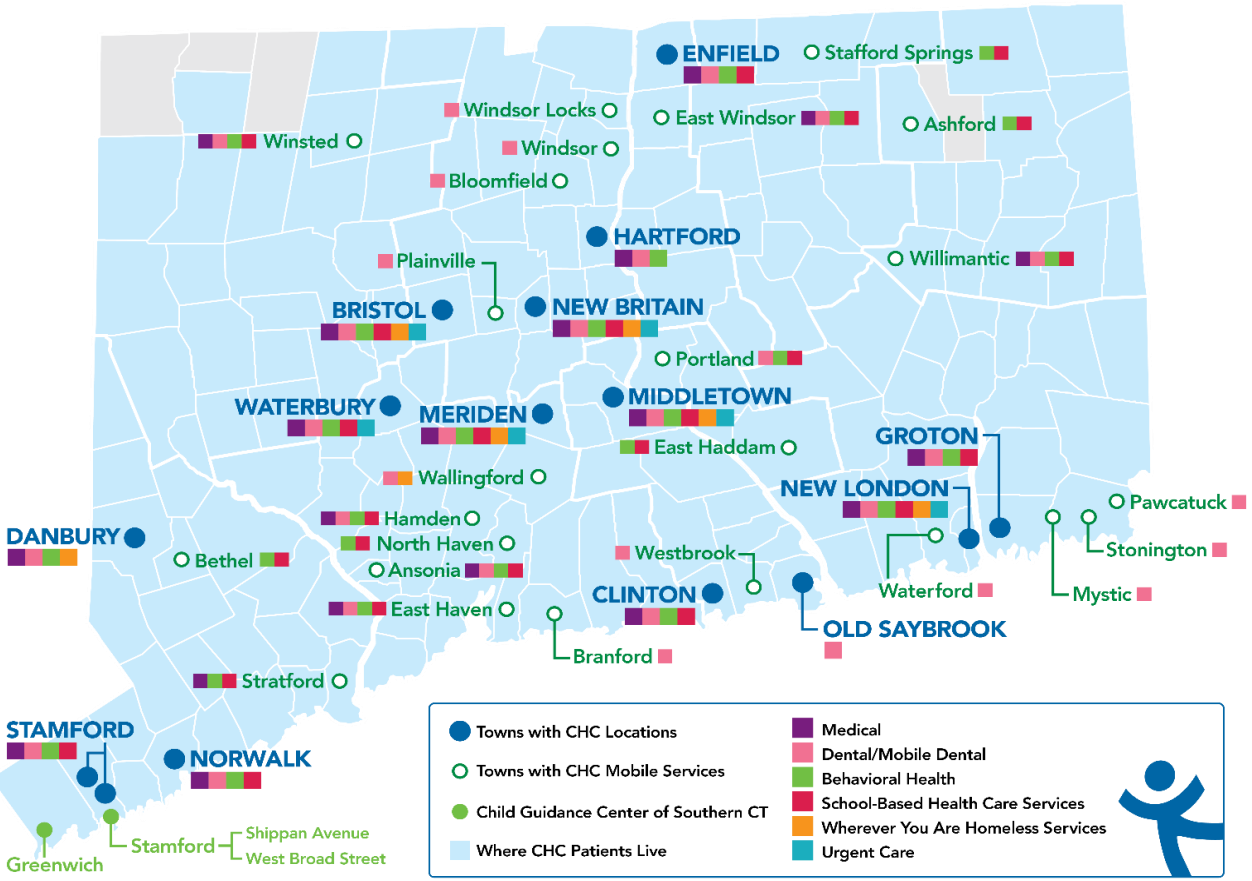
A center for innovative research, education, and policy.

Center for Key Populations

A health program with international reach, focused on the most vulnerable among us.

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Locations & Service Sites



Community Health Center, Inc.

THREE FOUNDATIONAL PILLARS

1	2	3
Clinical Excellence	Research and Development	Training the Next Generation

Overview

- Founded: May 1, 1972
- Staff: 1,400
- Active Patients: 150,000
- Patients CY: 107,225
- SBHCs across CT: 152

Year	2021	2022	2023
Patients Seen	99,598	102,275	107,225

National Training and Technical Assistance Partners (NTTAP)
Clinical Workforce Development

Provides **free** training and technical assistance to health centers across the nation through national webinars, activity sessions, learning collaboratives, trainings, publications, and more!

To learn more, please visit https://www.weitzmaninstitute.org/nca.

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $550,000 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

The National Nurse-Led Care Consortium (NNCC) is a nonprofit public health organization working to strengthen community health through quality, compassionate, and collaborative nurse-led care through:

-training and technical assistance
-public health programing
-consultation
-direct care

To learn more about NNCC, please visit our website at www.nurseledcare.org.

This program is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $550,000, with 0 percent financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, HRSA, HHS, or the U.S. Government.

NNCC NTTAP

Jillian Bird, MS, RN
Director of Training and Technical Assistance

Matt Beierschmitt, MPP
Senior Program Manager

Fatima Smith, MPH
Project Manager

Mekenzie Williams, BSN, RN, ACC
Nurse Training Manager

Regina Brecker, MPH
Project Coordinator

Junie Mertus
Program Intern

Speakers

Karoline Oliveira, EdD
Chief Officer for Clinical Excellence
Moses/Weitzman Health System

Mary Blankson, DNP, APRN, FNP-C, FAAN
Chief Nursing Officer
Moses/Weitzman Health System

Matt Beierschmitt, MPP
Senior Program Manager
National Nurse-Led Care Consortium

Learning Objectives

- Gain knowledge on foundational concepts to improve health outcomes.
- Understand the pivotal role RNs play in improving overall clinical quality.
- Learn actionable strategies to maximize RNs' contributions through structured initiatives, tools, and resources to improve health outcomes.

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Improving Health Outcomes

Health Outcomes

- Health outcomes refer to the health consequences brought about by the treatment of a health condition or as a result of an interaction with the healthcare system. It is a multidimensional concept that can be studied on multiple levels.[1]
- Health outcomes may be measured clinically (physical examination, laboratory testing, imaging), self-reported, or observed (such as gait or movement fluctuations seen by a healthcare provider or caregiver).[2]

1. https://link.springer.com/referenceworkentry/10.1007/978-94-007-0753-5_1251
2. https://www.sciencedirect.com/topics/medicine-and-dentistry/health-outcomes#definition

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Improving Health Outcomes

- Reduce Medical Errors and Improve Patient Safety
- Offer Telehealth and Other Technologies
- Manage Chronic Diseases
- Ensure Continuity of Care and Discharge Procedures
- Communicate with Patients and Educate Them About Their Health
- Create Opportunities for Staff Support and Development
- Analyze Data

https://healthadministrationdegree.usc.edu/blog/7-ways-to-improve-patient-outcomes

Variances in Health Outcomes

- Variances in health outcomes are observed as those preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by populations negatively impacted by factors in and outside of their control.
- **Examples**:
  - For both men and women, prevalence of diagnosed diabetes was higher among adults living in nonmetropolitan areas compared to those in metropolitan areas.[3]
  - Adults living in poverty are at a higher risk of adverse health effects from obesity, smoking, substance use, and chronic stress.[4]
  - College graduates have better self-reported health than high school graduates, and individuals with more education are less likely to report conditions, such as heart disease, high blood pressure, diabetes, anxiety, and depression.[5,6]

3. https://www.cdc.gov/diabetes/php/data-research/
4. https://doi.org/10.1377/hpb20180817.901935
5. Goesling, B. (2007). The rising significance of education for health? Social Forces, 85(4), 1621–1644.
6. https://doi.org/10.3386/w12352

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Strategies in Action to Address Variances in Health Outcomes:

Patient Demographics

Recognizing and appreciating the demographic makeup of the patient population.

Staff Training

Providing ongoing training for staff to understand and respect the norms, traditions, and practices of patients.

Community Outreach Programs

Engaging with local communities through targeted outreach to understand specific healthcare needs.

Health Education in Multiple Languages

Offering health education materials in multiple languages to accommodate the needs of the patient population.

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Strategies in Action to Address Variances in Health Outcomes:

Access to Care	Language Services	Care that Respects Different Perspectives	Financial Assistance Programs	Telehealth Access
Ensuring that all patients receive quality healthcare, regardless of their personal circumstances.	Providing interpreters and translated materials to support effective communication.	Training healthcare providers to offer sensitive and responsive services.	Providing financial assistance to help patients access affordable care.	Making remote healthcare services accessible to all patients.

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Strategies in Action to Address Variances in Health Outcomes:

Accessible Facilities

Designing healthcare facilities to accommodate patients with mobility and accessibility needs.

Collective Decision-Making

Actively involving a range of voices, including patients, in decision-making processes to ensure varied perspectives.

Patient& Staff Centered Practices

Implementing policies and practices that embrace and respect the backgrounds of both staff and patients.

Respectful Healthcare Policies

Developing and implementing policies that promote fair and respectful treatment for everyone.

Strategies in Action to Address Variances in Health Outcomes:

Resource Allocation	Health Policy Engagement	Community Engagement	Ensuring Fair and Objective Practices	Improving Health Outcomes Among Patient Populations
Ensuring appropriate distribution of funds/resources to address health Improvement goals.	Supporting policies that address challenges contributing to poor health outcomes.	Involving local community groups in decision-making processes.	Implementing staff training programs to support fair and impartial care.	Prioritizing interventions to address the unique needs of local patient populations.

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

What is the Role of the RN?

The Role of the RN in Improving Health Outcomes

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Role of the Registered Nurse

- Function within three domains of primary care:
  1. episodic/acute and preventive/routine care
  2. chronic disease management
  3. practice operations, ongoing QI, regulatory oversight/surveillance, and other practice improvement activities
- RNs can meet many of the patients' needs for in between care, including troubleshooting care plans with regards to barriers/facilitators of success as well as knowing when to escalate care needs to other providers as needed

Role of RN and Improving Health Outcomes

- The 2021 National Academies of Sciences, Engineering, and Medicine (NASEM) report on *The Future of Nursing* notes:

  "Nurses are uniquely qualified to help improve the quality of health care by helping people navigate the health care system, providing close monitoring and follow-up across the care continuum, focusing care on the whole person…" (p. 119).

Best Practices for Optimizing the Role of the RN for the purpose of Improving Health Outcomes

- Optimizing the role of clinical care team members, including RNs & LPNs can meet many of the patients' needs that providers try to handle alone or do not have time to address, such as questions about medications or laboratory tests, or issues related to care coordination and ongoing self-management

Best Practices

- Standing Orders or Delegated Orders
- Chronic Care Management
- Patient Centered Education and Support
- Nursing Leadership & Informatics
- Others?

Standing Orders

Standing Orders:

- are developed by an organization in accord with national evidence-based guidelines, and executed under the authority of the Chief Medical Officer or another licensed independent practitioner in leadership within an organization.
- apply to a specifically defined population
- allow RNs to manage common episodic health conditions or complaints, such as urinary tract infections (UTI), upper respiratory complaints, and some sexually transmitted infections (STIs)
- can also be used for more comprehensive visits for chronic diseases
- can be billed directly in some states, and in other states can contribute to nurse-assist visits for providers (fee-for-service) and/or value based payments/shared savings

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Standing Orders include:

- Policy statement
- Rationale
- Procedure, including:
  - Who the standing order applies to
  - When the standing order can be used
  - Required actions for all encounters with the standing order
  - Menu of other actions based on assessment outcomes
  - When to consult with provider
  - Expected follow-up
  - Expected documentation, including applicable templates in the E.H.R. to be used

Policy Name: **Standing Order for Nursing Visit for Hypertension Patients**
Location: **Provision of Care**
Department: **Medical**
Effective Date: [redacted]
Revision:
Reviewed:

Policy: The Chief Medical Officer of [redacted] has established a standing order for consistent comprehensive nursing visits for patients with Hypertension. Referrals may be received from the patient's Primary Care Provider (PCP). Nurses may also proactively identify appropriate patients via the care management dashboard or the Hypertension Dashboard. These visits may include nurses assessing the degree of blood pressure control based on blood pressure (BP) measurements collected at CHC or by the patient at home or in the community. In addition, nurses may complete medication titration as delegated by the PCP and documented in the Electronic Health Record (EHR). Nurses play a key role in managing patients in addition to provider visits and providing value added care through ensuring home blood pressure monitoring (including prescribing a home blood pressure monitoring cuff via this standing order), medication monitoring, laboratory ordering, engaging interdisciplinary team members, disease self-management, and lifestyle education.

Under this standing order nurses are able to complete the following:

1. Take a full set of vital signs (should be done at each visit)
2. Order Home blood pressure monitoring cuff
3. Refer patients to the Registered Dietician
4. Schedule follow up nursing visits
5. Perform medication reconciliation
6. Order regular/chronic hypertension medication refills at the time of the visit if due (See **The Nurse Management of Medication Refills** standing order policy)
7. Order routine point of care testing as noted as due on the Planned Care Dashboard
8. Set patient specific Self-Management goals (SMG's) with Confidence Intervals (CI) and have follow up to these SMG's with tracked progress toward goals using the accepted CHCI SMG template
9. Provide Hypertension education and strategies for lifestyle modification, including completing a nutrition assessment, addressing medication adherence and others
10. Complete routine applicable screens and data collection as due on the Planned Care Dashboard such as SDOH, SBIRT and others to ensure effort toward closing care gaps

- Management of Hypertension
  - Prescribe Home Blood Pressure Monitor (as needed), confirming
  - Document the home blood pressure values and enter in the average for the last five.
  - Referral to Registration Dietitian
  - Referrer current smokers to Behavioral Health for smoking cessation
  - Strategies for Nurse Management of Hypertension: Lifestyle Modifications Weight Reduction
  - Healthy eating (dash diet)
  - Moderate to vigorous physical activity
  - Moderation of alcohol consumption

  - Nurses shall order labs or point of care testing as appropriate.
    - Lipid Panel, if not done in the past 12 months.
    - Basic Metabolic Panel, if not done in the past 12 months.
    - Hemoglobin A1C for patients with DM, if not done in the past 6 months.
    - Urine micro albumin and creatinine ratio for patients with DM, if not done in the past 1 year.
    - INR for patients on Coumadin, if patient is due.

Delegated Orders

Delegated orders:

- are unique to an individual patient's plan of care, especially for patients with chronic conditions.
- requires a provider (typically the PCP, or specialty provider) to outline/document the specific orders, including what the RN should assess, and what actions to take based on the results of the assessment
- ensure individualized, patient-centered care that can go beyond a specific standing order
- these orders exist within the E.H.R. whereas standing orders are written in policy

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

How does this type of a delegated visit improve outcomes?

- Increases provider access
- Expands the patient's knowledge of their care team
- Allows more opportunities to build health literacy
- Supports proactive titration of medication, while also continuing lifestyle modification discussions
- Increases the focus on this particular chronic illness, ensuring that the patient understands that they will continue to be followed until control is achieved

Delegated Order Sets at Community Health Center, Inc.

A.R. is a 67-year-old Latinx male who sees his PCP to follow up regarding his hypertension. During the visit, the provider determines that the patient continues to have uncontrolled hypertension on his current regimen. The provider titrates his medication, and orders a follow-up visit for A.R. with the registered nurse in 2 weeks to re-evaluate his blood pressure. The provider puts the delegated order in a telephone encounter in the electronic health record and assigns it to the registered nurse on the team as follows:

> *"Mr. R. will be following up with you in 2 weeks. Please complete a brief history to include whether he is taking his new medication, and whether he has any concerns since taking it. Please also confirm that he has taken this medication daily, and that he has taken it on the day he is seen.*
>
> *If his blood pressure continues to be elevated (above 140/90), please call in a new dose of his medication, increasing from 10 mg to 20 mg once per day, and then have him follow-up with me in 2 additional weeks. He should call us immediately or dial 911 should he experience any dizziness, blurred vision, or severe headache in the meantime. If his BP is controlled (<140/90) when he sees you, please have him continue at the current dose and follow-up with me in 1 month for routine provider follow-up. Thank you."*

The registered nurse would then complete the visit as ordered, following the guidance given within the telephone encounter. Should there be anything that presents outside of this order, the registered nurse should consult with the provider during this visit. The provider can give additional guidance as needed at that time.

Care Coordination and Transition Manage

- Three main categories:
  1. Working with the patient and family/friends in collaboration with the care team;
  2. Linking the patient with the community and/or medical specialty services; and
  3. Working with the care team to coordinate areas of responsibility.
- Requires clinical judgment, knowledge of community resources, and general access barriers and facilitators based on the patient's insurance status, transportation availability, etc.
- Requires every member of the team to be involved, but often leadership of a nurse to coordinate/support

Chronic Care Management

- Chronic care management:
  - tends to be more population-focused than care coordination, which focuses more on individual patients (Agency for Healthcare Research and Quality, 2015).
  - is based on the principle that health risks can be reduced and costs decreased with the right interventions for populations of patients.
  - typically includes medication titration and other more advanced skills requiring the involvement of nursing staff
- Rather than wait for these patients to be hospitalized or use emergency care for exacerbations of their illness, nurses can manage, stabilize, and monitor these patients, either through nurse visits or telephonic check-ins, between visits with providers.
- Nurses can also work with other members of the primary care team, including community health workers and medical assistants, as well as with outside health care entities and community service providers to ensure optimal health for these patients (demonstrating leadership abilities).

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

How do frontline staff describe their work and all that they can do for our patients?

Complex Care Management at Community Health Center, Inc.

Complex care management at Community Health Center, Inc. (CHCI) offers patients high-level care coordination to those with chronic conditions, such as diabetes, high blood pressure, and more. When a patient is first referred to a registered nurse for care coordination, the nurse interviews the patient about personal goals. Where do you see yourself in a few weeks/months? What changes would you like to make to your lifestyle? From there, the nurse works with the patient to develop self-management goals. For instance, if a patient's goal is to lose weight, we break that down into smaller milestones, related to eating habits and exercise. We could also involve a registered dietician or a certified diabetes care and education specialist (CDCES).

Additionally, our nurses offer transitional care coordination to those patients being discharged from the hospital, those who are experiencing housing insecurity or homelessness, or rejoining the community after incarceration. For example, filling prescriptions can be a challenge for people with chronic conditions under these circumstances when their insurance does not cover the medication, they are uninsured, or they don't have stable housing. We are the medical home for these patients. Therefore, to meet the patients' needs, we do a thorough assessment of their health and social vulnerabilities and strengths, and develop a plan to first stabilize their situation so that they can move on with their lives. We often coordinate with community-based organizations, pharmacies, behavioral health, specialists, and other resources in the process. We are patient-driven and our flexibility allows us to be both comprehensive and individualized in our approach. Our goal is to empower patients and give them the strength and support to improve their health…and their lives.

—Leonela Espinal, BSN, RN, and Bozena Roberts, BSN, RN,
Staff Nurses, Community Health Center, Inc., Danbury, CT

Chronic/Complex Care Management

- Key populations for care management by registered nurses:
  - Patients transitioning from hospital to home
  - Patients transitioning from being incarcerated to rejoining the community
  - Patients with controlled chronic illnesses that require medication administration (long-acting injectable), relapse prevention support or other ongoing assessments as a part of their care plan
  - Patients with uncontrolled chronic illnesses
  - Patients with multiple co-morbidities, such as heart disease and diabetes, unstable housing, and lack of critical social support.
- Examples in action!

Patient Education

- RNs provide patient education and support, especially regarding medications and others therapies, and promote self-management in patients with chronic conditions.
- Most importantly, nurses develop strong relationships with:
  - Providers they work with to build trust in carrying out a larger plan of care for a patient
  - Other care team members who they may take hand-offs from when patients have questions that they cannot answer
  - Patients that they are empaneled to support
  - Leaders as they contribute ideas for process improvement and ultimately structures that contribute to better patient outcomes

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Case Review Examples: the Role of the RN in Improving Health Outcomes

Patient Profile

- Maria, a 45-year-old woman, is a single mother working two jobs to support her three children. She lives in a neighborhood with limited healthcare resources and has been experiencing chronic hypertension but hasn’t been able to afford regular check-ups or medication.

Setting:

- Community Health Center

Nursing Role:

- When Maria arrives for her scheduled appointment, she is greeted by Jessica, a registered nurse (RN). Jessica notices Maria seems anxious and hesitant to discuss her health concerns.

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

1. Establishing Trust:	2. Comprehensive Assessment:	3. Care Coordination:	4. Personalized Care Plan:	5. Follow-Up and Support:
• Jessica takes time to connect with Maria, asking about her family and acknowledging the challenges she faces as a working mother. Through empathetic communication, she helps Maria feel more comfortable sharing her health issues.	• Jessica conducts a thorough health screening and measures Maria's blood pressure, which is at a dangerously high level. Jessica explains the significance of this reading in simple, clear terms and educates Maria about hypertension and the importance of managing it effectively.	• Understanding Maria's difficulty affording medication, Jessica connects her with a social worker who helps enroll her in a medication assistance program. They also explore local resources like nutrition programs and stress management workshops.	• Jessica works with Maria to develop a care plan tailored to her needs, including dietary changes, exercise recommendations, and regular follow-up appointments. She provides educational materials on hypertension management with practical strategies for lifestyle changes.	• Jessica schedules a follow-up appointment and encourages Maria to reach out with any questions. She also ensures Maria has the tools and knowledge to monitor her blood pressure at home.

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Positive Outcome:

At her follow-up three months later, Maria reports consistent blood pressure monitoring and improved dietary habits. With the medication assistance program's support, she is taking her prescribed medications, and her blood pressure has stabilized. Maria feels supported in managing her health.

Conclusion:

Through Jessica's compassionate care and effective resource coordination, Maria achieved a positive health outcome. This holistic approach addressed Maria's immediate health needs and supported her overall well-being, highlighting the critical role of the RN in improving patient outcomes.

Patient Profile

- Ahmed, a 50-year-old man who has limited English proficiency and faces challenges understanding the healthcare system. Ahmed works in a factory and does not have health insurance. He recently visited a community clinic with symptoms of diabetes but has avoided seeking care due to concerns about medical costs and language barriers.

Setting:

- Community Health Center

Nursing Role:

- When Ahmed arrives at the clinic, he is warmly welcomed by Sarah, a registered nurse (RN) trained in effective and sensitive communication. Sarah quickly recognizes that Ahmed may feel uncertain and uncomfortable navigating the healthcare system.

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

1. Establishing Trust and Communication:

- Sarah begins by asking Ahmed if he prefers to communicate in English or his native language. When he chooses Arabic, Sarah uses an interpreter service to ensure clarity and comfort. She makes an effort to understand his background and any health beliefs he holds, demonstrating respect and sensitivity.

2. Comprehensive Assessment:

- Sarah conducts a thorough health assessment, carefully explaining each step and ensuring Ahmed understands his symptoms and the significance of his condition. She listens attentively as he describes his dietary habits and daily life, using this information to inform his care plan. Sarah also gathers complete and accurate data to support clinical decision-making and the development of effective training tools.

3. Health Education:

- Recognizing Ahmed's limited knowledge about diabetes management, Sarah provides tailored educational resources that respect his preferences. She works with him to incorporate traditional foods into a healthy meal plan and suggests practical, appropriate lifestyle changes.

4. Care Coordination:

- Aware of Ahmed's financial concerns, Sarah connects him with a community health advocate who assists him in applying for health insurance and accessing affordable medication. She also ensures Ahmed understands how these resources can benefit him, using relatable examples to ease his concerns.

5. Personalized Care Plan:

- Sarah collaborates with Ahmed to create a care plan focused on his specific needs and goals. This plan includes dietary adjustments, physical activity recommendations, and regular follow-up appointments. The data gathered from Ahmed's case contributes to training tools designed to help healthcare providers address similar patient needs.

6. Follow-Up and Empowerment:

- Sarah schedules a follow-up appointment and encourages Ahmed to reach out with any questions. She ensures he has the equipment and knowledge needed to monitor his blood sugar at home. Leadership and training teams use insights from Ahmed's experience to refine policies and improve staff training, strengthening their ability to support patients facing similar challenges.

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Positive Outcome:

At the follow-up appointment two months later, Ahmed expresses his gratitude for the care he received. He has successfully made dietary changes, has begun to manage his blood sugar levels more effectively, and has enrolled in a health insurance plan. Ahmed feels confident in navigating his health, thanks to Sarah's thoughtful and skilled approach. He also shares that his family has become more involved and is supportive of his health goals.

Conclusion:

Through Sarah's skilled and considerate nursing care, Ahmed experienced a positive health outcome. By respecting his personal values, facilitating clear communication, and providing tailored health education, Sarah helped Ahmed overcome significant challenges in managing his health. This demonstrates the profound impact that an RN can have on patients when they provide personalized care with attentiveness and respect.

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Workforce Development Resources

The Future of Nursing 2020 – 2023

- Consensus Study Report released by the National Academies of Sciences, Engineering, and Medicine (2021)

- Link to Report: https://www.ncbi.nlm.nih.gov/books/NBK573910/

The Future of Nursing 2020–2023
Chapter 5 - The Role of Nurses in Improving Health Outcomes

AAACN Tools

Practice Resources

- **Ambulatory Care Nursing**: AAACN provides resources such as the "Ambulatory Care Scope and Standards" and the "Core Curriculum for Ambulatory Care Nursing" to guide RNs in delivering high-quality care in outpatient settings. AAACN
- **Care Coordination & Transition Management (CCTM)**: Resources like the "CCTM Core Curriculum" and the "CCTM Toolkit" are available to enhance RNs' skills in coordinating patient care and managing transitions between care settings. AAACN
- **Telehealth**: AAACN offers resources to support RNs in providing telehealth services, including guidelines on telehealth nursing practice and educational materials. AAACN

Transition to Practice

- **Orientation and Competency Guide**: This guide assists RNs in transitioning into ambulatory care settings by outlining necessary competencies and offering orientation strategies. AAACN
- **Nurse Residency Program**: AAACN's residency program supports new RNs in developing the skills required for effective practice in community health centers. AAACN
- **Preceptor Guide**: This resource aids experienced RNs in mentoring and supporting their peers, fostering a collaborative learning environment. AAACN

Leadership Development

- **Ambulatory Care Nurse Executive Toolkit**: Designed to equip nurse leaders with the tools needed for effective management and leadership within ambulatory care settings. AAACN

4. Certification Preparation

- **Study Resources**: AAACN offers materials to prepare RNs for certification in ambulatory care nursing, enhancing their professional credentials.

- **Certification Review Course**: This course provides comprehensive preparation for the ambulatory care nursing certification exam.

Support/Resources

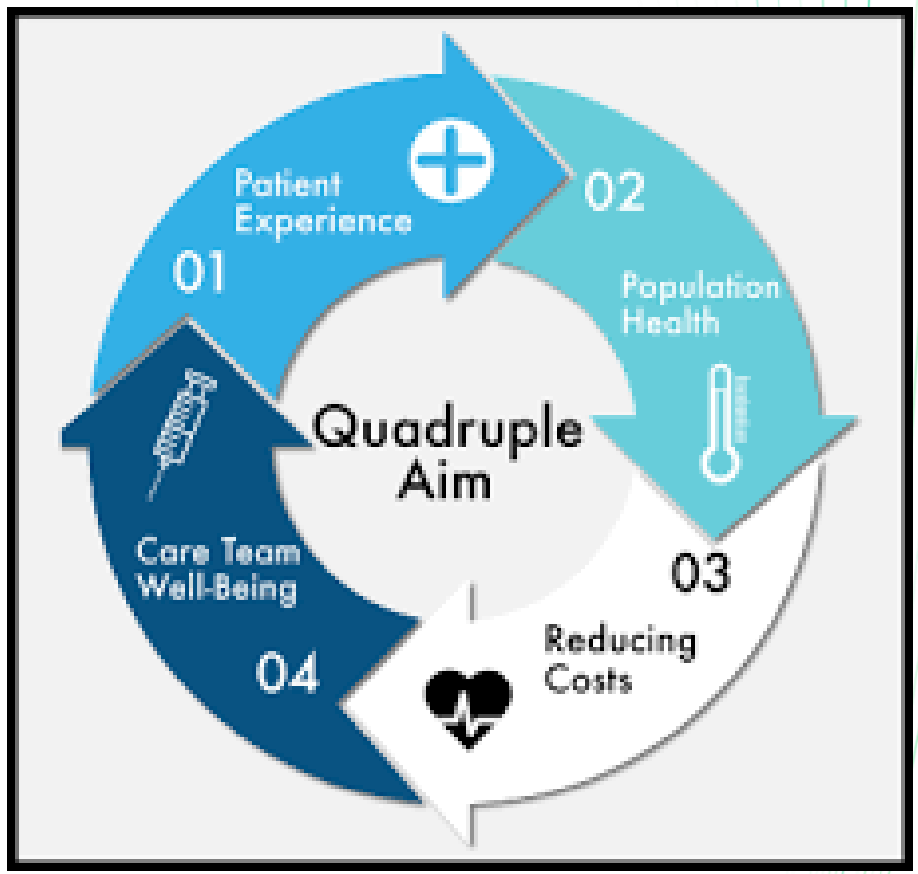
Scholarship and Loan Repayment Programs: These programs provide financial support to individuals pursuing careers in healthcare, including nursing. They aim to alleviate the financial burden of education in exchange for service commitments in underserved areas.

Bureau of Health Workforce

Advanced Education Nursing (AEN) Grants: These grants support nursing schools and health centers to enhance education and practice for nurses in master's and post-master's programs, preparing them for advanced roles such as nurse practitioners and clinical nurse specialists.

A Business Case For RNs in Community Health Centers

- Cost-effective
- Improved access and patient outcomes
- Improved population health
- Improved patient satisfaction/Reduced healthcare costs



1. Improving the Bottom Line: Seeing BSN-RNs in Primary Care as Value, not Just Cost
2. Nurse-Supported Revenue and ROI

Questions?

Wrap-Up

Cultivating Maternal Mental Wellness: A Vital Focus Across the Lifespan

Join National Nurse-Led Care Consortium (NNCC) for this three-part webinar on maternal mental wellness, focusing on mothers' needs across different life stages. The series is designed to provide health center staff practical tools to enhance care delivery for mothers utilizing health centers. Maternal mental wellness is a key factor influencing the health of mothers, infants, and families. Improving these outcomes is essential for promoting overall well-being.

When: May 8th, May 15th, and May 22nd at 3:00pm Eastern / 12:00pm Pacific

Register Here: link

Community Stewardship: Improving Health Outcomes through Organizational Relationships

Join CHCI for a 60-minute interactive session on strengthening organizational relationships to improve health outcomes, including building internal and external partnerships, fostering trust among teams, and promoting collaboration. Participants will reflect on their roles as community stewards, identify actionable steps to develop a framework, and share strategies and challenges in an open, supportive forum.

When: June 12th, 2025 from 1:00-2:00pm Eastern / 10:00-11:00am Pacific

Register Here: link

Explore more resources!

National Learning Library:
Resources for Clinical Workforce Development

https://www.weitzmaninstitute.org/ncaresources

Health Center Resource Clearinghouse

https://www.healthcenterinfo.org/

Contact Information

For information on future webinars, activity sessions, and learning collaboratives: please reach out to nca@chc1.com or visit https://www.chc1.com/nca