IJCWCN- International Journal of Community Wellness and Care in Nursing
Volume 1, Issue 2 | November-2025
e-ISSN: 3068-5818 ISSN Print: 3068-580X

Innovation Model to Incorporate Preventive Wellness to Enhance Basic Healthcare

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Received: 04-09-2025; Revised: 22-09-2025; Accepted: 13-10-2025; Published: 14-11-2025

Abstract

The ability to incorporate primary healthcare in the context of preventive wellness has become the priority of the global interest within the sphere of resilience and patient-centered development. In this paper, we are going to present a new model of RHWP Innovation Model that will supplement traditional primary care by providing more structured wellness pathways, allowing the community engagement as well as introducing holistic interventions. The model focuses on the early identification and lifestyle change alongside education, which is possible since it connects the two possible approaches to health care: curative and preventive. It also integrates wellness strategies with primary healthcare provision in terms of accessibility, equity and sustainability. Not only is this strategy empowering the efficiency of primary care, but it is also making individuals and communities responsible in controlling their health, which eventually supports the agenda of universal health coverage.

Keywords: ***Preventive Wellness, Primary Healthcare, RHWP Innovation Model, Health Integration, Holistic Care, Community Engagement, Chronic Disease Prevention, Health Systems Strengthening, Universal Health Coverage, Patient-Centered Care.***

1.Introduction

The challenge of the United States has long been how best to effectively and efficiently provide health care, given the growing incidence of chronic conditions, the complexity of social needs among patients, and the ever-wider gap between the perceived expectations of what is supposed to be delivered by primary care providers and the reality of time, resources, and the limits of the system to get the job done. Approximately 800,000 older adults reside in federally subsidized low-income housing nationwide and, there is also an overrepresentation of older adults in federally subsidized low-income housing developments, frailty and complex care needs as well as altering functional capacity and social isolation. In this cohort, about 50 percent are physically or functionally challenged to a high degree, over two-thirds are overweight, and one in 4 is diabetic(1). These figures indicate that there is an urgent need to manage chronic illness and social and environmental barriers that result in increased utilization of expensive health care services including emergency department, hospital, assisted living and nursing home facilities. Primary care providers (PCPs) have become a synonymous term to define the first line of the U.S health system, which is usually under immense pressure to diagnose, treat, manage and coordinate the care of these individuals. Nevertheless, the magnitude of demand for care, exacerbated in communities that are disadvantaged regarding rates of poverty, access to transportation, food deserts, crime, etc., tends to overwhelm providers and create fragmented, reactive rather than proactive treatment. It is within this context that novel solutions embedding health promotion, wellness, and social determinant interventions as woven into the fabric of primary care have emerged as a critical support in managing gaps in care delivery and producing value-based health outcomes.

This issue goes beyond clinical measurements to implications on society as a whole. Lack of uniform access to screening, health education, and healthy environments in vulnerable populations has a compounding effect that contributes to embedded health disparities. Diabetes may provoke amputations and blindness when not controlled, hypertension may trigger a stroke when not treated, and obesity can lead to accelerating cardiovascular disorder when it is not overcome. Meanwhile, when affordable transportation, safe neighborhoods, and nutritious food are not readily available, then access to available health care services even becomes a barrier. Among the low-income aged adults in urban housing complexes, these issues are especially acute since those populations tend to depend on the support of the state, receive fixed incomes, and experience an increase in risks associated with age and related diseases and social vulnerability. Conventional paradigms of care, in which the roles of physicians and nurse practitioners as the key agents of healthcare, are not enough on their own because they are not enough to address such multi-dimensional realities.

The situation in the region of Richmond, Virginia explains the national crisis. The percentage of residents living below the poverty threshold is an estimated seven percent and most of the neighborhoods have poor transportation, high crime rates and limited access to grocery stores and other necessary amenities. Poverty and ill health therefore makes the relationship among the given communities to be one of dependency on crisis-based care with the emergency rooms as the main channel of entry to non-emergent needs. In light of this need to change, faculty in the schools of nursing, pharmacy, medicine, social work, psychology, and allied health at Virginia Commonwealth University developed a model that might address these gaps. In their approach, they focused on the concept of aging in place, i.e., keeping older adults in their homes by assisting them as they safely age at home and preventing costly hospitalizations and/or institutionalization(2). This model recognized the strong intertwining of the environment, health behaviors, and general well-being by contacting the residents of low-income housing directly. The Richmond Health and Wellness Program (RHWP) which began in 2012 is a result of this realization. It was based on the fundamentals of academic-community partnership, with an aim of complementing, but not replicating the role of primary care. As compared to the conventional delivery of care that tends to be responsive to a disease, RHWP was founded on prevention, wellness, and the conscious and purposeful social determinants of health. It targeted the goal of alleviating demands on primary care providers as well as enhancing the well-being of residents through regular, convenient and comprehensive service in the same living community. The program redesigned the possibilities of how healthcare teams may effectively operate through directly integrating interprofessional collaboration and student learning within service delivery in the community. The new framework was both a win-win situation because it offered residents the necessary wellness support and the next generation of health care professionals a front row seat in learning how to live and react to the intricacies of the communities wellness.

The significance of such an innovation is that it allows taking the non-diagnostic tasks out of the primary care providers, and it is true that it allows them to concentrate more on their clinical skills, yet do not deprive the residents of sound support. As an example, instead of a PCP being the single determinant of ensuring that people have adherence to medications, food insecurity, or transportation barriers, RHWP placed trained students and faculty members in nursing, pharmacy, social work, and other disciplines who could assist the residents in overcoming those issues. In this sense, the model was analogous to emerging health reform priorities that focus on person-centered, holistic, and value-based care-giving as opposed to episodic, fragmented care.

The RHWP went beyond its direct clinical and community effect to constitute a natural change in philosophy. It did not only define health as the absence of disease, but to physical, mental and social peace, as it is also employed by the World Health Organization in its holistic definition. Likewise, the meaning of wellness was highly expansive, as it would include all intellectual, interpersonal, emotional, spiritual, occupational, and social aspects of life. This positioning prompted the program to go further than the control of a disease and sought to enable the residents with the abilities to cope, to be resilient, and have continued development even through the context of chronic illness(3).

2. Program for Richmond Health and Wellness

Richmond Health and Wellness Program (RHWP) was designed as a transformational solution to the conditions of low-income and disabled elderly people in urban housing development, where the demands of aging people have generally surpassed models of care commoditized in conventional systems of care delivery. Later in 2012, the RHWP was envisioned as an academic-community collaboration within the context of Virginia Commonwealth University with the aim of reshaping the disjoint between clinical care and communal wellness by incorporating health services into the living settings of vulnerable groups. This direction was in realization of the fact that besides medical diagnosis health is mediated by much more health factors; it is also significantly affected by social factors including food security, access to transport, housing stability and chances of social integration. Incorporating a wellness and interprofessionalism-focused model of care into low-income housing communities, RHWP has developed a model that serves communities without competing with primary care but instead works to supplement the care provided(4). It is also innovative having collaborated with residents in co-creating services with the residents, having students across the various health professions participate in applied learning, and having the program priorities matching national initiatives that aim to decrease disparities in health outcomes.

The RHWP has the philosophy of resident-centered care that identifies people as specialists of their lives, emphasizes their values, preferences, and lived experiences reflecting on building services. Rather than offering

Volume 1, Issue 2 | November-2025
e-ISSN: 3068-5818 ISSN Print: 3068-580X

top-down solutions, the program was the outcome of the broadly informed input of residents themselves whose highest ranking needs include support to manage diabetes, blood pressure monitoring, and access to medications, transportation to medical visits, and mental health care. This co-creation process was formalized with quarterly resident council meetings, pre-prepared with town-hall type discussions, so that the design of services could change in conjunction with changing resident priorities. Such a practice did not only enhance trust and satisfaction among residents, but also created a feeling of shared ownership which has been vital to the sustainability of the program. Unlike the traditional models that are usually read in limited ways about dangerous diseases, the RHWP is all about relationships, empowerment, and functional objectives which are of utmost importance to residents.

Multi-dimensional assessment and access to care is another pillar of the RHWP model, and starts with a baseline geriatric assessment at the point of enrollment. Besides tracking the medical history and taking medication, this assessment would capture the cognitive status, functional capability, causes of risks of becoming depressed or frail, and characteristics around food insecurity(5). The process organized by the interprofessional students and led by the faculty provides a background of personalized care planning and prioritization. Notably, the residents have freedom to select the contained provisions in which they want to participate in, encouraging autonomy and flexibility. This method also gives capacity to the students as they get the first hand experience in the application of validated instruments, the preparation of person-centered care plans, and the realities of the community-based work of health. This unique connection between assessments and individualized interventions makes the program not only holistic but also feasible and applicable founded on the limits of the lives of residents.

One of the major contributions of RHWP consists in healthy promotion and prevention services that should help to solve current problems and promote future wellbeing. In contrast to the operation based on the hospital interventions with rather limited scope of considering mostly acute disorders, RHWP lays stress on review of medication, safe living, education of self-management, as well as counseling aimed at the prevention of the disease development or development of complications. To give one such instance, pharmacy students work with nurse practitioners to assist residents with complex medication regimens, solve side-effect obstacles, and overcome access pricing obstacles. Students of nursing and social work visit the homes to execute home visits and help determine safety risks, post hospitalization shifts, and enhance functional independence. Such services do not only decrease hospital readmission and emergency visits but also enhance the confidence of the residents to take charge of their lives. This manner of demonstrates that RHWP is the potentiality of instilling prevention and wellness into the daily settings as opposed to saving it up on clinical interactions.

Ideally similar, the RHWP clearly covers the effects of social determinants of health which have been estimated to be responsible in contributing to nearly 70 percent in health outcomes in communities such as Richmond. Many of the residents are city dwellers who stay in food deserts, have no consistent way of transport and fear losing their homes which hamper their potential to care more about their wellness. To address such obstacles, the program can enable access to hot meals, legalization of advanced directives, financial counseling, and community organized social activities that limit the feeling of isolation. Collaboration with the food banks, law clinics, and housing authorities expands the program even further and allows building a system of the support crew that would magnify the healthcare services. RHWP breaks the cycle of instability that plague low-income populations, especially in underserved communities by placing interventions directly in the community where residents live.

The focus on care coordination and home visits is one of the most influential aspects of RHWP that ensures a feeling of continuity and connectivity between the residents and the primary care providers. Such clinics that are held regularly in housing facilities bring forth valid clinical data (like blood pressure or glucose levels) that occupants of the housing can give to their providers(6). The faculty and students train those in the residential care on the best ways to communicate with their doctors to ensure that clinical issues are presented and solved. The clinical home visits also support hospital discharge strategies, make sure that medications have been reconciled and emerging health risks get detected at the earliest before turning into a crisis. Not only does this proactive model reduce potential missed visits and extra emergency visits, but it also reinforces how the residents are connected to one another, to the providers, and to the students, making a network created around accountability and support.

The key ingredient to the success of the RHWP has been its interprofessional care team (IPT), which has as of 2017 involved over 780 students in the fields of nursing, pharmacy, medicine, social work, dietetics, law, and allied health. Students have an opportunity to gain academic credit and service learning is incorporated into the curriculum, as well as, propelling them into the parallel population-based workforce. Formulated team

conferences, motivational interviewing, and the community immersion of the students teach students how the real life of health is like outside the barriers of hospitals. They also face food insecurity, transport disparities, social isolation, learning to complexly understand the influence non-medical factors have on health. Residents find that student presence brings with it intergenerational interaction, mental stimulation, and the perception that they are valued people and faculty members bring supervision and the continuity of treatment. Such an interaction is a reciprocally beneficial process: the residents get a comprehensive aspect of help and the students exercise necessary skills in teamwork, cultural humility, and community health(7).

The community partnerships have also contributed to the success of the RHWP since partners ensure that there is fewer overheads of undertaking similar services and that more resources are pooled. The program has been able to meet the needs of residents in as holistic manner as aligning with agencies around the community concerning local food banks, homeless agencies, legal aid, and area agencies on aging have enabled the program to realize its fullness. Instead of matching its objectives with other available services, RHWP integrates its objectives with the partners to offer transportation, money management skills, stable housing needs and legal safeguards. Such partnerships complement the scope of the services; they promote policy advocacy as well as giving such chances that foster long-term sustainability.

3.Care for Residents in Community Wellness Models

Introduction. The transformation toward patient-/resident-centered care has become one of the pillars of quality improvement, equity, and sustainability in a modern health policy reform. In opposition, abiding by the philosophy of resident-centeredness, the Richmond Health and Wellness Program (RHWP) does not pose resident-centeredness as an additional feature but an underlying philosophy that leads to every service, decision and interaction. The idea that primary care is excessively provider-oriented, such that the efficiency, throughput, and biomedical priorities are prioritized over individual experience and preferences of care recipients, is decades-old. The resident-based care, in its turn, redefines the relationships between the providers and communities diverging from the existing logic and understanding of provider-recipient relations as the recipients, residents are not considered passive consumers but active participants in the care delivery process in which their voices, values and goals are to be the determinant factors. This tenet is greatly entrenched in the RHWP and it has enabled the program to create a trust, better results and creation of sustainable and healthy promoting communities in low-income and disabled housing facilities.

3.1 Empowerment by Collaboration

The use of co-creation is one of the identifiable features of the resident-centered care in RHWP. Instead of enforcing a pre-defined series of interventions, the scheme opened with long talks with the residents in order to have a clear picture of their most significant needs and hopes. These discussions indicated priorities that remained pratical and highly individualistic- e.g, addressing diabetes issues, checking blood pressure, and accessibility to prescribed drugs, sources of transport availability to medical appointments, mental health, and overall wellbeing. To this end, the RHWP was able to design services according to these facets, which built a mutual association whereby the lives of residents informed program priorities. Resident councils quarterly, formalized this group structure and made sure that the program changes were driven by continuous feedback. The program not only increased the satisfaction level but also developed the sense of ownership since those who took part in it felt that they were invested in continuing the program. This empowerment comes in stark opposition to the orthodox health systems where the patients have been reduced to being the subjects of expertise in replacement of health creation partners.

3.2 Whole-person Issues in Health

The idea of resident-centered care also implies looking at the people as individuals and not considering their diseases. The reality of older adults in most clinical settings is often reduced to a diagnosis label, such as, a diabetic, a hypertensive or a heart failure patient. The RHWP actively negates this reductionism placement by placing the residents as complete individuals with identities, networks and dreams that are not all about being sick. The care teams are taught to discuss with residents functional goals, their personal meaning, and life satisfaction instead of only discussing laboratory values or medication regimen areas. The measure of success can be exemplified by a resident setting success as more than receiving control in blood pressure, but achieving the trade-off to engage in church programs or being able to cook meals with grandchildren. Such a shift in focus to functional or relational

Volume 1, Issue 2 | November-2025
e-ISSN: 3068-5818 ISSN Print: 3068-580X

goals, and respect, not only builds rapport, but also ensures that health interventions become more meaningful and encouraging, to residents themselves.

3.3 Promoting Healing with Relationships

The RHWP emphasizes that the development of the relationships between the residents and the providers is part of the healing process which results not only in medical procedures or prescription. Respect, empathy, and trust are the key elements of resident-centered care, as they eliminate stigma and judgment to which the marginalized populations are subjected in the more standard health care context. Lots of laypeople in need of low-income housing have the background of being neglected, discriminated, or split-cared, and that may lead to mistrust of the institutions. Locating uniform teams of students and faculty in housing facilities and through a constant yet visible presence through weekly clinics, the RHWP created long-term relationships that solidified continuity. People were no longer made to feel as a cold number flowing into and out of insane health systems; rather, they received individual care on the part of people who knew their past experiences, surroundings, and issues. This level of relationship proved to be paramount not only in enhaging effectiveness in following medical recommendations but also resilience, motivation, and psychological wellbeing(8).

3.4 Team-Based Care: a Priority of Residents

The second aspect of the resident-focused care philosophy that RHWP follows is team-based care that residents have pointed out as a necessity in an understaffed environment. Contrary to the fragmented systems in which specialists, pharmacists, social workers and nurses work in isolation, the RHWP formed an interprofessional team (IPT) that can comprehensively tackle medical, social, and emotional needs in an integrated format. The nurses in residence strongly demonstrated a preference towards this nursing-led, interprofessional alternative, and identified its capability to offer comprehensive services, through a single umbrella. Integrating nursing with a health promotion/prevention focus and the technical skills of pharmacists, social workers, and allied health professionals in a single program program targeted various areas of wellness largely into practice. Correspondence of the resident preference to the team-based service provision exemplifies the very spirit of the resident-centered care the creation of systems based on what is important to people, and not what is important to institutional arrangements or on professional hierarchies.

3.5 Cultural/linguistic Awareness

One of the least noticed yet very important elements of resident-centered care is cultural, educational, and lingual differences-resistant communication. A large portion of RHWP residents lacked formal education, and close to one third did not finish high school; additionally, literacy is known to be a barrier to accessing healthcare information. In light of this, students and faculty were educated in applying functional, plain-language communication that was based on the vocabulary/worldview of the residents. As one example, teams did not refer to clinical terms such as glycemic control but instead talked about sustaining energy levels or avoiding future eyewear and movement complications. Communication those health messages in terms that were easier to understand and terms that were resident-focused instead of those that intimidated the residents, providers minimized the chances of intimidating such residents or defusing any desire by the residents to participate actively in their care. This practice can be seen as a part of a bigger cultural humility ethic where practitioners should first listen, modify language and interventions to the social and cultural context of a resident(9).

3.6 Beyond Population: To Personal Care

Although its goal was to reach the collectives of the population in lower-income housing, RHWP did not lose track of the individual in the population. The interprofessional team was required to not only monitor overall trends in community needs, but to respond to each individual resident as a unique story through resident-centered care. Indicatively, even though the fact that residents manage diabetes turned out to be a shared issue, the approaches to organization of managing it were strikingly different some residents needed assistance in paying for insulin, others needed assistance in being educated on how to use glucometers and others needed assistance in identifying safe areas where it was possible to exercise. The program did not use one-size-fits-all solutions and matched interventions with functional realities of the lives of in habitants residents. This flexibility pointed to responsiveness of the model, which was flexible to different and dynamic requirements of the same community.

3.7 Consequences of the Resident-Centered Care

The benefits of a resident-oriented approach to care have an effect beyond the housing facilities that RHWP directly serves. On a systems level, this model illustrates how community voices can be included and increase resource efficiencies, reduce duplication of services and improve efficiencies. When it is the residents speaking,

programs can be targeted to apply intervention accurately, removing unnecessary wastage and directing resources to what really counts. Individually, resident-centered care can foster dignity, autonomy, and resilience, all of which are as clinically valuable as blood pressure or hemoglobin A1c. Furthermore, the mechanism of the sustained communication between residents and providers creates higher social cohesion and the sense of collective power, which disseminate the feeling of wellness as citizens and community project rather than a personal responsibility.

4.Conclusion

Richmond Health and Wellness Program (RHWP) is a shinning testament to the fact that healthcare is not just about the hospital, clinic or the physician office, it is also about the people who live in those communities and grow old and develop their lives daily. As the handicap of chronic illness, disability, and social injustice only increase throughout the United States, the RHWP offers a schema of re-imagining how care can be provided in a sustainable and innovative scheme. Its model reflects that experiences using community settings where health and wellness are integrated, particularly those working in low-income residential complexes, where there is the most vulnerability, show health outcomes improve, costs decrease, and trust between the provider and residences increase. The end of the program is not just a recount of the successes of the program, but also an appeal to review the way health systems and academic organizations and communities can integrate so all have access, equitable opportunities and comprehensive wellness opportunities.

The central concept of this model is the realization that primary care could not possibly sustain the burden of the modern needs of healthcare on its own. Time pressures and resource constraints on the frontline are extreme and in many cases, physicians, nurse practitioners, and other frontline providers can barely manage all the medical, social, and emotional needs that are presented by vulnerable populations. The RHWP reduces these pressures by substituting instead of augmenting primary care; it stretches primary care to meet these demands with the preventive and health promotion service and social determinant interventions integrations. This transference of responsibility enables the primary care providers to concentrate on diagnosing and treating without neglecting residential and holistic care to residents. The viability of this mutually beneficial relationship is indicative of a paradigm change in the direction of healthcare paradigms where commonality is defined as a multi-disciplinary and multi-setting interdependence.

The RHWP also demonstrates how interprofessional education and service learning can transform. The program, through the immersion of students in nursing, pharmacy, social work, medicine, law, and allied health, directly in housing communities, introduces a generation of clinically competent graduates sensitive to the realities of social and cultural inequities and inequities and community health needs. Students get an understanding to look beyond laboratory outcomes and medical reports and getting a broader understanding of human and environmental factors influencing health outcomes. Such a dual investment of enhancing the wellness of the residents, as well as training the future professionals, sets in motion an upward spiral of constantly renewed knowledge, empathy, and innovation.

It is also paramount that the program upheld the principle of resident-centeredness which has become the key to its sustainability. Through valuing residents as collaborators instead of service recipients, the RHWP has established rapport, a sense of ownership and relevancy and viability of the services provided. The priorities set by residents in the areas of managing diabetes, access to medication, transport, and mental health support were given voice, whereas quarterly councils established the effective influence of residents in the development of the program. Such participatory framework not only contributes to increased satisfaction but also makes the interventions to meet the real needs of the world, thereby ensuring maximum utilization and minimum wastage. By so doing, the RHWP highlights one of the truisms that many ignore in healthcare reform, namely, a community-based approach to solutions is, in the long run, far more rewarding than one devised for a community.

Health outcomes are another aspect that confirms the significance of the program. Plots on pilot studies show a decrease in emergency room visits, decreased hospitalizations, and better communication between the residents and primary care providers. These findings verify that the high cost of crisis-driven care can be balanced by prevention-oriented and community based services. When used in tandem with robust collaborations between universities, insurers, housing administrators and community agencies, the RHWP has not only worked, but also been financially optimal. The fact that it is pursuing per-member-per-month contracts with insurers is an illustration of successful integration of wellness-based models into the existing payment systems, making a case that a similar replication of a program should happen here in the country, as well.

Volume 1, Issue 2 | November-2025
e-ISSN: 3068-5818 ISSN Print: 3068-580X

The RHWP has transformed the definition of health and wellness besides its clinical and financial performance. The program adopted a multidimensional approach to wellness that recognizes the need to eschew the concept of care being limited to absence of disease through adoption of the holistic vision of health as envisaged by the World Health Organization and National Wellness Institute. Wellness was also associated with empowerment, the ability to connect with others socially and resilience and the ability to live harmoniously as long as health issues persist. Such conceptualization on the large scale enabled the RHWP to incorporate a wide variety of services, such as communal meals, legal services, financial assistance, and social activities, into its model exhibiting that health cannot be discussed outside of the circumstances under which individuals live and possibilities they have.

To sum up, the model of the Richmond Health and Wellness Program is innovative, replicable, and scalable in terms of providing the complement to primary care in the form of community-based wellness programs. It notes the strength of resident-centered interaction, interprofessional action, and social determinant treatment in producing healthier communities. What is more crucial, it confirms that health system should go outside the walls of clinical realm and actually do something about inequities and enhance the quality of life. Bringing care into the places where people live, listening to their voices and matching the services with the needs, the RHWP has metamorphosed the dominos system of delivery of healthcare to a proactive, holistic and sustainable system. Its legacy is not just in the lives that it has made better in the housing facilities within Richmond but it can be seen as the blueprint to be used by communities around the country to help bring health and wellness into communities across the country as a daily rather than the elusive ideal known to many Americans.

Acknowledgement: Nil

Conflicts of interest

The authors have no conflicts of interest to declare

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