PCHC
PROVIDENCE COMMUNITY
HEALTH CENTERS

Providence Community Health Centers

Building Team Capacity

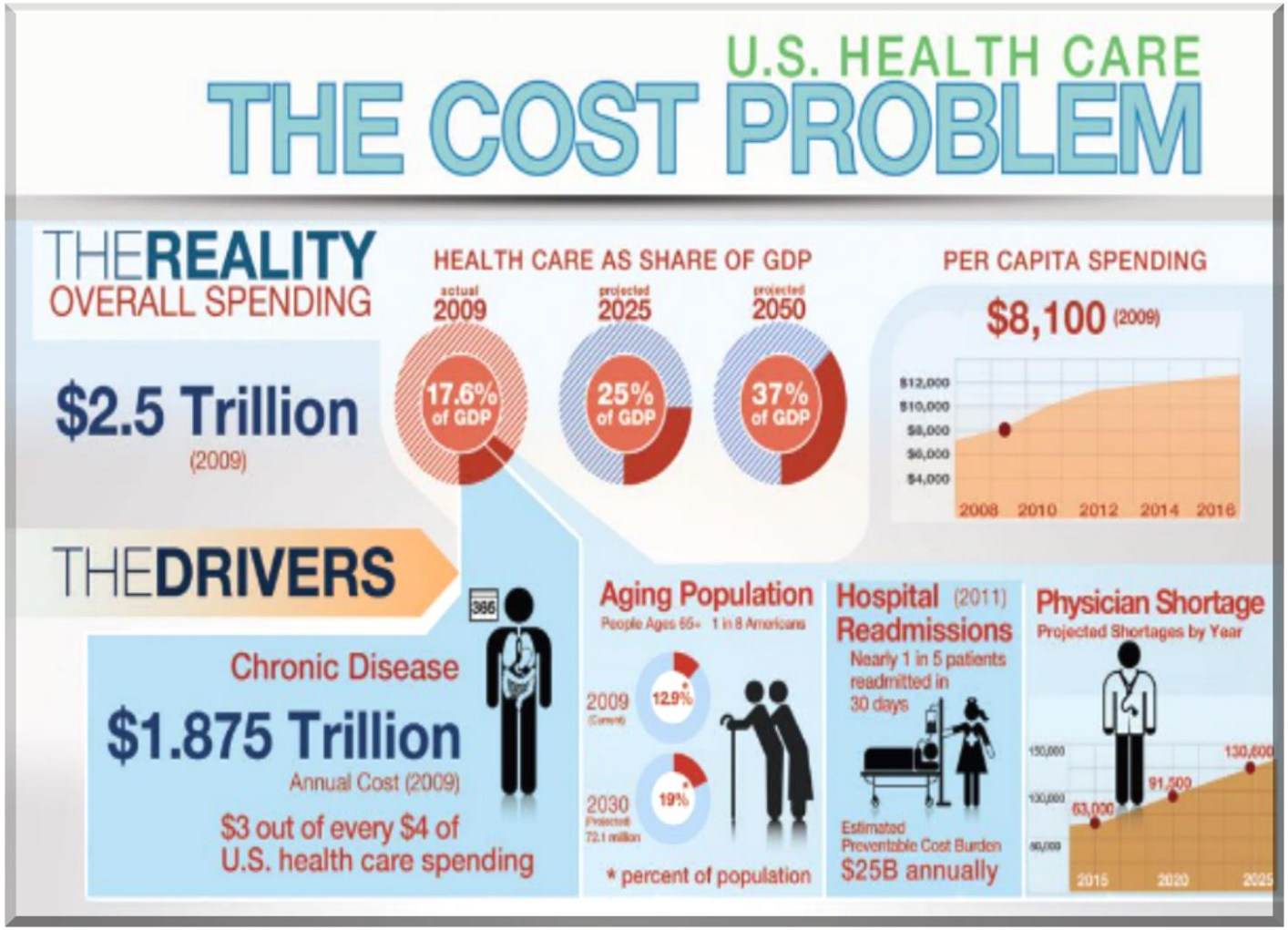
Utilizing Provider/RN Co-Visits

Wendy A. Chicoine, MSN, RN

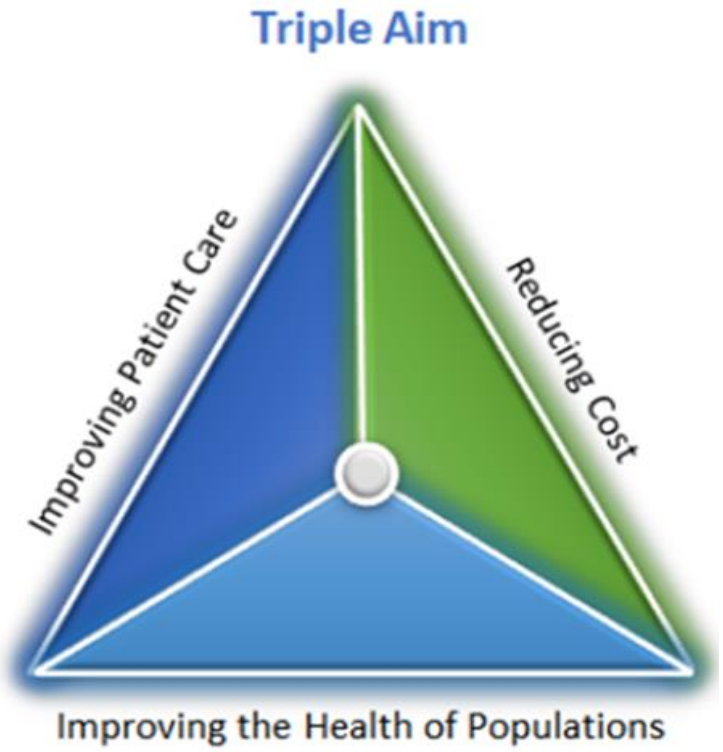
Objectives

- Describe the challenges in health care and primary care
- Review Providence Community Health Centers' response
- Describe the Provider/RN Co-Visit Model as a method of increasing access to care
- Discuss the care team's role in the Co-visit model
- Review program implementation process

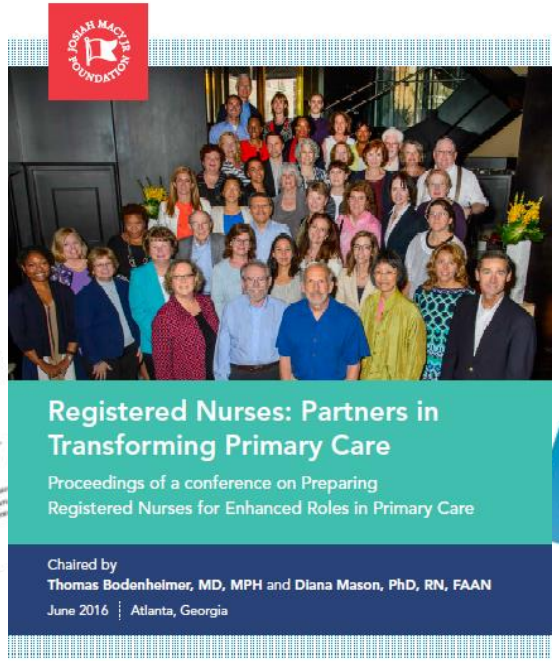
The Health Care Challenge

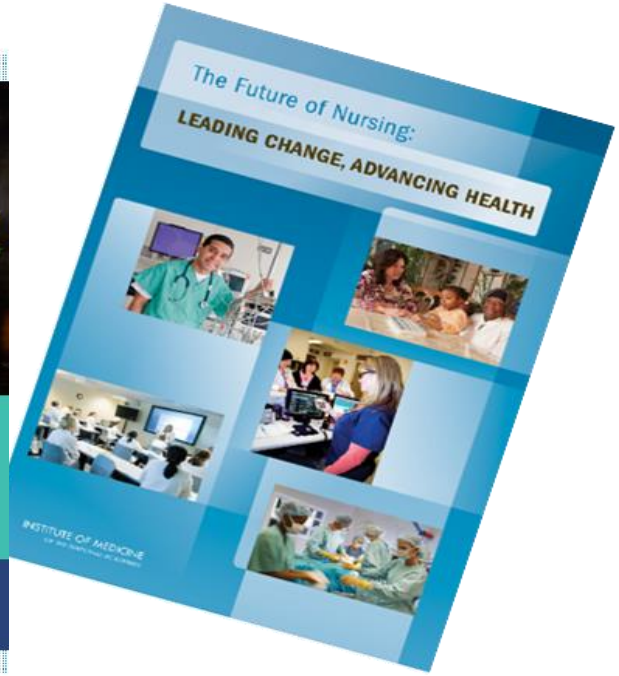


The Health Care Challenge



The Health Care Challenge: Responses





Providence Community Health Centers' Response

Care Visioning Team:

MDs, NPs, RNs, MAs, etc.

- Infrastructure needs
- Strategic pathway
- Vision/Value statement
- *All staff training day
- **Learning collaborative

FROM 2016		TO 2018
• Reactive, provider driven, inconsistent • Patients confused regarding plan of care • Patients confused regarding appointment process/flow	PATIENT ROLE IN CARE PLANNING	• Collaboration between patient and care team to develop care plan • Patient understands care plan
• Roles are not clearly defined • Limited access to extended care team • Lack of consistent communication among care team members • Variable work flows	CARE TEAMS	• Clearly defined roles • Responsibilities aligned with credentials • Direct and meaningful communication • Team care is a PCHC priority and supported
• Decision making is top-down and concentrated • Poor communication and lack of transparency • Clinical silos and structural barriers prevent real dialog/input	CLINICAL LEADERSHIP	• Centrally supported, site-based clinical leadership • Include frontline staff in setting clinical agenda • Invest in and trust our personnel
• Predominantly face-to-face office visits with providers • Limited flexibility once schedule is full • Work to keep patients out	MODES OF CARE DELIVERY	• Warm and welcoming first impression • Increase alternative visit types with extended care team • Advanced utilization of technology • Get to "Yes" - creatively meet today's demand
• Inconsistent • Patient readiness to change not regularly assessed • Limited support and contact once patient leaves the office	SUPPORTING PATIENTS IN DEVELOPING HEALTHY BEHAVIORS	• Develop pathways to assess patient readiness to change • Collaborate with patient on goal setting • Utilize health center and community resources to help patients • Structured follow-up capitalizing on technology
• Organization not educated about concept • Team members not involved • Lack communication • No access to real time data	POPULATION HEALTH MANAGEMENT	• Proactive outreach supported by advanced technology • Real time data accessible to teams • Assessment of social determinants and linkage to resources

Providence Community Health Centers' Response

*All Staff Training Day
  - February 2017
  - May 2018

Provider/RN Co-Visit Model

Implicit Bias, Institutional Racism & Health

Happy Patients Heal Faster

Building the Foundation of Successful Teams

Preparing for Change: MI

Social Styles in the Workplace

Culture of Health Workshop

Providence Community Health Centers' Response

**Learning Collaborative : An interdisciplinary team approach to solving problems

- Goal: Establish a standard of care for Providence Community Health Centers to:
  - Improve patient health outcomes
  - Improve patient access
  - Enhance the roles of our care team members

- Team building exercises
- Mind mapping
- Designing and innovation principles
- Education r/t disease processes
- Motivational interviewing
- Social determinants of health

- Outcome:
  - Reestablished an alternative visit type (Provider/RN Co-visit)

Providence Community Health Centers' Response

- Learning Collaborative Outcome:
  - Provider/RN Co-Visit Model for diabetes and hypertension
    - Previously developed model at PCHC
    - Redesigned model and adopted elements of Clinica Family Health's Co-Visit model (Funk & Davis, 2015)

Provider/RN Co-Visit Model
Care Team Roles

- What is a Provider/RN Co-Visit?
  - A patient visit in which elements of the visit are shared among the care team members

    - RN/HCA: Chief complaint, vital signs
    - RN: HPI, ROS
    - RN/HCA: POCT
    - RN: Verbal report to provider w/ patient
    - RN: Scribe for provider (optional)
    - RN: Patient education and plan of care
    - MD/NP: PE, Diagnosis, Orders

Provider/RN Co-Visit Model

- PCHC Provider/RN Co-Visit Types:

- ***Chronic***
  - Diabetes and Hypertension

- ***Acute***
  - Dysuria 13+
  - STI Screening for Males 18+
  - Sore Throat and Upper Respiratory Infections 13+

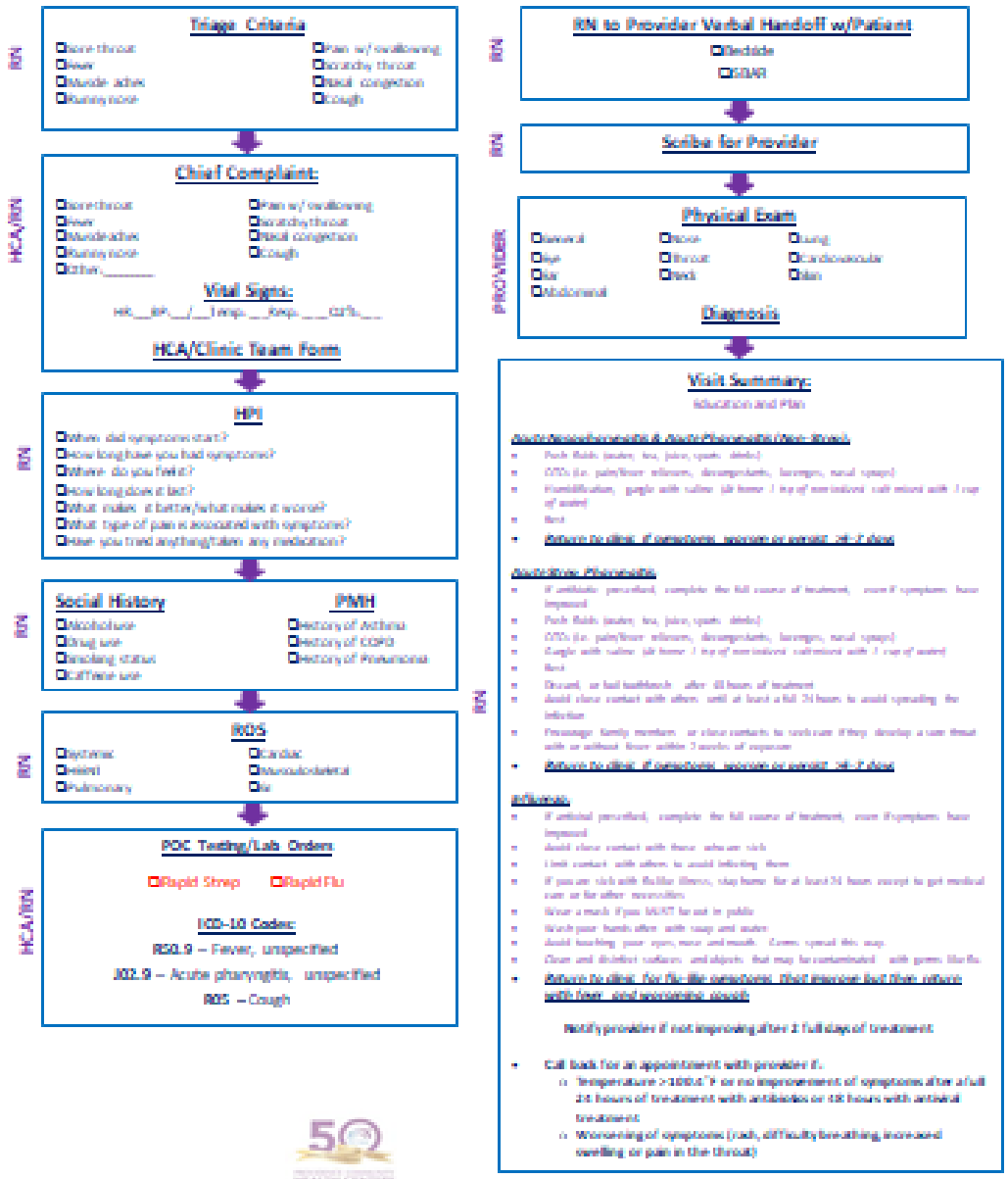
Provider/RN Co-Visit Model Implementation

- Pilot model at PCHC's Express Clinic
  - Presented model and results at All Staff Training Day, May 2018
- Perform needs assessments (i.e. education, resources, barriers)
- Provide education to RN staff
  - Completing a health history
  - Review of systems
  - Verbal hand-off (SBAR)
  - Delegation
- Identify first cohort

Provider/RN Co-Visit Model Implementation

- Resource development
  - Policies and procedures
  - Standing orders
  - Provider/RN Co-Visit workflow
  - Scheduling guidance
  - Patient educational material
  - Visit summary
  - PDSA forms
- Comprehensive training sessions with first cohort (Providers, RNs, MAs)
  - July, August, September

PCHC Provider/RN Co-Visit – Acute Sore Throat/URI 13+



Provider/RN Co-Visit Model Evaluation

- Evaluation
  - Reporting
    - Encounter report
  - Site check-ins
  - PDSAs
- Team feedback

Provider/RN Co-Visit Model
PDSA Template

Dysuria Co-Visit

PDSA WORKSHEET

Team Name:	Date of test:	Test Completion Date:

Project aim: Implement Dysuria Provider/RN Co-Visit to:

- Enhancing the roles of the care team members
- Improve patient access by utilizing all members of the care team
- Ensuring patients leave with a plan of care

Data Collection:

Identify patients on the providers' schedule who fit the Co-Visit criteria
Make a huddle note: "Dysuria Co-Visit"
Change the encounter type if a Dysuria Co-Visit occurs
Note on Worksheet:

- # of Co-Visit Opportunities
- # of Co-Visits Performed

Report Weekly

Day	Co-Visit Opportunity	Co-Visit Performed	Notes:
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			

PLAN:
What does my team want to accomplish *(e.g. perform 1 co-visit per day)*?
What steps did you take to achieve the goal?

DO:
Test the workflow and document above.
Make notes of observations.
What went well? What didn't?

STUDY:
Were the results as you had expected?
Were there lessons you learned about how this change was implemented?

Act:
Adopt/Adapt

STEPS Forward | Presented by the American Medical Association. (n.d.). Retrieved March 18, 2017, from https://www.ama-assn
Savage, C. L., Kash, J. E., & Grevers, S. L. (2016). *Public health nurse and nursing practice: Caring for populations*. Philadelphia: F.A. Davis Company

Provider/RN Co-Visit Model

- Why a Co-Visit Model?
  - Change in health care requires a team-based care model in which all members of the care team are utilized to their fullest scope of practice.
    - Allows for continuity of care
    - Improves patient access
    - Decreases ED utilization
    - Increased staff satisfaction
    - ***Increased Patient Satisfaction***

(Funk & Davis, 2015)

	TO 2018
PATIENT ROLE IN CARE PLANNING	• Collaboration between patient and care team to develop care plan • Patient understands care plan
CARE TEAMS	• Clearly defined roles • Responsibilities aligned with credentials • Direct and meaningful communication • Team care is a PCHC priority and supported
CLINICAL LEADERSHIP	• Centrally supported, site-based clinical leadership • Include frontline staff in setting clinical agenda • Invest in and trust our personnel
MODES OF CARE DELIVERY	• Warm and welcoming first impression • Increase alternative visit types with extended care team • Advanced utilization of technology • Get to "Yes" - creatively meet today's demand
SUPPORTING PATIENTS IN DEVELOPING HEALTHY BEHAVIORS	• Develop pathways to assess patient readiness to change • Collaborate with patient on goal setting • Utilize health center and community resources to help patients • Structured follow-up capitalizing on technology
POPULATION HEALTH MANAGEMENT	• Proactive outreach supported by advanced technology • Real time data accessible to teams • Assessment of social determinants and linkage to resources

Thank you!!

References

- Bodenheimer, T., & Mason, D. (2016). Registered nurses: Partners in transforming primary care. Josiah Macys Jr. Foundation. Retrieved from http://macyfoundation.org/docs/macy_pubs/Macy_Monograph_Nurses_2016_webPDF.pdf

- Funk, K. A., & Davis, M. (2015). Enhancing the role of the nurse in primary care: The RN “co-visit” model. Journal of General Internal Medicine, 30(12): 1871–1873. Published online 2015 Jul 21. doi: 10.1007/s11606-015-3456-6

- Institute of Medicine (U.S.). 2001. Crossing the quality chasm: a new health system for the 21st century. Washington, D.C.: National Academy Press.

- Institute of Medicine. (2010). The future of nursing: Leading change, advancing health. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK209880/