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 reality: overall spending
$2.5 Trillion
(2009)

Health care as share of GDP
17.6% of GDP
25% of GDP
37% of GDP

Per capita spending
$8,100 (2009)

The drivers:
Chronic Disease
$1.875 Trillion
Annual Cost (2009)

Aging Population
People Ages 65+ 1 in 8 Americans

Hospital Readmissions
Nearly 1 in 5 patients readmitted in 30 days

Physician Shortage
Projected Shortages by Year

$3 out of every $4 of U.S. health care spending
The Health Care Challenge

**Triple Aim**
- Improving Patient Care
- Reducing Cost
- Improving the Health of Populations

**The Missing Aim**
- Better Outcomes
- Improved Clinician Experience
- Lower Costs
- Improved Patient Experience
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

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<thead>
<tr>
<th>FROM 2016</th>
<th>TO 2018</th>
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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
Culture of Health Workshop
Social Styles in the Workplace
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
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

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<th>Day</th>
<th>Co-Visit Opportunity</th>
<th>Co-Visit Performed</th>
<th>Notes:</th>
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### PDSA Worksheet

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**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

#### 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

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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)*
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