Collaborative Care Nurses

Partners in Chronic Disease Management

Why pursue this concept in chronic disease management?

- Supply and Demand mismatch is growing.
- Aging workforce and aging population.
- In 2016 there will be more providers including associate provders leaving primary care than entering
- By 2025 estimates are anywhere from 45 to 52,000 primary care physicians short

Crisis vs Opportunity

- In 2011 a study suggested that if 75% of work is delegated than maybe a pcp could handle a panel of 1975 patients.
- These forces have given us a unique opportunity to evaluate and change the way we deliver primary care.
- Nurse's are the largest healthcare workforce- historically under utilized in the Ambulatory Care setting.

Redesign

- We have embarked on a change of care culture toward team-based care.
- Phase 1:
  - Creating the team environment and subsequently, teamlets.
  - Education of the Collaborative Care Nurse
- Phase 2 was the deployment of the Collaborative Care Nurse.

Top of License

- In this new model, with the growing demand for primary care, every member of the team must work to the top of their license not just providers.
- That means critical evaluation of each role on the team to make sure that tasks are aligned with clinical license.

Collaborative Care Model - Primary Care Provider (PCP) - led, team-based, collaborative care

Cheshire Medical Center
Dartmouth-Hitchcock Keene

PCP (MD/DO/Nurse Practitioner)

Diagnose. Prescribe medications. Development and oversight of your treatment plan. Directs your care.

Associate Providers

(Physician Assistants and Nurse Practitioners) Diagnose. Prescribe treatment/medications. Works closely with your PCP to ensure that your current treatment plans are being followed.

Collaborative Care Nurse

Works closely with your PCP to help manage stable chronic disease (diabetes, high blood pressure, COPD). Provides education and health coaching.

RN Care Coordinator

Helps facilitate your transitions of care from hospital to home or nursing home. Works closely with complex patients requiring support services. Follows up with you after an ER visit to ensure that you have appropriate follow-up care in place.

Team Phone Nurses

Helps triage and provides advice for your medical concerns/needs. Communicates directly with your provider.

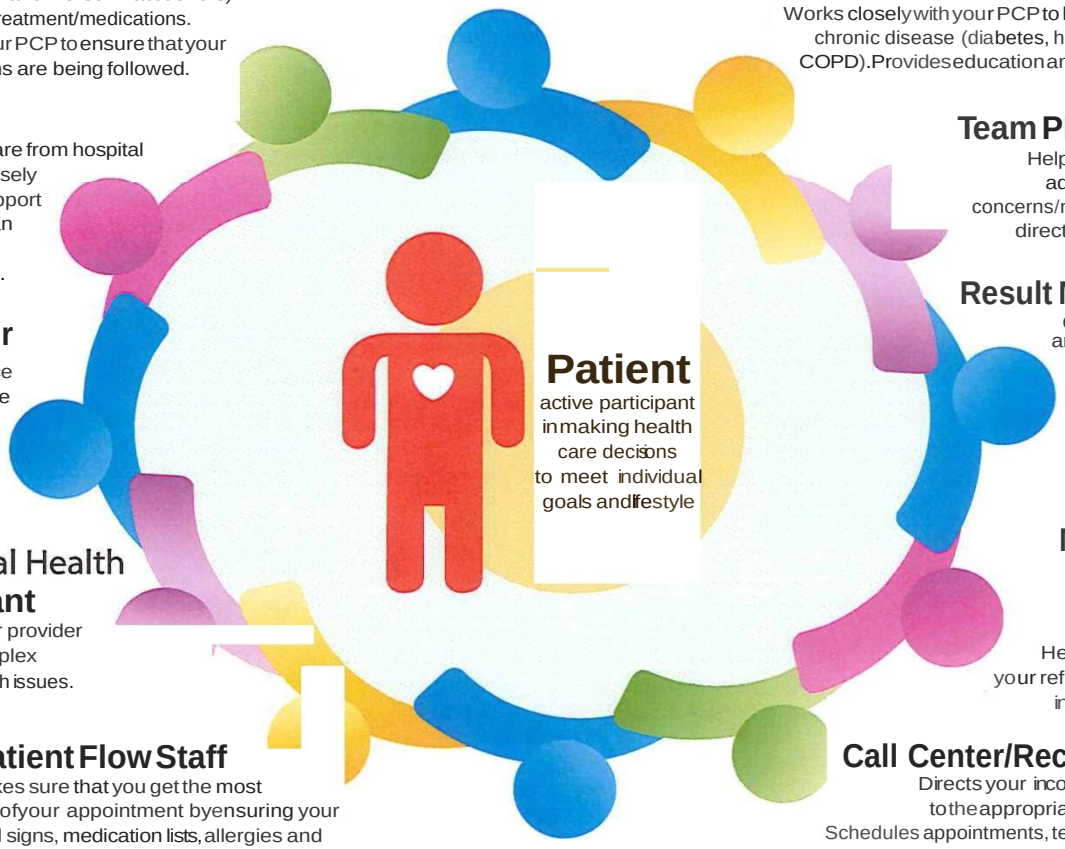
Registry Coordinator

Reaches out to you between office visits to ensure you are up-to-date with chronic and preventative guidelines (eg. mammograms, immunizations, high blood pressure management, etc.)

Result Management Nurse

Contacts you about test results and provider recommendations.

Communicates directly with your provider to help answer your questions about test results and arranges the appropriate follow-up care.



Behavioral Health Consultant

Works with your provider to manage complex behavioral health issues.

Medication Renewal Manager

Helps to ensure that your refills are completed in a timely fashion.

Patient Flow Staff

Makes sure that you get the most out of your appointment by ensuring your vital signs, medication lists, allergies and immunizations are up-to-date.

Call Center/Receptionists

Directs your incoming phone calls to the appropriate staff member. Schedules appointments, tests and consults.

Forms Manager

Helps to complete, track, and scan your paperwork into your medical record. Ensures that your paperwork is done in a timely manner. Works with pharmacist to obtain Prior Authorizations so that your prescriptions are covered by your insurance plan.

Example: PCP

adapted from Health Care Advisory Board:Care Transformation Center; 12 Lessons on Transforming Primary Care

Typical Primary Care Office

- Spends majority of visit addressing acute ailments
- Provides chronic care management in minutes after acute issues are addressed with little standardization across patients
- Often many opportunities for interventional and well-care are missed in this setting

New Medical Home Concept

- Patients are proactively scheduled for chronic care provider appointments
- Uses chronic care guidelines which provide a framework for consistency across patients and lead to best practice and better delegation to other team members

Example: Clinic RN

adapted from Health Care Advisory Board:Care Transformation Center; 12 Lessons on Transforming Primary Care

Typical Primary Care Office

- Like providers, spends vast majority of time on acute ailments in the form of walk-in care or triage on the phone.
- Takes incoming patient calls concerning medication and lab results.

New Medical home Concept

- Prioritizes time for patient follow up
- Proactively reaches out to patients to encourage self-management
- Provider or patient can schedule time with RN for one-on-one education
- Utilizes care protocols to improve chronic disease outcome measures.

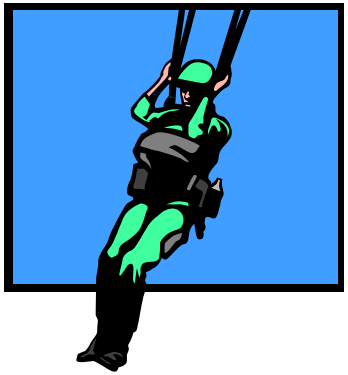
Challenges

- As the care team expands we must maintain clear role definiton to avoid resource depletion, duplication of work and team burnout.
- Managing resources to allow our Collaborative Care Nurse’s timely continuing education to foster growth in the role.

Phase I: Training of the Collaborative Care Nurses

- Began in mid-May 2014.
- Focused on Diabetes, HTN and COPD, Advanced Care Planning, and, Annual Wellness Visits.
- Met with providers from primary care and specialty as well as ancillary services like dietary and pulmonary rehab around these entities.
- They have learned technical skills such as glucometer teaching, insulin initiation and spirometry.
- Had educational opportunities for motivational interviewing.
- Have ongoing plan for continued education in these arenas, with a special emphasis on Diabetes.

Phase 2: Training/Deployment of Collaborative Care Nurses



- Mid-July 2014:
  - Care Coordinators identified patients requiring COPD Action Plans and included their Teams' Collaborative Care Nurses in the visit.
  - Collaborative Care Nurses began shadowing in the Nurse Clinic and were introduced to various visit types to familiarize themselves with the anatomy of a Nurse Visit.
  - EMR templates were created and Collaborative Care Nurses attended training on their use, as well as Version 11 note training.
- Early August 2014:
  - Collaborative Care Nurses began to perform visits in the Nurse Clinic on their own to help them put it all together (e.g., Assessment, Teaching, Documentation and Charging).
- Late August 2014:
  - Collaborative Care Nurse schedules were built in our scheduling system.
  - Receptionists were directed to book BP follow-ups with the Team's Collaborative Care Nurse.
  - Added Collaborative Care Nurse to our follow-up options for future care.

Collaborative Care Nurse Education Checklist

PROVIDER-BASED

- **COPD - Andy Tremblay MD**
  - **Completion of the slide deck from GOLD**
  - **Review of COPD Action Plans**
- **HTN – Don Mazanowski MD**
  - **Completion of slide deck from AHA**
  - **Review of current campus-wide HTN workflow**
- **Diabetes –Emily Presnall APRN and Eileen Duffy RN, CDE**
  - **Review of Diabetic Education and Insulin-start protocol.**
  - **Pharmacology review**
- **Motivational Interviewing –Tom Stearns PhD**

Nurse Care Review

- **COPD – Mary Ann Riley RT, Kate McNally, and, Staff from Family Medicine Team D**
  - **Spirometry**
  - **Inhaler Technique Review**
  - **CAT Review (also part of provider review)**
  - **Smoking Cessation (5 A's: Ask, Assess, Advise, Assist, Arrange)**
  - **Pulmonary Rehab**
  - **Medicare/Insurance Oxygen guidelines**
- **HTN – Nurse Clinic**
  - **Review of current campus-wide HTN workflow**
- **DM – Eileen Duffy RN, CDE**
  - **Glucometer teaching**
  - **Insulin administration teaching**

EMR/Documentation- Clinical Informatics staff

- **Create EMR Templates for use for Documentation**

So What Can they Do?

Hypertension

- All Blood Pressure follow ups you would normally send to the Nurse Clinic.

COPD

- Spirometry
- Update Immunizations
- COPD Action Plans
- Inhaler Use Teaching
- Symptom Monitoring

Diabetes

- Glucometer teaching.
- Diabetic Education on new and established Diabetic patients
- New Insulin starts.
- Medication Adjustment per protocols

Annual Wellness Visits

Sample Care Guide

COLLABORATIVE CARE NURSE COPD VISIT GUIDELINE

MEDICATION REVIEW

- Review Medications
  Refills?
- Review Allergies
- Assess inhaler technique
- Is the patient on oxygen?
  Last amb. O2 sat?

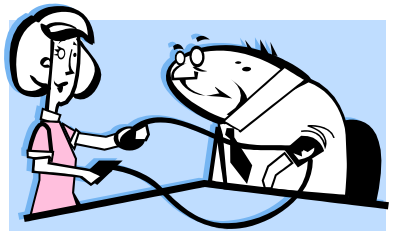
Metric Review

- Spirometry within last year? If not obtain and chart.
- Pneumovax completed? If not administer. (see flow chart)
- Annual Flu Vaccine given? If not administer.
- Smoking? Update status in EMR. If smoking in office counseling and suggest referral to tobacco cessation program. If pt accepts, make referral.
- Make referral to Pulm Rehab. They will then contact patient to further assess

COPD ASSESSMENT

- Any Recent Hospital stays related to COPD?
- Any ER visits for COPD related illness?
- Is there a COPD Action Plan?
- Was it recently activated? If so have meds been refilled?
- COPD Assessment Test (CAT) given, scored, documented in note and sent for scanning
- Are they using rescue inhalers more?
- Note to PCP for review

Collaborative Care HTN Guideline

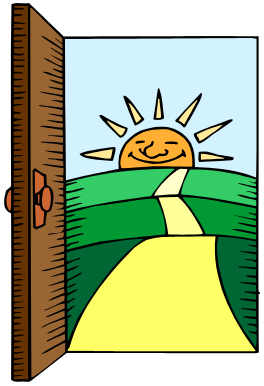


- **Medication Review**
  - Review medications/Allergies Taking as prescribed?
  - Refills needed?
  - Review home B/P readings - in control
- **Metric Review**
  - Yearly BMP/ CMP if on any cholesterol meds or ACE/ARB/Diuretics
  - Blood Pressure each visit
  - Assess Smoking status in Social History - if a smoker offer and document cessation counseling
  - Annual flu vaccine given? If not, offer/administer seasonally.
  - Pneumovax completed? If not, offer/administer per guidelines.
- **HTN Assessment**
  - Any side effects of meds?
  - Cough, fluid retention
  - Review lifestyle influences –
    - Weight
    - Exercise
    - ETOH
    - Stress management
    - Diet
    - Handouts - DASH diet, HTN pamphlet and B/P card

How do you access them?

Preferred

- Warm Hand-Off
- Face-to-Face Introduction



Other Options

- Utilize the Collaborative Care Nurse for follow-up appointments
- Send a task to your Collaborative Care Nurse

How do you access them?

What is a Collaborative Care Nurse?

A Collaborative Care Nurse is a Registered Nurse (RN) who helps with the care of patients with chronic disease.

Each Collaborative Care Nurse is directly associated with, at most, three providers. They work closely with your primary care provider (PCP) to help manage stable chronic disease, and assist with implementing the care plan that has been laid out by your PCP. Most often, this is accomplished by focusing on education and health coaching, but, it can also include making sure you have received all of the appropriate labs or tests for your condition. They also monitor other preventive health care screenings you may need based on your age, family history and health, for example: a mammogram or colon cancer screening. In addition, Collaborative Care Nurse's perform Medicare Annual Wellness visits.

Your Collaborative Care Nurse is:

_____

Your next appointment is:

Day _____ Date _____ Time _____

Lab Appointment:

Day _____ Date _____ Time _____

If unable to keep this appointment, please give **24 hours notice** by calling **603-354-5400** so we may offer that time to another patient.

Cheshire Medical Center
Dartmouth-Hitchcock Keene
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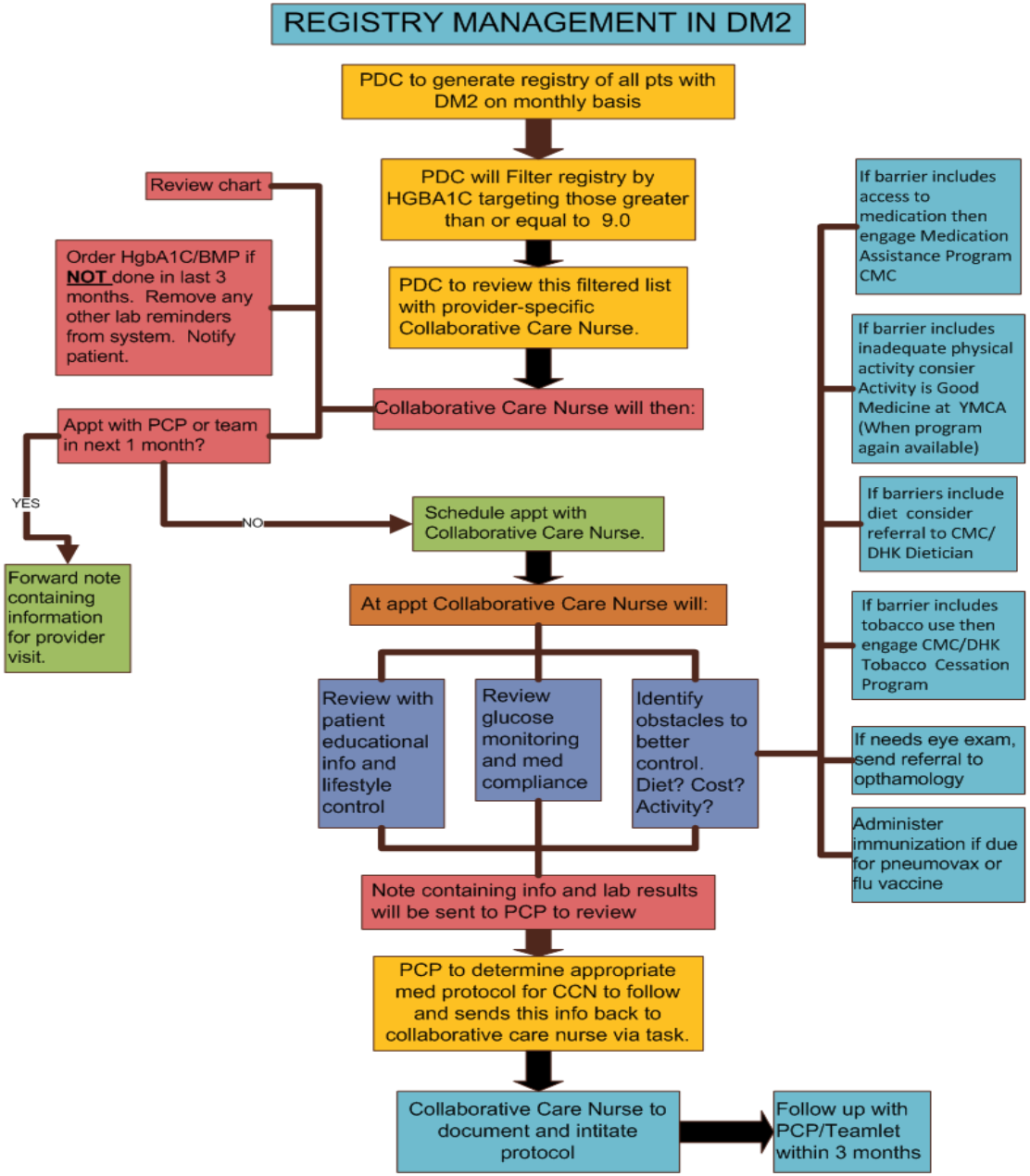
Our What's Next List as of 10/2014

- Focus on Diabetes and Health Coaching education
  - Actively seeking Continuing Education Opportunities/Conferences for the Collaborative Care Nurses to attend.
  - Collaborate with Dietician to align practice/patient education.
  - Collaborate with our Clinical Pharmacist to create medication protocols for Diabetes and HTN management.

Example of Integration of Collaborative Care Role With Patient Data Coordinators, Patients and PCPS



Sample of Medication Titration Protocol

Metformin (Glucophage) – Biguanide (SHORT ACTING) PREFER TO START EXTENDED RELEASE- SEE ER PROTOCOL

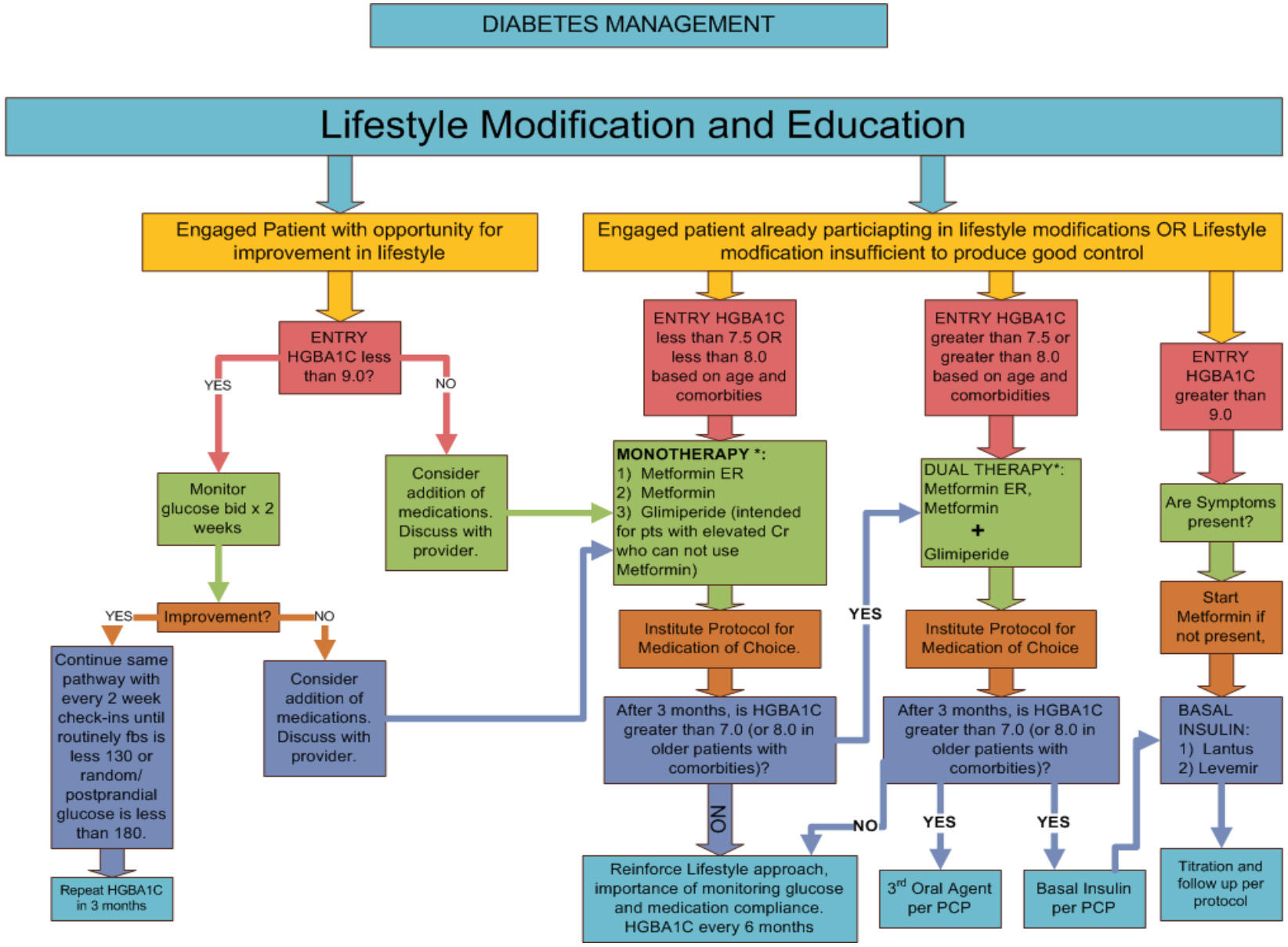
Medication titration:	
Time 0—APC or PCP Start	**Metformin 500mg (500mg in the morning, taken with food)**
Week 1	**Confirm medication adherence, review for exclusion criteria and side effects. If none, increase dose to:** **Metformin 1000mg (500mg in the morning and 500mg in the evening, taken with food)**
Week 2	**Confirm medication adherence, review for exclusion criteria and side effects. If none, increase dose to:** **Metformin 1500mg (1000mg in the morning and 500mg in the evening, taken with food)**
Week 3	**Confirm medication adherence, review for exclusion criteria and side effects. If none, increase dose to:** **Metformin 2000mg (1000mg in the morning and 1000mg in the evening, taken with food) - maximum effective dose**
Outcome monitoring: **Metformin 2000mg reached or maximum tolerated dose**	**Order A1c in next 3 months**

RN 2nd level check of exclusion criteria (at each dose increase) Review for: **-Creatinine levels in the last 12 months** **Contraindicated in renal disease** **SCr> 1.4 for females and SCr> 1.5 for males ,** **-Problem List diagnosis of hepatitis, cirrhosis, abnormal LFTs, nonalcoholic steatohepatitis** **-Age > 80** **-Excessive alcohol use (Males ≥3 drinks/day; Females >2 drinks/day)** **-Pregnancy** **If any of the above are present, consult clinician.**	**Side Effects to Assess for:** **-Diarrhea, nausea, vomiting, bloating, abdominal discomfort, flatulence, GI intolerance** **If GI side effects are present, verify medication is taken with food** **-Weakness** **-Metallic taste** **-Rash, headache** **-Hypoglycemia* (if used in combination with other DM agents)** **If any side effects, consult with clinician.**	**Monitoring (at time of enrollment):** **-Creatinine every 12 months. If no creatinine within the past 12 months, order creatinine** **If any lab abnormalities, consult with clinician.**

Safety Instructions: Stop Metformin at the time of and for 48 hours after IV contrast studies, procedures or surgery

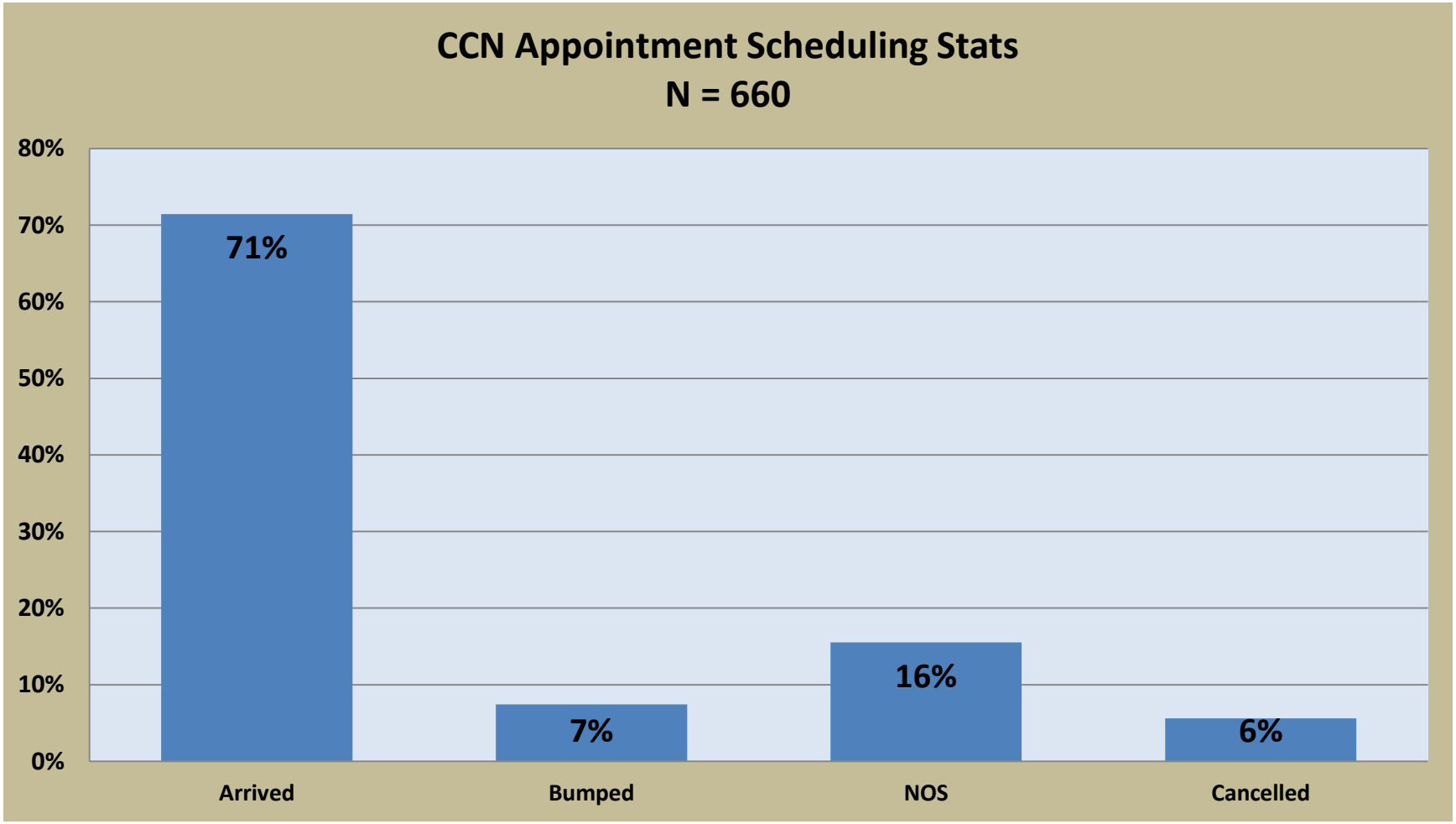
During acute episodes of sickness, please consult clinician.

Collaborative Care Nurse Working Algorithim for Patients with Diabetes



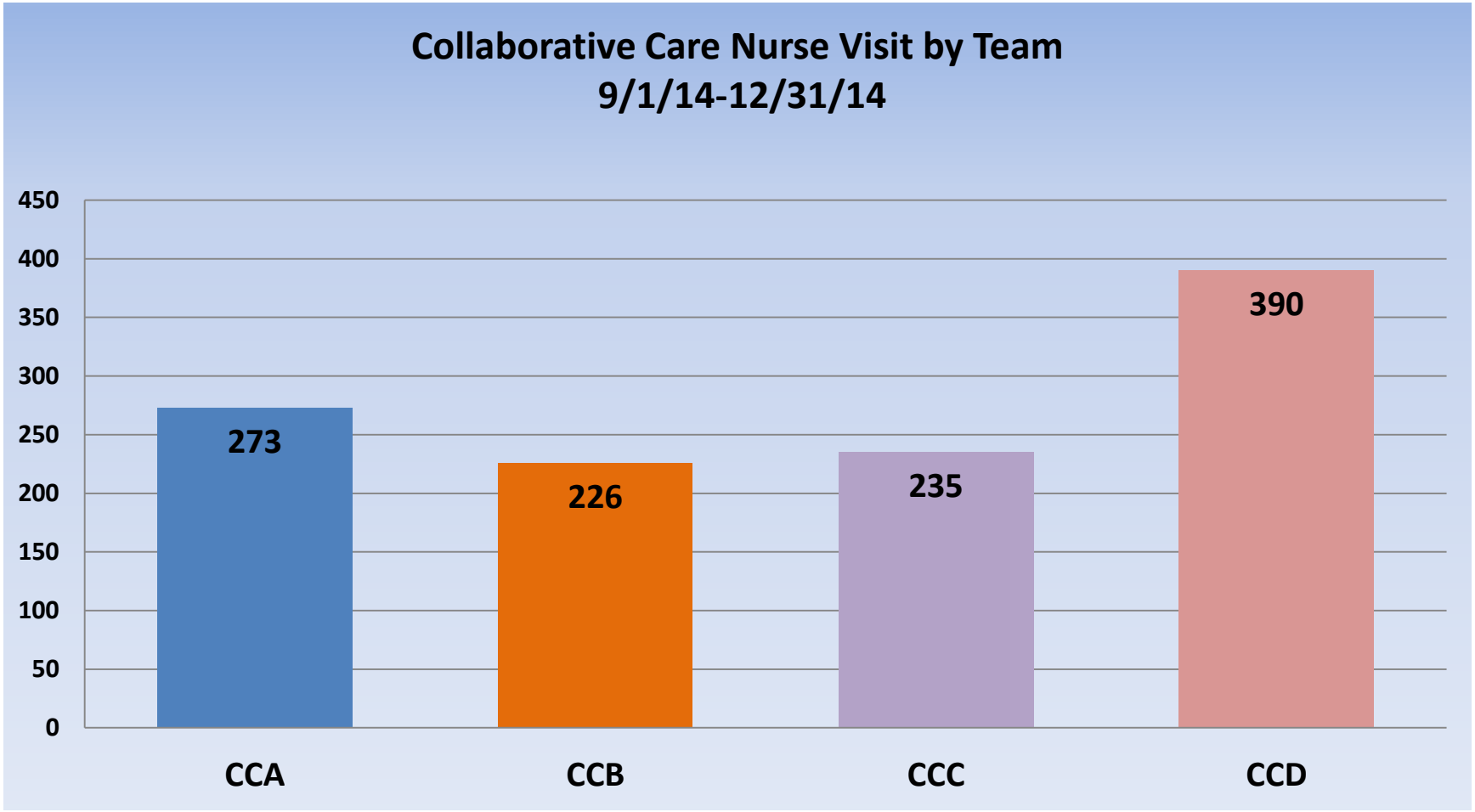
Collaborative Care Nurse Appointment Scheduling Statistics 9/1/14-10/31/14

(n=660)

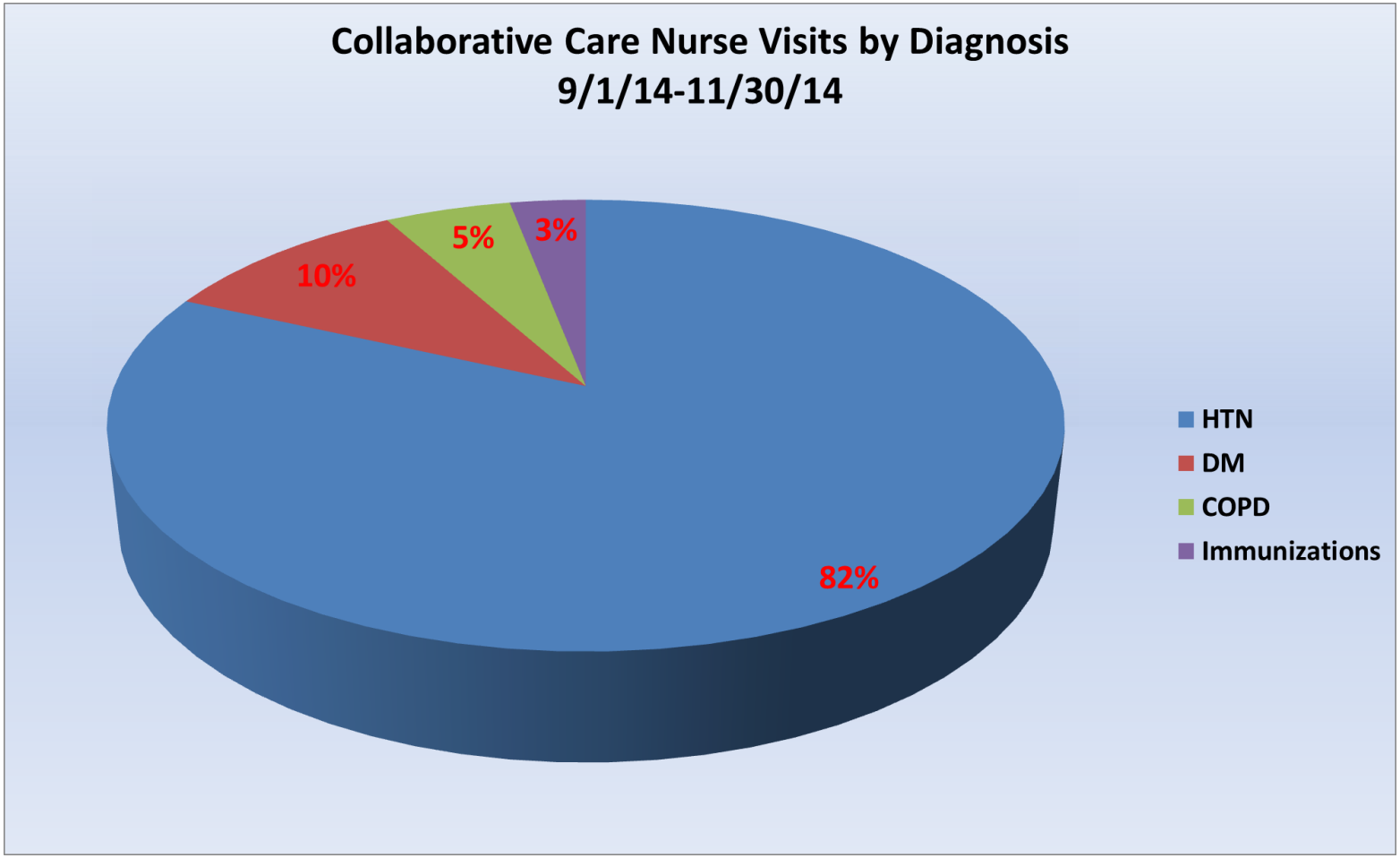


Collaborative Care Nurse Appointment Scheduling Statistics 9/1/14-12/31/14

(n=1,124)



Collaborative Care Visits by Diagnosis



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