Nurse Visits – A “Tasting Flight” of Visit Models

Charmian Casteel, RN, BSN, MN
Primary Care Innovations Specialist
CareOregon
• Quality Innovation Network (QIN)
• Quality Improvement Organization (QIO)
• CMS Quality Strategy:
  – Eliminating disparities
  – Strengthening infrastructure and data systems
  – Enabling innovation
  – Fostering learning organizations

Quality Improvement Organizations. 2014. About QIN-QIOs. Available at: http://qioprogram.org/about/why-cms-has-qios
QIO Program Fact Sheet – Handout.
Continuing Education

The presenter was asked to advise the audience that they have no relevant financial relationships to disclose. No individual involved in the planning or presentation of this activity has relationships with industry or other conflict of interest to disclose.

- **HealthInsight Nevada is accredited to provide continuing medical education for nurses.**

- **HealthInsight Nevada designates this live course for maximum of 1 Continuing Education Unit (CEU).** Nurses should claim only the credit commensurate with the extent of their participation in the activity.
We want to hear from you!

Type questions into the **Questions Pane** at any time during this presentation
Learning Objectives

• Assess the need for RN visits in your practice
• Describe four different RN visit types
• Extrapolate successes and opportunities from the Nursing Innovation Collaborative
• Develop a plan to bring this information back to their practice for implementation
Presenters

Charmian Casteel, RN, BSN, MN
Primary Care Innovations Specialist
CareOregon
Agenda

• Introduction (5 min.)
• Why nursing visits? (5 min.)
• Exploring different RN visit types (15 min.)
• Description of Nursing Innovation Collaborative (10 min.)
• Q & A before developing a plan (10 min.)
• Developing a plan (10 min.)
• Next steps and future webinars (5 min.)
The Future in Nevada

Workforce Projections 2010-2030

To maintain current rates of utilization, Nevada will need an additional 1,113 primary care physicians by 2030, a 77% increase compared to the state’s current (as of 2010) 1,428 PCP workforce.

Nevada Projected Primary Care Physicians Need

Petterson, Stephen M; Cai, Angela; Moore, Miranda; Bazemore, Andrew. State-level projections of primary care workforce, 2010-2030. September 2013, Robert Graham Center, Washington, D.C.
To maintain current rates of utilization, New Mexico will need an additional 326 primary care physicians by 2030, a 23% increase compared to the state's current (as of 2010) 1,377 PCP workforce.

Petterson, Stephen M; Cai, Angela; Moore, Miranda; Bazemore, Andrew. State-level projections of primary care workforce, 2010-2030. September 2013, Robert Graham Center, Washington, D.C.
The Future in Oregon

To maintain current rates of utilization, Oregon will need an additional 1,174 primary care physicians by 2030, a 38% increase compared to the state’s current (as of 2010) 3,027 PCP workforce.

Oregon Projected Primary Care Physicians Need

Petterson, Stephen M; Cai, Angela; Moore, Miranda; Bazemore, Andrew. State-level projections of primary care workforce, 2010-2030. September 2013, Robert Graham Center, Washington, D.C.
To maintain current rates of utilization, Utah will need an additional 1,095 primary care physicians by 2030, a 46% increase compared to the state's current (as of 2010) 2,375 PCP workforce.
Why Nursing Visits?
Visit Types

- Flip
- Nurse Visits
- Independent
- Protocol
Poll

Which of the visit types would you like us to explore in greater detail in this webinar?

- Flip Visit (with or without protocol)
- New patient/Establishing Care Co-Visit
- Protocolized RN Visit
- RN Visit
## Flip Visit Features

<table>
<thead>
<tr>
<th>RN Role</th>
<th>Provider Role</th>
<th>+/- Impact on Clinic</th>
<th>+/- Impact on Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vitals Medications</td>
<td>Expanded PE</td>
<td>+  Scheduling ease</td>
<td>+  Timely care</td>
</tr>
<tr>
<td>Allergies</td>
<td>Decision making</td>
<td>+/- Provider schedule takes slot</td>
<td>+  Continuity</td>
</tr>
<tr>
<td>HPI</td>
<td>Signs orders</td>
<td>+  Time to 3rd available</td>
<td>+  RN intervention</td>
</tr>
<tr>
<td>PE</td>
<td>LOS</td>
<td>+  Reimbursement</td>
<td>+  Team-based care</td>
</tr>
<tr>
<td>Scribe?</td>
<td>Closes encounter</td>
<td>+  RN scope</td>
<td>-  Time with provider</td>
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<tr>
<td>Places Orders Patient Education</td>
<td></td>
<td>+  Communication</td>
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</table>

- **HPI (History of present illness)**
- **PE (Physical Exam)**
- **LOS (Level of Service)**
## New Patient/Establishing Care Co-Visit

<table>
<thead>
<tr>
<th>RN Role</th>
<th>Provider Role</th>
<th>+/- Impact on Clinic</th>
<th>+/- Impact on Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vitals</td>
<td>PE</td>
<td>+ Scheduling ease</td>
<td>+ Introduction to clinic</td>
</tr>
<tr>
<td>Medications</td>
<td>Decision making</td>
<td>+ Provider schedule</td>
<td>team-based care</td>
</tr>
<tr>
<td>Allergies</td>
<td>Places/signs</td>
<td>- provider time</td>
<td>+ RN intervention</td>
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<tr>
<td>PMH</td>
<td>orders</td>
<td>+ RN scope</td>
<td></td>
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<tr>
<td>Patient Education</td>
<td>LOS</td>
<td>+ Communication</td>
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<tr>
<td></td>
<td>Closes encounter</td>
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</table>

*PMH (Past Medical History)*

*PE (Physical Exam)*

*LOS (Level of Service)*
## Protocolized RN Visit

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<thead>
<tr>
<th>RN Role</th>
<th>Provider Role</th>
<th>+/- Impact on Clinic</th>
<th>+/- Impact on Patient</th>
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</thead>
<tbody>
<tr>
<td>All visit components per protocol</td>
<td>As needed</td>
<td>- Scheduling</td>
<td>+ Timely care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+ Provider schedule</td>
<td>+ RN intervention</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Time to 3rd available</td>
<td>- Time with provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+ +/- Reimbursement</td>
<td>- Established patient only</td>
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<td></td>
<td></td>
<td>must meet “incident to”</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>+ RN scope</td>
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- **HPI (History of present illness)**
- **PE (Physical Exam)**
- **LOS (Level of Service)**
## RN Visit

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<th>+/- Impact on Patient</th>
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<tbody>
<tr>
<td>All visit components</td>
<td>As needed</td>
<td>- Scheduling</td>
<td>+ Timely, appropriate care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+ Provider schedule not affected</td>
<td>+ RN intervention</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+/- Reimbursement must meet “incident to” or bill procedure only</td>
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Reimbursement

- The patient must be established
- An evaluation and management (E/M) service must be provided
- The service must be separate from other services performed on the same day
- There must be either:
  - A plan of care
  OR
  - Provider consult
- A physician (billable provider) must be immediately available to provide assistance and direction throughout the time the practitioner is furnishing services
Nursing Innovation Collaborative

- **Session One** (February 12, 2016)
  - Communication, Data

- **Session Two** (March 11, 2016)
  - Documentation, Training, Billing, Visit Structure

- **Session Three** (April 8, 2016)
  - Provider Perspective, Teams, Pilot

- **Session Four** (May 27, 2016)
  - Attendee Requests, Deeper Dive Topics
<table>
<thead>
<tr>
<th>Clinic</th>
<th>Session 1</th>
<th>Session 2</th>
<th>Session 3</th>
<th>Session 4</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>• Create evaluation form for new patient visit</td>
<td>• Evaluation forms drafted</td>
<td>• Develop process for chart review</td>
<td>• RN schedule is 2 days independent visits, 2 days walk-in/triage, but exploring co-visits</td>
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<td>• Collect data from provider visits</td>
<td>• Collect data from provider visits</td>
<td>• Develop visit template/dot phrases</td>
<td>• Hire additional RN in Fall 2016 (team care manager role)</td>
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<td>• Collect staff feedback on protocol content</td>
<td>• Collect staff feedback on protocol content</td>
<td>• Plus/Delta</td>
<td>• RN runs huddle, schedule review</td>
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<td>• Strep protocol pilot with RN shadow provider</td>
<td>• Explore MA role in RN visits</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• Draft more RN protocols</td>
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<tr>
<td>2</td>
<td>• Establish priorities</td>
<td>• Explore clinical champion role options</td>
<td>• Review billing and need for Certified Professional Coder (CPC)</td>
<td>• # of protocols implemented</td>
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<tr>
<td></td>
<td>• Assess current visit/patient needs</td>
<td>• Implement “flip” visit</td>
<td>• Develop implementation team</td>
<td>• Silo RN visit restructured as co-visit with provider</td>
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<tr>
<td></td>
<td></td>
<td>• Draft RN training</td>
<td>• Explore provider availability</td>
<td>• Collaboration with finance department regarding RN visits</td>
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<tr>
<td></td>
<td></td>
<td>• Designate provider time for training</td>
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<td>• 6/7 “go live” with RN OB visits</td>
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<td>• Call center “preps” patients</td>
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<td>• Address public health RN role impact</td>
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<td>• Create iterative change environment</td>
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<td>• Summertime summit to address organizational direction changes</td>
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<tr>
<td>3</td>
<td>• Create charter and project plan</td>
<td>• Medical director position open</td>
<td>• Going with co-visit model</td>
<td>• Improved provider-RN collaborating (provider concern r/t revenue)</td>
</tr>
<tr>
<td></td>
<td>• Present RN visits to provider group</td>
<td>• Present RN visits to provider group</td>
<td>• Protocolized RN only visits on separate RN schedule</td>
<td>• Exploring RN role visits 2/2 resident program</td>
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<td>• Explore “flip” visits first</td>
<td>• Explore “flip” visits first</td>
<td>• Explore chronic disease/population management</td>
<td>• Creating high value patient encounter w/ RN and PCP (5/17)</td>
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<tr>
<td></td>
<td>• Going with co-visit model</td>
<td>• Going with co-visit model</td>
<td>• Improved provider-RN collaborating (provider concern r/t revenue)</td>
<td>• Patient success important</td>
</tr>
<tr>
<td>4</td>
<td>• Assess accomplishments and where to improve</td>
<td>• Acute nurse visit toolkit drafted and spread</td>
<td>• Clinician champion identified</td>
<td>• Acute RN visit protocols complete</td>
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<tr>
<td></td>
<td>• Acute nurse visit toolkit drafted and spread</td>
<td>• Develop nursing dashboards</td>
<td>• Develop communication strategy</td>
<td>• RN protocols include lab/treatment</td>
</tr>
<tr>
<td></td>
<td>• Assess accomplishments and where to improve</td>
<td>• RN training developed and implemented</td>
<td>• Focus group of senior leaders/clinicians</td>
<td>• RN visits on separate schedule</td>
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<tr>
<td></td>
<td>• Assess accomplishments and where to improve</td>
<td>• RN training developed and implemented</td>
<td>• Working with LPNs on protocolized visits</td>
<td>• RN training for more complex patient</td>
</tr>
<tr>
<td></td>
<td>• Assess accomplishments and where to improve</td>
<td>• RN training developed and implemented</td>
<td>• Review billing documentation</td>
<td>• Multidisciplinary team exploring case management and chronic disease RN visits</td>
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| 5      | • Leadership discussion regarding vision for implementation | • Engaged primary care director  
• Protocols for urgent care team w/expansion to primary care  
“flip” visits  
Explore options for respite program nurse | • Review billing issues  
• Explore space options  
• RN to shadow provider visits | • Protocol template complete  
• Number of urgent care protocols completed  
• Urgent care team created  
• Urgent care team test protocols  
• RN training in 2016  
• Staff success important/create trust |
| 6      | • Organizational discussion for setting clear direction  
• Quality officer engaged  
• Nurse champion identified to spread  
• Review RN diagnosis vs. medical diagnosis | • Quality officer engaged  
• Nurse champion identified to spread  
• Review RN diagnosis vs. medical diagnosis | • Review billing | • UTI, strep protocols complete  
• Standardize documentation to be in line w/providers  
• RNs review provider schedule for potential “flip visits”  
• Explore billable visits  
• RNs shadowing PA visits to build templates/dot phrases  
• Draft lactation “flip visits”  
• Goal of 8/16 all 10+ RN protocols completed |
<table>
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<tr>
<td>7</td>
<td>• Develop purpose&lt;br&gt;• Provider buy-in</td>
<td>• Develop team&lt;br&gt;• Medical director&lt;br&gt;• Review data and future</td>
<td>• Challenged by needed culture shift with provider group&lt;br&gt;• RNs completing wellness visits&lt;br&gt;• Organized/incorporated teams&lt;br&gt;• Met ALL metrics</td>
<td></td>
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<tr>
<td>8</td>
<td>• Designate provider champion&lt;br&gt;• Provider champion identified&lt;br&gt;• Provider trainer identified&lt;br&gt;• Draft foster care visit protocol&lt;br&gt;• Develop EHR tools for documenting</td>
<td>• Provider champion identified&lt;br&gt;• Provider trainer identified&lt;br&gt;• Draft foster care visit protocol&lt;br&gt;• Develop thrush and diaper rash protocols&lt;br&gt;• Provider champion monthly meetings for RNs and “pulling” RNs into specific visits to help educate on assessment&lt;br&gt;• Schedule RN visits&lt;br&gt;• Standardize RN documentation&lt;br&gt;• Develop visits for medically fragile</td>
<td>• Draft independent RN visit protocol for “constipation follow up”&lt;br&gt;• Completed thrust and diaper rash protocols, no patients&lt;br&gt;• Provider and staff/RNs satisfaction important</td>
<td></td>
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</tbody>
</table>
QUESTIONS? COMMENTS? REFLECTIONS?

Type questions into the Questions Pane
Plan

Communicate, Communicate, Communicate

Get the data
Use the data
Learn from the data

Train the nurse

Communicate, Communicate, Communicate
Poll!

How are you going to take this information back to your practice/team?
Next Steps

• Conference/Collaborative:
  – Nursing Leadership Track: Team-Based Care
    OCN Fall Conference (October 20, 2016)
  – CareOregon Nursing Innovation Collaborative, Cohort #2
    • Charmian Casteel: casteelc@careoregon.org

• Articles to read:
  – RN Role Reimagined
  – In the Incubator: Flip Visits

• Webinar to watch:
  – Oregon Primary Care Association “Best Practices for Documenting and Billing Non-Provider Visits: A Focus on RN Visits”*

*Information presented in this webinar does not represent the views of the presenters respective organizations.
Thank You!

• Please complete post-webinar survey

• Next webinar:

  Shared Decision-Making

  Thursday, September 22, 2016

  1-2 p.m. MT

  Noon-1 p.m. PT
Million Hearts® Targets

Changing the Environment

By 2017...

- **Reduce smoking**
  - The number of American smokers has declined from 26% to 24%

- **Reduce sodium intake**
  - Americans consume less than 2,900 milligrams of sodium each day

- **Eliminate trans fat intake**
  - Americans do not consume any artificial trans fat

Optimizing Care in the Clinical Setting

- **Aspirin use when appropriate**
  - Of the people who have had a heart attack or stroke, 70% are taking aspirin

- **Blood pressure control**
  - Of the people who have hypertension, 70% have adequately controlled blood pressure

- **Cholesterol management**
  - Of the people who have high levels of bad cholesterol, 70% are managing it effectively

- **Smoking cessation treatment**
  - Of current smokers, 70% get counseling and/or medications to help them quit

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- millionhearts@cdc.gov

Million Hearts® promotes clinical and population-wide targets for the ABCS. The 70% values shown here are clinical targets for people engaged in the health care system. For the U.S. population as a whole, the target is 65% for the ABCS.
References


  — For full description of the methodology, see http://www.grahamcenter.org/tools-resources/state-projections.htm.