RN Practice – Dynamic Evolution

Collaboration Shared Governance Autonomy

in Primary Care Clinics

PAST: "**Clinic Nurse**"

Functional Task Nursing

Interchangeable duties between Clinic RNs

1998 (and before) to 2005- 2006

To divide the work on a given day however, nurses would often rotate the tasks such as:

Nurse A triages walk-ins, completing unscheduled visit.
Nurse B completes scheduled nurse appointment.
Nurse C finishes phone calls returns plus is available for direct from clinic admissions and emergencies.
Nurse D assists with clinic flow issues for regularly scheduled Primary Care Provider visits, backing up LPN's in prevention screening of patients.

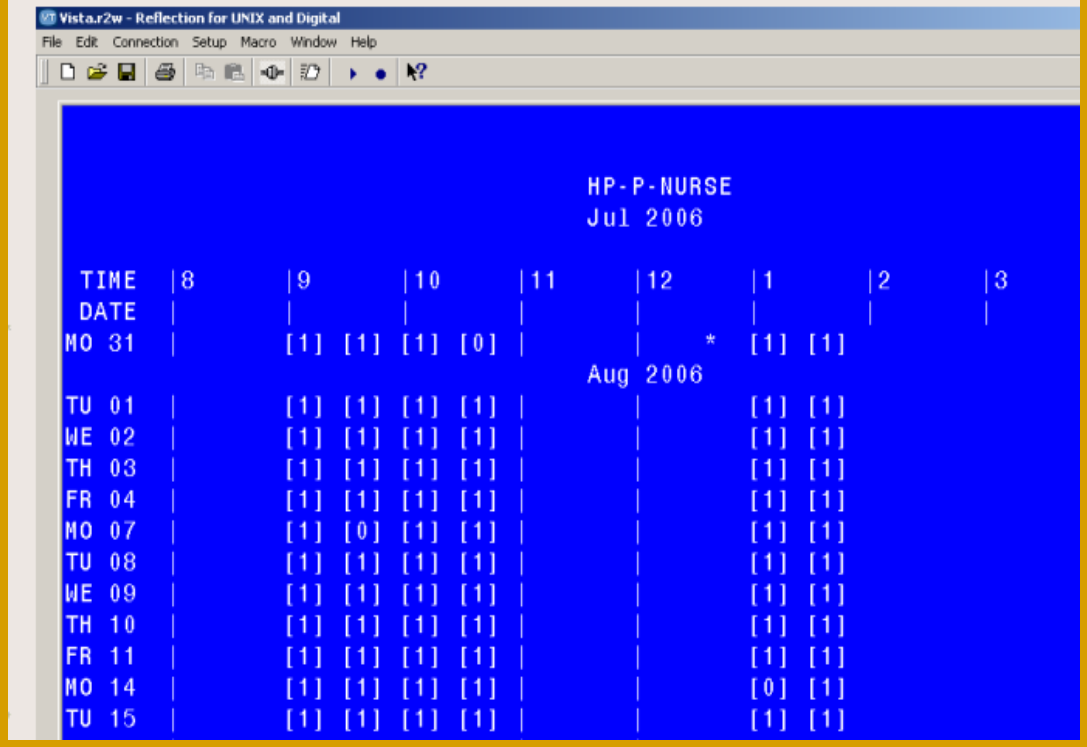
PAST: "**Clinic Nurse**"

A past scheduling grid is seen below.

Any clinic RN was assigned to see patients of their team in a generic "Nurse" clinic.

There was no particular association or Continuity between RNs and Primary care provider's panels.

How it looked before:



PRESENT: "**Case Manager**"

RN's assigned to Specific Patient Panels

collaborating with certain Pcp's associated with these Panels.

(2006 to 2010)

Actions Proposed and Done :

1. To eliminate the generic nurse appointments.
2. Create individual clinics for each case manager.
3. These clinics can not intersect with each other in terms of the time frames. Each case manager will have a clinic every day of the week.

Actions Proposed and Done:

Continued

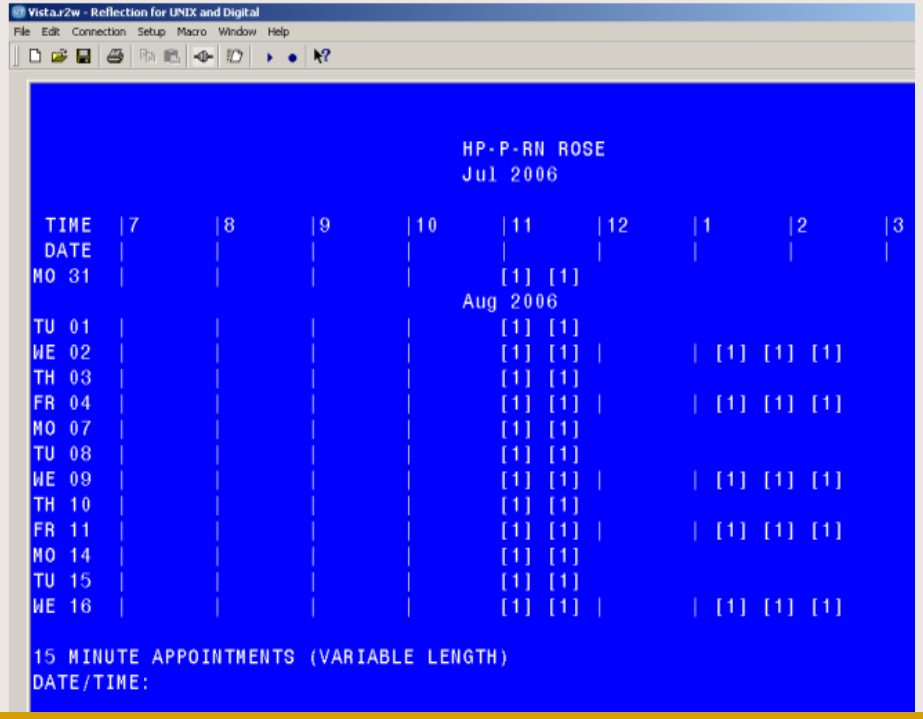
3. First available appointment times may improve and use of carve outs decrease as dependable precepting for RN nurse clinics can be planned.
4. No shows for these clinics will be followed by the case managers via phone calls, increasing patient safety.
5. In case of unexpected sick leaves, or absentees, these clinics will not be cancelled. On site case managers will take over seeing these patients in their nurse clinics.

PRESENT:

Example of one RN **Case Manager's** Scheduling Grid

Hp-p RN- Rose only

From Aug 1- Dec , 2006 216 visits

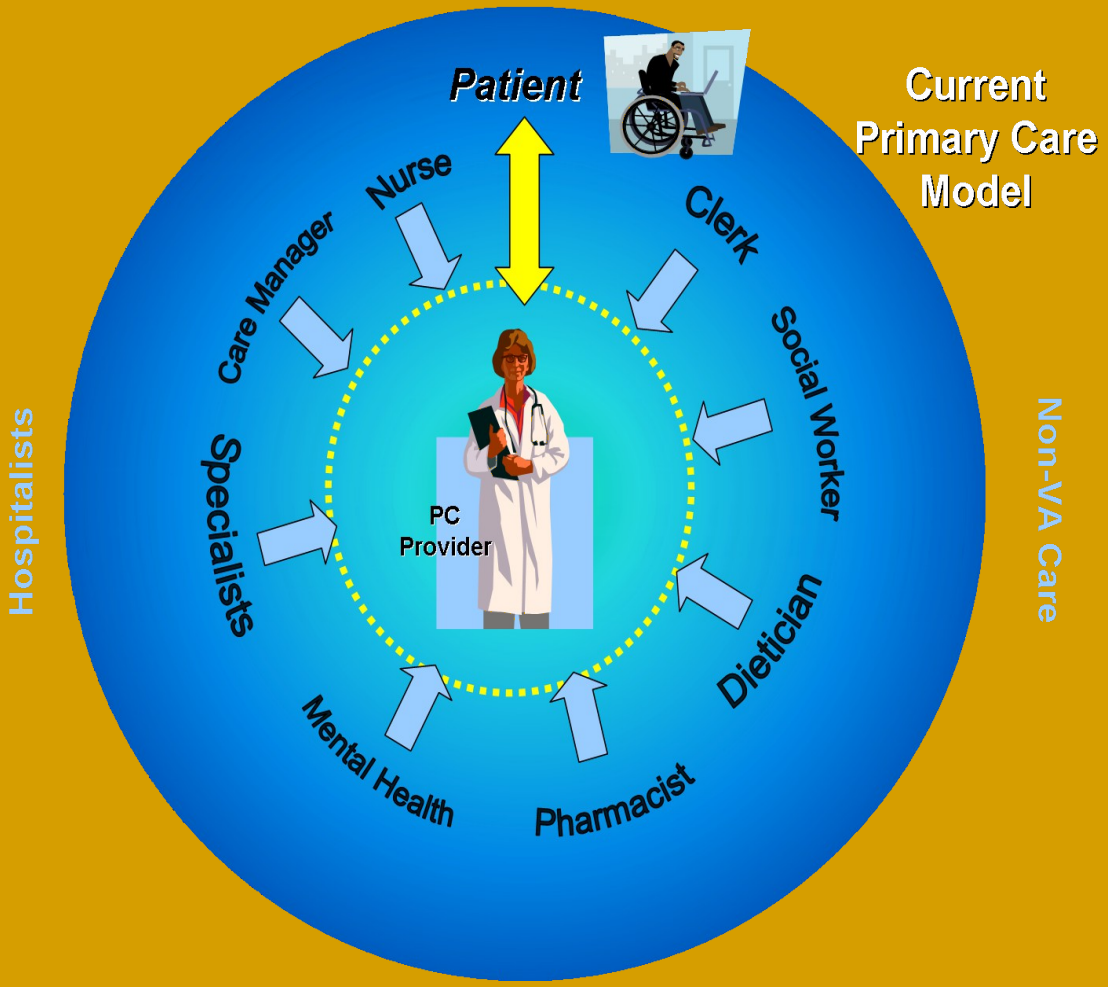


GOALS:

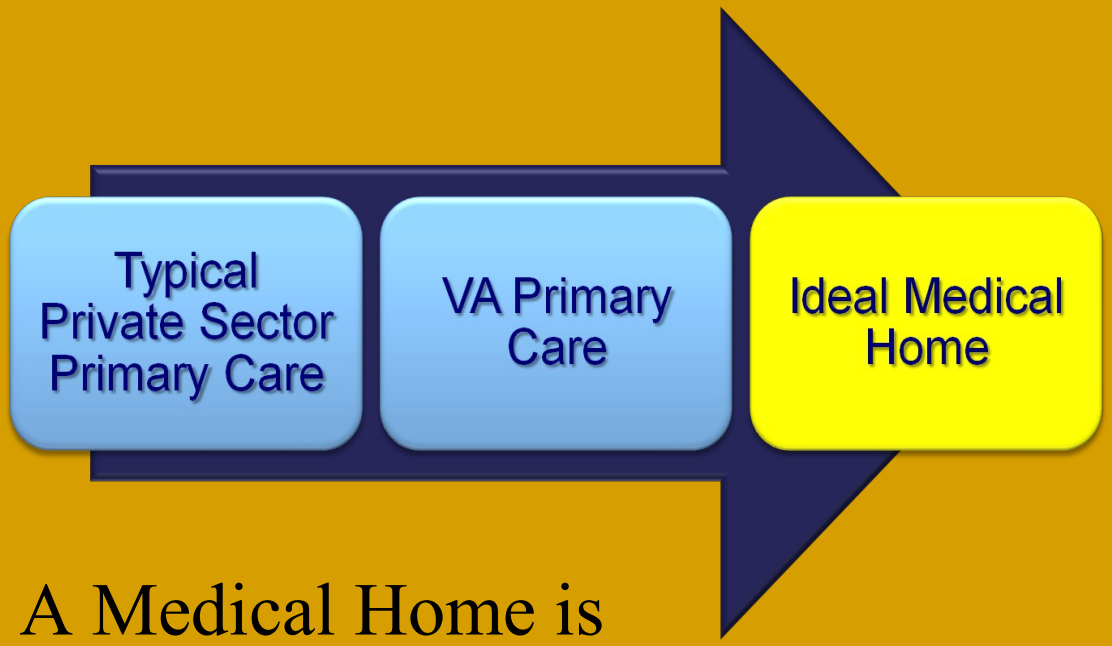
1. To increase continuity of care of patients coming in for nurse appointments.
2. To be able to document individual work loads of case managers.
3. Be able to custom schedule more complicated patients with the appropriate case managers around the administrative times of providers in case feedback is needed quickly.
4. Give individual case managers more control over their own schedules for seeing follow up patients.
5. Be able to identify patients who do not show to their follow up nurse appointments and ensure patient safety and follow up.

PRESENT:

RN **Case Manager's** collaboration is seen below, supporting the pcp/patient care delivery system.



FUTURE: RN Role
Medical Home **Care Manager**



A Medical Home is

Patient / Population focused rather than office visit focused.

This model is comprised of a personal PCP as well as a team of professionals at the practice level who collectively take responsibility for the lifetime optimum health of primary care veterans.

FUTURE: RN Role
Medical Home **Care Manager**

Expanded roles for RNs, others

- Algorithmic management for common conditions (HTN, DM, hyperlipidemia) Nurse works at top of license.
- Veteran/ Caregiver Motivational Interviewing
- Upstream palliative care information

Enhance Coordination of high risk Veterans that includes RNs who proactively contact high risk Veterans and direct phone access from Veteran to RN care manager

All PCPs and RNs have time allocated each day for non face to face care-phone/email/secure messaging.

THE FUTURE:

An enhanced scope of practice and a dynamic opportunity for professional growth.

Primary care is ever improving in communication, access to care, and quality of treatment.
All is being re-tooled with the philosophy of recognizing the Veteran as the Center of the Medical Home, rather than the organization or building.

What next?
To quote Robert Kennedy,
There are those who look at things the way they are, and ask why...
I dream of things that never were, and ask why not?”