The Collaborative Continuous Coordinated Care (3Cs) Model

HARTFORD INSTITUTE FOR GERIATRIC NURSING

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Goals of Project

• Build an **education-practice** model which increases pharmacologic adherence among older, homebound adults

• Develop an innovative interprofessional model which increases the formation of meaningful, Interdisciplinary collaborative relationships

• Create an opportunity for professionals to work together
Time Frame for Outcome?

• Began Fall 2013
• Ends June 2016
• Goal- To establish an evidence-based model which will be ready for dissemination throughout the country!
3C’s Model
Participants

NYU Nursing

NYU Silver School of Social Work

Touro College of Pharmacy

Visiting Nurse Service of New York

Hartford Institute for Geriatric Nursing
Organizational Capacity; VNSNY

- Home care agency
- In 2011, served 113,398 members
- 17,700 employees
- More than 50 languages spoken by staff
- Annual operating revenue of $2 billion
- 70 full/part time NPs
Professional Participants

Clinical preceptors from VNSNY

- Home Care Nurse Practitioners
- Home Health Social Workers
- Home Care Pharmacists
Structure of Team

True education-practice model:

• VNSNY Nurse Practitioners team up w/ ANP students from NYU

• VNSNY Social Workers team up w/ MSW students from NYU

• VNSNY Pharmacists team up w/ PharmD students from Touro College in NYC
Purpose

• Demonstrate the effectiveness of an innovative interprofessional model of collaborative, coordinated care that reflects communication across the health care system
Specific Aims of Model

1. Improve health outcomes by decreasing complexity of medication regimen
2. Decrease Emergency Department use and recidivism
3. Increase Quality of Life Index
4. Positively influence perceptions of interprofessional teamwork
Patient Population

• Dual eligible
• Chronically ill
• Culturally diverse
• Socio-economically vulnerable older adults
• Polypharmacy common
Team Members

- Professionals in practice from VNSNY
- Students from NYU
- Teams: NP, SW, Pharmacy
- Clinical rotations @ VNSNY
Formal Instruction

• All participants (both preceptors and students) encouraged to participate in formal, interprofessional practice classes each semester (at least 2 offered)
• Nurse practitioner leadership classes, as this is a nurse led initiative
• Combination of live and webinar modalities
Numbers of Participants?

200 students over life of grant:

- 50 NP students
- 50 MSW students
- 100 PharmD students
Challenges So Far?

• Most common- scheduling conflicts (meetings)
• Logistical challenge 2/2 homebound residents
• Some social work visits must be done virtually
• Enabling communication among groups- who reaches out to who?
• Historically, VNSNY has not had this many students
• Variable length of students rotations
Ways to Mitigate Challenges?

• Provide either live classes or via webinar
• Students offered credit towards clinical hours
• Offer nursing CE’s to nurse practitioners
• Clear point person @ VNSNY (employed by VNSNY) to navigate systemic challenges
• Ongoing formal meeting to delineate impending issues and ameliorate quickly
Formal Content of Ongoing Instruction

• Communication
• Value and respect for others’ profession
• Difference between Interprofessional vs. multidisciplinary
• Clear, thorough documentation
• Objectifying medication complexity
• Recognizing and appreciating the value of other professions
Medication Regimen Complexity Index (MRCI)

Provides a weighted score based on:

• Dosing Frequency (e.g., bid, qid)
• Routes of Administration (e.g., oral, inhalant, topical)
• Special Instructions (e.g., take with food, dissolve, sliding scale)
• Higher scores indicate more complex regimen
Practice Model

VNSNY CHOICE
INTERPROFESSIONAL COLLABORATIVE PRACTICE MODEL

NP team evaluates patient
- NP team complete medication reconciliation
- NP team calculates MRCI score
- If above 24, team begins gathering information per guideline
- **Ongoing** communication with interprofessional team begins
- Formal referral made: sends partially-completed guideline along with patient presentation to other teams via P:P
- Patient/family remain active members of health care team
- NP team continuously evaluating timeliness and comprehensiveness of information gathered
- When proposal is reached collaboratively, NP team reaches out to community care provider in attempt to implement plan

Social Work team
- Evaluates data (in conjunction with preceptor)
- Continues to gather info for guideline while medication list being modified by pharm team
- Evaluates pt in home (if possible)
- Proposes formal referrals to other disciplines
- Attempts to mitigate items that may negatively influence medication management and adherence

Pharmacy team
- Evaluates data (in conjunction with preceptor)
- Proposes changes to medication list
- Recalculates MRCI score reflective of proposed changes
- Provides info to NP/SW team re: other factors to consider in this specific patient
- Continues to keep IPC team involved
Progress so far?

• Entered 3\textsuperscript{rd} of 5 total semesters
• 19 page clinical guideline developed
• Developed webpage where archived webinars reside
• Discussion board created
• Feedback extremely positive!