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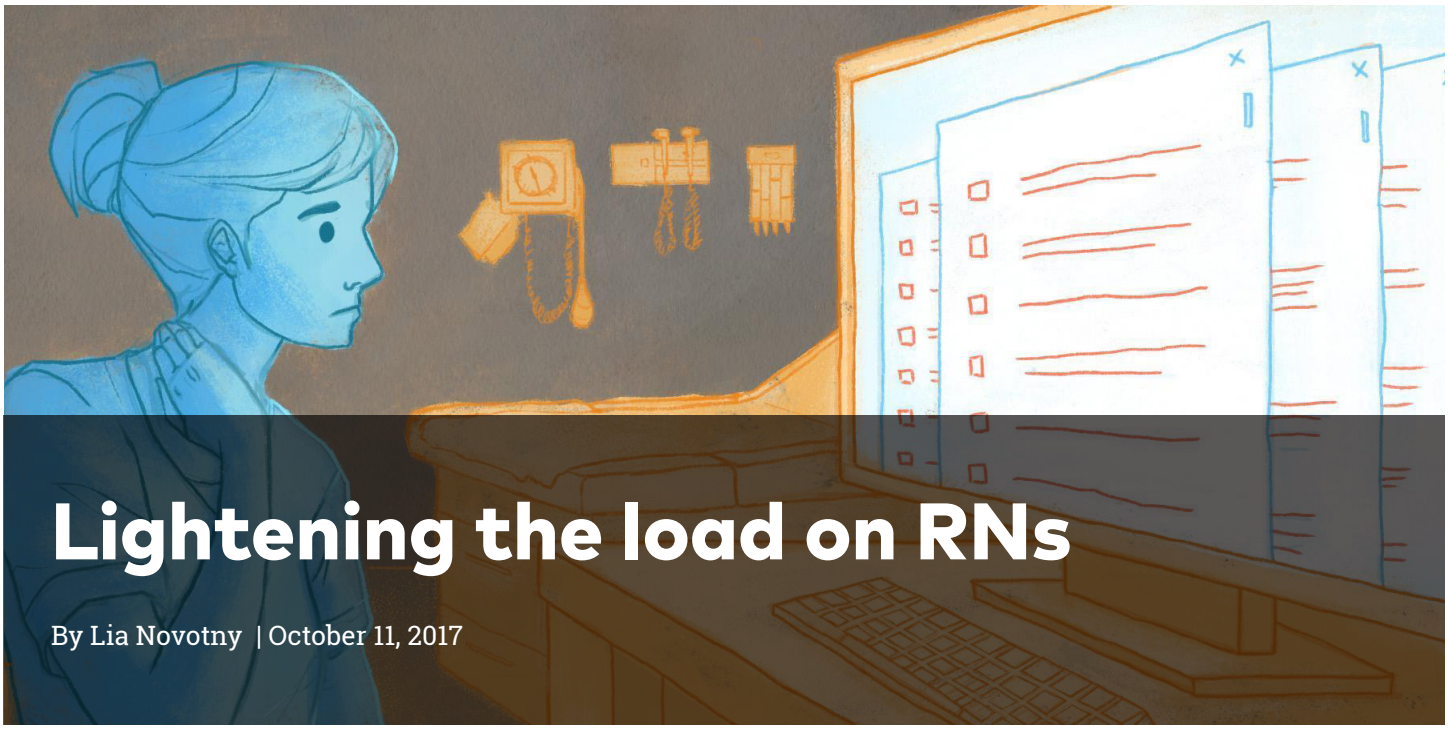

Lightening the load on RNs

By Lia Novotny | October 11, 2017

Population health management offers a number of benefits to patients and organizations, but it also requires additional documentation, care planning, and patient outreach. Much attention has been paid to the impact of population health management on physicians, but frequently a disproportionate burden falls on registered nurses.

Often the only member of the care team with both the clinical understanding to manage patient care and the technical understanding to leverage electronic health records, RNs are finding they have more and more on their plates.

athenaInsight sat down with Robin Virgin, M.D., director of primary care for PeaceHealth Medical Group, a 900-physician medical group based in the Pacific Northwest, to discuss the way RNs are pulled in multiple directions and how PeaceHealth is redesigning care delivery to make the RN workload more sustainable.

Q How you are organizing your care teams for population health management?

A We currently have four disease registries: diabetes, hypertension, congestive heart failure, and chronic obstructive pulmonary disease, and are working to build out wellness and high-risk registries by the end of the year. Currently our RNs and LPN's are doing much of the work of running these registries and performing outreach. In addition to this work, they are also expected to make transition and care management calls.

We also identify at discharge from the hospital those patients who are at the highest risk for readmission for care management. What our teams are discovering is that many of these patients have decompensated both physically and often socially as well. As a result, it can take a while to get them onboarded with community services or Medicaid support.

Q How much of this work falls on RNs?

A What we find from the get go is that our RNs are being pulled in a myriad of different directions. When they are embedded physically in one of our clinics, they are oftentimes the only team member that knows how to put in a Foley catheter or give IV fluids. They manage our high-risk patients as care managers and are frequently relied upon to perform other tasks, like phone triage. And we, like many organizations, use RNs as part of the provider team so patients who need a quick visit, like a blood pressure check, can come in for a nurse-only visit.

And the EHR presents its own set of challenges with respect to population health. While we are better able to capture information and do patient outreach, there is also a significant burden on us for documentation. We rely on our RNs, an integral part of our clinical education teams, to help us develop and train other team members on the EHR's documentation tools and workflows.

Q In your opinion, does it feel like this workload is sustainable for the RNs?

A The way it is right now may be very difficult to sustain. As we develop and roll out more registries, we've asked the care team to take on a larger panel of patients. They struggle to balance requests from local leadership, who want them in the clinic, with the requirements of the broader health system.

Like other organizations, we are working to keep up with the pace of change and continue to provide high-value care for our patients. That means enhanced access through our expanded care team, including RNs; and it means a significant focus on outreach to patients in poor control of chronic conditions. All of this places a burden on the nursing staff.

Another system initiative that primarily impacts our RNs is attesting to our compliance with the patient-centered medical home guidelines laid out by the National Committee for Quality Assurance (NCQA). Going through attestation at a corporate level required significant standardization of documentation for patient care plans. The feedback from our RN teams has been, "We don't have enough time. We are getting different direction from the system and local leadership about priorities."

With our priorities in conflict, this is not something we can sustain. Our challenge and opportunity is to find a way to make this work more sustainable for all the members of our clinical team.

Looking forward, we are using the funding from our Transforming Clinical Practice Initiative grant to do just that. We have used these funds to hire not just more team members, but process-improvement leaders to help us design a better system.

Q How do you envision changing the care teams in a way that will help RNs and all team members?

A We are working hard to do this in a way that is thoughtful and inclusive of our clinicians and caregivers. It starts with mapping out how much time should be spent on each of the different types of work, keeping in mind what work is optimal so that all members may work to the top of their license.

Clarity is probably the most important thing we can do as an organization, most specifically around our priorities – aligning system priorities with network and local initiatives and limiting the number of them whenever possible.

We are in the process of redesigning our care team – not just the caregivers (our term for

staff), but how our clinicians work together. We are moving toward shared panels of patients based on risk. And we will need to redesign clinician compensation away from individual productivity and toward measures that more accurately reflect the efforts of the wider team.

With so much change ahead of us, both known and unknown, we need to make sure that our care teams are being supported. Care redesign that involves efficient EHR and patient workflows, that allows for more virtual care, that ensures everyone is working at the top of their license, is essential so we can focus on what really matters: taking care of patients, which is why we all went into medicine in the first place.

If we don't find a way to bring the joy back into our work, RNs will continue to be pulled in too many directions, and we will end up losing them.About a year and a half later, he came back and said, "You don't recognize me, do you?" I said, "I didn't have a chance to review the chart before I went in the room. I know your name, but I just can't place you." He said, "Well, I lost 150 pounds, and I feel a heck of a bunch better now. You gave me the time to do what I needed to do for myself."

Lia Novotny is a contributing writer for athenaInsight.