Arizona College of Nursing

ENVISION ENGAGE INNOVATE

Innovation of an Interprofessional Collaborative Primary Care Practice

Audrey Russell-Kibble, DNP, FNP-C; **Sally Reel,** PhD, RN, FNP-BC, FAAN, FAANP; **Joan Shaver,** PhD, RN, FAAN; **Jason Shuffitt,** DNP, FNP-BC, FAANP

Background

Through NP-led and IP shared leadership, the **Health360** practice was funded to enact 3 central goals:

1) coordinated, connected, comprehensive care (for patients and families with actual or risk of chronic disease/illness)
2) interprofessional (IP) clinical training opportunities for students (to master collaborative practice core competencies)
3) community engagement (for disease prevention/health promotion)

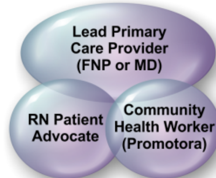
Purpose

To present concepts for achieving Goal 1:
Innovative Primary Care (coordinated, connected, comprehensive)

Methods

Establish the Health360 clinic:

Identify and Credential: Core Team Members



Align Extended Team Members:

- Pharmacist (UA College of Pharmacy) (medication management)
- Population Health Expert (UA Zuckerman College of Public Health) (train Community Health Workers, health/wellness program development)

Apply Ongoing Research and Development:

- Unique Practice Support and Delivery Innovations
- Evaluation Metrics

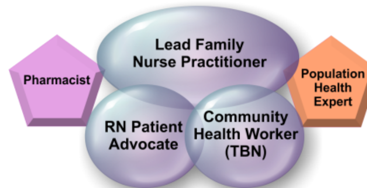
Results *(progress to date)*

Location:

The **Health360** clinic:

- launched in collaboration with the UA Department of Family Community Medicine
- within the primary care clinics at the UA Medical Center South Campus, Tucson, AZ

Core and Extended Team Formed:



Research and Development (ongoing):

Unique Practice Support Innovations Exemplar:

- New and continuing patient health status self-assessment with sentinel item alerts for clinicians
- Auto-generated referral report for access to potential community resources based on patient self-assessment
- Patient e-Portal with:
  - Personalized health profile with diagnostic information (e.g., lab results) and prescribed treatment with adherence guides
  - Medication audits and adherence support guides
  - Self reliance modules

Unique Care Delivery Innovations Exemplars:

- **Health360** Comprehensive Chronic Conditions Care Program (blends conventional chronic disease management with healthful lifestyle and stress modulation elements)
- Collaborative group visits
- Coordinated in-home and transitional care visits
- Access to telehealth support coaching

Evaluation:

Team

- DNP and MD clinicians
- Population health statistician

Metrics Exemplars

- HbA1c (diabetes)
- Blood pressure and lipid levels
- Depressive mood (often overlays chronic conditions)
- Team communication assessment

Implications

Health360 is a unique DNP-led ongoing initiative for redesigning care systems – to achieve greater patient safety, health care access and quality health outcomes. The intent is to place the focus of care where it is needed from simple to complex for efficient expenditure of resources.

We are doing so by:

- leveraging the use of health information technologies
- applying high value care delivery concepts
- assuring IP collaborations

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