Not Your Mama's Care Team: Innovative Approaches to Patient Centered Care

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Brattleboro Memorial Hospital
Brattleboro, VT
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Eilidh Pederson, MPH has no financial relationships to disclose relating to the subject matter of this presentation.
Learning Objectives
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1. Learn strategies for how one’s EMR can aid in care plan creation and improving patients’ health outcomes

2. Implement the use of Medical Scribes, with the intent of increasing access to care and patient satisfaction

3. Create shared care plans with community organizations; learn how community approach can improve the likelihood of meeting patient goals
Brattleboro Memorial Hospital
Brattleboro Memorial Hospital

• Works in partnership with:
  – Accountable Care Organization (ACO): One Care Vermont (OCV)
  – Blueprint for Health

• 61 bed community hospital located in Brattleboro, VT

• Serves a rural population of approximately 60,000 people in twenty-two towns in Vermont, New Hampshire, and Massachusetts

• Rapid expansion of BMH Medical Group
BMH Medical Group

- 55 Clinicians
- 88,000 visits in CY2017
- Total panel of 13,000 patients
- 10 RN Care Coordinators
- Supported by Community Health Team

- 12 Medical Group Practices
  - 7 primary care
  - 5 specialty
  - Share one EMR-Cerner
  - Care for the greater Windham County area in VT
BMH Approach to Primary Care

- Community Health Team
- Scribes
- Staff to Provide Prior Authorizations for Medications
- Pre-Visit Planning by Medical Assistants
- 2 FTEs of Clinical Support
- Full Time Referral Coordinator
- Manager for each Practice
- Standing Orders for Rx refills, Tests, and Immunizations
Vermont
Brattleboro, VT

Super Troopers
EMR Support in Care Plans
Care Plans

• Data determines who needs care plans

• Patients selected for care plans were highlighted during pre-visit planning

• Whole practice team works to implement, create and enforce care plans
# Care Plans

<table>
<thead>
<tr>
<th>RN Care Coordinator</th>
<th>Clinician</th>
</tr>
</thead>
<tbody>
<tr>
<td>High and Very High Risk Patients Identified</td>
<td>Identifies patients at time of visits, results or communication</td>
</tr>
<tr>
<td>Outreach</td>
<td>Shares concerns with RN Care Coordinator</td>
</tr>
<tr>
<td>In-person visit or Phone Calls</td>
<td>Documents ‘Care Plan’ at time of visit in Cerner</td>
</tr>
<tr>
<td>Goals and action plan created</td>
<td>Uses order sets</td>
</tr>
<tr>
<td>Shared Care Plan Created</td>
<td>Enlists support of ‘Referral Coordinator’</td>
</tr>
<tr>
<td>Documented in ‘Care Navigator’</td>
<td>Asks Scribe to set reminders of follow-up</td>
</tr>
<tr>
<td>Scanned into Cerner</td>
<td>Schedules next visit at time of check-out</td>
</tr>
</tbody>
</table>
Embedded Care Plans in EMR
Embedded Care Plans
<table>
<thead>
<tr>
<th>Component</th>
<th>Order Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labs</td>
<td></td>
</tr>
<tr>
<td>Hemoglobin A1c DC (Hemoglobin A1c)</td>
<td></td>
</tr>
<tr>
<td>Lipid Panel Standard</td>
<td></td>
</tr>
<tr>
<td>Microalbumin Urine. (Microalbumin, Random Urine)</td>
<td></td>
</tr>
<tr>
<td>Basic Metabolic Panel Standard</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Metabolic Panel Standard (CMP Standard)</td>
<td></td>
</tr>
<tr>
<td>Referrals</td>
<td></td>
</tr>
<tr>
<td>Referral Ambulatory</td>
<td>Ophthalmology, Eye Exam</td>
</tr>
<tr>
<td>Referral Ambulatory</td>
<td>Podiatry, Foot Exam</td>
</tr>
<tr>
<td>Referral Ambulatory</td>
<td>Endocrinology</td>
</tr>
<tr>
<td>Referral Ambulatory</td>
<td>Nephrology</td>
</tr>
<tr>
<td>Referral Community Health Team (CHT)</td>
<td>Community Health, DM</td>
</tr>
<tr>
<td>Referral Community Health Team (CHT)</td>
<td>Community Health, Nutrition</td>
</tr>
<tr>
<td>Referral Community Health Team (CHT)</td>
<td>Community Health, Health Coach</td>
</tr>
</tbody>
</table>
Use of Medical Scribes
Medical Scribes

- Certified Medical Assistants or M*Modal
- 1.0 FTEs
- Complete ROS, HPI and Order Entry
- CMAs are vital part of clinician’s care team
- Improve access to care
- Improve patient satisfaction
- Improve quality of patient care
Medical Scribes- Primary Care Practices

• Create care plans for clinicians
• Follow-up on goals and action items
• Assist with outreach
• Reinforce plan of care and every interactions
• Allow clinician to focus on medical decision making
### Medical Scribes-Improve Patient Satisfaction

<table>
<thead>
<tr>
<th>General</th>
<th>Positive</th>
<th>Nurse/Nurse aide, Positive Recognition, Respect to Patient</th>
<th>Sep 14, 2018</th>
<th>Jul 31, 2018</th>
<th>BRATTLEBORO INTERNAL MEDICINE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Paul S. and team (nurse Mark) have treated me better than I ever have my entire life. They give me a better quality of life. Truly amazing people. They all care about me.</strong></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>General</th>
<th>Positive</th>
<th>Access/Coord of Care, Nurse/Nurse aide, Positive Recognition, Respect to Patient</th>
<th>Oct 06, 2017</th>
<th>Jul 18, 2017</th>
<th>BRATTLEBORO INTERNAL MEDICINE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>My husband and i are both patients with Paul. He provided the best care we have experienced in twenty years with other groups. We can always depend on Paul and his nurse to be thorough and kind.</strong></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>General</th>
<th>Positive</th>
<th>Doctor/Physician, Positive Recognition</th>
<th>Jun 06, 2016</th>
<th>Apr 25, 2016</th>
<th>BRATTLEBORO INTERNAL MEDICINE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I am so glad to get back with Dr John Paul Stanchfield PA-C one of the best around Vt, NH I have seen many.</strong></td>
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**Scribe started July, 2015**

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</tr>
</thead>
<tbody>
<tr>
<td><strong>Paul doesn’t listen to what you have to say</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Physical Exam
Vitals & Measurements
T: 36.3 °C (Temporal Artery) HR: 74 (Peripheral) RR: 22 BP: 112/78 SpO2: 92%
HT: 167.64 cm WT: 150.8 kg BMI: 35.44
Constitutional: Alert/oriented, and in no acute distress.
Head and Face: Atraumatic, normocephalic.
Eyes: Sclera anicteric
Respiratory: Breathing unlabored, breath sounds clear to auscultation.
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops upon auscultation.
Skin and Subcutaneous Tissue: No rash, lesions, or areas of discoloration noted.
Neurologic: Growsly oriented to person, place, and time.
Psychiatric: Judgement and insight intact. Mood congruent with affect.

Assessment/Plan
1. Diabetes mellitus E11.9
2. Coronary artery disease 123.10
3. Lumbar disc disease with radiculopathy M52.10
   Hydrocodone refilled, referral to VNH for home PT/OT
Skin lesion L58.9
Referral to Dr. Crespo

I, Melissa Buffum, MA, am serving as a scribe to document services personally performed by Paul Stanchfield, PA-C based on my observations and the client’s statements to me.

Future Orders
- Basic Metabolic Panel Standard, Blood, Routine collect, *Est. 09/10/18 due within 1 month(s), Type 2 diabetes mellitus, Order for future visit
- Hemoglobin A1c, Blood, Routine collect, *Est. 09/10/18 due within 1 month(s), Type 2 diabetes mellitus, Order for future visit
- Microalbumin Urine, Urine, Routine collect: 10/9/18, Nurse Collect, Poor kidney function, Order for future visit
- TSH, Blood, Routine collect, *Est. 09/10/18 due within 1 month(s), Type 2 diabetes mellitus, Order for future visit
- Vitamin B12 Level 1, Blood, Routine collect, *Est. 09/10/18 due within 1 month(s), Type 2 diabetes mellitus, Order for future visit

Medications
- acetaminophen 325 mg oral tablet, 650 mg = 2 tab(s), Oral, q4hr, 5 refills
- acetaminophen-hydrocodone 325 mg-5 mg oral tablet, 1 tab(s), Oral, TID, PRN
- albuterol 0.5% inhalation solution, NEB, q6hr
- amlodipine 5 mg oral tablet, 5 mg = 1 tab(s), Oral, Daily, 3 refills
- clonidine 0.15 mg oral tablet, 75 mg oral tablet, 75 mg = 1 tab(s), Oral, Daily, 3 refills
- doxazosin 8 mg oral tablet, 8 mg, Oral, HS, 3 refills
- furosemide 40 mg oral tablet, 80 mg = 2 tab(s), Oral, Daily, 3 refills
- HumaLOG Mix 70/30 100 units/mL injectable solution, 20 units(t)
- Subcutaneous, TID
- HumaLOG Mix 70/30 100 units/mL injectable solution, See Instructions, 5 refills
- Imodium A-D 2 mg oral tablet, 4 mg, Oral, QID
- Lyrica 150 mg oral capsule, 150 mg = 1 tab(s), Oral, BID, 1 refills
- magnesium oxide 500 mg oral tablet, 1000 mg = 2 tab(s), Oral, TID
- metoprolol succinate 100 mg oral tablet, extended release, 50 mg = 0.5 tab(s), Oral, Daily, 3 refills
- nystatin 100,000 units/g topical powder, 3 app, TOP, TID, PRN
- ProAir HFA 90 mcg/inh inhalation aerosol, 2 puff(s), INH, q4hr, PRN, 5 refills
- simvastatin 40 mg oral tablet, 40 mg = 1 tab(s), Oral, Once a day (at bedtime), 3 refills
- spironolactone 25 mg oral tablet, 12.5 mg = 0.5 tab(s), Oral, Daily, 3 refills
- tramadol 0.1%, topical cream, 1 app, TOP, TID
- Vitamin E3 1600 int units oral tablet, 2000 Intunits = 2 tab(s), Oral, Daily

Allergies
- No Known Allergies

Social History
- Alcohol
  - Never, 08/18/2017
  - Employment/School

Brattleboro Memorial Hospital
Signature Line
[Electronically Signed on: 09/17/2018 18:34 EDT]

STANCHFIELD, JOHN PAUL PA

[Verified on: 09/17/2018 18:34 EDT]

STANCHFIELD, JOHN PAUL PA
Shared Care Plans
Logistics of Shared Care Plan

**RN Care Coordinators:**
- Identifies patients in need of care plans based on reports and pre-visit planning
- Seeks agreement from PCP
- Reaches out to patient and schedules a care plan visit
- Uses tenants of motivational interviewing during creation of care plan
- Documents in Care Navigator

**Patient:**
- Receives information and signs consent about community members being involved with care plan
- Decides which community members will have access and plays a role in determining lead care coordinator
- Works with lead CC to create goals and action plan

**Community:**
- i.e. ER; Rescue; Schools; Housing; Food, Nursing Homes, Mental Health Teams
- All community partners have ability to view Care Navigator (if consent is received)
- Those community partners involved in patient’s care, enhance and edit care plan in Care Navigator
Model for Shared Care Plans

Key Interventions in Vermont’s Integrated Communities Care Management Learning Collaborative (order of interventions may vary)

1. Use data and experience to identify people with complex needs
2. Recruit people for cross-organization care coordination
3. Use Tools to document person's story, goals and care team

4. Review person's health history
5. Conduct a root cause analysis
6. Convene Care Team Huddle (Organizational Meeting)

7. Identify person's lead care coordinator
8. Convene Care Team Conferences (Outline goals and actions, assess progress)
9. Develop, Implement and Monitor Shared Care Plan

Repeat Interventions as People's Needs Change Over Time
# Shared Care Plan

## Patient Information

<table>
<thead>
<tr>
<th>Patient's Name:</th>
<th>Gail Matthews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birthdate:</td>
<td>12/15/1938</td>
</tr>
<tr>
<td>Age:</td>
<td>77</td>
</tr>
<tr>
<td>Sex:</td>
<td>Female</td>
</tr>
<tr>
<td>Mobile Phone Number:</td>
<td>7047689087</td>
</tr>
<tr>
<td>Home Phone Number:</td>
<td>645-090-9765</td>
</tr>
<tr>
<td>Email Address:</td>
<td><a href="mailto:Matthews@mycarenav.com">Matthews@mycarenav.com</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th>1108 CHARLES STREET</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>St. Albans Street</td>
</tr>
<tr>
<td></td>
<td>0547837</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preferred Method of communication:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Voice call</td>
</tr>
</tbody>
</table>

## Insurance Information

## Emergency Contact Information

## ED Plan

Gail knows the when she is short of breath and has gained 5+ pounds she needs to contact her cardiologist.

## About Me

- Preferred activities: Gardening, Volunteering at NMC
- How I learn: Verbal with written information to refer to
- Interaction tips: has difficulty discussing her illness
- Communication style: discuss non-personal issues before personal
- Tips to avoid triggers/behaviors: Needs a family member present with discussing future plans
- Mobility:

## My Care Plan

<table>
<thead>
<tr>
<th>Gail Matthews</th>
<th>12/15/1938</th>
</tr>
</thead>
</table>

## My Care Team
Care Navigator

- My Tasks
  - Activity Name: Readmission risk eval
  - Status: Not Start
  - Assigned To: Sandy Smith
  - High Priority
  - Estimated End Dat: 3/31/2016

- My Appointments
  - Start Date: 6/15/2016
  - Patient: Edwin P. Gonzalez
  - Activity Name: Take Your Medication
  - Normal Priority

- My Patients
  - Search for records
  - No Patient records found.

What's new:
1. Find and follow your colleagues
2. Comment on posts and other activity
3. Display your profile picture

Welcome!
This is your personal wall, where you'll see news about the colleagues and records you follow.

Brattleboro Memorial Hospital
Outcomes
Metrics

• Improved Health Outcomes
  – MIPs scores
  – Blueprint Practice Profiles
  – Increase in number of wellness visits and Physical Exams
  – Decreased ER Visits

• Lower Cost of Care
  – One Care Vermont Reports

• Number of Care Plans

• Patient Satisfaction
Next Steps
Next Steps

- Community Forums
- Accountable Communities for Health
- RISE VT
- Piloting 3 Day SNF Waiver
- Adding Care Coordinators
- 2018 MIPs Results
- 2018 One Care Score Card
- Optimize EMR
Thank You!
Any Questions?