Innovations to Improve Access in Primary Care

MDH Learning Days
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Jill Swenson, BAN, RN, CCM
Melissa Hurt, BSN, RN

Robin Mikkelsen, BSN, RN
Hilary Odegaard, BSN, RN
Learning Objectives

• Explain different visit types used by the clinical care team to manage patients that are healthy or have chronic diseases within the primary care setting

• Describe Sanford’s experiences with alternative visit types in the primary care setting, integrating and collaborating with the clinical care team, and lessons learned
Serving 2.74 million people in 300 communities across 252,215 square miles in nine states and four countries.

- 44 medical centers
- $4.4 billion in annual revenue
- 291 clinics
- 48 senior living facilities
- 179,598 Sanford Health Plan Members
- 1,360 physicians, 921 advance practice providers and 6,348 registered nurses delivering care in more than 80 specialty areas
- 28,334 employees

Each year, Sanford provides:
- 5.3 million outpatient and clinic visits
- 81,637 admissions
- 159,032 surgeries and procedures
- 9,465 births
- 214,236 emergency department visits
291 clinics
1,592 clinicians
"Dr. Kittle is now taking bids for his ten o'clock appointment on Tuesday."
Mr. Jones

• 58 year old male with Diabetes Type 2
• Last clinic visit was 5 years ago
• Conditions
  – Newly Diagnosed Depression and Hypertension
  – Chronic Pain
  – Obesity
  – Tobacco Use
Diabetic Patient

- Physician
- RN Care Manager
- Protocols
- Video Visit
- Group Visits
Care Team Members

• Providers
• RN Care Manager – Ambulatory and Community
• Integrated Health Therapist
• Dietician/Diabetic Educator
• Pharmacist
• Community Paramedic
• Advanced Care Planning Facilitators
• Licensed Social Worker
• Panel Assistants
RN Care Manager

• Identify and engage at risk patients
• Assessment of care needs / gaps
• Coordination of services
• Individualized care planning
• Patient education
• Promote self management of chronic conditions
Diabetic Education

• RN Care Manager
  – Referral
  – Initial teaching

• Diabetes experts
  – Continuous glucose monitoring

• Pilot project to embed in primary care

• RN Care Manager – initial education

• Access
  – Telehealth for visits
Mood Clinic

- Integrated Health Therapist
- Depression or Anxiety
- Weekly Clinic
- Screening Tools
Hypertension Clinic

- RN – Nurse led visit
  - new diagnosis of HTN or change in blood pressure medication
  - 10-15 minute visit

- RN Hypertension Protocol
  - Medication dose / adjustments
Chronic Pain Clinic

• Group Visit
  – Nurse Practitioner
  – Integrated Health Therapist
  – LPN
  – Pharmacist

• Pain Contract

• Group Discussion
  – Support
  – Behavioral Modification
Wellness clinic

• Group Visit – 3-6 month follow up for chronic diseases
  – Diabetes, HTN, Hyperlipidemia
• Care Team Members
• Family Wellness
  – Healthy cooking demonstration
  – Exercise in gym with trainer
• Education / Smart goals
Tobacco Cessation Support Group

- Community Based Program
- Quitting Tobacco Curriculum
- Formal program – 1 year
- NRT prescriptions
- Guest speakers
- No cost to attend
Not Feeling Well? Stay Home

• Alternative Visit Types offered from your home or office
  o E-Visit
  o Video Visit
  o TytoCare Visit
Sanford + TytoCare

TytoCare Visits

• Acute/urgent care medical need
• TytoHome exam kit
• https://www.youtube.com/watch?v=Pwqc35vbeGI
Questions
Thank You

Jill Swenson – jill.r.Swenson@sanfordhealth.org

Melissa Hurt – Melissa.hurt@sanfordhealth.org

Robin Mikkelsen – robin.mikkelsen@sanfordhealth.org

Hilary Odegaard – hilary.odegaard@sanfordhealth.org