



**Expanding the Care Coordination Team and moving to
Advanced Medical Home
Sanford Luverne Clinic**

Sanford Luverne Clinic

Sanford Luverne Clinic is a primary care clinic that has Certified Medical Home designation. As part of the Sanford Health system, the clinic is a department of a critical access hospital which offers the full spectrum of inpatient and outpatient integrated care including Home Health and Home Medical equipment, Hospice Care/Hospice Cottage, and outpatient Chemical Dependency treatment.

The clinic provider leadership consists of 8 family medicine physicians, 1 certified nurse practitioner and 1 General Surgeon. An OBGyn will be joining the practice in 2017. The service population is approx. 10,000.



Three “Buckets of Work”



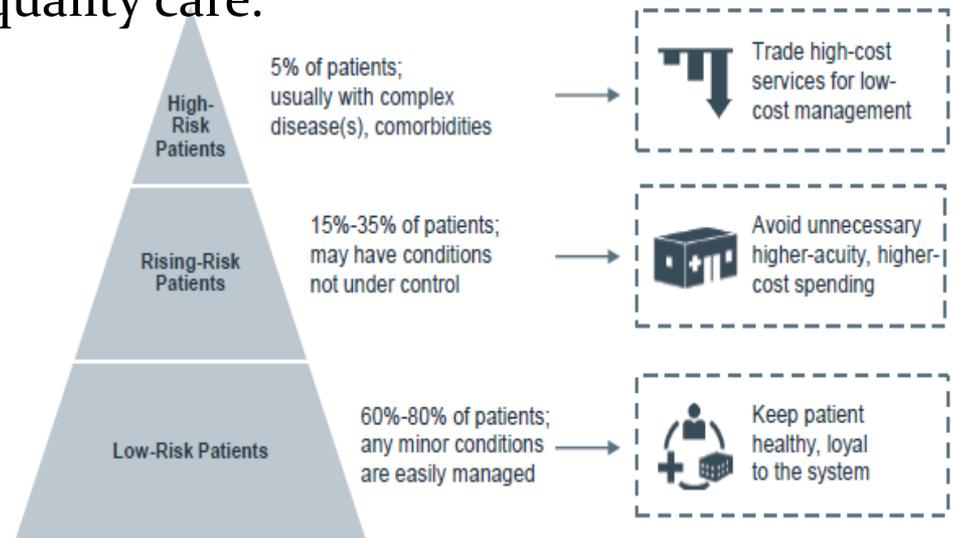
- Acute Illness
 - Ensure there is same day appointment access (with primary care provider (PCP) whenever possible) “Same Day at Sanford”
 - Patients seen in the right level of care
 - Visit is initiated by patients
- Chronic Disease Management
 - Patients are seen routinely for proactive management of chronic illnesses based on evidence based care management guidelines
 - Visit is initiated primarily by clinic -especially in diabetes and depression
 - Focus of our SIM grant
- Preventive Services
 - Patients are seen routinely for annual testing and exams
 - Work is initiated by clinic and patient

Advanced Medical Home Goals

Sanford Luverne Clinic was awarded a 6 month State Innovation Model (SIM) grant Feb 2015-July 2015. Goals were to:

Define the care coordination strategy

- Optimize population management of low risk, rising risk and high risk patients
- Focus all members of the care team (including the patient) on a common goal of efficient, quality care.



Advanced Medical Home Goals

Expand care coordination team

- Expand the team to include Behavioral Health Triage Therapist (BH TT), RN Health Coach, Care Coordinator Assistant (CCA), Certified Diabetes Educator (CDE) Dietitian. Future plan is to add a PharmD to the team.
- Adding a Care Coordinator Assistant to the team would allow other members of the team to work to the top of their licenses.

Increase optimal care in diabetes and depression

- Identify the processes and tools necessary to provide optimum evidence-based care.
- Improve clinical outcomes and compliance for patients diagnosed with diabetes and depression, improve MNCM scores (optimal diabetes and depression scores)

Advanced Medical Home Goals

Through increased efficiency of care coordination team, including the RN Health Coach, **allow for more face to face RN Health Coach visits and more patients tiered with Minnesota Health Care Home.**



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Optimal Care- Pieces of the Puzzle



Members of the Care Team



- Patient and family
- Physician or Advanced Practice Provider (APP) (PCP)
- Triage and Direct Support nursing staff
- Hospital, Home Health, Hospice care providers
- Patient Access and scheduling staff
- Community resources and behavioral health resources.
- Out-patient Chemical Dependency program

Members of the Care Team

Sanford Luverne Clinic Care Coordination Team

RN Health Coach (1 fte)

- Assists in identifying care needs of selected patient populations (Population management)
- Assesses, tiers and enrolls patients in the Health Care Home
- Acts as liaison between patient and provider
- Works directly with patients on goal setting and personal health planning, using motivational interviewing techniques to drive behavioral changes.
- Assists patients to appropriate additional resources for care, as identified- ie, Diabetes Education, Food Stamps, Family Services
- Assists team with coordination of clinically complex patient care, especially where resources are tight (Behavioral Health and Dietitian).
- Represents the clinic as part of a community based care team.

Members of the Care Team

Sanford Luverne Clinic Care Coordination Team

Care Coordinator Assistant (.6 fte)

- Using registries and reports, monitor populations for gaps in care and testing.
- Defines individual patient care coordination and preventive health/chronic disease management needs.
- Assists with pre-visit planning, proactive health management and preventive care.
- Using evidence based/physician approved criteria, directs patients to RN Health Coach and BHTT.
- Monitors and tracks patients' referrals for health care services. (HCH referral tracking)

Members of the Care Team

Sanford Luverne Clinic Care Coordination Team

Behavioral Health Triage Therapist (BHTT) (LICSW or LPCC) (.5 fte added after the grant)

- Assists in identifying behavioral health care needs of selected patient populations (Population management)
- Works directly with patients on goal setting and personal behavioral health planning, providing short term direct care.
- Transitions patients to appropriate specialty care as identified- ie, local mental health providers- SW Behavioral Health, Psych telehealth referrals, or referrals to providers in Sioux Falls.



Members of the Care Team

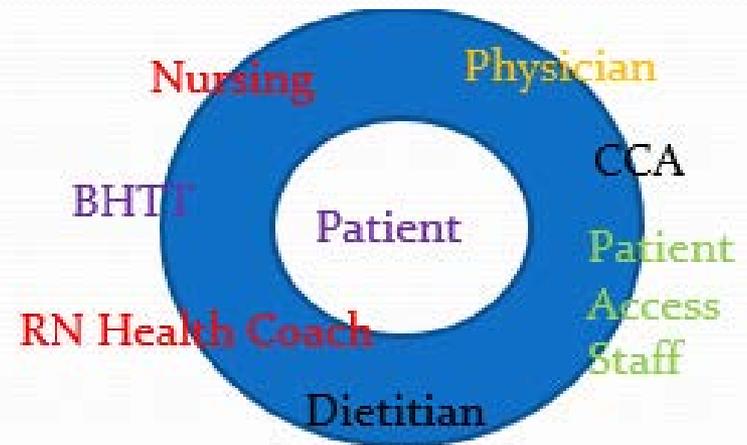


CDE Dietitian (.2 fte)

- Works with the physician, patient and RN Health Coach
- Provides focused patient counseling on diabetes, obesity and other medical nutrition therapy, (MNT), including Intensive Behavioral Therapy (IBT)
- Facilitates referral for formal diabetes education program as warranted.

Advanced Medical Home: Diabetes

- Chronic Disease Management visits per Diabetes Protocol
- Pre-visit planning by nursing
- Testing and Surveillance needs tracked individually and through Healthy Planet registry-- added to appointment note lines.
- Gap scores on the schedule and gap cards used at the visit
- Best practice alerts (BPA) and Health Maintenance are tools embedded in EPIC
- Providers enter disposition and recall system is initiated
- Front desk uses recall reports and disposition report to capture need for next visit.



Gap Scores

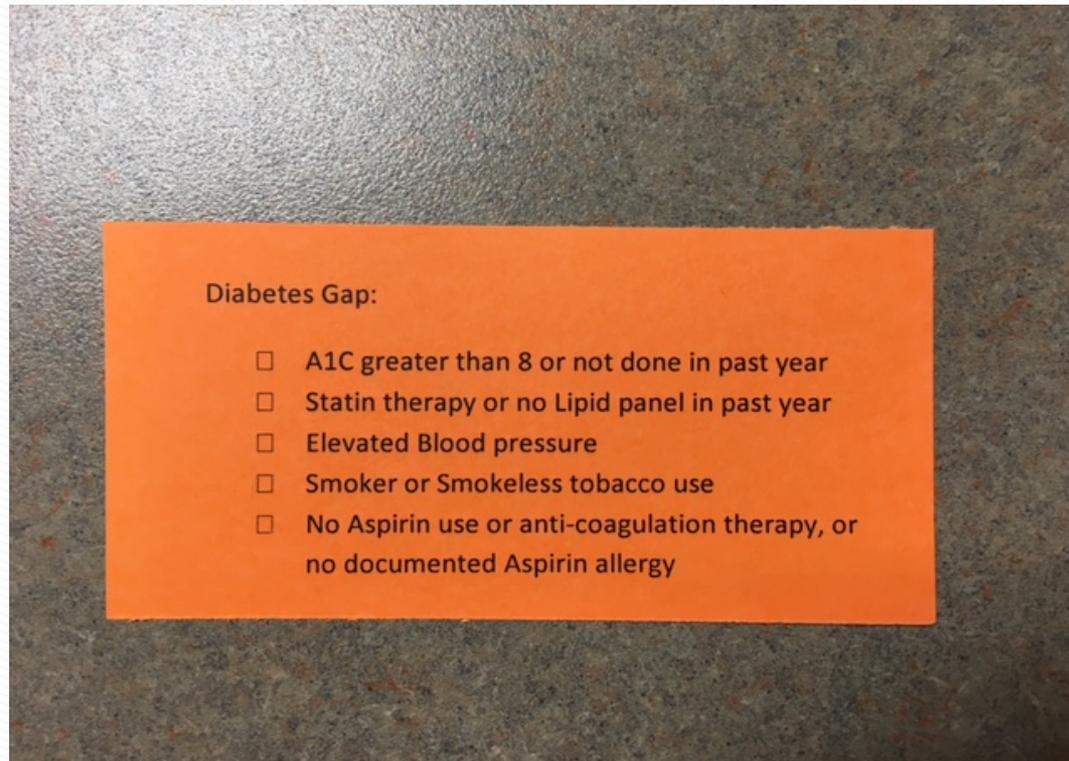


Patient Gap Scores

Hovering over a score will display a pop-up with scoring and rationale for each of the score components.

1	7/	1 Diabetes Gap Score This score indicates how many of the standard goals for optimal care a patient is failing to meet - A1c: < 8.0 and within last year; LDL: within last year, value and statin use (or allergy) based on age; Last clinic BP < 140/90; Tobacco free; Aspirin, Anticoagulant or Antiplatelet use (or allergy) if IVD Dx 0 points Hemoglobin A1c: 5.5 , A1c Date: 7/1/2014 1 point Age: 65 , Prescribed statins: No , Statin Allergy: Not on file , Last LDL: 102 , LDL Date: 7/1/2014 0 points Blood Pressure: 136/86 0 points Tobacco use status: Quit Age: 65 , Prescribed salicylates: No , Antiplatelet or Anticoagulant Allergy: No , Has IVD: No , Aspirin Allergy: No , Prescribed Antiplatelets or Anticoagulants: No	5/
2	2/		7/
2	9/		5/
2	3/		7/
0	1/		5/
2			7/
0	11/		4/
1	2/		0/

Gap cards are a low tech way to prompt providers as to patient needs. They are used by nurses on the floor at the time of visit.



Diabetes

CCA identifies patients from the registry who may have care coordination needs and refers to RN Health Coach for further assessment and follow up, using these general guidelines.

1. Polypharmacy- 10 or more medications or 5 or more prescription medications
2. 3 or more chronic conditions
3. Body Mass Index (BMI) > 30
4. Pre-diabetes - BMI > 30, A1C > 5 or screening blood glucose > 110, LDL/lipids elevated
5. Patient request for care coordination assistance

Advanced Medical Home: Depression

- The clinic identified a key gap in meeting the 5-7 month recheck criteria for PHQ-9 scores with MNCM
- A depression report was built and is provided for the clinic monthly.
- Provider and nurse training was done regarding the PHQ-9 screening tool and it's use.
- A consistent process for PHQ and GAD paperwork and screening was established with the front desk. (focus on operations)
- The clinic dealt with sensitivity to privacy and MD/Patient relationship

Care Coordinator Assistant works the depression report to ensure chronic disease management visits, timely PHQ-9 screening completion, dealing with the 5-7 month rescreening issue the clinic had problems managing.



Depression

After the Grant...

A part time LPCC Behavioral Health Triage Therapist was added in November, 2015 (after the grant period ended). The therapist receives referrals directly from the providers, and also identifies patients through care coordination. The CCA reviews the registry PHQ-9 scores and refers patients to the RN Health Coach and/or BHTT for follow up and care coordination.

Through demonstration of enhanced evidence based visit numbers as well as improved outcomes, the clinic was able to permanently staff a .6 CCA as part of the care team.

Findings

	2/15	7/15	2/16
• Average PHQ-9 score	12.15	11.36	10.25
• # pts w/ 9 or less score	29.8%	36%	42%
• Optimal Depression	0%	5%	6.1%
• Optimal Diabetes	38.1%	44.7%	51.9%



Questions

