OneCare Vermont Update

Green Mountain Care Board

March 16, 2017

OneCareVermont

OneCare CEO Update to GMCB

- Key Updates
  - VCO collaboration in place but still a work in progress
  - Vermont Medicaid Next Generation program is source of strong innovation and illustrates where providers want to go
  - Getting ready for the true APM era
    - 2018 planning and budgeting underway, aligned with implementation of Act 113
  - All along have been building the Quality Improvement and Population Health Management (PHM) capabilities with supporting advanced informatics
    - Updates in this arena will form the bulk of our presentation today
    - Philosophy always designed for community-based leadership by helping facilitate PHM as core function of the delivery system rather than a separate layer

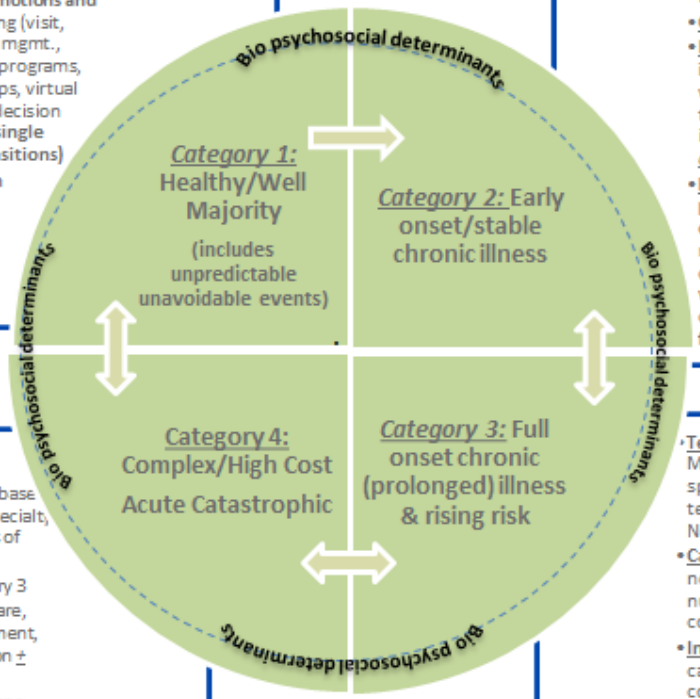
OneCare CEO Update to GMCB

- Other Messages and "Food for Thought"
  - **GMCB is essential element to APM and reform momentum in Vermont**
    - Drive continued understanding and support for APM across stakeholders
    - Help facilitate an effective ACO model as the backbone if serious about scale targets
  - **Shifting the Dialogue on Cost Control**
    - From "do ACOs save money?" to "is the ACO model the best way to improve quality and maintain or expand access while living within a pre-set cost target?"
    - Key Point: When move to risk-based ACO model, savings are "baked in" and Vermont must see that as a major advantage
  - **Even with GMCB leadership, ACO model requires Strong Payer Partnerships**
    - Must demonstrate that we bring a real and different approach to better, more efficient care ("walking the talk")
    - Programs must be mutually-acceptable on target-setting, risk-sharing, and quality measurement and incentives
    - Must do our best to avoid duplication or competition among ACO and payer-side infrastructure
  - **Transition Expenses and Early Investments are a Real Consideration**
    - Success on quality, public health, and cost measures in APM agreement will require early efforts since many will take years to deliver full impact
    - There are strong expectations on payment reform for primary care and reinvestment to upstream, community-based care and prevention
    - ACO infrastructure expenses are necessary and require support (especially if envision a unified ACO model), and are focused heavily on tools and assistance for Population Health Management

Population Health Model

Population Health Model

- Team: Primary care medical homewith practice level support
- Care Supports: 2,3,6,
- Interventions: Health promotions and wellness, wellness screening (visit, survey), panel and quality mgmt., preventive care, incentive programs, automated interaction (apps, virtual visits, pt. portals), shared decision making, and managing of single episode events (e.g., transitions)
- Focus: Primary prevention



- Team: Primary care medical home with specialty consultation and return to PCP
- Care Supports: 1-7
- Interventions: Motivational interviewing, healthy living workshops, defined referral to specialist, short term interventional services + *all category 1*
- Focus: Prevention progression and complication (optimal management of chronic disease), self management, wellness & education; care coordination, social and family support

- Team: PCMH, Community base care teams and ongoing specialt, center care and/or centers of excellence
- Care Supports: Per Category 3
- Interventions: Palliative care, specialty/tertiary management, intensive home intervention + *select category 3*
- Focus: Manage complications, avoid hospitalization, residential placement, and other rescue care, palliative care and end of life discussions

- Teams: Patient Centered Medical Home with ongoing specialty and community care teams ("Medical Neighborhood")
- Care Supports: 1-7 based on need with more intensive nurse-social worker coordination
- Interventions: Single point of care coordinator contact, full continuum integration, shared care planning + *majority of category 2*
- Focus: Category 2 plus Care coordination, social support and family support

- Complex individuals tend to have multiple co-existing severe conditions- requiring care coordination, community based services and partnerships with specialty care, CHT, and community health team serving the Medical Home
- That could be a Patient Centered Medical Home or select Patient Centered Specialty Practices (e.g., Designated Agencies, SSAs, oncology, cardiology, opiate Hubs) serving as specialty medical homes

Primary Care Medical Home Attributes:

- Access
- Continuity
- Coordination
- Holistic (inc. Social determinants)
- Performance driven
- Technology enabled

Patient Centered Medical Home Care (PCMH) Physician /Advanced Practice Provider Support Team NP, PA):

1. **Health Coaches**
2. **Medical Assistants**
3. **Triage Nurse**
4. **Nurse Care coordinator /Nurse educator**
5. **Social Worker**
6. **Registry manager**
7. **Community Health and Based Team (e.g. dietician, pharmacist, MH/SA, LADC, intensive family/school based clinicians, outreach providers, etc.)**

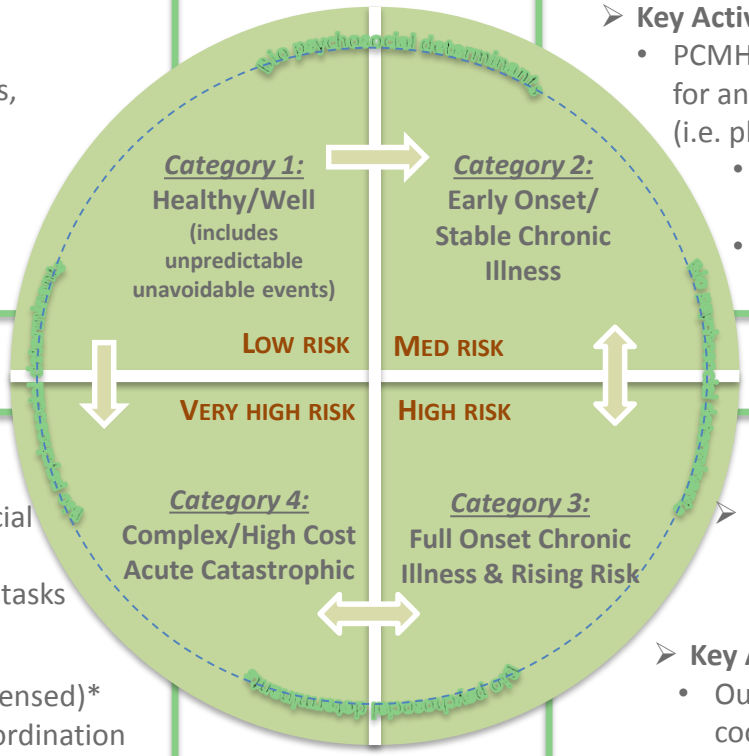
Future State:

- All types of Medical Homes have access to a Community Health Team
- Aligned and defined referral system with DA/SSA and community based care teams
- Embedded Community Health Team supports for larger practices
- Increase role of Health Coach and community health/based teams such as pharmacists, psychiatrists, psychologists, crisis workers, family based clinicians, physical therapy, etc.

Care Coordination Model

- **44% of the population**
- **Focus:** Maintain health through preventive care and community-based wellness activities
- **Key Activities:**
  - PCMH panel management
  - Preventive care (e.g. wellness exams, immunizations, health screenings)
  - Wellness campaigns (e.g. health education and resources, wellness classes, parenting education)

- **40% of the population**
- **Focus:** Optimize health and self-management of chronic disease
- **Key Activities:** Category 1 plus
  - PCMH panel management: outreach (≥2/yr) for annual Comprehensive Health Assessment (i.e. physical, mental, social needs)
    - Disease & self-management support* (i.e. education, referrals, reminders)
    - Pregnancy education



- **6% of the population**
- **Focus:** Address complex medical & social challenges by clarifying goals of care, developing action plans, & prioritizing tasks
- **Key Activities:** Category 3 plus
  - Designate lead care coordinator (licensed)*
  - Outreach & engagement in care coordination (at least monthly)*
  - Coordinate among care team members*
  - Assess palliative & hospice care needs*
  - Facilitate regular care conferences *

- **10% of the population**
- **Focus:** Active skill-building for chronic condition management; address co-occurring social needs
- **Key Activities:** Category 2 plus
  - Outreach & engagement in care coordination (≥4x/yr)*
  - Create & maintain shared care plan*
  - Coordinate among care team members*
  - Emphasize safe & timely transitions of care
  - SDoH management strategies*

* Activities coordinated via Care Navigator software platform

Overarching Population Health Management Themes

- Improve network performance on quality metrics
  - Vermont All Payer Model
  - Medicare SSP
  - Vermont Medicaid Next Generation
  - Commercial XSSP
- Support “risk communities” with Vermont Medicaid Next Generation contractual requirements in 2017 and prepare remaining network participants and affiliates to succeed in future risk contracts
- Favorably impact performance against “all inclusive population-based payment” targets
- Using data to drive delivery system change
- Special population emphasis
- Maximize participation by *all* network members
- Initiate a primary prevention project

Clinical Priorities

- High-risk patient care coordination
  - Goal: Reduce acute admissions and ED utilization by 5% in this high risk cohort
- Episode of care variation
  - Goal: Reduce skilled nursing facility length of stay 5%
- Mental health and substance abuse
  - Goal: Increase within-30-day ambulatory care follow-up for emergency room discharges for mental health and substance abuse diagnoses
- Chronic disease management optimization
  - Goal: Reduce ambulatory sensitive condition admissions/readmissions for COPD and heart failure by 5%
- Prevention and wellness
  - Goal: Increase network utilization of Medicare annual wellness visit, adolescent well child visit, and developmental screening by 5%

Quality Measurement and Improvement

2015 Medicare Quality Measure Scores

Performance Year 3: Reporting and Performance Measures

	Measure		PY 2015	30th (1.10)	40th (1.25)	50th (1.40)	60th (1.55)	70th (1.70)	80th (1.85)	90th (2.00)	OCV 2013	OCV 2014	OCV 2015	OCV QI	CMS QI	n 2015	Quality Points 2015
Patient/Caregiver Experience	1	Getting Timely Care, Appointments, and Information	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	83.81	85.01	79.26	▼	▽	261	1.70
	2	How Well Your Doctors Communicate	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	92.54	92.47	93.39			262	2.00
	3	Patients' Rating of Doctor	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	91.84	91.45	92.25			246	2.00
	4	Access to Specialists	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	82.21	86.00	79.71		▽	104	1.70
	5	Health Promotion and Education	P	54.71	55.59	56.45	57.63	58.22	59.09	60.71	59.46	60.61	57.55			310	1.40
	6	Shared Decision Making	P	72.87	73.37	73.91	74.51	75.25	75.82	76.71	75.98	73.81	75.71			233	1.70
	7	Health Status/Functional Status	R	N/A	N/A	N/A	N/A	N/A	N/A	N/A	73.70	74.12	75.19			310	2.00
	34	Stewardship and Patient Resources	R	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	20.26			293	2.00
Care Coordination	8	Risk Standardized, All Condition Readmissions	P	16.62	16.41	16.24	16.08	15.91	15.72	15.45	14.75	14.84	14.73			-	2.00
	35	Skilled Nursing Facility 30-day All-Cause Readmission measure (SNFRM)	R	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	15.72			-	2.00
	36	All-Cause Unplanned Admissions for Patients with Diabetes	R	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	52.08			-	2.00
	37	All-Cause Unplanned Admissions for Patients with Heart Failure	R	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	83.26			-	2.00
	38	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	R	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	66.82			-	2.00
	9	ASC Admissions: COPD or Asthma in Older Adults	P	1.75	1.46	1.23	1.00	0.75	0.56	0.27	1.25	0.89	0.83		△	-	1.55
	10	ASC Admission: Heart Failure	P	1.33	1.17	1.04	0.90	0.76	0.59	0.38	1.22	1.07	0.87		△	-	1.55
	11	Percent of PCPs who Qualified for EHR Incentive Payment	P	51.35	59.70	65.38	70.20	76.15	84.85	90.91	57.55	72.26	97.83	▲	△	783	4.00
	39	Documentation of Current Medications in the Medical Record	R	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	79.03			1750	2.00
	13	Falls: Screening for Fall Risk	P	17.12	22.35	27.86	35.55	42.32	51.87	73.38	46.30	47.31	65.56	▲	△	363	1.85
Preventive Health	14	Influenza Immunization	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	71.36	63.81	68.15		△	336	1.55
	15	Pneumococcal Vaccination	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	77.73	77.80	84.70	▲	△	366	1.85
	16	Adult Weight Screening and Follow-up	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	70.94	70.81	71.94			360	1.70
	17	Tobacco Use Assessment and Cessation Intervention	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	91.37	96.67	93.46	▼		367	2.00
	18	Depression Screening	P	5.31	10.26	16.84	23.08	31.43	39.97	51.81	24.71	28.07	35.42	▲	△	271	1.70
	19	Colorectal Cancer Screening	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	65.33	70.27	70.36			361	1.70
	20	Mammography Screening	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	68.04	71.12	75.14		△	362	1.70
	21	Proportion of Adults who had blood pressure screened in past 2 years	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	68.66	66.43	80.62	▲	△	258	1.85
At-Risk Populations	40	Depression Remission at Twelve Months	R	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	4.35			23	2.00
	Diabetes Composite	ACO #27:Percent of beneficiaries with diabetes whose HbA1c in poor control (>9 percent) Hemoglobin A1c Control (HbA1c) (<8 percent) ACO #41: Diabetes - Eye Exam	R	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	53.85			364	2.00
	28	Percent of beneficiaries with hypertension whose BP < 140/90	P	60.00	63.16	65.69	68.03	70.89	74.07	79.65	67.04	70.57	71.21			257	1.70
	30	Percent of beneficiaries with IVD who use Aspirin or other antithrombotic	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	86.65	90.02	92.86			308	2.00
	31	Beta-Blocker Therapy for LVSD	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	81.78	84.12	80.52			154	1.85
	33	ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD	P	64.37	70.43	75.07	78.28	82.53	86.75	91.67	N/A	N/A	84.75			223	1.70
																Total:	60.75

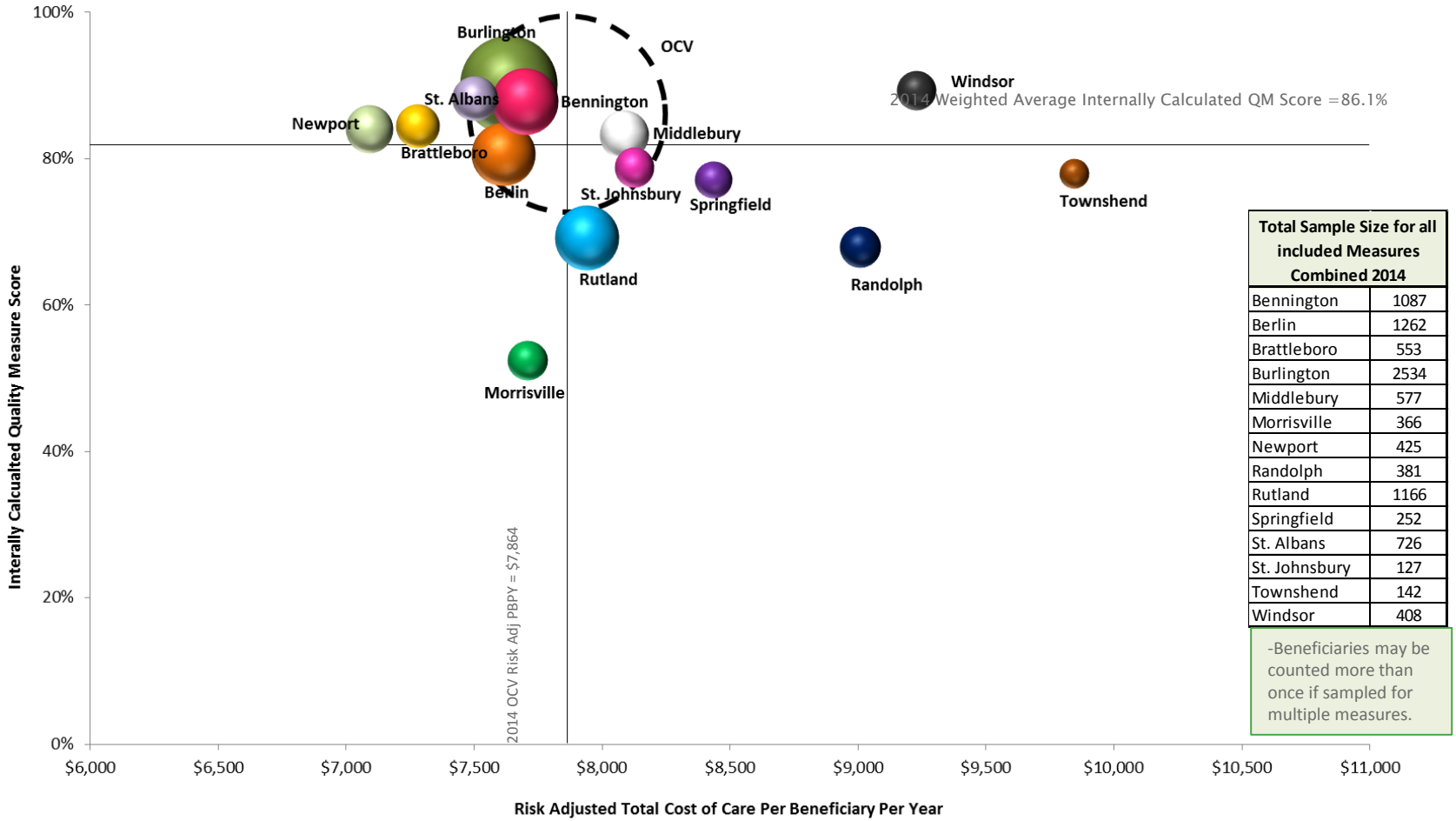
▲ = statistically significant improvement in score from 2014 to 2015 based on p-value < 0.05
▼ = statistically significant decline in score from 2014 to 2015 based on p-value < 0.05

△ = Significant Improvement based on CMS Quality Improvement Report.
▽ = Significant Decline based on CMS Quality Improvement Report.

2015 Percentile
2014 Percentile
2014 & 2015 Percentile (No Change)

2015 Final Score	2014 Final Score	Percent Change
96.1%	89.2%	↑ 6.9%

Medicare 2014 Quality Scores with Clinical and Claims Based Measures vs Risk Adjusted Total Cost of Care by HSA



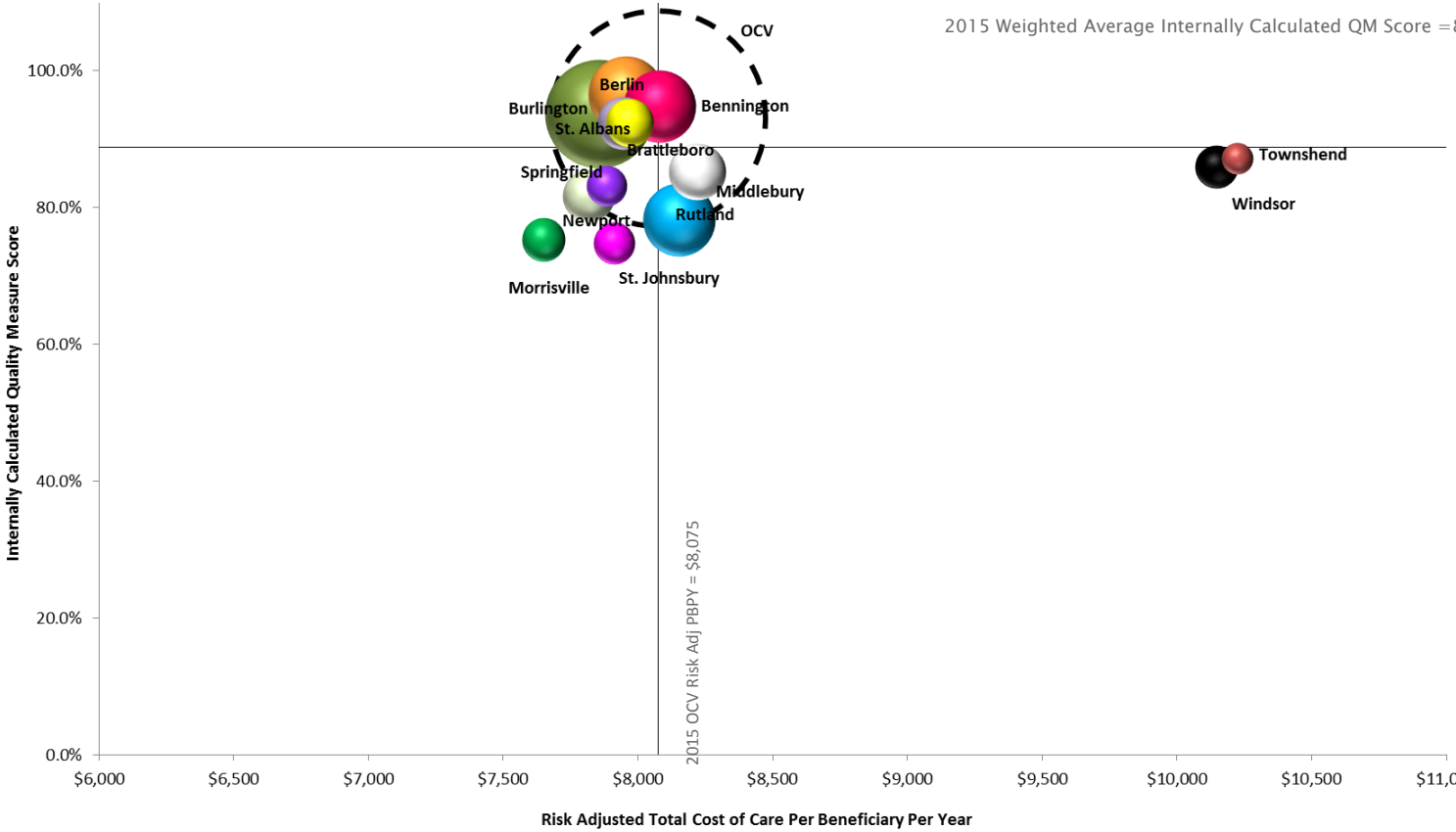
Total Sample Size for all included Measures Combined 2014	
Bennington	1087
Berlin	1262
Brattleboro	553
Burlington	2534
Middlebury	577
Morrisville	366
Newport	425
Randolph	381
Rutland	1166
Springfield	252
St. Albans	726
St. Johnsbury	127
Townshend	142
Windsor	408

-Beneficiaries may be counted more than once if sampled for multiple measures.

Notes:

- Measures that could reliably be broken out by HSA were included in internally calculated scores, this excludes measures calculated with O/E ratios by the payer and survey measures.
- Medicare 2014 includes measures 8, 12, 13, 14 ,15 ,16 ,17 ,18, 19, 20, 21, 22-26, 27, 28, 29, 30, 31, 32-33.
- Only about 5% of the Medicare population was chosen for clinical quality measure reporting.
- Bubble Size indicates population size (OCV attributed population).
- CMS-HCC risk score was used for risk adjustment.
- Spend based on OCV claims data 1/1/2014 - 12/31/2014 with claims run out through 3/31/2015. For beneficiaries attributed to OCV Q4 2014.

Medicare 2015 Quality Scores with Clinical and Claims Based Measures vs Risk Adjusted Total Cost of Care by HSA



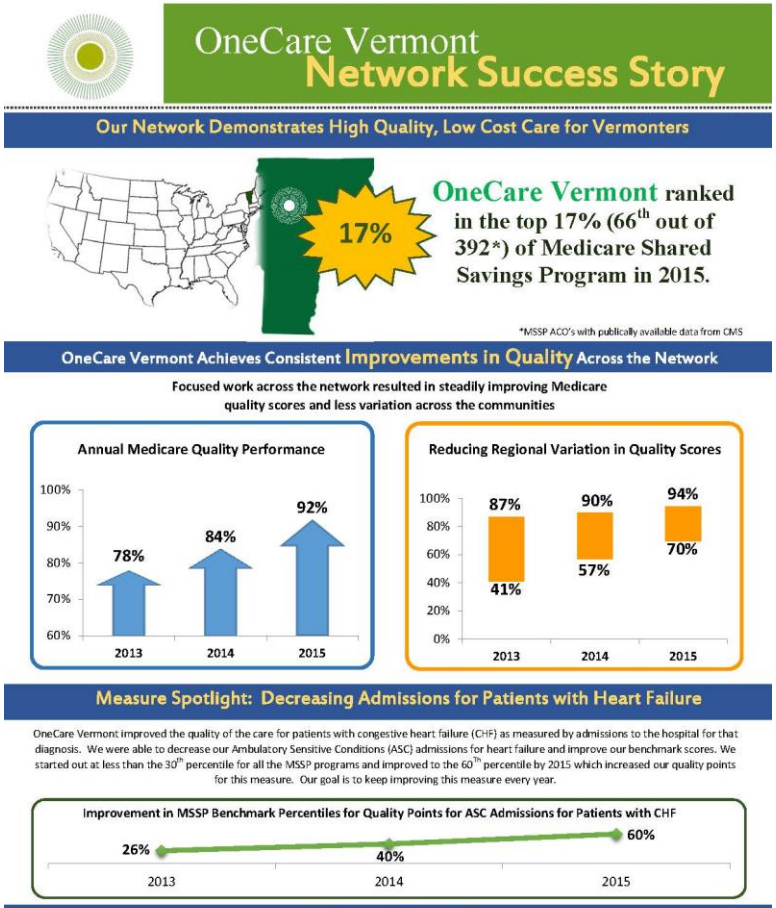
Total Sample Size for all included Measures Combined 2015	
Bennington	1624
Berlin	1726
Brattleboro	616
Burlington	3700
Middlebury	937
Morrisville	562
Newport	840
Rutland	1774
Springfield	531
St. Albans	782
St. Johnsbury	381
Townshend	234
Windsor	472

-Beneficiaries may be counted more than once if sampled for multiple measures.

Notes:

- Measures that could reliably be broken out by HSA were included in internally calculated scores, this excludes measures calculated with O/E ratios by the payer and survey measures.
- Medicare 2015 includes measures 8, 39, 13, 14, 15, 16, 17, 18, 19, 20, 21, 40, 27, 41, 28, 30, 31 and 33.
- Randolph HSA did not have any eligible individuals chosen for quality measures in 2015.
- Only about 5% of the Medicare population was chosen for clinical quality measure reporting.
- Bubble Size indicates population size (OCV attributed population).
- CMS-HCC risk score was used for risk adjustment.
- Spend based on OCV claims data 1/1/2015 – 12/31/2015 with claims run out through 3/31/2016. For beneficiaries attributed to OCV Q4 2015.

Network Success Stories



OneCare Vermont
Network Success Story

Our Network Demonstrates High Quality, Low Cost Care for Vermonters

17%

OneCare Vermont ranked in the top 17% (66th out of 392*) of Medicare Shared Savings Program in 2015.

*MSSP ACO's with publically available data from CMS

OneCare Vermont Achieves Consistent Improvements in Quality Across the Network

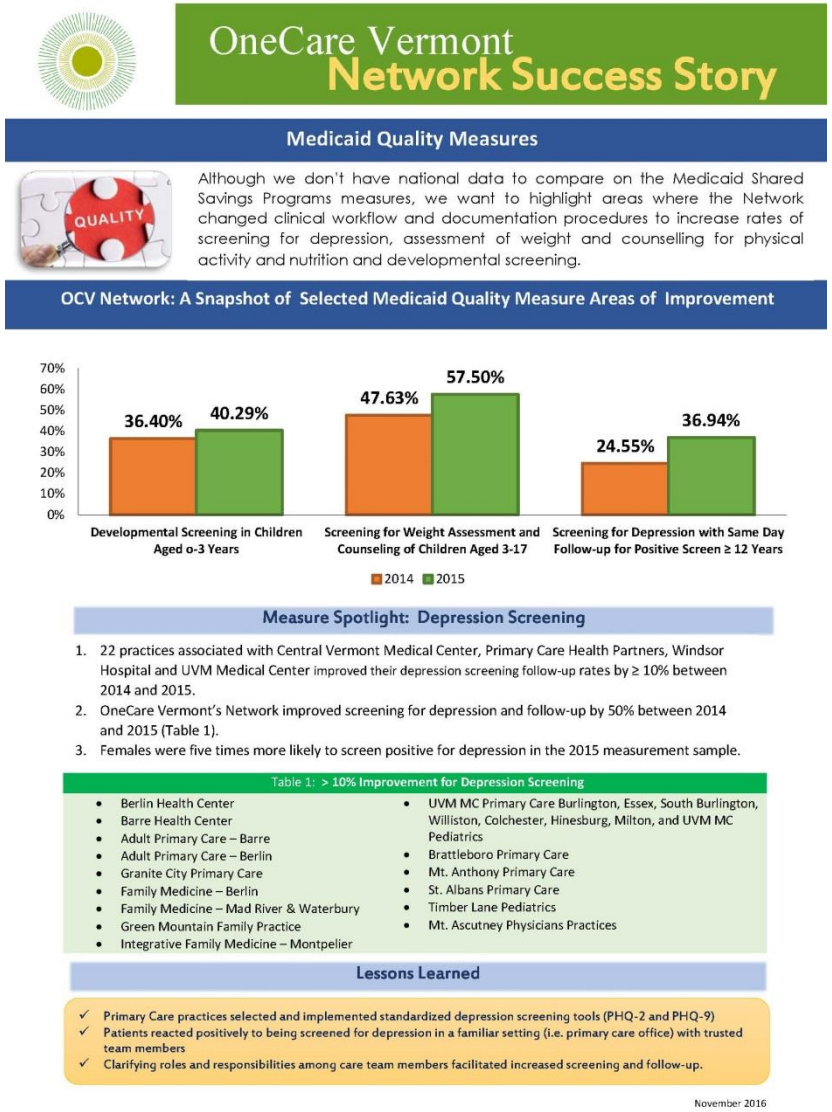
Focused work across the network resulted in steadily improving Medicare quality scores and less variation across the communities

Measure Spotlight: Decreasing Admissions for Patients with Heart Failure

OneCare Vermont improved the quality of the care for patients with congestive heart failure (CHF) as measured by admissions to the hospital for that diagnosis. We were able to decrease our Ambulatory Sensitive Conditions (ASC) admissions for heart failure and improve our benchmark scores. We started out at less than the 30th percentile for all the MSSP programs and improved to the 60Th percentile by 2015 which increased our quality points for this measure. Our goal is to keep improving this measure every year.

Lessons Learned

- Breaking performance goals down into small, actionable steps creates opportunities for meaningful improvement
- Appealing to provider's desire to provide the right care, at the right time, to the right patients is a good starting place to motivate change and improvement
- Sharing data across the Network generates positive competition and sparks action
- Testing a variety of interventions as pilots across the Network and spreading successes results in faster improvement in quality measure scores



OneCare Vermont
Network Success Story

Medicaid Quality Measures

Although we don't have national data to compare on the Medicaid Shared Savings Programs measures, we want to highlight areas where the Network changed clinical workflow and documentation procedures to increase rates of screening for depression, assessment of weight and counselling for physical activity and nutrition and developmental screening.

OCV Network: A Snapshot of Selected Medicaid Quality Measure Areas of Improvement

Measure Spotlight: Depression Screening

1. 22 practices associated with Central Vermont Medical Center, Primary Care Health Partners, Windsor Hospital and UVM Medical Center improved their depression screening follow-up rates by ≥ 10% between 2014 and 2015.
2. OneCare Vermont's Network improved screening for depression and follow-up by 50% between 2014 and 2015 (Table 1).
3. Females were five times more likely to screen positive for depression in the 2015 measurement sample.

Table 1: > 10% Improvement for Depression Screening

- Berlin Health Center
- Barre Health Center
- Adult Primary Care – Barre
- Adult Primary Care – Berlin
- Granite City Primary Care
- Family Medicine – Berlin
- Family Medicine – Mad River & Waterbury
- Green Mountain Family Practice
- Integrative Family Medicine – Montpelier
- UVM MC Primary Care Burlington, Essex, South Burlington, Williston, Colchester, Hinesburg, Milton, and UVM MC Pediatrics
- Brattleboro Primary Care
- Mt. Anthony Primary Care
- St. Albans Primary Care
- Timber Lane Pediatrics
- Mt. Ascutney Physicians Practices

Lessons Learned

- ✓ Primary Care practices selected and implemented standardized depression screening tools (PHQ-2 and PHQ-9)
- ✓ Patients reacted positively to being screened for depression in a familiar setting (i.e. primary care office) with trusted team members
- ✓ Clarifying roles and responsibilities among care team members facilitated increased screening and follow-up.

November 2016

Medicare Quality Payment Program

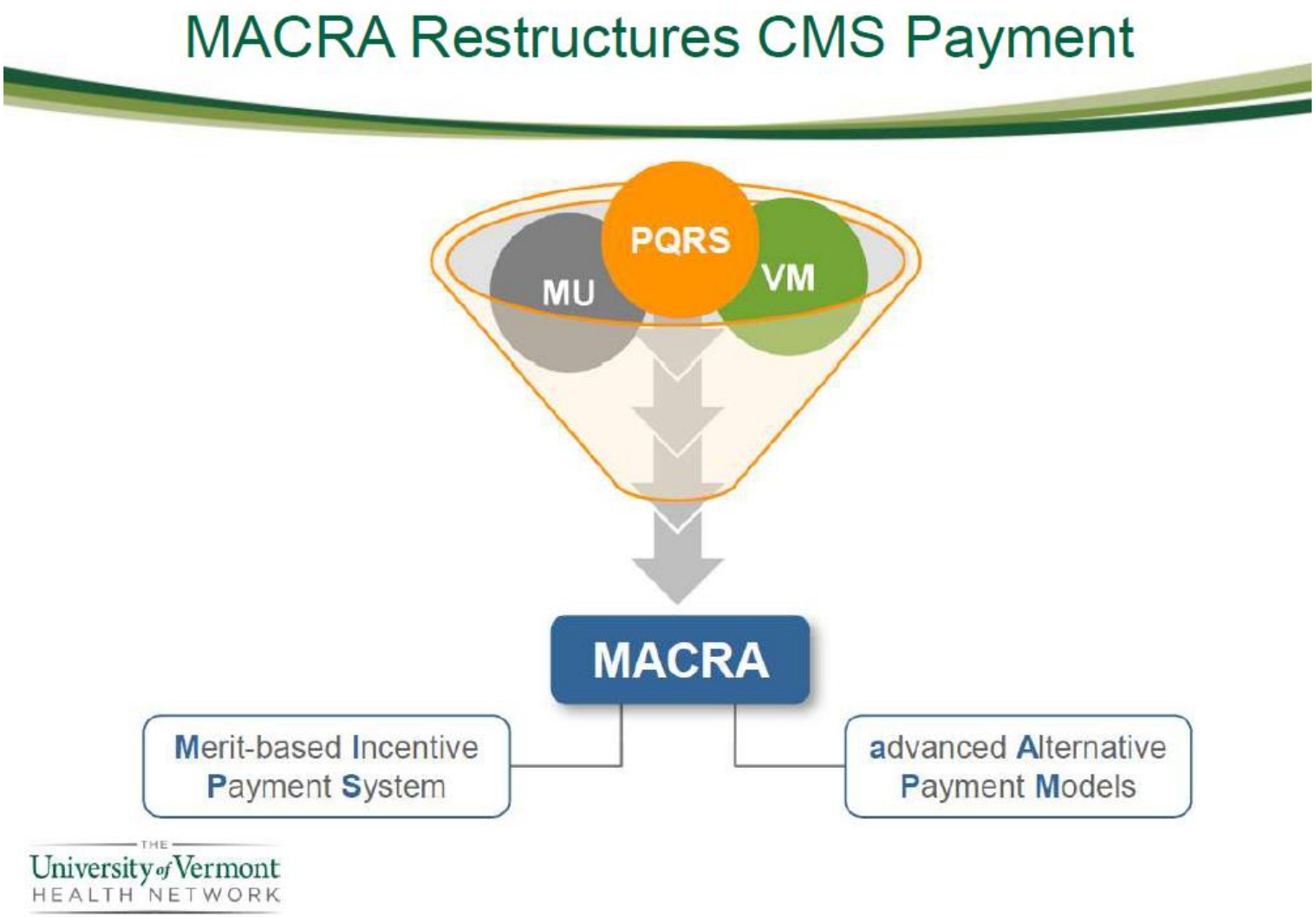
MACRA/MIPS

Congress created the Merit-based Incentive Payment System to “fix” (repeal) the Medicare Sustainable Growth Rate (SGR) methodology annual crisis and blend existing CMS quality/value programs into a single score with significant potential for impacting physician reimbursement.

Even if you are not in an ACO there is *no place to hide*…

Linking payment to quality…

MACRA/MIPS (Cont'd)



Bottom Line for Medicare Shared Savings ACOs

- **QUALITY:** MSSP quality measure reporting
- **ADVANCING CARE INFORMATION (ACI):** each TIN submits attestation using MIPS data submission mechanism; ACO score is weighted average of all participant TINs
- **COST:** not applicable for 2017 MIPS score; begins in 2018
- **CLINICAL PRACTICE IMPROVEMENT ACTIVITIES:** Track 1 MSSP ACOs receive full credit

Bundles (Episodes) of Care

Context

- **Most common surgical procedure for OneCare Vermont's attributed Medicare patients**
- 90 day "bundle" data on 1216 primary hip/knee arthroplasty procedures in 2015
- DRG 469 and 470
- 234 cases (19%) non-participant hospitals
- **Mean 90 day bundle Medicare expenditure $25,149**
- $30,581,907 total Medicare expenditures for OneCare Vermont primary hip/knee bundles

Variation – 90 day Bundle (by hospital)

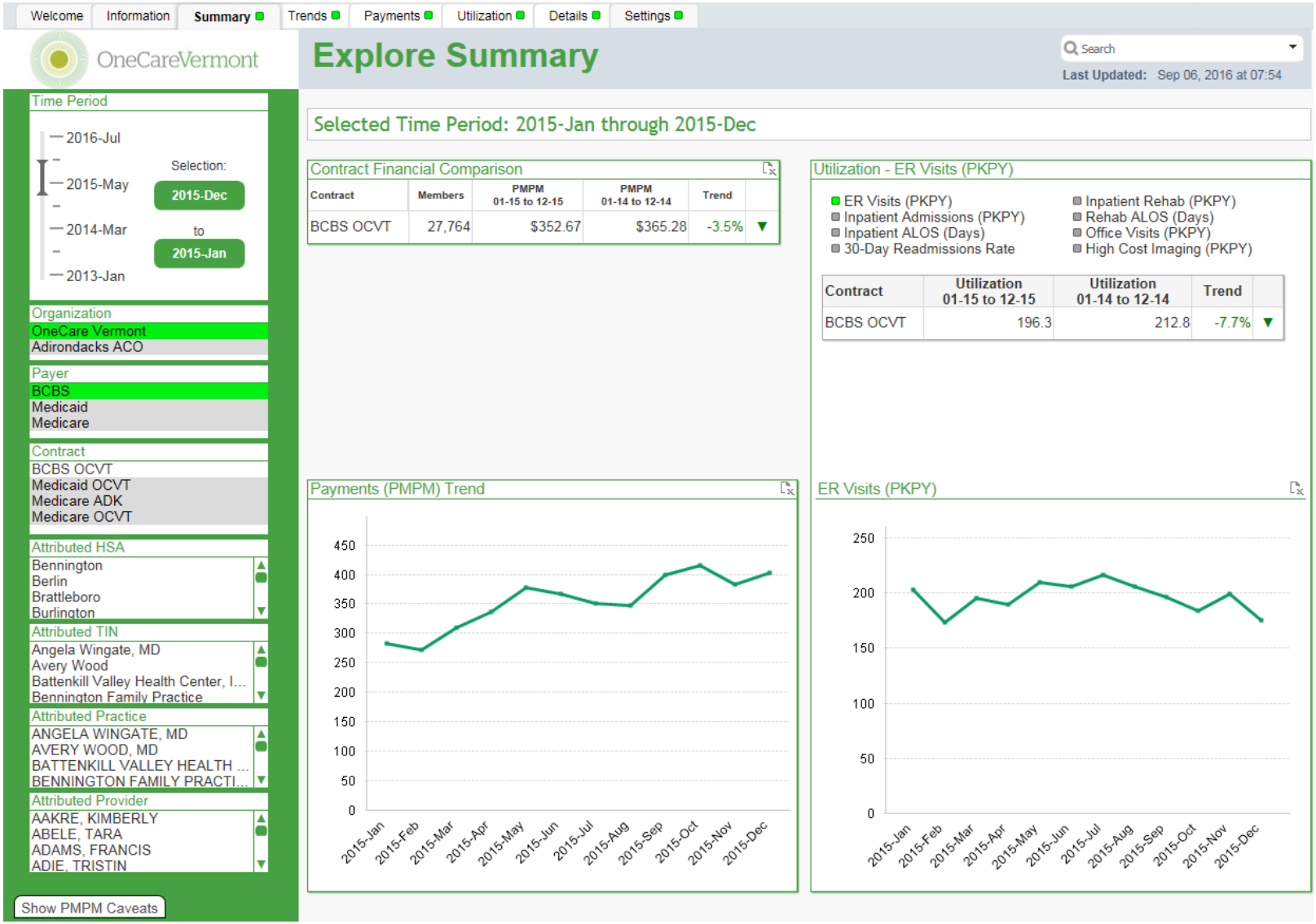
- **In-network hospital case volume (15-219)**
- **Post-acute total Medicare expenditure ($5097-$14,576)**
- **Post-acute expenditure as % of total bundle (28-59%)**
- Bundle total ($12,185-$35,944)
- Acute hospital length of stay (2.35-4.29 days)
- Swing bed length of stay (2-15 days)
- Home health episode duration (18-36 days)
- Home health visits (9-17)
- Inpatient rehabilitation length of stay (6-11 days)
- **SNF usage (7-66%)**
- **Skilled nursing facility length of stay (11-46 days)**

Impact

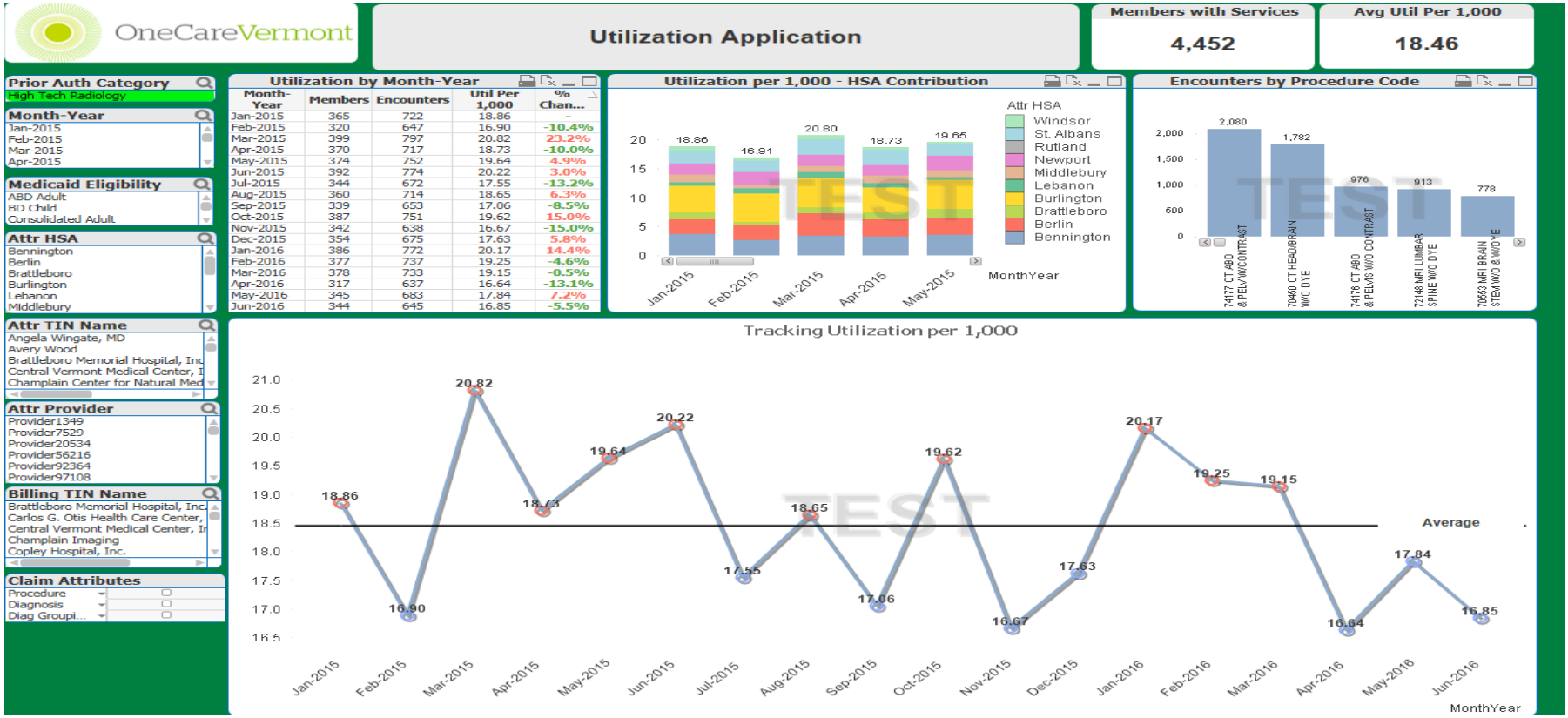
- Hospitals/surgeons examining post-acute services usage
- Matching patient clinical need with appropriate venue of care
- Enhance report with 3M Potentially Preventable Readmission software for more clinical relevance
- Provide this report to OneCare Vermont network to analyze medical and surgical DRG/Bundle resource use variations

Population Health Tools

PMPM Analyzer



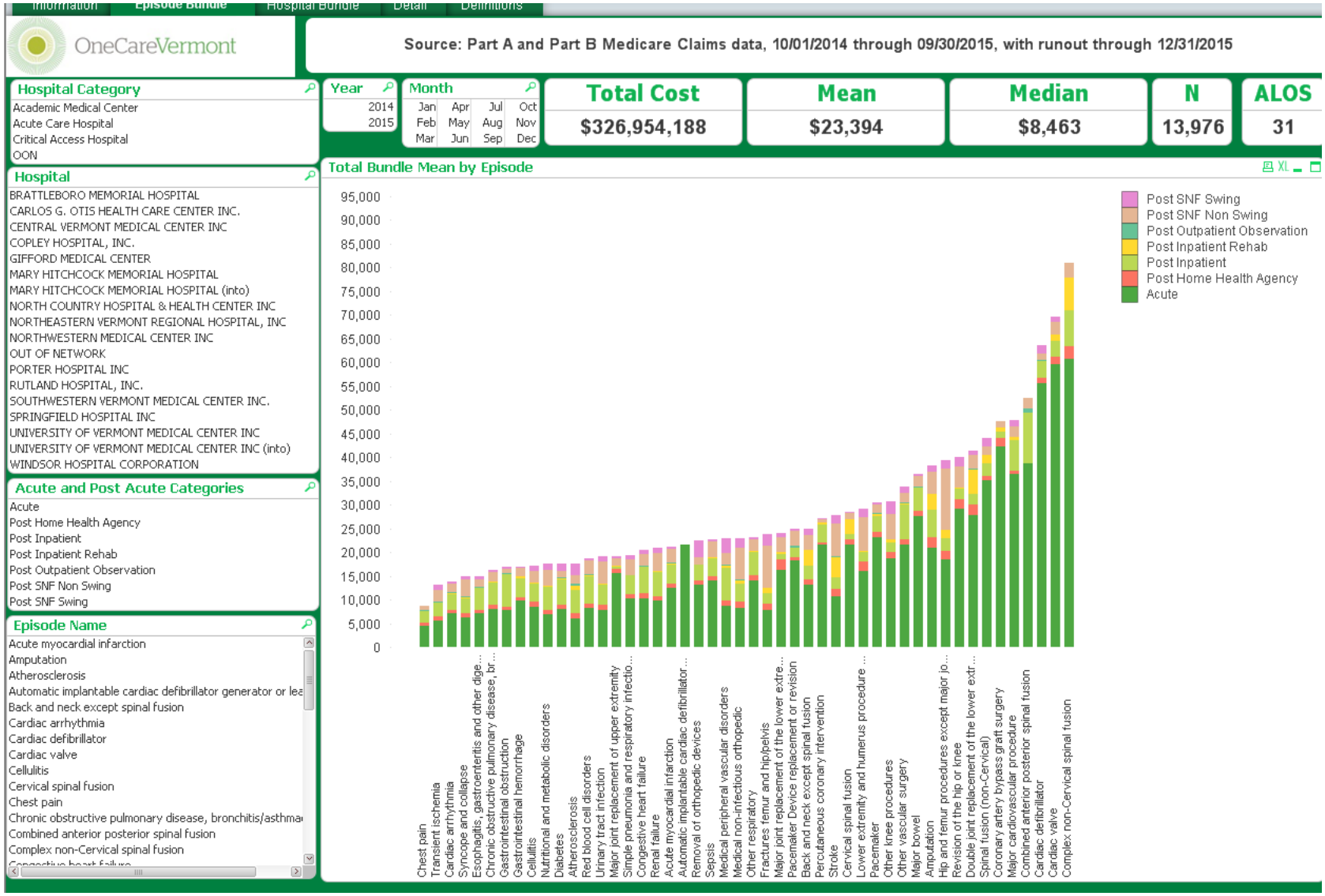
Utilization Review



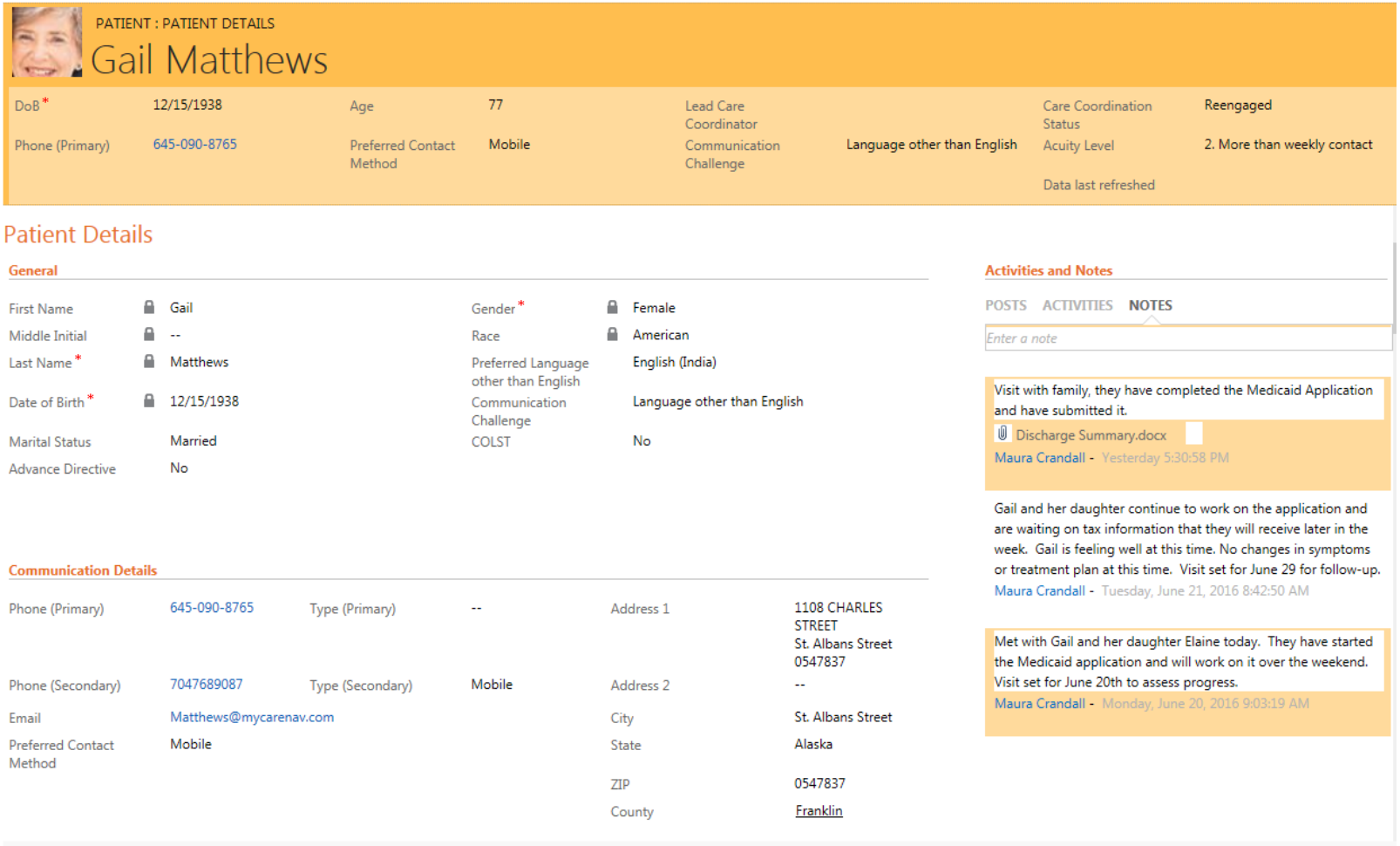
- Utilization
  - Members, Encounters, and Utilization per 1,000
    - Month by month with percent change
  - Contribution by HSA
  - Encounters by Procedure Code
  - Tracking by month for trends or shifts

NOTICE: All data produced by OneCare VT is for the sole use of its contracted OneCare VT Participants and must not be distributed to other individuals or entities who do not hold a legally binding contract with OneCare VT. These materials are confidential and may only be used in connection with OneCare VT activities. The use of these materials is subject to the provisions of the Business Associate Agreement and/or Participation or Collaboration Agreement with OneCare Vermont.

Bundled Episodes



Patient Dashboard



PATIENT : PATIENT DETAILS

Gail Matthews

DoB *	12/15/1938	Age	77	Lead Care Coordinator		Care Coordination Status	Reengaged
Phone (Primary)	645-090-8765	Preferred Contact Method	Mobile	Communication Challenge	Language other than English	Acuity Level	2. More than weekly contact
						Data last refreshed	

Patient Details

General

First Name	Gail	Gender *	Female
Middle Initial	--	Race	American
Last Name *	Matthews	Preferred Language other than English	English (India)
Date of Birth *	12/15/1938	Communication Challenge	Language other than English
Marital Status	Married	COLST	No
Advance Directive	No		

Communication Details

Phone (Primary)	645-090-8765	Type (Primary)	--	Address 1	1108 CHARLES STREET St. Albans Street 0547837
Phone (Secondary)	7047689087	Type (Secondary)	Mobile	Address 2	--
Email	Matthews@mycarenav.com			City	St. Albans Street
Preferred Contact Method	Mobile			State	Alaska
				ZIP	0547837
				County	Franklin

Activities and Notes

POSTS ACTIVITIES NOTES

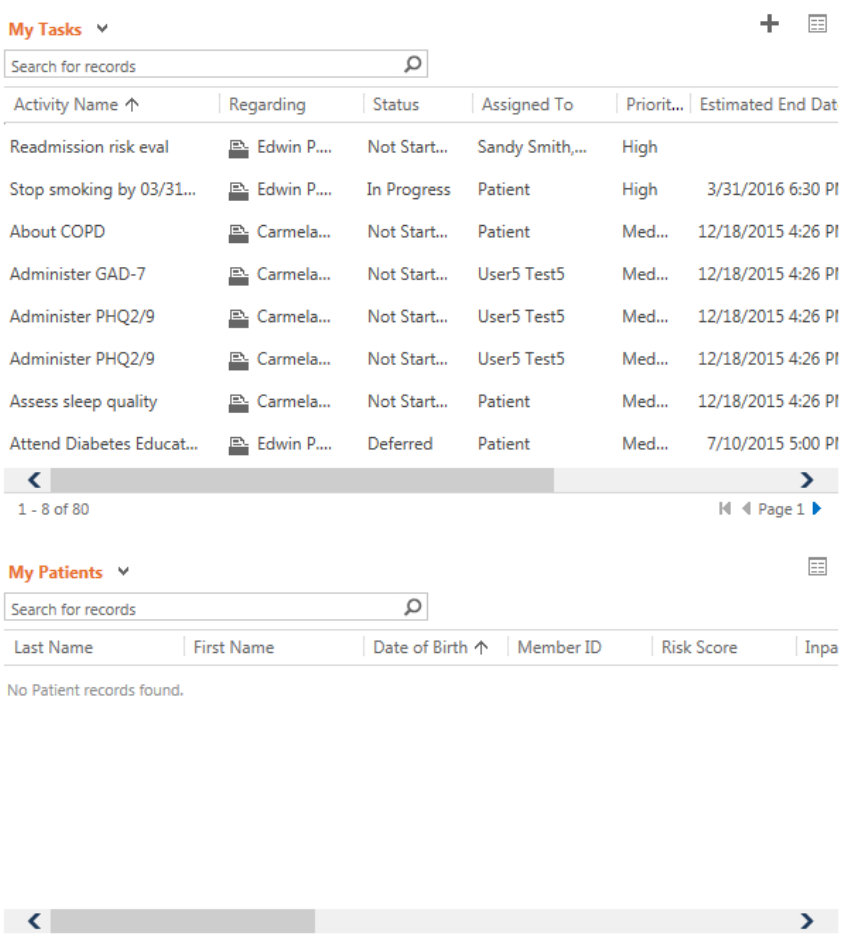
Enter a note

Visit with family, they have completed the Medicaid Application and have submitted it.
Discharge Summary.docx
Maura Crandall - Yesterday 5:30:58 PM

Gail and her daughter continue to work on the application and are waiting on tax information that they will receive later in the week. Gail is feeling well at this time. No changes in symptoms or treatment plan at this time. Visit set for June 29 for follow-up.
Maura Crandall - Tuesday, June 21, 2016 8:42:50 AM

Met with Gail and her daughter Elaine today. They have started the Medicaid application and will work on it over the weekend. Visit set for June 20th to assess progress.
Maura Crandall - Monday, June 20, 2016 9:03:19 AM

Care Coordinator Dashboard



My Tasks

Search for records

Activity Name	Regarding	Status	Assigned To	Priorit...	Estimated End Dat
Readmission risk eval	Edwin P....	Not Start...	Sandy Smith,...	High	
Stop smoking by 03/31...	Edwin P....	In Progress	Patient	High	3/31/2016 6:30 PI
About COPD	Carmela...	Not Start...	Patient	Med...	12/18/2015 4:26 PI
Administer GAD-7	Carmela...	Not Start...	User5 Test5	Med...	12/18/2015 4:26 PI
Administer PHQ2/9	Carmela...	Not Start...	User5 Test5	Med...	12/18/2015 4:26 PI
Administer PHQ2/9	Carmela...	Not Start...	User5 Test5	Med...	12/18/2015 4:26 PI
Assess sleep quality	Carmela...	Not Start...	Patient	Med...	12/18/2015 4:26 PI
Attend Diabetes Educat...	Edwin P....	Deferred	Patient	Med...	7/10/2015 5:00 PI

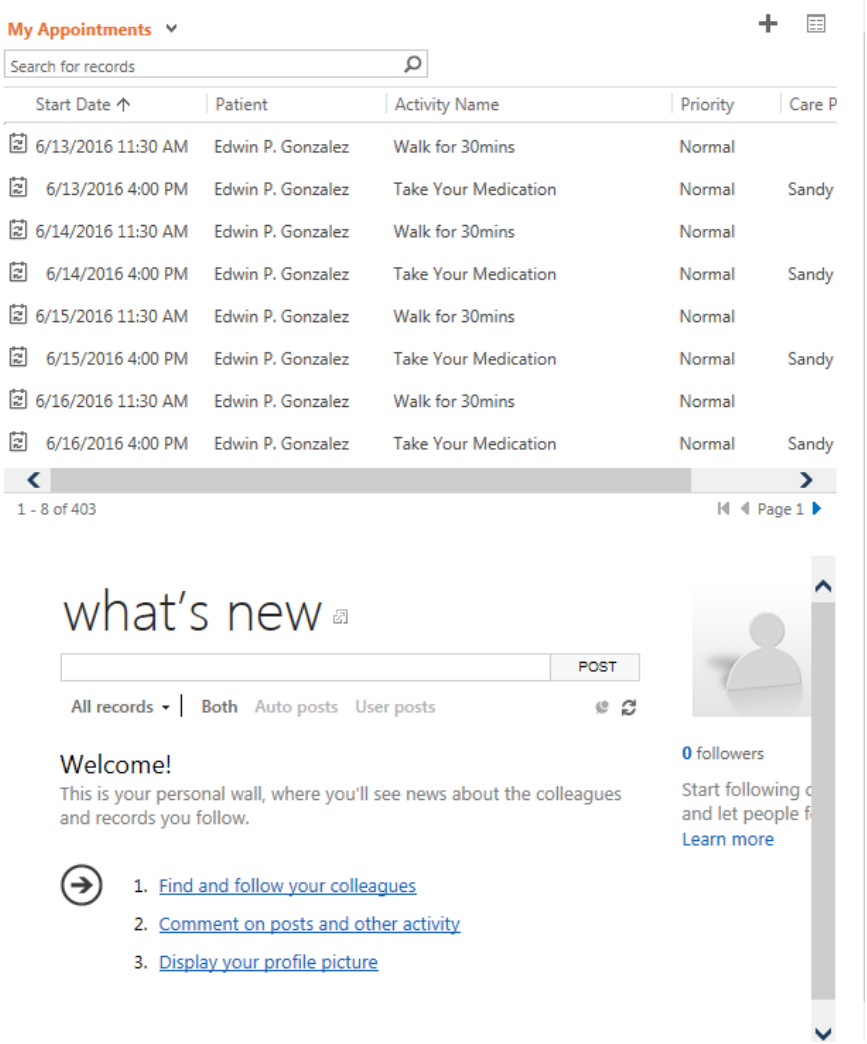
1 - 8 of 80 Page 1

My Patients

Search for records

Last Name	First Name	Date of Birth	Member ID	Risk Score	Inpa

No Patient records found.



My Appointments

Search for records

Start Date	Patient	Activity Name	Priority	Care P
6/13/2016 11:30 AM	Edwin P. Gonzalez	Walk for 30mins	Normal	
6/13/2016 4:00 PM	Edwin P. Gonzalez	Take Your Medication	Normal	Sandy
6/14/2016 11:30 AM	Edwin P. Gonzalez	Walk for 30mins	Normal	
6/14/2016 4:00 PM	Edwin P. Gonzalez	Take Your Medication	Normal	Sandy
6/15/2016 11:30 AM	Edwin P. Gonzalez	Walk for 30mins	Normal	
6/15/2016 4:00 PM	Edwin P. Gonzalez	Take Your Medication	Normal	Sandy
6/16/2016 11:30 AM	Edwin P. Gonzalez	Walk for 30mins	Normal	
6/16/2016 4:00 PM	Edwin P. Gonzalez	Take Your Medication	Normal	Sandy

1 - 8 of 403 Page 1

what's new

POST

All records | Both Auto posts User posts

Welcome!

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

1. Find and follow your colleagues
2. Comment on posts and other activity
3. Display your profile picture

0 followers

Start following c
and let people f
Learn more

Shared Care Plan Document

Shared Care Plan

Patient Information

Patient's Name:			Mobile Phone Number:	
Gail Matthews			7047689087	
Birthdate: 12/15/1938	Age: 77	Sex: Female	Home Phone Number: 645-090-8765	Email Address: Matthews@mycarenav.com
Address: 1108 CHARLES STREET St. Albans Street 0547837			Preferred Method of communication: ☐ Voice call ☐ Email ☐ Text	

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 n

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

Gail Matthews 12/15/1938

My Care Team