
Taking Care of Patients
Outside of the Office
2020~ MHP ECHO
MISSION
HEALTH PARTNERS

MHP Care Coordination Team

Physician Leadership

- Medical Director
- ParaMedic Medical Director
- Specialty Consults

Nursing

- ED avoidance program
- Transitional Care
- Disease management
- Complex Care Coordination

Social Work

- BH Transitional Care
- Copestone and community partner collaborations
- Opioid abuse

Pharmacy

- Medication adherence
- Prescription assistance
- Medication management
- High cost medications

Community Paramedic

- Home Safety Assessment
- Transitional Care support
- Acute Care Assessment

Community Resource Specialist

- Community Resource linkage and collaboration
- Primary care provider linkage

Care Management Approach

Mixed model:

- Traditional clinical care
  - Transitional care
  - Chronic care management
  - Care coordination

Social Determinants of Health

- Programs to address issues that:
  - Preclude adherence to care (i.e., transportation, nutrition)
  - Exacerbate clinical conditions (i.e., mold and asthma)
  - Safety risks (i.e., falls risk in the home)
  - Life style (i.e., smoking, drug misuse)

Care Coordination Interventions during COVID

What's being done:

- Transition calls
- Identifying high risk patients
- COVID check ins
- Community collaboration
- Food box deliveries
- Encouraging chronic illness visits
- Medication adherence
- Attribution support

By the numbers:

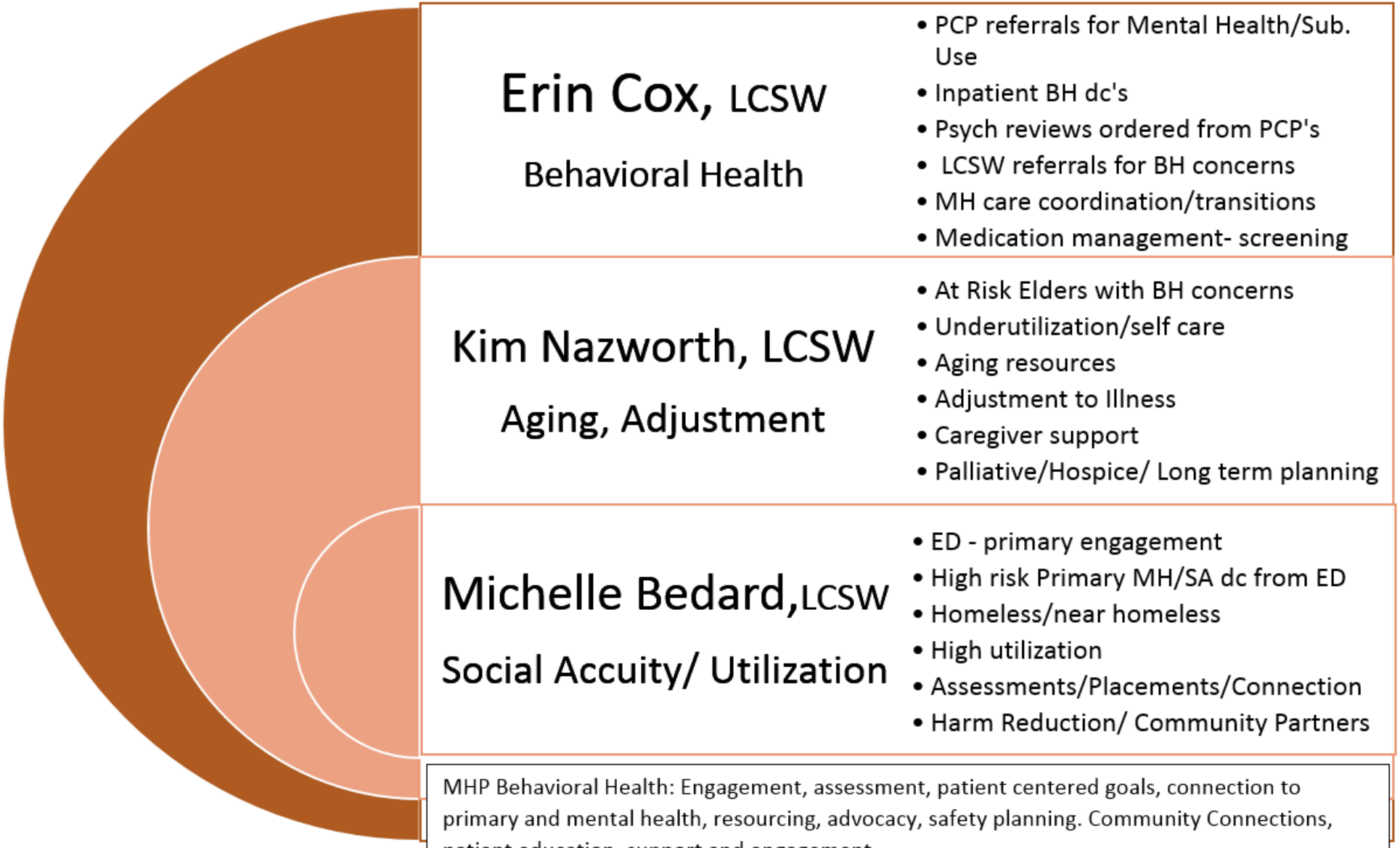
- 1344 patients
- 5988 interventions
- 305 assessments
- 99 home visits
- 381 medication adherence calls
- 3710 phone calls
- 101 care planning meetings
- 26 specialist linkages
- 69 social services

Impact for patients enrolled in CM 2019

Enrollee change 6 months post enrollment, compared to declined group

- Overall healthcare: $248.35 PMPM decrease
- Inpatient: $ 3,680.93 PMPM decrease
- ED: $12.31 PMPM decrease
- ED visits: 550.14/K decrease
- Hospitalizations: 15.64/K decrease
- Readmissions: 243.41/K decrease

MHP Behavioral Health Team



Erin Cox, LCSW

Behavioral Health

- PCP referrals for Mental Health/Sub. Use
- Inpatient BH dc's
- Psych reviews ordered from PCP's
- LCSW referrals for BH concerns
- MH care coordination/transitions
- Medication management- screening

Kim Nazworth, LCSW

Aging, Adjustment

- At Risk Elders with BH concerns
- Underutilization/self care
- Aging resources
- Adjustment to Illness
- Caregiver support
- Palliative/Hospice/ Long term planning

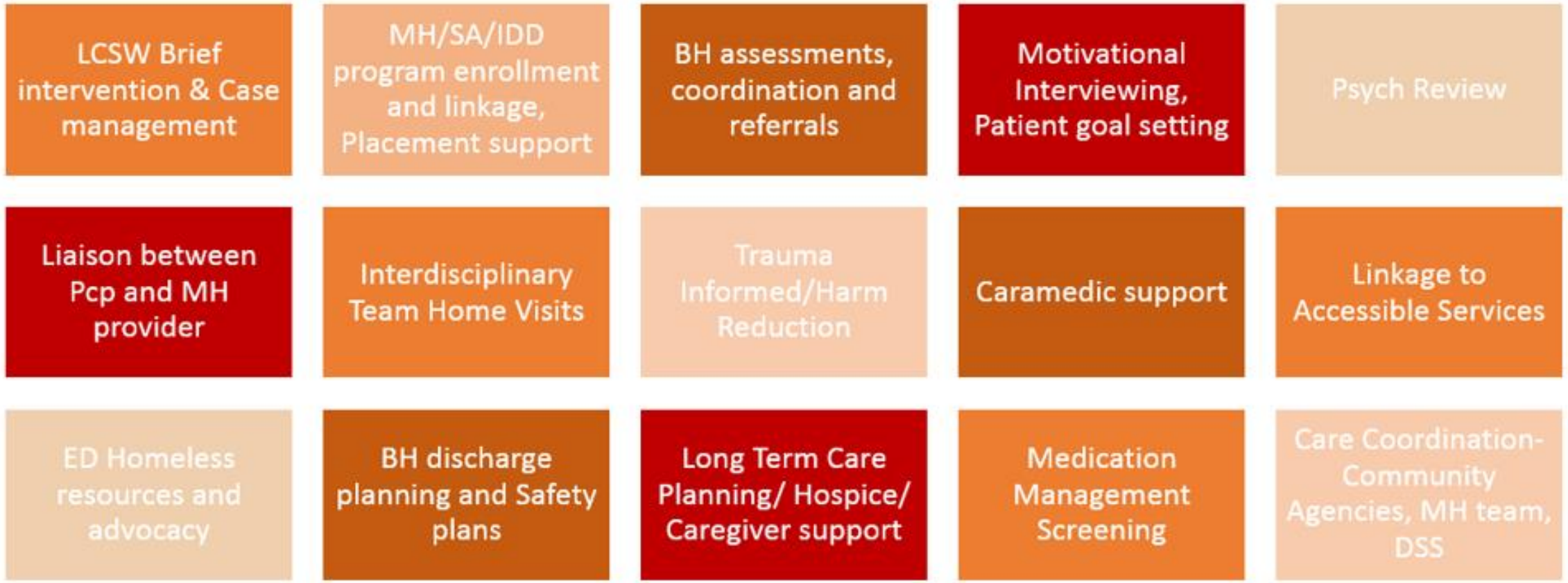
Michelle Bedard,LCSW

Social Accuity/ Utilization

- ED - primary engagement
- High risk Primary MH/SA dc from ED
- Homeless/near homeless
- High utilization
- Assessments/Placements/Connection
- Harm Reduction/ Community Partners

MHP Behavioral Health: Engagement, assessment, patient centered goals, connection to primary and mental health, resourcing, advocacy, safety planning. Community Connections, patient education, support and engagement.

BH Initiatives and Tools



LCSW support during COVID

Increased check-ins with patients addressing COVID issues and needs:

- Focus on coping skills
- Access to MH services
- Adjusting to telephonic resources
- Self-care strategies
- Brief supportive therapy to reduce anxiety and increase resiliency during a time of crisis

Community Partnerships

- Resource and donation support for food boxes and basic needs

Case review with Dr. Trujillo

Referred due to having multiple chronic health conditions

- Kidney disease, cirrhosis of the liver, diabetes, multiple falls
- BH conditions: bipolar d/o, history of trauma, isolation/loneliness

- Goals of Care
  - Relationship/trust building
  - Palliative Care collaboration
  - Care coordination
  - Behavioral Health linkage
  - Specialist connection
  - Medication

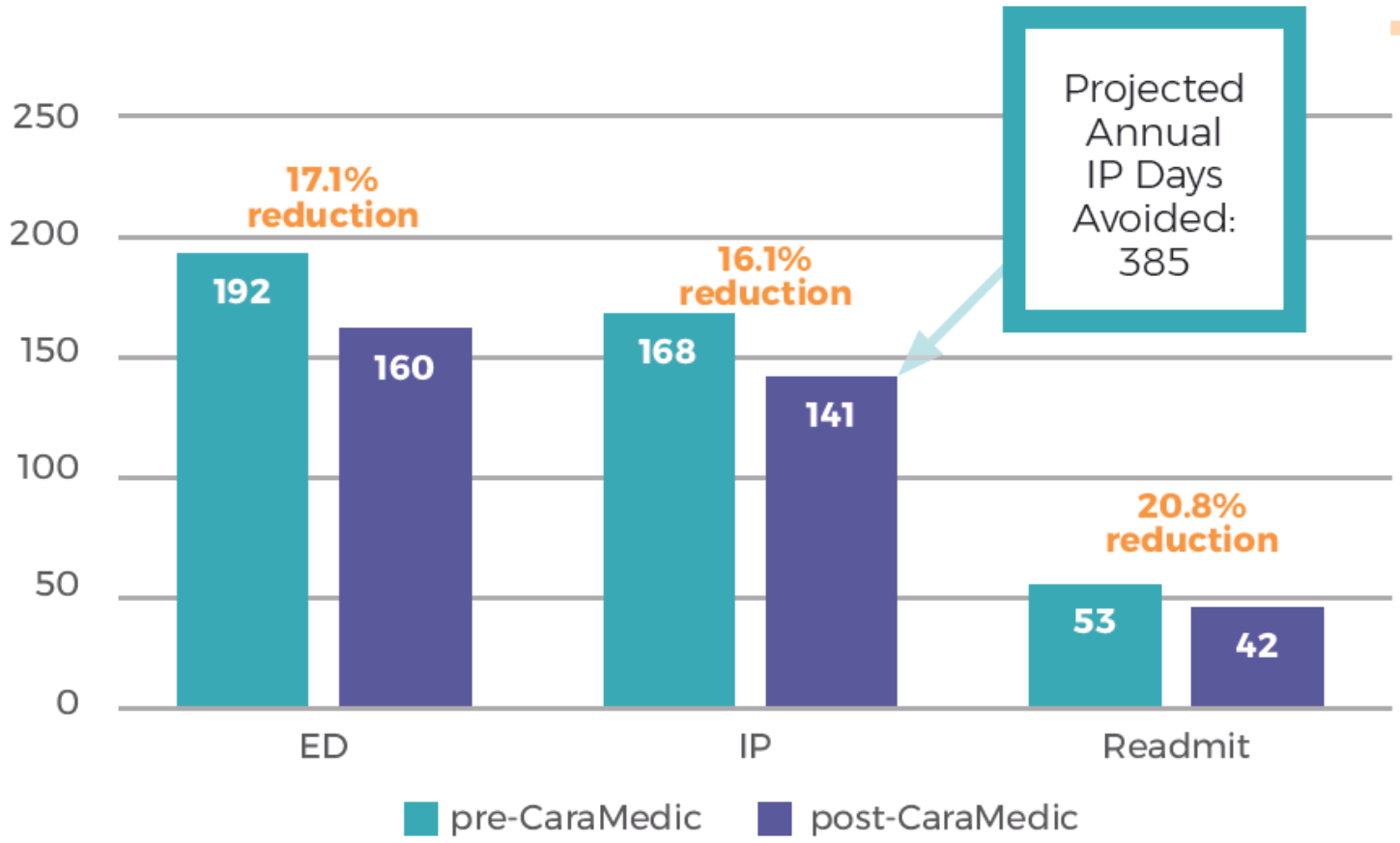
CaraMedic Program

- Function as provider's and nurse's eyes and ears in rural homes
- Chronic disease management plan initiation and follow up
- Outreach to urban and rural areas
- Safety and wellness initiatives
- Health screening and assessments
- Health education and support
- Community Resilience

CaraMedic Credentials

- EMT Paramedic – North Carolina Office of EMS
- Critical Care Transport Paramedic – UMBC
- Pediatric and Neonatal Critical Care Transport Paramedic - UMBC
- National Registry Paramedic - NREMT
- Community Paramedic Certified – International Board of Specialty Certification (MHP / Mission Health Team members are among the first 100 in the world to have received this credential)
- Certifications in Advanced Cardiac Life Support, Pediatric Advanced Life Support, Basic Life Support, International Trauma Life Support
- Community Resiliency Modeling
- Crisis Intervention Training
- Critical Incident Stress Debriefing
- Mental Health First Aid
- Designated alternative practice setting

Healthcare Utilization 6-Months Before/After CaraMedic Initial Visit



Projected Annual IP Days Avoided: 385

Projected Annualized Savings:

$3.3M in gross charges

$910K in Medicare Savings

Savings estimate based on annualized utilization savings and Mission Hospital FY 2016 average Medicare charges, payments and ALOS.

Telemedicine Backpacks

INTRODUCING THE DOT TELEMEDICINE BACKPACK

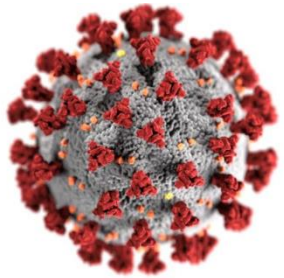
The world's first truly mobile telemedicine solution for Mobile Integrated Healthcare (MIH) – reliably connecting and delivering care even where bandwidth is low.

Doctors Used to Carry Bags...Bags Now Carry Doctors

- Powered by swyMed's patented software
- DOT Telemedicine Backpack is light, easy to use, and delivers unparalleled connectivity.
- It includes everything needed for a reliable, exceptional-quality video telemedicine encounter.
- Redundant dual-modem connection.
- Integrated speaker/microphone
- Digital Dermascope
- Digital Otoscope
- Digital Stethoscope
- Full HD camera.

Source: http://swymed.com/dot-telemedicine-backpack/

CaraMedic Response During the Coronavirus (COVID-19) Pandemic



- **“Contact Home Visit’s”**
  - When physical assessment required
  - Full PPE
- **“No Contact Home Visits”**
  - Direct patient contact is unnecessary
  - Interaction can occur at a distance of greater than 6 feet.
  - PPE limited to a surgical mask and gloves
  - Primarily coordination of provisional support materials,
    - Supplies, food, medications
    - No PPE required

Case Presentation- Dr. Wendy Coin:
Connecting you to your patients

- Recent hospital and SNF discharge
- History of: HF, ICD, Afib, COPD, renal disease
- MHP CM identified CHF exacerbation
- CaraMedic perform patient vitals and physical assessment
- Facilitate televisit with PCP and Cardiologist
- Primary care and specialty visit collaboration
- Medication management and assistance
- Ongoing visits with CaraMedics

Questions?

MOC IV – Improving Practice

- Participation in this call or other telehealth learning ECHOs
- Completion documents and submit by October 20th.
  - A3 form
    - Define –What is the problem?
    - Measure -% Telehealth visit
    - Analyze –What factors will drive improvement – Workflow, Billing, Platform
    - Improve –Increase in visits %
    - Control – How do you sustain.
  - At least 4 months of data
  - Signed attestation that you participated
- Recorded ECHO and example A3 Form on app and Website.

MISSION HEALTH PARTNERS	Project Title		QIP Measure		Practice Team Members	
	Practice		TIN			

Define

Problem Statement / Business Case (What problem are we trying to solve, and why is it important)

Patients are unable to come to the office due to social distancing. Patients still need access to care. Billable visits are essential to sustaining a practice financially

Project Goals (Specific, Measurable, Attainable, Relevant and Time-Bound (SMART): From-To-By When?)

1. Increase billed telehealth visits from 0-90% within one week.
2. Use Athena platform to identify patients that need AWVs

Measure

Current State / Baseline (Detail Process Map, Baseline Data)

1. No telehealth visits
2. No workflow for non clinic visit.
3. No telehalth tool
4. Telehalth codes not in EHR
5. Need for support with more complex patients

Analyze

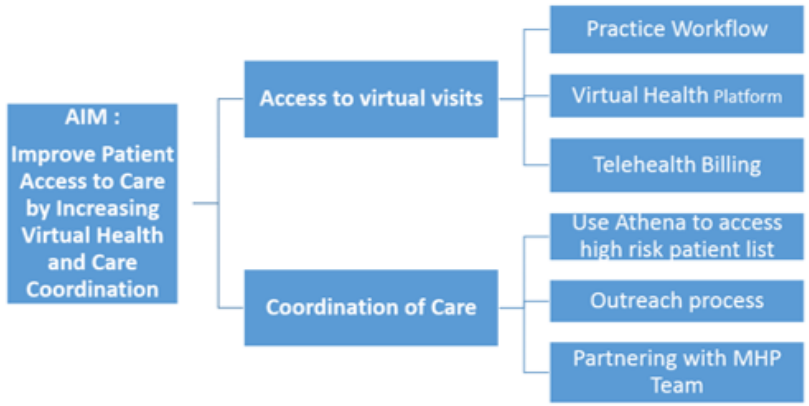
Analysis (Root Cause Analysis)

Current State / Baseline (Detail Process Map, Baseline Data)
Workflow designed to schedule in person visit.
No technology in place for video visit.
Documentation and billing unclear
Uncertain about resources for complex patients in the home.

Analyze

Analysis (Driver Diagram, Cause and Effect, Future State Map)

REV 03/31/2020



Improve

Future State Implementation Plan (PDSA: Plan Do Study Act)

No.	Intervention Idea	Owner	Start	Finish	Status
1	Test seeing patient in car with facetime				
2	Put new billing codes and modifiers in EHR				
3	Try free online platform				
4	Test seeing patient with online platform				
5	Coordinate care with MHP				
6					

Metrics / Results / Outcomes (What did we learn?)

60% of visit now done through telehealth platform
30% of visit are done by phone
Began billing for previously unbilled quick phone visits to make up for lower billing reimbursement. Used team to improve workflow efficiency and number of visits

Control

Sustainment (How we ensure the improvements will be sustained over time: Control Plan)

Choose telehealth platform to use long term. Update workflow and financial model to make virtual visits part of routine workflow.