Utilizing Technology & Data to Enhance Patient Engagement and Population Health

By Art Jones, MD

Today’s Presentation

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Chicago, IL
WEBINAR OBJECTIVES

Participants will be able to:

- Better manage their full member panels across the continuum of care.
- Recognize how primary care is being redesigned to enhance patient convenience and facilitate better patient self-care.
- Appreciate how telehealth, remote patient monitoring, patient portals, application programming interfaces and secure messaging can improve patient experience, contain costs, and improve care management.
- Understand how FQHCs and other primary care providers are using alternative payment models to underwrite these new care models.

POLLING QUESTION

Which service industry has least used technology to change how their services are accessed?

- a. Banking
- b. Movie
- c. Healthcare
- d. Telecommunications
- e. Retail
### PRE-PANDEMIC: DECLINING USE OF PRIMARY CARE AMONG ADULTS

- 142 million primary care visits among 94 million member-years were examined
- **Visits to PCPs declined by 24.2%**, from 169.5 to 134.3 visits per 100 member-years
- The proportion of *adults with no PCP visits in a given year rose* from 38.1% to 46.4%
- Rates of *visits addressing low-acuity conditions decreased by 47.7%*
- **Visits to alternative venues, such as urgent care clinics, increased by 46.9%**


### COMMUNITY HEALTH CENTERS FACE NEW COMPETITORS

**July 8, 2020** – Walgreens Boots Alliance, Inc. (Nasdaq: WBA) and VillageMD announced today that Walgreens will be the first national pharmacy chain to **offer full-service doctor offices co-located at its stores** at a large scale, following a highly successful trial begun last year.

This expanded partnership will **open 500 to 700 “Village Medical at Walgreens” physician-led primary care clinics in more than 30 U.S. markets** in the next five years, with the intent to build hundreds more thereafter. The clinics will uniquely integrate the pharmacist as a critical member of VillageMD’s multi-disciplinary team.

The clinics will accept a wide range of health insurance options, and offer comprehensive primary care across a broad range of physician services. Additionally, **24/7 care will be available via telehealth and at-home visits. More than 50 percent will be located in Health Professional Shortage Areas and Medically Underserved Areas/Populations.**

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**Health Management Associates**
Market Events: **Disruptive Primary Care and Retail Moves**

**Oak Street Health**

**Implications:**
- Competition will grow in the Safety Net
- Network linkage & clinical asset differentiators key
- Total Cost of Care and true risk assumption critical – not just care coordination and shared savings
- Data liquidity and interoperability an imperative
- Developing member loyalty and consumerism focus is table stakes

**Walgreens plans hundreds of in-store doctor offices**

The chain is investing $1 billion in Chicago-based primary care startup VillageMD, expanding their existing partnership.

**Walgreens and Village MD – Primary Care delivery innovation in response to consumer demands for Access, Location, Convenience**

**COVID-19 Unemployment Tipping Point Puts Medicaid on the Radar New Competitors**

As Medicaid numbers grow, payors likely to increase interest in value-based contracting

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**POLLING QUESTION**

Telehealth expands access to care even outside a pandemic.

- A. True
- B. False
**POLLING QUESTION**

Current telehealth payment rules will continue even after the pandemic.

- A. True
- B. False
- C. True but only visual with audio

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**POLLING QUESTION**

My CHC will continue to offer telehealth services even if Medicaid stops paying for them.

- A. True
- B. False
Practice Transformation

*without a*

Financial model

*is not*

sustainable

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Delivery System Transformation

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Payment System Transformation

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Payment Reform

*without*

Practice Transformation

*doesn’t*

change outcomes.

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CHC REVENUE: A PIECE OF CAKE

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Preserving Revenue

- Fee-for-service PPS or Capitated APM

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Icing on the Cake

- CM fee
- PCMH
- P4P
- Shared savings
- Partial capitation for non-PCP services

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A Bigger Piece of the Cake (Market Share)
CALCULATION OF A CAPITATED PRIMARY CARE APM

Primary Care Revenue

# of empaneled Medicaid Member Months in Baseline Year

\[ \text{\# of empaneled Medicaid Member Months in Baseline Year} = \text{PER MEMBER PER MONTH APM RATE}\]

*Rate is inflated annually by current trend rates; broken into State and MCO portions

ASSUMPTIONS FOR ILLUSTRATION PURPOSES

• PPS $135/visit
• PCP productivity 3500 visits/yr.
• PCP panel size 946
• % Medicaid 57%
• Medicaid panel size 539
• Total PCP visits 3.7—3.5—3.3
• Demand for PCPs willing to serve Medicaid recipients allows panel expansion to fill resultant capacity at same payer mix

• PPS FFS equivalent revenue $269,325

• ($135/visit X 3.7 average annual visits X 539 Medicaid member panel size)
### The Payment Model for Virtual Primary Care

<table>
<thead>
<tr>
<th>Per FTE PCP</th>
<th>Baseline Year</th>
<th>Year One</th>
<th>Year Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP Visits PMPY</td>
<td>3.7</td>
<td>3.5</td>
<td>3.3</td>
</tr>
<tr>
<td>PCP Panel Size</td>
<td>946</td>
<td>1000</td>
<td>1061</td>
</tr>
<tr>
<td>% Medicaid</td>
<td>57%</td>
<td>57%</td>
<td>57%</td>
</tr>
<tr>
<td>PCP Medicaid Panel Size</td>
<td>539</td>
<td>570</td>
<td>605</td>
</tr>
<tr>
<td>Medicaid Payment Equivalent PMPM</td>
<td>$ 41.63</td>
<td>$ 39.38 PPS</td>
<td>$ 37.13 PPS $ 41.63 APM</td>
</tr>
<tr>
<td>PCP Panel Medicaid Revenue per FTE</td>
<td>$269,325</td>
<td>$269,325 PPS</td>
<td>$284,715 APM $269,325 PPS $301,970 APM</td>
</tr>
<tr>
<td>Increase PCP Panel Revenue per FTE</td>
<td>$ 0 current</td>
<td>$15,390 APM</td>
<td>$ 0 current $32,645 APM</td>
</tr>
</tbody>
</table>

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State Medicaid Agencies are Pursuing Similar Paths

- Reward patient-centered, high quality care
- Reward health plan and system performance
- Align payment and reforms with CMS
- Improve outcomes
- Drive standardization
- Increase sustainability of state health programs
- Achieve Triple Aim

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Health Management Associates
DIGITAL HEALTH: TOOLS TOO OFTEN LEFT IN THE TOOLBOX

Patient Engagement Options

- PATIENT TEXTING
- TELEHEALTH VIRTUAL VISITS
- E-VISITS
- E-CONSULT
- MOBILE APPS
- REMOTE PATIENT MONITORING

OUTREACH VIA TEXT MESSAGING

- 2017 survey of almost 400 assigned but not yet seen patients at six FQHCs and free clinics; 66% English, 34% Spanish;
- 91% reported having a smartphone;
- 57% of patients reported having had their phone number for >2 years;
- 81% of surveyed patients reported having an unlimited texting plan, while 67% reported having an unlimited data plan;
- “Members without a Visit” workflow using text messaging increases the scheduling rates by 3-4x (typically from low single digits with manual outreach to ~20%)

Source: Survey by Care Message; used by permission
**THE NEW NORMAL FOR PRIMARY CARE PROVIDERS**

+ To keep our patients healthy (not just safe), we will keep our patients from unnecessarily entering a healthcare facility when their needs can be met remotely.
+ We will minimize patient cycle time no matter the visit type.
+ Patients will opt to use the EHR patient portal and/or EHR-interfacing apps rather than just phone calls to request service.
+ We will use online surveys for specific common symptoms.

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**THE NEW NORMAL FOR PRIMARY CARE PROVIDERS**

+ More if not most patient encounters will start with a triage encounter, using a defined set of clinical criteria to determine the need for face-to-face visits.
+ We will use a team-based approach to care.
  + The medical assistant checks vital signs virtually, performs structured assessments and medication reconciliation and checks refill history online.
  + The provider will complete the remote visit, supported population health and preventive screening dashboards.
  + At the end, another staff member schedules the next visit including appointment type and times.
THE NEW NORMAL FOR PRIMARY CARE PROVIDERS

+ We will utilize artificial intelligence (AI) to transcribe visits for patients, documenting key details about their visits including diagnosis and prescription names, all in an app controlled by patients.

+ We will move as many staff as possible out of our centers to working from home and implemented a new shift-based remote staffing model that matches patient need with time of day availability

+ We will set up appointment times for patients to get lab tests or to pick up medications

+ We will track cycle times for all types of patient encounters, and they will become a major metric in practice redesign efforts

A DIGITAL FRONT DOOR FOR PATIENTS

<table>
<thead>
<tr>
<th></th>
<th>Before the Visit</th>
<th>During the Visit</th>
<th>Post Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Digital self schedule</td>
<td>Self-check-in</td>
<td>Remote monitoring with peripheral devices and commercially available wearables</td>
</tr>
<tr>
<td></td>
<td>Fill medical history</td>
<td>As clinically appropriate practitioner responds via secure message, telehealth or in-person</td>
<td>Post-procedure tasks</td>
</tr>
<tr>
<td></td>
<td>Get reminders</td>
<td></td>
<td>HIPAA compliant secure messaging</td>
</tr>
<tr>
<td></td>
<td>Get pre-visit tasks</td>
<td></td>
<td>eConsult specialty care</td>
</tr>
<tr>
<td></td>
<td>E-sign consent forms</td>
<td></td>
<td>Telehealth follow-up care</td>
</tr>
<tr>
<td></td>
<td>Pay balance / co-pay</td>
<td></td>
<td>Notifications and health tips</td>
</tr>
</tbody>
</table>

Health Management Associates
THE NEW NORMAL FOR PRIMARY CARE PROVIDERS

+ We will secure remote monitoring devices like glucometers, home BP monitors, scales, digital thermometers and simple pulse oximeters for our patients that are blue tooth enabled and interface with our EHRs.

CURRENT MANAGEMENT OF HYPERTENSION

+ Nearly half of American adults have high blood pressure.
+ About 11 million of them do not know their blood pressure is too high and are not receiving treatment.
+ Only about 1 in 4 adults with hypertension have their condition under control (below 130/80 mm Hg).
+ 62% of TN FQHC patients nationally with hypertension had their blood pressure controlled to less than 140/90 mmHg.
+ Depending solely on office BP readings leads to treatment errors (white coat effect and masked hypertension)
+ Strong scientific evidence shows that self-measured blood pressure monitoring (SMBP), plus clinical support helps people with hypertension lower their BP and is recommended by the AHA
MHN's Hypertension Management Program: *Self Monitored Blood Pressure & Resources*

Medical Home Network has created a hypertension management program (HMP) to support identified and at-risk members by using a dynamic and personalized approach.

*The program has several offerings including:*
- Utilization of risk screens for proactive member identification
- Machines for home Self-monitored Blood Pressure (SMBP) at no cost to the member
- Infrastructure for data collection
- Established care team relationships for outreach and a key factor for success; Provider and care team engagement.

*The Script Includes:*

- SMBP
- Outreach
- Toolkit
- Scheduling Follow-Up
- Ongoing Monitoring
THE CARE TEAM APPROACH TO MANAGEMENT OF HYPERTENSION

The new normal for primary care providers

- We will demonstrate that care management belongs at the primary care and behavioral care practice level.
WE WILL BE PART OF A CLINICALLY INTEGRATED NETWORK

7 Key Building Blocks to Population Health and Value-based Care

NCQA CERTIFIABLE CM MODEL OF CARE
Table 2.1 Member, Cost, and Utilization by Risk Level – Medicaid Expansion

<table>
<thead>
<tr>
<th>HRA Risk Profile</th>
<th>Member Count</th>
<th>% Members</th>
<th>ER Visits / 1000</th>
<th>Inpatient Admits / 1000</th>
<th>Medical + Rx Cost PMPM</th>
<th>Relative Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>1,606</td>
<td>21%</td>
<td>415.2</td>
<td>56.68</td>
<td>$217.1</td>
<td>100%</td>
</tr>
<tr>
<td>Low - CHW</td>
<td>6,181</td>
<td>54%</td>
<td>620.2</td>
<td>96.19</td>
<td>$349.4</td>
<td>161%</td>
</tr>
<tr>
<td>Medium by Social Factors</td>
<td>663</td>
<td>9%</td>
<td>742.1</td>
<td>143.29</td>
<td>$423.3</td>
<td>195%</td>
</tr>
<tr>
<td>Medium by Utilization</td>
<td>320</td>
<td>4%</td>
<td>1,856.3</td>
<td>281.25</td>
<td>$479.9</td>
<td>221%</td>
</tr>
<tr>
<td>High by Social Factors</td>
<td>127</td>
<td>2%</td>
<td>834.6</td>
<td>125.98</td>
<td>$404.7</td>
<td>186%</td>
</tr>
<tr>
<td>High by Utilization</td>
<td>865</td>
<td>11%</td>
<td>1,053.2</td>
<td>679.77</td>
<td>$821.4</td>
<td>378%</td>
</tr>
<tr>
<td>Total</td>
<td>7,762</td>
<td>100%</td>
<td>757.8</td>
<td>165.29</td>
<td>$387.2</td>
<td>178%</td>
</tr>
</tbody>
</table>

*Note: This analysis includes ACA adults who were continuously enrolled for twelve months post Health Risk Assessment (7,762 observations) and their associated claims during that period.

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TRANSITIONS OF CARE WORKFLOWS SUPPORTED BY ADT AND AI

Real-Time ADT Alerts
Risk Stratification for Readmission
Hospital Relationships
Patient Engagement
Warm Handoffs Medical Records
Post-Discharge Contact with Med Reconciliation & Ambulatory Visits

THE NEW NORMAL FOR PRIMARY CARE PROVIDERS

We will manage total cost of care with financial accountability
MANAGING TOTAL COST OF CARE UNDER SHARED SAVINGS/RISK

- What bundle of services can I be accountable for given the data sources, analytics and actionable reporting?

CONNECTIVITY & DATA ANALYTICS

<table>
<thead>
<tr>
<th>Data Feed</th>
<th>Type</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Plan Member Attribution</td>
<td>Flat File/Excel</td>
<td>Monthly</td>
</tr>
<tr>
<td>Eligibility Terminations</td>
<td>Flat File/Excel</td>
<td>Weekly</td>
</tr>
<tr>
<td>ED Visit and Inpatient Admissions</td>
<td>ADT Direct Connect</td>
<td>Near Real Time</td>
</tr>
<tr>
<td>Inpatient Census</td>
<td>Flat file/Excel</td>
<td>Daily</td>
</tr>
<tr>
<td>Hospital Discharge Data</td>
<td>ADT Direct Connect</td>
<td>Near Real Time</td>
</tr>
<tr>
<td>Attributed Member Claim History (MCO)</td>
<td>Flat file/Excel</td>
<td>Weekly</td>
</tr>
<tr>
<td>PCP EHR Data</td>
<td>Flat file/Excel</td>
<td>Weekly</td>
</tr>
<tr>
<td>Case Management Data</td>
<td>Flat File/Excel</td>
<td>Weekly</td>
</tr>
</tbody>
</table>

Health Management Associates
## PROGRESSING FROM 30-DAY READMISSION RATES TO ACTIONABLE INFORMATION

<table>
<thead>
<tr>
<th>Days Post Discharge</th>
<th>1-30</th>
<th>31-60</th>
<th>61-90</th>
<th>91-120</th>
<th>121-150</th>
<th>151-180</th>
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<tbody>
<tr>
<td><strong>Claims Category:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>86.7%</td>
<td>78.4%</td>
<td>78.1%</td>
<td>75.7%</td>
<td>73.7%</td>
<td>72.0%</td>
</tr>
<tr>
<td><strong>Pharmacy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psych/Sub</td>
<td>50.5%</td>
<td>43.9%</td>
<td>45.1%</td>
<td>38.7%</td>
<td>40.8%</td>
<td>39.4%</td>
</tr>
<tr>
<td>Other</td>
<td>54.6%</td>
<td>46.3%</td>
<td>46.0%</td>
<td>44.7%</td>
<td>43.7%</td>
<td>46.2%</td>
</tr>
<tr>
<td><strong>Ambulatory Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psych/Sub</td>
<td>64.5%</td>
<td>54.0%</td>
<td>52.3%</td>
<td>49.4%</td>
<td>48.0%</td>
<td>45.2%</td>
</tr>
<tr>
<td>Other Services</td>
<td>52.4%</td>
<td>45.9%</td>
<td>44.9%</td>
<td>42.5%</td>
<td>43.1%</td>
<td>40.5%</td>
</tr>
<tr>
<td>Primary Care</td>
<td>40.3%</td>
<td>27.6%</td>
<td>30.1%</td>
<td>25.7%</td>
<td>26.9%</td>
<td>27.5%</td>
</tr>
<tr>
<td><strong>Emergency Department</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psych/Sub Diagnosis</td>
<td>13.9%</td>
<td>10.8%</td>
<td>12.8%</td>
<td>9.4%</td>
<td>10.9%</td>
<td>8.2%</td>
</tr>
<tr>
<td>Other Diagnosis</td>
<td>20.2%</td>
<td>16.0%</td>
<td>15.6%</td>
<td>15.4%</td>
<td>15.0%</td>
<td>16.1%</td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psych/Sub Diagnosis</td>
<td>16.3%</td>
<td>11.8%</td>
<td>15.7%</td>
<td>12.1%</td>
<td>14.2%</td>
<td>10.6%</td>
</tr>
<tr>
<td>Other Diagnosis</td>
<td>2.9%</td>
<td>2.5%</td>
<td>2.0%</td>
<td>3.6%</td>
<td>2.1%</td>
<td>3.0%</td>
</tr>
</tbody>
</table>

## MHN TIME OF ED REGISTRATION FOR A MIXED MEDICAID POPULATION

<table>
<thead>
<tr>
<th>Day</th>
<th>6-8 AM</th>
<th>8-10 AM</th>
<th>10-12 Noon</th>
<th>Noon-2 PM</th>
<th>2-6 PM</th>
<th>6-10 PM</th>
<th>10 AM – 2 AM</th>
<th>2-6 AM</th>
<th>10 AM – 7 PM M-F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mon</td>
<td>2.1%</td>
<td>13.3%</td>
<td>7.0%</td>
<td>12.6%</td>
<td>26.6%</td>
<td>19.6%</td>
<td>16.8%</td>
<td>2.1%</td>
<td>65.0%</td>
</tr>
<tr>
<td>Tues</td>
<td>5.3%</td>
<td>7.9%</td>
<td>13.2%</td>
<td>7.9%</td>
<td>16.7%</td>
<td>28.1%</td>
<td>15.8%</td>
<td>5.3%</td>
<td>57.0%</td>
</tr>
<tr>
<td>Wed</td>
<td>1.7%</td>
<td>10.9%</td>
<td>14.3%</td>
<td>7.6%</td>
<td>28.6%</td>
<td>20.2%</td>
<td>13.4%</td>
<td>3.4%</td>
<td>64.7%</td>
</tr>
<tr>
<td>Thurs</td>
<td>4.6%</td>
<td>10.0%</td>
<td>11.5%</td>
<td>13.1%</td>
<td>16.9%</td>
<td>25.4%</td>
<td>10.0%</td>
<td>8.5%</td>
<td>57.7%</td>
</tr>
<tr>
<td>Fri</td>
<td>1.7%</td>
<td>10.2%</td>
<td>11.9%</td>
<td>13.6%</td>
<td>20.3%</td>
<td>18.6%</td>
<td>14.4%</td>
<td>9.3%</td>
<td>63.6%</td>
</tr>
<tr>
<td>Sat</td>
<td>2.8%</td>
<td>4.7%</td>
<td>14.2%</td>
<td>16.0%</td>
<td>18.9%</td>
<td>20.8%</td>
<td>15.1%</td>
<td>7.5%</td>
<td></td>
</tr>
<tr>
<td>Sun</td>
<td>2.7%</td>
<td>6.3%</td>
<td>9.9%</td>
<td>14.4%</td>
<td>22.5%</td>
<td>19.8%</td>
<td>16.2%</td>
<td>8.1%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>3.0%</td>
<td>9.3%</td>
<td>11.5%</td>
<td>12.1%</td>
<td>21.6%</td>
<td>21.8%</td>
<td>14.5%</td>
<td>6.2%</td>
<td>45.8%</td>
</tr>
</tbody>
</table>
MHN ACO: Driving Health Outcomes by Reducing Social Determinants

MHN OUTCOME 37.4% reduction in total social risk factors impacting health

**Social Risk Factor Reduction of High Risk and Medium Risk Adults in Care Management**
3,315 members, July 2014 – June 2018

<table>
<thead>
<tr>
<th>Social Risk Factor</th>
<th>Initial HRA</th>
<th>Latest HRA</th>
<th>% Change</th>
<th>Predictive of Future Cost and/or Utilization*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Social Factors</td>
<td>11,124</td>
<td>6,963</td>
<td>-37.4%</td>
<td></td>
</tr>
<tr>
<td>Rates overall health as Fair or Poor</td>
<td>2,019</td>
<td>1,378</td>
<td>-21.1%</td>
<td>✓</td>
</tr>
<tr>
<td>Difficulty making appointments</td>
<td>685</td>
<td>396</td>
<td>-42.2%</td>
<td>✓</td>
</tr>
<tr>
<td>Difficulty getting to appointments or filling prescriptions</td>
<td>1,396</td>
<td>885</td>
<td>-36.6%</td>
<td>✓</td>
</tr>
<tr>
<td>Untreated Depression</td>
<td>1,172</td>
<td>511</td>
<td>-56.4%</td>
<td></td>
</tr>
<tr>
<td>Untreated drug/alcohol use</td>
<td>304</td>
<td>156</td>
<td>-48.7%</td>
<td>✓</td>
</tr>
<tr>
<td>Difficulty securing food, clothing, or housing</td>
<td>1,717</td>
<td>868</td>
<td>-49.4%</td>
<td>✓</td>
</tr>
<tr>
<td>Currently homeless or living in a shelter</td>
<td>126</td>
<td>68</td>
<td>-46.0%</td>
<td>✓</td>
</tr>
<tr>
<td>Difficulty paying for meds</td>
<td>1,000</td>
<td>270</td>
<td>-73.0%</td>
<td>✓</td>
</tr>
<tr>
<td>Does not feel physically or emotionally safe at home</td>
<td>213</td>
<td>143</td>
<td>-32.9%</td>
<td>✓</td>
</tr>
<tr>
<td>Refused smoking cessation program</td>
<td>607</td>
<td>226</td>
<td>-62.8%</td>
<td>✓</td>
</tr>
</tbody>
</table>

Evaluation criteria: Most recent HRAs for ACO members with 12+ months continuous enrollment and minimum of 2 HRAs at least 30 days apart.

The presence of even one social risk factor dramatically increases a patient’s cost & utilization.

**MONITORING COMPLIANCE WITH TOC WORKFLOWS**

<table>
<thead>
<tr>
<th>Bundle Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care Manager contacts the patient during hospitalization</strong></td>
<td>1. Ask patient why they came to the hospital&lt;br&gt;2. Reinforce existing care plan&lt;br&gt;3. Reinforce relationship with the medical home&lt;br&gt;4. Document in MHNConnect</td>
</tr>
<tr>
<td><strong>Care Manager call:</strong>&lt;br&gt;• Within 48 hours of discharge&lt;br&gt;• Notifies care team of patient discharge&lt;br&gt;• Consults with care team on frequency of up to 4 weekly calls following discharge</td>
<td>1. Provide patient with customized information and instructions&lt;br&gt;2. Address short term needs&lt;br&gt;3. Reinforce signs and symptoms; where/when to call for help</td>
</tr>
<tr>
<td><strong>7-Day Follow-up Appointment with PCP or BH Provider</strong></td>
<td>1. Attempt to schedule the appointment before the patient is discharged&lt;br&gt;2. Confirm that the patient has attended</td>
</tr>
<tr>
<td><strong>Medication Review post-discharge</strong></td>
<td>1. Perform Medication Review and/or medication reconciliation</td>
</tr>
</tbody>
</table>
Referrals to High-Value Specialists is the New Efficiency Metric for PCPs

- Faster and efficient access to specialty care
- Improved patient engagement and person-centered care
- Reduced inappropriate referrals
- Fewer unmanaged chronic conditions
- More cost-effective specialty utilization
- Fewer unnecessary specialty care visits
- Decreased ED visits
- Less duplicative testing

*eConsult offers a modern, provider-friendly, patient-centered approach to specialty access that supports whole-person care and improves outcomes.*

MHN eConsult: Patient Story

“An Esperanza provider sent an eConsult with photograph for a patient with a concerning skin lesion. Prior to eConsult, it would have taken the patient 3-6 months to be seen at CCHHS.

Upon seeing the concerning photograph, the CCHHS Dermatologist scheduled the patient to be seen within 1 week.

The Dermatologist’s biopsy showed a melanoma, which was fortunately caught before it became metastatic and the patient was treated appropriately.

*In this dramatic case, the innovative eConsult system literally saved the patient’s life.*

- Physician, Esperanza Health Centers
DAILY HEALTH MANAGEMENT WITH AN INTERACTIVE AI CHATBOX

- Completion of HRAs
- Daily check-ins on how the patient is feeling
- Daily health briefing
  - Transportation
  - Appt reminders
  - Medication management e.g. reminders
  - Proper use of the ER
  - General chronic disease education based on patient conditions

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