Patient Panel Coordinators,

- *CoreLife, and Stay Home Safely*

CCN Member Resource Briefing III
March 2019

What We'll Cover

After you complete this module, you'll know more about:

What patient panel coordinators do and how they improve patient outcomes and practice performance across the CCN.

How to maximize benefit from PCCs.

Answering Your Needs: You Told Us; We Heard You

Busy practice life: you spend all day and evening seeing patients, charting, doing refills, reviewing results. Yet you are also responsible for all patients attributed to you, and there is a dashboard telling you which ones are failing their measures. By the time you get to that task, you're exhausted and it's too late at night to contact anybody. These patients are not on the patient portal, so you can't send them an email. It would be great if someone else scrubbed those dashboards for you, and contacted these patients, using prescribed protocols that made you confident that the work is being done right.

This is a familiar scenario in everyday medical practice.

Patient Panel Coordinators

The CCN provides patient panel coordinators (PPCs) to do this work for you, behind the scenes.

PPCs are first being used at the CCN primary care practices, where CCN patients are most heavily attributed. Key specialty practices will follow. ***Since a single patient may be attributed to several CCN specialties, any work the PPC does to improve primary care and key specialty dashboard scores will improve other CCN member scores.***

Practices are assigned a regular PPC who will meet with you individually at a time that is convenient for you.

So How Does This Work?

The PPC will analyze your dashboard and remove the patients that are deceased, have moved away, or have moved on to other physicians.

She will condense the dashboard findings so that you have a short list of patients that need help.

The two of you then decide how best to reach out to those patients. She will do the outreach or direct your staff to do it, whichever is more efficient.

Everyone has a style, and your patients appreciate that. The PPC will work with you to preserve that style when she does outreach.

Typical Workflows a PPC Develops with You Regarding Patients with Care Gaps

We've provided the PPCs with patient-facing scripts and have coached them on what to say and what not to say. Feel free to review the scripts.

When they reach out to patients, they identify themselves as working with you, and that they are carrying out your orders.

Examples of questions the PPCs will ask you:

How do you want me to handle patients who need a mammogram?
Do you offer FIT if average-risk patients don't want colonoscopy?
How often do you think this particular patient needs a visit?
Is it okay if I order the lab test for you?
You haven't seen this patient in 2 years, is it safe to assume he's moved on?
Can I suggest a new workflow for office staff so that we can find the results of this screening test more easily next time?
I've identified some non-medical issues and/or health needs. Shall we connect the patient to One Call Care Management?

How to Optimize the PPC Role In Your Practice

Agree on a time she comes to visit you, weekly or biweekly or monthly
If you have distinct preferences about anything, let her know, early on.
If she offers you alternative workflow suggestions, please consider them. It may save you and your staff much more time later.
If you know certain patients require certain types of interactions, let her know so that you both will succeed.
Take a look at her prescribed scripts so that you feel confident in the interaction she has with the patient.
Make sure your practice staff members understand the PPC role and that she is not enlisted to do work that is not directly related to managing patients in your panel. She won't displace other practice staff members.

Weight Loss Healthcare

- An Integrated Obesity Care Pathway of the Collaborative Care Network

www.corelifemd.com

Practice Overview

- Community-based, multidisciplinary healthcare clinic that combines and coordinates the core disciplines necessary to treat overweight, obesity, and their underlying behavioral factors

- 16+ Clinics in Maryland

- Staffed with MDs, CRNPs, RDs, RNs, CPTs, LCSWs

- Built as a resource and pathway for PCPs, Surgeons, and Specialists

Typical Layout

Patient experience

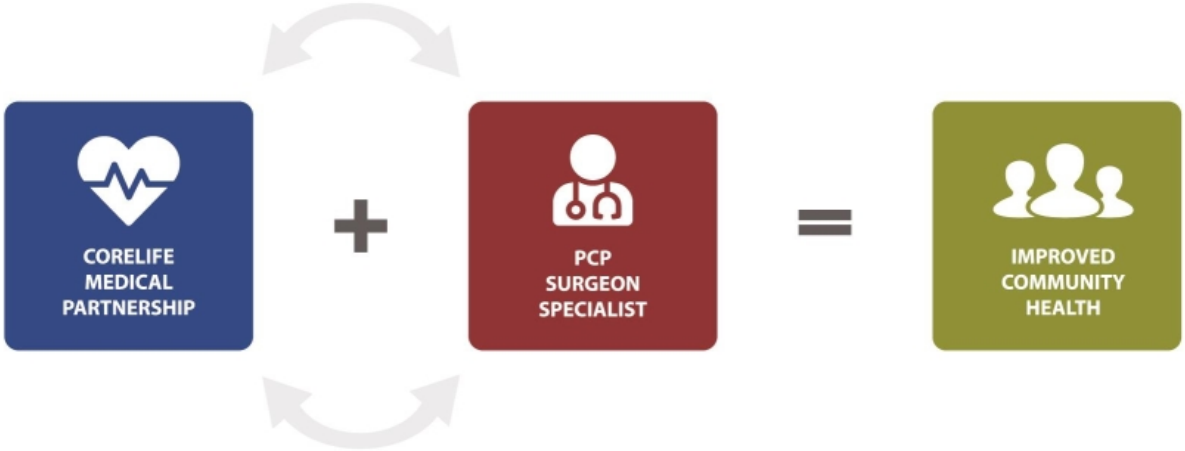
- Patients follow a standard process of evaluation leading to a specific care plan:
  - Medical history and assessment
  - Lab and diagnostic testing
  - Nutrition assessment and plan
  - Exercise assessment and plan
  - Habits/Behavior assessment and plan

- Our care team, headed by the medical provider, develops a unique care plan for the patient

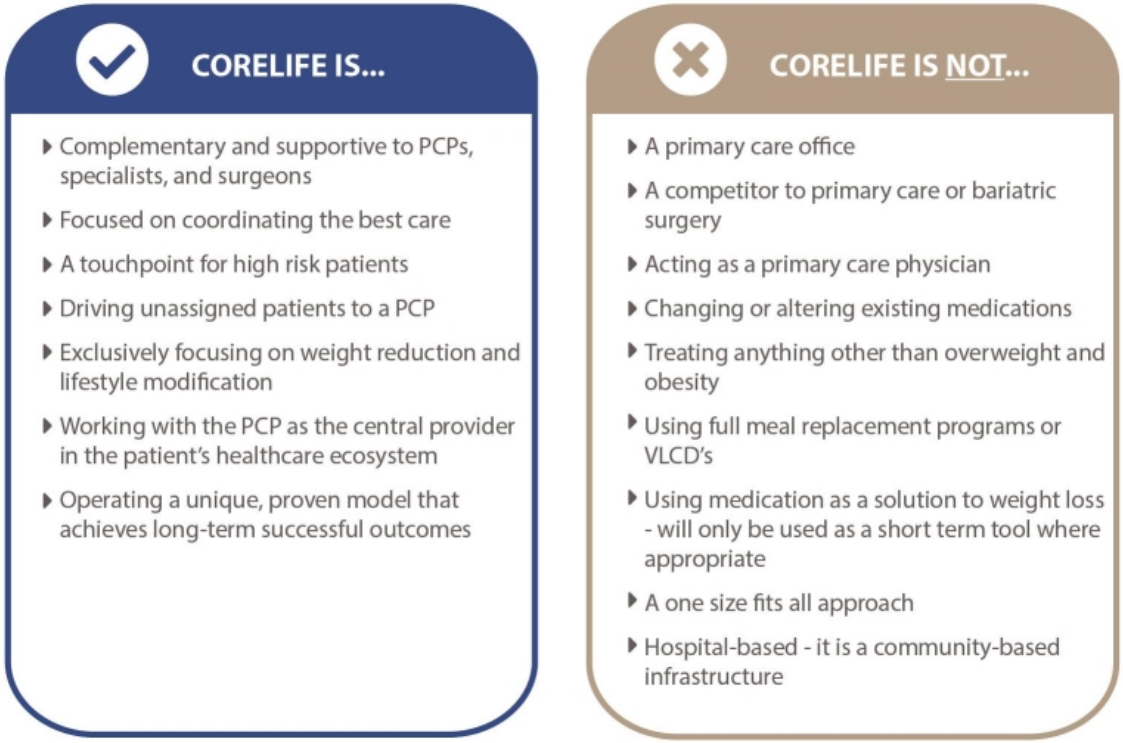
- This care plan is carried out on a weekly or biweekly basis

Partnering with healthcare providers

- Work in complement with PCPs, Specialists, and Surgeons
- Provides a resource and pathway that did not previously exist
- Customizable communication flow
- Dedicated provider liaisons in the community



Some important distinctions

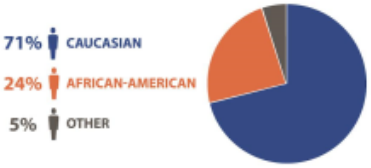


Patient Profile & Outcome Data

PATIENT PROFILE DATA

GENDER

RACE



28%
PATIENTS ENGAGED WITH A FRIEND OR FAMILY MEMBER

AVERAGE PATIENT AGE

29%
PATIENTS WITH UNDIAGNOSED OR UNCONTROLLED CONDITIONS

PATIENTS REFERRED BY A MEDICAL PROVIDER

PATIENTS WITH CHRONIC CONDITIONS[1,2]

81.8%

PATIENTS WITH PRE-DIABETES OR DIABETES

56%

AVERAGE NUMBER OF CHRONIC ILLNESSES PER PATIENT **3.27**

Tracking Outcomes: CoreLife tracks detailed profile, treatment, and verifiable outcome data on more than 250,000 patient visits over a 72-month period.

PATIENT OUTCOME DATA

AVERAGE NEW PATIENT BMI

AVERAGE BMI DECREASE
16.4%

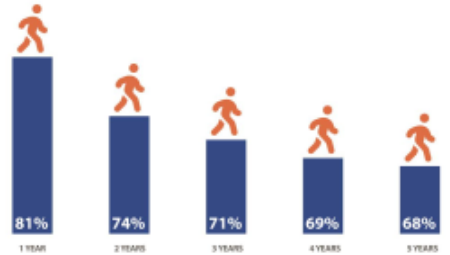
AVERAGE HbA1C REDUCTION
1.58bps
High HbA1C at baseline was associated with a greater reduction in HbA1C

AVERAGE LENGTH OF TIME ENGAGED

73%
PATIENTS THAT ACHIEVE PREDETERMINED GOAL[1,3]

76%
PATIENTS THAT ACHIEVE PREDETERMINED BMI[1,2]

PATIENTS THAT MAINTAIN BMI AFTER GOAL[4]



1. Excluding 14% of patients that drop out of program within first 5 weeks
2. Maintain a BMI +/- within 2%
3. A predetermined goal may be remaining or qualifying for surgery, an improved health outcome, improving other comorbidities, specific weight loss, reducing or eliminating medications, improving overall health profile, etc.

Referral Process

- To learn more about CoreLife, referring patients, and becoming connected to a CoreLife Physician Liaison please contact:

- David DeLeonibus, EVP

daved@corelifemd.com

877-377-6112 Ext 702

Stay Home Safely

- A Medically based home safety pathway of the Collaborative Care Network

  www.stayhomesafely.com

Stay Home Safely's Mission

- Our mission is to provide individuals of all ages with the opportunity to safely and independently remain in their home for as long as possible through home modifications

What is home modification and why is it important

- Home modification is an adaptation of the permanent physical features of the structure of the home which makes tasks easier, reduces accidents, and supports independent living.

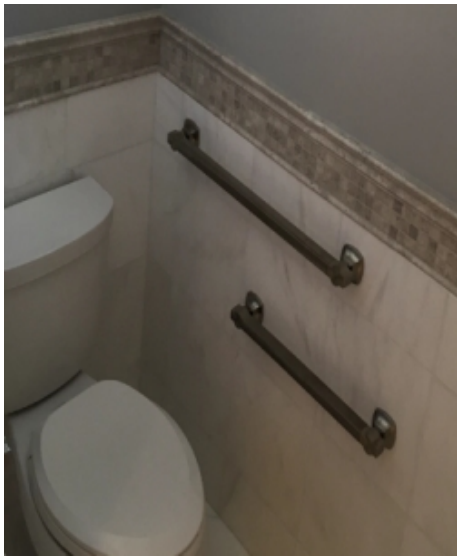
Stay Home Safely Overview

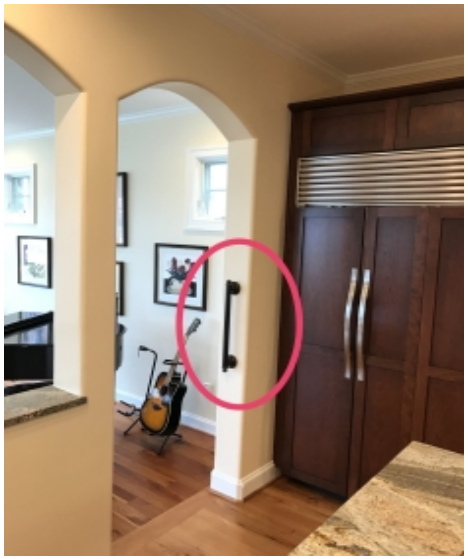
- We observe how an individual is functioning in their home environment and make recommendations to increase independence and reduce fall risk

- All assessments and recommendations are performed by **Certified Aging in Place Specialists** who are also **licensed physical therapists**

Home Modifications

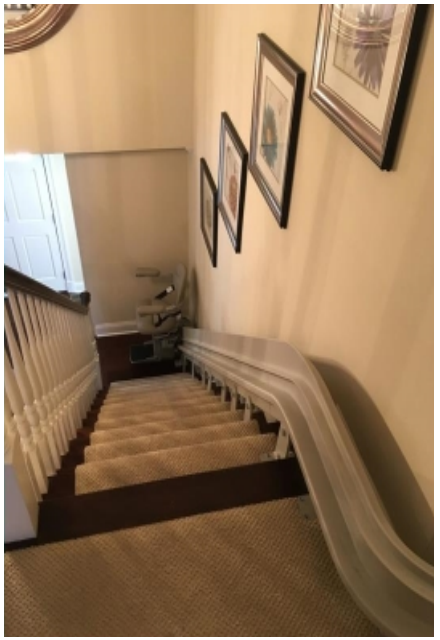
- Grab bars
- Bathroom safety (zero entry showers, elevated commodes, toilet hand rails, hand held showerhead, shower and tub seats)
- Non-slip floor resurfacing
- Elevators , stair lifts and vertical platform lifts
- Exterior railings and ramps
- Kitchen modifications
- Relocation of master bedroom and bath to first floor
- Modifications to support wheelchair accessibility





Services Included:

- Individualized home assessment and plan
- Purchase, delivery and installation of safety products
- Patient education and training on home safety equipment/modifications and activities of daily living
- **Preparing the home for a safe discharge from hospital or rehab facility**



Who do we serve?

- People of all ages
- Progressive neurological disorders
  (ex. Parkinson's disease, MS, CVA, ataxia)
- Orthopedic conditions and joint replacements
- Generalized deconditioning or changes in functional status

How does our Process Work?

- Home interview with client and family to establish client's functional limitations and goals
- Thorough assessment of client's interior and exterior living spaces
- Written report of prioritized recommendations
- Stay Home Safely is MHIC licensed and insured allowing us to oversee all small and large home modification projects
- Patient education and training on home modifications
- Follow up with referring physician

How to connect your patient with Stay Home Safely:

- Call: **443-679-6200**

- Email: **info@stayhomesafely.com**

You have completed all the modules.

Thank you!

Please proceed to the Quiz Module for CME Credit