

MedStar Health Connected Care initiative

The MedStar Health Connected Care initiative is a collaboration between the MedStar Institute for Innovation and the MedStar Medical Group that utilizes telehealth and related technologies to help transform our care model in primary care to improve patient access, clinical continuity, practice efficiency, and provider wellbeing in financially sustainable ways.

Workforce redesign:

The [CPC model](#) supplements MedStar Health's existing broad geography of primary care offices across our community with the addition of a nurse practitioner and medical assistant team who work 100% via telehealth in support of a group of 4-5 practices in an existing geographic "pod". Each resulting pod contains 20-25 primary care providers supported by the NP/ MA team who coordinate closely to ensure that local practices are understood and that patients know that their established provider is always involved in their care. Additionally, a "third tier" of support is made available by a group of clinicians who have developed broad expertise in on-demand telehealth that permits management of additional volume and any other gaps that may occur.

Workflow transformation:

The common pain points for patients include inability to access providers when care is needed, especially for an acute issue, assistance with medications and opportunities to improve care of chronic conditions. Provider wellbeing is severely impacted by a considerable workload of portal messages, prescription refill requests and a sense that their patients are unable to get in to see them because of an already overloaded schedule. To address these issues, the connected care workforce provides several services:

Same day/ next day visits via telehealth:

Existing patients contacting the office with a request to see their established primary care provider are always offered their own provider first if there is availability. If no appointment is available, the Connected Care NP schedule is accessed to permit care of the patient. This access ensures patients do not need to go elsewhere, such as an urgent care, ED or non-affiliated telehealth service for an acute issue but can maintain continuity.

Prescription refill automation and standardization:

MedStar Health partnered with a vendor, Healthfinch in defining a broad array of standard, evidence based clinical practices for review and refill of chronic medications. Patient requests and some automatic triggers result in a workflow that pulls relevant data from the patient's record for review by the CPC MA and NP. Data is reviewed and if no restrictions are identified the renewal can be issued. If a visit, lab testing, or other items are needed the patient is contacted and arrangements made.

Remote Patient Monitoring (RPM):

Remote patient monitoring allows a clinical care team to be connected to a patient daily and be partners in data collection and management to guide care of chronic illness. The CPC NP and MA team are the core clinical team supporting the primary care practices of RPM for HTN in the MedStar Health model. Patients appropriate for the clinical service and willing to participate are enrolled by their primary care provider during an office visit. Patients are given a connected device for blood pressure measurement. MedStar Health elected for a cellular connected device that relays information directly to a cloud server, thus eliminating a patient's need to manage Bluetooth connections and ensuring equitable access to patients who may not have a smart phone.

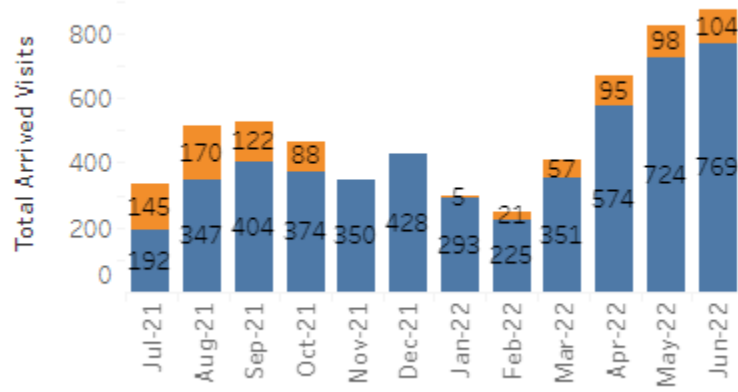
Implementation and Impact:

As of July 1, 2022, the CPC model:

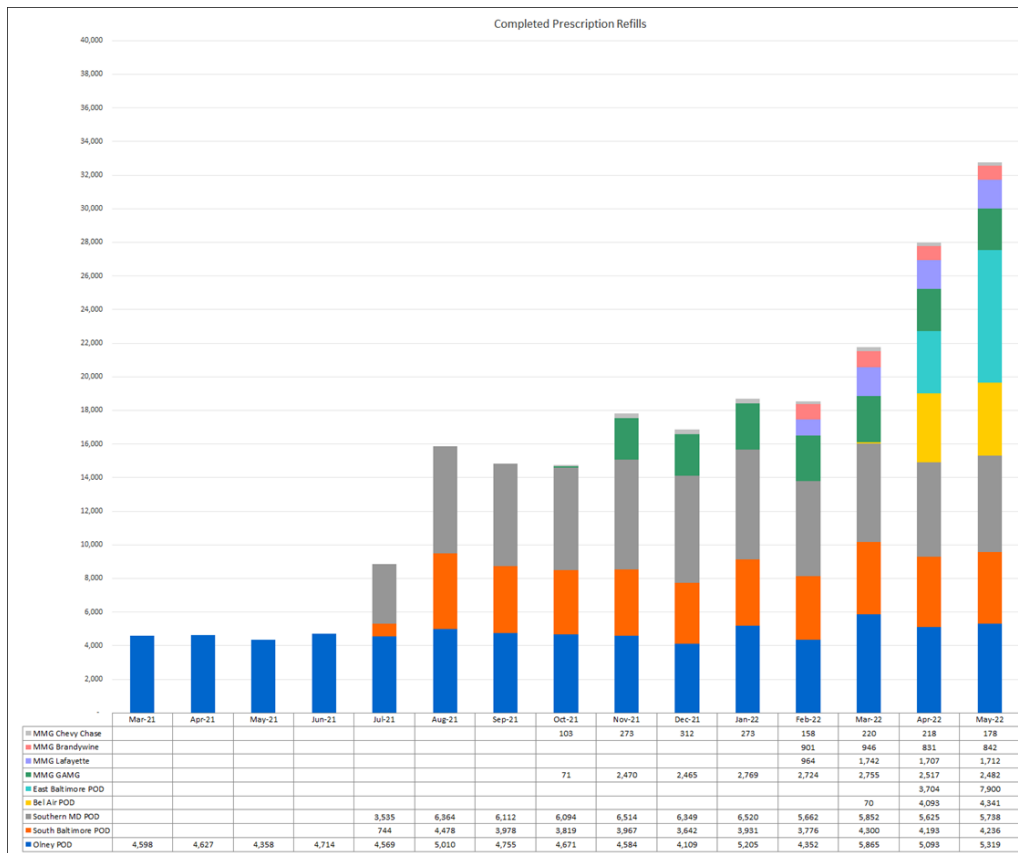
- Supports 26 traditional primary care practices and more than 120 providers.

- Has delivered more than 6,000 telehealth visits to patients within 24 hours of request. The addition of 3 new geographies in Spring 2022 continues growth.

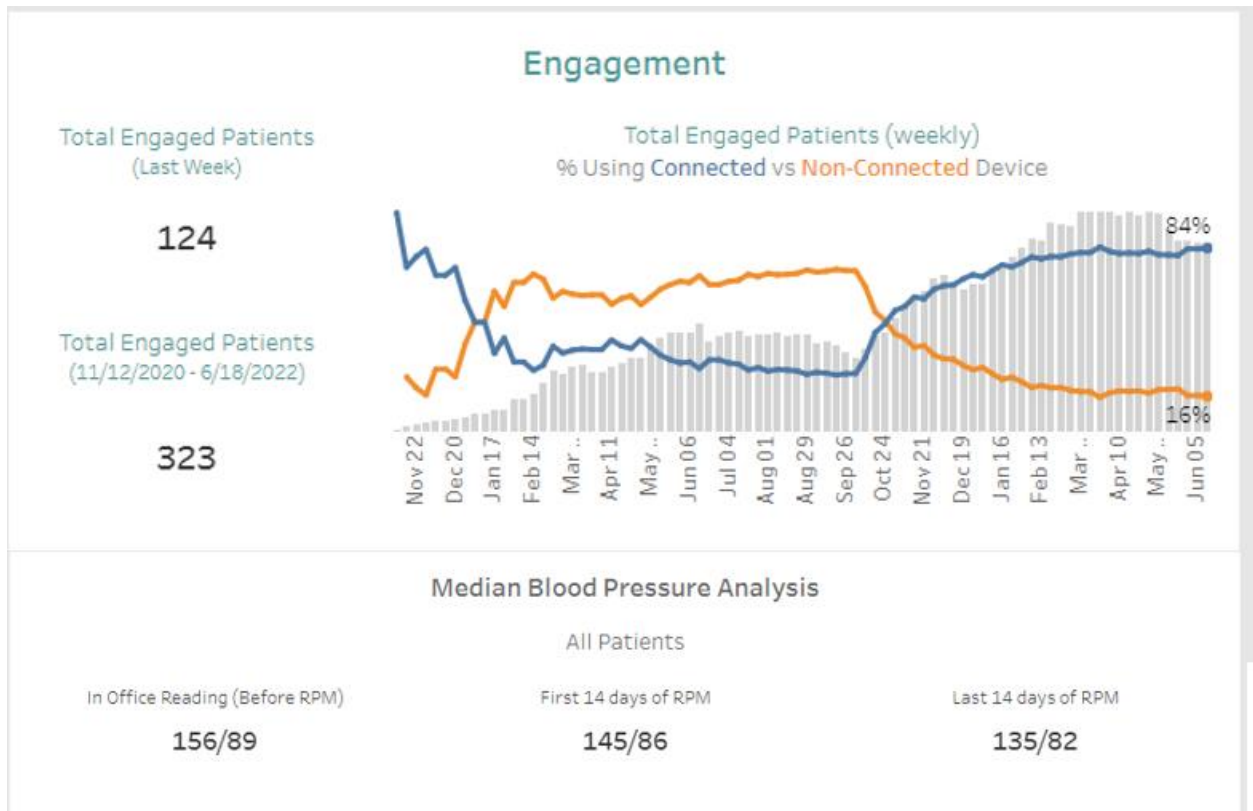
Total Monthly Arrived Visits - CPC vs Tier 3 Providers



- Has processed over 240,000 prescription renewals, removing more than 6,000 hours of provider labor, improving turnaround time for patient requests from more than a day to approximately 4 hours, and improved adherence to established practice protocols for lab monitoring and visits.



- Enrolled more than 400 patients in a fee-for-service supported RPM program for HTN management with a substantial improvement in the number of patients with blood pressure measurements in the well-controlled range.



- Improved patient satisfaction as demonstrated in benchmarked patient experience surveys:

	n size	Likelihood to Recommend Practice				Likelihood to Recommend CP	
		Overall		Percentile Rank		Percentile Rank	
		Top Box	Percentile Rank	Top Box	Percentile Rank	Top Box	Percentile Rank
Connected Primary Care	20122	81.18	51	84.79	44	88.64	59
Non Connected Primary Care	19970	79.37	33	81.53	28	86.47	44

Sustainability:

The connected primary care model has made measurable impact on provider wellbeing, patient experience and access to care and quality metrics, all valuable endpoints that improve the delivery of primary care and the experience of providing it. It has done so without any outside subsidy of the economics and is sustainable with a slightly above break-even financial model on fee-for-service revenue alone. Automation in prescription refills, responsiveness to patient demand for telehealth, and workflow efficiencies allow the clinical teams to devote time and energy to non-revenue activities with a portion of their time but maintain activities that allow sustainability and growth of the model, including the administrative support needed for virtual practice management. While the model is sustainable on clinical service revenue alone, the impact of the program on cost control and continuity of patient care was clear to our largest commercial payer partner and they have agreed to support faster growth of the model to ensure service to our shared at-risk patient population.

Opportunities and barriers:

The model has been successful in implementation with better patient access, continuity, and opportunities for data driven chronic care management and meaningful impact on provider wellness. Opportunities for expansion include full coverage of our primary care footprint of more than 300 providers, which we intend by the end of 2023 and improvement in our enrollment of patients in RPM.

Barriers include uncertainty in ongoing reimbursement for telehealth activities, challenges of delivering care via telehealth in a geography that spans three state licensing jurisdictions and patient confusion or objection to out of pocket cost for telehealth services such as portal messages, virtual check-ins, and RPM. We have had direct feedback from patients that an out-of-pocket cost of less than \$10 monthly for RPM is a barrier for participation and that multiple, small co-insurance payments for services that are given in continuity is inconvenient and confusing. Executing an improved method would include opportunities to unify consenting, co-payment and other administrative tasks into a more continuity oriented model and one less bound by an encounter driven process.