
NWMOMENTUM
HEALTH PARTNERS
www.nwmomentumhealthaco.com

# The Town Hall will begin shortly…

Thank you for joining us today.

Due to the number of attendees, attendees will be muted.

To ask a question at anytime during the presentation, please use the **“question”** box to submit your question.

This webinar will be recorded and posted to the Partner Portal by end of day.

*Please note: Some slides have been removed from the posted version of this presentation in order to protect NWMHP’s Intellectual Property.

# WELCOME

## NW Momentum Health Partner's ACO
## Next Generation ACO Town Hall

February 11, 2021

# Agenda

- NWMHP General Update
- Monthly Performance Report
- CMS Data & Report
- Care Management
- Open Forum

# 2019 Performance

**NW Momentum Health Saves $1.3M in Shared Savings as Participant in Next Generation Accountable Care Organization Model**

- Received a 94.25% quality rating score
- Achieved $1.3M in shared savings for the 2019 reporting

| 2019 performance year 3 | 2018 performance year 2 | 2017 performance year 1 |
|---|---|---|
| **94.25%** overall quality score | **92.81%** overall quality score | **100%** overall quality score |
| **Ranked 1st** for lowest cost in post-acute care | **Ranked 1st** for lowest cost in post-acute care | **Ranked 2nd** highest gross savings/loss % performance |
| **Ranked 2nd** for lowest cost of care per beneficiary | **Ranked 2nd** for lowest cost of care per beneficiary | |
| **$1.3M** in Shared Savings | **$2.4M** in Shared Savings | **$3.3M** in Shared Savings |
| Reduced ACO spending by **2%** | Reduced ACO spending by **4.38%** | Reduced ACO spending by **8.2%** |

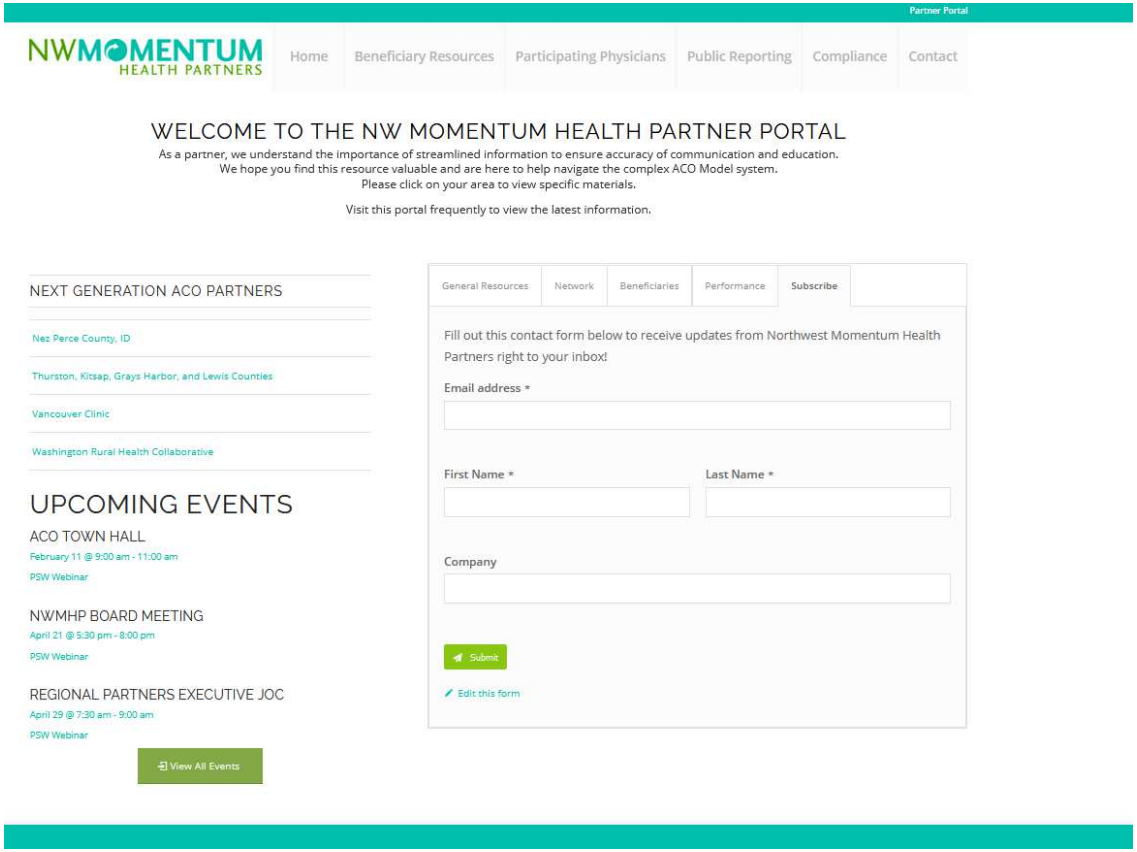




# Your #1 Resource: NWMHP Partner Portal

**Recently available:**

- NGACO Scorecard Example
- How to be Successful in an ACO
- Pathway to Wellness (AWV)
- Provider Network Validation Form
- Beneficiary Notification Letter
- Innovaccer 101
- Town Hall FAQ
- QP Thresholds FAQ




**Don't forget to subscribe to the NWMHP mailing list today!**

# Expanded Resource Meetings

| MEETING | PURPOSE | AUDIENCE | SCHEDULING |
|---|---|---|---|
| Regional Executive JOC | Engagement<br>Board connection<br>Model success<br>Policy & Advocacy | Executive leadership from regional partners | Jan<br>April<br>July<br>Oct |
| Town Hall | Education & Communication<br>Deep dive on all operational requirements<br>Resources to support success | Staff, leadership, partners involved in ACO participation | Feb<br>May<br>August<br>November |
| SNF/PAC Care Management | Review current performance<br>Review program updates<br>Identify areas of opportunity<br>Report on current initiatives | NWMHP to complete outreach to all partners to design schedule / attendees | NWMHP Care Management to schedule with partner |
| Partner Check-in | Review Innovaccer scorecard<br>Address actionable data<br>Evaluate opportunities | Individual regional partners | Scheduled directly with partner |





# Provider Network Management

Per CMS guidelines provider additions and terminations must be updated monthly.

- A reminder email will be sent monthly to submit these adds and terms
- The email will contain a form to be filled out
- Forms to be returned by the 15th of the month

Failure to meet the requirements may result in remedial action, up to and including, termination of the ACO's agreement with CMS.

For any questions regarding the process of submitting changes to your provider roster:

Contact Angie Valderrama at **ProviderNetwork@pswipa.com**

# NWMHP General Updates

# Quality Payment Program (QPP) Update

Advanced Alternative Payment Models (APMs) are a track of QPP, offering a 5% incentive (APM bonus) payment to eligible Participant providers for achieving threshold levels of payments or patients.

**Why is it important?**

- Creates incentives for providers to participate in Advanced APMs under MACRA rules.

**What changed for 2021?**

- The Consolidated Appropriations Act has frozen Qualifying Participant (QP) Thresholds for the 2021 and 2022 performance year.

**What does this mean for Participant Providers?**

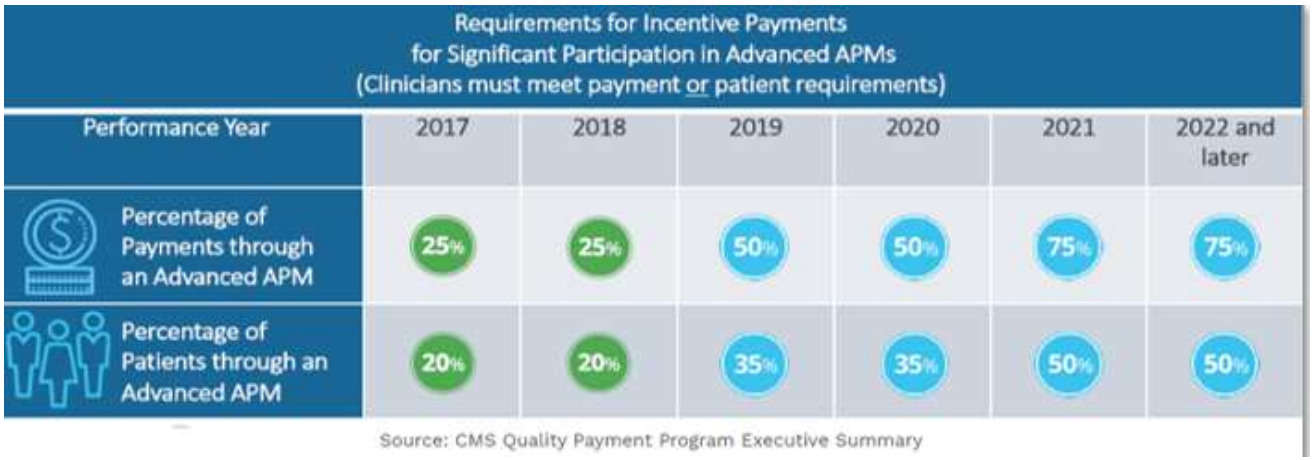
- The freeze on thresholds allows for better chances for NWMHP has a whole to reach QP status. Reaching QP status will allow eligible Participant Providers to receive the 5% APM Bonus payment and be excluded from reporting MIPS.

**Where can I find more information?**

- Visit the NWMHP Partner Portal to view the QP Thresholds FAQ and a link to the QPP website.

# QP Threshold Freeze Approved

Before:



Requirements for Incentive Payments for Significant Participation in Advanced APMs (Clinicians must meet payment or patient requirements)

| Performance Year | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 and later |
|---|---|---|---|---|---|---|
| Percentage of Payments through an Advanced APM | 25% | 25% | 50% | 50% | 75% | 75% |
| Percentage of Patients through an Advanced APM | 20% | 20% | 35% | 35% | 50% | 50% |

Source: CMS Quality Payment Program Executive Summary

After:

Requirements for Incentive Payments for Significant Participation in Advanced APMs (Clinicians must meet payment or patient requirements)

| Performance Year | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 and later |
|---|---|---|---|---|---|---|
| Percentage of Payments through an Advanced APM | 25% | 25% | 50% | 50% | 50% | 50% |
| Percentage of Patients through an Advanced APM | 20% | 20% | 35% | 35% | 35% | 35% |

Source: CMS Quality Payment Program Executive Summary

Allows more providers to qualify for the 5% APM bonus. NWMHP would likely not have been able to meet the thresholds if they had not been frozen.

# 2021 Beneficiary Notification

- Annual CMS required notification letter (template)
- Purpose
  - Informs beneficiary their provider is participating in an ACO
  - Assures beneficiary this does not change their Medicare rights
  - Provides information on availability of value added services
    - Beneficiary enhancements
    - Care Management
- NWMHP manages mailing per CMS guidelines for entire ACO
  - Provide call center support and answer questions/concerns
  - Copies will be provided to partners prior to mailing (March 1st)
  - Provide a FAQ that partners can use to address questions (March 1st)
- Schedule
  - Must be distributed between March 1st and May 31st, 2021
  - Mailed to 33,000 beneficiaries in 3 stages
    - Legacy population (3/22) - Lewiston population (3/26) – TVC/TRC (3/30)

# 2021 Beneficiary Notification

## Partner/Provider Responsibilities

- Review and share the FAQ with providers and staff
- Prepare staff for to answer beneficiary questions
- Educate beneficiaries on why your facility chose to participate in an ACO and what it means to them
- Reach out to NWMHP with any questions or concerns

# 2021 Quality Update

- The current CMS Web Interface for ACO quality reporting will sunset and is being replaced by a new reporting framework known as APM Performance Pathway (APP).

- The APP will have a quality measure set that consists of 3 eCQM measures, a CAHPS Survey measure, and 2 measures that will be calculated by CMS using administrative claims data;

- For the 2021 performance year only, we have the option to continue to report the 10 CMS Web Interface measures OR 3 eCQM measures via the APP.

- PY 2022 we will be required to report via the APP.

# 2021 Quality Reporting

## Core Measure Set

| Measure # | Measure Title | Collection Type | Meaningful Measure Area |
|---|---|---|---|
| Quality ID#: 321 | CAHPS for MIPS | CAHPS for MIPS Survey | Patient's Experience |
| Quality ID#: 479 | Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups | Administrative Claims | Admissions & Readmissions |
| Quality ID#: 480 | Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for ACOs | Administrative Claims | Admissions & Readmissions |
| | | | |
| Quality ID#: 001 | Diabetes: Hemoglobin A1c (HbA1c) Poor Control | eCQM/MIPS CQM/CMS Web Interface | Mgt. of Chronic Conditions |
| Quality ID#: 134 | Preventive Care and Screening: Screening for Depression and Follow-up Plan | eCQM/MIPS CQM/CMS Web Interface | Treatment of Mental Health |
| Quality ID#: 236 | Controlling High Blood Pressure | eCQM/MIPS CQM/CMS Web Interface | Mgt. of Chronic Conditions |
| | | | |
| Quality ID#: 318 | Falls: Screening for Future Fall Risk | CMS Web Interface | Preventable Healthcare Harm |
| Quality ID#: 110 | Preventive Care and Screening: Influenza Immunization | CMS Web Interface | Preventive Care |
| Quality ID#: 226 | Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention | CMS Web Interface | Prevention and Treatment of Opioid and Substance Use Disorders |
| Quality ID#: 113 | Colorectal Cancer Screening | CMS Web Interface | Preventive Care |
| Quality ID#: 112 | Breast Cancer Screening | CMS Web Interface | Preventive Care |
| Quality ID#: 438 | Statin Therapy for the Prevention and Treatment of Cardiovascular Disease | CMS Web Interface | Mgt. of Chronic Conditions |
| Quality ID#: 370 | Depression Remission at Twelve Months | CMS Web Interface | Treatment of Mental Health |

*Performance Year 2021 APM Performance Pathway: CMS Web Interface Measure Benchmarks for ACOs (https://qpp.cms.gov/resources/resource-library)

# Monthly Performance Report

# Monthly Performance Report

**NWMHP Monthly Performance Report**: what you need to know

- Access to Innovaccer's Population Health Platform supports the drill-down of patient specific data
  - Inpatient admission and readmission
  - Skilled Nursing Facility (SNF)
  - Emergency Department (ER)
  - Annual Wellness Visit metrics

- Provides cost allocations

- Monthly Performance Reporting Calendar is available on the Partner Portal

*45 days lag to CMS's data timeline added to allow reporting with a 95% or better completion rate





# Reporting Access

PSW/NWMHP delivers a variety of provider data reports via Box.com

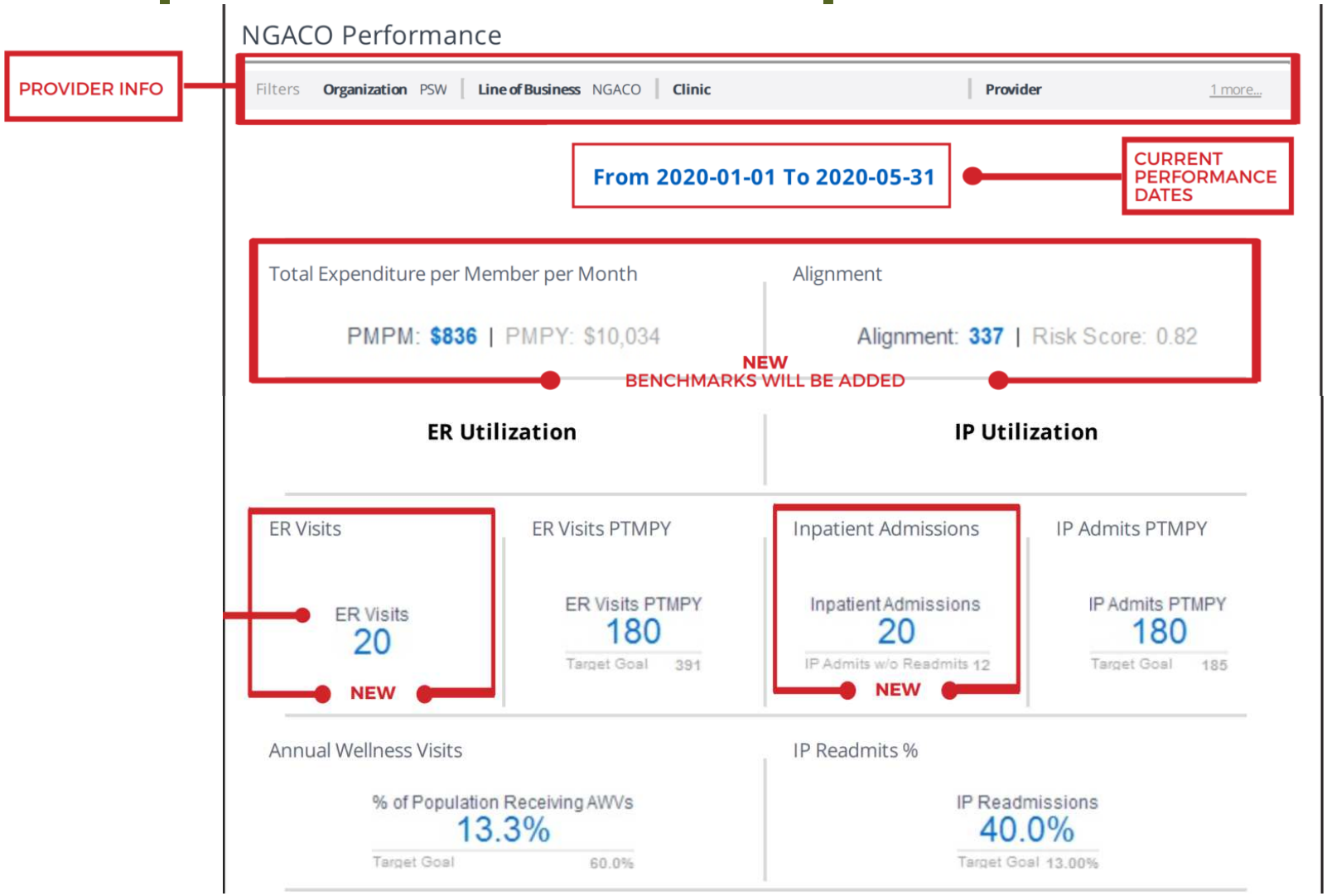
- Monthly Performance Report (Scorecard)
- Quarterly Data Reports
- GAP Reports
- High Utilizer Reports (HURR)
- Patient Evaluation Forms (PEF/HCC)


Box.com is a secure web-based portal that allows NWMHP to send provider performance and related data.

Instructions for accessing Box.com are available on the Partner Portal

For questions regarding Box.com, please contact Angie Valderrama at **ProviderNetwork@pswipa.com**

# Example Performance Report



# Example Performance Report


*By having access to Innovaccer, you will be able to drill down to patient level data

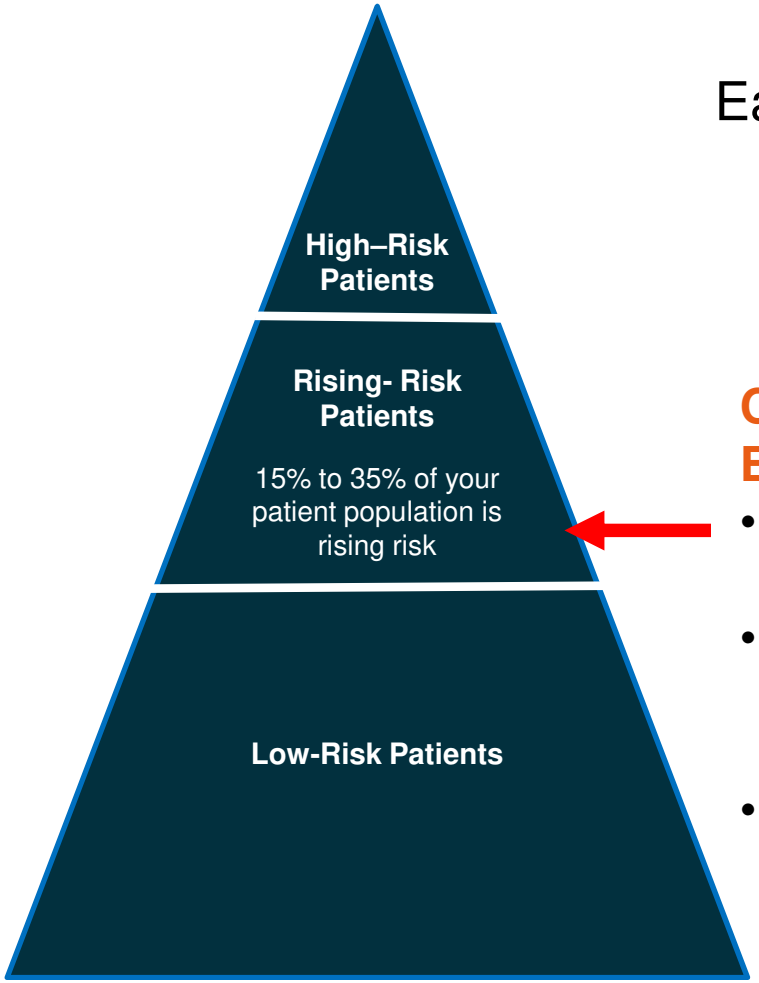
# Identifying High and Rising Risk Patients

Effective Identification requires the ability to:

- Understand Chronic condition prevalence in populations
  - Cardiovascular Conditions
  - Diabetes
  - Respiratory
  - Renal Disease
- Assess localized/community based risk factors
  - Through the use of a social vulnerability index

# Risk Populations

## Patient Risk Escalation




Each year about 18% of rising risk patient escalate to high-risk patients.

### Common Triggers of Rising Risk Escalation

- Unpredicted exacerbation where patient is unable to recover
- Patient unaware of condition or ignores it and therefore is not managing
- Natural deterioration based upon based upon managed condition

# High Risk

## Rising Risk Identified Patients

Innovaccer Risk Dashboard

**NGACO Population**

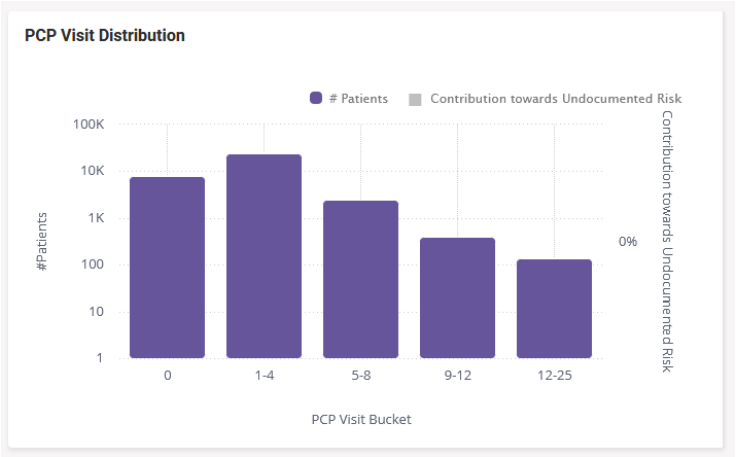
| Disease | # Patients | Prevalence |
|---|---|---|
| Diabetes | 4205 | 26.7% |
| CHF | 2329 | 14.8% |
| Cancer | 2452 | 15.6% |
| COPD | 2248 | 14.3% |
| Chronic Kidney Failure | 1699 | 10.8% |
| Morbid Obesity | 1245 | 7.9% |
| Ulcer | 611 | 3.9% |
| Cardiac Respiratory Failure | 553 | 3.5% |
| End Stage Renal Disease | 54 | 0.3% |
| HIV/AIDS | 3 | 0.0% |

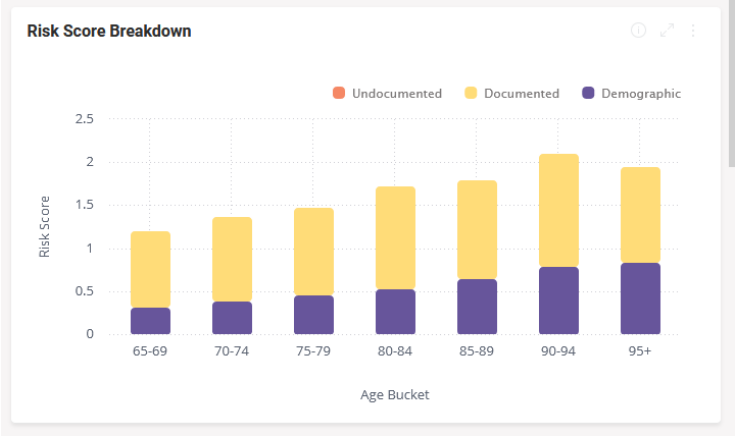




# Rising Risk Variables

## Innovaccer Risk Dashboard: A Case Study Example




**Managing disease states:** understand and filter on several factors:

- PCP Visit distribution
- Age grouping

**Additional filtering options:**

- Annual Physical or Wellness Visit Completion
- Open care gaps
- Undocumented diagnosed chronic conditions year over year

**CASE STUDY EXAMPLE:**

**Data ➡ Actionable Information**

- Filter on the Chronic Kidney Failure population of 1699
- Look at the age group between 65 and 69 where a patient did not have a PCP visit in 2020, needs an AWV, and has nine or more open care gaps.
- Narrows patient list from **1699 to six patients** needing outreach.

NWMOMENTUM HEALTH PARTNERS

# Innovaccer Training

- Sign up for Innovaccer Training to receive an in-depth overview
  - Monthly Attribution Lists
  - Quality Metrics
  - Patient Level Drill-Downs
    - Assist with gap closure
    - Identification of high utilizers
    - Risk adjustment
  - Admit, Discharge, and Transfer (ADT) through Collective Medical Technologies
    - Used for the generation of Care Management Protocols

- Visit the Partner Portal and click on Performance to sign up

Innovaccer training specific to Care Management will be offered by Care Management Team

# CMS Data & Reports

# Alignment vs. Attribution

| FILE | DEFINITION | AVAILABLE |
|---|---|---|
| Alignment File | Provided by CMS and is the prospective patient alignment to the NGACO | January |
| Attribution File | NWMHP builds this file using historical claims data to determine if attributed primary care provider or specialist based on dates of service and spend | February |

- NWMHP cannot remove beneficiaries; must be done by CMS
- Beneficiary alignment will reduce each month due to removal of Medicare Advantage enrollees

# NGACO: 2021 Beneficiary Alignment

- Alignment file total: 33,145
- Original estimate: 29,300

| County | Aligned |
|---|---|
| Thurston, Pierce, Mason | 7984 |
| Clark | 4340 |
| Lewis | 2621 |
| Lewiston ID, Asotin WA, Clearwater ID | 4575 |
| Pend Oreille WA and Bonners ID | 1822 |
| Grays Harbor | 3045 |
| Pacific | 1414 |
| Kitsap | 1106 |
| Klickitat | 499 |
| King | 141 |





# Care Management

# Care Management Program

## What will be Covered

- Goals of Care Management Program
- Services and Resources
- Benefit Enhancement Program
- Expectations of Partners
  - Priority areas of focus
  - How to get started

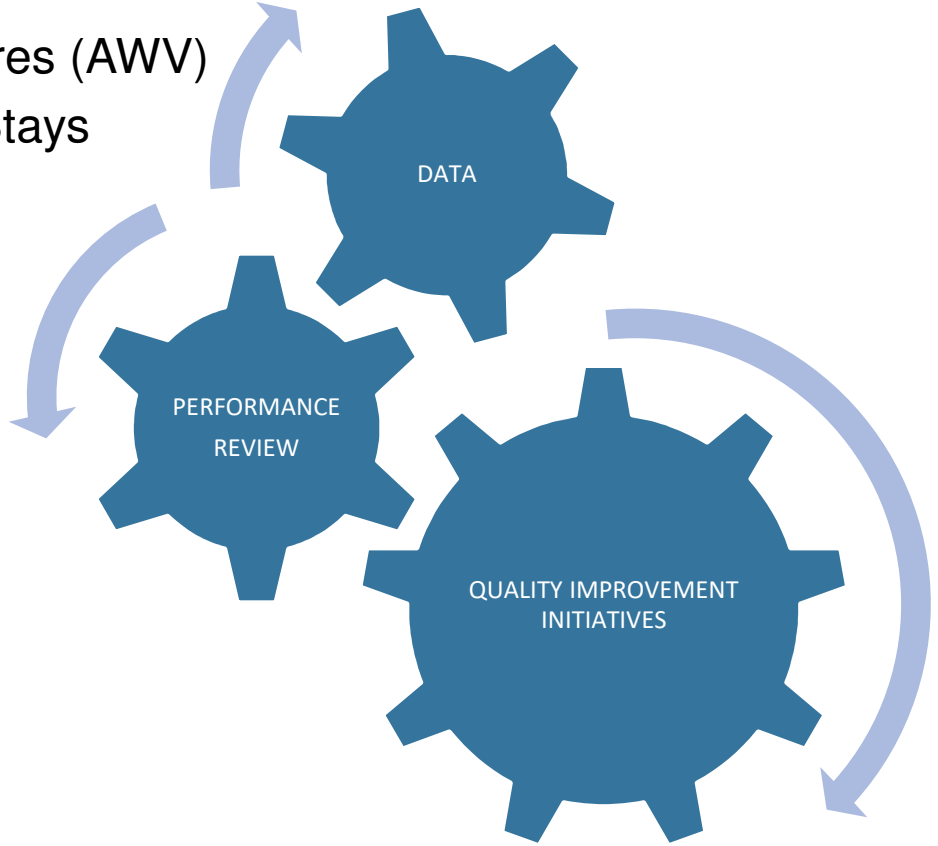
# Goals of Care Management

## Reduce overall costs of healthcare

1. Emphasize prevention
2. Support shared decision making
3. Reduce unnecessary duplicative diagnostics
4. Reduce emergency room utilization
5. Reduce avoidable inpatient stays
6. Improve population self-care for chronic disease management
7. Utilize community programs for SDoH needs

# Key Performance Indicators

1. **Member Engagement**
   - i. Preventative Health Measures (AWV)
   - ii. TCM for ED and Inpatient Stays
   - iii. Care Management (CCM)
2. **Provider Engagement**
   - i. Care Collaboration
   - ii. Setting Appointments
   - iii. Care Planning
3. **Data Analytics**
   - i. Trends and Opportunities
   - ii. High Risk Evaluation
   - iii. Performance Outcomes
   - iv. Quality Outcomes



NWMOMENTUM
HEALTH PARTNERS

# Care Management Services

# Care Management Services

1. Prevention and Education (AWV)
2. Transitional Care Management
3. Comprehensive Case Management
4. Social Determinants of Health
5. Remote Patient Monitoring
6. Post-Acute Care Management

Team consists of licensed nurses, care navigators and post-acute coordinators

# Care Management: Getting Started

- Annual Wellness Visits
- Reduce ED Visits
- Post-Acute Management

# Annual Wellness Visits: Getting Started

What is purpose/value?

What steps can be taken today?

- Identify patients
- Set up workflows
- Schedule
- Communicate benefits

Resources (Path to Wellness on Partner Portal)

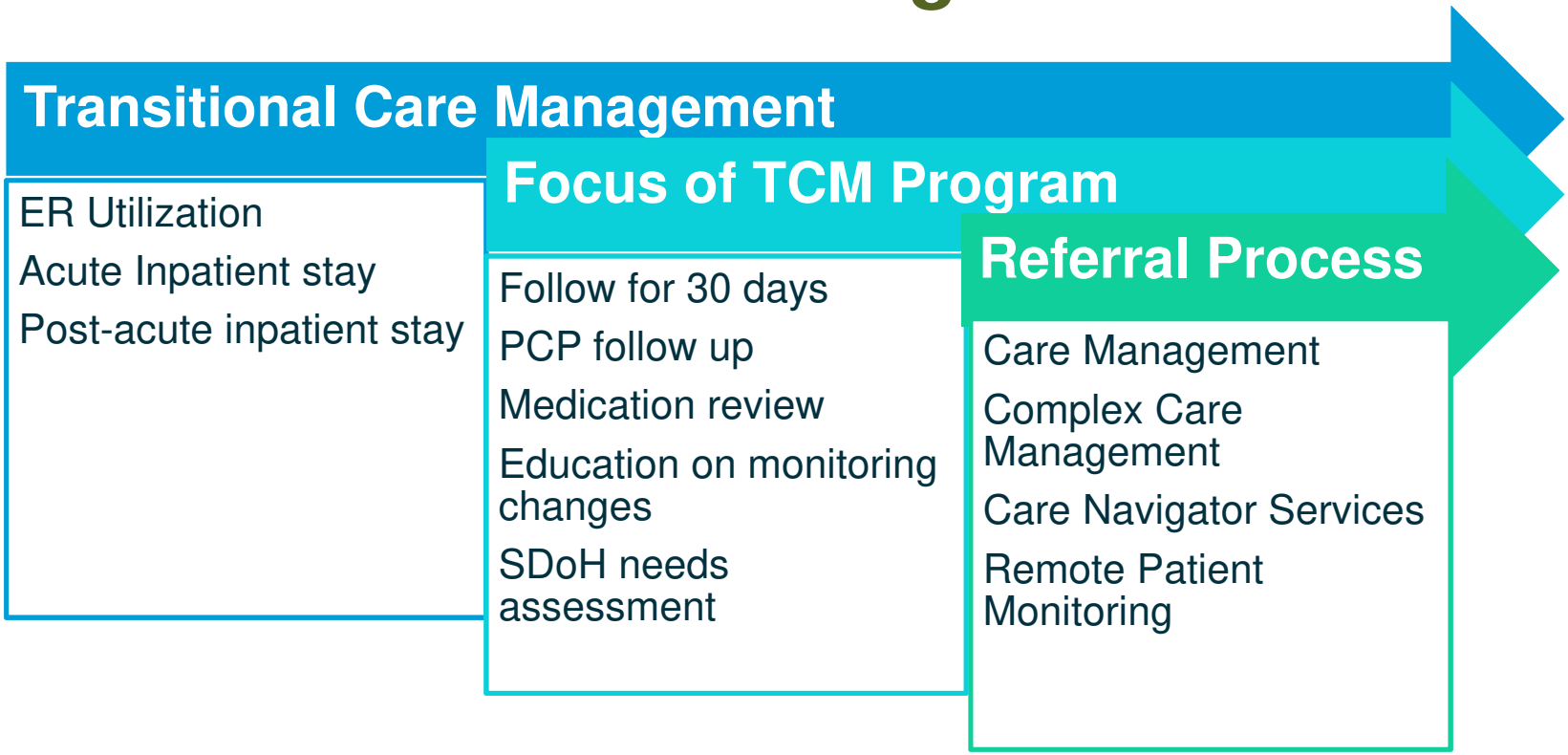
- Beneficiary facing
- Provider facing

# Reducing ED Visits: Getting Started

- Urgent Care utilization education
- Education on green, yellow, red signs and symptoms
- Engagement
  - Does the beneficiary have a primary care provider?
  - When were they last seen?
  - Opportunity to re-establish a lost patient?

**KEY STEP:**
Provide and distribute list of urgent care facilities in your area

# Transitional Care Management



# Care Management Services

- Care Coordination
  - Provider engagement
- Complex Care Management
  - Disease management education
- Remote Patient Monitoring
  - Improving self-care
- Social Determinants of Health Program

# SDoH Needs Assessment

- Evaluate needs with each engagement
- Identify qualifications for ACO benefits
- Referrals to community resources

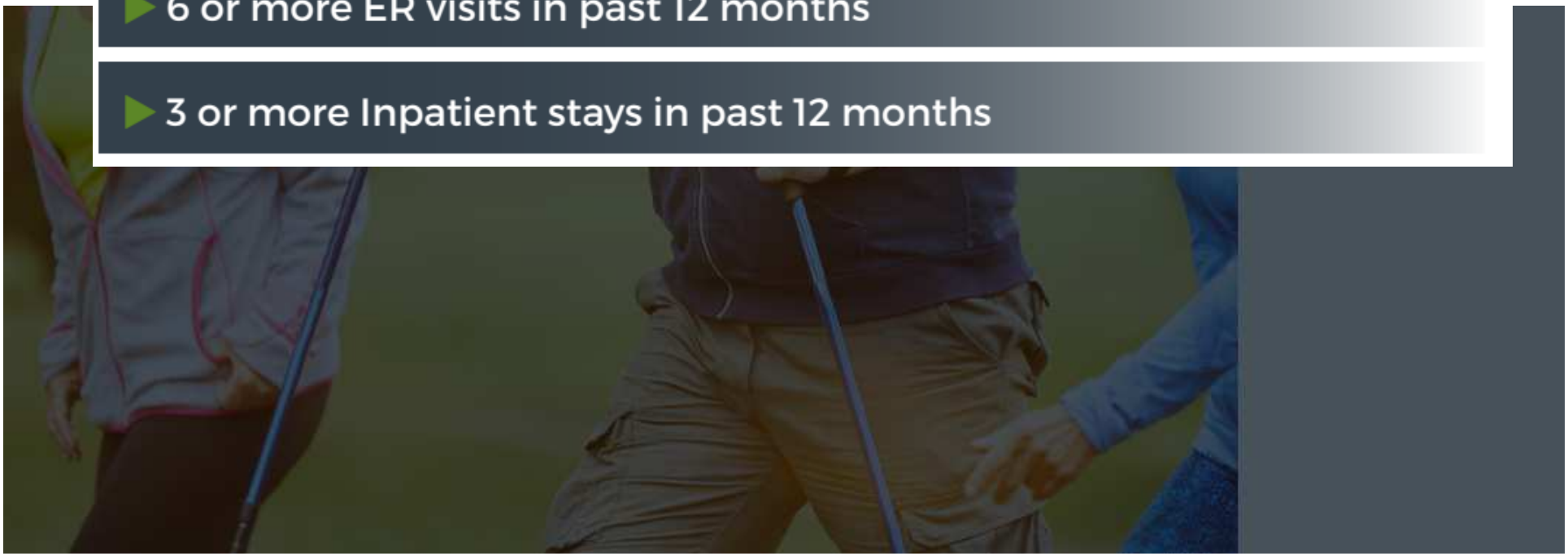
NWMOMENTUM
HEALTH PARTNERS

# High Risk

# Definitions for High Risk Population

## HIGH- RISK STATUS

- 2 or more ER visits in the last 30 days
- 2 or more Inpatient stays in the past 6 months
- 6 or more ER visits in past 12 months
- 3 or more Inpatient stays in past 12 months



# High Risk Focus

| MICKEY MOUSE | NGACO | Dr. Do Right | The Do Right Clinic | |
|---|---|---|---|---|
| DOB: 1952-04-04 | ER Visits | Inpatient Stays | RAF: 1.15 | |
| Last 12 Months | 8 | 3 | Readmission: Y | DSNP: N |
| Last 6 Months | 2 | 1 | Diabetic: Y | Remote Monitoring: N |

**PreManage Encounters**

**2020-03-23 04:44:00: Emergency at Providence Saint Peter Hospital Diagnosed with: S0101XA:Laceration without foreign body of scalp, initial encounter; ems ed3 glf, head lac; Fall. Discharged to home or self care (routine discharge) on 2020-03-23 06:35:00.**

**2020-02-25 23:44:00: Emergency at Providence Saint Peter Hospital Diagnosed with: ems glf; Fall; M6282:Rhabdomyolysis; N179:Acute kidney failure, unspecified; G9340:Encephalopathy, unspecified. No discharge date.**

**2020-02-25 23:44:00: Inpatient at Providence Saint Peter Hospital Diagnosed with: G919:Hydrocephalus, unspecified; G9340:Encephalopathy, unspecified; E871:Hypo-osmolality and hyponatremia; I10:Essential (primary) hypertension; L03116:Cellulitis of left lower limb; R29898:Oth symptoms and signs involving the musculoskeletal system; N179:Acute kidney failure, unspecified; R569:Unspecified convulsions; M6282:Rhabdomyolysis; G039:Meningitis, unspecified; J189:Pneumonia, unspecified organism; R410:Disorientation, unspecified; G9341:Metabolic encephalopathy; I5032:Chronic diastolic (congestive) heart failure; G0490:Encephalitis and encephalomyelitis, unspecified. Discharged/transferred to skilled nursing facility (SNF) on 2020-03-18 15:39:00.**

# Managing My Health

## Heart Failure

GOAL WEIGHT: _____

PATIENT INFORMATION: _____


360.786.8690
careteam@pswipa.com

Example of resources available for beneficiary engagement

NWMOMENTUM HEALTH PARTNERS

NWMOMENTUM
HEALTH PARTNERS

# Post – Acute

# Why Post – Acute Management (PAC)?

- Improve transitions of care
- Reduce risk of readmission
- Improve health outcomes
  - Provide continuity of care across settings
  - Reduce adverse effects
- Improve community collaborative care

# Goals of PAC Management

- Reduce cost of care
  - Manage appropriate LOS
  - Reduce readmissions
  - Utilize SNF Direct Admission Waiver
- Improve transitional care post-discharge
  - Follow up appointments within 7 days
  - Supporting needs at home

# Implementation Steps

- Collaborative partnerships
  - Setting up meetings to educate about the ACO program
- Active engagement
  - Set up weekly calls for beneficiary review
- Direct Admits
  - Complete agreements
  - Educate on the process steps

# Post-Acute Interventions

- WARM HANDOFFS
  - Nurse-to-Nurse
  - Provider-to-Provider Reports
- PROVIDER FOLLOW-UP CARE
  - Nurse-to-Nurse
- ADVANCE CARE PLANNING DISCUSSIONS
- WEEKLY STATUS UPDATES
- MEDICATION RECONCILIATION
- BENEFICIARY ABILITY TO PROVIDE SELF-CARE
- REVIEW READMISSIONS FOR TRENDS AND EDUCATION PURPOSES





NWMOMENTUM
HEALTH PARTNERS

# Skilled Nursing Facilities

# SNF Joint Operating Committees

- Purpose
  - Review current performance
  - Review program updates
  - Identify areas of opportunity
  - Report on current initiatives
- Attendees
  - Care Management team members from hospital or clinic partner
  - PSW Director of PAC Network and Post-Acute Care Coordinator
- Frequency
  - Quarterly

# Post – Acute: Expectations

- Support transitions of care interventions
- Appropriately manage patient length of stay
- Participation in utilization of the 3-day SNF waiver
- Provide clinical records upon request
- Partner / Support NWMHP (PSW) for beneficiary management during SNF stay
  - Reoccurring phone calls with Post-Acute Care Coordinator to discuss ACO patients
- Attend and participate in quarterly JOCs



# Benefits of Participation

- No risk of any kind to participate
- Utilization of 3-day SNF waiver
- Movement of patient care and volume to a preferred post acute network of providers
- Enhance relationship with healthcare partners in the community

NWMOMENTUM
HEALTH PARTNERS

# Benefit Enhancements

# NGACO Benefit Enhancements for 2021

| BENEFIT ENHANCEMENT | GENERAL INFORMATION | IMPLEMENTATION PLAN |
|---|---|---|
| **SNF 3-Day Waiver** | **Eliminates the requirement of a 3 mid-night inpatient stay before admission to SNF** | **Q1-2 2021** PRIORITY |
| Care Management Home Visit | Allows providers to initiate two care management in home visits in a 90 day period that are not home bound, to supplement provider visits to support improved health outcomes following a provider appointment. | TBD |
| Post-Discharge Home Visit | Allows for 9 home visits in a 90 day period following an inpatient stay by licensed or certified personnel under the supervision of a provider. | TBD |
| Telehealth | Supports beneficiaries by allowing them to originate a synchronous telehealth encounter in their home with their provider. | TBD |
| Cost Sharing for Part B Services | Aim is to offer cost sharing support to reduce financial barriers for beneficiaries, to support adherence with treatment plans and improve health outcomes. | CMG to pilot first |
| Chronic Disease Management Reward Program | Allows NGACOs to provide gift cards up to $75 annually to incentivize participation in chronic disease management program. | Q1-2 2021 |

# Goals for Utilization

- Reduce costs of care
  - Utilization of ED and Inpatient Stays
- Improve beneficiary engagement with PCP
  - Understanding chronic disease
- Improve adherence to interventions
  - Assisting beneficiaries to meet their health goals
- Improve self-care
  - Shared decision making

# Priority Implementation: Q1-2 2021

1. SNF 3-Day Rule Waiver ("Direct Admit")
    i. All partners
    ii. Engaging SNF partners over next 30 days

2. Chronic Disease Management Reward
    i. Begin with partners who have an active Care Management program

3. SDoH Program
    i. Setting up vendor contracts over next 30-60 days

# Criteria for BE Utilization

- SNF 3-Day Rule Waiver
  - Established preferred provider
  - CMS 3 Star Rating or above
- Chronic Disease Management Reward
  - Requires beneficiary to be enrolled in CM program for a minimum of 60 days

| | |
|---|---|
| • COPD | • CHF |
| • Diabetes | • Depression |
| • Parkinson's | |

- SDoH Program
  - Demonstrated need
  - Care plan how benefit helps meet healthcare goals



# Benefit Enhancements: Getting Started

**Direct SNF Admit Waiver**

- SNFs bill Medicare as usual
- Agreements with participating SNFs
- Added/approved by CMS as preferred providers
- Documentation and reporting requirement workflows

**Chronic Disease Management Reward Program**

- Permits use of gift card incentives for participation in care management
- $75 annual limit – Gift card selection and documentation
- Related to specific disease or chronic conditions
- Funded and distributed by the NGACO
- Documentation and reporting requirement workflows

**SDoH Program**

- Vendor selections for meal and transportation program
- Documentation and reporting requirements and workflow
- Budget review

# SDoH Program

- Food insecurities
  - Groceries (1 time benefit)
  - 30 days of meals through Meals on Wheels
- Transportation
  - Covers transportation from home to provider office or other healthcare services needed
  - Max benefit x 6 per year
- Non-covered medical equipment
- Pet food or supplies

NWMOMENTUM HEALTH PARTNERS

**CARE MANAGEMENT**
SOCIAL DETERMINANTS OF HEALTH

NWMHP continues to dedicate resources to support our Accountable Care Organization (ACO) members. For those who qualify, NWMHP provides interventions for high-risk clients to meet nutritional and healthcare needs.

**FOCUSED INTERVENTIONS**

**TELEHEALTH:** identify potential client needs to coordinate telehealth opportunities that reduces in office visits.
- Assist with appointment scheduling coordination with PCP
- Education and execution of DispatchHealth or urgent care options (in areas serviced)

**REMOTE PATIENT MONITORING*:** helping patients improve their health and decrease emergency room visits and acute patient hospitalizations.
- Home delivery with customer service support for equipment set up

**NUTRITIONAL SUPPORT:** targeting clients with multiple co-morbidities, increased risk factors for illness (implied increased need for self-isolation), and may be facing financial instability.
- Utilization of community resources available
- Order and delivery coordination of meals to homes for 30 days
- Using local supermarkets to provide food staples up to $200** for order delivery (1 time benefit)

**MEDICATION MANAGEMENT:** included with all interactions to support adherence.
- Education regarding mail order pharmacy
- Assist with navigating local pharmacies for home delivery
- Assist with drive through pharmacy utilization
- Coordinate services for immediate prescription needs for same-day refills and new prescriptions

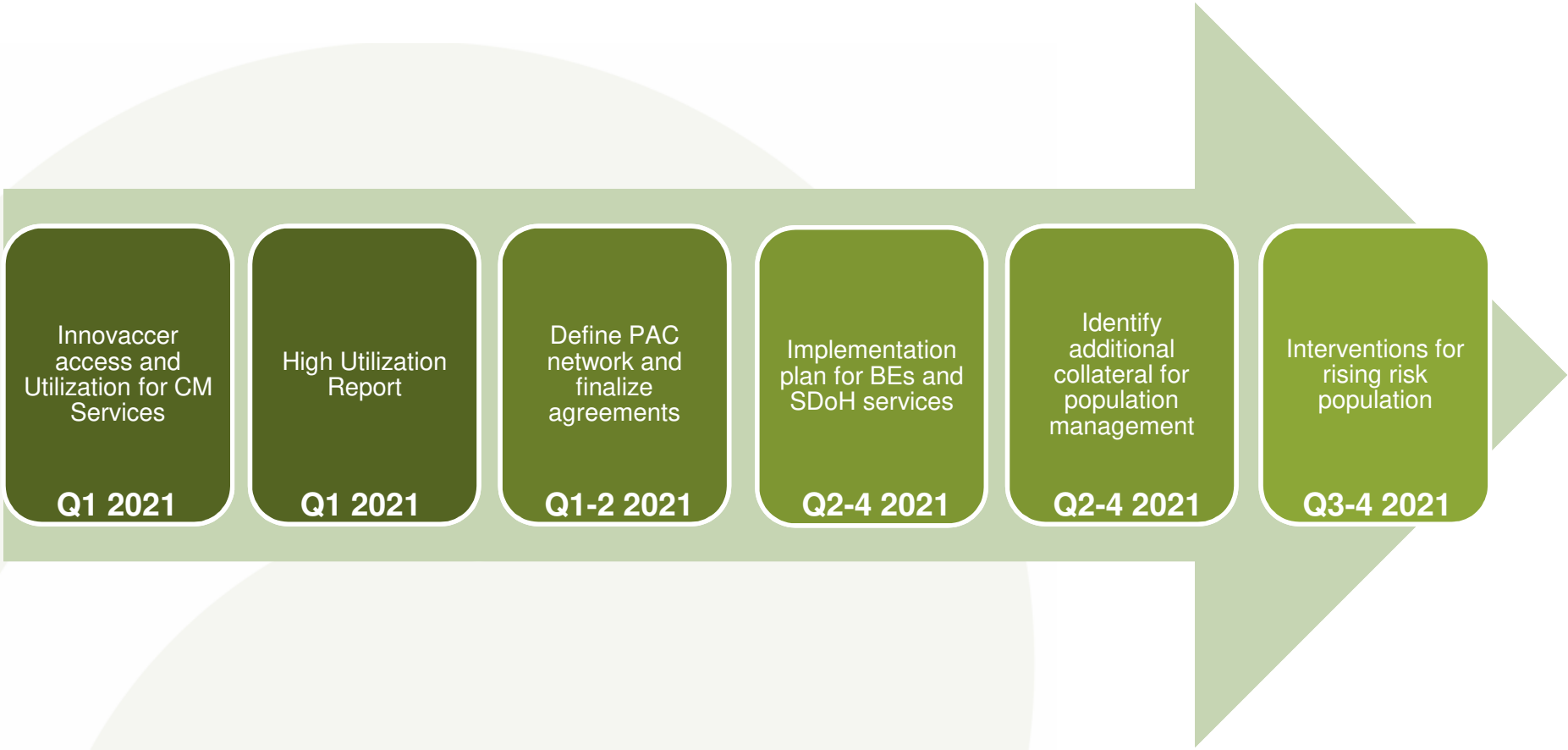
**PET ASSISTANCE:** addressing patients with limited resources to support pet needs versus food and medication needs.
- Providing food and other resources for patient's pets

**NON-COVERED MEDICAL EQUIPMENT:** assistance with equipment that may not be covered by insurance
- Body weight scales, shower chairs, etc.

**CONTACT YOUR PROVIDER FOR MORE INFORMATION**
[insert provider URL and phone]

*SDoH flyer will be available on the Partner Portal

# Next Steps



# Next Steps

- Scheduling weekly Care Management meetings with each partner
- Outreach to identified skilled nursing facilitates in region
- Scheduling weekly PAC meetings with each partner
- Purpose/ expectations

*If you haven't heard from NWMHP / PSW by **2/19**, please contact JacobW@pswipa.com

# Next Town Hall

May 13th at 9am

# Open Forum

Visit the partner portal and sign up to receive updates, news and reminders.

**nwmomentumhealthaco.com** - click the “Partner Portal” button in the top right