Freedmen's Medicine Corporate Profile

Timothy P. McNeill, RN, MPH

FREEDMEN'S MEDICINE
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Company Named in Honor of Freedmen's Hospital

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Freedmen's Hospital, founded in 1862 as first and only Federally-funded hospital for Black people in the United States.

Freedmen's Hospital (now Howard University Hospital)

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Corporate History

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House Calls of the District of Columbia

- Founded in 2016
- Home-Based Primary Care Provider
- Initial Target population:
  - Homebound older adults in Ward 7 & 8
- One of the largest providers ordering EPD Waiver services in the District

d/b/a Freedmen's Medicine

- Rebranded as Freedmen's Medicine in 2020
- Expanded the service area to all Wards in the District of Columbia.
  - Serving Wards 1 – 8
- Analysis of current population showed the following data:
  - 85% had a co-morbid behavioral health condition
  - 25% had a known substance use disorder
- Implemented a Collaborative Care Management Model.
- Actively recruit and enroll persons with a behavioral health condition or SUD and a chronic medical condition.

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Executive Management Team

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Chief Executive
Tim McNeill, RN, MPH

Chief Medical Officer
Dr. Paul S. Rhodes

Chief Administrative Officer
Thaddeus Jenkins

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Populations Served

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- All Patients receive the same model of care -- regardless of the payer:
  - Original Medicare
  - Dual-Eligible (Medicare + Medicaid)
  - QMB/SLMB
  - Medicaid Fee-for-Service
  - Medicaid MCO (AmeriHealth, Amerigroup, & MedStar Family Choice)
  - DC Alliance (AmeriHealth, Amerigroup, & MedStar Family Choice)
  - United Healthcare Dual Complete
  - Maryland Medicaid
  - Currently we accept all Commercial Insurance Carriers except Kaiser

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Home-Based Primary Care Services

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- Full Service, In-Home Primary Care Medical Management
  - Medical Management of chronic disease
    - Hypertension / Cardiovascular disease
    - Diabetes Management
    - Chronic Kidney Disease Screening/Management
    - Chronic disease management (2+ chronic conditions)
    - Obesity management
    - Wound care management
    - Integrated behavioral health (Collaborative Care/Psychiatric NP)
- Services rendered at the location the person calls home (apartments, independent living, CRFs, low-barrier shelter, hotels, cars, etc.).
- Each person is assigned a Freedmen's Medicine provider (MD/NP).

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HRSN Screening and Interventions

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- Every person is screened for Health-Related Social Needs (HRSNs) every 6 months or more frequently if there is a change in social needs status.
- Accountable Health Communities (AHC) tool.
- Person-Centered Social Care Plan is developed.
- Priorities are set in a person-centered manner with the consumer.
- Care Manager and Community Health Worker is assigned to address HRSNs, based on the social care plan.
- Weekly updates are provided to the medical management team on the progress in addressing HRSNs.
- HRSN interventions are deployed along with emotional supports to facilitate long-term behavior change, if needed.
- Medicare (Duals, QMB, SLMB) reimburse for Community Health Integration for labor to address Health-Related Social Needs. Service provided to Medicaid beneficiaries but not compensated for the care.

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Collaborative Care Model

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- Evidence-Based Behavioral Health Integration Model
- Collaborative Care Team
  - Primary Care Provider
  - Behavioral Health Care Manager
  - Psychiatric Nurse Practitioner (serves in a consulting role only)
- Coordinate care closely with the consumer behavioral health care team (Core Service Agency, ACT Team, and CRF staff).
- Provide intensive support to ensure that the medical treatment and behavioral health treatment are aligned.
- Not meant to replace or displace the existing mental health provider or psychiatrist.

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Auxiliary Services

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- Case Management
  - HRSN Screening (Accountable Health Communities [AHC] tool)
  - HRSN Interventions (Housing, Food, Transportation)
  - Level of Care coordination
  - EPD Waiver/State Plan Enrollment
  - QMB Enrollment assistance
- Coordination of Homecare services.
- In-home laboratory services (mobile phlebotomy services).
- In-home radiology services (x-ray, ultrasound, DVT study, EKG).
- Pharmacy management (North Capitol Pharmacy, medication pill pack delivery).

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Homecare Coordination

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- In-Home medical visit to establish medical necessity for skilled and unskilled services.
- ePOF order submission and coordination with Liberty to secure LOCs.
- Application or Renewal of waiver services (EPD Waiver / Services My Way).
- Nursing home placement, if the consumer can no longer remain in the community.
- Homecare agency oversight, clinical supports, and order submission.
- Ordering of skilled services
  - Physical Therapy (PT)
  - Occupational Therapy (OT)
  - Wound Care
- Ordering of non-skilled homecare
  - Personal Care Aide (PCA)
  - Respite

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Medication Management

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- Comprehensive medication reconciliation is performed in the home.
- Review of all active medications, OTCs, narcotics, to include medication prescribed and not taking.
- Review and development of narcotic chain of custody plan.
- Coordinate pain management referrals and coordinate pain management plan with pain management clinic (all patients with chronic pain must have an ongoing relationship with a pain clinic or we will establish a referral for pain management).
- Medication delivery and pill pack service coordinated with **North Capitol Pharmacy**.
  - Pharmacist review and coordination with medical team for all patients co-managed with North Capitol Pharmacy.

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Money Follows the Person (MFP)

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- Provide transition services to persons that have been in an institutional setting for at least sixty (60) days.
  - Complete in-person assessment at the institutional setting -- prior to discharge.
  - Submit an ePOF and obtain LOC results.
  - Complete the DACL transition referral.
  - Work with the consumer, guardian, and care team to complete the EPD Waiver application.
  - Identify appropriate housing to facilitate the transition.
  - Coordinate with DACL to obtain transition support services (furniture, utility assistance, pantry stocking, etc.).
  - Provide ongoing home-based primary care services post transition.

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CRF Support Services

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- Coordination is the CSA/ACT Team to complete CRF applications.
- Assist with securing the all supporting documentation to complete a CRF application.
- Assist with setting up interviews with potential CRFs.
- Participate in interviews with potential CRFs.
- Present Freedmen's Medicine services and coordination of Long-term Services and Supports to continue after placement in a CRF.
- Provide ongoing medical management, medication management, and oversight of all required homecare services.

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Hospital / SNF Transition Services

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- Evidence-Based hospital transition program (Naylor Model).
- Priority population:
  - Persons with extended length of stay
  - Persons with a Behavioral Health/SUD + Chronic Condition
  - Persons with 1+ Health-Related Social Needs
- Pre and Post Discharge visits
  - HRSN Screening (AHC Tool) and Case Mgmt meeting prior to discharge to determine needs
  - Home-based primary care visit within 7 days of discharge (MD or NP)
  - Deployment of Social Care interventions to address HRSNs (Housing, Foods, Transportation)
- Comprehensive medication review and coordination with pharmacy
- Coordination of specialty care and auxiliary support services (lab, X-ray, homecare)

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Opioid Response Case Management

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- Coordination with Methadone Clinic OTPs to provide medical management and care coordination for persons with chronic disease.
- Support to ensure compliance with methadone treatment and medical regimen.
- HRSN screening and interventions to ensure barriers to adherence are addressed.
- Coordinate specialty care, to include pain management.
- Embedded case management staff or monthly referral review:
  - Behavioral Health Group (BHG Clinic)
  - UPO

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Returning Citizens Transition Services

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- Transitions Service Case Management
  - Coordination with DHCF Office of the Health Care Ombudsman and Bill of Rights
  - Coordination with CSOSA
  - Coordination with assigned legal counsel
  - Coordination with the Bureau of Prisons (BOP)
  - Complete ePOF and LOC
  - Set up support services
  - Coordinate long-term care options
  - Receive consumer and setup home-based primary care
  - Address health-related social needs (HRSNs)
  - Provide ongoing medical management and care coordination

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Referral Process

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- General Referral Process is to send an email to our referral team
  - referrals@freedmensmedicine.com
  - Fax: 202-588-5971

- Complex or urgent referrals contact our referral line:
  - #1. Call the Office Line: 202-683-4340
  - #2. Send an email to our referral team
    - referrals@freedmensmedicine.com

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