HEALTH SYSTEM REFORM

Lower Shore Emerging Models

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Eastern Shore Forum
Hospital/Community Partnerships
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Health Care Reform "Triple Aim"

1. Improve access to care
2. Improve quality and health outcomes
3. Reduce expense- to payers, patients
   - Hospital waiver model

KEY: Coordinate care- reduce error, duplication, improve service delivery

2 Examples:Hospital/PH Collaboration

1. 2012- AGH and WCHD

- AGH awarded CMS Innovations Grant
- 3 year Grant
- CMS Drivers for readmits, ED use

2. 2013- AGH, PRMC, McCready, LHIC

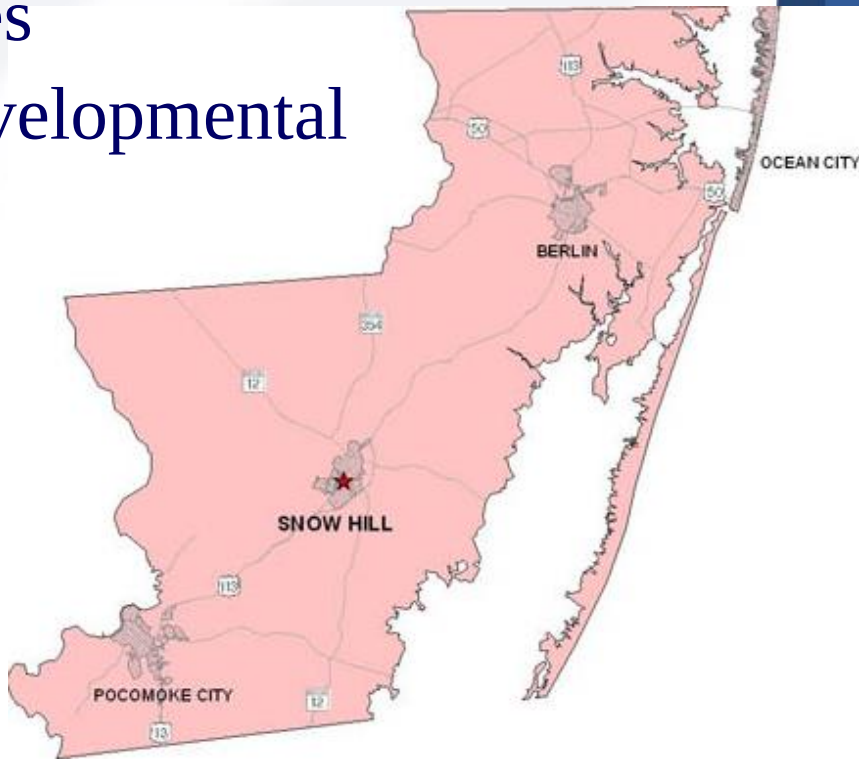
- LHIC awarded 1 year grant
- SHIP data for diagnoses
- ED visit drivers

Collaboration Goals

- Improve overall population health
- Contribute existing resources to “Triple Aim” of HCR
- Assist Hospitals and PCP’s to meet goals and requirements of PCMH model
- Assist Hospitals/FQHC’s in reducing ER overuse, early readmits
- Reduce risk of discharge from practice for non-adherence, poor P4P outcomes

Worcester Public Health Resources

- CM >1000 clients/year Worcester and Somerset
- Licensed Medical & BH case managers
  - RN, SW, Bachelor's, CHOW
- MAP/AERS- Adult/Aging- in home evaluation for Long Term Support Services
- Mental Health, Addictions, Developmental
- HIV Case Management
- TB Case Management
- High risk OB/ infants



Collaboration #1 AGH & WCHD

- Atlantic General Hospital (AGH) received CMS Health Care Innovation Challenge grant July 2012
- 3 year grant
- GOALS: Expand AGH Patient Centered Medical Home pilot services
  - Reduce hospital admission rates by 20%
  - Reduce emergency department visits by 20%
  - Achieve a 15.5 percent reduction in total cost of care
- Population: Medicare Enrollees

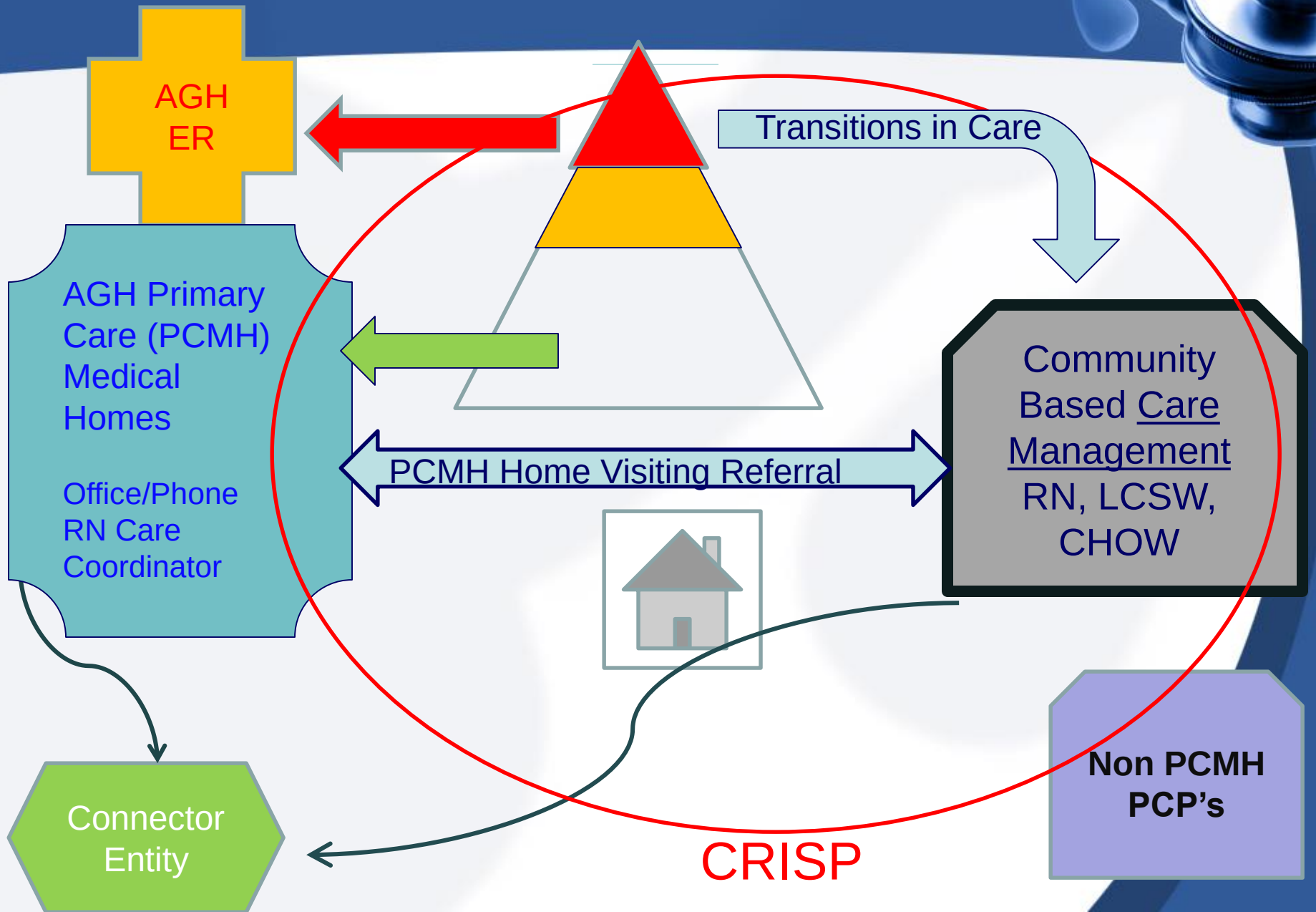
  CHF, COPD or Diabetes

  AGH owned Primary Medical Home

WCHD Care Management Team

- Home visiting outreach arm of hospital owned PCMH
- AGH contracts WCHD for RN, SW
- Evidence based Care Management Model "Guided Care"
- Residents of Worcester County
- Medical and Nonmedical Resources
- Coordinate with AGH PCP and office team

CMS Innovation Partnership



Standard Home/Community based Intervention

- Identify PCP status
  - Facilitated referral/ transport to PCP
- Evaluation of social/financial needs
  - Modified STEPS, InteRAI
  - Refer for LTSS, waivers, AERS eval
  - Insurance- Connector entity
- Medication Reconciliation
  - CRISP, Pharmacy, PCP, patient lists
- Chronic Disease teaching (COPD, CHF, DM)

Shared PCMH patients: 2013-2014

- TIC referrals : 402
- PCMH Home visiting referrals: 119
- FTF visits (RN&SW): 168
- Phone calls: 1657

Overall Outcomes: Outpatient costs increase, but inpatient and ER costs decrease

Michelle Clifton Atlantic General Hospital

PCMH Personal Testimony #1

52 year old single male referred by PCP team

- Type 1 Uncontrolled Diabetes, Kidney Transplant, Traumatic Amputation of foot, Triple Coronary Bypass, Hypertension, and Diabetic Neuropathy.
- BH: stress/anxiety/ depression due to managing care providers and diabetic needs
- Limited income- unable to afford meds, specialist copays, many bills
- Kidney Disease assistance ending
- Frequent insulin regimen changes
- High Cost ER use and admissions

PCMH Home based Intervention

- RN- in home teaching insulin injections.
- Medications comparison- switch pharmacies for lower cost than delivery through mail
- Diabetes education- improved glucose levels, weight loss, and improved motivation on managing diabetes.
- Mission of Mercy for dental care, then TLC
- prosthetic shoe- taken to podiatrist, assisted in ordering

- SW – MCO annual right to change, assistance locating specialist w/in network, setting up appointments with specialists, and ongoing assistance with MCO ACCU ombudsman.
- Worked with DSS for food stamps, home owner's tax credit and Shore Up for energy assistance.
- transportation

PCMH #1 Outcomes

- Initial contact was once or twice a week, in home, transport, sometimes with multiple calls within one day.
- Pt has become well established with specialists
- improved mental health- improved ability to maintain healthcare needs.
- Med adherence, better clinical outcomes
- pt regained control of managing his health care needs and accessing resources as needed
- Contact with WCHD has reduced significantly
- Contact with PCP, providers increased

- Outpatient costs increase, but inpatient and ER costs decrease

PCMH Testimony #2

- 64 year old divorced male referred by PCP team
- Severe Arthritis B knees, CHF, HTN, COPD.
- Depression due to severe knee pain- Suicidal plan if unable to get knee pain addressed
- Lives alone, poor housing, limited income- unable to afford meds, etc
- Non-adherent to diuretic regimen, unclear purpose of meds
- PAC transition, Eligible but not enrolled for MA, awaiting MC
- High Cost ER use and admissions

PCMH #2 Intervention

- RN provided in home education regarding diuretics
- Initial contact daily, weekly in home med reconciliation
- Communicated with PCP re: medication reconciliation
- Identified in network orthopedist, arranged appointment
- Made/kept appointment with cardiologist

- SW – MA application assistance, spend down, MA approved
- Medicare benefits
- File of Life, Advanced Directives, cremation info provided
- Medicare Part D plan
- Senior Drug Assistance Plan
- AGH Financial Assistance
- transportation

PCMH #2 Outcomes

- Initial contact was once or twice a week, in home, sometimes with multiple calls within one day.
- Pt established with orthopedic specialist, cardiologist
- Knee pain being addressed
- Improved mental health- no longer suicidal
- Med adherence diuretics- better clinical outcomes
- Contact with WCHD has reduced significantly
- Contact with PCP, providers increased
- Significant reduction in ER use

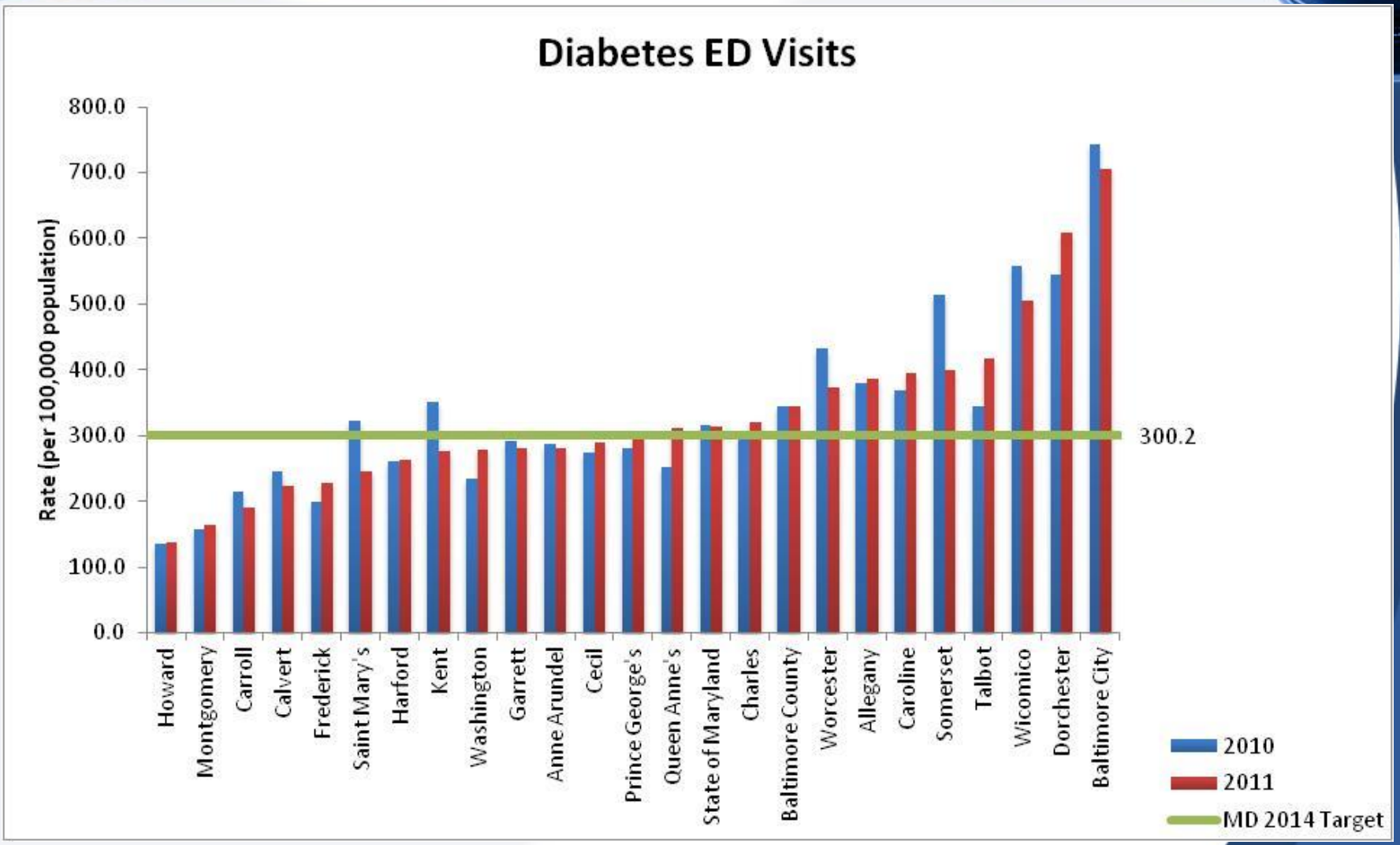
- Outpatient costs increase, but inpatient and ER costs decrease

Collaboration #2
Tri-County Health Planning Board

Worcester, Wicomico and Somerset Counties (LHIC)
and
3 Regional Hospitals

Reduce Diabetes Related ED visit rate
and
Reduce racial disparities in ED visit rates
through
Community Integrated Diabetes Care Management

Maryland SHIP Objective 27

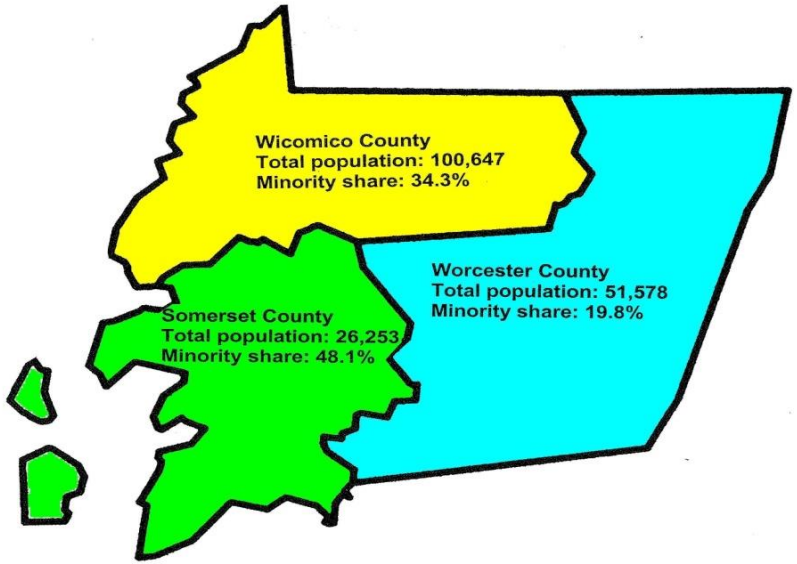


Diabetes Related ED Visits Lower Shore Region

Maryland State Health Improvement Plan 2014

Goal: 300/100K

State: 316/100K



Year	Lower Shore (total)	NH Black	NH White
2010	515.1	962.7	241.7
2011	450.7	893.7	331.8
Wicomico	505.1	1,020.5	366.3
Worcester	372.7	1,217.1	249.5
Somerset	398.6	408.7	414.7

Tri County Diabetes Management Program

- Hospital refers list of ED utilizers for Diabetes from each county hospital.
- LHIC Uses ED data to identify geographic or population “hotspots” in 3 counties
- Evidence based Chronic Disease Care Management model
- Address medical and social determinants of high ED utilization
- Population: any payer source, any PCP status, ages 18+, DM as 1st or 2nd Dx

Diabetes ED visit Data Evaluation

12 months prior to CHRC LHIC RFP

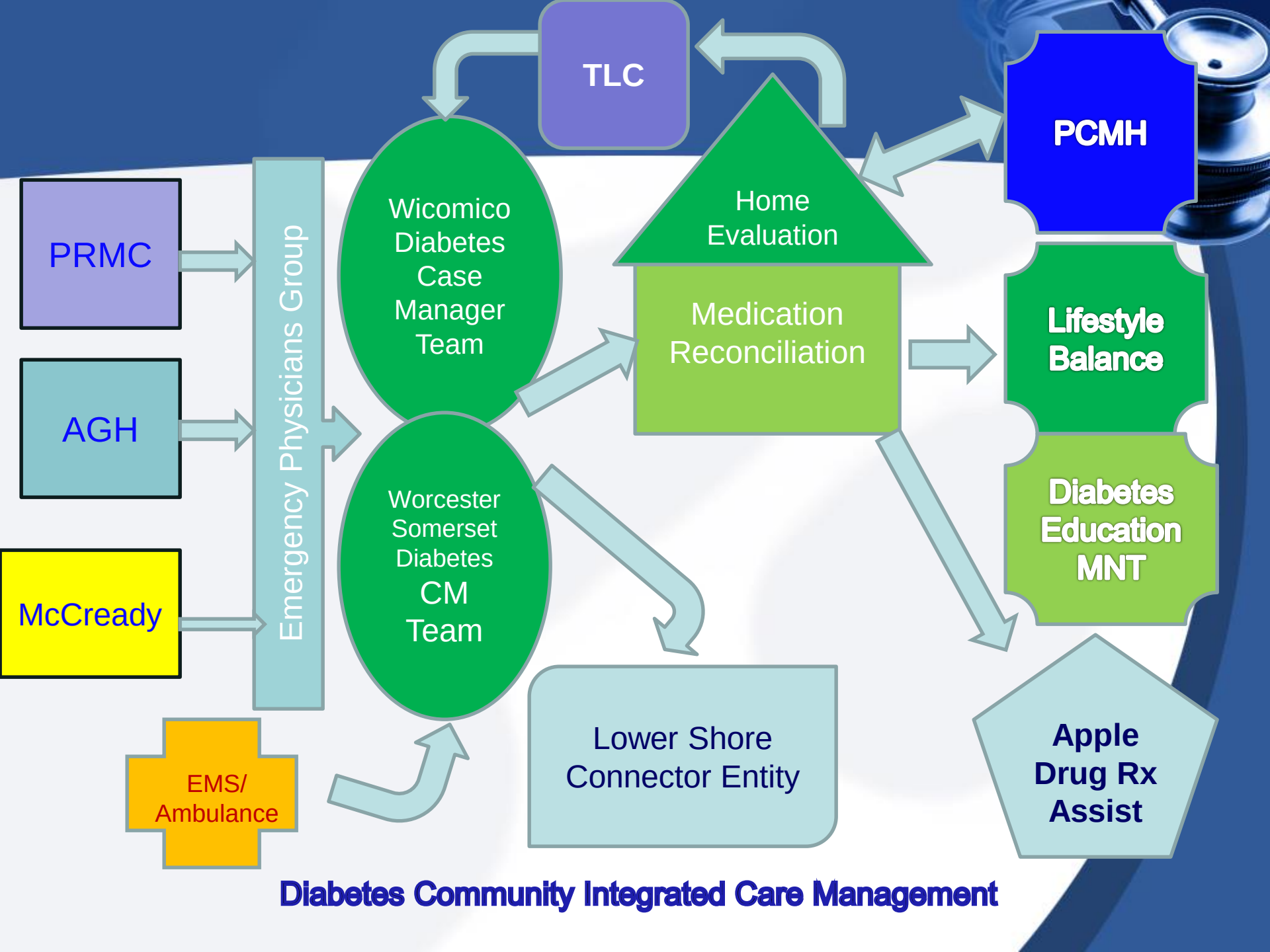
- 45% Medicare
- 22% Medicaid or Self pay
- 38% 65+ age

AGH: 10 patients with 3 or more visits

- 76% white, 22% black

PRMC: 14 patients with 3 or more visits

- 47% white, 49% black


TLC
PCMH
PRMC
AGH
McCready
Emergency Physicians Group
Wicomico Diabetes Case Manager Team
Home Evaluation
Medication Reconciliation
Lifestyle Balance
Diabetes Education MNT
Worcester Somerset Diabetes CM Team
EMS/ Ambulance
Lower Shore Connector Entity
Apple Drug Rx Assist
Diabetes Community Integrated Care Management

Implementation Achievements

1. Execution of MOU's and BAA's between LHIC and 3 hospitals
2. LHIC performs Quarterly Analysis of 3 ED data
3. Universal referral process into Diabetes Care Management
4. 2 Care Management Teams provide home evals, medication reconciliation
5. Patients complete Diabetes Education programs- many options
6. CRISP enrollment for CM teams to promote Community Medical Record
7. Referral for insurer status to MD Connector Entity
8. Coordinate resources & services to avoid ED visits

Outcomes: Jan 2014- Sept 2014

59 Total enrolled

- 56 ER visits 12 mos prior to CM
- 8 ER visits since CM

8 pts highest users

- 38 ER visits 12 mos prior to CM
- 4 visits since CM

31% BH Dx

49% <200% poverty

45% Medicare

36% Dual eligible

90% assisted to PCP

14% QMB, SLMB, LTSS

27% transportation, POC -meds, DM supplies

Challenges and Observations

- Initially low acceptance from call post ED visit
- Highest ED users may decline- dilutes effect size
- Limited resources, no payer source for many needs
- Uptake is higher once PCP is established
- Program growing rapidly for Primary Care referrals
- Need to accept referrals before highest use begins

Future Growth

- Expand model to 3 Diagnoses for 3 hospitals & 3 counties
- Expand CHW role to increase services and acceptance rate
- Optimize hotspot data to position CHW and resources
- Calculate savings to ED & reinvest :

  MOU to continue services beyond grant

Karen Poisker – PRMC

Sustainability Considerations

- Home & Community Chronic Disease Care Management: needs to be billable service
- Primary Care partnerships- contract for CM services?
- Contract with ACO
- Public Payer shared savings programs- PCMH or like models
- Continued Grant funding for program

Questions?

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