MCHRC
Maryland Community Health Resources Commission

# Maryland Medicaid Advisory Committee

July 23, 2015

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# TODAY'S REMARKS

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- **Background and purpose of CHRC**
- **Recent grantmaking priorities and CHRC awards**
- **CHRC-supported programs impacting Medicaid**
- **CHRC grants in later context of health reform, All-Payer Model, and ongoing population health improvement efforts**

# BACKGROUND ON THE CHRC

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- **The Community Health Resources Commission (CHRC) was created by the Maryland General Assembly in 2005 to expand access to health care for low-income Marylanders and underserved communities in the state.**

- **The Maryland General Assembly approved legislation (Chapter 328) in 2014 (vote was unanimous) that re-authorized the CHRC for another ten years, until 2025.**

# BACKGROUND ON THE CHRC

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- **Eleven members of the CHRC are appointed by the Governor.**

- **Below is a listing of the CHRC Commissioners (one vacancy).**

- **John A. Hurson**, **Chairman**
- **Nelson Sabatini**, **Vice Chairman**
- **Elizabeth Chung**, Executive Director, Asian American Center of Frederick
- **Charlene Dukes**, President, Prince George's County Community College
- **Maritha R. Gay**, Executive Director of Community Benefit and External Affairs, Kaiser Foundation Health Plan of the Mid-Atlantic States Region
- **William Jaquis, M.D.,** Chief, Department of Emergency Medicine, Sinai Hospital
- **Sue Kullen**, Southern Maryland Field Representative, U.S. Senator Ben Cardin
- **Paula McLellan**, CEO, Family Health Centers of Baltimore
- **Barry Ronan**, President and CEO, Western Maryland Health System
- **Maria Harris-Tildon**, Senior Vice President for Public Policy and Community Affairs, CareFirst BlueCross BlueShield

# BACKGROUND ON THE CHRC

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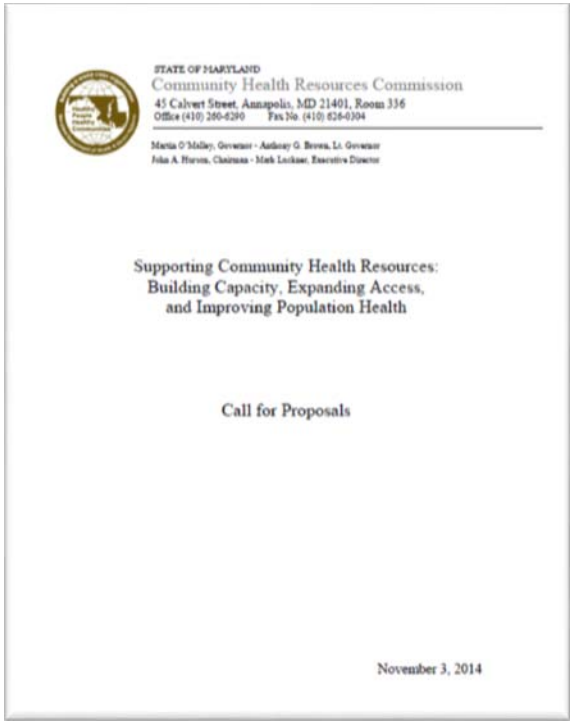
- The CHRC has issued eight Calls for Proposals (RFP) over nine years. These have focused on the following public health priorities:

- **Reducing infant mortality**
- Increasing access to dental care
- **Promoting ED diversion programs**
- Expanding primary care access
- **Integrating behavioral health**
- Investing in health information technology
- Addressing childhood obesity
- Building safety net capacity



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Supporting Community Health Resources:
Building Capacity, Expanding Access,
and Improving Population Health

Call for Proposals

November 3, 2014

# IMPACT OF CHRC GRANTS

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- **Since 2007, CHRC has awarded 154 grants totaling $52.3M.**
- **CHRC has supported programs in all 24 jurisdictions. These programs have collectively served nearly 200,000 Marylanders.**
- **Most grants are awarded to community-based safety net providers, including FQHCs, LHDs, free clinics, and outpatient BH providers.**
- **Demand for CHRC grant funding far outstrips supply (budget). The Commission received 593 requests for $276.2M, funding approximately 19% of requests.**

# PROMOTING PROGRAM SUSTAINABILITY

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- **CHRC looks to support programs that are sustainable and leverage additional grant funding.**

- **Grantees have utilized CHRC grant funding to leverage $17M in <u>additional</u> federal and private/non-profit resources ($2.3M in federal; $14.7M in private/non-profit/local).**

ACCESS carroll INTEGRATED HEALTH CARE

WAY STATION
A Subsidiary of Sheppard and Enoch Pratt Foundation

Mosaic COMMUNITY SERVICES

HealthCare Access MARYLAND

Access Wholistic and Productive Living AWPLI

# FY 2015 CALL FOR PROPOSALS

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- **The FY 2015 Call for Proposals was issued in November 2014 and contained the following three strategic priorities:**
  (1) Expand capacity;
  (2) Reduce health disparities; and
  (3) Promote efforts to reduce avoidable hospital utilization.

- **FY 2015 grants were awarded to eleven organizations (below):**

| **Dental Care** | **Access to Primary Care** |
|---|---|
| Allegany Health Right | Harford Health Department |
| Frederick Memorial Hospital | Union Memorial Hospital |
| Total Health Care, Inc. | Esperanza Center |
| Health Partners | HealthCare Access Maryland |
| **Capacity of Safety Net Providers** | **Infant Mortality** |
| Family Services, Inc. | Community Clinic, Inc. |
| Calvert Health Department | |

# CHRC GRANT MONITORING

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- **CHRC grants are monitored closely.**
- **Twice a year, as a condition of payment of funds, grantees submit program narratives, performance metrics, and an expenditure report.**

**CHRC Grantee Monitoring Report**

| | |
|---|---|
| **Grantee:** | Harford County Health Department |
| **Grant #:** | 15-008 |
| **Reporting Period:** | Report #1: May 1, 2015 - October 31, 2015 |
| **Project Goal(s):** | Improve health outcomes and reduce costs through community-based, comprehensive care coordination of high risk, high-cost populations. |

**SHIP Focus Area(s) & Measure(s):**
Healthy Beginnings - Early prenatal care; Infant death rate; Babies with low birth weight; Sudden unexpected infant death rate
Quality Preventative Care - ED visits due to diabetes; ED visits due to Hypertension

**NOTE #1:** Any measurement counting "unduplicated" patients **CANNOT** include the same patients over different reporting periods. The "Totals" column for these measures should sum only unique individuals. For example, if an individual is counted in reporting period 1, then that person should **not** be counted again in reporting period 2.

**NOTE #2:** The program data with its associated data source reported by the grantee on this M&D report is subject to audit by the CHRC.

**NOTE #3:** The CHRC will utilize output **1f** for its "**Total Patients/clients Engaged**" measure, and output **1g and 1h** for its "**Total Patient/client encounters**" measures.

**NOTE #4:** "Patient/Client Encounters" is defined as any face-to-face or telephonic contact with a nurse care manager in a care coordination program.

**Process Metrics**

| Key Project Objectives | Output | Data Source | Year One | |
|---|---|---|---|---|
| | | | Reporting Period #1 | Reporting Period #2 |
| **Improve health outcomes for low income patients through Nurse Case Management** | 1a) # of clients referred to Nurse Case Manager from UM-UCH Emergency Department | Internal Data Tracking System | | |
| | 1b) # of clients referred to Nurse Case Manager from Beacon Health | Internal Data Tracking System | | |
| | 1c) # of clients referred to Nurse Case Manager from UM-UCH Birthing Unit | Internal Data Tracking System | | |
| | 1d) # of clients referred to Nurse Case Manager from other Community Medical Providers | Internal Data Tracking System | | |
| | 1e) Total # of unduplicated clients referred to Nurse Case Manager | Internal Data Tracking System | | |
| | 1f) Total # of referred clients successfully engaged with Nurse Case Manager* | Internal Data Tracking System | | |
| | 1g) Total # of patient encounters, face-to-face, by Nurse Case Manager | Internal Data Tracking System | | |

- **Grantee progress reports (sample above) are a collection of process and outcome (some) metrics; grantees are held accountable for performance.**

# CHRC GRANTS IMPACTING MEDICAID PROGRAM

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- **The authorizing statute directs CHRC to support programs that serve low-income individuals and support safety net providers.**

- **Most CHRC grants support goals of the Medicaid program in terms of expanding access, improving health outcomes, etc.**

- **Several types of CHRC grants may have cost implications (reductions) for Medicaid:**
  - **Hospital ED diversion**
  - **Behavioral health integration**
  - **Maternal/child health/home visiting**

# ED DIVERSION GRANTS

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- **Helping to reduce avoidable hospital costs is central to the CHRC's mission.**
- **Programs have deployed grant-funded positions in hospital EDs and implemented care coordination for 'super-utilizers', linking individuals with primary care and other social support services.**

| Grantee | Award Amount |
|---|---|
| Chase Brexton Health Services | $200,000 |
| Frederick Community Action Agency | $353,585 |
| Atlantic General Hospital | $355,000 |
| Total Health Care | $100,250 |
| University of MD Department of Family Medicine | $499,749 |
| Upper Chesapeake Health | $485,743 |
| Health Care for the Homeless | $140,000 |
| HealthCare Access Maryland – Sinai | $800,000 |
| HealthCare Access Maryland – FHCB | $555,000 |
| MedStar Union Memorial – Total Health Care | $150,000 |
| Harford County Health Department | $320,000 |
| **TOTAL ED Diversion Grants** | $3,959,327 |

# ED DIVERSION EXAMPLE #1

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- Grantee: **Health Care for the Homeless**
- Duration and amount: One year / $140,000
- Description:
  - ED diversion program targeting homeless individuals in Baltimore City who utilize hospital EDs at high rates
  - Establish “medical home” and long-term relationship with these individuals
- Key intervention strategies:
  - Implementation of an ED Diversion team
  - Partnering with three local hospitals (Hopkins, Maryland, Mercy)
  - Linkage to primary, preventative, BH services
  - Promoting health insurance enrollment
- Outcomes tracked:
  - Identified 48 individuals in EDs; of this total, 42 (88%) enrolled in program at HCH

# ED DIVERSION EXAMPLE #2

- Grantee: **HealthCare Access Maryland**
- Duration and amount: Three years / $800,000
- Description: Access Health - Partnership with Sinai
- Key intervention strategies:
  - Target super ED utilizers (4+ visits per 4 months)
  - Embed care coordinators in Sinai ED for full integration to achieve patient access/enrollment
  - Intensive community-based care coordination; refer to Chase Brexton and others for primary/specialty care
  - Address other social determinants of health, including access to transportation, reduced price pharmaceuticals, housing issues, etc.
  - Home visiting for all clients

# ED DIVERSION EXAMPLE #2, CTD

- Grantee: **HealthCare Access Maryland**
- Outcomes tracked and deliverables reported:
  - As of June 30, 2015, a total of 544 individuals were referred to the Access Health Program and 267 accepted enrollment
  - Total visits (ED & IP) from this cohort group have reduced by 71% as of April 2015
  - Working with CRISP on data analytics to support program evaluation and 'all hospital' impact in addition to Sinai
  - Avoided hospital utilization from start of program (June 2014) through April 2015 amounted to $437,175, with a monthly avoided charges of approximately $62,454
  - Projected avoided charges in year 2 (FY16) at full staff is calculated to be $1,259,065

# BEHAVIORAL HEALTH EXAMPLE #1

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WAY STATION
A Subsidiary of Sheppard and Enoch Pratt Foundation

- Grantee: **Way Station**
- Duration and amount: One year / $170,000
- Description: Launching Medicaid Behavioral Health Home Pilot (Missouri Model)
- Key intervention strategies:
  - Co-locate primary care services in Way Station's BH sites, partnering with two FQHCs (Chase and Walnut Street)
  - Add PCPs to Community Mental Health Teams and create Health Home Team
  - Promote client participation in care through Integrated Illness Management and Recovery
  - Nurse Care Managers complete individual health reviews every 6 months

# BEHAVIORAL HEALTH EXAMPLE #1, CTD

- Grantee: **Way Station**
- Outcomes and deliverables reported:
  - 680 clients enrolled in HH; all receive care management and are monitored for chronic conditions; 186 clients receive primary care from co-located services
  - 154 clients with Type 1 or 2 diabetes; 49% (75) have controlled diabetes (HbA1c <8)
  - 180 clients with Hypertension; 75% (102) have controlled hypertension
  - Achieved program sustainability; Health Home providers began billing in October 2013
  - Executed data sharing agreement between DHMH, Way Station, HIT Care Management vendor, and Dartmouth (evaluation); Utilize CRISP alert system
  - Care management tool available to additional Maryland BH providers and provide monthly trainings to other providers

# BEHAVIORAL HEALTH EXAMPLE #2

- Grantee: **Mosaic Community Services Inc.**
- Duration and amount: Two years / $550,000
- Description: Full integration of behavioral health and primary care service delivery
- Key intervention strategies:
  - Full BH and primary care service integration at new Steven S. Sharfstein M.D. Center on North Charles (just opened)
  - Partnership with Baltimore Medical Systems (BMS); Mosaic psychiatrist provides consultation to BMS PCPs who provide BH and addiction services
  - Hire three Behavioral Health Interventionists; deploy at Mosaic and BMS sites, implement SBIRT screening at all clinic locations
  - Train PCP providers on SBIRT and motivational interviewing

# BEHAVIORAL HEALTH EXAMPLE #2, CTD

- Grantee: **Mosaic Community Services Inc.**
- Outcomes tracked and deliverables reported:
  - In the first year of the grant, 49,711 patients were seen by Mosaic and BMS practitioners resulting in 78,674 visits
  - Utilize BMS EMR to gather patient baseline data on key health indicators (BP, BMI); utilize CRISP for ED and inpatient utilization data
    - Baseline data collected for 688 enrolled clients of BMS or Mosaic
    - Identified 480 individuals requiring intervention
    - Interventions for many of the clients have been implemented by the nurse care manager
    - Results of interventions are trending in a positive direction

# CHRC GRANTS IN LARGER CONTEXT

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- **Assist ongoing health reform efforts**
  - Build capacity of safety net providers to serve newly insured
  - Assist safety net providers in IT, data collection, business planning
- **Support All-Payer Model**
  - Provide initial seed funding for several community-hospital partnerships (next slide lists several)
  - Fund community-based intervention strategies that may help achieve reductions in avoidable hospital utilization
  - Issue white paper, “Sustaining Community-Hospital Partnerships to Improve Population Health” (authored by Frances B. Phillips)
- **Support population health improvement activities**
  - Align with State Health Improvement Process (SHIP) goals
  - Build LHIC infrastructure and facilitate other community – hospital – payer ‘interdisciplinary’ conversations

# CHRC GRANTS IN LARGER CONTEXT, CTD

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## Highlights of select CHRC-supported community-hospital partnerships:

1. **Cecil County HD with Union Hospital of Cecil County**
   Over a 15-month period, 160 individuals received services. The program helped reduce avoidable hospital utilization (ED visits and admissions) for chronic conditions (diabetes, heart disease, others), and the hospital partner estimated savings of more than $662,000 (more than $4,100 per participant). Adjusted for program expenses, the result was a net savings of $460,000.

2. **Worcester County HD with Atlantic General and Peninsula Regional**
   Over a 12-month period, 59 individuals received services. When comparing pre- vs. post-enrollment, the program estimated a total of $189,000 in savings due to averted diabetes-related ED visits and reduced hospitalizations.

3. **HealthCare Access Maryland (HCAM) with Sinai Hospital**
   A sample of 7 frequent utilizers was selected for a pre- vs. post-comparison. Four months prior to participating in the program, these 7 individuals visited the ED 24 times. Four months after participating in the program, these individuals visited the ED 6 times. With average costs estimated at $3,452 per visit, the program estimates savings of $62,118 from reduced/avoided ED visits from these 7 individuals.