Rural Health Collaborative Meeting Minutes
February 6, 2019
Time: 5:00pm to 8:00pm
Location: Queen Anne's County Health Department, 206 N. Commerce St., Centreville, MD, 21617, 2nd floor conference room

The following Rural Health Collaborative (RHC) members were in attendance:

Victoria Bayless, MHSA
Jim Bogden, MPH
Mary Bourbon
Childlene Brooks
James Chamberlain, MD
Joseph Ciotola, MD
Michael Clark, MS
Santo Grande, EdD
Katelin Haley, DO
Roger Harrell, MHA
Ken Kozel, MBA, FACHE
Beth Anne Langrell, MS
Scott LeRoy, MPH
Maura Manley, MBA
Sara Rich, MPA
Teresa Schaefer, PhD
Timothy Shanahan, DO
April Sharp, LCSW
Anna Sierra, MS, EMT
Derek Simmons, MEd, EdD
Sonia Lorelly Solano Torres, PhD
Fredia Wadley, MD
William Webb, MS

Also in attendance: Lindsey Snyder, Esq., Assistant Attorney General, Maryland Department of Health (MDH); Cheryl DePinto, MD, MPH, FAAP, Director, Office of Population and Health Improvement, MDH (phone); Pamela Tenemaza, MPA, Policy Analyst, Deputy Secretary's Office, Public Health Services, MDH (phone); Ron Bialek, MPP, Executive Director, RHC, and President, Public Health Foundation (PHF); Kathleen Amos, MLIS, Assistant Director, Academic/Practice Linkages, PHF; Elizabeth Slye, Intern, PHF; Brian Baker, MD, Chair, Anne Arundel Medical Center (AAMC) Collaborative Care Network; Steve Clarke, AAMC; Patrick Dooley, MA, Vice President, Population Health, and Executive Director, University of Maryland Quality Care Network, University of Maryland Medical System; Angelo Edge, CEO, Aetna Better Health of Maryland; Luisa Franzini; Sarah Haas, MSHA, MBA, Manager, Healthcare Payment Redesign Programs, AAMC; Travis Johnston; Jason Kepple; Renee Kilroy, AAMC; Dushanka Kleinman; Joanne McNamara; Gene Ransom III, JD, CEO, MedChi; Kelley Raye; Seun Ross, President, IMBUEfoundation; Helayne Sweet; Amy Travers, Senior Practice Manager, AAMC

Welcome, Introductions, and Review of Agenda
Fredia Wadley, MD, Talbot County Health Officer

Meeting was called to order at 5:08pm by RHC President Fredia Wadley, MD. Dr. Wadley thanked everyone for attending, welcomed everyone to the meeting, and reviewed the agenda for the meeting.

Review and Approval of December 5, 2018 Meeting Minutes
Fredia Wadley, MD, Talbot County Health Officer

Dr. Wadley requested any comments on the draft minutes for the December 5, 2018 meeting. No additions or corrections were provided. April Sharp, LCSW, made a motion to approve the minutes.

Roger Harrell, MHA, seconded the motion. The RHC unanimously approved the minutes.

Transportation Issues and Strategies Impacting Access to Care

A. Introduction of Issue

Scott LeRoy, MPH, Caroline County Health Officer, and Roger Harrell, MHA, Dorchester County Health Officer

Scott LeRoy, MPH, welcomed three guest speakers to share their expertise on transportation issues and strategies: Angelo D. Edge, CEO, Aetna Better Health of Maryland; Santo Grande, President and CEO, Delmarva Community Services, Inc.; and Seun O. Ross, President, IMBUEfoundation.

B. Speakers:

Angelo D. Edge, CEO, Aetna Better Health of Maryland

Mr. Harrell introduced Mr. Edge. Mr. Edge presented on Aetna's work related to transportation for its patients and addressed questions from the RHC. Presentation slides are attached. Highlights included:

- Aetna has employed a variety of methods for supporting transportation for its patients, including managing its own transportation services and broker-based models where it hired outside companies to provide transportation services. Aetna currently uses a hybrid between a broker model and a rideshare model. This allows people to schedule transportation on demand.
- When trying to address transportation needs in rural communities, there can be a lack of well-structured public transportation systems, limited availability of taxi systems, and people may lack knowledge of what benefits they qualify for. In rural communities, Aetna is leaning in the direction of a rideshare model. It works with Uber Medical, Veyo, and Lyft. Drivers submit trip tickets to get reimbursed. The rideshare model does not work well for people who need assistance; Aetna has a broker model available for them.
- Aetna transportation services are for people who have exhausted all other options to obtain transportation, such as having a family member provide transportation, access to bus routes, or the ability to pay for a taxi.
- Aetna is seeing significant benefits in no show rates for medical appointments, higher medication adherence rates, and happier providers as a result of this effort. In addition to the health benefits, this can have an economic impact for people in the community. Useful data can be gathered related to these efforts, such as demographics or peak times for services.
- Transportation services represent a significant opportunity to make a profound impact. Services should be managed in a way that makes sense for the organizations and communities involved and produces the outcomes desired. There is no one right model; explore the options and determine what works best for the community. Managing transportation services in-house can be overwhelming. There may be an opportunity to entice a rideshare company to do a pilot at no cost, where they would run the program for a period of time to show that it would save you money, before entering into a contract. Anything that can be done to make accessing services easier for patients and providing services easier for providers will result in a better program.

Santo Grande, President and CEO, Delmarva Community Services, Inc.

Mr. LeRoy introduced Dr. Grande. Dr. Grande presented on Delmarva Community Services/Transit (DCS/DCT) transportation services and addressed questions from the RHC. Presentation slides are attached. Highlights included:

- DCS is both a transit and service provider and has existed for 45 years. DCS/DCT has been providing public transportation since the late 1980s/early 1990s and operates a fleet of vehicles, including buses, cutaway buses, and minivans.
- Much of the funding for these services is provided by the Maryland Transit Administration, and funding is provided through a federal/state/local matching program. In addition to traditional transit funding, diverse funding streams are used to provide services. Capital expenses, such as the purchase of vehicles, are one of the most expensive parts of the system. County matches for funding these services tend to be part capital and part operating expenses.
- DCT serves a four county area (Caroline, Dorchester, Kent, and Talbot Counties) and works with Queen Anne's County. Services provided include transportation to medical services, Choptank Community Health Centers, kidney dialysis, senior centers, and veterans court.
- Barriers for transportation services in rural areas can include time and distance, lack of knowledge, fear, dependence on family and neighbors, and lack of faith in public transportation. There is a need to build trust and to help people know what services are available.
- DCT provides mobility management services, including door-to-door services and travel trainers. Travel trainers work with people and accompany them on their first three rides to help them learn how to use and be comfortable with public transportation. Mobility management and coordination will likely continue to be critical moving forward. How community transportation serves an aging population is also a major issue.
- To address health issues, there needs to be recognition that lack of transportation is a problem. Financial resources are necessary for providing good transit and getting people to services.
- If more resources were available, it would be nice to have a more seamless transit system, with technology that would make it easier to contact transit and arrange trips with fewer transfers.

Seun O. Ross, President, IMBUEfoundation

Mr. LeRoy introduced Dr. Ross. Dr. Ross presented on IMBUEfoundation's transportation services in Caroline County. Highlights included:

- IMBUEfoundation was created in response to experience at a healthcare facility of seeing patients wait all day after an appointment for transportation home.
- IMBUEfoundation uses many of the same things discussed by Mr. Edge. Lyft is used for transportation services, which addresses concerns related to liability and insurance. The requirements for Lyft drivers in terms of driving record and age of vehicle limit who can qualify, so recruiting drivers can be a challenge.
- It is necessary to not only develop ideas, but to develop the groundwork for implementation of those ideas.

C. Q&A and Discussion

- The presentations highlighted the need for advocacy, funding, and leveraging resources.
- People interested in joining the Improving Rural Public Transportation Workgroup can email Ron Bialek or Kathleen Amos. Workgroup meetings will be held by phone.

Opportunities for Care Transformation Organizations (CTOs) to Impact the Goals of the Rural Health Collaborative
Fredia Wadley, MD, Talbot County Health Officer

Dr. Wadley welcomed and introduced a panel of guest speakers to share information about their CTOs: Patrick Dooley, Vice President, Population Health, and Executive Director, University of Maryland Quality Care Network, University of Maryland Medical System; Gene M. Ransom III, CEO, MedChi; and Brian Baker, Chair, Anne Arundel Medical Center Collaborative Care Network.

A. Panel:
Patrick Dooley, Vice President, Population Health, and Executive Director, University of Maryland Quality Care Network, University of Maryland Medical System

Mr. Dooley presented on Transform Health MD. Presentation slides are attached. Highlights included:

- Transform Health MD is the CTO system provided by the University of Maryland and leverages previous work done through the University of Maryland Quality Care Network.
- This CTO will provide a variety of services, including behavioral health and telepsychiatry, pharmacy expertise, practice transformation specialists, social risk assessment, support for transitions of care, quality improvement activities, and data analytics, and will help practices navigate the value-based model of care.

Brian Baker, Chair, Anne Arundel Medical Center Collaborative Care Network

Dr. Baker presented on Anne Arundel Medical Center (AAMC) Collaborative Care Network. Presentation slides are attached. Highlights included:

- The AAMC Collaborative Care Network is working with 17 practices, five of which are on the Eastern Shore. These five practices consist of 18 providers.
- This CTO uses an integrated care management team, with the patient at the center of care. This team can include the physician, care manager, one call care management, clinical social worker, community health worker, and behavioral health navigator.
- The CTO is expanding and developing services in one call care management, social determinants of health, working with Queen Anne's County EMS, behavioral health, tele-visits, home care, and psychiatric consults.

Gene M. Ransom III, CEO, MedChi, The Maryland State Medical Society

Mr. Ransom presented on MedChi's CTO. Highlights included:

- MedChi's CTO was created to be available to any physician who wants to use it, although it is not currently serving any physicians on the Eastern Shore.
- MedChi has a care management team working with practices.
- MedChi will help physicians sign up to access a CTO. Providers who did not sign up to participate in the CTO program can contact MedChi for assistance with signing up.

B. Q&A Session

The panel addressed questions from the RHC and engaged in discussion about attribution of patients to practices, eligibility for the CTO program, the CTO program application process, physician shortages, CTO services, evaluation of CTOs, the ratio of care managers to beneficiaries, and risk stratification.

Discussion of Community Health Resources Commission (CHRC) Proposal

Dr. Wadley requested input on two concepts that are being considered for a proposal to the Community Health Resources Commission (CHRC).

A. Mobile Integrated Health Concept/Projects
Joe Ciotola, MD, Queen Anne's County Health Officer

Joe Ciotola, MD, presented on the Queen Anne's County Mobile Integrated Community Health (MICH) program and addressed questions from the RHC. A summary of the program is attached. Highlights included:

- The MICH program started in 2014, has served around 285 patients, and helps link a vulnerable population with needed services. The program focuses on population health and increasing quality of life by identifying unmet needs and linking patients to resources.
- The program uses a multidisciplinary team to target individuals who are considered high risk for overutilization of emergency medical services (EMS), frequent use of the emergency department, and frequent inpatient hospital admissions. Participants are offered a home visit by the MICH team, which consists of a community health nurse from the health department, a paramedic, and depending on need, a visit from a behavioral health and substance abuse counselor. Home visits include a review of the patient's current and past medical history, health literacy status, physical assessments, fall risk assessments, nutrition status evaluation, social support evaluation, analysis of substance abuse risk, basic mental health evaluation, home safety assessments, and condition-specific education. The program also provides patients with a telehealth consult with a PharmD, which includes a medication reconciliation, comprehensive medication review, and medication-specific education.
- Data is being collected that demonstrate the impact of the program in terms of health outcomes and cost savings.

- The program is currently operating two days/week, but that is not meeting all of the need; would like to increase this to three or four days/week, but are limited by funding. There is currently no reimbursement for EMS for MICH visits.
- This program started in Queen Anne's County, and seven jurisdictions in Maryland now have a MICH program. There has also been discussion about starting a program on the Lower Shore. Funding from a CHRC grant would be used to start another MICH program on the Eastern Shore, perhaps in Talbot, Dorchester, or Caroline County, depending on resources. Funding is a challenge for the program and program expansion. Linking to the primary care model may offer some sustainability.

B. Community Hub Concept
Fredia Wadley, MD, Talbot County Health Officer

Dr. Wadley presented on the concept of a community hub for integrating social services and clinical services and addressed questions from the RHC. Presentation slides and a summary of the program are attached. Highlights included:

- There is a need for coordination of clinical services, coordination of social services, and coordination of clinical services with social services.
- One idea for addressing this need is a community hub. This hub could facilitate referrals and sharing of information among social support services and primary care practices and help provide coordination to support high-risk, high-need individuals. The program would look for opportunities to connect with existing resources within the community.
- There is a need for an equivalent of the medical home structure for social services – a social health home. This would provide coordination and assist individuals with locating and enrolling in social services.
- The hub could be located in a health department and involve a registered nurse and community health outreach workers to receive referrals, do in-home assessments, develop plans for care, link with other social services, and track and share information on progress.
- Data would be collected on the impact on health, costs of care, and social services needs.
- The hub could help establish a better process for facilitating referrals, track high-risk patients, increase use of social services to improve health, bridge the public and private sectors to enhance coordination, and provide an opportunity to collect data to inform the Total Cost of Care Medicare Waiver.

Wrap-Up, Workgroups, and Next Meeting
Fredia Wadley, MD, Talbot County Health Officer

Dr. Wadley reminded RHC members that the next RHC meeting will be on April 8, 2019. The first meeting of the Integrating Clinical and Social Support Services Workgroup will be on February 7, 2019. Mr. LeRoy encouraged RHC members to join the Improving Rural Public Transportation Workgroup.

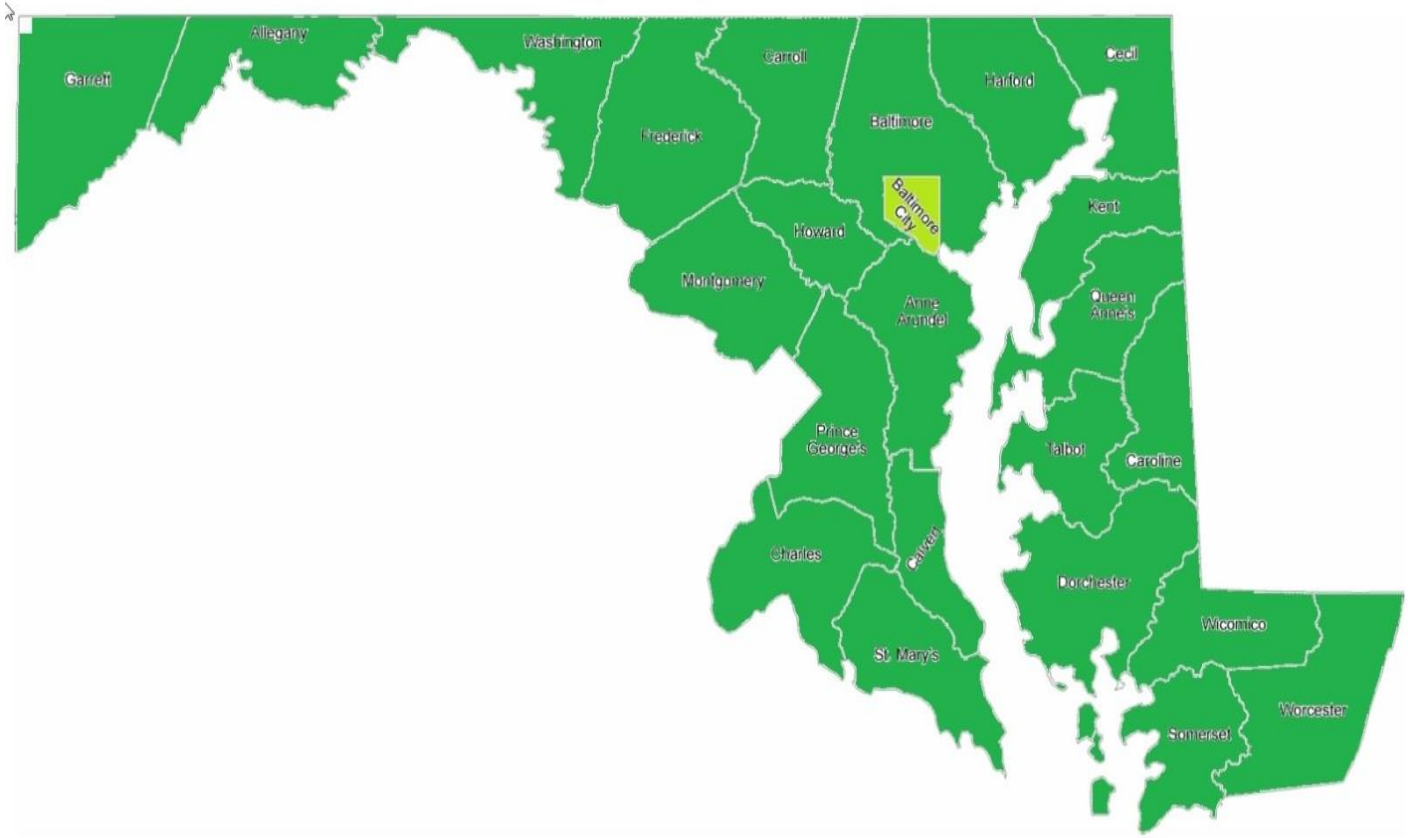
Meeting was adjourned at 8:02pm.

Aetna Medicaid Overview

Non Emergent Medical Transportation (NEMT)

February 2019

Aetna Better Health of Maryland



Launched

November 2017 as Regional Plan

Certified “State-wide” in December 2018

800%+

Growth
Since January 2018

Population

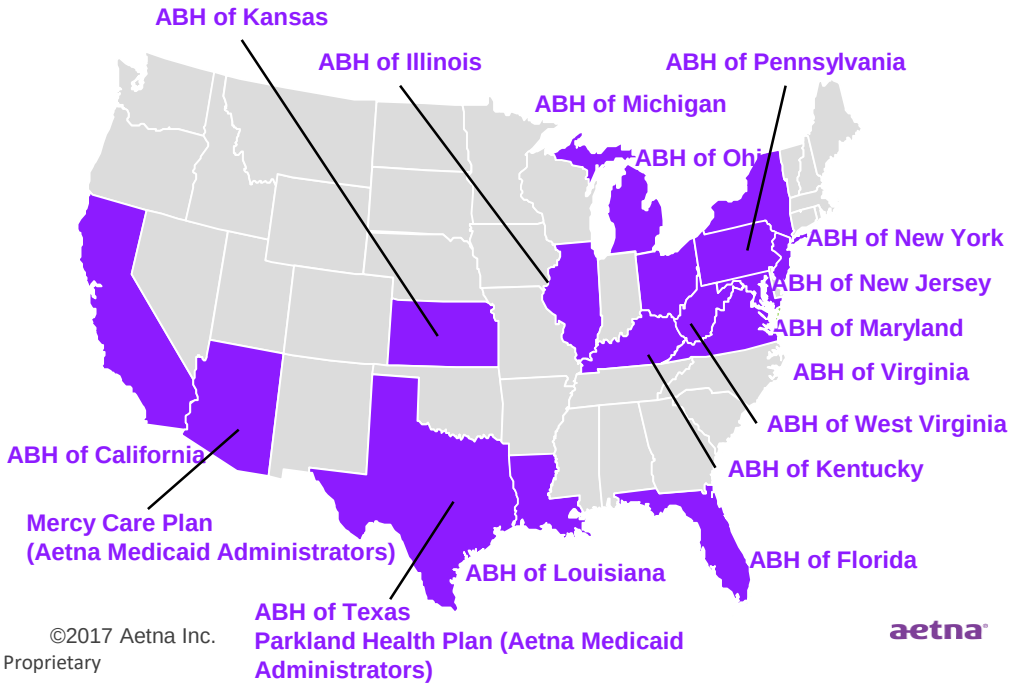
49% TANF
41% ACA
8% CHIP
2% ABD

~18,000

Members Currently Enrolled

Aetna Medicaid by the Numbers

We are providing innovative solutions and technology to support Medicaid beneficiaries in achieving their optimal health and quality of life, while also honoring their culture, goals and needs for self determination



35 contracts across 16 states

Administer Medicaid programs in 16 states across the nation with a varying number of contracts

30 plus years experience

Across all populations including managing the care of complex, high-risk populations; Best-In-Class winner of the 2017-18 Medicaid Health Plan Association Award

2.7M managed members

In ASC and risk agreements across all footprint states and programs as of 2Q18

aetna

NEMT Services

Value-added benefit for eligible Aetna Medicaid beneficiaries, who need to get to and from medically necessary services and have no other means of transportation, to take them to and from medical providers (appointments, medications, treatment plan prescribed services).

Providing dependable NEMT services that are safe and on time:

- ❑ Help improve access to medical services
- ❑ Contributes to improved health outcomes
- ❑ Helps aide our members in achieving their goal of having a better and healthier quality of life

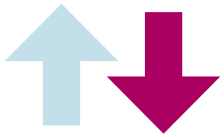
Aetna's NEMT Experience Background

Evolution

- **In-House Management** of fleet and call center for NEMT Services for each State Plan
- **Broker Model** for scheduling relay, ASO model (PM/PM sub-capitation)
- **Ride Share Model** where the provider, member and case managers can schedule NEMT

NEMT Usage

- **1.5M** rides per year under the in-house model
- **3.9M** rides per year under the broker (LogistiCare, MTM, Access2Care) model
- **~5.2M** rides per year using ride share (Uber Medical, Lyft, Veyo) model for the past 2 yrs.



Clinical and Financial Outcomes

- Reduction in "non-show" rates due to transportation problems
- Reduction in avoidable ED utilization
- Increase in PCP and wellness visits
- Increased medication adherence
- Increased treatment plan adherence
- Happier providers

NEMT Considerations for Broker or Rideshare Models

- Try to coordinate NEMT with human services transportation and public transportation.
- Whenever possible, use fixed-route transit for appropriate NEMT trips at the lowest cost.
- Develop or adopt a model that will enable you to measure the contribution of transportation to better health outcomes and reduced health care costs.
- Coordinate NEMT with public transportation to meet the unique requirements of Medicaid beneficiaries, particularly in rural areas.
- Identify the key data required and establish standard procedures for data collection and reporting of NEMT performance.
- Collect and analyze your rideshare data from the vendor to demonstrate and evaluate the value of a ridesharing program for NEMT medical appointments.
- Use technology to enhance NEMT program administration and verify medical trips.
- Coordinate shared-ride, demand-response NEMT with other transportation programs to reduce costs per trip.
- Establish a procedure to set a rate for NEMT trips on ADA paratransit that is consistent with Medicaid guidelines.

NEMT Considerations for Broker or Rideshare Models
(Cont.)

- Negotiate operations practices and reimbursement rates for transportation providers to recover the direct costs of delivering NEMT service.
- Develop procedures, criteria and timelines for invoicing and payment for NEMT

Delmarva Community Services/Transit

A Service Provider AND a Transit Provider

INCLUSIVE PLANNING Rural Health Collaborative 2019

Delmarva Community Services, Inc.

Our planning formula
Diversification = Sustainability

Developmental Disability Services
Senior Services
Respite Care
Community Action CAP
Public and Community Transportation
MA Transportation/Mobility Management
Housing

Regional Coordination

- Create a Local Coordinated Plan
- Create a Coordinating Entity

Include the Stakeholders

- MUST Advisory Committee
- CTAC

Regional Budget Planning

- Utilize diverse funding streams in addition to traditional transit funding
  - 5310/ 5311/ SSTAP/ USDA/ DDA/ MAT/ United Way/ Rural MD. Council/ VTCLI

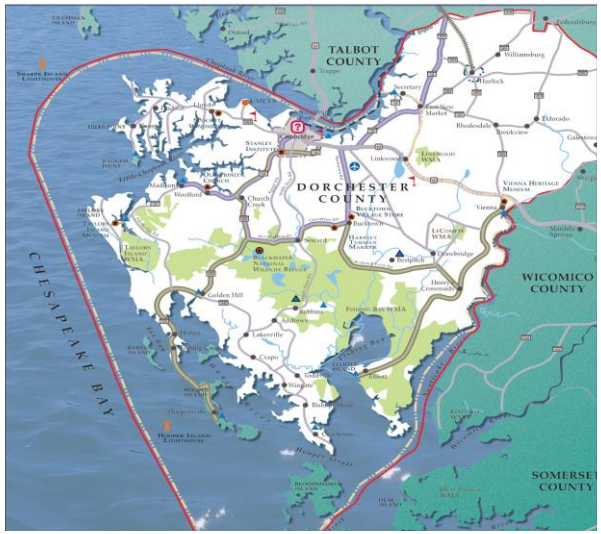
Services we are asked to provide

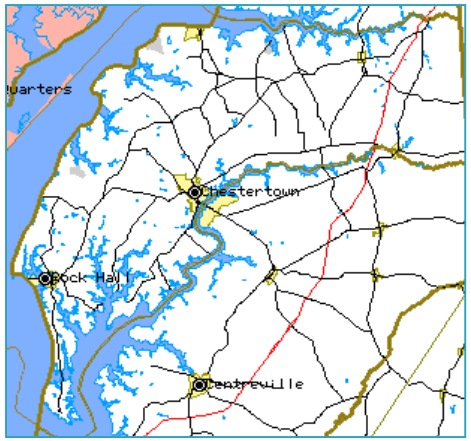
- Medical Transportation
- Choptank Community Health – seasonal workers – days and nights
- Kidney Dialysis
- Benedictine & other DD providers
- Senior centers in 4 counties
- Dor. Co. District Veterans Court

What is the cost?

Regional Budget Planning

- Coordinating 4 counties requires 4 county local matches





Break Down Barriers

- Mobility Management goes further than traditional ADA services

- Traditional rural barriers include
  - Time and distance
  - Lack of knowledge
  - Fear
  - Dependence on family and neighbors
  - No faith in public transportation

The Future

- Mobility Management = Coordination
- Dorchester County TDP
- Small efficient ramp vehicles

Advocacy

- The Intersection of Aging and Community Transportation – Are We Ready?

Coordinate with town planners

More door to door services

Travel Training

Advocacy

- Recognizing the transportation needs and challenges of rural populations.

We all agree we need…

- Financial resources to provide good transit
- Evening and weekend services
- Marketing to make folks aware of services that DO exist
- Transit champions at ALL levels of government and the private sector.

That Aha Moment!

- When riders realize… transportation is the SOLUTION *not* the problem

Thank You

Santo Grande ED.D
Delmarva Community Services, Inc.
santo@dcsdct.org

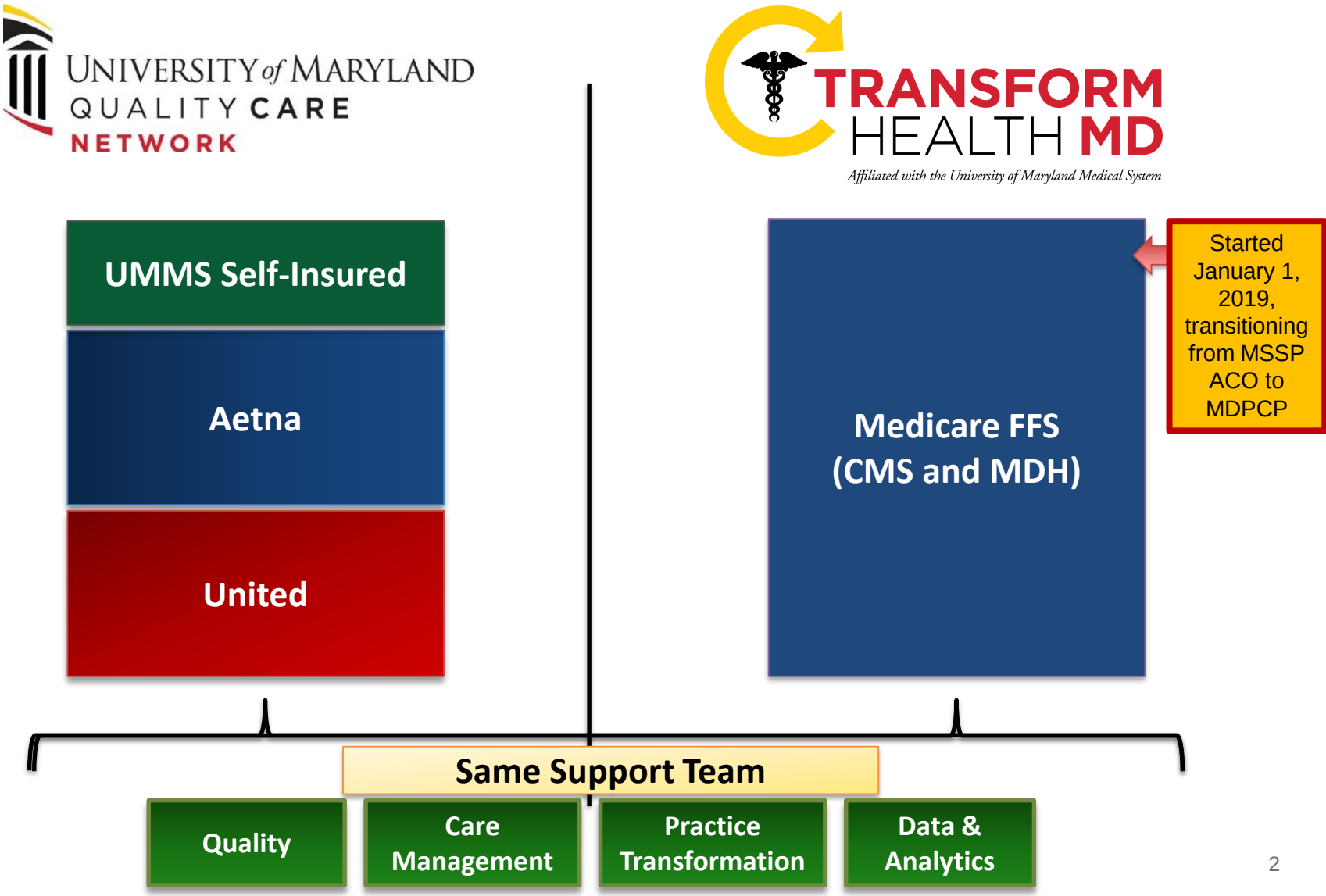
410-221-1900

TRANSFORM HEALTH MD

Affiliated with the University of Maryland Medical System

Patrick Dooley
Executive Director, Transform Health MD

Transform Health MD: Experience with Value Based Care



Transform Health MD Services

Our patient-centered care model uses a team-based approach to work collaboratively with providers on care delivery transformation that is tailored to their individual needs.

Transform Health MD Experience

Transform Health MD

- ✓ Proven experience through the University of Maryland Quality Care Network (QCN) in reducing unnecessary utilization for acute admits and emergency department visits

Table 3
University of Maryland Quality Care Network
Utilization for Selected Categories

	Utilization Last 12 Months Ending					Change vs. 2016			
	2016	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4
Transition of Care / Care Coordination Utilization									
30-Day All-Cause Readmissions Per 1,000 Discharges	158	149	139	135	137	-5.8%	-11.7%	-14.4%	-13.4%
30-Day Post-Discharge Provider Visits Per 1,000 Discharges	797	792	803	805	808	-0.6%	0.7%	0.9%	1.4%
Ambulatory Care Sensitive Conditions Discharge Rates Per 1,000 Beneficiaries									
Chronic Obstructive Pulmonary Disease or Asthma	8.45	9.22	9.63	10.01	9.28	9.1%	13.9%	18.4%	9.8%
Congestive Heart Failure	10.97	14.03	13.34	12.88	12.75	27.9%	21.6%	17.4%	16.2%
Acute Composite	N/A	17.34	16.11	15.47	14.43	N/A	N/A	N/A	N/A
Additional Utilization Rates (Per 1,000 Person-Years)									
Hospital Discharges, Total	264	260	248	246	237	-1.4%	-6.0%	-7.0%	-10.1%
Skilled Nursing Facility or Unit Discharges	52	47	46	45	44	-8.9%	-11.8%	-13.7%	-15.6%
Skilled Nursing Facility or Unit Utilization Days	1,258	1,155	1,099	1,088	1,040	-8.2%	-12.6%	-13.5%	-17.4%
Emergency Department Visits	595	585	572	574	564	-1.7%	-3.9%	-3.5%	-5.3%
Emergency Department Visits that Lead to Hospitalizations	201	198	187	184	176	-1.8%	-7.3%	-8.6%	-12.5%
Computed Tomography (CT) Events	737	720	723	748	752	-2.2%	-1.8%	1.5%	2.1%
Magnetic Resonance Imaging (MRI) Events	328	317	311	322	325	-3.4%	-5.0%	-1.5%	-0.7%
Primary Care Services	9,739	9,653	9,638	9,756	9,845	-0.9%	-1.0%	0.2%	1.1%
With a Primary Care Physician	3,767	3,705	3,669	3,694	3,719	-1.7%	-2.6%	-1.9%	-1.3%
With a Specialist Physician	5,047	4,997	4,990	5,036	5,077	-1.0%	-1.1%	-0.2%	0.6%
With a Nurse Practitioner / Physician Assistant / Clinical Nurse Specialist	920	948	974	1,022	1,044	3.0%	5.9%	11.0%	13.5%

UNIVERSITY of MARYLAND QUALITY CARE NETWORK

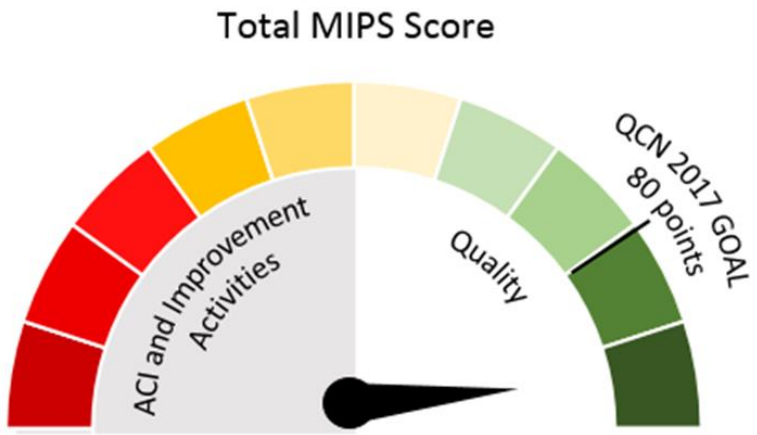
10.1% reduction

5.3% reduction

Transform Health MD Experience

Transform Health MD

- ✓ Strong track record of assisting practices to optimize performance under value based payment programs, including the Merit-based Incentive Payment System



Final MIPS Score Breakdown

93.3 points

Advancing Care Information: 30 of 30 points
Improvement Activities : 20 of 20 points
Quality: 43.3 of 50 points

Payment Adjustment: **+1.65%** increase to Physician Fee Schedule

Effective Date: January 1, 2019

Applicable To: All practices in UMQCN ACO receive this score and corresponding fee schedule increase

Transform Health MD Experience

Transform Health MD

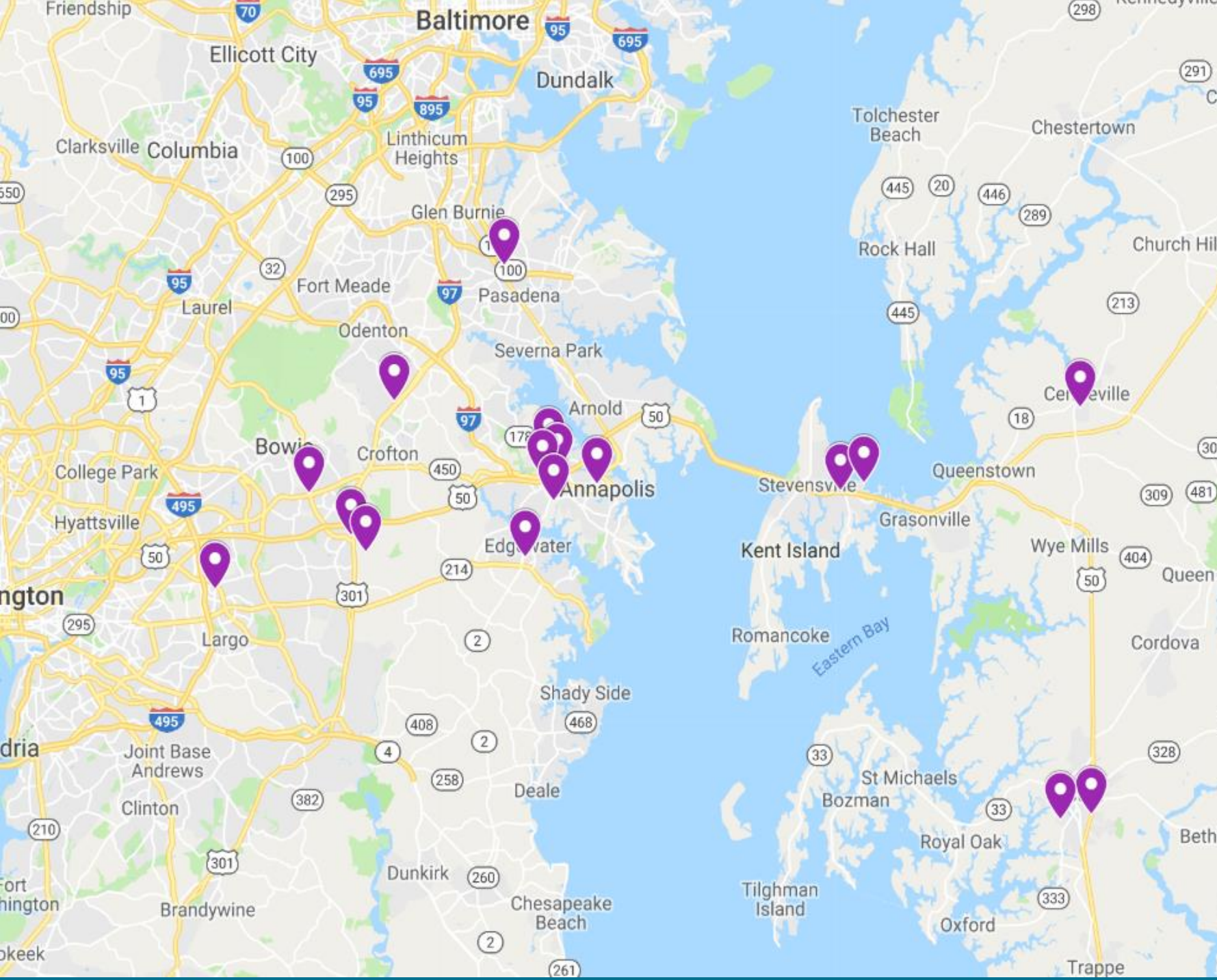
- ✓ We will help navigate practices new to this value-based model of care and provide insight on successful workflow processes and strategies to help your practice and your patients.
  - ✓ *Training and educational resources available to transform care*
  - ✓ *Practice transformation experience to support risk adjustment*

- ✓ We have developed clinical models including case management, pharmacy, and social work that can be leveraged to accelerate your practice's success under MDPCP.
  - ✓ *Strategic Partnerships for innovative clinical programs and initiatives including UMB, Pfizer, Abbott, Pack Health, CVS, etc.*
  - ✓ *Our interdisciplinary care management team can assist in performing risk stratification to help better support your beneficiaries' needs to engage them with social service organizations, community-based organizations, and public health agencies.*

The Maryland Primary Care Program

Rural Health Collaborative

February 6, 2019



AAMC Community Clinics

AAMG Annapolis Primary Care

AAMG Centreville Family Medicine

AAMG Chesapeake Family Medicine

AAMG Eastern Shore Primary Care

AAMG Kent Island Primary Care

AAMG Largo Primary Care

AAMG Pasadena Primary Care

AAMG River Family Physicians

AAMG South River Family Physicians

AAMG Waugh Chapel Family Medicine

Annapolis Internal Medicine

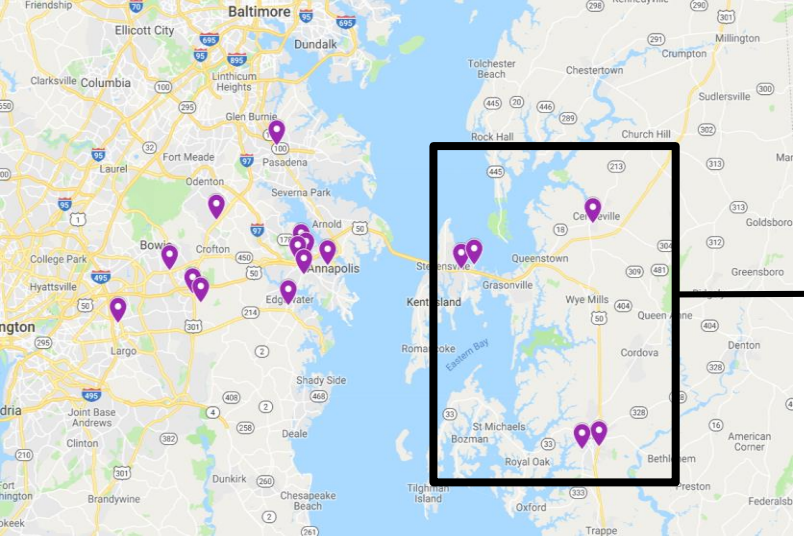
Dobin Internal Medicine

MATCARE, LLC

Metropolitan Medical Consulting

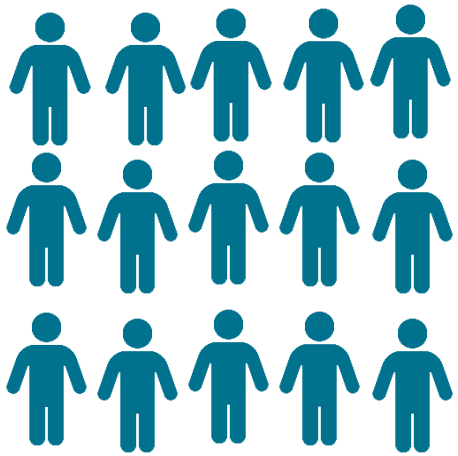
Miles River Physicians

Rakesh Arora, MD

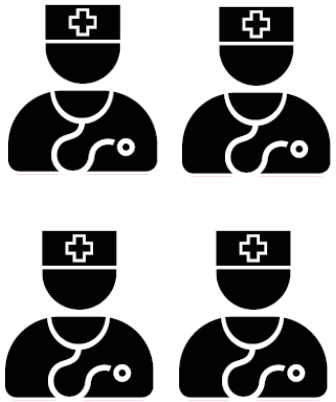


What are the numbers?

3,000 Medicare beneficiaries;
22,000 Visits



18 Providers

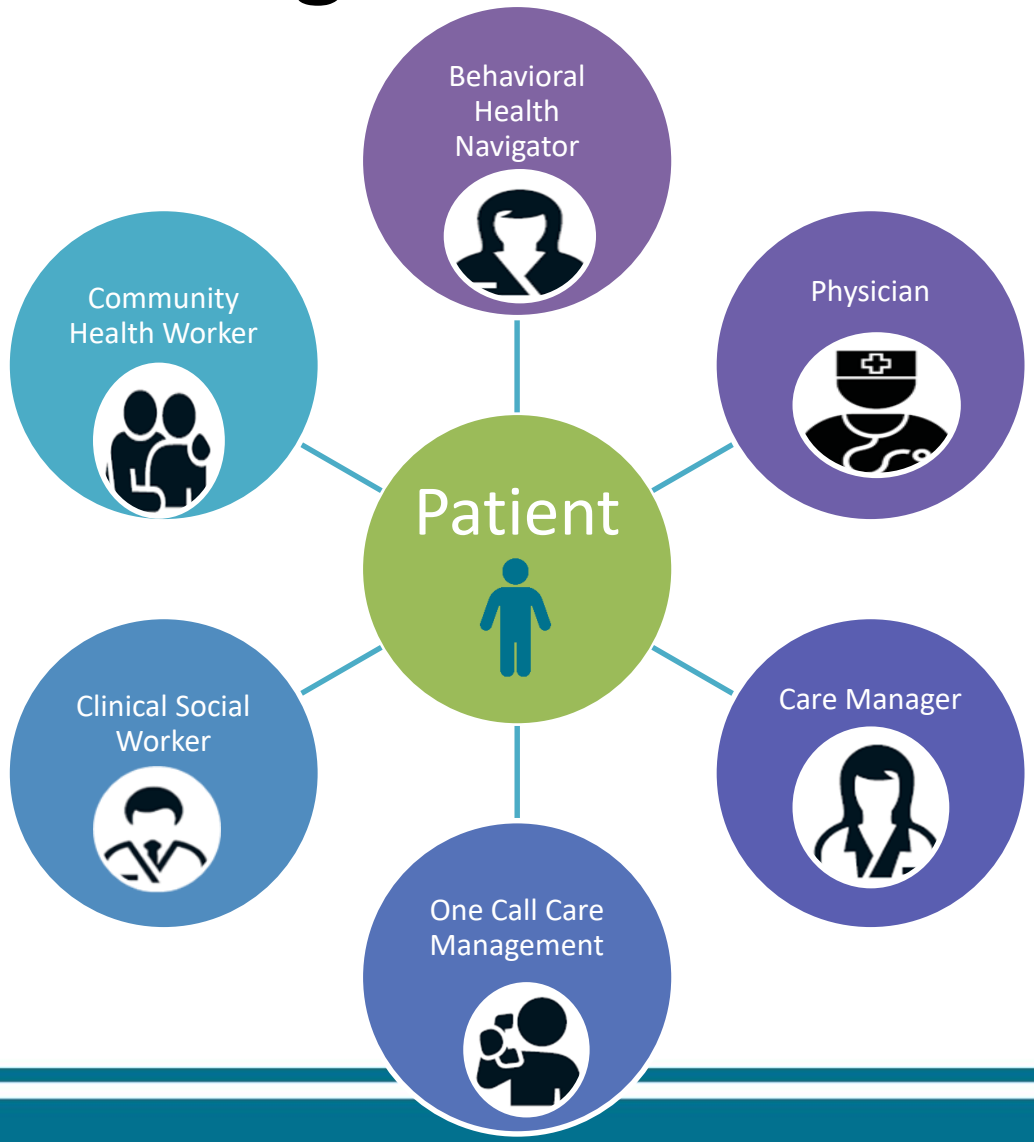


$680K Care Management Funding

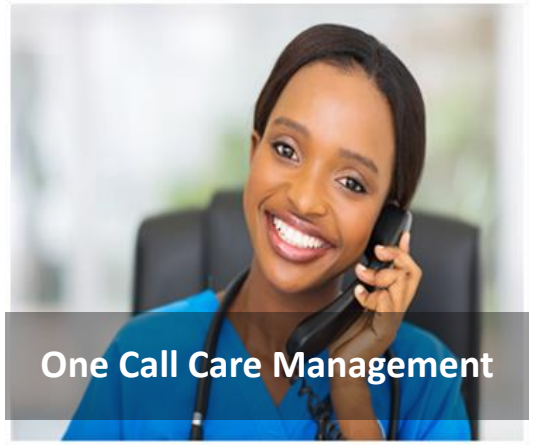
10 New FTEs

Care Managers
Social Workers
Behavioral Health Specialists
Community Health Workers
And more!

Integrated Care Management Team



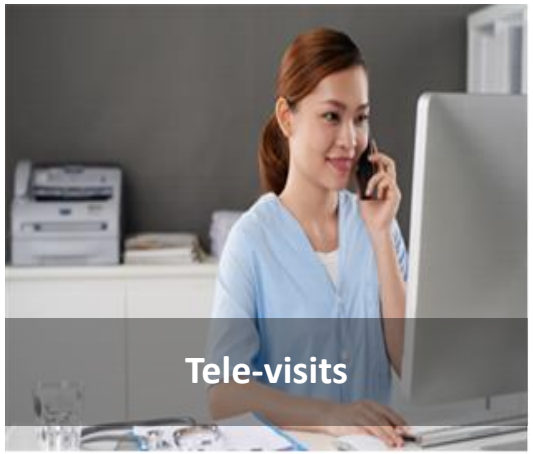
Expanding & Developing Services


One Call Care Management


Social Determinants of Health


Queen Anne's EMS


Behavioral Health


Tele-visits


Home Care


Psychiatric Consults

LIVING HEALTHIER **TOGETHER.**

Queen Anne's County Mobile Integrated Community Health Program

The Queen Anne's County Mobile Integrated Community Health program (MICH) utilizes a multidisciplinary team to target county residents who are considered high risk for overutilization of emergency medical services, frequent use of the emergency department, and frequent inpatient hospital admissions. Program participants are offered a home visit by the MICH team which consists of a community health nurse from the Department of Health, a paramedic from the Department of Emergency Services and, if the patient's individual situation requires it, a visit from a behavioral health and substance abuse counselor. Using mobile internet and telehealth technology, the MICH team creates a tele-vist for each patient with a PharmD from the University of Maryland Shore Regional Health System. The MICH program focuses on population health and increasing the patient's current quality of life by identifying each patient's unmet needs and then linking patients to existing community and healthcare resources. MICH home visits consist of a review of the patient's current and past medical history, health literacy status, physical assessments, fall risk assessments, nutrition status evaluation, social support evaluation, analysis of substance abuse risk, a basic mental health evaluation, home safety assessments, and condition-specific education.

During the tele-visit, the PharmD completes a medication reconciliation, performs a comprehensive medication review, and offers medication-specific education to each patient. All medication inventory issues are communicated to the patient's primary care physician prior to the conclusion of the home visit. By utilizing the expertise of a team of health professionals in the patient's home and conducting a full assessment of home and personal safety using evidence-based scales and a medication telehealth consultation, MICH has refined a program model that is both collaborative and effective in empowering patients with the tools to improve their personal management of chronic disease. In a county with scarce health resources (Queen Anne's County does not have a definitive care hospital within the county) and a limited public transportation system, Queen Anne's County's MICH is meeting the challenge to address the clinical and non-clinical needs of their patients (mostly elderly low income citizens with a high level of chronic disease) in an effort to improve their overall quality of life.

The cost of the first full fiscal year of the program was $275,000 which included major one-time purchases such as Ford Interceptor which is used as the MICH vehicle and a Zoll Cardiac Monitor. The current cost of the program is $341,000 which covers the increase in salary from one part-time community health nurse to two community health nurses, the addition of a contractual program manager, the addition of a research statistician, numerous IT hardware and software purchases, and increased visits leading to increased cost of paramedic utilization. Current funding for the program is provided as follows:

University of Maryland Shore Regional Health - $50,000

Anne Arundel Medical Center - $75,000

County Government - $56,000

CareFirst Telehealth Grant - $133,332*

Estimated In-Kind Cost - $31,000

*The CareFirst Telehealth Grant was an awarded amount of $400,000 over three years. The last payment for the current fiscal year was received in August 2018.

CONCEPT BEHIND CHRC PROPOSAL

Alignment with the Charge to Rural Health Collaborative and Maryland's Total Cost of Care Waiver

RURAL HEALTH COLLABORATIVE CHARGE

Design Rural Health Model

- Improves access and delivery
- Can scale to other rural areas
- Aligns with Maryland's Total Cost of Care Waiver
  1. Triple Aim: decrease cost, improve outcomes, patient centered
  2. Improve population health

MARYLAND'S TOTAL COST OF CARE MEDICARE WAIVER

- Have global budgets for hospitals and incentives
- Adding outpatient with stronger medical home and care manager (CTO)
- Recognizes social determinants of health and value of population health efforts
- Participating providers start in Track 1: responsible for linking clinical and behavioral services; care manager assigned
- By third year must be Track 2: responsible for linking patients with social services

CHALLENGES WITH WAIVER

Medical home is to be strengthened in order to better provide the care that is needed and care manager to coordinate services

BUT

1. Social Support Services are not integrated or coordinated well
2. No entity accepts responsibility for linking and tracking clients
3. It is unlikely the one Care Manager being added can coordinate clinical, behavioral and social services

NEED AN EQUIVALENT TO MEDICAL HOME

COORDINATION ACTIVITIES FOR CLINICAL SERVICES

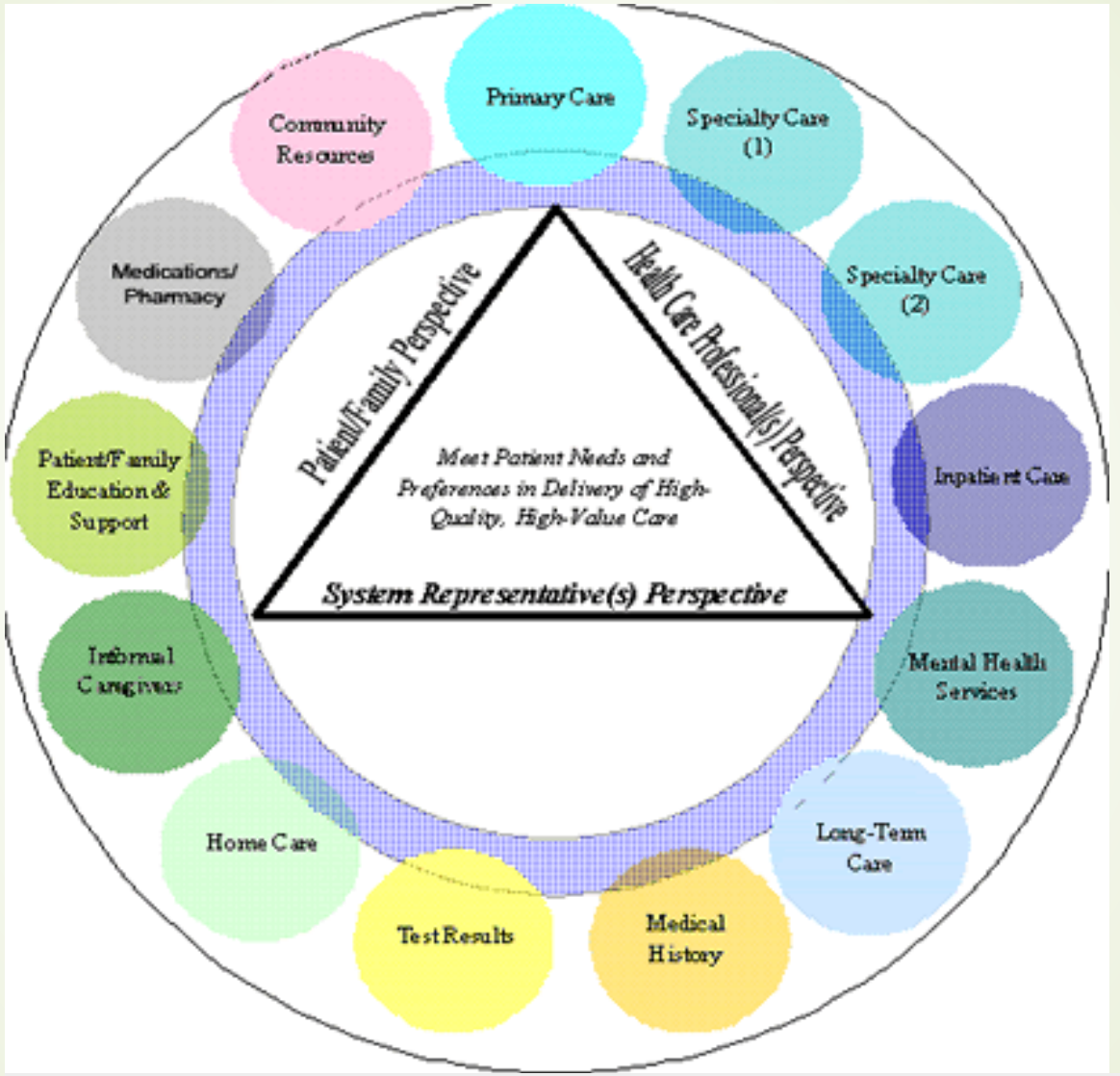
- Establish Accountability or Negotiate Responsibility (MEDICAL HOME)
- Communicate
- Facilitate Transitions
- Assess Needs and Goals
- Create a Proactive Plan of Care
- Monitor, Follow Up, and Respond to Change
- Support Self-Management Goals
- Link to Community Resources
- Align Resources with Patient and Population Needs

Coordination Activities Social Services

- Establish Accountability or Negotiate Responsibility (Social Health Home)
- Communicate (Multiple Agencies)
- Facilitate Transitions (Between all social agencies and non profits with charitable services)
- Assess Needs and Goals (In home assessments determines more needs)
- Create a Proactive Plan of Care (# of needs, plan to resolve each)
- Monitor, Follow Up, and Respond to Change (another crisis may arise)
- Support Self-Management Goals (Health Dept. could help manage CD)
- Link to Community Primary Care Provider (or CM with Medical Home)
- Align Resources with Patient and Population Needs

INFRASTRUCTURE FOR RURAL MODEL

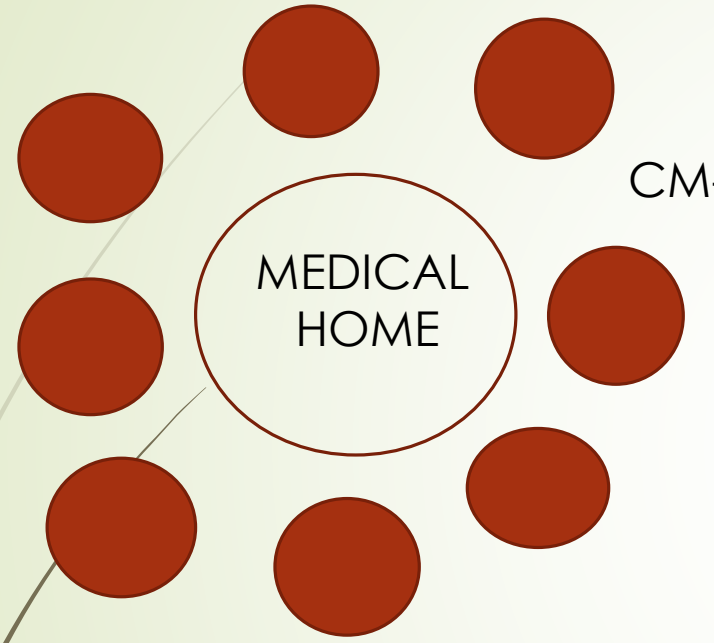
- Establish a community HUB with RN(s), SW(s), CHOW(s) based on population, community needs, agency willingness to host
- Responsible for getting Social support service agencies to establish formal processes to facilitate meeting clients' needs
- Responsible for accepting high risk referrals, completing social needs assessment, developing care plan for resolving needs, referrals and completions, tracking, and data collection
- Responsible for working with Care Manager of PCP for sharing info
- Works with partners that have a care coordination piece to add such as Mobile Integrated Health, Senior Care, or other innovations or unique services
- Expands to handle high risk Medicaid patients, Addiction Clients, Children with Special Healthcare Needs, etc… as TCOC Waiver expands


Primary Care
Specialty Care (1)
Specialty Care (2)
Inpatient Care
Mental Health Services
Long-Term Care
Medical History
Test Results
Home Care
Informal Caregivers
Patient/Family Education & Support
Medications/ Pharmacy
Community Resources
Patient/Family Perspective
Health Care Professional(s) Perspective
System Representative(s) Perspective
Meet Patient Needs and Preferences in Delivery of High-Quality, High-Value Care

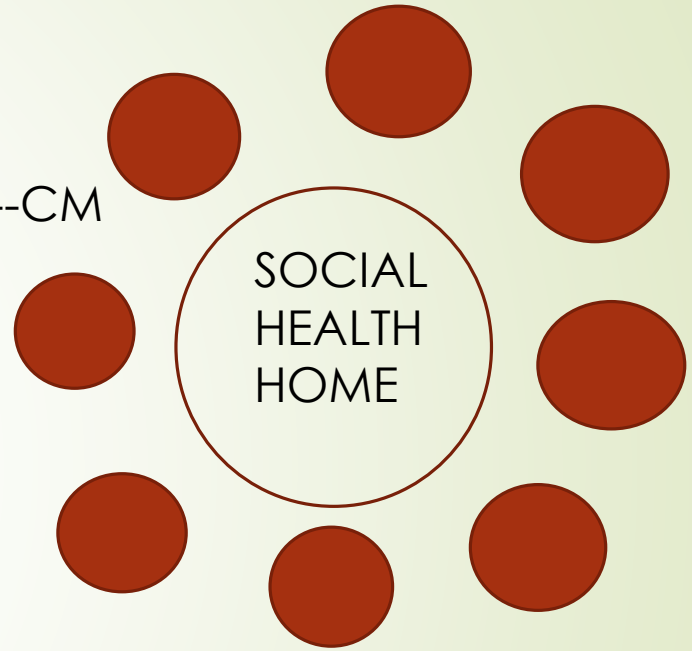
Clinical Services

Social Services

CM---- ---Care Coordination--- ---CM



CO-LOCATE FOR SUCCESS



EXAMPLE OF HUB COMPONENTS

County Health Department

1. Space and support services
2. Assists in establishing processes and agreements with community agencies
3. Assists in establishing process for sharing information with CM of PCP
4. Define data elements that can/will be collected
5. Implement new components such as IT solution

Registered Nurse

1. Oversight of HUB and CHOWs
2. Social needs assessment and plan of care for those enrolled
3. Works with TCHD on processes with agencies and data collection
4. Primary communicator with CM of clinical services of PCP
5. Decisions financial assistance if no existing resource available

HUB COMPONENTS cont'd

Community Health Outreach Workers

1. Accepts referrals, schedules home visits
2. Assists with linking, transporting, helping with documents needed, and home visits
3. Assists with data collection until IT solution can be utilized
4. Periodic contacts to assure no new crisis

BUDGET FOR CHRC

RN – CONTRACT	$60,000
CHOWS – CONTRACT $34,000 X 2 =	68,000
FUNDS FOR GAPS ALONG SENIOR CARE GUIDELINES	30,000
COMPUTERS AND PHONES	5,000
Travel	2,000
Indirect – buffer for unexpected needs	10,000
TOTAL	$175,000

WHAT DATA& INFORMATION?

- What is a feasible way to evaluate care coordination in addition to endpoints (ED visits, hospital admissions, improved CD measures, TCOC)
- What social needs are frequent in certain age groups, income levels, Dx…?
- Are resources adequate for each type of need? Gaps? Solutions?
- On average how much time involved in resolving specific type of need?
- How much time involved in stabilizing beneficiaries with high need scores?
- Which social indicators should be used for risk stratification for Care Coordination reimbursement or planning case loads?
- What achievement steps reached along social pathway to resolving need of significant importance for future impact on cost of care and health

ADVANTAGES OF HUB MODEL

- Better processes established to facilitate referrals of low risk patients to SS
- HUB model for referred high risk/complicated clients with more needs
- Increase social services utilized to improve health and well being
- Can start with Medicare and add other groups/payers as TCOC grows
- Can vary with community resources, needs and willingness to house HUB
- In time the bridge between public and private sectors (2 CM) might be merged (clinical and social coordination by same entity)
- When ready for IT solution, have better chance of implementing
- Offers good opportunity for data collection to advise Waiver

COMMUNITY HUB FOR INTEGRATION OF SOCIAL SERVICES AND CLINICAL SERVICES

PROBLEM:

1. Maryland's Total Cost of Care Waiver (TCOCW) has incentives for hospitals and Primary Care Providers (PCPs) to improve health outcomes and decrease costs; 2. A Case Manager (CM) is assigned to PCPs to coordinate and assure services; 3 Social support services (SSS) for complex, high risk Medicare beneficiaries are not coordinated between SSS agencies or with clinical providers; 4. Gaps in SSS often results in referrals not resulting in services.

SOLUTION: The long term solution includes ability to electronically share information between clinical and social providers to facilitate referrals, document needs resolved and those remaining. This must be coupled with well defined processes and responsibilities of each entity involved. MCOs and ACOs were envisioned to do this but the greatest challenges have been in securing SSS. To assure the CTOs and TCOCW are successful, we envision an interim step(s) of using a HUB as the infrastructure to build toward the long term solution. The HUB will

- Be located in local health department (LHD) which will take the lead on developing processes to facilitate referrals and sharing of information between SSS agencies and with care manager of PCP
- Have RN and two CHOWs to receive referrals, do in home assessment (often missing link for why patient is not improving), develop plan of care, link with other SSS, track, share information on progress
- Use limited funds when no existing resources (according to same criteria as Senior Care Program)
- Link with LHD and other services for chronic disease control and assist with providing checks and counseling for clients with uncontrolled diabetes and hypertension.

EVALUTION and PRODUCTS: 100 clients served

- Collect data on costs of care (or events if costs not provided by HSCRC) 12 months pre-enrollment and 24 months following to separate transient and persistently high cost beneficiaries (*Health Affairs, Jan 2019)*
- *D*etermine impact on diabetes and hypertension control of clients enrolled;
- Collect data on type and frequency of social needs of this high risk group to inform TCOCW on social factors needed in risk stratification for care management reimbursement
- Compare SSS needs identified by CM of PCP versus in home assessment
- Identify gaps in services to inform state and TCOCW decisions on best investments for resolving SSS needs that impact health status and improving population health

FUNDING: Once the groundwork has been built with agreements for referrals and responsibilities, the costs of the HUB could decrease in subsequent years. Until this is accomplished the staff would be hourly employees on contract: RN @ $70,000, two CHOWS approximately $64,000; phones and travel @ $5,000; Purchase of Care if client meets Senior Care criteria $20,000 (example- medication co-pay, transportation, home safety, in home personal for homemaker services) and $16,000 evaluation assistance.

SUSTAINABILITY: STEPS assessment by RN are covered but discussions are underway to stop reimbursement. If state continues this reimbursement the costs for the nurse would be covered and this project will hopefully encourage the state to continue this reimbursement. The CTO could contract for RN/CHOW services; state and CMS could invest Medicare savings in this model along with enhancements such as software for IT solution.

FUTURE: *This HUB infrastructure can facilitate clinical referrals for social services for clients with less complicated needs, demonstrate value in home visits and assessment with more complex high risk Medicare beneficiaries, and be used to develop the same service for Medicaid high risk beneficiaries.*