**Anne Arundel County Public Forum on Health System Transformation**

**June 23, 2015**

**Minutes**

**Jinlene Chan, M.D., M.P.H, Health Officer of Anne Arundel County** welcomed the assembly to the forum, noting that this is currently an exciting time amid a changing health care landscape in Maryland and across the country. All stakeholders are now incentivized to work together to achieve health, wellness and prosperity for residents. Systems are realigning to work more closely together and partner to support common goals.

Dr. Chan also spoke about health equity and the recent local Health Equity Summit. She spoke about creating opportunities within systems—not just health systems—to help people achieve health and wellness. That is the true root goal of this health system transformation and this forum encourages discussion about these and other related topics.

Dr. Chan reviewed the speakers, agenda, and materials. She urged the assembly to walk away with ideas and continue this conversation through deeper community engagement in improving the county.

**Vincent DeMarco, President of the Maryland Citizens’ Health Initiative,** thanked Dr. Chan and offered some context for the conversation. This forum is the 10th in a statewide series of forums the organization has hosted since the start of 2015. He also reviewed the speakers and urged the participants to actively participate in the Q&A session and/or share written comments when completing the evaluation forms.

**John Colmers, Chair of the Health Services Cost Review Commission (HSCRC),** then presented information about the national, state and local health care landscape. He noted that there is a significant amount of fragmentation of health care and variation in how health care is accessed, the type of care that is provided and how much it costs. One of the most significant examples of that variation manifests in health disparities. There is a 20-year difference in life-expectancy among different parts of Anne Arundel County.

Another challenge currently experienced by consumers and the health care system is the aging population that tends to be older and sicker. As more people from the baby-boomer generation age and enroll in Medicare, it will place significant stress on our health care system and economy.

Coverage and access provided for in the Affordable Care Act (ACA) is great but 1) “coverage” doesn’t necessarily mean “access” and 2) significant populations in our state still can’t get covered. Dr. Colmers also highlighted workforce shortages, waste and high costs as additional challenges. These are all factors that spurred the creation of the ACA.

Dr. Colmers also noted that the US spends more than other similarly developed countries on health care. Other developed countries spend 50% of what the US spends. Total expenditures as a percentage of GDP is also considerable—particularly compared to other countries.

The US ranks fourth highest in infant mortality, highest percentage of adult obesity, bottom third in life expectancy compared to all other developed countries in the world. A big factor in these rankings can be explained by the US’s tremendous health disparities—we experience a 2 to 1 difference in life expectancy of people who are white vs. black. (\*See presentation for more specific rates and percentages.) Dr. Colmers cited County Health Rankings—for a lot of the important measures, Maryland did not have great rankings. Anne Arundel County ranks in the top third among all Maryland counties on these outcomes.

Because of these experiences and realigned incentives, Dr. Colmers noted that more concerted efforts are focusing on changing these tides. A new paradigm of simultaneously improving the health of the population, the patient experience of care and the per capita cost of care. Years ago, we would have been thrilled to do one of those things, but today we need to achieve all three at once.

The implication of these efforts is that payment moves away from a fee for service system to move from basing payment on quantity of services to quality of services. In Maryland we have done things differently for quite some time, particularly in how hospitals are paid. Hospitals in Maryland have had their rates set by HSCRC since the mid 1970s. The HSCRC is an independent seven member commission that was created by the legislature to serve as a watchdog and regulator. It functions as a public utility, like gas and electric.

Maryland hospitals have been waived from federal Medicare payment methods. All Maryland hospitals participate in an alternative “all-payer” system. Maryland is the only state in the country with this system.

The all-payer system has helped hold costs down relative to elsewhere and funds access to care. We don’t have a public/private hospital system that you’ll see in many other jurisdictions, so we have more equitable access to high-quality health care services. This system also leads to greater transparency (prices, procedures, etc.). We are leader in linking quality to payment and providing hospitals local access to regulators.

We worked out a new demonstration grant with Centers for Medicare upon renewal of our waiver. What we have now is a 5 year demonstration program that went into effect 1/1/2014. Now, it gives hospitals more of a stake in keeping costs down, helping people stay healthy, getting better outcomes for patients and working more collaboratively even with providers outside of their walls (formal and informal.)

This requires hospitals to become more patient and family-centered. Patients can expect greater care coordination and expect more outreach from providers. They’re going to be looking to provide the right care, at the right time, in the right price at the right price.

They began testing this new system with 10 total patient revenue (TPR) hospitals in rural areas across the state. [The New York Times recently published an article](http://www.nytimes.com/2013/08/28/business/economy/lessons-in-maryland-for-costs-at-hospitals.html?_r=0) praising their innovation and approach to diverting patients from the emergency room to more comprehensive, primary care.

Another example was the Washington county hospital that ran the school health center to prevent students with asthma from showing up at the emergency room. This program saved lives and money.

To date the performance of Maryland hospitals the new waiver’s criteria to date is strong. In the first year, we achieved $116 million in savings for and expenditures for hospitals and physicians fell, unlike the upward trend in the rest of the country. Hospitals are still working toward further reducing readmissions and hope to meet all of the goals established by the waiver agreement.

Dr. Colmers described this waiver as “a call to action” that creates a path to sustainable, impactful change. The new gold standard is “quality” and we need to measure it and work together to achieve it.

Next, a panel of local providers spoke about their work under this new waiver. Dr. Jinlene Chan noted that in her role as Health Officer, she has primary responsibility for achieving the shared population/public health goals. Public health has long been focused on population health, esp. serving those residents who have greater barriers to accessing care. The department’s focus has been on community health principles. They are accustomed to responding to social, community, family and environmental factors that can impact health. Dr. Chan used Community Health Nurses do home visits as an example of how their work in the community gives them a much better picture of how the context can impact the health outcomes an individual can achieve. Additional programs she referenced include:

* [REACH program](https://www.aahealth.org/programs/uninsured/adults/reach)- Local medical providers have agreed to serve uninsured/underinsured residents at free or discounted rates. The health department provides case management.
* [Healthy Start Home Visiting Program](http://aahealth.org/programs/children-services/babies/healthy-start)—nurses visit high risk pregnancy to try to coordinate care. They often find that stressors (job loss, lack of support system, housing) are what most put that pregnancy at risk. The Dept. of Health can serve these women
* The [Healthy Anne Arundel Coalition](http://aahealth.org/about/healthyannearundel) is building community capacity to assist residents to achieve health and wellness through partnerships.
* Hispanic Health Network—group of Hispanic groups and faith based organizations to promote health in specific areas (obesity prevention, cancer, etc.) **English: 410-222-7143  Spanish: 410-222-4479** at 3 Harry S. Truman Pkwy., Annapolis, MD  21401
* [Health Smart](http://aahealth.org/health-smart) Church program trained and worked with churches to address high blood pressure. It did not get funded, but the hospital is taking it on. It allows them to reach further into the community.
* [Mental Health Agency have crisis response program](http://www.aamentalhealth.org/pr_warmline.cfm). Case manage and coordinate care (housing so that immediate medical needs can be met)

Dr. Chan also described a recent planning grant award from the HSCRC for the Bay Area Transformation Partnership. The stakeholders involved in the partnership include Anne Arundel Medical Center, Baltimore Washington Medical Center, MedChi, the local departments of health and social services in an effort to weave our systems together. Deliverables for the grant include an interim report due this September and final report in December. The goal of the grant is for these players, who serve many of the same residents, to better align their systems to better meet the consumers’ needs. This will include strategic IT to connect communications together, while protecting consumers’ privacy.

**Karen Olscamp, President and Chief Executive Officer of the University of Maryland Baltimore Washington Medical Center** (BWMC) made a presentation on the hospital’s response to these efforts. They are prioritizing better coordination of care, further development of their clinical program and actively promoting health and wellness in the community. BWMC partners within and beyond the hospital campus will put clinical information in the hands of trusted providers so care can be more coordinated across settings. Examples of external partnerships include working with CVS minute clinics and federally Qualified Health Centers.

BWMC found that the most common reasons for readmission is lack of follow-up appointment with primary care provider and lack of adherence to medications. In response, they are providing bedside delivery of medications and helping to schedule follow-up appointments prior to discharge.

From this experience, they found that mental health patients had to wait 6-8 months to get a follow-up appointment. So BWMC created a psychiatric bridge program to provide that timely care and serve as a “bridge” until the patients could get an appointment with their main doctors.

BWMC also offers an elective “centering program” for pregnant women. Some care is provided individually and some in group sessions. It creates a support network. Thus far, the clinical outcomes are very impressive. Pre-term delivery rate is 2% countywide and it’s 12% among centering program participants. Low birth weight is 11% county-wide, but 4% among centering program participants. It is an example of a program that is achieving the Triple Aim Dr. Colmers mentioned in his presentation with better patient experience, better clinical outcomes achieved in a cost-effective manner. Because some of the care is provided in groups, it is also helping to address provider shortage.

**Paula Widerlite, Chief Strategy Officer of Anne Arundel Medical Center**  (AAMC) then spoke about her hospitals approach to population health. AAMC developed a [strategic plan in 2009](http://www.aahs.org/aboutus/v20.php) with a redefined mission, vision and values.

Ms. Widerlite discussed the changes in the health care landscape, particularly relating to how their hospital manages transitions of care and responds to needs identified in their Community Health Needs Assessment. They identified obesity, behavioral health, cancer (lung and melanoma) diabetes, and health disparities among the top concerns locally. They are preparing to do another Community Health Needs Assessment to determine how to better intervene on these issues further up-stream.

Ms. Widerlite also referenced how AAMC is working with community health workers to assist with case management, health coaching and patient-self-management. They may meet with a patient in the patient’s home.

AAMC offers patient and family centered care. They have 80+members of patient and family advisors who provide direct consumer feedback that has been invaluable to the hospital’s strategy and development. AAMC has facilitated this degree of consumer engagement for the past 40 years. It has improved their capacity to respond to these new challenges and change.

Other specific ways AAMC is incorporating more patient-centered population health into their standard operating procedures include routine screenings for domestic violence, BMI, etc. They also promote access to care through patient centered medical clinics at Forest Drive and Morris Blum. At these sites, patients may or may not have an appointment but will still be able to be seen. They take a strength based approach to care planning and treatment. These efforts have been successful in helping residents be healthier and avoid unnecessary hospitalizations.

**Suzanne Schlattman, Deputy Director for Community Outreach and Development** then presented on the Congregational Health Network, an evidence based model of hospital-community partnerships to reduce avoidable hospitalizations. Ms. Schlattman walked the assembly through the model from the perspective of a patient.

The Congregational Health Network was established in 2006 as a partnership between Methodist LeBonheur Hospital and local clergy. They developed a covenant agreement that committed the hospital to hiring dedicated staff to work with the faith leaders to promote the health of their congregants. Whenever a congregant is admitted to the hospital and authorizes the hospital staff person to alert the faith-based representative, together they identify ways the patient’s faith community can support them and their family during this tough time to regain their health and full functioning. Many faith leaders like this model because often they don’t learn about a congregant’s needs until it’s too late. They can provide a lot of support, but it has been difficult to connect those resources with those who need it the most.

In Memphis, they report spending $600K of their community benefits dollars on the program, while saving $4 million annually in having a healthier community and reducing uncompensated care. Ms. Schlattman said that this is a great model that aligns well with the themes discussed in this forum. It will be piloted by LifeBridge Health this year and their coalition helps to spread the model. She urged to consider it in the mix of population health interventions and offered the coalition’s support in moving an initiative like this forward locally.

**Bishop Larry Lee Thomas, a very involved local faith leader** responded, noting that Anne Arundel County already has a strong faith network from which this could be built.  He is the pastor of the Empowering Believers Church, Religious chair of NAACP of Anne Arundel County, Presiding Prelate of The General Assembly of the St. James Churches, and a member of United Christian Clergy Alliance (formerly United Black Clergy where he served as president for 13 years.) He also serves on the board of directors of the Maryland Citizens’ Health Initiative.

Over the years the faith community has been partners with the hospitals, health departments and other community base health system. They have done outreach with these institutions in numerous ways. In this role, the faith community has been a central part of the transformation of health care and they would like to be recognized as the boots on the ground.

Many local places of worship have food pantries and other ministries that do outreach into the community. The faith community is still sounding an alarm through education and empowerment.

Bishop Thomas leads the Smoke free Holy Ground Initiative, a coalition of over 300 churches that prohibit tobacco use on church property. They educate their youth groups about the dangers of tobacco while wrapping their arms around and supporting their members who are trying to overcome addiction to tobacco.

Bishop Thomas said that the faith community has and will always have a holistic approach to caring for people and they look forward to being involved as these partnerships and alignments take shape.

**Novella Tascoe, Executive Director of Community Health Services at Keswick Multicare Center** and sub-group member of the Consumer Engagement Taskforce, spoke about how the HSCRC recognizes and values consumer engagement in this health system transformation. They recognize that no meaningful change can be made without first having the true engagement of the individuals that these changes are intended to serve.

The HSCRC is working to do this in two avenues. First, by providing public forums like this. The other way is through partnerships with hospitals and learning how best to promote collaborations across providers. They created the Consumer Outreach Taskforce led by Vinny DeMarco and the Consumer Engagement Taskforce led by Leni Preston.

The goal of the Consumer Engagement taskforce is to promote collaboration between people and health care providers to improve health in Maryland. They will also make recommendations on how hospitals can be more consumer-centered.

They also hope to help promote health literacy among consumers.

The taskforce will issue a draft report for public comment in August and will issue a final report of recommendations/considerations to the HSCRC in September 2015.

15 min for discussion

A gentleman from the United Methodist Men shared that he recently suffered from a heart attack but had received good care from Johns Hopkins. He provided a critique that health resources are concentrated in certain parts of Anne Arundel County and not spread out to meet the needs of all residents. Dr. Chan responded that the county has 4 Federally Qualified Health Centers for anyone of any income. Total Health Care is coming to Anne Arundel County (they are looking at a location in Odenton.) She said that he could expect to see options growing throughout the region. Ms. Olscamp of BWMC also responded that they are excited that Chase Brexton just opened a clinic near their facility in December 2014.

Becky Boeckman, Director of Pastoral Care at First United Methodist Church in Laurel thanked Dr. Chan for her leadership and for the good forum. As a Faith Community Nurse, she urged the hospitals to reach out to faith community nurses in the region and their affiliated health ministries to support their goals of helping the population be healthier. She said that they are there for their church and their broader community.

A gentleman who serves as a legislative aid to the Anne Arundel County Council thanked Dr.Chan. He said that while they were working on the budget, they received a lot of comments about needs for health care services in the schools. The example Dr. Colmers gave about hospitals in Western Maryland providing early intervention for students with asthma. He asked how that type of project might be developed in Anne Arundel County. Dr. Chan reported that there are school psychologists in all schools in Anne Arundel County. They have been bringing mental health providers into the schools that need it for medication management within the school setting. They serve many students who wouldn’t get services otherwise. They are finding that younger children are presenting with complicated mental health conditions.

A representative from Seeds for Success described their program as one that serves kids and families in public housing, including many for whom English is a second language. They have a great partnerships with AAMC and the school system. He asked about a system-wide plan to provide primary care to families in public housing. Dr. Chan responded that they recognize that non-native speakers and those who don’t have legal status experience significant challenges accessing care. In these cases, she said the Hispanic Health Network, churches, and other community based organizations provide tremendous support.

Dr. Nelson Goodman, a local provider and board member of the Maryland Citizens’ Health Initiative raised the issue of high rates locally of heroin overdose, HCV and HIV. He said the “war on drugs” is fueling these health care problems. It will be an issue before the UN in 2016. It is important to have an enlightened health care community when we have to face these problems.

A representative from the MD Department of Aging asked, “How are we going to better connect systems serving older adults and people with disabilities in multiple counties?” They spent the last ten years setting up a system to screen people about resources and providing action plan (caregiver supports, helping with Medicare payments, etc.) She asked how her agency could better connect with hospital systems. Dr. Chan said that the Department of Aging is a partner in the Bay Area Transformation planning grant and integration is the focus.

DeMarco closed the forum, thanking everyone for participating. He reminded everyone to fill out their evaluations.