**Montgomery County Forum on Maryland's All Payer Health System Transformation**

June 15, 2015

5:00-7:00PM

Holy Cross Hospital, 1500 Forest Glen Rd, Silver Spring, MD 20910

~73 attendees

**Welcome**

**Kevin J. Sexton, President & CEO of Holy Cross Health,** thanked representatives from faith communities, hospitals, officials, and the general public for attending the forum. He stated that everyone has an opportunity to make healthcare better and make it more attuned to the needs of the public while also making it more economical. It is important to understand the conditions that the federal government has imposed to give us this special permission to have the waiver. Maryland cannot spend more on healthcare growth than the growth of the Maryland economy. What Maryland hopes to do is challenging and has never been done before. He concluded that if we are going to get this done it will take team work, which is why they decided to host the forum. Mr. Sexton then thanked Vinny DeMarco from Health Care for All! for this opportunity.

**New Maryland Health Care Landscape**

**Vinny DeMarco, President of Maryland Health Care for All!,** said that it has been a privilege to work with people all over the state to expand healthcare in Maryland. He thanked Kevin Sexton for being a leader for healthcare in the state. Mr. DeMarco stated that hospitals are working with communities in a unique way to make healthcare better for everyone, and that we are fortunate to have the Health Services Cost and Review Commission (HSCRC). The HSCRC created two taskforces to engage consumers to make sure that health system transformation in Maryland works well. This forum is a part of the work of one of those task forces to educate attendees about what is going on and to hear from attendees about how to make this successful. This is the eighth forum Maryland Health Care for All has hosted and two more are coming up. Mr. DeMarco walked through the agenda and requested that participants fill out evaluation forms at the end. He then recognized David Romans of the HSCRC for his role in helping design health system transformation.

**David Romans, Director of Payment Reform and Innovation at the HSCRC,** recognized the great role that consumers and community leaders are playing in health system transformation. Mr. Romans stated that health reform is more than just health exchanges—the ACA also created a Center for Medicare and Medicaid Innovation which was charged to create demonstration projects around the country to improve healthcare. Maryland has the largest demonstration in the nation.

Challenges in Maryland for healthcare include high costs, fragmentation and variation (not much communication across different kinds of providers), workforce shortages (particularly in rural areas), coverage and access (not everyone with new coverage has received education on how to use it), health care disparities (particularly for minority communities), and an aging and sicker population. As the population continues to age, there will be more challenges ahead. Mr. Romans shared data showing that costs in the US are increasing faster than other developed nations without generating comparable improvements in health outcomes. In addition, he pointed out that 15% of Medicare Beneficiaries in Maryland have 6 or more chronic conditions, which account for ½ of the cost.

Mr. Romans compared Medicare beneficiaries to state and national averages for disease prevalence. Montgomery County has a lower rate of diabetes, high cholesterol, and high blood pressure than the national and state averages.

Mr. Romans then asked, “What can we do to improve healthcare in Maryland?” He discussed three goals in the Triple Aim: 1) improve the health of the population, 2) enhance the patient experience of care, and 3) reduce the per capita cost of care. In the past Maryland was excited to improve any one aspect, and now we are trying to improve all three at the same time. Currently the HSCRC is trying to work with hospitals, physicians, providers, and communities to achieve these goals. Next year they are hoping to make improvements in care coordination and care for the chronically ill.

All of this means that Maryland is moving away from paying hospitals based how the volume of care, and changing it to be paid for providing better care. This is a big change in the system, and everyone needs to be engaged to make it successful. Maryland is in a unique spot because it has set hospital rates since the in the mid-1970s via the independent 7 member commission, the Health Services Cost Review Commission (HSCRC). In Maryland any carrier will pay the same amount for the same service in any hospital, which means we have lower rates than elsewhere in the country. This requires a partnership with the federal government because they are the Payer for Medicaid and Medicare. In this way Maryland funds access to care, is transparent, links quality and payment, and provides hospitals direct access to regulators.

In 2014 Maryland received a new federal agreement with Medicare via a 5 year demonstration project grant. For patients and families, this means that hospitals are going to be more focused on quality of safety and patient satisfaction because their funding streams are now tied to their scores on these measures. Patients and families can also expect better care coordination when hospital patients go to another facility or home—change can include having prescriptions at discharge and getting better instructions. Consumers can also expect more outreach from providers, especially those with chronic illness. Ultimately Maryland is trying to move the system to provide the right care at the right time in the right place for the right price.

This new system has been tested in Maryland for 4 years among rural communities, which has resulted in better quality, reduced costs, and reasonable profitability for hospitals. Mr. Romans described examples of successes in Maryland. One hospital collaborated with schools to reduce asthma through home visits. Another hospital sends its doctors into the nursing homes to do rounds with patients to avoid readmissions back to the hospital.

Mr. Romans concluded that it is going to take communities across the state working together to educate patients and consumers about these changes. The HSCRC’s interest is the public interest—they have no financial stake in the process. The focus of this transformation is to be proactive, not reactive. Value is the new gold standard. Having gone through a year of this approach, the initial results are very positive. There has been a reduction in hospital acquired infections and other outcomes, and hospital finances have remained stable. The growth of healthcare costs in Maryland grew slower than the national rate.

At this point, **Mr. Demarco** recognized the Maryland Health Care for All! staff and **Ken Reichert from Senator Cardin’s office.** Mr. DeMarco then introduced the local panel.

**Local Panel**

**Annice Cody, President, Holy Cross Health Network, Holy Cross Health** discussed a new regional partnership program called Nexus Montgomery, which is one of eight statewide efforts funded by the HSCRC. The goal is to improve the care of seniors who are frail and/or have multiple chronic conditions who live in Montgomery County. The project is a community collaborative, which includes the 4 hospitals in Montgomery County represented at the forum, 25 senior living communities, community-based healthcare and social service agencies, Montgomery County DHHS, the Primary care coalition of Montgomery County (project managers), and technical experts. Ms. Cody stated that the funds from the HSCRC over the next 6 months will allow them to create a care management model using expert knowledge that will be sustainable.

Teams made of nurses and community health workers will work together to create and implement care plans by making connections and identifying gaps. Effective risk assessments and serving people in their homes will be key features. Nexus Montgomery will work with senior living communities to reach people where they live. Nexus Montgomery will also leverage existing resources by building better connections. Another important feature is engaging participants in their care planning—doing things “with” people rather than “to” or “for” people. The last component is a rigorous design to make sure that the system is effective and sustainable.

**Patrick Garrett, MD, President, Adventist Medical Group and Senior Vice President** described being frustrated that when patients left his office, he did not know what happened to them afterwards. Now in his position, he can help create a system that provides better care. Adventist is trying to figure out how to bring together different physician groups. One gap is having people agree on the system. Dr. Garrett stated that they are creating an accountable care organization that brings different systems together, called One Health Quality Alliance (OHQA). This is a physician-led clinically integrated network designed to help providers enhance the quality of healthcare and lower total costs for the Washington, DC region. OHQA and its participants must accept responsibility for improving quality and lower costs, track and report on different measures, regularly review performance, collaborate and agree upon protocols that minimize variation in care, invest in resources needed, and be physician-led. It is important that data move with the patient so that providers can access it. Patients with multiple chronic conditions really need physician leadership.

**Robert Rothstein, M.D., Vice President, Medical Affairs, Suburban Hospital** stated that quality and affordable healthcare for all is our goal—how we will get there is the challenge. Population health requires looking groups of people while still treating each patient as an individual. Suburban Hospital has established an “Office of the Patient and Family Experience.” Suburban has continued efforts with the Patient and family Advisory Council (PFAC) which is part of Suburban’s committees. They are consulting with the Studer Group and have formed an ACO, which includes providers in the Johns Hopkins Network and beyond.

Dr. Rothstein stated that it is very important to promote care coordination because patients will interact with multiple health care providers in different settings. The “My Get Well Kit” is a brochure that helps consumers with health literacy that received an award from the Institute for Plain Language. It helps patients write things down and leads them through thedischarge and recovery process. Patients who get in to see their physician within 7 days after discharge have better health outcomes, so they have created a Patient Transition Coordinator pilot program. They also have physicians do rounds at nursing homes, make post-discharge phone calls to check up on medications, and try to provide care partners and Health Buddies so that the patient’s caregiver knows all pertinent health information to provide effective support. Suburban supports palliative care fellows as well as endocrine/diabetes fellows. It has been alluded to that electronic systems are difficult to coordinate, and this is true. Some systems Suburban uses include CRISP (a statewide electronic system), CareLink (a patient portal), and Curaspan (for nursing homes to access patient data). Suburban also is creating clinical protocols to ensure consistency of care.

Dr. Rothstein discussed providing care in the most appropriate setting—e.g. making sure that patients within the hospital end up in the correct area, then also make sure discharged patients end up in the correct community health setting (outpatient surgery centers, physician offices, urgent care (such as Patient First), acute care in nursing homes, and specialty clinics).

**T. J. Senker, Chief Operating Officer, MedStar Montgomery Medical Center,** stated that MedStar has a vision for population health called MedStar 2020. It’s about adjusting their system to meet patient needs and provide coordinated care. MedStar Montgomery Center created a program in Aspen Hill based on their community needs assessment. They identify uninsured residents who may be at risk for heart disease, then provide monthly screenings (blood pressure, cholesterol, glucose levels, etc.) and counseling for healthy lifestyle habits. Residents are then referred to primary care for follow up. Since February of 2014, 90 residents have been screened.

Mr. Senker discussed two more programs: one program is focused on the emergency department and primary care connection. Low-income uninsured patients are referred by navigators to primary care—so far this has been done for over 370 patients. Another program is the Healthy Montgomery Hospital Workgroup, which is comprised of the four hospitals on the panel.

**Maryland Faith Community Health Network**

**Suzanne Schlattman, Maryland Health Care For All! Coalition,** theninvited the assembly to envision themselves in the role of the patient amid health system transformation and consider the potential benefit of building religious-health partnerships to help patients in their communities adjust to the new system. Imagine yourself sick and at the hospital and being asked by the hospital if you are part of the Congregational Health Network. You vaguely remember signing up after worship and say yes. A navigator loops in a liaison from your congregation. Someone from your congregations comes to visit you and sits with you while the hospital describes your discharge plan. You feel at peace when you are discharged. But, once you are home, you forget some of the details about your after-care. You speak with your liaison, who does not miss a beat—they call your navigator at the hospital and get all of the information you need to fully recover.

Ms. Schlattman described that this scenario represents the Congregational Health Network, piloted in Memphis Tennessee in 2006 at Methodist LeBonheur Hospital. The hospital there entered into a covenant with local faith leaders to reduce avoidable hospital stays among members of their congregations and communities. They found that this arrangement—where the hospital provided additional staff to work with a volunteer liaison appointed by the congregation to help care for people after they left the hospital—had a positive impact on consumer satisfaction, adherence and spending. To date there are over 600 congregations who are part of this network, with ~20,000 members as part of the network. The hospital spends $600K of their community benefits dollars on the program and reports saving $4 million annually. Ms. Schlattman noted that our coalition believes this model can help Maryland health care providers achieve the goals of the waiver. Anyone who is interested in this project should contact Ms. Schlattman (Suzanne@healthcareforall.com) or 410-235-9000.

**Rev. Kasey Kaseman, Interfaith Community Liaison for Montgomery County** recognized faith leaders’ long partnership with Maryland Health Care for All to expand healthcare for Marylanders. Rev. Kaseman discussed his role as Interfaith Community Liaison to leverage resources to improve healthcare. Their healthcare committee seeks to reaffirm the spiritual dimension of healing that will shift focus from disease and profit to wellness, prevention, integrative, patient-centered healthcare. The committee gives special attention to the poor and vulnerable. They identify key partnerships with other organizations that share their vision, creating an atmosphere for collaboration and constructive change, and providing educational opportunities for faith communities to become effective advocates. The committee includes representatives from the Primary Care Coalition, Washington Adventist Hospital, Holy Cross Hospital, Suburban Hospital, Interfaith Works, Community Ministries of Rockville, and a number of congregations. Their top priority has been enforcing the ACA and advocating for funding for outreach. They successfully advocates for one part-time person for 2 ½ months who made 16,000 direct contacts and contributed to many people being enrolled. He discussed frustration at funding being reduced for outreach. Rev. Kaseman hopes to leave this forum having made new partners to collaborate in improving healthcare in the county.

**Dr. Irance Reddix, St. Johns United Methodist Church,** spoke to the Faith Community Health Network model from the perspective faith leader, health care provider, and community member. The Maryland Faith Community Health Network is a web that connects the patient in the hospital to their home and community in a seamless way. When people are hospitalized, the navigator calls the patient’s pastor/imam/rabbi and involves them in the process. The liaison walks right along with the patient and helps with recovery. The liaison knows the member, their likes and dislikes, their needs. That advocate speaks to the patient in a way they understand to make sure they know what is going on. Once the patient feels better, the liaison helps them reintegrate with the congregation and feel whole again. In Memphis, patients talked about having a great experience with their hospitals and congregations because it was a person-to-person, community-to-community experience. Rev. Dr. Reddix concluded that under the model proposed today, “people know your name. They know who you are—they aren’t just concerned with where you live, what your illness is, or what hospital you go to the next. They care about you as a person, how you are feeling, and whether you make it to the congregation.”

**Mr. DeMarco then** announced the LifeBridge Health is piloting this network in the fall at Carroll, Sinai, and Northwest hospitals, and recognized various faith leaders throughout the room.

**Next Steps and Public Outreach**

**Tiffany Tate, Consultant for Health Services Cost Review Commission,** discussed the consumer engagement taskforce. When the HSCRC began the work with the all-payer-model, they decided it was important to engage consumers. They brought in Vinny DeMarco to lead the consumer outreach task force and Leni Preston to lead the consumer engagement taskforce. The Consumer Outreach Taskforce is hosting forums around the state to educate the public about health system transformation and working on the Maryland Faith Community Health Network. The Consumer Engagement Task Force is considering what consumer engagement means and what tools they need to be engaged. They also encourage consumers being involved in policy development. In order to ensure the health system is consumer-friendly, they are first focusing on health literacy—it starts with health insurance literacy, then health care literacy, and finally full patient engagement. Second, they are working on getting recommendations from consumers about ways for consumers to provide feedback for hospitals. Next steps include issuing a draft report of recommendations and considerations in August 2015 and then a final report to the HSCRC in September 2015.

**Q&A and Discussion**

**Mr. DeMarco** thanked NAACP members for attending forums, and reminded attendees to fill out their evaluation forms and take a group picture at the end.

**Q: Virginia Richardson, Unitarian Universalist leader,** stated that a number of attendees here went to a monthly Democratic Central Committee breakfast this morning. Mark Elrich, of the Montgomery County Council, said that they need more money than they have for basic needs like public transportation, etc. that will impact the consumers’ ability to be well and healthy. Ms. Richardson came away with a deep sadness about the lack of resources. She asked, “To what extent will deficits and lack of income for Montgomery County affect health system transformation?”

**A:** **Mr. DeMarco** responded that if done correctly, health system transformation will result in better care and lower expenditures. For example, the Congregational Health Network saved the hospital money in Memphis and resulted in better health outcomes.

**Q: Kathy Deerkoski** said that Mark Elrich was concerned about uncompensated care from undocumented immigrants.

**A:** Mr. DeMarco responded that the Maryland Faith Community Health Network would also help undocumented immigrants

**Tom Pruski from Wesley Ecumenical Seminary,** stated that he was excited to work with Kasey Kaseman to talk about how to work together. Nobody has unlimited resources, including the faith communities, who don’t have unlimited volunteers. Spirituality and prayer are a big part of health recovery. Mr. Pruski asked faith community health nurses in the audience to stand up—about 6-9 individuals stood up. Mr. Pruski would like to work with them.

**Q: Neville Ramroop** stated that everything at the forum presented was good. What will happen if people on Capitol Hill reverse the ACA?

**A: Mr. DeMarco** said that hopefully that will not happen. However, this health system transformation is independent of the ACA and independent of politics.

**Q:** **Rev. Louise Malbon-Reddix** stated that she is a nurse and a minister and does faith health nursing. In Maryland there are still a lot of disparities, and she hopes that this work will reduce those disparities. She would like to hear more about this work addressing disparities. She believes that increasing consumer engagement and getting nursing homes to be more proactive will help.

**A:** **Mr. DeMarco** stated that the Maryland Faith Community Health Network is a way to address disparities.

**Q:** **Megan Pauly, NAMI,** asked how this fits in with meeting behavioral health needs.

**A:** **Annice Cody** said that Holy Cross looking at partnerships with behavioral health organizations.

**A:** Megan Pauly stated that NAMI is looking at having volunteers available in a similar role to liaisons in in the Maryland Faith Community Health Network.

**Q:** **Ms. Jones**, faith community nurse program at holy cross hospitals, said nurses have been in the churches doing this for a very long time as registered nurses. She asked in the model presented, where does the faith community nurse fit? Most of these nurses are not paid by their congregations—will they be paid under this model?

**A:** **Mr. DeMarco** said we do not have funding, but in Memphis congregations decided who their liaisons were. Sometimes it was a nurse, and sometimes it was a lay person. Whoever the congregation chooses, the hospital is obligated to work with that liaison.

**A:** **Rev. Dr. Irance Reddix** stated the liaison does not necessarily have to be a faith community nurse. The faith community nurse might even be over-qualified to be a liaison. We don’t have the funding to pay, but what nurses bring are additional resources to this network.

**A:** **Tom Pruski** stated that hehas been working on creating more faith nurses throughout.

**Odile Brunetto**, DHHS Aging and Disability services, said she would like to participate in this project.

**Wendy Friar, Holy Cross Health,** talked about Community Health Workers (CHW’s). Their model addresses inequities in care. CHW’s work hard to make their work culturally competent and linguistically accessible. They work with Montgomery County DHHS. CHW’s are with people in the streets, address their needs, and lead them to resources. As we look at faith programs, it’s important to remember that there are many CHW’s (some volunteer, some stipend, some salaries) who are great at meeting needs of communities as they do house visits and house calls.

**Q:** **Teresa King**, co-chair of the Behavioral Health Coalition African American health program, asked hospitals “How are you engaging peer advocates in community health?” As Medicare has opened up a lot of roles to be positioned to be reimbursed, how are hospitals reaching out to people who are certified to help, especially for behavioral health?

A: **Annice Cody** said that she saw recently a copy of the Montgomery County Behavioral Health Plan, which included making better connections between behavioral health organizations and other organizations. Looking at that plan and seeing how the connections could be made would be a great next steps.

A: **Tiffany Tate** responded that the HSCRC gave grants around the state. Each grantee had to have a consumer engagement component. The University of Maryland has a workgroup that focuses on behavioral health integration in primary care and will be having focus groups.

A; **Pegeen Townsend**, MedStar, said this is a top issue that hospitals around the state are focusing on because behavioral health is a big driver for readmissions. This is a very high priority for hospitals and it optimistic—the financial incentives may be right this time to make it work.

Q: **Susan DeFrancesco**, Institute for Public Health Innovation, took care of her father for ten years and was his advocate. She stated that it is very necessary to support caregivers. What about policies that can sometimes make things too costly? The assisted living place her father was in had a policy that if the person falls, they had to be taken to the emergency room no matter what even if nothing was wrong. How much of the transformation has to do with policies in community based settings?

A: **Annice Cody** said this is important and thinks there is movement on a case-by-case basis and in pilot forms They are working with EMS in Montgomery County looking at alternatives for 9-1-1 that are less invasive and costly and is a better experience for that patient. It is important to keep looking for opportunities and after pilots show success of changes, it could be shared more broadly.

Q: **Kathy Coleman**, faith community nurse coordinator at Adventist Health Care, asked as the program is implemented and extended between hospitals and churches, is there an opportunity for faith community nurses to sit at the table for planning purposes. Through their network, they encouraged faith community nurses to attend the forum.

A: **Mr. DeMarco** said absolutely yes and asked Ms. Coleman to provider her contact information. There are two ongoing roles—the navigator at the hospital (who could often be a faith community health nurse) and the liaison at the congregations (who sometimes is a faith community health nurse). As the program is developed, it is very important to have faith community nurses at the table.

The meeting concluded at approximately 7:05PM, with a group picture and networking immediately afterward.