**Northern Maryland Forum on Maryland's All Payer Health System Transformation**

Co-Sponsored by Maryland Health Care for All! and the Northern Maryland LHIC

February 11, 2015

8:30-10:30AM

Carroll Hospital Center, Shauck Auditorium

291 Stoner Ave., Westminster, MD 21157

**Minutes**

**Welcome**

Dr. Henry Taylor, the Interim Health Officer of the Carroll County Health Department, welcomed the assembly to the meeting of the public forum on health system transformation. He noted that the changes that are coming are good ones, but will require assistance from many stakeholders—including those who may not have been previously explicitly engaged in public health or direct health care work.

Kevin Kelby, CFO of the Carroll Hospital Center, welcomed everyone to the Carroll Hospital Center. He agreed with Dr. Taylor, citing specific ways the hospital has modified their approach and become more seamlessly interwoven into the whole local health care systems. He thanked everyone for taking the time to be a part of these important discussions and looked forward to continuing the conversation even after the forum through new collaborations.

Vincent DeMarco, President of the Maryland Citizens’ Health Initiative and Health Care for All! Coalition served as MC for the event, highlighted location logistics and noted that the meeting was being recorded. He also clarified that this is the third of ten regional forums that the Coalition is conducting throughout the state in the coming months.

**New Maryland Health Care Landscape**

Donna Kinzer, Executive Director of the Maryland Health Services Cost Review Commission (HSCRC), explained the New Maryland Healthcare Landscape. Health reform is more than just addressing coverage issues through the health exchanges. High costs, workforce shortages, fragmentation and variable quality have led to significant health disparities. Considering our aging population, there has been interest both at the system level and consumer level to improve care coordinating and reduce costs.

Ms. Kinzer reported that The United States spends more on healthcare than other nations, but does not have better outcomes. Nationally, 14% of Medicare beneficiaries have six or more chronic conditions, which accounts for half of the cost of total Medicare spending. Of Medicare beneficiaries, 27% have diabetes, 45% have high cholesterol (more in Carroll and Frederick Counties), and 55% have high blood pressure (slightly less in Frederick County). Maryland has worse prevalence than the national average for all three diseases.

Ms. Kinzer explained that the Institute for Healthcare Innovation has called for a “Triple Aim” for healthcare improvement that includes efforts to simultaneously improve the health of the population, enhance the patient experience of care and reduce the per capita cost of care.

Maryland’s response to this charge has been to innovate on how hospitals are paid. A new culture for patient care will emerge over a three year period. Payment will move away from fee-for-service. “The more you do the more you get paid” is being replaced with “The better you do the better you get paid.” Providers are assuming more responsibility for outcomes, which will require integration and collaboration. Change is here and now.

Ms. Kinzer discussed how since the 1970s, hospitals were paid at a rate set by the HSCRC, rather than by each individual payer. This was made possible by a waiver from the Center for Medicaid and Medicare Services. Maryland is the only state in the nation with this waiver.

As a result of this arrangement, compared to the rest of the nation our system was able to hold down costs, have better transparency, link quality and payment, create local access to regulators, and fund access to care.

Maryland had to renegotiate the terms of this waiver in 2014. The new federal agreement is a 5 year demonstration with CMS that focuses on holding down costs, provides rewards for improving outcomes, and encourages team work across the health care system.

Key implications of this change for patients and their families include the fact that a growing amount of revenue will be based on quality, safety, and satisfaction scores, which will require hospitals to become more patient and family-centered. Patients and their families will now be able to expect improved transitions of care from the hospital to their local provider. Primary care providers will be able to expect more outreach and partnership with their local hospital, especially for those with chronic illnesses. Ultimately, it is expected that this will help individuals get the “right care at the right time at the right place and at the right price.

Ms. Kinzer closed with a statement that the new arrangement with CMS is a call to action that will help everyone who is working to make Maryland’s health care system better, work together towards a clear common goal. It creates a path for change that is proactive, not reactive. Value is the new gold standard, with a focus on quality, appropriate hospital care, new partnerships, cost efficiency, and population health focus.

**Local Response**

Sharon Sanders, V.P. of Clinical Integration at Carroll Hospital Center, stated that “we have people who are well, we have people who are at risk for chronic disease, and we have people who have chronic disease.” Historically people who have chronic diseases have received the most attention. Carroll County has learned that they need to put programs in place to keep the well people and people with risk factors stay well. They have also learned that people with chronic disease can become better engaged and become better managers of their own care.

As a result, Carroll is integrating care into the community across multiple settings, including long term care facilities, palliative care, and hospice. They want community members to have proper referral systems and to have access to primary care, transportation, and affordable medications. Ms. Sanders told the story of a family that came to the emergency room for asthma 3 times or more per month. When they investigated further, they found out that the family did not have access to a good heating system at home, which was exacerbating the asthma. The hospital helped the family connect with resources to get a better heating system. This is a success of paying attention to a social determinant of health.

Dot Fox, the CEO/Executive Director of the Partnership for Healthier Howard County, discussed how the Partnership was established in 1999. After an initial needs assessment showed a need for a coordinating hub, the Carroll Hospital Center, Carroll County Health Department, and local community organizations created a partnership that connects people, inspires actions, and strengthens the community.

Barb Rodgers, of Community Health Promotion for the Carroll County Health Department echoed the earlier comments by Dr. Taylor. She said the health Department was very excited to be collaborating with the hospital on shared population health goals. She specifically noted her appreciation for the data the hospital is sharing with the partnership to aid in deploying effective population health interventions in a timely, effective and efficient fashion. The collaborations have helped all parties avoid duplication of efforts and generate greater synergy.

**Maryland Faith Community Health Network**

Suzanne Schlattman from the Maryland Health Care For All! Coalition presented next. She highlighted an example of successful collaborations between faith and health care institutions known as the Congregational Health Network and then described how and why this model could be integral to achieving the current goals for health system transformation.

The Congregational Health Network was started by Methodist Le Bonheur hospital in 2006 to improve health outcomes for people who frequently visited their Emergency Department and reduce the rate of unpaid medical bills by these patients. The hospital entered into a “covenant” with local faith leaders that committed the hospital to hiring Navigators to work with the faith leaders whenever someone from their congregations were admitted to the hospital. The faith leaders agreed to promote the program and provide support to their congregational members when they were discharged from the hospital. As a result of this partnership, the hospital found tremendous improvements in health outcomes for their patients and great cost-savings for their hospital. The hospital reports spending $600,000 on the program and saving $4 million each year.

Ms. Schlattman shared examples of the covenant agreement between the hospital and congregations and the Community Care Plan. She noted that faith leaders and hospitals in Maryland are very interested in this model. Her organization—with hundreds of local faith leaders and health care professionals-- is currently working on laying the groundwork for a Maryland Faith Community Health Network.

Rev. Irance Reddix of the Baltimore Washington Conference of the United Methodist Church then spoke from her perspective as a primary care doctor and ordained minister. She believes that this model can be successful in Maryland and that these human resources can be helpful to primary care as well as hospitals. She urged health care institutions to consider this model as they look to achieve the goals of the waiver.

**Closing Comments**

Vincent DeMarco then offered closing comments, encouraging those in the room to consider their roles in the work ahead and use this forum as a time to brainstorm what additional collaborations are possible and necessary to achieve the goals of the waiver. He offered the assistance of the Health Care for All! Coalition to support these efforts.

**Q&A and discussion**

One participant had a question about how the behavioral health clinic model works with the partnerships. Ms. Rodgers stated they have put together a universal referral form for the hospital to use. Every time a person comes into ER, even outpatient ER, the hospital can fill out the referral form. The health department then does a cold follow up call to see how they can help them follow up. The Ms. Sanders invited the participant to come discuss the process with them in order to learn more about it.

One nurse asked Ms. Kinzer whether payment reform would include increasing payment for nurses for prevention, for example, for prescription for exercise or home assessment. Ms. Kinzer responded that HSCRC sets hospital rates. Moving from fee for service to global budget means that hospitals are financially incentivized to keep people healthy and not in the emergency room. They can use the savings from not having a person come back to the hospital to do these preventive services.

One participant asked about how the community benefits reporting is structurally changing to ensure that the community truly benefits. Ms. Kinzer responded that the budget for hospitals includes “infrastructure,” and hospitals need to report what they are doing with that money. There is a new RFP for primary care providers, nursing homes, and hospitals come together to decide how they can work together.

One participant asked for more details about the Congregational Faith Network. Rev. Reddix responded that most navigators are nurses. The liaisons are congregation-specific lay people (or in some cases parish nurses) who receive training on HIPAA, ethics, end of life care, support care, how to speak the language from medicine and for faith, etc. If anyone is interested in learning more, Memphis has standing trainings that everyone is welcome to go to.

One community health leader said that the process to get technical assistance for community-based and faith-based associations needs to be part of the infrastructure. We must do training to help people understand the system, particularly for immigrant groups. The business sectors must also be part of this care coordination team. We have to hold people accountable to use dollars effectively to make changes.

One participant asked is there anything in Maryland at the local level going on around physician payment reform so that patients have access to their doctors in the evenings and weekends? Ms. Kinzer responded that there is a big medical home model in Maryland, but nothing in Medicare which has all of these chronic conditions. On January 1 physicians get $500/year for care coordination and that applies to any patient that has 2 or more chronic conditions, which is consistent with what we are trying to do and the medical home models. There are many conditions doctors must meet to collect that fee. There is also discussion happening with the care coordination work group. Ms. Kinzer wants to move this reform forward. Maryland has filed a $35 million training grant application with the federal government and Ms. Kinzer is cautiously optimistic that hospital and physician colleagues will really want to move this forward. It could bring over $100 million to Maryland for care coordination, which would be an amazing opportunity to improve chronic care.

One retired pastor stated that the Faith Network is an excellent opportunity to help connect body, soul a spirit. As a retired pastor, he felt that because of privacy concerns it has been more difficult for pastors to help congregation members who are sick. This is a great opportunity to help people, and also to connect secular communities.

One parish nurse would like to see the faith network implemented in Carroll County. She emphasized that parish nurses can be important in this model and are very effective in keeping the well community well and the at-risk community. They are also a great resource to push out messages in the community that a hospital, health department, and providers can’t do by themselves.

In the last few minutes, one participant mentioned that in Lynchburg, VA there is a dynamic faith community effort starting up. Another participant pointed out that community groups should apply for grant funding to take advantage of this initiative. Another pointed out that addressing homelessness can reduce ER admissions.

Evaluations were collected and the program closed at 10:45AM.