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

Co-Sponsored by Maryland Health Care for All! and Collective Empowerment Group

February 6, 2015

8:30-10:30AM

Location: Sanctuary at Kingdom Square

 9033 Central Avenue,

 Capital Heights, MD 20743

**Minutes**

**Welcome**

Reverend Anthony Maclin, President of the Collective Empowerment Group, offered the welcome at 8:30AM. Rev. Marcellous Buckner offered an opening prayer and invited the assembly to partake of the meal for a $10. Reverend Dr. Earl trent of Florida Avenue Baptist Church in Washington DC offered the meditation on scripture, as is customary for Collective Empowerment Group meetings. They also collected an offering for the Rev. Jonathan L Weaver Scholarship Fund and introduced strategic partners in attendance.

Rev. Maclin introduced Vinny DeMarco, President of the Maryland Health Care for All! Coalition, of which the Collective Empowerment Group is a founding member. DeMarco thanked the group for their support over the years which has directly resulted in advancing Maryland from 32nd to 14th in the country for providing health care coverage to low-income Marylanders. He said that because of the Collective Empowerment Group’s advocacy for a $1 increase in the tobacco tax, smoking rates in Maryland decreased at a rate twice as fast as the national average and noted similar statistics resulting from other related public health campaigns. The Collective Empowerment Group voiced approval and enthusiasm for this progress.

**New Maryland Health Care Landscape** (20 min)

DeMarco introduced Steve Ports of the Maryland Health Services Cost Review Commission (HSCRC), an independent state agency that regulates hospitals and hospital rates. Ports noted that Maryland is indeed in the forefront with health care coverage AND delivery system reform. Many other states—and other countries—are looking to Maryland to see if our efforts to improve cost and quality will be successful. Ports noted that Maryland is the largest demonstration project in the country from the Center from Medicare Services.

Ports described local health disparities, demographic trends of aging and sicker patient populations, coverage and access issues, workforce shortages and high costs (without better outcomes) as key contextual factors at play in Maryland’s health care system. He noted that the size of the population over 65 years of age would double by 2030 and because there are a lot of entitlements for aging population, costs will continue to rise, and therefore we all have a stake, and will be playing a role in ensuring that these reforms are successful.

Ports highlighted local health statistics relative to the state and national average. Prince Georges County has a higher rate of diabetes among Medicare beneficiaries than both the state and national average, but better (i.e. lower) rates of high cholesterol and high blood pressure than both the state and national average. He noted that health system transformation efforts are focused at these chronic conditions because about 1/3 of the US population have a chronic condition and 70% of deaths are due to chronic conditions.

Ports referenced the “Triple Aim” of improved health, improved care and improved per capita costs that is incorporated into the Affordable Care Act. Maryland’s goal in our demonstration project is to achieve significant improvement in all three areas.

He then elaborated on the demonstration project and his organization’s role in the effort. The HSCRC is a seven member independent commission based on the public utility model. The HSCRC sets rates at Maryland hospitals based on costs which is unique in the country. Medicare and all other payers (Medicaid, private insurers, self-pay, etc.) pay the same rates set by the commission. This is also unique in the country. As a result, the HSCRC has held down costs. Hospitals don’t turn people away. There is more transparency on hospital costs and spending.

They are now working on using this commission to achieve the Triple Aim. Hospital rates will be set based on how well they do at keeping people out of the hospital—renewed emphasis and partnerships for wellness and prevention. Ports indicated that hospitals will be more patient and caregiver centered, making sure that patients have their prescriptions filled and follow-up appointments scheduled before they are discharged from the hospital.

Ports noted that some hospitals in rural areas of the state have been operating under this different arrangement for the past four years and have had huge successes, reflected in better population health outcomes and declining costs with stable, reasonable profit margins. He cited examples.

Ports concluded his presentation noting that this is a tremendous opportunity to redirect our health system to keep people healthy—being proactive rather than reactive. He also noted that hospitals will need to be collaborating with primary care and community-based providers like those in the room in order to achieve success and encouraged those in the room to get more involved.

**Prince George's County Health Leaders Response** (30 min)

Pam Creekmur, Prince George's County Health Officer, offered a brief presentation on how the local health department has been preparing for and engaging in the changes described by Mr. Ports. Transportation is a major issue for the majority minority community. The coalition she works with on the Community Care Team is working to make the system well-integrated and intuitive so that patients are able to navigate the system of resources effortlessly.

She highlighted the preliminary outcomes from the Health Enterprise Zone initiative that set a goal to have 5 new medical practices in the 20743 zipcode in 5 years. To date, they have established 3 with a fourth scheduled to open in a couple of weeks. She attributed this success to strong, diverse partnerships across stakeholder groups, perinatal counselors/Community Health Workers, and a grant from the Community Health Resources Commission that she hopes is renewed for another year.

Then Dr. Carnell Cooper, Chief Medical Officer, Dimensions Health Care System spoke about their response to the changes described by Mr. Ports. He noted that this is a true revolution in health care, one that requires providers to treat patients wholistically. He noted that the transition, while good, will be difficult. Dimensions is committed to making sure that all of their patients have a number they can call and a primary care doctor they will be seeing after discharge. Within 24-48 hours after discharge, they will get a call from a nurse to make sure that their meds are okay and answer any outstanding questions. They hope that this initiative will make it less likely that those patients will need to return to the hospital. He also noted that the hospital will be taking advantage of hospital admissions to offer full suite of primary care services to patients; for example, he said they’d be offering the flu shot to all hospital patients while they are there. They are also working on a Telehealth initiative in consultation with patients and providers in nursing homes once a week for a month after discharge.

To address workforce shortage concerns, Dr. Cooper noted that Dimensions collaborated with the health department on opening additional practices to achieve the goal of the Health Enterprise Zone initiative and is also hosting medical residency program at the hospital.

Dimensions is also launching a patient experience committee as a channel for feedback. He encouraged those in the room to engage in that channel and talk with him afterwards to discuss other ideas.

Ms. Christine Wray, FACHE, President of MedStar Southern Maryland Hospital and MedStar St. Mary's Hospital and Senior Vice President of MedStar Health spoke next and opened with a brief history of Southern Maryland Hospital since it was opened in 1977. It is the larges not-for-profit health care system serving the region. She described the system’s response to the new waiver as one with a public health focus, emphasizing patient safety and improving quality. She concurred with the earlier presenters that growing primary care capacity is a top priority and noted that a new clinic will be opening in Brandywine soon. She cited examples of investing in the county to stabilize practices, helping existing practices branch out to new specialties (surgery, breast health, neurology, kidney transplant, etc.) and helping these actors work together most effectively. She said that next month, all physicians in the network will have the same electronic medical record software, making it easier for providers and patients to communicate.

Ms. Wray also noted the availability of MedStar Family Choice and MedStar Medicare Advantage plans to help ensure access to their providers.

**Maryland Faith Community Health Network** (15 min)

Next, DeMarco introduced his colleague Suzanne Schlattman, Deputy Director at the Maryland Health Care For All! Coalition who spoke about an innovative approach to collaboration between hospitals and faith-based community groups pioneered in Memphis.

Methodist LeBonheur Hospital in Memphis entered into a “Congregational Health Network” covenant with 600 local congregations that required the hospital to hire Navigators to work with members of their congregation when they were admitted to the hospital. The Navigator meets with the patient every day that they are in the hospital and consults with them to determine if they want their congregation involved in their care. If so, the Navigator contacts a volunteer liaison identified by the congregation at the time that they enter into a covenant with the hospital, and together they all develop a “Community Care Plan” that ensures that the patient has all of their needs address so that their healing can continue even after they leave the hospital. Examples of elements of a Community Care Plan include things that many faith communities already do—preparng meals, arranging transportation, prayer, visitation, etc. Many congregations like having a single point person they can consult if questions or problems arise after discharge.

Schlattman noted that this program is a part of their electronic medical record and as such, they have been able to track the impact of the program on patient health outcomes and hospital spending. Members of the Congregational Health Network had better outcomes related to morbidity, mortality and length of stay and incurred fewer charges than their peers. The hospital spends $600,000 on the program, primarily from their Community Benefits funding and reports saving at least $4million every year.

Rev. Diane Johnson, Executive Director of the Collective Empowerment Group spoke next. She had joined DeMarco and Schlattman and others on a recent site visit to Memphis to learn about the Congregational Health Network. She said that as a faith leader, she was very impressed by the model and thought that it would be a great one to replicate in Maryland. She elaborated that any local arrangement should take into consideration the needs of the congregation and hospital savings generated by the program should be shared with the faith community to help sustain the ministries that are supporting the patients and contributing to the success of the health system transformation described by Mr. Ports.

**Q&A and discussion** (15 min)

DeMarco moderated discussion. The first question was from Melissa Cramer who is a part of a program funded by NIH in Prince George’s County. She said that while the presenters talked about great programs that are available, most of the people she serves do not know about these services. She asked, “How these services were being promoted?” Health Officer Creekmur replied that funding for promotion is limited and greatly dependent on availability of grant funds.

Pastor Andrea Foster from United by Faith Christian Church asked how Navigators in the Congregational Health Network interacted with chaplains as a part of the hospital care team. DeMarco responded that they are the primary point of contact for the volunteer liaison. Often, in Memphis, the Navigator is also trained as a chaplain.

Another faith leader asked for elaboration on how funds would be available for a Congregational Health Network. DeMarco responded that any replication of the program would have to be tailored to the needs and resources of each community. He also thanked the group for their interest and enthusiasm in the model. Raquel Samson from Amerigroup affirmed this response. She said that if there is an organized interest from the faith community and demonstrated impact and savings, Amerigroup may be interested in investing in the model as well.

Shari Curtis, the ACA program manager for Prince George’s County made an announcement that open enrollment in the Maryland Health Connection closes on 2/15. They are encouraging places of worship to promote awareness of this through “Get Covered Sunday” initiatives the next two Sundays. She also reported that while the county had initially set a goal of enrolling 33,000 residents, they have already exceeded that goal by assisting more than 35,000 residents gain coverage.

Rev. Maclin closed this portion of the meeting encouraging those leaders in the room to network with the guests after the meeting to share contact information and comments. He said that as faith leaders, they hear complaints that can be valuable and funneled back to these leaders to improve the system and make it work better for members of the community. He said this is perfectly aligned with the broader mission of the Collective Empowerment Group and that they’d be following it closely.