**Western Maryland's Forum Health System Transformation**

**April 28th**

**11:00-1:00PM**

Western Maryland Health System

Physician Meeting Room

12501 Willowbrook Road

Cumberland, MD

**Minutes**

**Welcome**

Suzanne Schlattman, Health Care for All! Coalition

 2 goals: Asked for the group’s “words of wisdom” on how hospitals across the state can replicate their success, and asked about how consumers can be engaged to support further improvements in health care outcomes and care coordination.

**Broad Perspective of Maryland Health Landscape**

Steve Ports, Maryland Health Services Cost Review Commission, Executive Director

* ACA – lot more to it than access to insurance coverage – CMMI created, charge w/ improving quality of care and reducing cost – MMD=pilot state
* Fragmentation between community providers and hospitals, besides CRISP
* “Inexcusable” gap across country in care access
* Aging and sicker population – cost and quality implications
* Comm. + edu. needed to ensure coverage works
* Avg. worker is 50 yrs. old – retiring, nurses leave as economy improves
* 2010 – 40 million US citizens over 65, number will double
* All pay through taxes rising health care costs
* US spending growth and percent of GDP = much higher than developing countries, but quality not better
* Many costs are results of chronic conditions – Medicare beneficiaries with multiple conditions suffer from them most
* MD has higher % of Medicare beneficiaries with diabetes, high cholesterol, high blood pressure, than national average
* New Paradigm Triple Aim of CMMI waiver– improve population health, improve care experience, and reduce care cost
* Year 2 of Triple Aim – key item = care coordination btwn. community, community providers, etc.
* Implications of all-payer model – moves system from value to volume-based
* If hospitals do not achieve success, profitability declines
* HSCRC – ind. 7-member commission that provides oversight + reg. of hospitals
* Value of all payer system – hold down costs, fund access to care for anyone who enters hospital, HSCRC collects data and makes it public, hospitals can negotiate payment issues w/o going to Medicare
* New all payer model – 5 yr. demonstration with Medicare – focus on holding down costs, encourages teamwork
* Implications for patients and families – hospitals required to become more patient + family friendly, improved transitions of care between settings
* Model has been tested in MD successfully – preventive, rather than acute, asthma care improved in W. MD
* HSCRC represents public and promotes Triple Aim implementation
* Question about hospitals paying insurance – full billed amount

**Maryland Faith Community Health Network**
Suzanne Schlattman, Health Care for All! Coalition

* Patient enters hospital and place of worship representative is contacted to provide support, continued after retuning home from hospital – drives, meals, prayer
* Faith rep. calls point person at hospital to keep patient on track
* System established at Methodist LeBonheur Hospital in Memphis, TN – 2006
* Designed covenant agreement for Congregation Health Network (CHN) – hospital hires full-time employee (navigators) to work with liason reps. Appointed by congregations
* Goal was to work with 400 congregations, now work with 600
* Congregational Care Plan – congregation decides what capacities it has to help healing process
* CHN improved mortality, length of stay, time-to-readmission, charges, referral to other comm. Services
* LifeBridge hospital interested in network
* Question about how comm. health workers fit in

**Local Response**

Joyce Hedrick, Parish Nurse Coordinator- Western Maryland Health System

* 90-90-20 rule, applied to Parish Nursing – 90% of people lie 90% of their lives with 20 miles of birth
* 1974 – Granger Westburg of Chicago, physician/Lutheran minister, initiated a model of nurses in health ministry – focus on preventive care
* 1997 – W. MD Health System (WMHS) began Local Parish Nurse Program
* Annual Westburg Symposium in Memphis, TN
* Health Ministries Association – faith comm. nurses, health ministers (not RNs)
* WMHS mission – superior care for all served
* 36 Parish nurses and 17 Health Ministers working in MD, WV, + PA – all volunteers
* 1/3 of Parish nurses nationally are paid
* WMHS Parish Nurse Program – collaborate with hospital and comm. agencies to promote health and provide funding
* Provide orientation, ongoing educational support (webnars, bi-monthly newsletter, retreats, etc.), professional support, monthly clergy meetings that include non-members
* Monthly Activity Reports for volunteers – questions about services they provide (visitations, blood pressure screenings, etc.) and self-care
* Back Door Readings in toilet stalls!
* Received 5 mini-grants from Allegany Co. Health Dept. + MD DHMH Cigarette Restitution Fund -- $26,700
* Free meals to public, interfaith food pantries, exercise/craft classes, Grief Ministry
* Anti-smoking policy implementation with different orgs.
* Collaborating w/ Frederick Memorial Hospital and Western Maryland Health System
* Challenges in health care delivery – nurses aging, many have sick spouses to care for
* Positive changes – collaboration, not competition

Tormod Svensson, Reverend, St. John’s Lutheran Church

* Poverty is biggest obstacle to health in region
* Food desert in church’s neighborhood (poorest) in S. Cumberland
* Bridges to Opportunity – about moving people from getting by to getting ahead
* Using faith comm. resources to prevent drug abuse, provide food, etc.
* Church started Hunger Ministries to provide free, healthy meals
* Works with MD Food Bank in Hagerstown
* How to move from providing food to people getting their own and moving forward?
* Initiating local Farmer’s Market , cooking classes
* Summer Lunch Box Program for children w/ other faith comms.
* Working w/ neighborhood ass. to clean up + make comm. stronger
* Started Spirituality group at church and mental health floor of hospital

Michele Martz, Vice President-Physician Enterprise- Western Maryland Health System

* 50 employed providers, encourages local employment so patients can get necessary care in Cumberland
* Challenges/opportunities – education of physicians, staff, + community, focus on unnecessary utilization and appropriateness of admission, as physicians’ pay still based on volume, keep patients out of hospital – no longer comm. center
* Now, all steps, before + after hospitalization, equally important
* Est. Center for Clinical Resources – 5 free service lines (diabetes, chronic heart failure, COPD, etc.)
* Positive outcomes – decreases in admissions + ED visits
* Last 4 yrs. 32% decrease in admissions, 46% in last 2 yrs.
* Go to patients rather than take them to hospital
* Prep. for future – pop. health management, Accountable Care Organizations (ACOs) – patient centered medical homes + case management
* ACO – network that works together to improve quality + reduce cost of a patient pop. – over 500 nationwide
* Value-based purchasing
* Bundled payments
* Medical homes
* Shared Savings distribution
* Provider-driven, unlike HMOs – enhanced pay for performance opportunity – incentivizes physicians to save money by caring better for patients
* Want Primary, Medical, and Urgent care, and home visits to increase
* CMS est. a Medicare Shared Savings Program
* Patient Centered Medical Home (PCMH) – person-management central location, Primary Care Physician manages whole patient + uses a specialist as consultant
* Changes – better hours, following pediatricians’ model, on call, after hours answering services
* Community Case Management – “health coach” for chronically ill patients to manage continual care
* Conduct ongoing ed. about existing services, data and health info exchange
* Using technology for telemedicine, telemonitoring via iPads, wireless transmission of data via Smartphones
* Data used to show how doctors are performing in treatment of patients
* Question about lack of primary care providers answer – nurse practitioners are being used in that setting, and physicians should have time freed up to see more patients

Lesa Diehl, Director-Mental Health System's Office (CSA)-Allegany County Health Department

* Addresses pop. health – early intervention, prevention
* Coalition of orgs. Works to develop joint health plan
* Encourages flu vaccines, provides travel immunization clinic, substance abuse prevention programs for youth
* Works with child care centers to provide nutrition, augment exercise for young children
* Provide direct services (safety net services) not otherwise available locally
* Health Dept. dental clinic for adults for whom private insurance isn’t accepted by private dentists
* Works with school health nurses
* Provides mental health first aid classes
* Provides classes for outpatient kids with mental health issues
* State hospital network shrining, outpatient program expanding
* JACO or CARF accreditation expected to improve quality of care
* 4 psych rehab programs for kids and adults, access to crisis beds, 30 residential rehab beds
* Question abt. Behavior Health dept. + risk of putting all resources into some departments, answer abt. PDMP to monitor drug utilization + readmissions, manages homeless people

**Closing Comments**

**Q&A and discussion**