



Health Services Cost
Review Commission

Meeting Agenda
Consumer Engagement Taskforce
May 29, 2015 * 9:30 a.m. to 12 p.m. * HSCRC

Dial In: 888-585-9008 Conference Room Number: 129-421-649

Meeting Objectives:

- Review patient engagement resources and related subgroup presentations
- Continue learnings on consumer engagement initiatives
- Refine communication strategy and prioritize approach
- Consider final report outline and content
- Consider opportunities to support Regional Transformation grantees

I. Welcome and Introductions

II. Review of Minutes from April 10 Taskforce Meeting

III. Presentations: "Successes and Lessons Learned in Patient Engagement "

- ***Shannon Hines, Sr. Director, Regional Health Education***
Kaiser Permanente
- ***Dr. Andrea Mathias, Deputy Health Officer***
Worcester County Health Department
- ***Mary Jane Joseph, Project Manager***
Primary Care Coalition HEALTH Partners

IV. Taskforce and Subgroup Updates

- Consumer Outreach Taskforce
- Consumer Outreach & Engagement Subgroup
 - Forum Evaluation Summary
 - CETF Update at Forums
- CETF Charge #1-2 Subgroup
 - Update on Patient Advocacy Projects
 - Patient Engagement Tools and Resources
 - Communication Strategy Refinements

V. Update & Discussion: Regional Health System Transformation Grants

VI. Action Items and Next Steps

VII. Public Comment

Meeting Minutes
Consumer Engagement Task Force
April 10, 2015 * 9:30 a.m. to 12 p.m. * HSCRC

Scribe: Tiffany Tate

In Attendance:

Linda Aldoory (p), Tammy Bresnehan, Kim Burton, Michelle Clark, Dianne Feeney, Michelle Larue (p), Theresa Lee, Karen Ann Lichtenstein, Susan Markely, Steve Ports, Hillery Tsumba, Gary Vogan, Suzanne Schlattman, and Tiffany Tate.

Guest – Dorothy Fox, Sharon Sanders, Barbara Rogers

I. Welcome

Leni welcomed the members and guests.

II. Review of Minutes

The minutes from the March 6 meeting were accepted with no changes.

III. Presentation: “Patient Engagement in Global Budget Environment”

Sharon Sanders, Carroll Hospital Center and Sharon Sanders & Barbara Rogers, Carroll County Health Department

The presenters discussed their programs, services, and experiences working on population health issues in a total patient revenue (TPR) environment. The TPR concept is very similar to the new all-payer model. Carroll County has been operating under this system for about ten years. The presenters shared details about various vehicles they employ to engage patients, including a patient advisory council, the local health improvement coalition, Population Health Governance Group, and the Partnership for a Healthy Carroll County. Details about the programs are available in the presentation, which is posted on the Taskforce’s website.

IV. Taskforce, Workgroup, and Subgroup Updates

Consumer Outreach Taskforce Update

Suzanne Schlattman provided an update on the NAPM forums that are being held around the state. There have been five forums so far. The next one is scheduled for April 20, at which DHMH Secretary Van Mitchell will be speaking. Additional forums will be held in Baltimore County, Baltimore City, and Montgomery County. The Consumer Outreach Taskforce will be submitting their report to the Commission in July. Suzanne thanked the Consumer Outreach and Engagement Subgroup for their additions to the forum evaluation.

Consumer Outreach and Engagement Subgroup Update

Tiffany provided an update on the subgroup. The group began an ongoing discussion on ways to engage providers, in light of responses on the forum evaluations which suggest that people might like to learn about the NAPM from their provider. Vinny already has begun discussions with MedChi. He and Tiffany will be meeting to discuss a coordinated provider outreach effort.

Tiffany shared that she feels that there may be a knowledge gap between what hospitals and local health departments know about how the other operations. There was discussion about possibly working with Advanced Health Collaborative to host sessions or a program to bridge the gaps. Tiffany will reach out to Robb Cohen about this.

CETF Charge 1-2 Subgroup Update

Leni reviewed the taskforce's Charge #2 and discussed the key activities related to communication with consumers. They include:

- Engage with decision-makers, regulators, etc. on the impact on individual and/or community health issues of the design and implementation of the reform initiatives and principally the NAPM
- Ensure an appropriate and consumer-friendly communications process for those directly impacted by the NAPM's goals.

Theresa provided an update on the research her team at the Maryland Health Care Commission conducted to various efforts at Maryland's hospitals related to securing consumer feedback, patients' rights councils, and the processes for accepting and responding to complaints. She provided a detailed review at the taskforce's subgroup meeting.

There was discussion about existing and emerging metrics that can help measure patient engagement. It was noted that there are metrics related to patient activation in an article Theresa shared with the taskforce.

Hillery Tumba reviewed a document she prepared that offered recommendations on prioritizing communication and outreach by geography. There was discussion about an expanded approach to hot-spotting. Dianne shared that the HSCRC soon will be releasing an analytics tool: an area deprivation index that might be useful in this effort.

Care Coordination Workgroup

Steve Ports provided an update on the Care Coordination Workgroup's final report. He said it highlighted the need to prioritize data, use care plans, and share data. It was noted that the final plan should mention consumer engagement. Leni provided input on the report related to consumer engagement. Steve reported that Leni's comments are being considered and some already have been incorporated.

It was agreed that the report should have a more consumer focus since it will require patient buy-in. Mental health and advanced directives were suggested as possible

inclusion to the report. The next step for the Care Coordination Workgroup is to have CRISP present about when it might be able to incorporate or enhance their system to support the workgroup recommendations.

V. Updated Taskforce Timeline and Proposed Meeting Schedule

Leni reviewed the taskforce’s updated Communication Strategy Table and Operation Plan. Leni will be proposing a schedule for full taskforce and subgroup meetings through the end of the year. Tiffany will circulate the dates when they are finalized.

VI. Action Items and Next Steps

There was discussion about who should present at future meetings. Representatives from local health departments, and the Primary Care Coalition were mentioned as options. Leni and Tiffany will discuss further and invite them to future meetings.

VII. Meeting Action Items

Date	Action	Responsible	Due Date	Status
1-30-15	Provide feedback to Health Care for All on NAPM handout	Charge #1 Subgroup	2/10/15	Closed
1-30-15	Share breakdown of consumer complaints	Theressa, Barbara, and Susan	3/6/15	Closed
1-30-15	Share various resources discussed during meeting.	Leni and Tiffany	2/16/15	Open
3-6-14	Provide feedback communications strategy table	Members	3/11/15	Open
3-6-15	Provide feedback on the operations plan and forum evaluation questions	Members	3/13/15	Open

Public Health in an All-Payer Model

*HSCRC Consumer Engagement
Task Force
May 29, 2015*

Becky Jones RN, BSN, MSN
Nurse Program Manager-Adult Services
Worcester County Health Department

Collaboration Goals

Use Public Health workforce to:

- ▶ Assist Hospitals and PCP's to meet goals and requirements of PCMH model
- ▶ Assist Hospitals/FQHC's in reducing ED overuse, early readmits
- ▶ Reduce risk of discharge from practice for non-adherence, poor outcomes
- ▶ Improve overall population health

Collaboration History

2012- AGH and WCHD

- ▶ AGH awarded CMS Innovations Grant (3 yr)
- ▶ CMS Drivers for readmits, ED use
- ▶ 3 diagnoses: COPD, CHF, Diabetes

2013- LHIC and AGH, PRMC, McCready

- ▶ LHIC awarded 1 year grant
- ▶ SHIP measure, use HSCRC data for ER use
- ▶ ED visit drivers, diabetes

Worcester, Wicomico and Somerset Counties (LHIC) and 3 Regional Hospitals



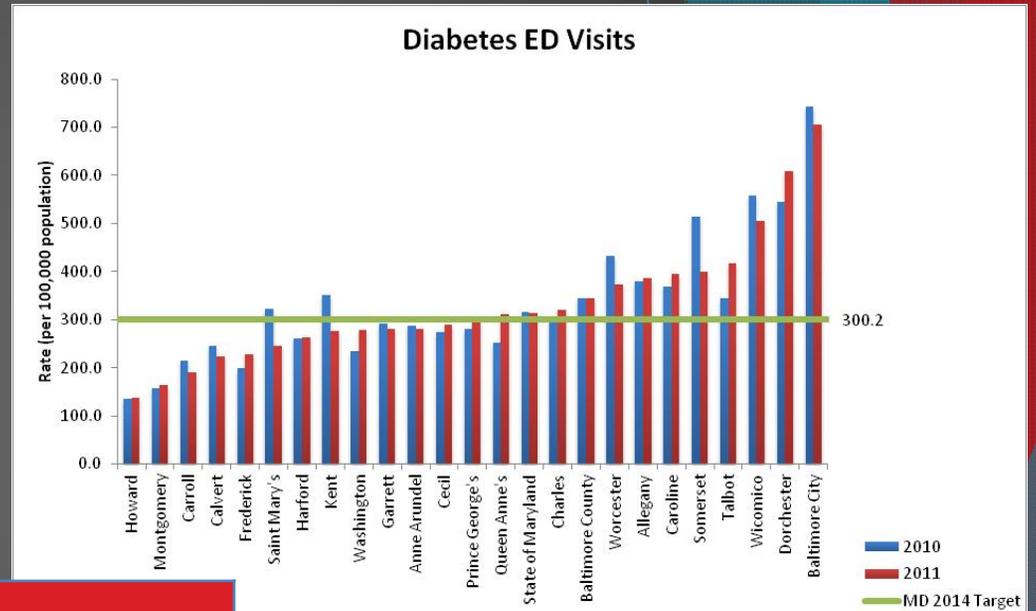
- ▶ Reduce Diabetes Related ED visit rate and
- ▶ Reduce racial disparities in ED visit rates through

Community Integrated Diabetes Care Management

Diabetes Related ED Visits Lower Shore Region

Maryland State Health
Improvement Plan 2014
(SHIP #27)

Goal: 300/100K
State: 316/100K



Year	Lower Shore (total)	NH Black	NH White
2010	515.1	962.7	241.7
2011	450.7	893.7	331.8
Wicomico	505.1	1,020.5	366.3
Worcester	372.7	1,217.1	249.5
Somerset	398.6	408.7	414.7

Tri County Diabetes Management Program

- ▶ 3 county Hospitals refer ED utilizers with Diabetes to the Health Department Chronic Disease Case Management team
- ▶ Identify geographic or population “hotspots” in three counties
- ▶ Evidence based Chronic Disease Care Management model
- ▶ Address medical and social determinants of high ED utilization
- ▶ **Population:** any payer source, any PCP status, ages 18+, Diabetes as 1st or 2nd Dx

Chronic Disease Case Management Staff Team

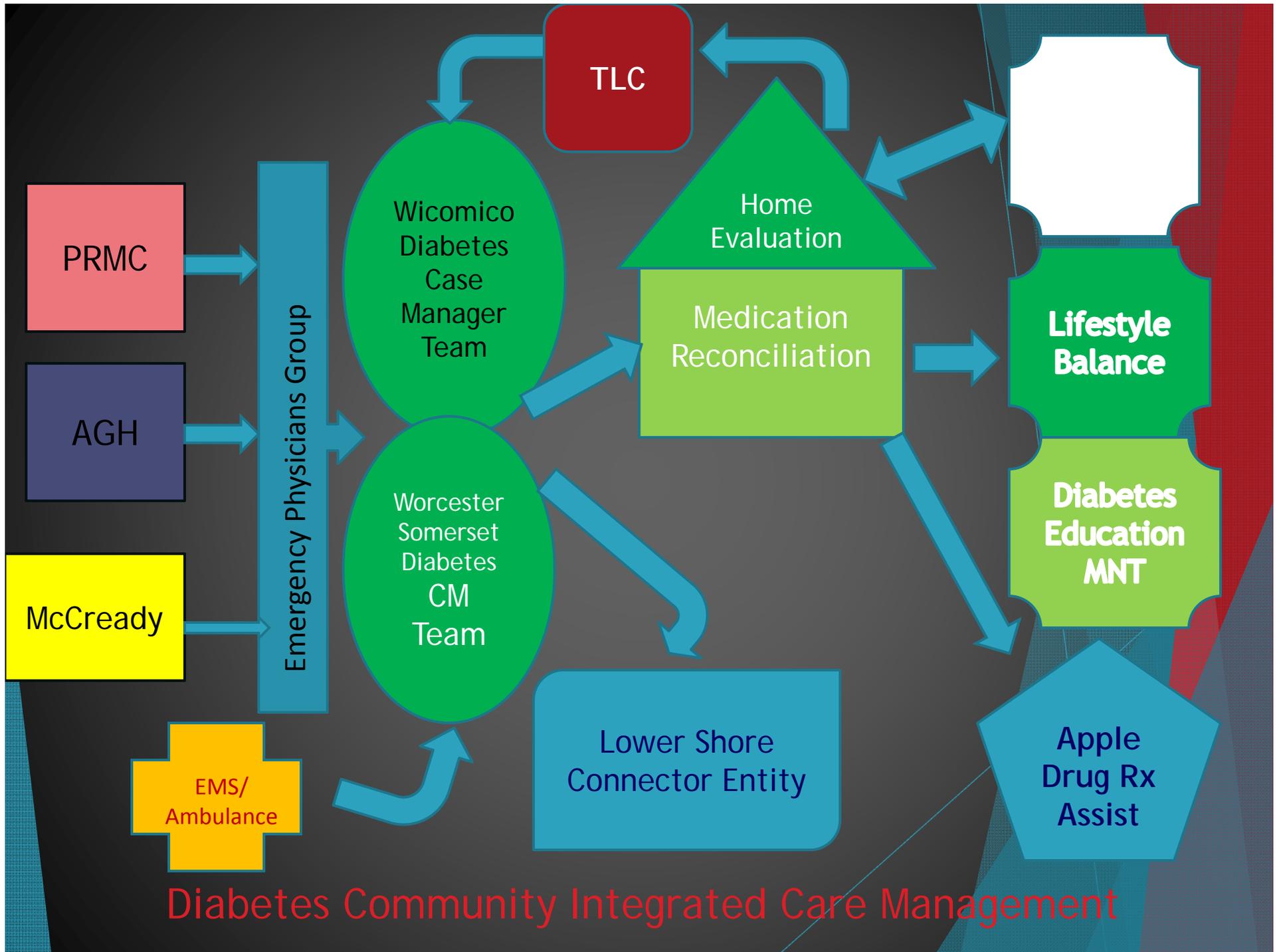
- ▶ Public Health workforce experience with Case Management- repurpose for Chronic Disease
- ▶ RN/SW- for mental health, HIV, DD, cancer, Adult, lead, high risk OB etc,
- ▶ Two teams-3 counties. Each team comprised of:
 - ▶ 1 full time registered nurse
 - ▶ 0.5 social worker

Standard Home/Community Based Intervention

- ▶ Identify PCP status
 - ▶ Facilitated referral/ transport to PCP
- ▶ Evaluation of social/financial needs
 - ▶ Modified STEPS, InterRAI
 - ▶ Refer for LTSS, waivers, AERS eval
 - ▶ Insurance- Connector entity
- ▶ Medication Reconciliation
 - ▶ CRISP, Pharmacy, PCP, patient lists
- ▶ Chronic Disease teaching (home or formal CDE)

Engagement Strategies

- ▶ Persistent involvement = trusted resource
- ▶ Person centered approach
 - ▶ Motivational interviewing
- ▶ Supporting compliance and self management
 - ▶ Glucose logs, pill boxes, calendars, ect.
- ▶ Improving access (transportation)
- ▶ Modeling provider communication



Diabetes ED visit Data Evaluation

12 months prior to CHRC LHIC RFP

- ▶ 45% Medicare
- ▶ 22% Medicaid or Self pay
- ▶ 38% 65+ age

AGH: 10 patients with 3 or more visits

- ▶ 76% white, 22% black

PRMC: 14 patients with 3 or more visits

- ▶ 47% white, 49% black

Implementation Achievements

1. Execution of MOU's and BAA's between LHIC and 3 hospitals
2. LHIC performs Quarterly Analysis of 3 ED data
3. Universal referral process into Diabetes Care Management
4. 2 Care Management Teams provide home evaluations, medication reconciliation
5. Patients complete Diabetes Education programs- many options
6. CRISP enrollment for CM teams to promote Community Medical Record
7. Referral for insurer status to MD Connector Entity
8. Coordinate resources & services to avoid ED visits

Outcomes: Jan 2014- Sept 2014

59 Total enrolled

- ▶ 56 ER visits 12 mos prior to CM
- ▶ 8 ER visits since CM

8 pts highest users

- ▶ 38 ER visits 12 mos prior to CM
- ▶ 4 visits since CM

31% BH Dx

49% <200% poverty

45% Medicare

36% Dual eligible

90% assisted to PCP

14% QMB, SLMB, LTSS

27% transportation, POC -
meds, DM supplies

Summary of Prevented ER visits

	Total Patient	ER visits 12 months prior to Diabetes Case Management	ER visits in 12 months since case management	% ER use reduction	Cost savings in prevented ER visits	Cost Savings in prevented hospitalizations	Total Savings
Total enrolled	92	56	8	85%	\$45,000	\$144,000	\$189,000
Highest Utilizers*	8	38	4	89%			

*(3-14 visits per year, subset of total enrolled)

Patient Characteristics of Enrolled Clients

31% have significant Behavioral Health Diagnoses	49% live at <200 % federal poverty level
90 % received assistance to make or keep PCP appointment	45% Medicare
14% deemed eligible for QMB, SLMB	36% Dual eligible
27% needed assistance with transportation	20% Financial assistance for diabetes meds & supplies

Case Scenario #1

- ▶ 63 yo white married female
- ▶ Type II Diabetes, HTN, Cholesterol, Depression/Anxiety
- ▶ Medicare/Medicaid (Disability)
- ▶ Frequent ED utilization for elevated BS
-400+
- ▶ Inconsistent with BS monitoring
- ▶ Non compliant with medications

Case Scenario #1-Interventions

- ▶ Medication reconciliation-substantial education, coordination with Primary Care
- ▶ Diabetes Education
- ▶ Referred to WCHD dietician
 - Meal planning
- ▶ On going follow up via phone and home visits
- ▶ Participating in maximal eligible services

Case Scenario #1-Post Interventions

- ▶ Improved Diabetes Self Management
 - Monitoring BS, Meal Planning
- ▶ Improved BS:FBS 190 vs 400
- ▶ Better weight control, Increased physical activity
- ▶ Improved compliance with medications
- ▶ Reduced ER visits

Case Scenario #2

- ▶ 46 yo AA male
- ▶ Type II Diabetes, TBI (limiting short term memory)
- ▶ Medical Assistance
- ▶ ED utilization for diabetes care

Case Scenario #2-Interventions

- ▶ Reinforce importance of PCP
- ▶ Diabetes self management- in home, customized to TBI
 - BS testing, medication administration, meal planning
- ▶ Education on MA benefits
 - Transportation, RX plan
- ▶ Referral to PRMC Diabetes Education Class-
 - ▶ Assured regular attendance

Case Scenario #2-Post Interventions

- ▶ Completed Diabetes Classes
- ▶ Decreased ED visits
- ▶ Decreased A1C from 13.2% in April, 2014 to 8.3% in January, 2015
- ▶ Compliant with PCP appointments

Case Scenario #3

- ▶ 64-year-old African American Male
- ▶ Referred by local ministry for the homeless
- ▶ Memory deficits, limited formal education, very low literacy
- ▶ Expressed desire to obtain diabetes medications. Received evaluation, treatment at ER for hyperglycemia. Lost prescriptions as well as printed discharge instructions from ER. Could not make realistic plan to obtain needed health care.
- ▶ Family support limited to housing, medication reminders, some meal prep, occasionally transportation.

Case Scenario #3-Interventions

- ▶ Establish & maintain primary care
- ▶ Home visits by RN & LGSW almost weekly
- ▶ Establish specialty care - Podiatry, Ophthalmology, Neurology.
- ▶ Preparation & oversight of applications for QMB & Medicare Part D enrollment
- ▶ Referral to Department of Social Services - Project Home, Adult Protective Services
- ▶ Case presentation to county Multi-disciplinary Team
- ▶ Referral to county health department Communicable Disease Program for follow up & treatment

Case Scenario #3-Post Interventions

- ▶ Transport and escort for all primary care and specialty appointments.
- ▶ Referred to DSS for Project Home shortly after admitted to our program, was placed in Project Home but left after a few days.
- ▶ Referred again to DSS for APS February 2015 due to decline in physical & cognitive functioning, need for increased care for communicable disease treatment, unwillingness of family to meet increased care needs.
- ▶ DSS pursuing appointment of guardian for client. Client admitted to hospital, then nursing facility April 2015 for treatment-remains in nursing facility for LTC.
- ▶ HgA1C on 6/30/2014 was 14%, on 2/5/2015 was 9.7%.

Future Growth

- ▶ Expand model to 3 Diagnoses for 3 hospitals & 3 counties
- ▶ Expand CHW role to increase services and acceptance rate
- ▶ Optimize hotspot data to position CHW and resources
- ▶ Calculate savings to ED & reinvest :
MOU to continue services beyond grant

Sustainability Considerations

- ▶ Home & Community Chronic Disease Care Management: needs to be billable service
- ▶ Primary Care partnerships- contract for CM services?
- ▶ Contract with ACO
- ▶ Public Payer shared savings programs- PCMH or like models
- ▶ Continued Grant funding for program

Questions?

andrea.mathias@maryland.gov

HSCRC Consumer Engagement Taskforce Meeting

May 28, 2015



primary care coalition
of Montgomery County, Maryland

8757 Georgia Ave, 10th Floor
Silver Spring, MD 20910

www.primarycarecoalition.org

About the Primary Care Coalition (PCC)



Vision:

A community in which all residents have the opportunity to live healthy lives
Montgomery County: A model for providing access to high quality, efficient care for all.



Mission:

Develop and coordinate a community-based health care system that strives for universal access and equity for low-income, uninsured, and ethnically diverse community members.



About the Primary Care Coalition (PCC)

Core competencies:

- Collaboration
- Integration
- Process improvement

What We Do:

- Foster and coordinate a high quality, efficient community-based health care system
- Strive for universal access and health equity for low-income uninsured and underinsured community members
- Create models for providing access to high quality and efficient care for all
- Administer public-private partnerships that provide health care for low-income, uninsured, ethnically diverse individuals



H.E.A.L.T.H. Partners

2011

- Partnered with Montgomery County DHHS Aging and Disabilities, Holy Cross Hospital, and Housing Opportunities Commission to improve care transitions for dual eligible patients

2013

- Coalition formed with Delmarva
- 16 organizations and residents of Holly Hall
- Access to hospital Medicare admission and readmission data
- Small tests of change

2014

- Over 20 organizations representing multiple disciplines
- Change from Delmarva to VHQC
- Spread other senior housing units

H.E.A.L.T.H. Partners

Mission:

To improve the transition of care from hospital to community for residents of the region, thereby reducing preventable readmissions to acute care hospitals.

Purpose:

- To build and sustain a community coalition with a focus on improving transitions of care.
- To be a vehicle for the patient and family voice.
- To encourage person-centered and person-directed models of care.
- To collaborate and encourage efforts of organizations with shared visions.
- To advance public policies that furthers the vision.
- To share Best Practices in caring for community residents.



First Site-Holly Hall

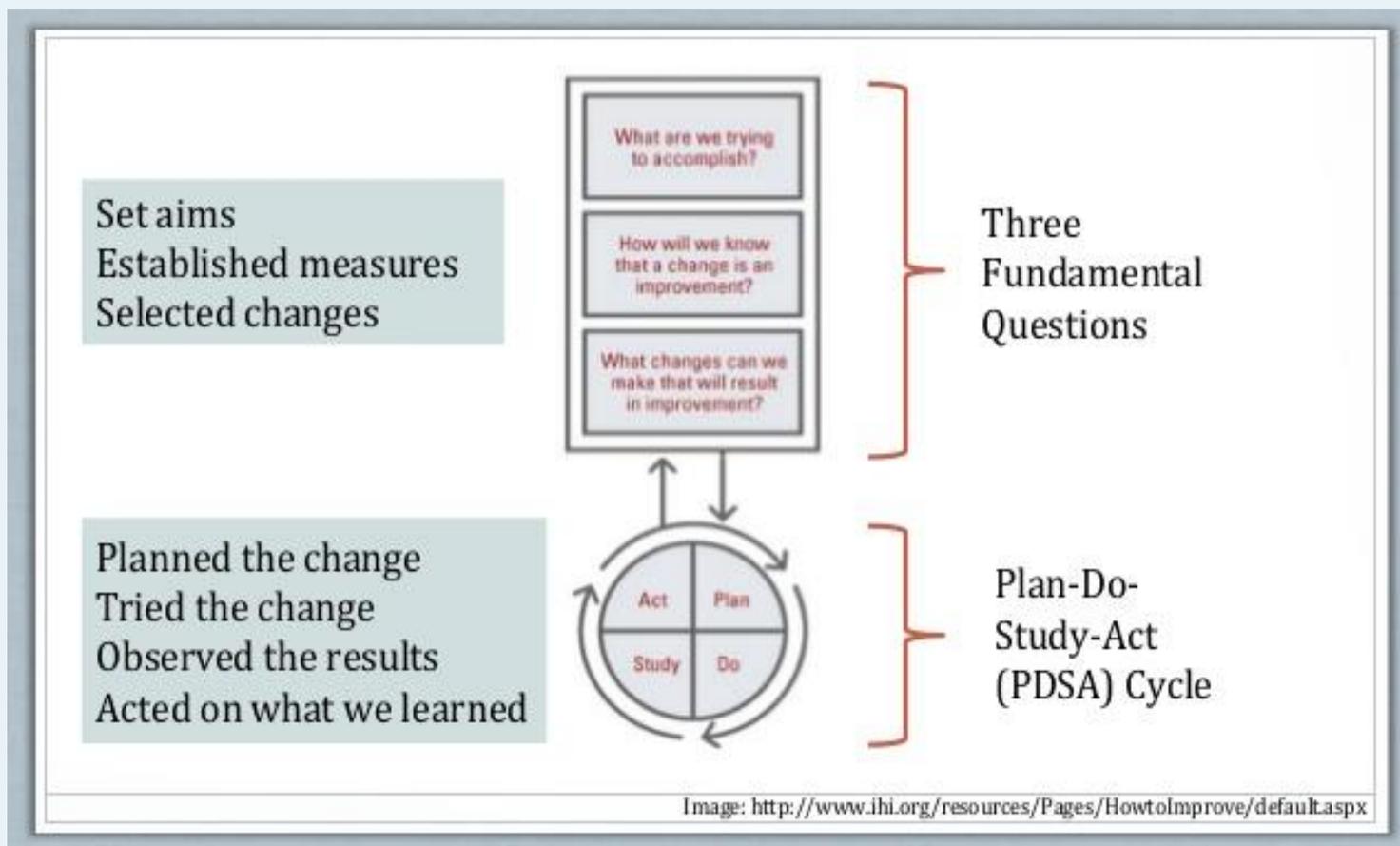


96 units/112 Residents
On site resident counselor

Race <ul style="list-style-type: none">○African American 49%○Asia 18%○White 32%○Middle Eastern 1%	Age <ul style="list-style-type: none">○< 60 years 17%○> 60 years 83%
Ethnicity <ul style="list-style-type: none">○Hispanic 22%○Non-Hispanic 78%	Disabilities: <ul style="list-style-type: none">○Medically Frail 42%○Physical Disability 29%○Psychological/Neurological 16%○Cognitive 10%



Interventions/Tests of Change



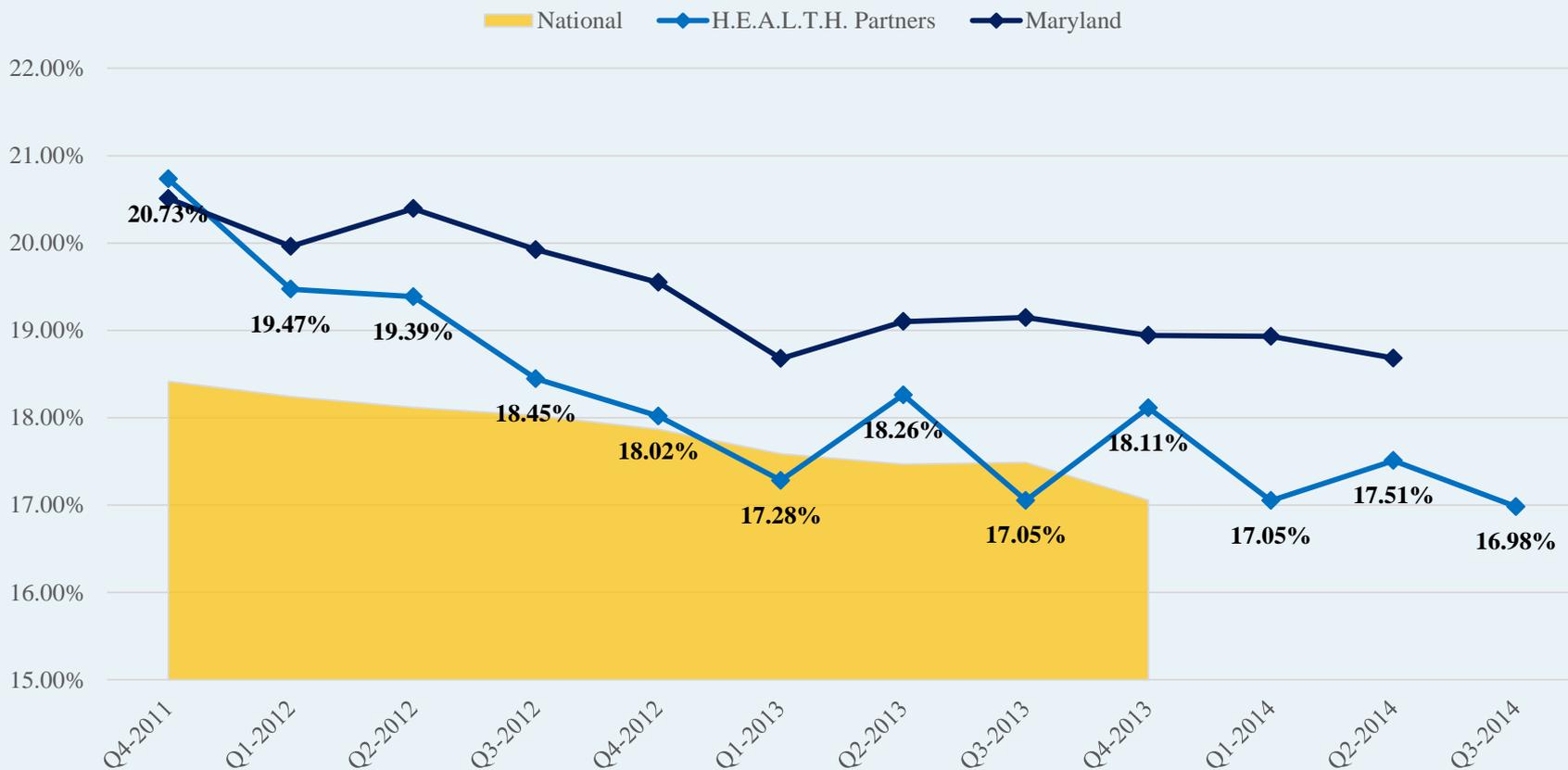
Data

- The H.E.A.L.T.H partners community (Montgomery County has approximately 127,434 Medicare beneficiaries.)
- VHQC provides part A & B claims data and ongoing analysis for communities to assist with the identification of improvement opportunities.
 - Readmissions
 - Admissions
 - ED visits
 - # of days from discharge to readmission
 - Top Diagnoses
 - Specific Focus Areas



Data

H.E.A.L.T.H. Partners % of Discharges Readmitted Within 30 Days



Resident Engagement

- Resident Meeting
- Resident Brochure
- Resident Interviews



An unnecessary trip back to the hospital means longer recoveries and higher health care bills. Research indicates that readmission can be avoided with successful health care coordination after discharge. H.E.A.L.T.H. Partners can assist with reducing a patient's risks for an avoidable hospital readmission.

H.E.A.L.T.H. Partners

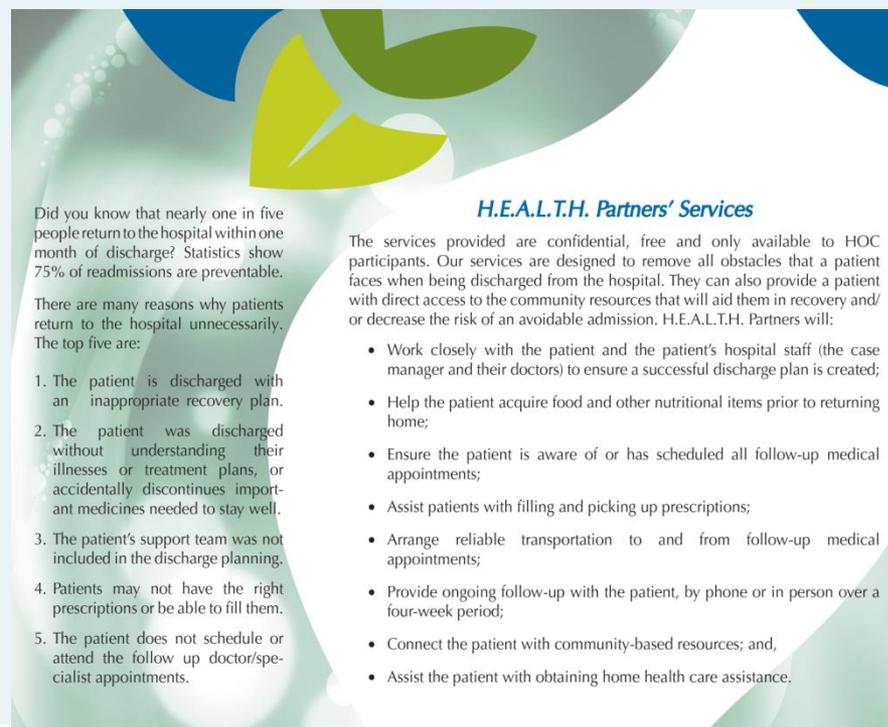
Washington Adventist Hospital
ALFA
API
HOC
Care Health
DFMC
H.C.
MedStar Montgomery Medical Center
primary care coalition
HOLY CROSS HOSPITAL

Introduces
H.E.A.L.T.H. Partners

Hospitals
Effectively
Assisting
Lasting
Transitions
Home

For additional information or to sign-up, please contact:
Stephanie Gilbert
Resident Counselor
stephanie.gilbert@hocmc.org
or (301) 439-8652

A collaboration with HOC, the County Government, local hospitals, and other health care organizations.



H.E.A.L.T.H. Partners' Services

The services provided are confidential, free and only available to HOC participants. Our services are designed to remove all obstacles that a patient faces when being discharged from the hospital. They can also provide a patient with direct access to the community resources that will aid them in recovery and/or decrease the risk of an avoidable admission. H.E.A.L.T.H. Partners will:

- Work closely with the patient and the patient's hospital staff (the case manager and their doctors) to ensure a successful discharge plan is created;
- Help the patient acquire food and other nutritional items prior to returning home;
- Ensure the patient is aware of or has scheduled all follow-up medical appointments;
- Assist patients with filling and picking up prescriptions;
- Arrange reliable transportation to and from follow-up medical appointments;
- Provide ongoing follow-up with the patient, by phone or in person over a four-week period;
- Connect the patient with community-based resources; and,
- Assist the patient with obtaining home health care assistance.

Did you know that nearly one in five people return to the hospital within one month of discharge? Statistics show 75% of readmissions are preventable.

There are many reasons why patients return to the hospital unnecessarily. The top five are:

1. The patient is discharged with an inappropriate recovery plan.
2. The patient was discharged without understanding their illnesses or treatment plans, or accidentally discontinues important medicines needed to stay well.
3. The patient's support team was not included in the discharge planning.
4. Patients may not have the right prescriptions or be able to fill them.
5. The patient does not schedule or attend the follow up doctor/specialist appointments.

File of Life

- The File of Life consolidates basic health information such as medical history, allergies, medications, and other health-related topics in one place. It is designed to hang by a red magnet on a refrigerator door in case emergency personnel need to assist the occupant of a home
- Completed with the Resident Counselor
- Updated yearly



Discharge Planning

- Release of Information



10400 Detrick Avenue
Kernington, Maryland 20895-2484
(240) 627-9400

Authorization to Release Hospital Discharge or Emergency Medical Services Information

I authorize the Housing Opportunities Commission (HOC) of Montgomery County, Resident Counselor at _____ to release and/or receive information from the organizations checked below:

Holy Cross Hospital Medstar Montgomery Medical Center
 Washington Adventist Hospital Emergency Medical Services (EMS)
 My Primary Care Physician _____

Information to be released and/or received may include:

File of life
 Discharge plan
 EMS notification of response to call from resident
 Other: _____

_____ I understand that my authorization will remain effective from the date of my signature until _____ [date], and that the information will be handled confidentially in compliance with all applicable federal laws.

_____ I agree that my File of Life, discharge plan and other discharge related information may be in Care2Care, which is a secured database accessible only to HOC Resident Counselors

_____ I understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time either orally or in writing.

_____ I understand that I may see the information that is to be shared with the HOC Resident Counselor and in Care2Care.

_____ I understand that the Resident Counselor will help me connect to my healthcare provider(s) but will not assume responsibility for the health care service delivery.

I hereby state that I have read and fully understand the above statements.

Resident's Name (printed) Date of Birth Phone number

Resident's Address

Signature of Resident or Legal Representative Date

Relationship to Patient, if signed by Legal Representative

Signature of Witness Date

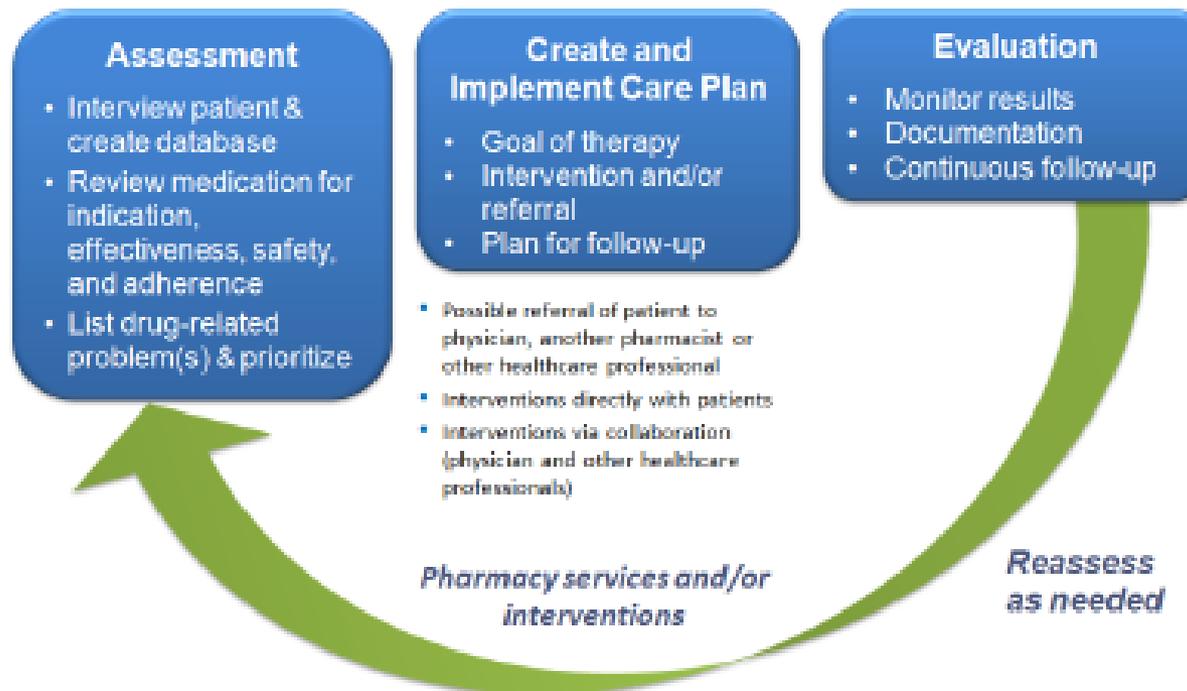


primary care coalition
of Montgomery County, Maryland

Medication Therapy Management



Pharmacists' Role in Medication Management



This image has been adapted from the Medication Therapy Management (MTM) format outlined by the American Pharmacists Association and the National Association of Chain Drug Stores



EMS Interventions

Daily notification

New Hampshire Ave Incident Shift Date 808/09/2014						
Incident	Date	Time	Call Type	Unit	Apartment	Location
14-0090550	08/09/2014	19:02:58	26-A-11	A716	310	10120 New Hampshire Ave.

Monthly Stats

2014 EMS Visits Holly Hall 2012-2013 Average = 4 per Month													
Building	1/14	2/14	3/14	4/14	5/14	6/14	7/14	8/14	9/14	10/14	11/14	12/14	Total
10100	3	2	4	2	3	3	5	2	1	1	2	4	32
10110	0	2	2	0	0	1	1	0	1	2	1	3	13
10210	0	0	0	0	4	1	1	2	0	2	2	0	12
Total	3	4	6	2	7	5	7	4	2	5	5	7	57

EMS Visits by Building (2012-2014)				
Building	Apartments	EMS 2012/100 Apartments	EMS 2012/100 Apartments	EMS 2012/100 Apartments
Arcola Towers	141	28	23	48
Elizabeth House	160	23	25	38
Forest Oaks	175	32	33	75
Waverly House	158	46	34	46
Holly Hall	96	55	45	63
Bauer Park	142		13	17
Town Center	112		13	20



Nursing Interventions

- University of Maryland School of Nursing
- 2 days /week
- Health Education
- Health Screening
- Assessments
- Case Management
- Referral and Follow-up



Technology

- **Care2Care**
 - Care 2 Care software provides a patient-centered record that consists of the essential care elements, barriers to care and self-management goals to facilitate optimal outcomes as the patient moves through the continuum of care
- **Community Health Gateway**
 - Web and call center solution
 - Easy to understand discharge instructions & medication information
 - Help in navigating healthcare and community services
 - Increased community collaboration



Successes

- Community Engagement
- Over 60% of residents have signed release of information
- Hospital transitional care teams working together
- EMS notification and follow-up
- MTM with positive outcomes on 9 residents
- On-site nurses
- Introduction of technology to assist in personal health management



Contact:

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MaryJane_Joseph@PrimaryCareCoalition.org

301-628-3458



Health Services Cost Review Commission
New All-Payer Model: Consumer Engagement Taskforce
Proposed Useful Definitions and Principles

=====

The following are based upon the Consumer and Community Engagement Framework¹ developed by Health Consumers Queensland and are proposed here as a basis for consumer engagement.

Proposed Useful Definitions

Consumers: Consumers are defined as people who use, or are potential users, of health services. This may include family members as well as those who provide care in an unpaid capacity.

Community: Community refers to groups of people or organizations with a common local or regional interest in health. There are three primary ways in which a community may be formed: (1) geographic boundaries (neighborhood, region, etc.); (2) interests such as patients, health care providers, industry sector, profession, etc.; and/or (3) specific issue such as improvements to public health or groups that share cultural backgrounds, religions or language(s).

Consumer Engagement: Consumer engagement informs broader community engagement. Health consumers are people who actively participate in their own health care and, more broadly, in health policy, planning, service delivery and evaluation at service and agency levels.

Community Engagement: Community engagement refers to the connections between government, communities and citizens in the development of policies, programs, services and projects. It encompasses a wide variety of government-community interactions ranging from information sharing to community consultation and, in some instances, active participation in government decision-making. It incorporates public participation, with individuals being empowered to contribute in decisions affecting their lives, through acquisition of skills, knowledge and experience.

¹ The full document can be found at <http://www.health.qld.gov.au/hcq/publications/consumer-engagement.pdf>

Proposed Principles - Consumer and Community Engagement

#1 - Participation: People and communities participate and are involved in decision-making about the health care system.

#2 - Person-centered: Engagement strategies and processes are centered on people and communities.

#3 - Accessible and Inclusive: The needs of people and communities, particularly those who may experience barriers to effective engagement, are considered when determining steps to enhance accessibility and inclusion.

#4 - Partnership: People, including health care providers, community and health-related organizations work in partnership.

#5 - Diversity: The engagement process values and supports the diversity of people and communities.

#6 - Mutual Respect and Value: Engagement is undertaken with mutual respect and the valuing of other's experiences and contributions.

#7 - Support: People and communities are provided with the support and opportunities they need to engage in a meaningful way with the health care system.

#8 - Influence: Consumer and community engagement influences health policy, planning and system reform, and feedback is provided about how the engagement has influenced outcomes.

#9 - Continuous Improvement: The engagement of people and communities are reviewed on an on-going basis and evaluated to drive continuous improvement.

CETF Consumer Communication Strategy Summary

Target Population	Messenger/Ambassador (Person/Organization)	Time/Venue Message Delivery	Information/Message	Approach/Medium
High-Utilizers: 3+ hospital admissions			Do you know your primary care physician? Do you have a care plan?	
High-Utilizers: 25+ hospital admissions	(1) Hospital (2) Clinic (3) Social worker/case manager	<ul style="list-style-type: none"> • ER admission • Discharge 	Navigation to community resources. Do you have a care plan? Do you understand what to do when you leave the hospital? Do you know who to call when you leave the hospital?	
Medicare Chronic Conditions				
Medicare Caregivers				
<65 - Priority 1 Chronic Conditions				
<65 - Priority 2 Family, Friends, Influencers				
General Public				

Charles County Health System Transformation Presentation Evaluation Report

April 20, 2015

Number of attendees: **65**

Number of evaluations collected: **36**

(Majority serving diverse populations/minorities, low-income and providers; also additional write-in of mental and behavioral health patients/providers. *Perhaps this category should be added to the evaluation form and special outreach to these providers to participate in future forums?*)

This forum was the only regional forum to be held at a local public school and to coincide with a community event. An installation of the AIDS quilt was on display in the school's gymnasium and participants were able to view the exhibit before attending the forum.

The evaluation response rate was a bit better than other forums, perhaps due to more frequent reminders to complete them throughout the presentation and clear explanation of how feedback would be applied to future consumer outreach and engagement work.

Of those who completed evaluations **about three-quarters of respondents had never heard about the waiver or other health system transformation (HST) before (27)**. Of those who were aware of HST prior to attending the forum (9), they predominantly worked with/for the health department and local hospital (perhaps due to the instrumental role the health department played in planning and publicizing the event.) They had heard about it from the following sources:

- MHA
- Employer
- UMD monthly read reduction mtgs
- Local health department and/or hospital and/or LHIC
- Maryland Women's Coalition
- Indianapolis(?)
- UMRHCC (?)

There was not a significant difference in following responses between those who were learning about this issue for the first time and those who were already familiar with the concept. Responses are detailed below in aggregate.

Majority of respondents felt that after attending this forum, the best way to describe Maryland's HST was the following statement:

- **Creates a system where all health care providers work together to help keep the public healthy. (27)**
- **Enhances the overall healthcare system by improving the quality of care and reducing costs. (4)**

Two other suggested descriptions volunteered by participants include, "Reducing ER visits by using community resources," and "It will depend on the citizen given often give/receive care across county lines."

The highest ranking aspects of HST that they felt would interest their constituents include:

- **Hospitals, healthcare providers, and community-based organizations will be working together to help Marylanders be as healthy as possible (34).**
- **Hospitals have an added incentive to keep people healthy (15).**

- The changes are to control health care costs (11).

When asked how they felt their constituents would want to be involved in implementing HST, most felt that **they'd like to "be more knowledgeable about healthcare services and options that can help improve their health and help save costs (27) and be more active in and knowledgeable about their own healthcare (19)."**

Most wanted to get information about HST from social media (24), their health care provider (18) and public meetings for patients and caregivers (14). About two-thirds wanted to get information now and every time new information becomes available (20).

Respondent profile

Organization	First learning about the waiver at this forum	Already familiar with the waiver
Private Citizen	6	0
CBO	7	1
Civic Org	2	0
Provider Group	3	4
FBO	1	2
Private Provider	3	0
No answer	1	0
Other	6 FQHC Local affiliate of national nonprofit (NAMI) Area Agency on Aging Psychiatric rehab ctr Elected official Local Health Department Home care provider	2 Health Department Hospital

1. Have you attended meetings before about health system transformation related to changes in how hospitals are paid?

No--27

Yes—9

- MHA
- Employer
- UMD monthly read reduction mtgs
- Local health department and/or hospital and/or LHIC
- Maryland Women’s Coalition
- Indianapolis(?)
- UMRHCC (?)

2. After attending this forum, which of these statements best describes how you would summarize Maryland’s health system transformation? (Select ONE)

Maryland’s health system transformation:

27- Creates a system where all healthcare providers to work together to help keep the public healthy.

4- Enhances the overall healthcare system by improving the quality of care and reducing costs.

1- Will be most beneficial to people who go to the hospital frequently.

1- May cause people to get less care when they go to the hospital.

0- I need more information to summarize Maryland’s health system transformation. It is a little complicated.

1- Other- “Reducing ER visits by using community resources” “It will depend on the citizen given often give/receive care across county lines.”

1- No answer

3. Which aspects of Maryland’s health system transformation do you think will interest your constituents most? (Select up to TWO)

34- Hospitals, healthcare providers, and community-based organizations will be working together to help Marylanders be as healthy as possible.

11- The changes are to control healthcare costs.

15- Hospitals have an added incentive to keep people healthy.

4- There is a regulatory body that oversees hospitals.

1- Other__ “Quality of care”

4. In what ways do you think your constituents might want to be involved in implementing Maryland’s health system transformation? (Select up to TWO)

19- Be more active in and knowledgeable about their own healthcare

27- Be more knowledgeable about healthcare services and options that can help improve their health and help save costs

9- Participate in Town Hall Meetings where they can learn more and provide input on how the health system transformation is implemented

8- Participate on advisory boards to help hospitals and the State understand how health system transformation is impacting healthcare consumers

- 4- Other “Help train FBO to better serve as liaisons b/w health care provider organization and their congregation;”
- “Get more specialists on board with new transformation”
- “Do nurses sit on advisory boards currently?”
- “[blank]”

5. What do you think is the best way to share information about Maryland’s health system transformation with your constituents? (Select up to THREE)

- 18- Information from healthcare provider**
- 11- Information when at/in the hospital
- 24- Social media, website**
- 7- Billboards
- 14- Public meetings for patients and caregivers
- 7- Flyers, handouts, brochures
- 10- TV and radio commercials
- 5- Newspaper advertisement
- 3- Other “[blank]”
- “provide info and resources to key partners in community to share with their clients/patients”
- “Commuter bus signs/VanGo”

6. When do you think is the best time for the state and hospitals to inform the public about Maryland’s health system transformation? (Select ONE)

- 20- Now and every time new information becomes available**
- 7- When there is information the public can easily understand and act on
- 9- When there are new programs resulting from the transformation that the public can understand and act on
- 0- When they personally experience a new program that resulted from the transformation.
- 1- Other “Presentation at churches, clubs, etc.”

7. Which of these best describes the organization you represent?

- 6- I am a private citizen
- 8- Community-based organization**
- 2- Civic organization
- 8- Other (see profile above)
- 7- Provider group
- 3- Faith-based organization
- 3- Private provider office
- 1- no answer

8. Who are your primary constituents? (Select up to THREE)

- 7- I am a private citizen
- 12- I am a healthcare provider**
- 15- Diverse populations / minorities**
- 9- Seniors
- 11- Low-income populations**
- 0- Immigrants
- 3- Chronically ill
- 5- Children
- 7- Families
- 5- Caregivers
- 4- Parishioners in a faith-based organization
- 2- Healthcare providers
- 2- Other “All county citizens [elected official]”
- “behavioral health/mentally ill”

April 28, 2015

Western Maryland Forum evaluations

25 people in attendance

11 evaluations collected

This forum was held during the regular meeting time of the Cumberland Ministerial Association. This forum was different from others because this region has been operating under global budgets for more than 4 years. They had more programming and impact to share/report.

Some important background to consider: The hospital addressed global budgeting by modifying their campus to offer more preventive services on-site rather than tapping into/partnering with existing community assets. While this helps patients overcome transportation barriers, it has inadvertently weakened the broader primary care structure as more patients are diverted from the FQHC and other independent primary care providers to the hospital.

Because of the fact that this was a ministerial association mtg, there was great interest in the congregational faith network. Follow-up meeting will be held to discuss further in June.

Of the 25 people gathered for the forum

- 7 were nav/assisters from Healthy Howard; one was from Rural Area Enrollment Network, an enrollment program by Maryland Rural Health Assc.
 - 6 were from local faith-based organizations
 - 2 were from the hospital and 2 were from the health department
 - the rest were from community based organizations like the NAACP and United Way
-
- Two had heard of HST before because they worked for Western Maryland Health Systems (chaplain and parish nurse coordinator); the rest had not (2 didn't answer the question). Which is interesting since they've been operating under the global budget model for 4 years.
 - They thought that Maryland's HST was best described by the statement: "Enhances the overall health care system by improving the quality of care and reducing costs."
 - They thought the two aspects of HST that would most interest their constituents were "Hospitals, health care providers and community based orgs will be working together to help Marylanders be as healthy as possible." (given the background stated above, this is an interesting choice—perhaps because it was the first option on the list?) And "Hospitals have an added

incentive to keep people healthy.” (strongly reiterated by Steve’s presentation and local doc presentation on the new ACO)

- They thought their constituents might want to be more involved in implementing Maryland’s HST by “being more active in and knowledgeable about their own healthcare.” And “Be more knowledgeable about healthcare services and options that can help improve their health and help save costs.”
- They felt the best time to share the information was when there are new programs resulting from HST that the public can understand and act on.
- They felt the best way to share this information with their constituents was through their health care providers, information when at/in the hospital and through local tv/radio/print media. More than one respondent encouraged “low-tech” resources to better reach their congregants who are not likely to see health information (or any information) online. This region has an aging population.

There were a few questions about how a global budgeting and unique hospital system is reflected on their EOBs; how patients take advantage of a patient-centered-medical-home and physician led ACO (Western Maryland Health System); if/how Congregational Health Network is duplicative/supportive of Community Health Worker model.

The local panel of experts were more prospective (promoting new and future programs) rather than reflective of their early years of experience working under global budgets. Not sure we got a lot of valuable feedback on how it’s going—perhaps because of tensions between actors in the room and by virtue of the fact that it was hosted on hospital grounds. When pushed for ideas on how to engage consumers in this ongoing process, there was general agreement that further investing in faith-based partnerships was an avenue to explore, but no additional ideas were shared.