

Public Health in an All-Payer Model

*HSCRC Consumer Engagement
Task Force
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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



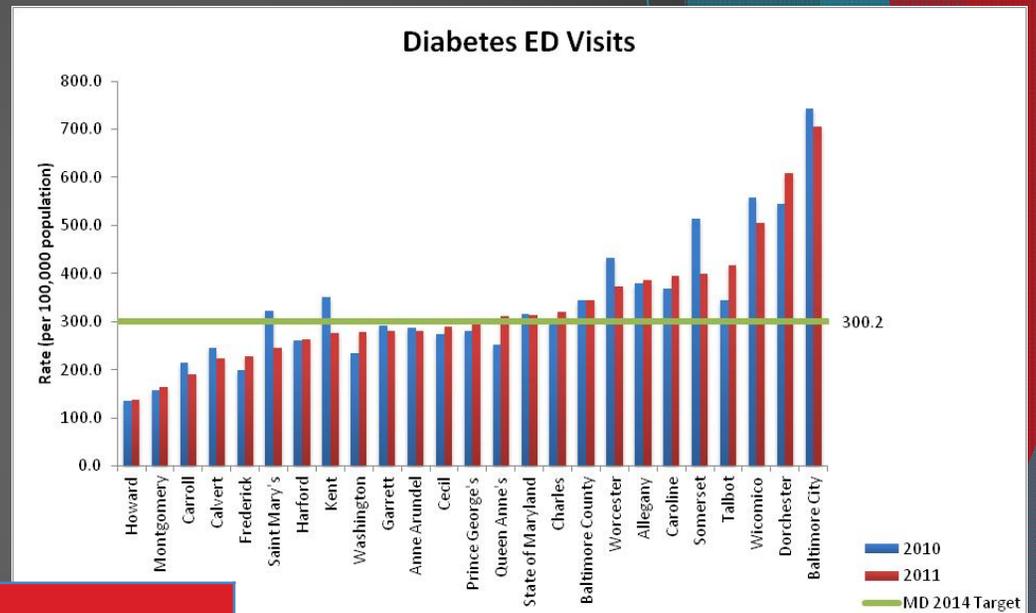
- ▶ Reduce Diabetes Related ED visit rate and
- ▶ Reduce racial disparities in ED visit rates through

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

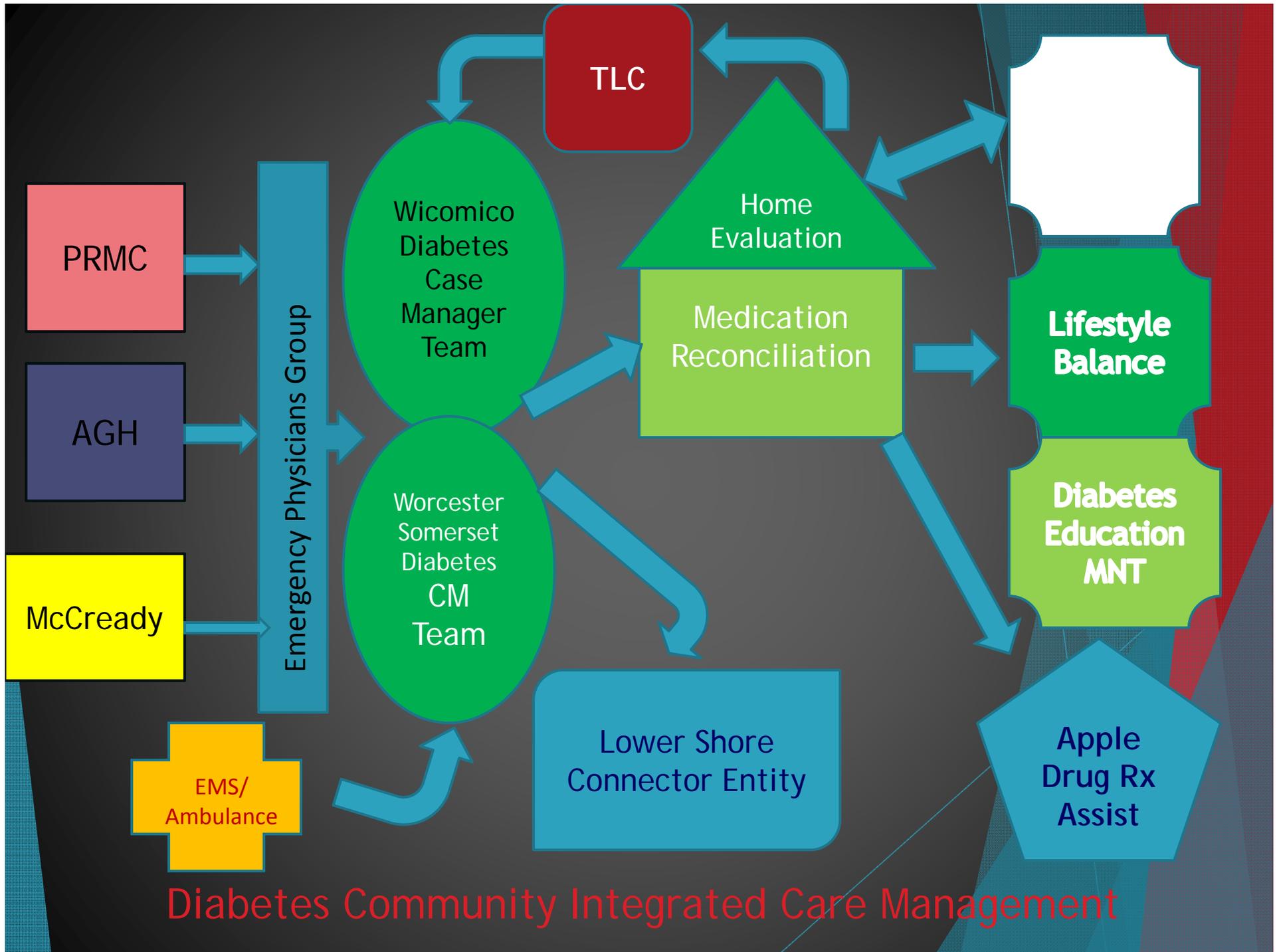
- ▶ Public Health workforce experience with Case Management- repurpose for Chronic Disease
- ▶ RN/SW- for mental health, HIV, DD, cancer, Adult, lead, high risk OB etc,
- ▶ Two teams-3 counties. Each team comprised of:
 - ▶ 1 full time registered nurse
 - ▶ 0.5 social worker

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?

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