HSCRC Consumer Engagement Taskforce Meeting

May 28, 2015
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

<table>
<thead>
<tr>
<th>Race</th>
<th>Age</th>
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<tbody>
<tr>
<td>African American</td>
<td>o&lt; 60 years 17%</td>
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<tr>
<td>Asia</td>
<td>o&gt; 60 years 83%</td>
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<tr>
<td>White</td>
<td>o Middle Eastern 1%</td>
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<tr>
<td>Middle Eastern</td>
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<table>
<thead>
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<th>Ethnicity</th>
<th>Disabilities:</th>
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<tbody>
<tr>
<td>Hispanic</td>
<td>o Medically Frail 42%</td>
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<tr>
<td>Non-Hispanic</td>
<td>o Physical Disability 29%</td>
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<td></td>
<td>o Psychological/Neurological 16%</td>
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<td></td>
<td>o Cognitive 10%</td>
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Interventions/Tests of Change

Set aims
Established measures
Selected changes

Three Fundamental Questions

Plan-Do-Study-Act (PDSA) Cycle

Planned the change
Tried the change
Observed the results
Acted on what we learned

Image: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx
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.
  o Readmissions
  o Admissions
  o ED visits
  o # of days from discharge to readmission
  o Top Diagnoses
  o Specific Focus Areas
Data

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

- National
- H.E.A.L.T.H. Partners
- Maryland

Q4-2011: 20.73%
Q1-2012: 19.47%
Q2-2012: 19.39%
Q3-2012: 18.45%
Q4-2012: 18.02%
Q1-2013: 18.26%
Q2-2013: 18.02%
Q3-2013: 17.28%
Q4-2013: 17.05%
Q1-2014: 17.51%
Q2-2014: 17.05%
Q3-2014: 16.98%
Resident Engagement

- Resident Meeting
- Resident Brochure
- Resident Interviews
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
Medication Therapy Management

Pharmacists’ Role in Medication Management

Assessment
- Interview patient & create database
- Review medication for indication, effectiveness, safety, and adherence
- List drug-related problem(s) & prioritize

Create and Implement Care Plan
- Goal of therapy
- Intervention and/or referral
- Plan for follow-up

Evaluation
- Monitor results
- Documentation
- Continuous follow-up

Possible referral of patient to physician, another pharmacist or other healthcare professional
Interventions directly with patients
Interventions via collaboration (physician and other healthcare professionals)

Pharmacy services and/or interventions

Reassess as needed

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

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<th>Time</th>
<th>Call Type</th>
<th>Unit</th>
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### Monthly Stats

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Nursing Interventions

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

• Care2Care
  o 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
  o Web and call center solution
  o Easy to understand discharge instructions & medication information
  o Help in navigating healthcare and community services
  o 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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