HOWARD COUNTY
LOCAL HEALTH IMPROVEMENT COALITION

FULL MEETING November 18, 2015

Agenda

- 8:30 – 8:40 Welcome & Introductions — Maura Rossman, Co-chair
- 8:40 – 9:10 Regional Partnership Report — Elizabeth Edsall Kromm
- 9:10 – 9:55 Office on Aging Report — Starr Sowers/Phyllis Madachy
- 9:55 – 10:00 Approval of Minutes & Member Announcements
- 10:00 – 11:00 Work Group Meetings
  - Behavioral Health – Severn
  - Access to Care – Rescheduled for Friday November 20 at 8:30 a.m.
  - Healthy Weight – Cancelled

OPENING REMARKS

MAURA ROSSMAN, MD
HEALTH OFFICER, HOWARD COUNTY HEALTH DEPARTMENT

HOWARD COUNTY GENERAL HOSPITAL

JOHNS HOPKINS MEDICINE

Howard County Regional Partnership

Local Health Improvement Coalition

November 18, 2015

Agenda

- Planning grant process recap
- Target population
- Selected interventions
- Regional partnership governance

Maryland Waiver

All Payer Model Implementation

Year 1 Focus

- Global budgets
- Meeting test metrics
- Monitoring infrastructure
- Potentially avoidable utilization concepts & data
- Stakeholder input

Year 2 Focus (Now)

<u>Clinical improvement</u>

- -Better chronic care
- -More coordinated care
- -Better episodes

<u>Payment alignment</u>

- -Medicare chronic care fees
- -Medicare willing to innovate
- -Gain sharing and P4P
- -Dual eligible & integrated networks

Year 3 Focus

- Implementation of infrastructure, work flows, and models to improve care coordination and chronic illness
- Engage patients, families, and communities
- Focus on additional alignment opportunities

Regional Partnership (RP) Expectations

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- Target services based on patient and population needs
- Plan and develop care coordination and population health improvement approaches
- Plan and describe delivery and financing model
- Identify infrastructure and workforce needed to support model
- Collaborate on analytics
- Report on required process, outcome and cost savings measures

Deliverables

1. Planning Grant Final Report
2. Implementation Funding Application
3. Multi-year Strategic Hospital Transformation Plan

- Shovel ready projects ready to implement as of January 2016
- Detailed project timeline for RP work in CY16

Revised Planning Structure

Approved by Steering Committee 8/3/15

July – Nov 2015

24 large group events
39 planning/prep meetings
Too many to count – sticky notes, white paper, cookies and wrap sandwiches

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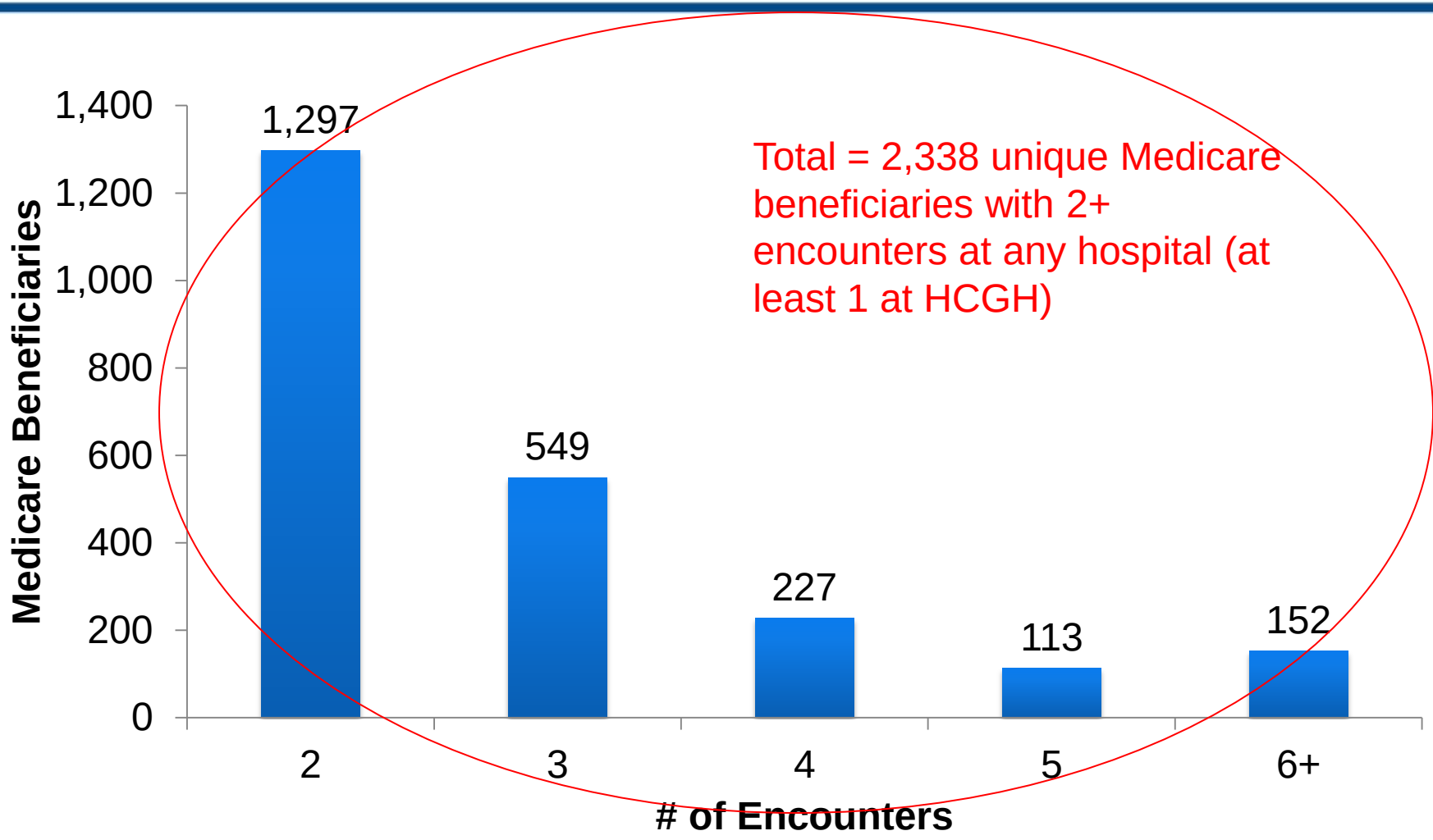
TARGET POPULATION

Target Population

- Howard County Residents

- Selection criteria for initial intervention focus
  - Medicare beneficiaries
  - At least 2 hospital encounters in past 365 days
  - 2+ chronic conditions

Medicare High Utilizers (9/14-8/15)



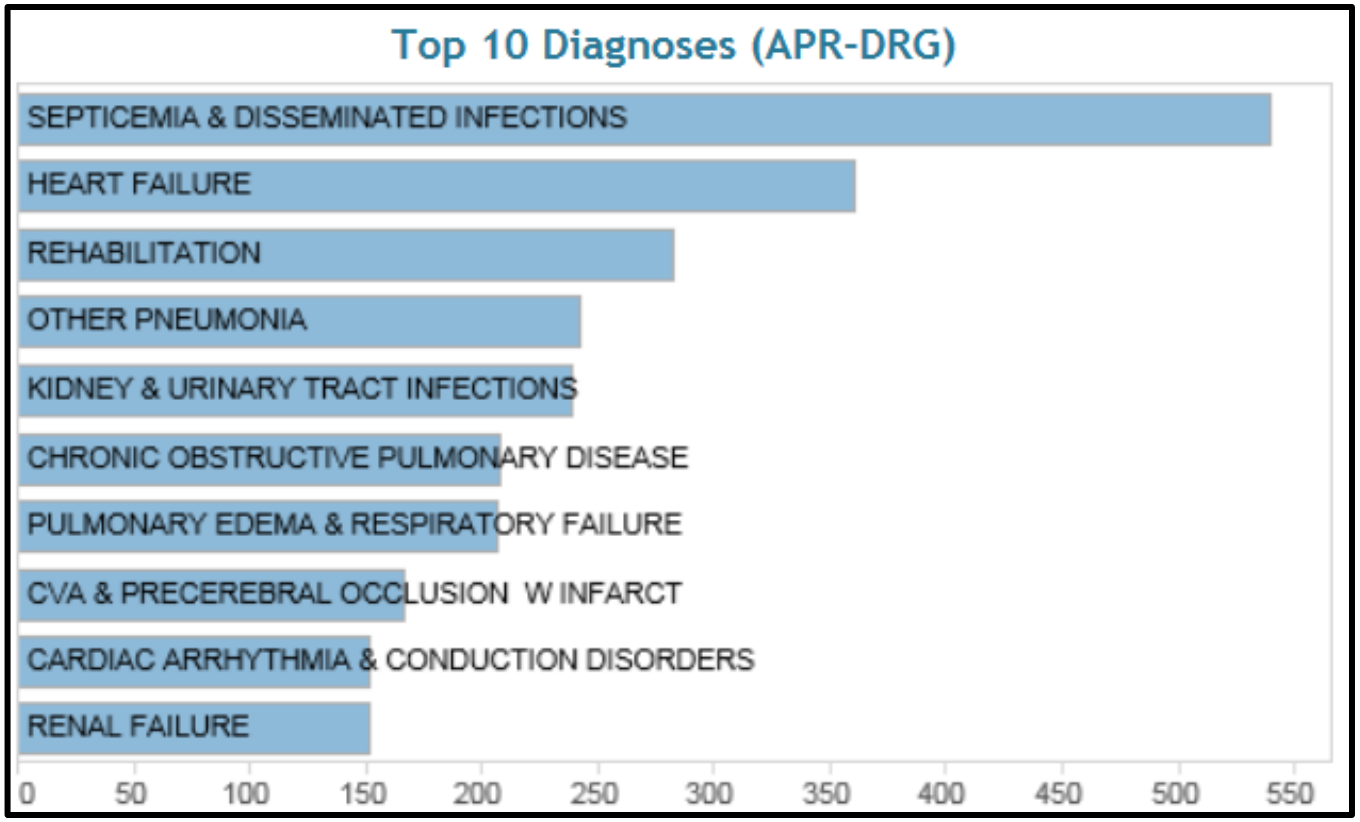
Source: HSCRC/CRISP PaTH Report

HCGH Utilization by Payer

Howard County Residents, 2+ encounters, at least 1 visit at HCGH (8/14-9/15)		
	All Payer	Medicare
# of Unique Patients	9,570	2,338
# of Visits	25,791	6,950
Total Charges	$87,390,202	$42,291,713

Source: HSCRC/CRISP PaTH Report

Top Medical Conditions



Source: HSCRC/CRISP Tableau report, CY14 [based on 2+ inpatient admissions]

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SELECTED INTERVENTIONS

Selected Interventions

- Community Care Team (CCT) for target population
- Processes, procedures and new delivery models to support care coordination in 3 care settings:
  1. Acute
  2. Primary Care
  3. Post-Acute (SNF)

Community Care Team (CCT)

- Based on Camden Coalition model
- Up to 90 day intervention
- Staffing: CHN, CHW, LCSW
- Referral sources: acute, PCP, home care and SNF

- Key components:
  - Hands-on transition at time of discharge
  - Connect with primary care, other health care needs
  - Address social determinants
  - In-home medication reconciliation and chronic disease management education
  - Care plan development
  - Pre/post Client Perception of Care survey

Acute Care – In-patient

- ESDP score to trigger workflow
- Multi-D rounds
- Home Care to drive CCT referral process
- Discharge summary modifications (based on provider preferences)
- *Expand medication reconciliation efforts*
- *Discharge materials and patient education modifications (based on patient/caregiver preferences)*
- *PAL line*

Acute Care – Emergency Dept.

- Risk score and use of CRISP alerts
- Direct admit
- Mental health RAP
- Embed Social Work and Pharm Tech
- *Urgent care collaboration*
- *PCP connection upon discharge*
- *CCT referral*
- *PAL line*

Post Acute Care - SNF

- Strategic partnership between HCGH, CIMS hospitalists, Gilchrist, and Lorien
- Standard discharge process from HCGH to SNF
- Care pathways for top causes of readmissions – Sepsis, CHF, Respiratory Failure/Pulmonary Edema
- Dashboard of shared patients and conduct monthly chart review
- *Telemedicine*

Primary Care

- Advanced Primary Care Collaborative (APPC) as vehicle to engage practices
  - Pilot groups: JCHP, CMP, Centennial
- Practice-based referrals to CCT
- Shared Care Plan/Profile
- *Align APPC w/ hospital provider committees*
- *TCM and CCM fee - % to CCT*
- *Network development and specialist involvement*

Other RP Functions

- Training
  (E.g. patient engagement training for CCT, PCP)
- CQI
- Evaluation
- Patient education and engagement
- Caregiver intervention
- Connect and track community referrals (e.g. Healthify)
- Data analytics and reporting
- Legal agreements and MOUs

CRISP Connections

- Care alert
- Care profile and care team members
- Care management status
- Ambulatory provider connectivity
- *Secure texting solution*
- *Advanced directives/MOLST*

Implementation Timeline

	2016 Q1-Q2	**2016** Q3-Q4	**2017**
Primary Care	3 Pilot Practices	Expand to APCC	Establish Network Standards
Post Acute Care	Standardized Discharge to SNF	SNF Care Pathways	SNF Specialty Rounding & Telemedicine
Acute Care	Standardized Inpatient Process, Admit to Discharge	ED Referrals to Primary Care & CCT	Urgent Care PAL line

Governance Structure

- Committee of HCGH Board

- Sub-committees (draft list)
  - Provider Alignment (PCP and specialist)
  - Post-Acute Care
  - CQI
  - Analytics and Reporting
  - Patient/Caregiver Advisory

RP & LHIC

- Operationalize connection to LHIC
  - Tie to Action Plan
  - Connect larger population health goals to RP outcomes
  - Behavioral health
- Subcommittee participation

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QUESTIONS?

Creating an Age-Friendly Community

A 20-year plan for the growing older adult population in Howard County.

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Department of Citizen Services

Report Highlights

- Planning project commissioned by the Department of Citizen Services.
- Result of a year-long effort which engaged more than 1,600 community members.
- Findings reflect national as well as local trends.
- Six major priority areas were identified.
- Issues identified will be addressed over the next 20 years

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Demographics

- By the year 2035 it is projected –
  - 28,000 Howard County residents will be 75 years of age and older.
  - Howard County's 85 and over population will increase by 253% by 2035 rising to 23,334 people
  - This older demographic is an essential threshold for planning.

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Planning & Priorities

- The planning process helped to identify 6 priorities essential to creating an age-friendly community.
- Responsibility for carrying out the priorities falls on both County Government and community stakeholders; some are identified in the priority slides which follow, but the list is not exhaustive.
- Department of Citizen Services/Office on Aging steps in implementation are in **bold** on the following slides.
- The implementation strategies identified on the following slides should be considered starting points.

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Priority One

- **Provide advocacy, services & safety net for vulnerable adults.**
  - **Ombudsman program - continue to coordinate & collaborate with other agencies in the county that have direct contact with the aging community.**
  - **Recognize the need to expand Case Management services.**
  - Monitor the financial and health status of the county's most vulnerable residents, in collaboration with community partners.
  - Expand community education and outreach on elder abuse to include scams evolving due to the emerging cyber culture.
  - Enhance coordination among agencies with a role in the welfare of older adults, including in times of emergency.
  - Explore educational programs that support an individual's right to self-determination such as "Supportive Decision Making."

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Priority Two

- **Promote the physical, emotional & financial well-being of caregivers as well as those for whom they care.**
  - **Recruit a Caregiver Support Program Manager**
  - **Expand caregiver education & evidence-based programming opportunities**
    - Launch Powerful Tools for Caregivers
    - Increase education via methods such as electronic, in person & in collaboration with partners
  - Draft and execute a Community Caregiver Needs Assessment

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Priority Three

- **Ensure diverse housing options are available to allow residents to remain in the community and be as independent as possible.**
  - Requires diversity in both housing stock and diversity in pricing
  - Realignment of policies within County government
  - **Provide education to the public about aging in the community, including home modification and financing options (e.g., Livable Homes Tax Credit)**

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Priority Four

- **Provide affordable, accessible, reliable, safe, convenient, cost-effective mobility options to get people where they want and need to go.**
  - Utilize traditional methods of transportation (bus/taxi/car/etc.) as well as partnerships with organizations like NeighborRide
  - Increase efficiency of paratransit services
  - Explore expanded options for public transportation
  - Realignment of policies within County government to move mobility options forward
  - Increase the number of driver support programs such as the AARP Mature Driver Course and travel training programs for those new to using public transportation

Priority Five

- **Optimize opportunities for a healthy quality of life for all residents that integrates physical, behavioral, and spiritual well-being, in a manner that supports personal choice.**
  - Assess the need for increased mental health services for older adults.
  - **Continue to offer evidence based programming in a variety of languages.**
  - **Collaborate with the local health care system to impact population health and reduce hospital readmissions.**
  - **Collaborate with the LHIC to create the Health Aging Workgroup.**
  - **Expand relationships between the Office on Aging, Workforce Development, AARP, and HCC to enable older adults to transition in retirement or into new careers more effectively.**

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Priority Five (cont)

- Optimize opportunities for a healthy quality of life for all residents that integrates physical, behavioral, and spiritual well-being, in a manner that supports personal choice.
  - Launch the Go50+ fitness center membership option in partnership with Rec & Parks to promote better health outcomes for older adults throughout the lifespan.
  - Continue to explore a county-wide health information network that would combine data currently used by social service agencies and healthcare providers.
  - Conduct a behavioral health awareness campaign.

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Priority Six

- **Prepare residents for the new demographic reality at both the personal and community levels.**
  - **Collaborate with HCPSS - create an interactive, lifelong learning curriculum to address health and wellness, financial/retirement planning, essential coping skills to successfully age in place, & address aging through the lifespan issues.**
  - **Explore "Supportive Decision Making," a process where individuals use friends, family members and professionals to help them understand the situations and choices they face, so they may make their own decisions.**

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How is the Report Shaping OOA Activities?

- Offering an evidence-based caregiver support program, “Powerful Tools for Caregivers” this year.
- Loan Closet-By expanding the capacity and operating hours of the program in this fiscal year, the Loan Closet will be able serve up to 2,500 residents and will be able to accept donations of larger items, such as scooters and stair glides.
- Using recommendations for 50+ Center facilities to guide the design, construction, and renovation of new and existing centers (ongoing).
- A new Elkridge 50+ Center is in the design phase.

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How is the Report Shaping OOA Activities?

- Expanding the Kindred Spirits program to 5 days per week in 2016
- Making technology in the centers more user-friendly for participants.
- Collaborating with Columbia Association on areas where plans overlap.
- Created an elder abuse campaign in partnership with the Howard County Police Department and the Vulnerable Older Adult Committee.
- Rebranded senior centers as 50+ Centers in July 2015.

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County Executive's Roll-Out

- Form a subcabinet task force to address the supports and barriers of supporting an aging population in county agencies, policies, and programs.
- Appoint an Age-Friendly Leadership Council, staffed by Office on Aging and Department of Citizen Services and made up of community leaders.
- Structure a strategic partnership and shared timeline with the Columbia Association for implementation of focus areas.
- Engage the community in full understanding of the priorities of Creating an Age-Friendly Community
- Encourage community participation to support individuals striving to stay in the community.

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Questions?

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APPROVAL OF MINUTES 9.24.15

Announcements

- LHIC New Member Handbooks
- LHIC Member Announcements
- LHIC Website Demo (Time Permitting)

Wrap-Up

- Questions/Comments
- Work Group Meetings

  Behavioral Health ⇒ Severn

  Access to Care ⇒ Friday, November 20, 8:30 a.m.

  Healthy Weight ⇒ Cancelled
- March Community Forum Planning Meeting – Barton A
- Please sign in if you haven't already
- Please leave nametags on registration table

THANK YOU!