

**MEMORANDUM**

September 11, 2012

TO: Health and Human Services Committee

FROM: Linda McMillan, Senior Legislative Analyst 

SUBJECT: **Montgomery Cares: FY12 End of Year Report**  
Evaluation of ED-PC Connect

***Expected for this session:***

Uma Ahluwalia, Director, Department of Health and Human Services  
Jean Hochron, Administrator, Montgomery Cares Program, DHHS  
Steve Galen, Executive Director, Primary Care Coalition  
Barbara Eldridge, Manager of Quality Improvement, Primary Care Coalition

At the session, the Health and Human Committee will receive an update from the Department of Health and Human Services on the number of patients, encounters, and expenditures for Montgomery Cares during FY12 as well as the issues going forward in FY13. Following this update on Montgomery Cares, the Primary Care Coalition will present the findings from the evaluation of the ED (Emergency Department) – PC (Primary Care) Connect program that worked to reduce ED visits by connecting low-income patients to Montgomery Care clinics so that their conditions might be addressed in a primary care setting.

**Montgomery Cares FY12**

Attached at ©1-38 is the FY12 End-of-Year Report on Montgomery Cares that was prepared by the Primary Care Coalition and presented to the Montgomery Cares Advisory Board. Attached at © 39 is a table summarizing the budget and expenditures for FY12. The End-of-Year Report shows that:

- In FY12, Montgomery Cares served 27,814 unduplicated patients in FY12. This includes patients served through the Healthcare for the Homeless Program. This is an increase of 937 patients from FY11.

- These patients had 77,162 encounters at the primary care clinics. This is an increase of 3,800 from FY11.
- The actual FY12 encounters exceeded the 75,000 that were assumed in the original FY12 budget. These additional visits were funded in part through a \$50,000 grant from CareFirst to the Primary Care Coalition and in part through a reallocation of funding within the DHHS budget.
- The Council approved FY13 funds to expand both the number of patients that can be served and the number of encounters funded. The report (©5) lists ways that the clinics can increase their capacity for FY13. They include increasing hours and providers at current clinics, facility expansion/renovation, increasing the efficiency of operations, developing and outreach strategy, and expanding participation to other providers (a new provider is participating in FY13 and the new Holy Cross Clinic is open).
- Demographics of the patient population are included at ©9. Most patients are female and a majority of patients have incomes below the Federal Poverty Level.
- Community Pharmacy, through careful management, stayed within its FY12 budget. Information on ©12-14 show that the use of Medbank continues to increase; \$3.68 million was received in FY12. This is more than double the \$1.78 million in funding that was provided by the County. The report notes that PCC is looking at the current tracking system that is becoming an increasing management burden for the clinics.
- Information on Specialty Care is included at ©17-25. As was discussed during budget, there is an increasing demand for specialty care. Adjustments have been made to the payment to AHCN to ensure continued access.
- Circle 38 provides summary comments and recommendations from PCC to the MC Advisory Board for moving forward in FY13.

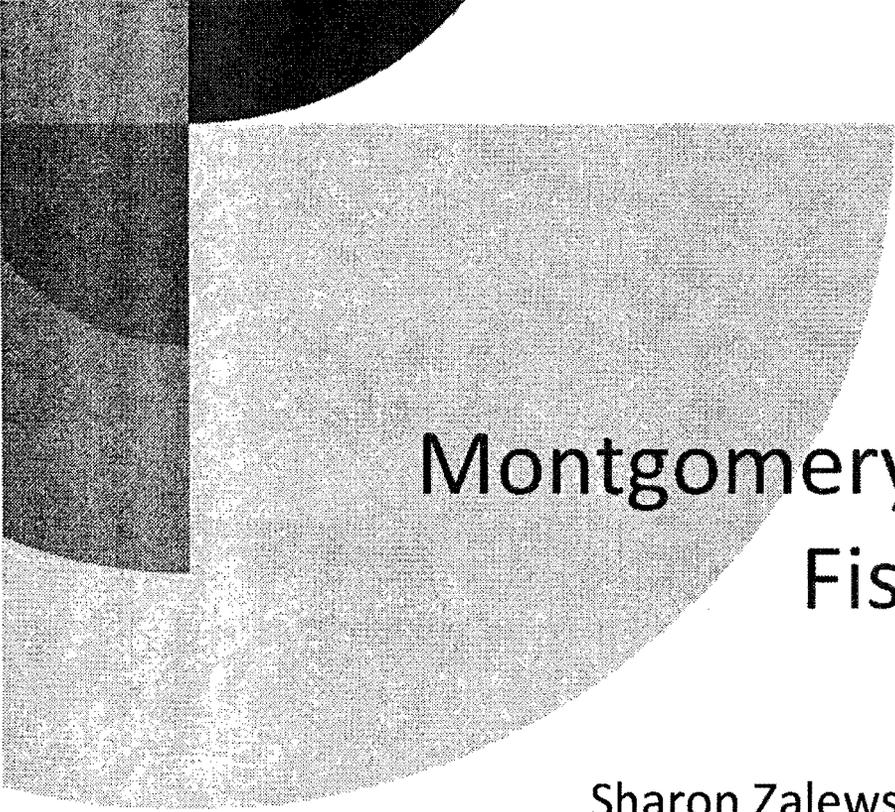
### **ED-PC Connect Evaluation**

Barbara Eldridge from PCC will brief the Committee on the evaluation of the ED-PC Connect Program. The Executive Summary and Key Findings are attached at ©1-5. The ED-PC Connect program was funded from 2009 to 2011 through a CMS ED Diversion Grant from the Maryland Department of Health and Mental Hygiene. The goal of the program is to reduce the use of emergency departments by people who could be treated in a primary care setting or who could avoid using the emergency room in the future by having their condition address through primary care. Each of the county hospitals partnered with one or more Montgomery Cares clinics. Appropriate low-income patients were identified in the emergency department and then referred to a clinic. Each of the hospitals had a navigator who attempted to contact those being referred. The following table provides some of the data by hospital and shows that over 10,000 people who visited the emergency departments during the evaluation period were referred to a clinic. The hospital navigators had very different success rates in terms of the percentage of those contacted by a navigator. This is important as it was more likely that a patient would follow-up if they were contacted by a navigator in addition to getting referral information from the ED.

ED-PC Connect	Holy Cross Hospital and HCH Clinic	MedStar Montgomery and Proyecto Salud	Shady Grove and Mobile Med	Suburban Hospital and Holy Cross Clinic, Mobile Med, Proyecto Salud	Washington Adventist and Mary's Center
Total Patients referred to ED-PC Connect	2,636	1,557	4,977	604	987
Patients contacted by Navigator	1,238	684	802	388	332
Percent of referred Patients contacted	47%	44%	16%	64%	34%
Patients who visit clinic for follow-up	852	314	717	125	164
Percent of Total Patients referred	32%	20%	14%	21%	17%
Percent of Patients who went to clinic for follow-up if given both a referral at ED and were contacted	52%	30%	31%	21%	19%
Patients who had more than one follow-up clinic visit	602	206	496	86	97
Percent of all Patients with clinic follow-up	71%	66%	69%	69%	59%
Percent of Patients making clinic appts seen in 7 days or less	25%	32%	29%	26%	15%
Percent of Patients making clinic appts seen in 30 days or less	80%	72%	63%	54%	54%

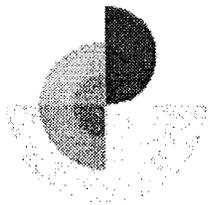
**The evaluation showed that ED referrals, especially when paired with follow-up contact by a navigator can reduce future visits to the ED. This not only impacts the wait times in ED but also can result in substantial cost avoidance to the hospital. The evaluation has some interesting trends in terms of the differences in ED use by those seeking help for a chronic condition and those seeking behavioral health services.**

Council staff suggests that the Committee discuss with PCC and DHHS the current state of ED-PC Connect, as Council staff understands that it has not continued at all county hospitals. What might be done not only to reinstate the program across all the hospitals but to enhance it to allow a higher percentage of follow-up by the navigator? In addition, can any longer term evaluation be completed after 2012 to determine what percentage of patients continue at the clinics and what their use of the ED has been.



# Montgomery Cares Year End Report Fiscal Year 2012

Sharon Zalewski, Director, Center for Health Care Access  
Barbara Raskin, Montgomery Cares Program Manager

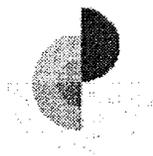
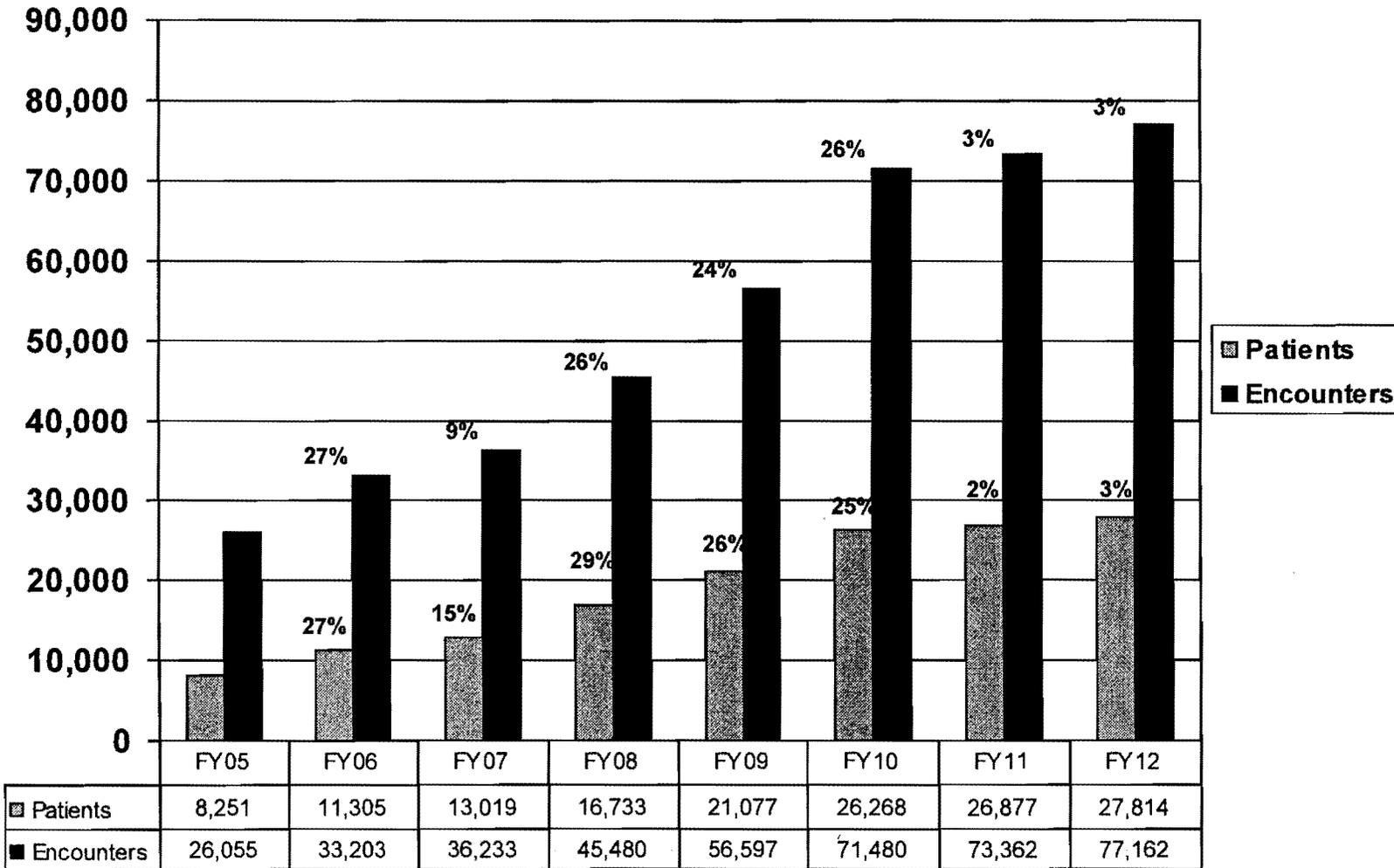


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# Montgomery Cares Patients and Encounters FY05 – FY12



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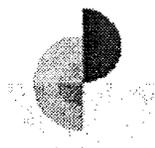
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# YTD Patients and Encounters – June 2012

Year to Date					Budget Allocations		
	Clinic	FY 2011 Unduplicated Patients	FY 2011 Encounters	FY12 Unduplicated Patients	FY12 Encounters	FY12 Budgeted Encounters	Percent of Budget Target
CCACC-PAVHC	374	719	411	784	734	107%	50
Community Clinic, Inc.	2,965	9,671	3,011	9,788	9,871	99%	(83)
CMR - Kaseman Clinic	1,744	4,202	1,769	4,334	4,289	101%	45
Holy Cross Hospital Health Centers	4,900	13,416	4,733	13,272	13,693	97%	(421)
Mary's Center	528	1,236	619	1,635	1,262	130%	373
Mercy Health Clinic	2,193	6,777	2,347	7,985	6,917	115%	1,068
Mobile Med	5,406	12,572	5,723	14,127	13,830	102%	297
Muslim Community Center Clinic	1,850	5,953	2,204	6,525	6,076	107%	449
Proyecto Salud - Wheaton & Olney	4,720	13,399	5,021	13,654	13,675	100%	(21)
Spanish Catholic Center	1,087	2,798	801	2,316	2,856	81%	(540)
The People's Community Wellness Center	777	1,761	826	1,934	1,797	108%	137
<b>General Medical Clinic Sub-totals</b>	<b>26,544</b>	<b>72,504</b>	<b>27,465</b>	<b>76,354</b>	<b>75,000</b>	<b>102%</b>	<b>1,355</b>
CCI - Homeless	219	502	229	535	1000	54%	
CMR - Kaseman Clinic - Homeless	114	356	120	273	500	55%	
<b>Homeless Medical Clinic Sub-totals</b>	<b>333</b>	<b>858</b>	<b>349</b>	<b>808</b>	<b>1,500</b>	<b>54%</b>	<b>0</b>
<b>Medical Clinic Totals</b>	<b>26,877</b>	<b>73,362</b>	<b>27,814</b>	<b>77,162</b>	<b>76,500</b>	<b>101%</b>	

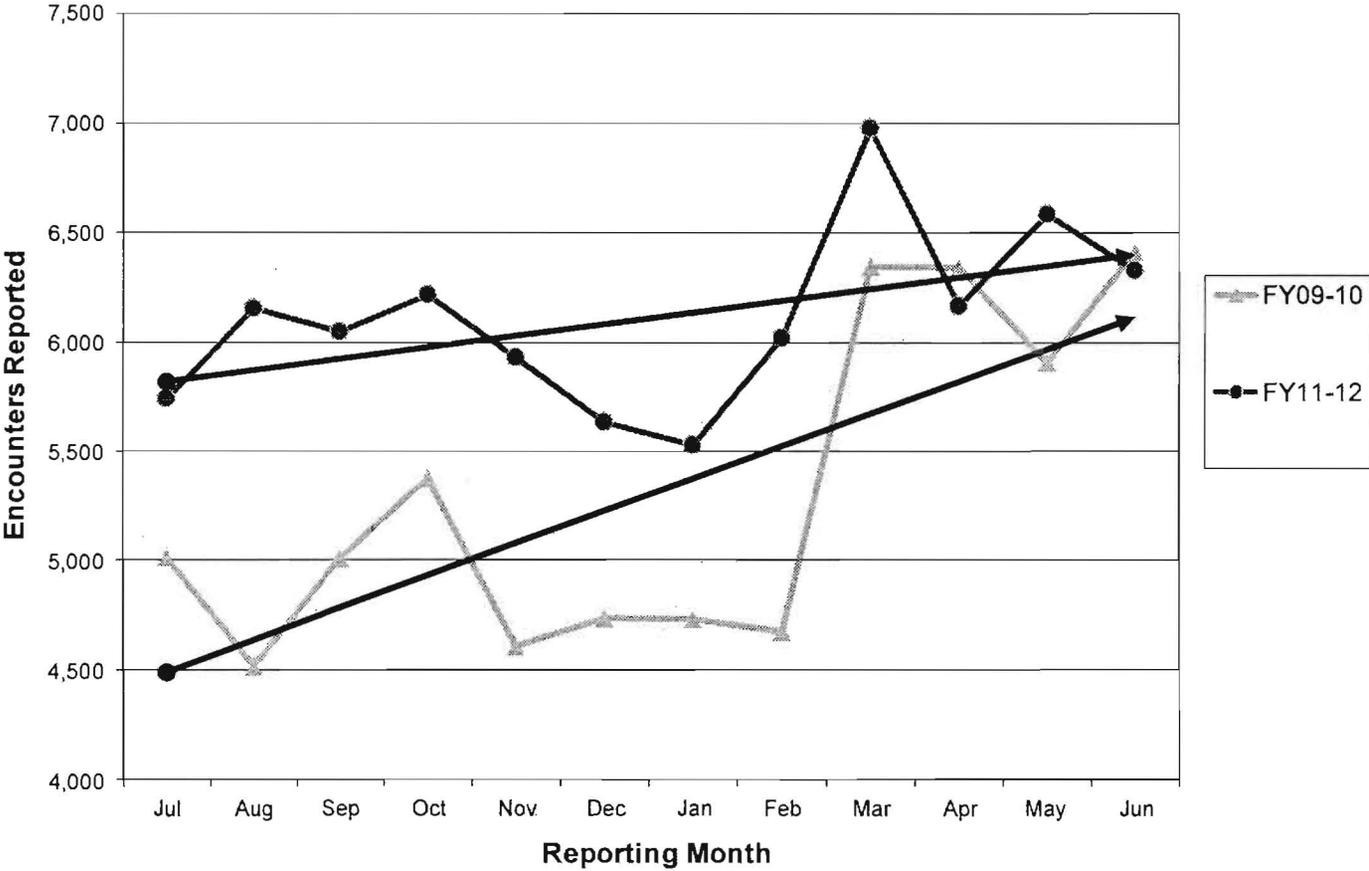
\*\$50,000 supplement (766 visits) for new patient encounters was received from CareFirst in the Fall of 2011.

\*\$75,000 supplement (1210 visits) for primary care encounters was received from DHHS in April 2012.



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# FY09/10 – FY11/12 Growth Trends



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# Program Performance

**Growth:** Montgomery Cares continues to plateau growing 5 % in the last two years compared to the 21% average growth rate of previous years.

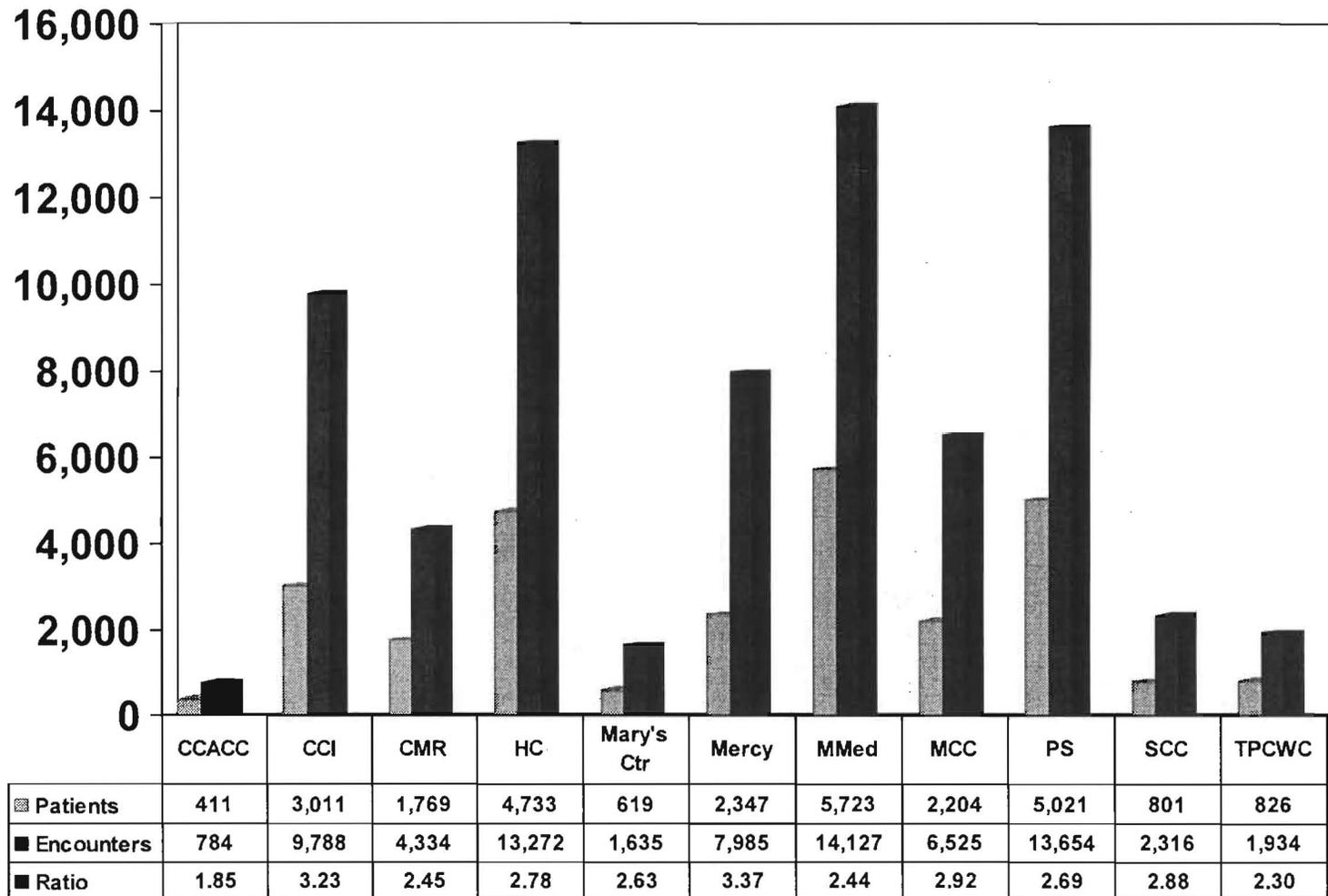
- The number of patients served in FY 12 increased 3% from 26,877 to 27,814.
- The number of encounters increased 5% from 73,362 to 77,162.
- The average patient/encounter ratio is 2.8.

**Capacity:** Capacity among providers changed little during FY12 although there is room for expansion among several providers.

- Increase hours of operation in current facilities.
- Facility renovation or site expansion.
- Add primary care providers at current clinic sites.
- Improve efficiency in operations.
- Develop and implement an outreach strategy.
- Resource development to diversify funding for program and clinics.
- Expand participation in Montgomery Cares to other primary care providers.

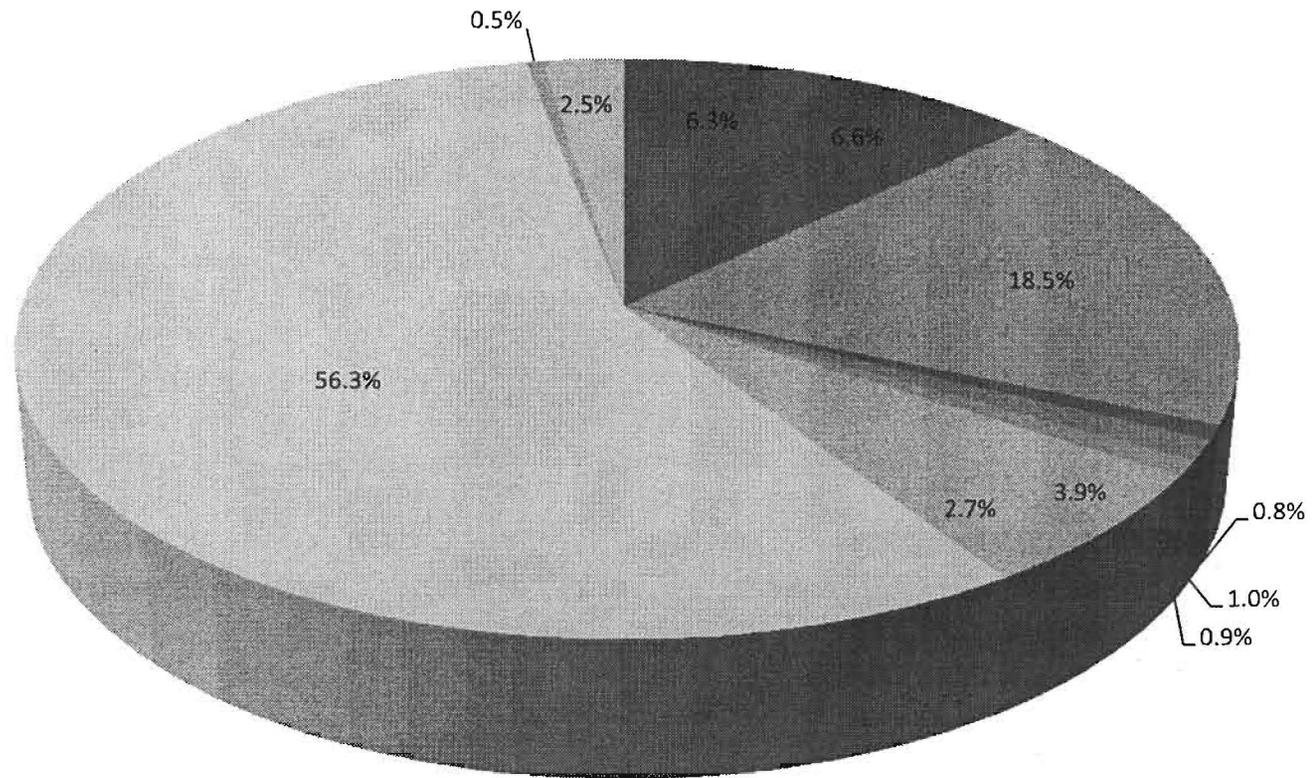


# Unduplicated Patients & Encounters by Clinic

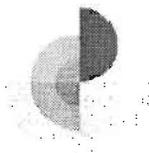


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# PCC's Montgomery Cares Expenditures for FY12



- Administration
- Behavioral Health Program
- Community Pharmacy
- Diabetes Education
- Homeless Services
- Facilities-Aspen Hill
- Information Technology
- Oral Health Program
- Primary Care
- Quality Improvement
- Specialty Care

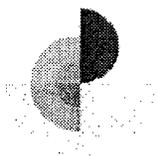


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# Budget and Resources

- PCC's Montgomery Cares FY12 expenditures were \$8,799,487; \$26,000 was unspent resulting in a budget variance of .3%.
- Roughly, 88% of MC funds supported direct services; 11% supported MC administration and network services (IT and QI); 1% supported a new facility.
- Early in the year, CareFirst contributed \$50,000 to support 766 new patient encounters. In April, DHHS added \$100,000 to support primary care encounters and \$75,000 to support Holy Cross Hospital's Aspen Hill facility build-out.
- There were shortfalls in specialty care beginning mid-year; \$57,000 was shifted to direct specialty care services. PCC contributed \$3,500 to cover the cost of an urgent neurosurgery. DHHS added \$11,322 to the AHCN contract increasing it from \$50,000 to \$61,322.
- Funds were also shifted to cover PCC's MC administrative costs, IT costs and to provide HIPAA training for clinic, PCC and DHHS staff.
- With little growth, funds to support primary and specialty care encounters at clinics has been adequate; funding for specialty care, behavioral health and oral health continues to be insufficient to meet population needs.



# Montgomery Cares Patient Demographics

Mostly Female 68.1% Majority Hispanic 58.5%

Mid-Age  
8.2% are 65+  
30.8% are older 50 to 64  
22.5% are in their 40's  
22.0% are in their 30's  
16.5% are young adults 18 to 29

Racially Diverse  
16.3% White  
20.6% Black  
10.8% Asian  
44.9% Other (includes Hispanic)  
6.7% Native American, Alaskan, Pacific Islander

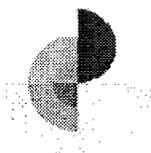
Very Poor  
60.6% report income <= 100% FPL  
16.4 % report income between 101 - 133% FPL  
22.7% report income between 134-250% FPL

77% of Montgomery Cares patients, 18,830 people, report incomes that will meet Medicaid's expanded income threshold in 2014. Considering other eligibility criteria and completing applications successfully, as few as one-third of Montgomery Cares patients, 6,277 people, are likely to obtain Medicaid early on.

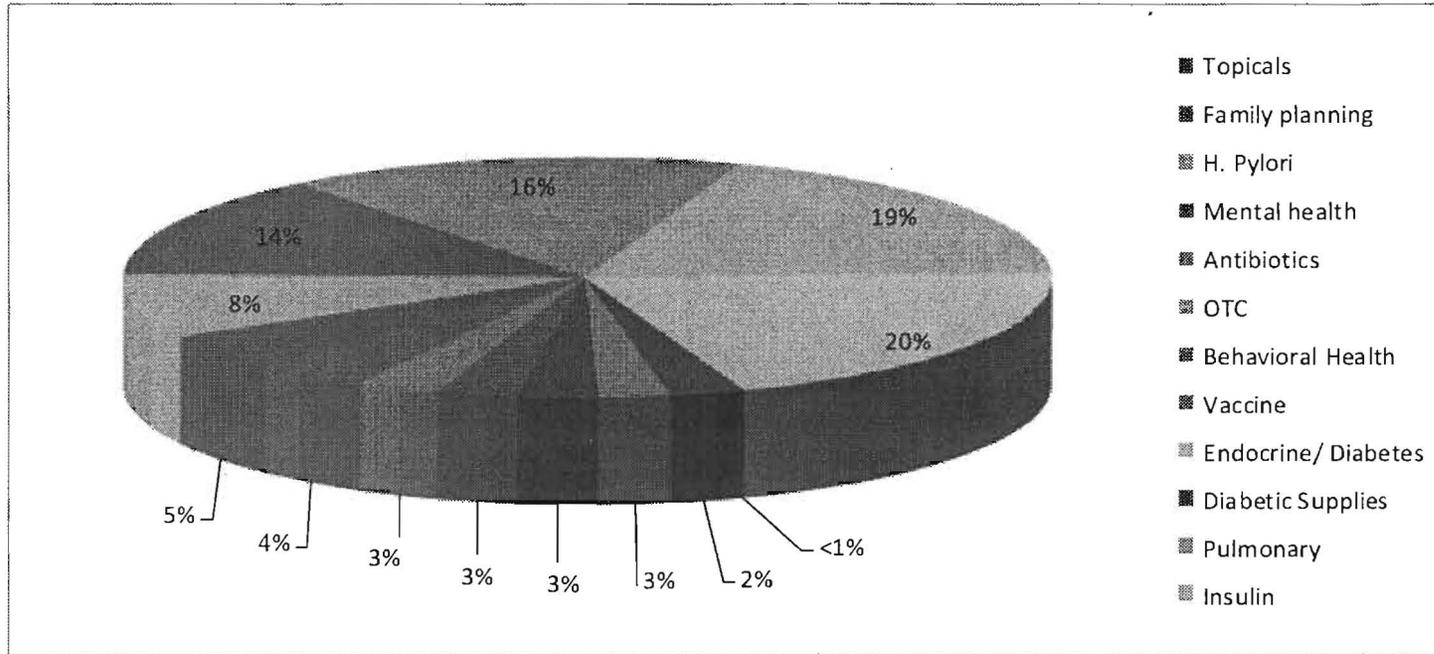
# Community Pharmacy Expenditures FY12

Category	FY12 Allocation	Q1	Q2	Q3	Q4	Total Expenditure	% Expenditure	Budget Remaining	% Remaining
General Formulary	1,092,448	221,834	261,953	263,708	260,413	1,007,908	92%	84,540	8%
Diabetic Supplies H. Pylori	290,589	28,257	72,256	35,450	95,383	231,346	80%	59,243	20%
Behavioral Health	60,622	14,522	12,333	19,429	11,900	58,184	96%	2,438	4%
Vaccine	67,908	42,607	22,385	0	3,339	68,332	101%	-424	-1%
Bradley Pharmacy	3,000	764	993	250	1,054	3,061	102%	-61	-2%
Over-The-Counter					39,802	39,802		0	
New Clinic - Aspen Hill					23,797	23,797			
<b>Total</b>	<b>1,514,567</b>	<b>307,984</b>	<b>369,920</b>	<b>318,837</b>	<b>435,688</b>	<b>1,432,429</b>	<b>95%</b>	<b>82,138</b>	<b>5%</b>

\*Variance between budget and product purchase represents distribution to other Montgomery Cares program areas.



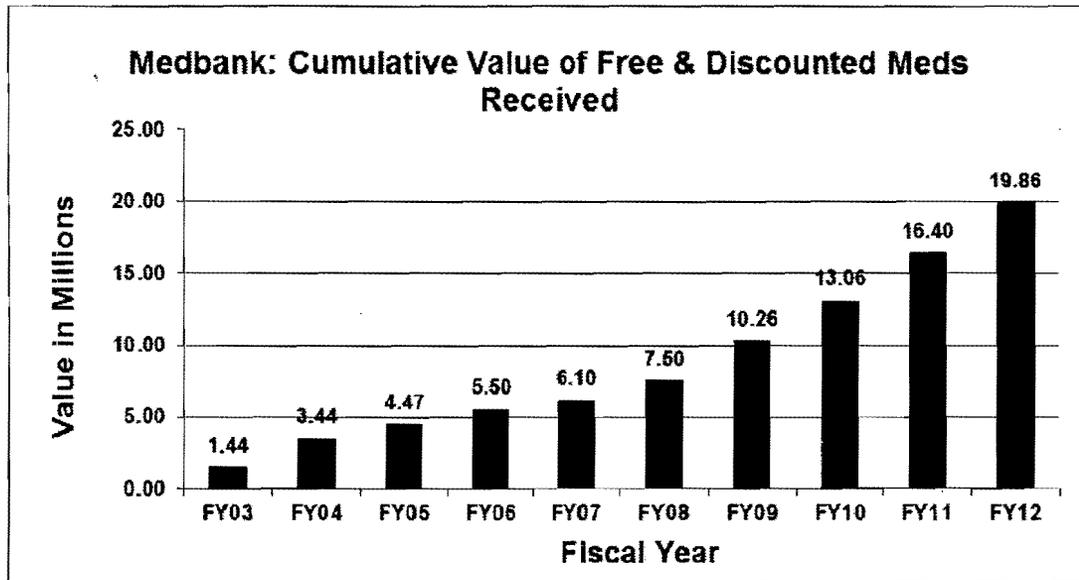
# Pharmacy Expenditures Breakdown by Category



FY12 Expenditure	
Point of Service Medication	\$ 1,195,228
Diabetic Supplies/ H. Pylori	\$ 234,140
Bradley	\$ 3,061
<b>Total</b>	<b>\$ 1,432,429</b>



# Medbank Program Impact FY12



**Value of Meds Received**      \$3,684,214  
**Patients Assisted**                      1,631  
**Prescription Requests Processed**      6,979  
**Prescription Requests Received**      5,745  
**Medication Received Success Rate**      82%

## Medbank Value of Free and Discounted Medication (\$ million)

	FY03	FY04	FY05	FY06	FY07	FY08	FY09	FY10	FY11	FY12
<b>Fiscal Year Value</b>		2.00	1.03	1.03	0.60	1.40	2.76	2.80	3.34	3.68
<b>Cumulative Value</b>	1.44	3.44	4.47	5.50	6.10	7.50	10.26	13.06	16.40	19.86



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# Community Pharmacy

## Community Pharmacy continues to implement cost reduction strategies.

- Clinics refer patients at 116% FPL and above to retail pharmacies for discounted generic medications and utilize Medbank to obtain free name brand medications.
- Six additional medications in 3 classes, antibiotics, cardiovascular and pulmonary, were added to the formulary along with purchase of insulin syringes.

## Challenges

- National drug shortages of Triamterene/HCTZ and Clarithromycin resulted in significant cost increases (\$9.50 to \$22 for HCTZ and \$60 to \$140 for H. Pylori blister packets) as well as gaps in availability.
- National voluntary drug recalls for generic medications on community pharmacy formulary were more frequent in FY12. There were 2 recalls at the clinic level and 1 recall at the patient level. Implementation of recall protocols revealed deficiencies in medication tracking that impacted timely and effective recall. As a result, mock recall exercises were implemented increasing recall effectiveness from 75 to 98 percent.

**Future Considerations:** After 7 years of growth, the POS meds manual tracking system has increased the pharmacy management burden on clinics. PCC is evaluating this issue against the backdrop of new EHR implementation; increased utilization of prescriptions for discounted retail programs; and the cost v. benefit of third party administration by a Pharmacy Benefit Management company (PBM).



# Medbank

## Medbank utilization has increased significantly.

- 8% growth rate over FY11 from 1,508 to 1,631 patients.
- 10% increase in value of medications received.
- Over \$1 million in costs have been avoided primarily related to obtaining insulin, behavioral health medications and pulmonary inhalers through Medbank rather than POS.

## Current Challenges

- Steady decline in medications available through Pharmacy Assistance resulting from:
  - Branded medications becoming generic.
  - Manufacturers not accepting new applications for certain medications.
  - Manufacturers removing medications from the program.
  - Manufacturers' changes in eligibility criteria or required documentation.

**Future Considerations:** PCC received a County Council Grant of \$59,055 to support technology upgrades that will streamline the Medbank application process and facilitate enrollment.



# HRSA Patient Safety and Clinical Pharmacy Collaborative (PSPC)

The MC Community Pharmacy continued its award-winning participation in the HRSA Patient Safety and Clinical Pharmacy Services Collaborative (PSPC) to support and implement clinical pharmacy services into safety net systems.

- FY12 project expanded to Proyecto Salud and The People's Wellness Center.
- 3 new team partners added - Maryland Pharmacists Association, Delmarva Foundation for Medical Care, and University of Maryland Eastern Shore School of Pharmacy.
- Team received HRSA PSPC "Life Saving Patient Safety" and "Outstanding Performance" awards.
- Voted "Best Collaborative/Community Partnerships" at the American Pharmacists Association 2012 Annual Meeting.
- Director of CMA was selected to the new Innovation Advisors Program with the project entitled: "Pharmacy Collaboration for Better Health".
- The Journal for Health Care for the Poor and Underserved will publish a PSPC project-focused field report, "Inter-professional Collaborative Model for Medication Therapy Management (MTM) Services to Improve Healthcare Access and Quality for Underserved Population," in the August 2012 issue.



# Specialty Care Appointments by Source FY12

Appointment Source	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	Cumulative Total
Clinic On-Site Specialty Care	1,319	1,225	1,661	1,006	<b>5,211</b>
AHCN	352	374	332	242	<b>1,300</b>
Project Access	600	535	569	552	<b>2,256</b>
MM Heart Clinic	131	128	171	140	<b>570</b>
<b>TOTAL</b>	<b>2,402</b>	<b>2,262</b>	<b>2,733</b>	<b>1,940</b>	<b>9,337</b>



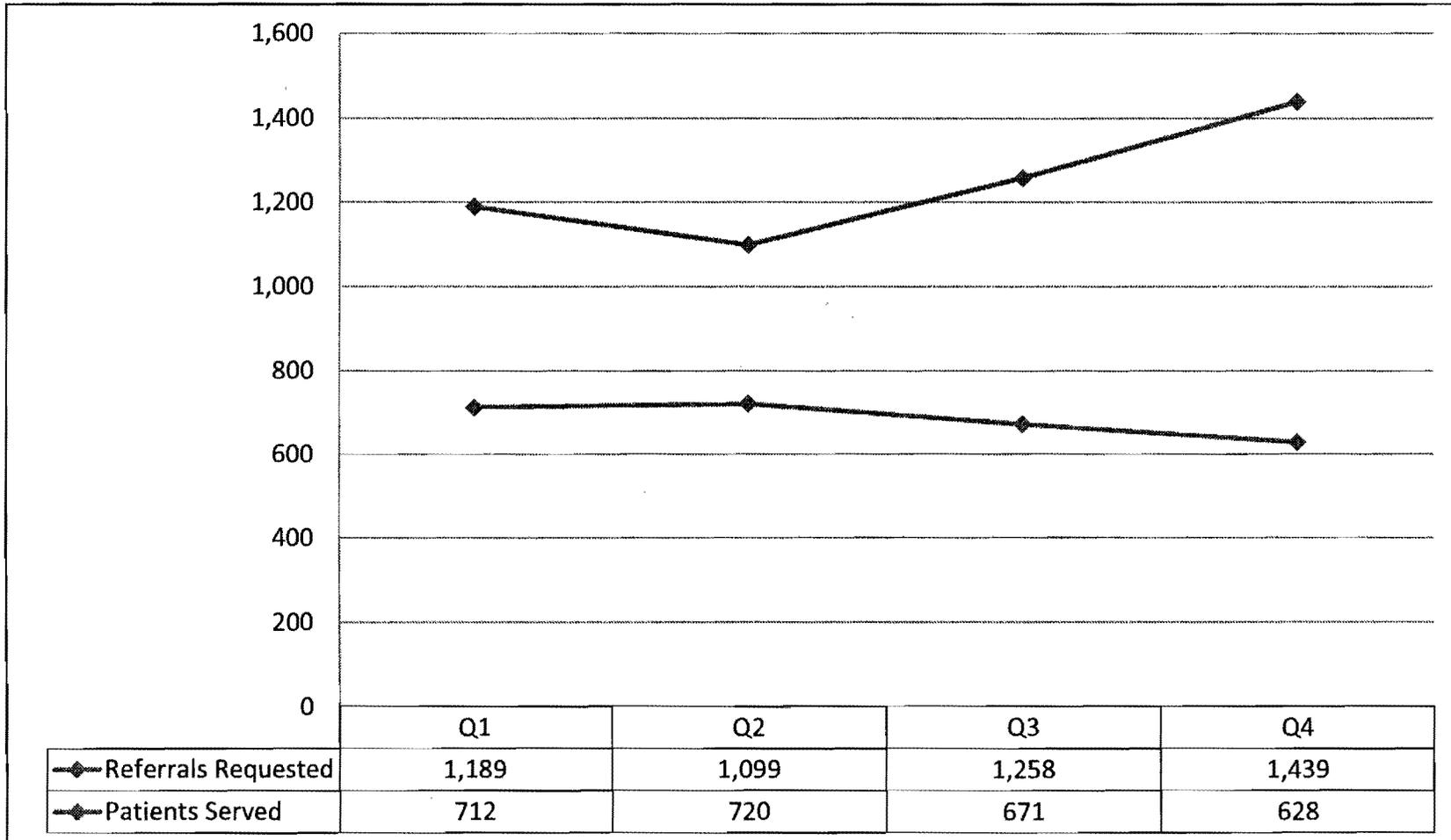
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# Montgomery Cares Support for Specialty Care

Montgomery Cares FY12	
PA (Staff and Program)	\$219,061
RN Triage	\$ 82,462
AHCN	\$ 61,322
Direct Specialty Care Services Managed by Project Access	\$170,505
Clinic On-Site Specialty Services (\$62 per visit)	\$358,422
<b>Total</b>	<b>\$891,772</b>



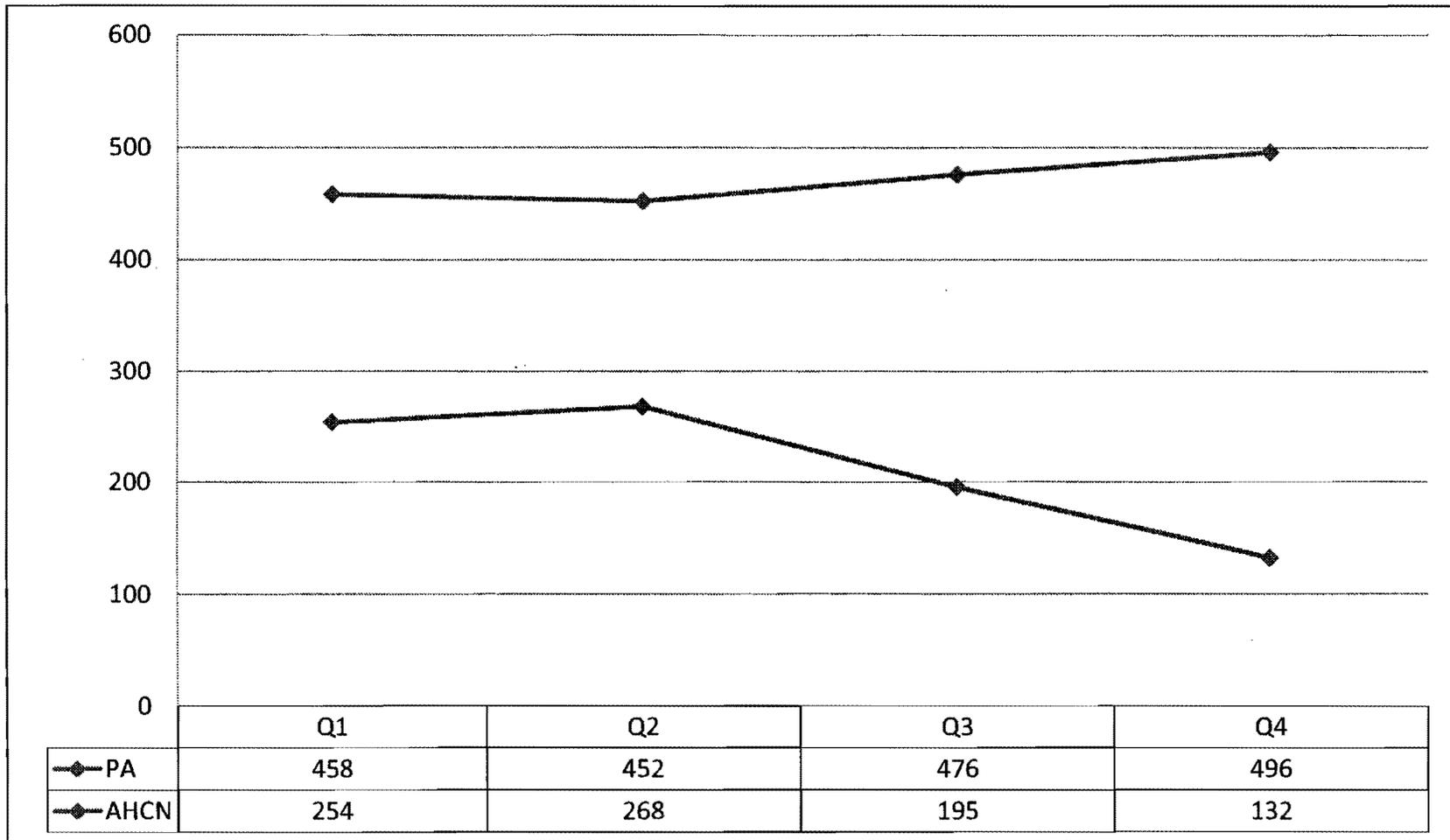
## Specialty Care Referral Networks: Referral Requests vs. Patients Served FY12



Note: Data for Montgomery Cares eligible patients referred to PA or AHCN



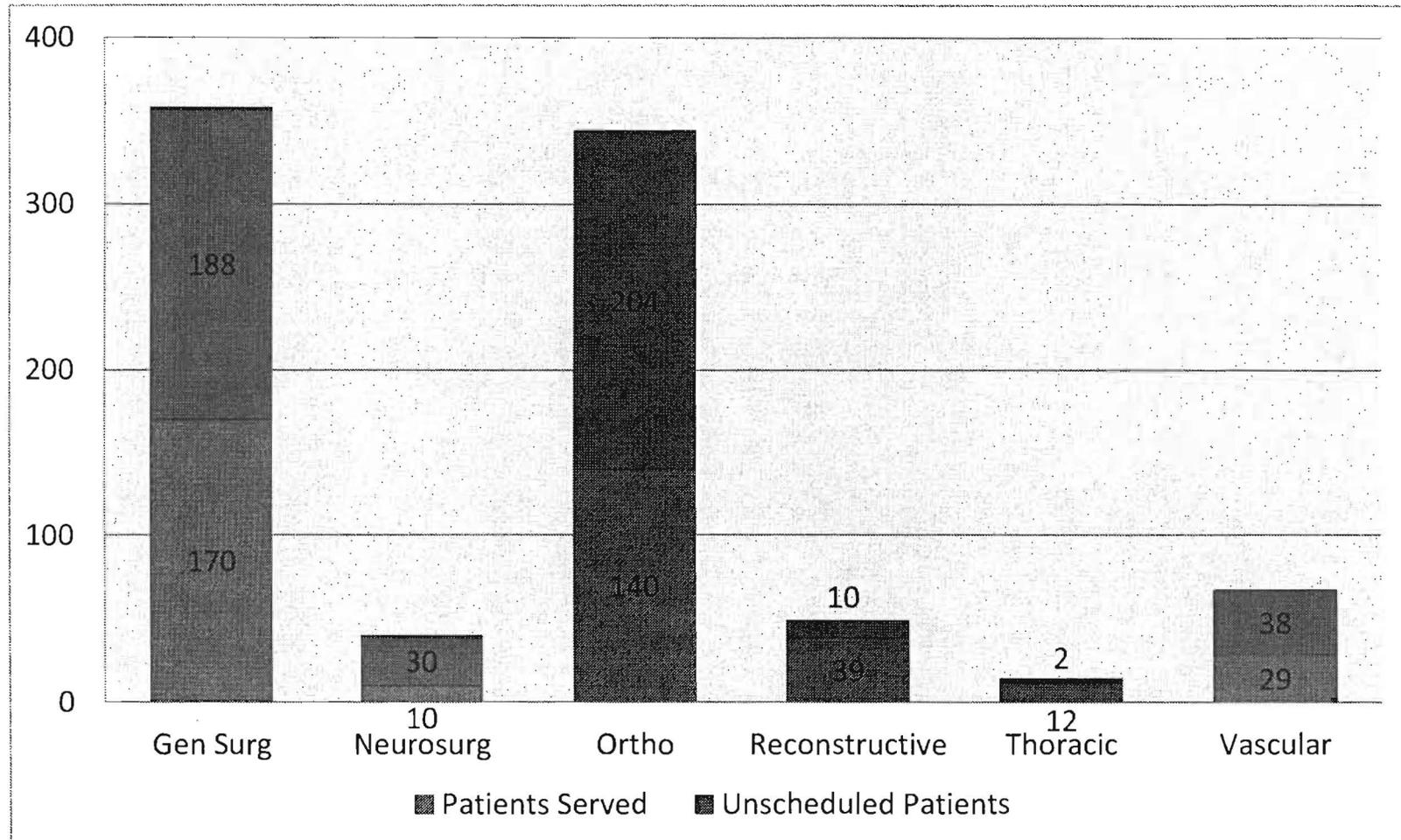
# Unduplicated Patients Served FY12: Project Access vs. AHCN



Note: Data for Montgomery Cares eligible patients referred to PA or AHCN



# Project Access: Referral Requests vs. Patients Served by Selected Specialty Area FY12



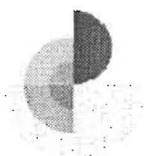
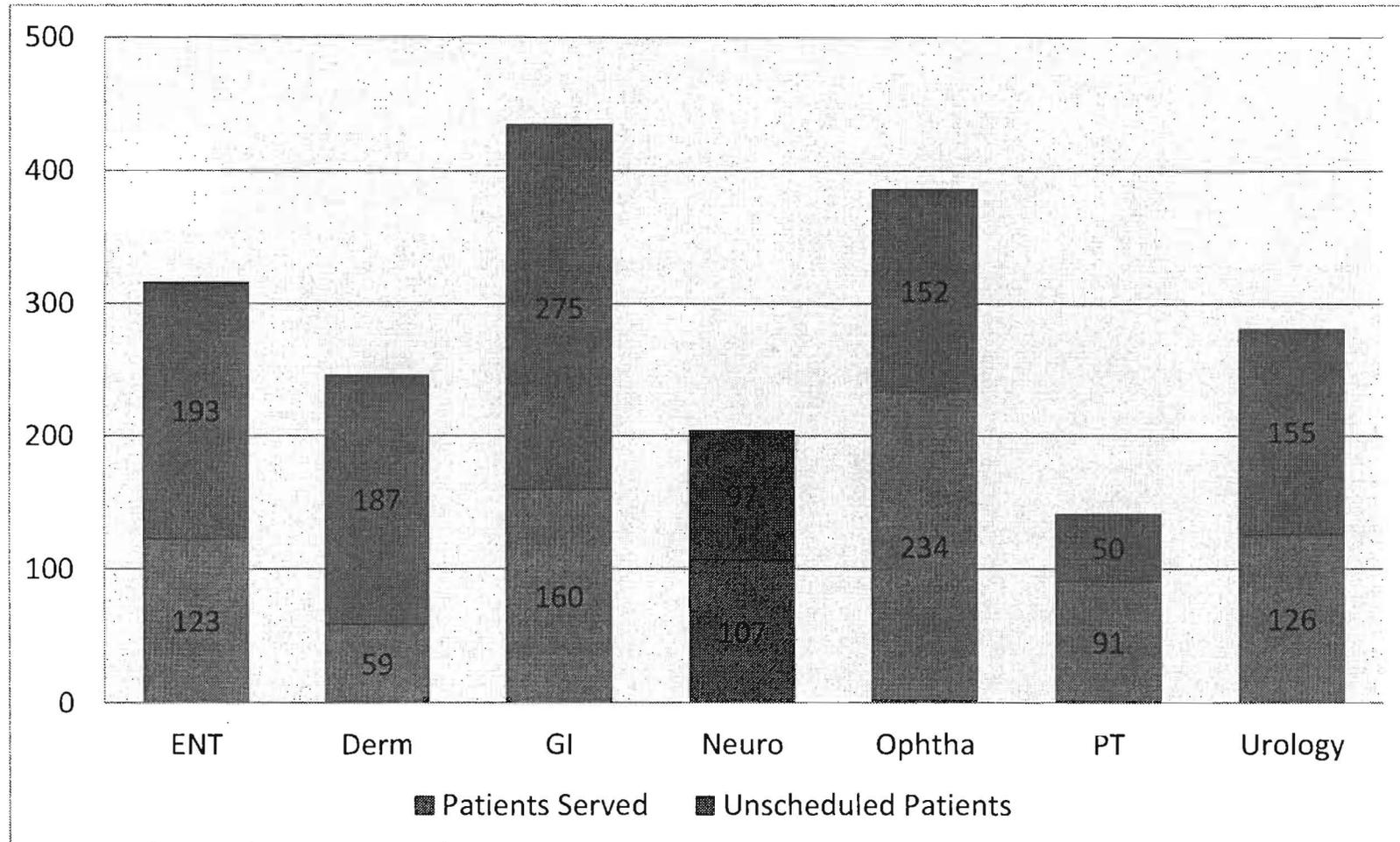
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## Project Access FY12 Summary for Selected Specialties

Specialty	Patients Served	Procedures Commonly Performed	Hospital Support (since Jan 2012)
General Surgery	170	Gall bladder removal Hernia repair Tumor biopsy Tumor excision	37 operations
Orthopedic Surgery	140	Arthroscopic knee surgery Fracture casting and repair Knee replacement Hip replacement	28 operations
Reconstructive	39	Superficial tumor biopsy Superficial tumor excision Hand surgery	3 operations
Vascular Surgery	29	Varicose vein surgery Arterial studies Arterial surgery	7 operations
Thoracic Surgery	12	Lung mass biopsy Lung mass resection	3 operations
Neurosurgery	10	Spinal cord surgery Brain surgery	5 operations



# Project Access: Referral Requests vs. Patients Served by Selected Specialty Area FY12



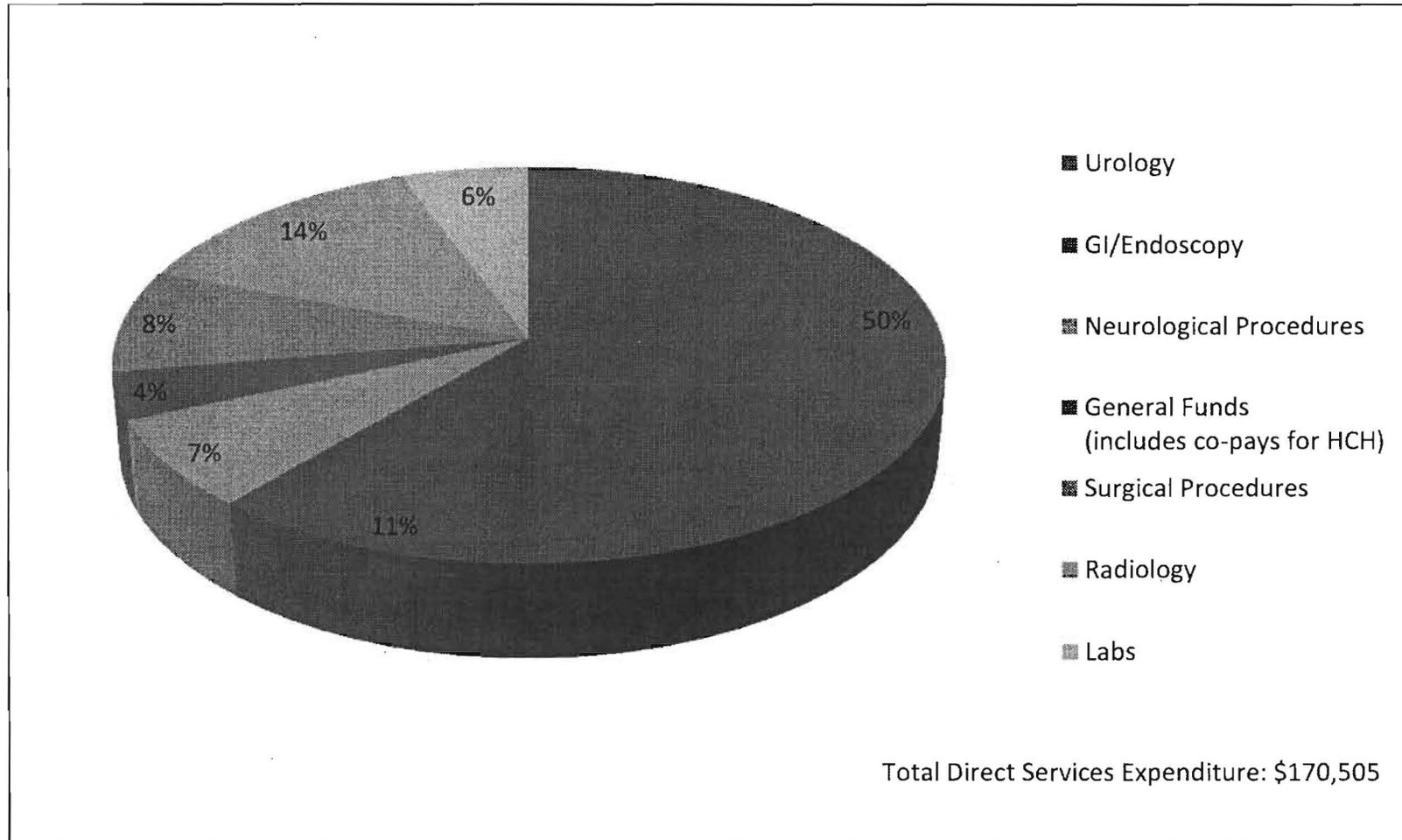
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# Project Access FY12 Summary for Selected Specialties

Specialty	Patients Served	Procedures Commonly Performed
Ophthalmology	234	Cataract surgery Laser retinal therapy
Gastroenterology	160	Colonoscopy Upper GI endoscopy
Urology	126	Cystoscopy Bladder function studies Prostate biopsy Prostate surgery
ENT	123	Tumor biopsy Tumor excision
Neurology	107	Nerve conduction studies Brain wave studies
Physical Therapy	91	Post-operative joint therapy Non-operative joint therapy Back therapy
Dermatology	59	Skin tumor biopsy Skin tumor excision



# Project Access Direct Services Expenditures FY12



Note: In addition, PCC contributed \$3,500 for one complex surgery.

# Project Access Highlights FY12

## Referral Process Improvement

- Required submission of clinical supporting documents by clinics.
- Triage of referral requests by clinical priority.
- Collaboration with County SEU to screen patients for Medical Assistance.
- Collaboration with AHCN to streamline and standardize referrals.

## Network Expansion

- New collaboration with hospital-based general surgery at Medstar Montgomery.
- New collaboration with Georgetown Orthopedic Group at Medstar Montgomery.
- New collaboration with Dr. Deirdre Byrne (general surgery), Spanish Catholic Center and Sibley Memorial Hospital.
- Expanded collaboration with Dr. Daniel Lahr (orthopedics) and Suburban Hospital.



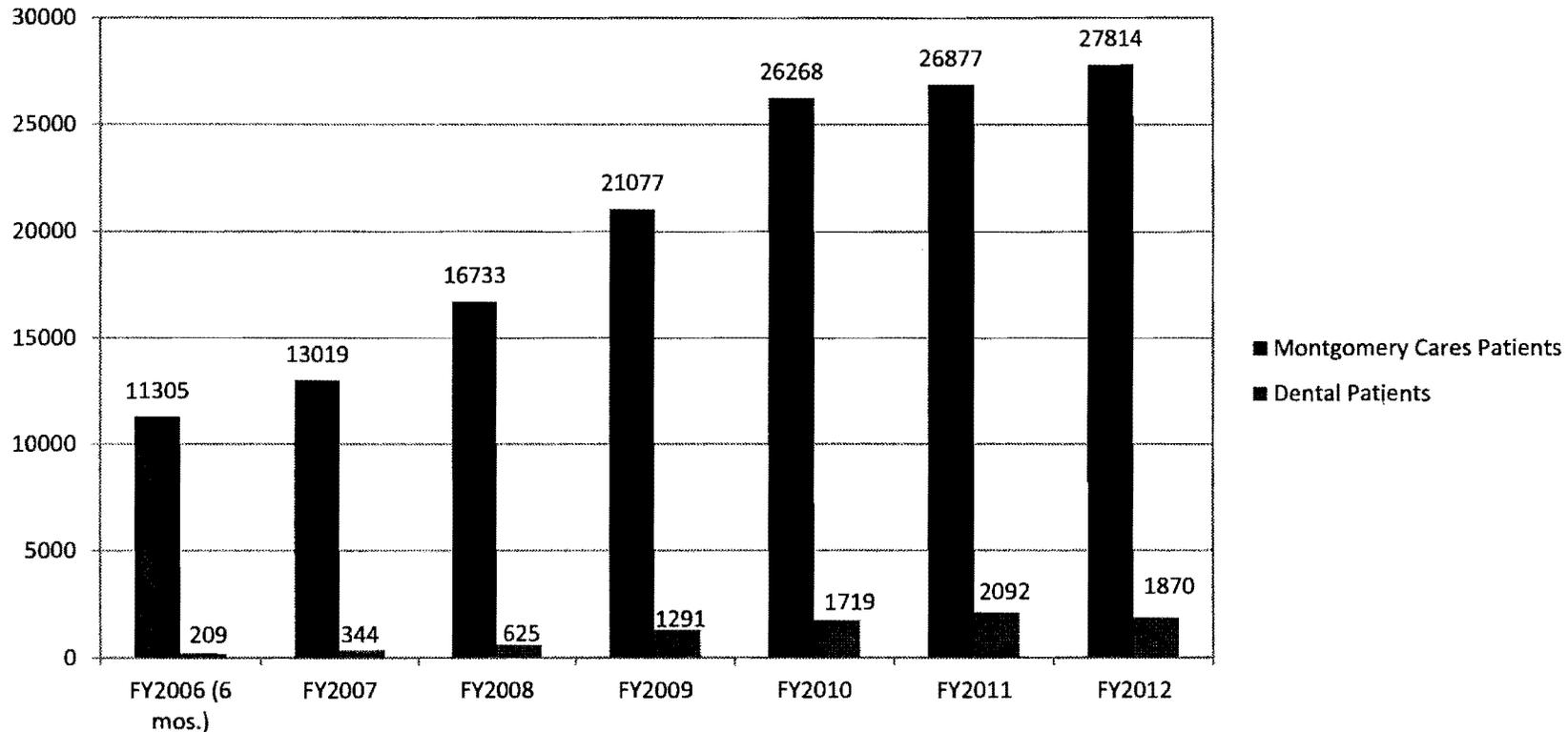
# Oral Health Program FY12

Oral Health Care Provider	Unduplicated Patients	Encounter	Patient/Encounter Ratio
Spanish Catholic Center	977	2,425	2.48
DHHS Adult Dental Services at Metropolitan Court	893	1,592	1.78
Total	1,870	4,017	2.14

- The demand for dental care continues to exceed the services available through current MC funded providers. Metro Court has a 3 week wait for routine appointments; Spanish Catholic Center has a four month wait.
- There was a 10.6% decrease in the number of patients served and a 19% decrease in encounters between FY11 and FY12.
- The Montgomery Cares oral health program budget has been increased for FY 2013. SCC plans to add 16 clinic hours per month in FY 2013. Metro Court will increase staffing for its Metro Court clinic.
- DHHS Adult Dental Services plans to implement patient co-pays for services. SCC currently charges for procedures on a sliding fee schedule.
- Both CCI and Mary's Center offer dental services on a sliding fee schedule based on patient income and serve Montgomery Cares patients.



# Oral Health Program FY 2006 - FY 2012



Oral health capacity decreased in FY12 with 6.7% of Montgomery Cares patients receiving care compared to 7.7% in FY11.

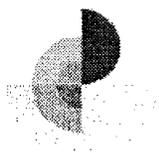


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# Montgomery Cares Behavioral Health Program

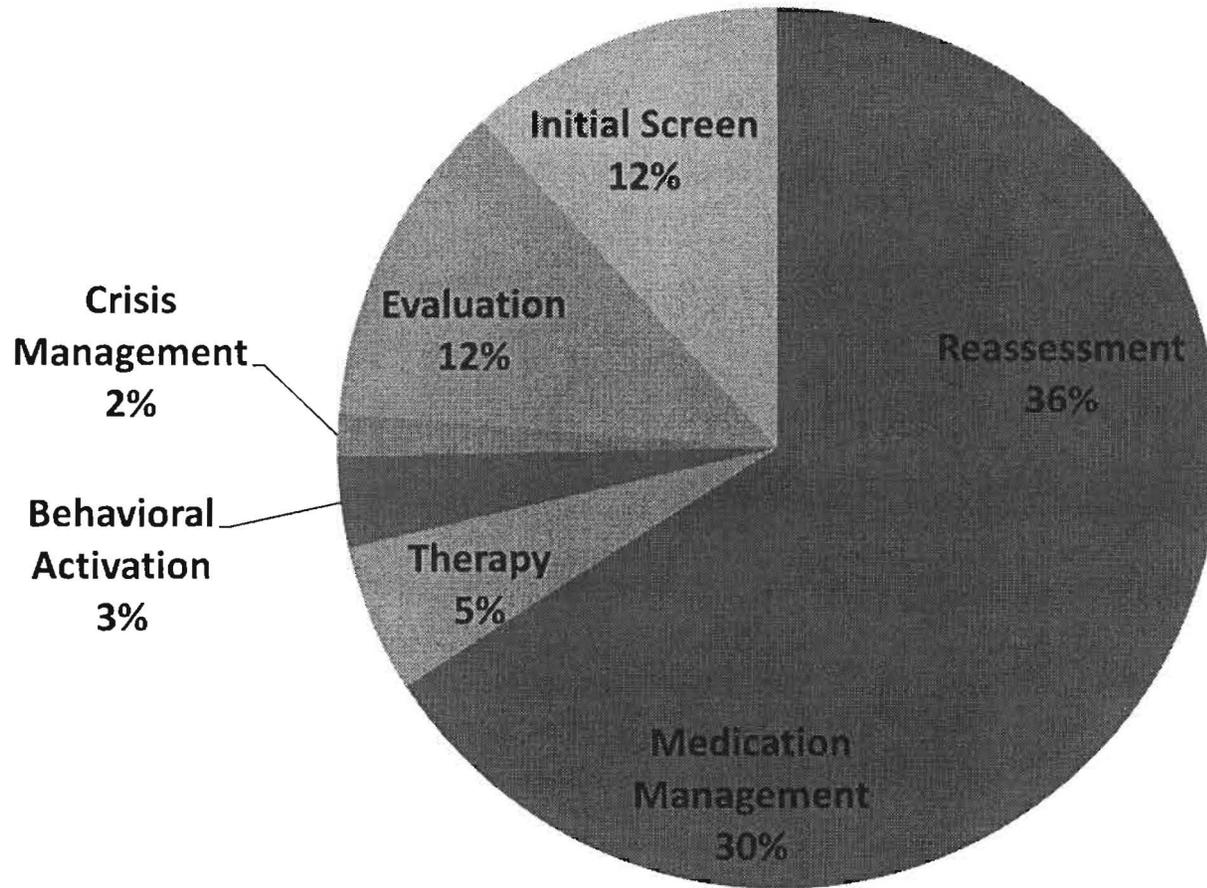
The program conducted 2,585 Face to Face Encounters and 5,558 Phone Encounters, averaging 5 encounters per patient.

Clinic Site	Total Patient Population	Total Patients Served By MCBHP	Percent of Population Served
Holy Cross	4,733	771	14.2
Proyecto Salud	5,021	449	8.9
Mercy	2,347	382	16.3
<b>Total</b>	<b>12,101</b>	<b>1,502</b>	<b>12.4</b>



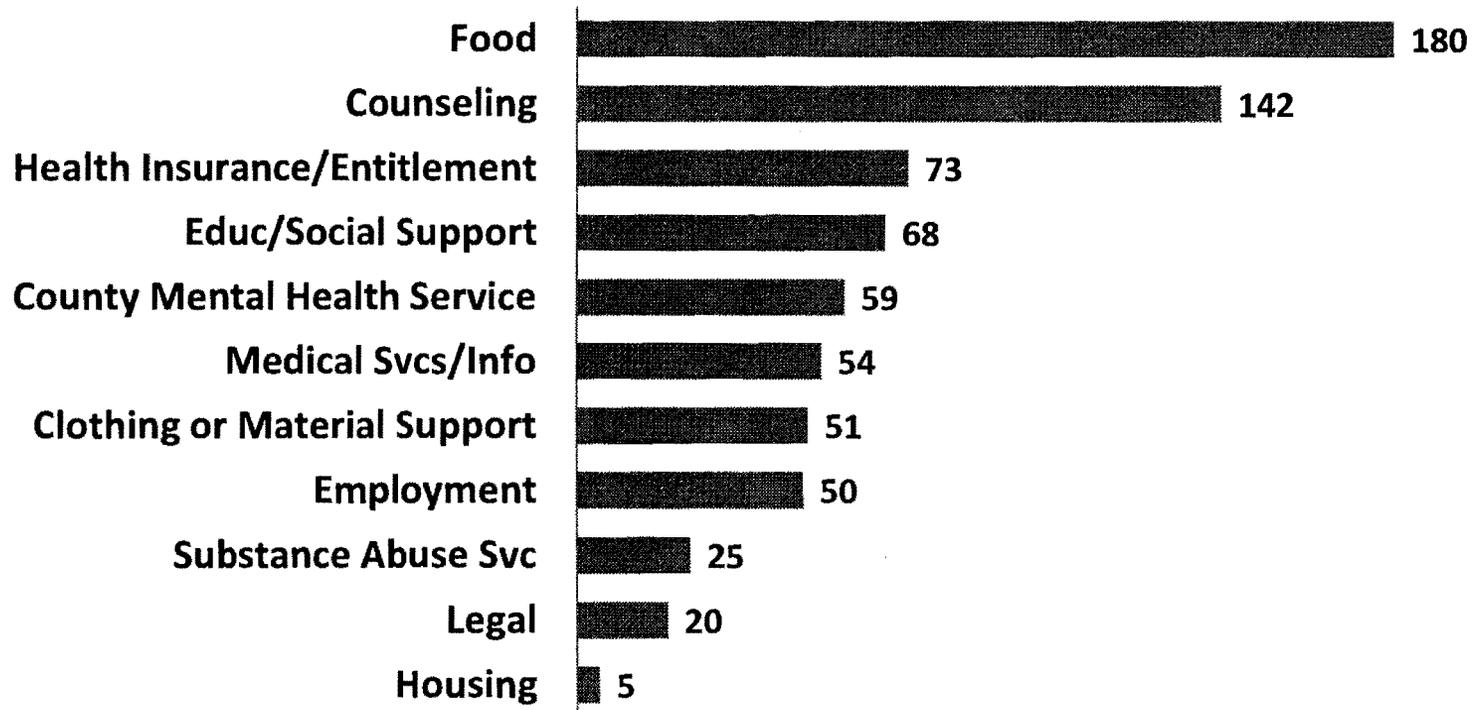
# Clinical Services Provided BY MCBHP

Total Encounters: 4,259



# Referrals to Community Resources

727 Total Referrals\*

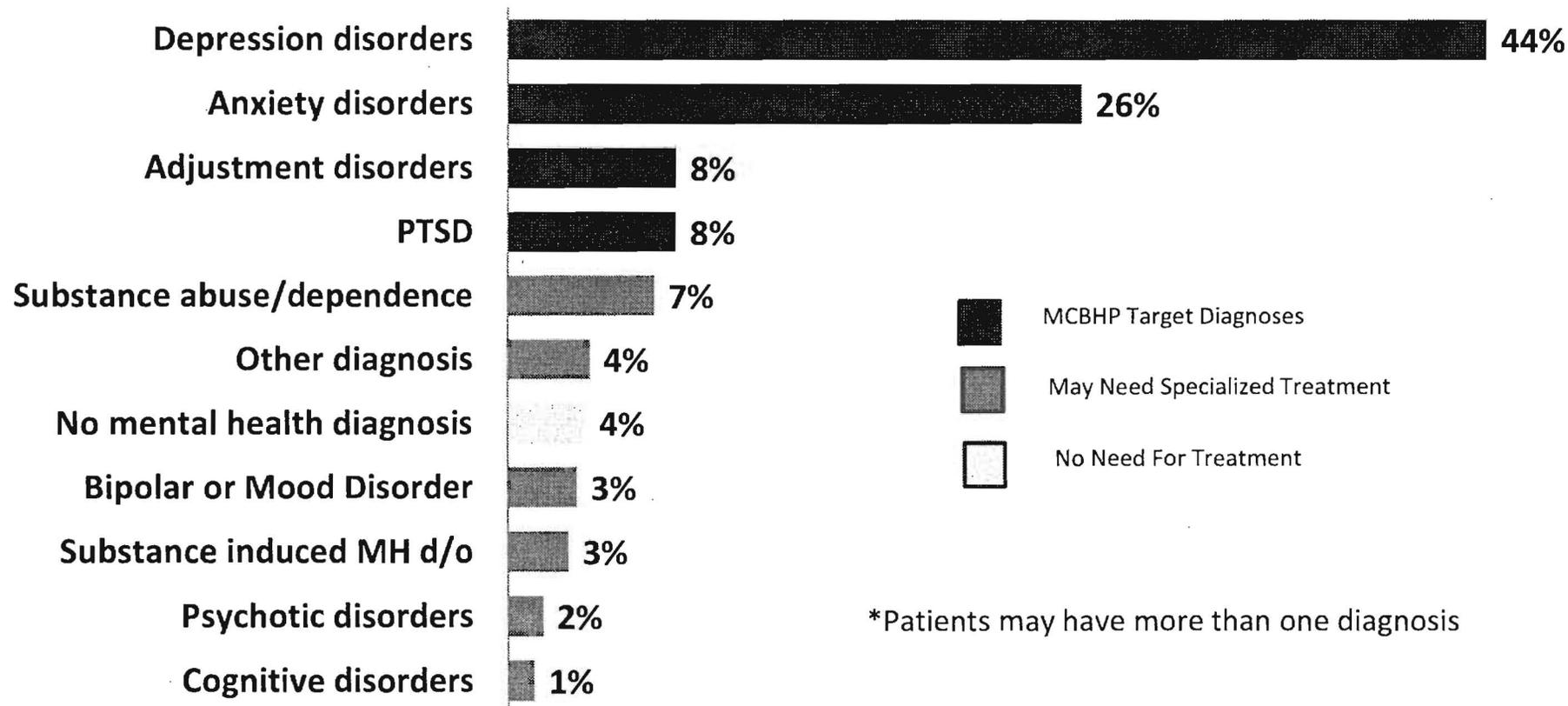


*\*An additional 204 referrals were provided to patients in other categories.*



# Prevalence of Mental Health Diagnoses Among Patients Evaluated by MCBHP

513 patients were evaluated in FY 12\*



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# Behavioral Health Work Group

- Hosted a symposium: October 6, 2011: **Integrating Behavioral Health and Primary Care: Moving To Action In Montgomery County.** Attended by over 70 leaders in county, state, federal agencies, local health and behavioral health organizations.
- Formed a quarterly Learning Collaborative, hosted by Raymond Crowel, PsyD, Chief of Behavioral Health and Crisis Services. Meetings were held in January and April, 2012
- Formulated actionable projects that are currently underway:
  - **Psychiatric Consultation Pilot:** County psychiatrists will be linked to two Montgomery Cares clinics to provide consultation and training to primary care providers. The expected start date is September 2012.
  - **SBIRT Training:** A skills training will introduce participants to Screening, Brief Intervention, Referral and Treatment (SBIRT) and Motivational Interviewing techniques. The second training will address implementing SBIRT in clinic settings.



primary care coalition  
of Montgomery County, Maryland

The Behavioral Health Work Group is supported by the  
Healthcare Initiative Foundation, PCC and MC-DHHS.



# FY2011 Quality Metrics

- Clinics demonstrate improvement in chronic care management over time.
- Consistently achieve HEDIS benchmark performance in chronic care.
- Cancer screening continues to fall below targeted benchmarks.

Measure	FY 08	FY 09	FY 10	FY 11	Target Range (mean-90 <sup>th</sup> percentile)
* Diabetes: Annual HgA1c Testing	54%	74%	77%	83%	82-91%
* Diabetes: Annual LDL Testing	47%	65%	70%	77%	75-84%
* Diabetes: Good HgA1c Control ( $\leq 7$ )	26%	35%	37%	41%	35-44%
* Diabetes: Poor HgA1c Control ( $\geq 9\%$ )	57%	44%	37%	36%	44-29% (Note: Lower numbers demonstrate improvement)
* Diabetes: LDL Control ( $\leq 100$ mcg/dL)	22%	32%	35%	38%	35-46%
* Hypertension: BP Control ( $\leq 140/90$ )	52%	60%	65%	64%	56-68%
Breast Cancer Screening	12%	26%	29%	32%	51-63%
Cervical Cancer Screening	7%	15%	29%	39%	67-79%
Colorectal Cancer Screening	1%	2%	2%	3%	N/A



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# Quality Improvement Activities

## Medical Director FY12 Priorities and Initiatives

Hypertension/Heart Disease: Participation in ABCS Preventive Health grant program with MC DHHS

Colorectal Cancer Screening: Developed screening guidelines

Yahoo Group for Shared Resources

Technical Assistance to Improve Clinic Operations and Services

## QHIC External Resources and Process Improvement

Behavioral Health Integration

Public Health Revised Forms and Referral Processes

Electronic Clinical Pharmacology Tool Tested and Purchased

CRISP Training and Utilization for Tracking Patient Services

## Grant-Funded Projects

Breast Cancer Screening

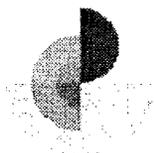
Diabetes Management



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# Patient Centered Medical Homes

- 4 of 12 CareFirst Safety-Net Patient Centered Medical Homes Grants were awarded to Montgomery County organizations including: CCI, Mary's Center, PCC and Spanish Catholic Center.
- PCC was awarded \$600,000 to transform two Montgomery Cares clinics into patient-centered medical homes: Holy Cross Health Clinic at Aspen Hill and Proyecto Salud.
- PCC will establish learning collaboratives based on PCMH principles that will be open to all MC clinics interested in adopting PCMH models.
- The PCMH goal is to improve health outcomes for patients with multiple diagnoses while improving patient experience and reducing over all costs.
- Participating clinics will:
  - Empanel patients with physician led care teams.
  - Employ RN Care Managers to develop care plans, facilitate patient engagement, promote communication between patients and care team members and conduct regular assessments patient surveys and assessments.
  - Measure health outcomes, patient experience and cost.



# Medicaid Participation

Funded by Kaiser Foundation through DHHS

## Montgomery Cares Clinic Engagement with Medicaid Managed Care Organizations

### Imminent

- Holy Cross Hospital Health Centers
- Mobile Medical Care
- Muslim Community Center Medical Clinic
- Care for Your Health (not part of project)

### Active Interest

- Community Ministries of Rockville
- Spanish Catholic Center

### Longer Term

- CCACC – Pan Asian Volunteer Health Clinic
- Proyecto Salud
- The People's Community Wellness Center



# EHR Selection

The EHR selection process began in the fall of FY10 with PCC conducting an assessment of all MC Clinics and establishing an EHR selection committee with representation from all 7 clinics currently using CHLCare. On-going EHR discussions and meetings have included participation of all clinics and DHHS representatives.

**Clinic Assessments:** Initial steps included an organizational and IT infrastructure assessment of clinics, education of clinic leadership, building a common understanding of “meaningful use” and user requirements. PCC also assessed clinic EHR priorities and needs.

**Product Assessment:** PCC conducted a market assessment of products including open-source and commercial systems that included clinic and individual provider demonstrations and technical training for PCC staff. PCC conducted technical assessments, reference checks with organizations using the selected systems, meetings with consultants that implemented both systems and an on-site visit with an organization supporting E-Clinical Works. PCC solicited pricing and proposals that included licensing, training and support.

**Partnership Development:** In March, Montgomery County DHHS joined the project and began participating in assessment activities including bi-weekly status update calls with PCC and collaboration on a decision memorandum for DHHS leadership. TAYA Clinic (Teen And Young Adult Connection) also joined the collaboration.

**Vendor Negotiations:** PCC initiated price negotiations with E-Clinical Works and NextGen. The addition of MC DHHS substantially increased group purchasing power along with the size of the prospective market share. Vendors are currently engaged in competitive bidding on the Montgomery County contract.



# Conclusion

- In order to grow, Montgomery Cares needs to maintain its focus on expanding capacity to meet the needs of the low-income, uninsured residents of Montgomery County.
- Approximately, 10% of the Montgomery Cares budget supports specialty care services. Additional resources, combined with increasing support from hospitals, expansion of the volunteer provider networks and improved care management at the clinic level are necessary to keep pace with the specialty care needs.
- Behavioral health services, particularly integrated models of care, need further development and support so that Montgomery Cares can efficiently address the behavioral health needs of the majority of its population.
- Montgomery Cares needs a strategic plan to address oral health needs among its population that is inclusive of all potential resources and providers.
- Additional investments in training, technical assistance and infrastructure are necessary to support transitions that will allow safety-net clinics to take advantage opportunities that will be available under health care reform. (Medicaid preparedness, EHR transition and PCMH transformation)
- Resources are needed to sustain and build-on grant-funded programs and initiatives that have had a significant impact on patient care and health outcomes (ED-PC Connect, clinical pharmacy services, PCMH, Komen Breast Health Initiatives).



## DHHS Montgomery Cares Budget Summary

MONTGOMERY CARES	FY10 Budget	FY11 Budget	Original FY12 Budget	FY12 Budget with DHHS Reallocation**	FY12 Actuals	FY13 Budget	Change FY12 Budget to DHHS reallocation	Change FY12 w/reallocation to FY12 Actual
Enrollment for Patients not served through Healthcare for the Homeless	23,000	28,000	28,000	28,000	27,465	32,250		(535)
Budgeted Number of Primary Care Encounters at \$62 per visit	62,100	70,000	75,000	75,000	76,354	85,625		1,354
<b>Services Areas:</b>								
Support for Primary Care Visits*	3,682,800	4,340,000	4,650,000	4,725,000	4,682,050	5,308,750	75,000	(42,950)
Community Pharmacy-MedBank	2,136,590	1,785,590	1,785,590	1,785,590	1,784,810	1,862,550	-	(780)
Cultural Competency	75,000	45,000	22,500	28,000	23,930	22,500	5,500	(4,070)
Behavioral Health and Oral Health	950,000	930,000	930,000	930,000	928,000	1,059,120	-	(2,000)
Specialty Services	660,468	450,468	450,468	486,790	465,460	730,470	36,322	(21,330)
Program Development	343,070	260,960	110,840	110,840	110,640	110,840	-	(200)
Information and Technology	350,360	320,360	315,360	315,360	314,660	415,360	-	(700)
PCC-Administration	569,274	529,274	502,774	507,621	503,050	502,770	4,847	(4,571)
HHS - Eligibility Determination*	205,137	-	-	-	-	-	-	-
HHS - Administration	484,030	482,296	478,186	478,186	478,190	487,880	-	4
Facility	311,700	67,040	67,040	142,040	142,040	142,040	75,000	-
<b>Subtotal</b>	<b>9,768,429</b>	<b>9,210,988</b>	<b>9,312,758</b>	<b>9,509,427</b>	<b>9,432,830</b>	<b>10,642,280</b>	<b>196,669</b>	<b>(76,597)</b>
<b>Healthcare for the Homeless</b>								
Budgeted Enrollment	1,000	800	500	500	349	500	-	(151)
Budgeted Primary Care Encounters	2,700	2,400	1,500	1,500	808	1,500	-	(692)
Support for Primary and Specialty Care	435,000	435,000	217,500	217,500	115,540	217,500	-	(101,960)
HHS Administration (includes hospital discharge planning)	303,972	255,158	266,140	266,140	262,450	266,140	-	(3,690)
<b>Subtotal</b>	<b>738,972</b>	<b>690,158</b>	<b>483,640</b>	<b>483,640</b>	<b>377,990</b>	<b>483,640</b>	<b>-</b>	<b>(105,650)</b>
<b>TOTAL</b>	<b>10,507,401</b>	<b>9,901,146</b>	<b>9,796,398</b>	<b>9,993,067</b>	<b>9,810,820</b>	<b>11,125,920</b>	<b>196,669</b>	<b>(182,251)</b>

\*does not include \$50,000 for primary care visits funded by PCC from a grant from Carefirst - visits are included in the total encounters

\*\* During FY12 DHHS reallocated funds to add \$75,000 for primary care visits, \$5,500 for additional language funding, \$25,000 for specialty care visits, \$11,322 to support ACHN \$4,847 for PCC indirect costs, and \$75,000 to support the new Holy Cross Hospital Clinic in Aspen Hill.

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**primary care coalition**  
Maryland, New Jersey, Maryland

## **Emergency Department – Primary Care Connect**

*“Linking low-income uninsured patients from the  
Emergency Department to a medical home”*

**Program Evaluation**

*(March 1, 2009 – December 31, 2011)*



**Primary Care Coalition of Montgomery County**  
*Emergency Department-Primary Care Connect (ED-PC Connect)*  
*“Linking low-income uninsured patients from the emergency department to a medical home”*

*The ED-PC Connect project relied on the generous commitment of the five participating Montgomery County hospitals, four participating Montgomery Cares clinics, and the Montgomery County DHHS. The Primary Care Coalition of Montgomery County would like to acknowledge the participation and contributions made by each of the hospitals and clinics that partnered to connect low-income, uninsured Montgomery County residents to affordable primary care services.*

Holy Cross Hospital

Holy Cross Hospital Health Center

Montgomery General Hospital

Mary’s Center for Maternal and Child Health

Shady Grove Adventist Hospital

Mobile Medical Care, Inc.

Suburban Hospital

Proyecto Salud

Washington Adventist Hospital

## Executive Summary

Emergency department (ED) utilization has increased dramatically over the past two decades. Studies have shown that as many as 50% of these ED visits could have been avoided if patients had received appropriate and timely care in other settings.<sup>1</sup> Avoidable ED utilization places a financial burden on hospital EDs and denies patients the continuity and consistency of care available in primary care settings.

The Primary Care Coalition of Montgomery County (PCC) was founded in 1993 as an independent non-profit organization charged with facilitating access to and development of high quality, evidence-based primary care services for low-income and uninsured residents of Montgomery County, Maryland. In 2009, PCC received a CMS ED Diversion Grant through the Maryland Department of Health and Mental Hygiene with the goal of reducing avoidable ED visits made by low-income, uninsured county residents by linking them with primary care offered by safety-net clinics in the county. Working with all five county hospitals and four safety-net clinics, PCC formed the Emergency Department – Primary Care (ED-PC) Connect project which successfully developed a coordinated screening and referral process for linking patients discharged from the EDs to clinics for follow-up and continuing primary care.

The project developed a steering committee using a learning system model, instituted eligibility screening and appropriate referral processes (each hospital-clinic partnership used specific strategies to implement ED-PC Connect, based on unique institutional characteristics and partner relationships). The project team interviewed patients to learn what leads to avoidable ED visits, and implemented changes to increase the number of ED patients linked to safety-net medical homes. The project demonstrated the importance of collaborative process redesign between emergency departments and safety net clinics.

Between July 2009 and December 2011, the EDs in Montgomery County identified and referred more than 10,000 low-income uninsured patients. More than 2,200 patients visited a clinic following referral, making more than 10,000 total clinic visits subsequent to their referrals. The clinics provided appointments within 30 days of their referral for the majority of patients. Two-thirds of patients that made an initial clinic visit returned to the clinic for additional visits. Patients diagnosed in the ED with hypertension and/or diabetes were more likely to visit the clinic, while patients diagnosed with behavioral health conditions were less likely to do so. The most effective strategy in every partnership was a combination of a referral by the ED provider plus contact in person or via phone by a patient navigator.

A DHMH independent evaluation conducted at the end of two years found that ED-PC Connect successfully reduced avoidable ED utilization for project patients by linking them to clinics. PCC confirmed these findings based on the full three years of the project. Clinic patients had far less ED utilization than patients who were never seen in the project clinics:

- The greatest impact was demonstrated on patients with chronic and/or behavioral health conditions. During the three year period of the project, ED utilization by project patients with chronic health conditions was reduced by a projected 68%, resulting in an estimated cost savings of \$670,000. ED utilization by project patients with behavioral health conditions was reduced by a projected 41%, resulting in an estimated cost savings of \$230,000.
- Even before the referral process was implemented, patients with a prior clinic relationship were significantly less likely to have utilized the ED for any reason, and also less likely to have made a potentially avoidable ED visit. These findings illustrate the value of primary care access for vulnerable populations and suggest that the savings estimated during the project period will continue as relationships between patients and primary care clinics are established and maintained.

This project demonstrates that programs such as ED-PC Connect can significantly decrease ED utilization and health care costs by assuring that low-income, uninsured patients have reliable access to primary care.

<sup>1</sup> National Hospital Ambulatory Medical Care Survey: 2007 Emergency Department Summary. August 6, 2010. Hyattsville, MD: National Center for Health Statistics.

## **Key Findings**

The ED-PC Connect project partners used multiple strategies to link patients from the hospital ED to the Montgomery Cares partner clinic(s). Project accomplishments are noted throughout the evaluation. The overall key findings from the project are listed below in three categories: 1) Overall Project and Patient Population, 2) Project Impact on Montgomery Cares Clinic Utilization, and 3) Project Impact on ED Utilization.

### **1. Overall Project and Patient Population: Montgomery Cares Patients Less Likely to Utilize the ED**

- ED-PC Connect established a system-wide coordinated ED referral process to link low-income, uninsured patients in Montgomery County to primary care clinics.
- The population of low-income, uninsured patients seen in Montgomery County EDs is racially and ethnically diverse.
- The overwhelming majority of patients (89%) referred by the ED are new to the Montgomery Cares clinic system.
- Despite their higher disease burden, Montgomery Cares patients are significantly less likely to utilize the ED than low-income, uninsured patients who have not visited a clinic.
- Montgomery Cares patients are significantly less likely to make an ED visit that is classified as “potentially avoidable” than low-income, uninsured patients who have not visited a clinic.
- Patients with chronic and/or behavioral health conditions visited the ED at higher rates than patients without chronic and/or behavioral health conditions.
- A small number of project patients (8%) accounted for more than two-thirds of all ED visits.
- The majority of patients who are “frequent flyers” ( $\geq 3$  visits in the year prior to the index visit) have chronic conditions and/or behavioral health problems.

### **2. Project Impact on Montgomery Cares Clinic Utilization: Effective Linkage Results in Clinic Engagement**

- Twenty-one percent (2,257 of the project’s 10,761 patients discharged from EDs) made subsequent clinic visits.
- Project patients made a total of 9,753 visits to participating clinics.
- The most effective project intervention was a combination of ED provider referral plus subsequent navigator contact. The 2,207 project patients (25%) who received information from both provider and navigator were twice as likely to make clinic visits as patients who received only one of these interventions.
- Montgomery Cares clinics provided access to the majority (70%) of patients referred from the ED within 30 days from their index ED visit.

- Two-thirds of patients that completed an initial subsequent clinic visit returned to the clinic for a second visit.
- Patients who come to the ED for reasons associated with hypertension and/or diabetes are significantly more likely to make a subsequent clinic visit.
- Patients who come to the ED for reasons associated with behavioral health problems or injury/poisoning are significantly less likely to make a subsequent clinic visit.

### 3. **Project Impact on ED Utilization: Clinic Relationship Decreases ED Utilization**

A DHMH independent evaluation of the project completed by the Hilltop Institute at the University of Maryland Baltimore County after the initial two years demonstrated that project patients were significantly less likely to return to the ED with a “potentially avoidable” diagnosis if they had made a subsequent clinic visit. PCC analyzed the full three year project experience, comparing utilization of new patients who did not make a subsequent clinic visit with those that made two or more visits.

- The greatest project impact was on patients with chronic or behavioral health conditions. As compared to new patients with chronic or behavioral health conditions who did not make a subsequent clinic visit, new patients with chronic or behavioral health conditions that made 2 or more subsequent clinic visits demonstrated the following:
  - Larger reduction in “potentially avoidable” utilization
  - Lower *total* subsequent ED utilization
  - Estimated reduction in total ED utilization of 67.4% (chronic conditions) and 41.2% (behavioral health conditions), saving approximately \$664,000 and \$231,000 respectively
  - Lower “potentially avoidable” subsequent ED utilization
  - Estimated reduction in potentially avoidable ED utilization of 60.7% (chronic conditions) and 20.3% (behavioral health conditions), saving approximately \$517,000 and \$77,000, respectively
- New patients who made 2 or more subsequent clinic visits demonstrated greater reduction in “potentially avoidable” ED visits.
- Project findings demonstrate that connecting new patients with chronic and/or behavioral health conditions to Montgomery Cares clinics will dramatically decrease ED utilization and significantly reduce ED costs for the uninsured population in Montgomery County.

### 4. **Qualitative Findings**

- ED patients reported the top five reasons they utilize the ED to be: 1) acuity of patient condition, 2) clinic hours, 3) lack of clinic access, 4) perceived clinic capability to treat patient problem, and 5) speed of service provided at the ED.
- The majority of subsequent clinic patients surveyed stated that it was easy to make an appointment with the clinic and they would go back to the clinic again.