Bringing the Focus to Complex Care

Highlighting Frederick Integrated Healthcare Network (FIHN)
Community: Integrated Care Management

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Please chat in…

- Who is on the webinar with us today,
- What organization you are with,
- Where are you located, and
- Your role within your organization?

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Introducing Speaker

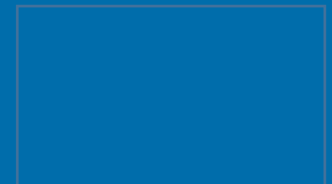
Leigh Hunter, LCSW, ACM-CM, CCP, is the Manager of Integrated Care Management at Frederick Health, located in Frederick, Maryland. She has over 22 years of experience in medical social work and care management in skilled nursing facilities, hospice, acute and ambulatory care settings, as well as value-based care.

Caring for the Community: Integrated Care Management

Leigh Hunter, LCSW, ACM-SW, CCP

Manager Integrated Care Management

Frederick Health



Frederick Health

- Our Mission:
  To positively impact the well-being of every individual in our community

- Frederick Health Hospital (269 licensed beds), Frederick Health Medical Group, Frederick Health Employer Solutions, Frederick Health Home Care, Frederick Health Hospice

- Frederick County: 40% population growth over the past 25 years resulting in an additional 95,000 people in the health system's service area

Frederick Integrated Healthcare Network (FIHN)

- Clinically Integrated Network
- 2014 - 2020: Accountable Care Organization (ACO) for MSSP
- 2019 - Current: Care Transformation Organization (CTO)
- Administrative/IT/Care Management support
- Supports Maryland Primary Care Program (MDPCP) and additional payer agreements

FIHN & MDPCP

- FIHN CTO established in 2019
- Medicare FFS attributed beneficiaries
- 2019: 5 primary care practices
- 2020: 7 primary care practices
- 2021: 16 primary care practices
- 2022: 15 primary care practices
- Q4 2022 Attributed Beneficiaries: 9,556

Frederick Health Medical Group Primary Care

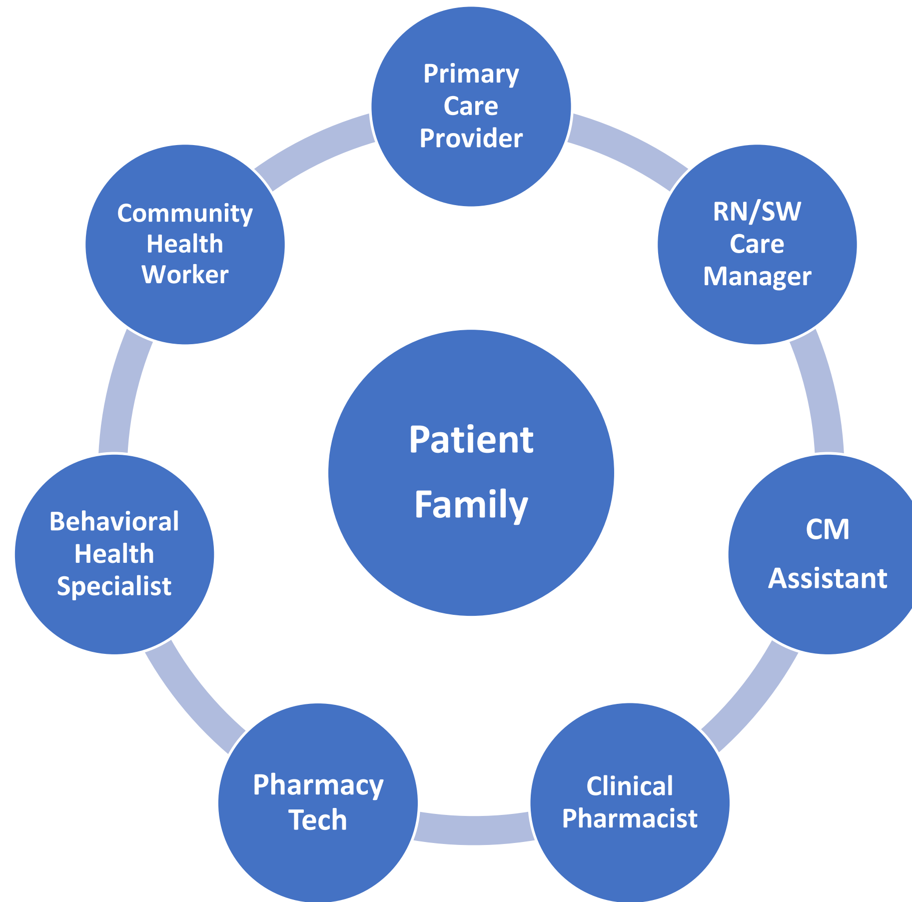
- 9 primary care practices
- ~40,000 patients across sites
- Participates with FIHN for MDPCP and other value-based care agreements

Integrated Care Management

- Who are we?
  - A multidisciplinary care management team supporting primary care practices

- Who do we support?
  - FIHN (Frederick Integrated Healthcare Network) primary care practices
  - Frederick Health Medical Group primary care (1 specialty practice)

Integrated Care Management Team



Care Managers

- RN and SW Care Managers
- Assigned to primary care providers/practice
- Embedded in practice and hybrid (remote/in-person)
- Managing rising/high risk beneficiaries identified using risk stratification tools, provider referrals, transitions of care outreach
- Telephone outreach, home visits, community visits

Care Management Assistants

- Care Management Assistants/Coordinator (MA/CNA)
  - Conduct outreach after ED/IP/OBS/SNF discharge
  - Ensure discharge follow up appointments are scheduled
  - Collaborate with Care Management team
    - Transportation
    - Appointment Scheduling
    - Referrals
    - Patient outreach

Clinical Pharmacist

- Comprehensive medication management
- Review/engage during transitions of care (hospital/SNF discharges)
- Assess for barriers that may affect medication adherence
- Provide medication recommendations to providers with goal of optimizing medication management and outcomes
- Assess for polypharmacy and high-cost medications
- Medicare D Open Enrollment assistance

Pharmacy Technician

- Proactively assists with identifying high risk patients following hospital encounters
- Assists with obtaining medication history
- Medication access (affordability/transportation)
- Connections to Patient Assistant Programs/Community Resources
- Medicare D Open Enrollment assistance
- Collaborates with care management team/primary care provider

Integrated Behavioral Health Specialist

- LCSW-C and LCPC to provide behavioral health services including psychosocial assessment, diagnosis, counseling, referrals, education and support to referred patients
- Depression, anxiety, caregiver role strain, adjustment disorder
- Refer out for substance abuse treatment
- Collaboration with Care Management team, primary care, community partners
- Advocacy
- Home visits as needed
- Will assist with establishing long term behavioral health treatment if needed

Community Health Worker (CHW)

- Frontline public health worker with an understanding of the community served
- Serves as a link between social and health services to facilitate access to services
- Assist with goal setting, education to promote health behavior change, community resource navigation, care coordination
- Telephone contact, home visits, community visits (including medical appointments)
- Works alongside care management team

Engagement

- Transitions of Care
- Provider/care Team Referrals
- Risk Stratification Tools
- Community Partner Referrals

Interventions

- Transportation Assistance
- Information & Referral
- Advanced Care Planning
- Caregiver Support
- Self-Management Education
- Goal Setting
- Home Visits
- Appointment Scheduling
- SoDH Assessment
- Long Term Care Planning
- Comprehensive Medication Management
- Behavioral Health Support

Community Partners

- Agencies (Dept of Aging)
- DSS
- Private Duty
- HHC
- FH Ambulatory CM Programs
- Food Security Agencies
- Transportation Services
- SNF/ALF
- CDSMP/DPP
- Pharmacies

Collaboration Opportunities with SNF/AL

- May receive contact from CM team for updates on discharge plans
- CM team can provide important information on home environment/social needs/barriers to care
- Clinical pharmacist communication
- Contact within primary care practice to help facilitate post-discharge appointments
- Referrals for placements from community (skilled, respite, LTC)

MDPCP Measures

MDPCP Program Goal: 5% of beneficiaries are engaged with care management

FIHN CTO: 20.6%

CY2022 (Q3)

MDPCP Care Management Measures

- Discharge Follow Up Interactions
- <2 days after inpatient discharge (includes SNF)
- <7 days after ED visit

MDPCP: Discharge Follow Up Rates

- 2021: **93%**
- 2022: **98%**
- **MDPCP minimum rate: 50%**

Choosing the Right Level of Care in a Medical Emergency

Everyone knows that a primary care doctor is the best place to go when you are sick or in pain. By seeing your primary care physician on a regular basis, they will have your complete health history and an understanding of any underlying conditions you may have.

Sometimes you become sick or injured when the doctor's office is closed, and sometimes you need more urgent medical attention than your doctor can provide. This handout helps to explain **where to seek the best care in your time of need.**

Primary Care

Call to make an appointment with your primary care provider if you have symptoms of a regular illness or need a regular check-up.

- Treatment of illness, including:
  - *Colds and coughs*
  - *Sore throat*
  - *Flu and flu-like symptoms*
  - *Ear infections*
  - *Urinary tract infections*
  - *Minor aches and pains*
  - *Allergies*
- Management of chronic conditions, such as:
  - *Diabetes*
  - *Heart Disease*
  - *COPD*
- General medical advice
- Annual Well Exams
- Immunizations
- Respiratory problems

If you believe a life is in jeopardy, always call 911!

Urgent Care

is an option if you have a minor illness or injury, your primary care provider is not available, and your problem cannot wait.

- Treatment of illness, including:
  - *Colds, coughs, and upper respiratory infections;*
  - *Sore throat;*
  - *Flu and flu-like symptoms;*
  - *Ear infections/Earache;*
  - *Suspected urinary tract infection;*
  - *Sexually Transmitted Illness;*
  - *Fever* **If having seizures, go to the Emergency Department**
- Upset stomach
- Nausea or vomiting
- Adult IV hydration
- Skin rashes and infections
- Abscesses
- Sprains or suspected minor broken bones
- Musculoskeletal injuries
- Back pain or joint pain
- Toothache (if dentist is not available)
- Allergies
- Animal or insect bite
- Eye irritation and redness
- Minor cut/abrasion and sutures/stitching
- Minor burn
- Frequent, bloody, or painful urination
- Motor Vehicle Collision exams
- Workman's Comp exams
- Sports/DOT physicals
- Travel vaccines
- Laboratory and blood work
- X-Rays

(over)

The Emergency Department (ED)

is open 24 hours a day, 7 days a week. You should seek care at the Emergency Department without delay if you have a serious or a life-threatening illness or injury.

- Chest pain or other heart attacks symptoms, such as:
  - *Pressure, fullness, squeezing/pain in the center of your chest*
  - *Tightness/burning/aching under the breastbone*
  - *Chest pain with lightheadedness*
- Signs of a stroke, such as:
  - *Sudden weakness or numbness of the face/arm/leg on one side of the body*
  - *Sudden dimness or loss of vision*
  - *Loss of speech or trouble talking*
  - *Sudden severe headaches with no cause*
- Head injury or eye injury
- Sudden and severe headache or loss of vision
- Heavy bleeding that won't stop
- Dislocated joints
- Severe abdominal pain
- Deep cuts or severe burns
- High fever
- Severe asthma attack
- Loss of consciousness
- Severe or worsening reaction to an insect bite, sting, or medications
- Constant, severe/persistent vomiting
- Coughing up or vomiting blood
- Poisoning **Call Poison Control at 1-800-222-1222 and ask for immediate home treatment advice**
- Domestic violence or rape
- Feelings of suicide

If you believe a life is in jeopardy, always call 911!

Patient Story: Mr. T

- Referred to MDPCP practice for primary care April 2019
- Engaged with CM, Pharmacist, Pharm Tech, CHW, CCMP for longitudinal care management
- Educated on use of primary care/urgent care vs. ED
- Self management of diabetes
- Lowered prescription costs
- Financial assistance with eyeglasses/hearing aides
- Expired prescriptions removed from home

Patient Story: Annual Medical Cost

Year	Annual Medical Cost
2019	$46,547
2020	$55,079
2021	$10,907

Patient Story: Clinical Outcomes

Year	A1C
2019	12.5
2020	7.4
2021	6.9

Open Discussion

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Upcoming Best Practice Learning Circles

Date	Time	Activity
02/09/2023	12-12:30pm	South County Health and Rhode Island Parent Information Network (RIPIN) Hospital Care Transitions Initiative- HomeHealth
02/16/2023	12-12:30pm	Medicaid Accelerated eXchange (MAX) Action Team- NYC Health & Hospital/ Queens Improving Care for High Utilizers and Sustaining Change
02/23/2023	12-12:30pm 12:30-1pm	SmartCare- Massachusetts Mobile Integrated Healthcare Wrap-up and Discussion

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