

Safety Net Health Centers Patient-Centered Medical Home Initiative and Project Overview

Overview

In 2011, CareFirst BlueCross BlueShield (CareFirst) launched a commercial Patient-Centered Medical Home (PCMH) program to help primary care providers (PCPs) improve care quality and control health costs for CareFirst members. The program was driven by data showing that 12 percent of CareFirst members account for more than 60 percent of total health care costs, and nearly 80 percent of those patients suffered from multiple chronic conditions.

The initial years of CareFirst's "commercial" PCMH program and the realization that this model of care held tremendous potential for medically-underserved populations prompted CareFirst President and Chief Executive Officer Chet Burrell to conceive the Safety Net Health Centers Patient-Centered Medical Home Initiative. The goal of the initiative was to support community health centers' implementation of patient-centered care models. The grants essentially served as catalytic funding for free clinics, community health centers and federally-qualified health centers to transition into patient-centered medical homes.

In early 2012, CareFirst awarded \$8.5 million dollars in grants to safety net health centers in Maryland, the District of Columbia, and Northern Virginia aimed to improve health outcomes and contain costs in caring for medically-underserved, chronically-ill individuals. The Safety Net Health Centers PCMH Initiative supported implementation of medical home and care coordination models in grant projects involving the following safety net health centers.



Arlington Free Clinic

Arlington Free Clinic (AFC) is a community-based organization that provides free health care to low income, uninsured residents of Arlington County. They offer primary and specialty care, mental health services, oral health, nutrition education and physical therapy through internal resources and partnerships with private providers and the Virginia Hospital Center. AFC largely operates through volunteers and financial and in-kind support.

AFC was awarded \$350,000 over three years to fully transition into a patient-centered medical home, allowing empanelment of all patients with serious and chronic health conditions. CareFirst's support enabled hiring and training staff, improving internal processes, and improving internal and external communication.

AFC applied grant funds towards hiring medical assistants to complete existing care teams composed of a volunteer physician, registered nurse and pharmacist. Grant funds also were used to implement disease registries, develop templates to measure health outcomes, create a mechanism to exchange patient data with community partners, and implement strategies to address and overcome health disparities.

During the grant project period, Arlington Free Clinic served 1,456 patients. At least 75 percent of these patients achieved measureable improvements in biometric indicators.



Baltimore Medical System

Baltimore Medical System (BMS) is a federally-qualified health center, and the largest community health center system in Maryland. They provide comprehensive primary and preventive health care to approximately 45,000 people annually through five health centers and eight school-based sites.

BMS was awarded \$498,905 over a two-year period to assist in implementing a system of care that empowers primary care providers (PCP) to screen and treat chronically-ill mental health patients by using social workers as intermediaries between the psychiatrist and PCP. In some cases, allowing brief interactions with a behavioral health provider during primary care visits. The project design entailed behavioral health screening at all primary care visits and subsequent social work referrals for patients who scored outside the normal range.

During the grant project period, BMS served 311 patients. The majority of these patients show clinically significant improvements in depressive disorders and nearly 90 percent reported that they had learned to better manage their condition.



Calvert Healthcare Solutions

Calvert Healthcare Solution (CHS) is a non-profit organization that arranges access to primary and specialty health care, radiologic and laboratory, and prescription medications to people between 117 percent and 200 percent of the federal poverty level. Through partnerships with Calvert Memorial Hospital, Calvert County Health Department, Calvert County Department of Social Services, and other community agencies, CHS provides supplemental reimbursement to healthcare providers who collectively treat more than 1,600 medically-underserved adults.

CHS was awarded \$287,762 over two years to target chronically-ill uninsured and publicly insured adults receiving services in three hospital-affiliated primary care practices. Patients with diabetes, hypertension and behavioral health issues received care coordination from a nurse case manager supporting primary care providers. The grant also provided for supplemental reimbursement to participating providers for related pharmaceuticals, specialist visits and disease management classes.

CHS served 190 patients and created 106 care plans over the project period. More than 40 percent of patients experienced measureable improvements in their HbA1c levels and over 60 percent experienced a clinically significant reduction in blood pressure. Further, emergency department visits decreased from 25 percent to 4 percent, diagnosis-related hospitalizations decreased from 6 percent to 1/2 percent, and cost per patient decreased from \$1,127 to \$68 annually.



Chase Brexton Health Services

Chase Brexton Health Services is a federally-qualified health center that provides comprehensive health services in medically-underserved communities.

In existence for more than three decades, it operates four practice sites in Baltimore City, Baltimore County, Howard County, and Talbot County. Chase Brexton serves approximately 18,000 patients annually.

Chase Brexton was awarded \$250,000 over two years to expand implementation of the Healthy Outcomes through Patient Empowerment (HOPE) Program, which aims to improve health outcomes for chronically-ill patients with a history of non-adherence or who are at-risk for non-adherence to medical appointments and medication regimen. HOPE also endeavors to reduce costs associated with the care of these patients.

The HOPE program is an integrated, multidisciplinary model of care that provides medication adherence assessment, education, and support to patients diagnosed with chronic illnesses. Grant funds fully or partially supported employing a patient navigator, clinical pharmacist, nurses, pharmacy technician, and three behavioral medicine clinicians. In addition to addressing medication adherence, the team referred patients for ancillary services and provided disease management education.

During the grant project period, Chase Brexton served 228 patients and created care plans for every patient. More than 60 percent of diabetic patients experienced a clinically significant reduction in HbA1c levels, and 84 percent experienced a measureable reduction in blood pressure. In addition, 92 percent of patients reported improvements in perceived health status, and 24 percent experienced reductions in outpatient acute care visits.



Choptank Community Health System

Choptank Community Health System (CCHS) is a non-profit, 501(c)3 community health center that provides comprehensive medical, dental and behavioral health services to residents on Maryland's Eastern Shore. CCHS treats more than 26,000 patients annually.

CCHS was awarded \$400,000 over a two-year period to provide comprehensive diabetes education and care coordination for uninsured and publicly insured diabetics who were referred by a primary care provider. Grant funds supported the purchase of diabetes education materials, hiring two nurses, and securing the nurses' AADE (American Association of Diabetes Educators) certification.

During the project period, Choptank served 748 patients. Among these patients, the average HbA1c level was reduced by 2 percent and average systolic and diastolic blood pressure readings fell four and two points, respectively.



Community Clinic, Inc.

Community Clinic, Inc. (CCI) (dba CCI Health & Wellness Services) is a federally-qualified health center that operates eight medical practice sites, three dental programs, and five Women, Infants, and Children (WIC) sites in Montgomery and Prince George's County. CCI serves approximately 27,000 patients annually. CCI partnered with Greater Baden Medical Services (GBMS), another FQHC in Prince George's County, in implementing their grant project.

CCI was awarded \$1,585,521 over three years to provide care management to patients with diabetes, hypertension, asthma and HIV/AIDS. Grant funds fully or partially funded employing care managers and community health workers who provided care coordination and outreach.

The project planned, managed and tracked the care of high-risk patients by providing standardized education to patients and their families, developing a plan to address identified barriers, assisting with referrals, tracking appointments and services, and documenting resolution or significant improvement.

During the grant project period, CCI and Greater Baden served 11,076 patients and created 6,158 care plans. At the end of the project, 74 percent of diabetic patients had an HbA1c level lower than 9 percent, and 89 percent of patients with hypertension had controlled blood pressure. Additionally, 90 percent of HIV patients had an undetectable viral load.

Health Care for the Homeless



Health Care for the Homeless, Inc. (HCH) is a 501(c)3 agency that provides and coordinates comprehensive health care services for families experiencing homelessness. HCH operates clinics in Baltimore City, Baltimore County, and Howard County. It serves over 6,400 individuals annually in Baltimore City, where this program was targeted.

HCH was awarded \$750,000 over a three-year period to implement a patient-centered medical home for chronically-ill people experiencing homelessness by empaneling them to care teams. The project entailed hiring a physician and support staff to create a prototype care team to inform eventual clinic-wide implementation of the PCMH model.

The initial phase of the project built collaborative provider-nurse teams that would facilitate expanding nurses' roles to provide intense education, support, and disease management to diabetes patients. Upon full expansion of the nurses' role, the project was extended to patients with hypertension and asthma.

Over the course of the project period, HCH served 863 patients and created 309 care plans. Among these patients, 65 percent experienced control with their diabetes and 57 percent had controlled blood pressure. Further, overall cost per patient decreased from \$1,523 to \$1,426.



**Mary's
Center**

Mary's Center

Mary's Center for Maternal and Child Care is a non-profit 501(c)3 organization that promotes improved health and social outcomes among low-income and immigrant families. Through two locations in Washington, DC and one in Montgomery County, Mary's Center provides health care, education and social services at no or low cost to more than 36,000 people annually.

Mary's Center was awarded \$596,665 over three years to implement the Chronic Care Initiative, which aimed to address the chronic disease burden among patient with uncontrolled diabetes, hypertension and asthma. The project entailed strengthening their existing integrated care model and supporting integration of a universal care planning tool into their electronic medical record that could be accessed in real time by all care team members. Grant funds supported hiring a nurse care coordinator, panel manager, and health educator to collaboratively coordinate and monitor optimal implementation of the PCMH model.

During the project period, Mary's Center served 960 patients and created 855 care plans. Nearly 70 percent of these patients experienced an HbA1c levels lower than 9 percent and 61 percent had controlled blood pressure.



primary care coalition
of Montgomery County, Maryland

Primary Care Coalition

The Primary Care Coalition of Montgomery County (PCC) is a 501(c)3 non-profit organization that assures primary care through a network of eleven independent safety-net health centers. The organization provides administrative

support, helps establish quality standards, promotes process and quality improvement, coordinates technical assistance, and manages clinic-based behavioral health services. In addition, it offers clinic infrastructure, including a shared electronic medical record system, generic point-of-care pharmacy, a pro-bono specialty care network, and chronic care management and preventive health programs.

PCC was awarded \$599,514 over a three-year period to implement the PCMH model in the clinics of two coalition members, Holy Cross and Proyecto Salud. Grant funds supported hiring a care manager for each site and partially funding a project director, who led a learning collaborative, standardized tools and procedures, and conducted project evaluation.

The care managers in the two practices served low income, uninsured patients with complex chronic medical and psychosocial issues by conducting formal medical and behavioral health assessments, developing care plans, collaborating to provide interdisciplinary team care and patient self-management education and coaching, sharing community resources, and coordinating specialty care appointments and transitions of care.

Over the course of the project period, PCC served 488 patients and created 444 care plans. More than 60 percent of projects participants experienced improved HbA1c levels and more than 50 percent experienced improvements in blood pressure. Among patients with abnormal biometric results at baseline, 70 percent experienced measureable improvements.



Total Health Care

Total Health Care (THC) is a federally-qualified health center that provides comprehensive health services to the underserved and uninsured. THC operates ten health centers throughout Baltimore City, serving approximately 31,000 patients annually.

THC was awarded \$1.14 million over three years to implement the PCMH model and reduce unnecessary emergency department visits in three federally-qualified health centers.

The grant funds supported implementation of the PCMH model, assembling a care team comprised of a nurse care coordinator, social worker, pharmacist, nutritionist, behavioral health social worker, and project director. Community health workers, who were paid with THC funds, completed the care team.

THC served 5,680 patients through the grant project and created 2,800 care plans. More than 50 percent of patients experienced an HbA1c level lower than 7 percent and more than 60 percent experienced controlled blood pressure.



Unity Health Care

Unity Health Care (UHC) is a 501(c)3 non-profit community health center that provides comprehensive care to homeless and medically-underserved populations. Unity provides health care to approximately 40 percent of the underserved population in Washington, DC, equating to approximately 82,000 people annually.

UHC was awarded \$913,801 over a three year period to: (1) implement same-day and after-hour, walk-in clinics at two locations; (2) launch a robust emergency department (ED) diversion project; and (3) provide care coordination to chronically-ill high-utilizers of the ED. Funds supported start-up expenses associated with opening the "Convenient Care" clinic and hiring staff to support ED diversion activities and performance outreach to chronically ill patients who were believed to not be engaged with a primary care provider (PCP).

Over the course of the project, UHC served a total of 30,212 individuals through 57,324 Convenient Care visits. The ED diversion project served 4,168 people. Of the patients who received care coordination services, 70 percent had HbA1c level lower than 9 percent and 60 percent had controlled blood pressure at the end of the project. Additionally, patients who were serviced by the ED Diversion team experienced a 35 percent show rate for appointments with their PCPs.