Healthy Anne Arundel Coalition
VISION

Healthy County, Healthy People!
Healthy Anne Arundel Coalition
MISSION

Working together as a community to promote the health and wellness of Anne Arundel County residents
Agenda

- Welcome and Introductions
- Review of Minutes and Updates
- Action Plan Revisions
- Discussion of the Coalition’s Future
- Announcements
- Next Steps and Concluding Remarks
State Innovation Models (SIM) Grant Solicitation

- Released by Center for Medicare & Medicaid Innovation (CMMI) at CMS
- Purpose: Develop, implement, and test new health care payment and service delivery models at the state-level
- Maryland received “Model Design” award
  - $2.37 million
  - 6-month planning grant (April 1 – September 30, 2013) to develop “Community-Integrated Medical Home”
  - Opportunity to apply for “Model Testing” award for up to $60 million to fund implementation over a 4 year period.
Community-Integrated Medical Home

- Integration of a multi-payer medical home model with community health resources
- 4 pillars:
  1) Primary care
  2) Community health
  3) Strategic use of new data
  4) Workforce development
- Goal is for CIMH to be an umbrella program with certain programmatic standards that allows for innovations across payers
Community-Integrated Medical Home

Community Health
- Local health departments
- Community organizations
- Social services
- Hospitals
- Other providers

Primary Care
- Primary care physicians
- Nurse practitioners
- Allied health professionals
- Community pharmacists

Care Manager

Community health Worker

Shared Data
Planning Process

- Two parallel stakeholder engagement processes
  1) Payers and Providers
  2) Local Health Improvement Coalitions
- All-stakeholder summit near the end of 6-month period to review recommendations from both processes and make final recommendations
- Health Quality Partners will manage planning process and provide content expertise
Payer and Provider Engagement Process

- Develop a governance structure for CIMH program
- Establish a public utility to administer payment and quality analytics processes
- Set programmatic standards, such as
  - Criteria for practice inclusion
  - Quality metrics
  - Analytics
  - Shared savings methodology
- Hilltop Institute and Optumas will conduct actuarial modeling of health costs to demonstrate savings expected from CIMH
Capacity of LHICs

Current:
✓ Prioritization & identification of target populations
✓ Selecting appropriate interventions for target populations
✓ Convening/facilitating partnerships to address population priorities and leverage community resources

Added Capacities:
• Data analytics and aggregation
  – LHIC will develop the role of a data integrator to build capacity and readiness for CIMH.
• Continuous quality improvement to enable LHIC partners to hit community-level cost and quality targets
• Hiring, Training, Deploying, Managing Community Health Workers
Potential Mapping Capability
Key Questions for LHIC Development

• Are these the appropriate functions for the expanded role of the LHIC to support CIMH?

• What does the certification of LHIC look like?

• How will LHICs leverage the functions of existing organizations that have core competencies to meet the expanded LHIC role?

• How does the LHIC have to structurally change to meet the new expanded role of the LHIC proposed here?

• Is there a tiered approach to readiness for the LHICs?
Model Refinement through Concentrated Stakeholder Input

- Establishment of workgroups to provide targeted feedback on key areas of SIM model design
  - Governance
  - Payment model
  - Participation standards
  - The role of the LHICs
  - Phasing in implementation

All-Stakeholder Summit rescheduled for September 10, 2013
CMS Health Care Innovation Awards – Round 2

• $900 million for new innovation awards
• Seeking state proposals on innovative health care delivery models to improve quality and reduce costs in Medicare, Medicaid, and CHIP
• Maryland: funding for the three "fundable" Health Enterprise Zone proposals not designated and develop the LHIC capacity/infrastructure and payment model for all 8 HEZs in MD.
• Build capacity of LHICs to support continued, sustainable infrastructure for data integration and continuous quality improvement for HEZ and future CIMH program
Co-Occurring Disorders Subcommittee
GOAL #1: Increase the County’s capacity to provide an integrated, continuous and comprehensive system of care for persons with Co-occurring Disorders, utilizing the “no wrong door” approach, ensuring more timely access to the full continuum of treatment.

- **By June 30, 2013, create a strategic plan to conduct outreach activities to somatic care providers**
  - By March 31, 2013, the Change Agents will conduct a Somatic Care Provider Survey, analyze the results and make recommendations to the Committee -- **ACHIEVED**
  - By September 30, 2013, the Change Agents, in cooperation with Maryland Integration Learning Community, will identify resources and create a Toolkit for Somatic Care Providers to assist them in screening patients for Mental Health and Substance Abuse needs.
  - By October 31, 2013, the Change Agents will develop a plan to distribute the Toolkit to Somatic Care Providers.
  - By February, 2014, the Change Agents, in conjunction with the Core Service Agency, will develop a series of trainings for Somatic Care Providers in order to increase their skills in screening for Co-occurring Disorders.

- **By June 30, 2013, implement an Overdose Prevention Plan**
  - By July 1, 2013, the Health Department will develop/write an Overdose Prevention Plan and submit to DHMH -- **ACHIEVED**
By June 30, 2014, develop and implement strategies to reduce the time spent waiting for services

- By July 31, 2013, the Committee will develop a workgroup to identify evidence-based practices that can be implemented by service providers to reduce the time clients spend waiting for services. **ACHIEVED**

- By October 31, 2013, the Workgroup will report their findings back to the Committee so that providers can develop and implement strategies within their agencies.
GOAL #2: Reduce Health Disparities by utilizing data from the Community Health Needs Assessment, to identify County residents at increased risk due to both geographical and demographical barriers to services.

- By June 30, 2014, identify non-traditional “points of entry” into the system of care such as primary care providers, schools, faith-based and community partners, social service agencies, etc., to promote early identification and intervention
  - By December 31, 2013, the Committee will analyze the 2013 Community Health Needs Assessment, taking a “Hot Spot” approach, to identify both geographical and demographical barriers to service.
  - By June 30, 2014, the Committee will identify service options, including Wellness Centers, Clubhouse models, community-based trainings, etc., that are or will be implemented to break down barriers and serve the under-served.
By June 30, 2014, increase the availability of treatment providers in underserved areas, such as South County

- By June 30, 2014, the Committee will identify and support providers who are in the early planning and/or implementation stage of opening services in South County.

By June 30, 2014, increase the availability of treatment providers for persons with specific barriers, i.e. language, culture, mobility, insurance, etc.

- By June 30, 2014, the Committee, in conjunction with the Core Service Agency, will develop trainings to educate providers on Co-occurring Disorders and other related topics.
- By June 30, 2014, the Committee will identify and support providers in the development of programs and services that specifically target:
  - Uninsured
  - Aging population
  - Hearing Impaired
  - Mobility Impaired
  - Trauma survivors
Goal #3: Develop and implement strategies that specifically address the Co-occurring needs of adults and adolescents involved in the criminal justice system.

- By June 30, 2014, develop and implement a plan to allow continued enrollment in MA/PAC, pending disposition
  - By October 1, 2013, enroll as many clients as possible into PAC, to ensure continued coverage under Affordable Health Care Act.

- By June 30, 2014, implement and fund a program that provides early identification of adolescents with Mental Health, Substance Abuse and Co-occurring Disorders
  - Health Department grant application pending.

- By June 30, 2015, establish Behavioral Health Treatment Courts
  - By June 30, 2014, the Committee will establish a workgroup to study this topic and make recommendations for proceeding.
Goal #4: Identify and implement environmental strategies that promote public awareness of Co-occurring Disorders and its effects on community well-being.

- By June 30, 2014, in collaboration with consumer groups, ROSC, Western AA County Substance Abuse and Northern Lights Coalitions, develop and implement a campaign of events that promote public awareness and anti-stigmatization.

  - On an on-going basis, the Committee members, the Health Department and the Core Service agency will collaborate to promote the following community-based awareness activities:
    - Underage Drinking Surveys (on-going)
    - Teen Summit, June 29, 2013
    - Recovery Walk, September 14, 2013
    - Mental Health First Aid, AA Community College
    - Kids at Hope Training
    - Mental Health First Aid for Kids “Train the Trainer”, Core Service Agency
Goal #5: The Co-occurring Steering Committee will disseminate information to providers regarding regulatory changes, i.e. workforce development, accreditation, reimbursement/funding, Behavioral Integration issues.

- On an on-going basis, the Committee will monitor the ADAA and DHMH websites and make members aware of any regulatory changes via: Provider Alerts, HD Transmittals, linkages to Behavioral Health Integration websites, etc.
Community Engagement Subcommittee
Discussion of the Coalition’s Future
Healthy Anne Arundel Coalition

Proposed Process

- Assessment of Community Health Needs
- Refine Action Plan Strategies
- Action Planning
- Implementation of Action Plans
- Evaluation
Healthy Anne Arundel Coalition

Proposed Structure & Flow of Information

Executive Committee

Planning & Assessment Subcommittee

Co-Occurring Disorders Subcommittee

Promotion & Publicity Subcommittee

Community Engagement Subcommittee

Obesity Reduction & Prevention Subcommittee
Announcements

An opportunity for Steering Committee Members and Supporters to share information that would be helpful to the Coalition and Coalition members.
Next Steps

- Next Steering Committee Meeting:
  September 25, 3:00 p.m. – 4:30 p.m.
  Location TBA

- Acknowledgements

- Closing Remarks
Healthy Anne Arundel Coalition
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Vanessa Carter, Chief, Administrative Services Office of Assessment, Planning and Response
Laurie Fetterman, M.S.W., Health Planner, Office of Assessment, Planning and Response

Steering Committee Member Organizations:
A.A. Co. Office of the County Executive
A.A. Co. Dept. of Aging and Disabilities
A.A. Co. Dept. of Detention Facilities
A.A. Co. Dept. of Health
A.A. Co. Dept. of Recreation & Parks
A.A. Co. Dept. of Social Services
A.A. Co. Public Schools
A.A. Co. Mental Health Agency, Inc.
Anne Arundel Community College
Anne Arundel County NAACP
Anne Arundel Economic Development Corporation
Anne Arundel Health System
Arundel Community Development Services, Inc.
Baltimore Washington Medical Center
Care First Blue Cross Blue Shield
City of Annapolis Mayor’s Office
Community Foundation of Anne Arundel County
Housing Authority of the City of Annapolis
MedStar Harbor Hospital
People’s Community Health Centers, Inc.
Rite Aid Corporation
School of Public Health, University of Maryland

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