Appendix Q

The Little Engine That Could: How a rural hospital and an area agency on aging joined forces to improve the health, well-being and equity of Maryland’s Lower Shore

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MAC, Inc. Area Agency on Aging
Session Discussion Topics

- Options for expanding services to engage individuals who are in recovery from surgery and clinical interventions into wellness and support programs.
- Innovative strategies that are of benefit to health care partners in providing a continuum of care to individuals with chronic conditions.
- Opportunities to bundle an array of services and programs to improve participants' health outcomes and quality of life.
Maryland’s Population Health focus requires culture change. Hospitals need to reach beyond their walls and work with community partners to: leverage assessment of individuals for health risks; link home and community-based services; assist in improving clinical outcomes; and provide feedback to providers.

“Population Health Management is a ‘team sport’ and PRMC cannot resolve the issues of the health care system in isolation. The need to develop community and other clinical relationships and ways of providing care outside of the walls of hospitals has become more important than ever. Hospitals are essentially being held responsible for reducing cost across the healthcare system in Maryland, so it is essential to play a significant role in helping orchestrate access to care and approaches that resolve many of the social problems that prevent people from using health care earlier.” Karen Poisker
By aligning services to meet these healthcare goals, MAC, Inc. Area Agency on Aging, and Peninsula Regional Medical Center (PRMC) expanded services:

1. A multi-pronged approach to link clinical and home services to homebound individuals;
2. Offering support groups, a community garden, and healthy cooking courses for cancer survivors;
3. Screening and behavioral interventions for individuals dealing with depression; and
4. Co-delivering wellness services for weight loss patients.
Initial Partnership Tools and Resources

* Participant Registry Shared Across Partner Agencies
* Provider Referral Forms
* Reporting Tool for Community/Clinician Referral Forms
* Client Information and Tracking
* Plan of Care Process Flow/Feedback Loop
* Blood Pressure Action Plan and Protocol
* Webinar on Community Services
* CDSM Courses / Access Regionally
* Contribution in Staff and Supervision to Support Effort
* CHW Assessment
Chronic Disease Assessment

- Do you have 2 or more chronic medical conditions?
- Are you taking more than 5 medications?
- Do you have difficulty managing your condition(s)?

Falls Risk Assessment for patients over 65

- Have you fallen in the past year?
- Do you feel unsteady when standing or walking?
- Do you worry about falling?

Depression Screen: Over the past two weeks, how often have you been bothered by any of the following problems?

- Little interest or pleasure in doing things
- Feeling down, depressed or hopeless
Assessed hypertension, diabetes and falls risk and delivered home-based and/or community workshops to lower rates of poorly managed hypertension by 62% and reduce falls rate for older adults by 31%.

Delivered evidence-based self-management programs to 452 individuals to improve their knowledge and skills for better-management of their chronic conditions

- 38% African American
- 18% Medicaid
- 52% multiple chronic conditions

Created an extensive support network for 154 cancer survivors who participated in 1,418 visits.
A Multi-Faceted Approach to Meet Client and Health Care Partner Needs

* **Evidence-Based Programs:** CDSME (CDSMP, CPSMP, CTS, DSMP, Stanford CDSMP Home Toolkit), EnhanceFitness, Tai Chi for Better Balance, Stepping On, Hypertension Recruitment Module, PEARLS

* **Referral and Plan of Care Process Loop:** evidence-based programs, provider, homecare-based CHW for monitoring of clinical outcomes, AAA-based CHW for home and community-based services

* **Hospital services provided at MAC:** staff support for evidence-based program implementation, cancer (support and navigation, organic garden, teaching kitchen), weight loss center (monitored exercise, nutritional counseling, teaching kitchen)
CDSME Workshops July 1 2015 – June 20 2016
3,500 Hours of Self-Management Workshops*

<table>
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<tr>
<th>COUNTY</th>
<th>PARTICIPANTS</th>
<th>COMPLETERS</th>
<th>RETENTION RATE</th>
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<tbody>
<tr>
<td>Dorchester</td>
<td>112</td>
<td>96</td>
<td>85.7%</td>
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<tr>
<td>Somerset</td>
<td>71</td>
<td>49</td>
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<td>Worcester</td>
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<td>38</td>
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<tr>
<td>TOTAL</td>
<td>423</td>
<td>331</td>
<td>AVE 78.1%</td>
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*2-1/2 hours x 4 weeks x 331= 3,310 hours + 95 x 2.5 = 230 hours
TOTAL NUMBER OF CANCER SURVIVOR PARTICIPANT VISITS PER PROGRAM

- Tai Chi: 280
- Vegetable Pick-Up: 467
- What's Cooking: 231
- GYM: 509
- CTS: 61
- Intake/Navigation: 195
- Coloring/Holiday Party/Garden Art Project: 177
## Stepping On August 2015 – June 2016
179 Participants  157 Completers

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<tr>
<th>Location</th>
<th>Date</th>
<th>Participants registered</th>
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<tr>
<td>Mac Inc.</td>
<td>August 19</td>
<td>18 enrolled/ 13 com</td>
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<td>Mac Inc.</td>
<td>December</td>
<td>13 enrolled/10 com</td>
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<tr>
<td>Berlin Senior Center</td>
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<td>Mac Inc.</td>
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<td>Mac Inc.</td>
<td>November 23</td>
<td>21 enrolled /18 completed</td>
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<td>Somerset County Senior Center</td>
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<td></td>
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<td>15 enrolled/10/com</td>
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Utilize a hypertension recruitment module and blood pressure screening to identify risk and engage/refer participants

Provider referrals identify chronic disease and identify appropriate program intervention

Care Transitions Team utilizes online HIPAA compliant Autofill referral

Embedding standardized chronic disease, falls, depression risk assessments into hospital, provider and AAA referrals (soon to include malnutrition screening)
Quality Assurance, Referral and Tracking Measures

- Hospital’s Accountable Care Organization measures include requirement to refer to CDSME
  - Pulling patient panels by disease for workshop referrals
  - Satisfaction survey self-efficacy questions align with ACO quality measures
- With participants’ permission, we link participants back to health care provider to determine changes in utilization at the local level
Integrating a healthcare/community partnership empowers practitioners and patients, reduces health care costs and improves quality of life.

Co-locating Diabetes nonclinical services at MAC utilizing a referral process to prioritize and ensure the appropriate level of diabetes resources.

Applying for a HRSA Rural grant using multiple providers and partners to:
- Expand telehealth services in rural, isolated areas
- Embed CDSME and other evidence-based behavior change programs as part of routine delivery of services
- Expand use of PRMC and MAC CHWs to do assessments, track engagement and provide an array of in-home services
Discussion/Questions

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