Mercy Medical Neighborhood

Melissa Skahan, Vice President of Mission Integration
Mercy

www.mercyhospital.org

Mercy Intent of Neighborhood

- MEHAF Grant Funded Payment Reform Initiative Expanded through A2QC
- Innovative approaches to health care delivery that reduce cost, maximize value, and deliver better health
- Mercy charity care patients
- Payer Agnostic System of Care

www.mercyhospital.org

Mercy Service to the Poor

- 14.6 million in charity care in 2013
- 40% increase in requests for Financial Assistance
- High ED utilization from a small population
- Patients with SPMI struggle to maintain medical home.
- Diverse patients struggle to navigate the system
- No structure or metrics for care of the uninsured

www.mercyhospital.org

Mercy Payer Agnostic System of Care

- Required connection with Financial Counselors to screen for resources for patients
- Prior authorization for all non-emergent services
- Medical Necessity screen for all services
- Utilization Review Team to evaluate all requests for referrals, procedures, and surgery
- Care coordination across the continuum

Mercy Financial Counseling

- Highly trained staff to secure Maine Care and other coverage solutions
- Certified Application Counselors
- **Great rate of conversion**
- Warm hand off to neighborhood team member for referrals
- Streamlined referral process for FQHCs

Mercy Utilization Review

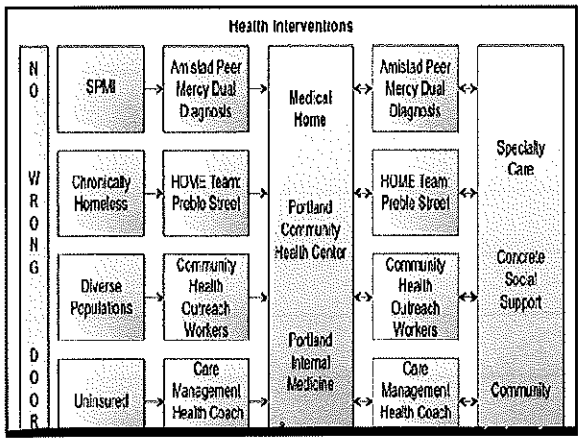
- Scope of program defined and criteria purchased – McKesson Interqual platform
- All requests to the UR Team with 24/48 hour turn around
- Elimination of unnecessary and duplicative care.
- ED Care Manager and team assist with real time care management, coordination, and utilization review.

Mercy Medical Neighborhood

- **Data Reports**
  - Overarching Legal Structure
  - Data Sharing Agreement and Releases
  - Daily activity list in the ED for uninsured patients
  - Weekly report of all activities from FQHCs
  - Weekly spend by dept.
  - Monthly detailed report by dx, patient, provider, service line, and cost
  - Care manager and targeted recovery team assigned to high cost patients

Mercy Medical Neighborhood

- **Technology tools**
  - Allscripts access for IP Case Managers/UR Team to fully integrate care
  - Medical Necessity Screen (web-based and free)
  - Patient Portal extended to PCHC
  - Shared technology platform for community partners
  - Healthinfo net predictive modeling



Mercy Medical Neighborhood

- **Team approach**
  - Release for patients with Behavioral Health Concerns
  - Financial counseling/Maine Care application
  - Engagement of appropriate resources to facilitate transition to medical home
  - Referrals to Amistad's Peer Support Program
  - Coordination with Street Outreach Workers for Chronically Homeless (Preble Street, HOME Team, and City of Portland staff)

Mercy Medical Neighborhood

- **Team approach**
  - Warm hand off to Primary Care Centers
  - Streamlined referral process
  - Real time appointments across the neighborhood
  - Follow up calls and texts
  - Weekly team meetings
  - No wrong door approach – any agency can refer
  - Developing cohort of Health coaches(Health Leads)

Mercy Medical Neighborhood

- **Amistad**
  - Excellent results with engagement
  - Assisting with identification and enrollment with PCP
  - Expert peer coaching for patients in crisis
  - Development of natural and sustainable supports
  - Refers and assists patients with integration into the medical home
  - Training and enrollment access for patient portal

Mercy Medical Neighborhood

- **Healthcare for the Homeless and PCHC**
  - Training for staff
  - Shared EHR
  - Mercy's Patient Portal at PCHC
  - Care coordination between providers(Direct admit/Referrals)
  - Warm hand offs to outreach coordinator and CHOWs from ED
  - Streamlined and revised referral process

www.mercyhospital.org

Mercy Medical Neighborhood

- **Opportunity Alliance**
  - Co-location of Behavioral Health LCSW at PIM
  - Build natural connections within the mental health community for uninsured patients
  - Resource for primary care staff
  - Refer for medication management
  - Refer for mental health support
  - Help with enrollment in patient portal and successful integration within system of care

www.mercyhospital.org

Mercy Medical Neighborhood

- **The Milestone Foundation and Preble Street**
  - Build natural connections with the chronically homeless
  - Resource for primary care staff
  - Help with concrete supports and successful integration within system of care
  - HOME Team provides transportation
  - SSI/SSDI and Maine Care Disability apps
  - Adult Protective Services staff assigned to the neighborhood team

www.mercyhospital.org

Mercy Medical Neighborhood

- **Portland Internal Medicine**
  - PCMH, ACO, CCT access for uninsured
  - Behavioral Health Home
  - Peers or outreach staff attend first few appointments
  - Manager attends weekly team meetings and has consistent communication with peer and outreach
  - Patients that traditionally have struggled to maintain relationships do well at PIM

Mercy Stories

- Milestone brings forth a concern about an end stage alcoholic community member. Gentleman had lost the ability to walk and toilet himself. While not a high user of ED services, very high user of community resources such as partner's service, police, EMS, and other social services. In a partnership, we have stabilized and placed in a safe home.

Mercy Stories

- 58 year old male from Burundi with highly unstable diabetes and no medical home. He listed PCHC, but they had no record of him. Several high cost admissions with chronic no shows and failed referrals at Mercy. Successful connection made by the CHOWs to a medical home and the Manager of Mission assists with transportation, meds, food and asylum status process.

Mercy

Stories

- 29 year old male with SPMI and chronic alcoholism is Mercy's highest user for two years(ED and MRC) with charity costs nearing $200K. Patient is served by the neighborhood model; and through daily contact with peer and ED care manager, he engages and enjoys eleven months of sobriety. Patient relapses and quickly becomes a best customer again. Team re-engages and through daily contact, reduced utilization and moving towards stability.

Mercy

Stories

- 50% no show rate from PCHC referrals to Mercy GI. Team meets and develops a plan to develop a new approach, which blocks time in the acute setting in Portland, provides transportation using the Mercy shuttle, and embeds CHOWs and interpreters to reduce cost and no show rates.

Mercy

Successes

- Systemic transformation
- Responsive care delivery system
- Identification and connections for vulnerable patients beyond the acute setting
- Behavioral change – ED utilization and shared language(intake/tour; best customers/frequent flyers)
- Improved relationships with most vulnerable with potential for preventive care (Power of Peers)
- New partners bring scale to serve all uninsured and underinsured