FAIRVIEW

Testimony from Marge Page, R.N.
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Good afternoon Chairman Abler and members of the House Health Finance Committee. I'm Marge Page, vice president for adult acute services at the University of Minnesota Medical Center, Fairview. The medical center is an academic medical center and part of Fairview Health Services. I'm also the operations lead for the medical center's Coordinated Care Delivery System (CCDS).

Thank you for the opportunity to share our experiences as one of four CCDS in the state. Last spring, Fairview stepped forward to be part of the new and undeveloped CCDS structure within General Assistance Medical Care. We felt very strongly that participating was the right thing to do for our patients—despite the significantly low reimbursement and the incredibly short timeframe to create a program.

With a few weeks to plan and prepare, we opened a primary care clinic on June 1—UMMC Riverside Primary Care Clinic—to exclusively serve as the medical home for our CCDS enrollees.

The enrollees in our CCDS have unique and complex needs. Up to 85 percent of our enrollees have co-occurring medical and mental health diagnoses. Approximately 60 percent have three or more different diagnoses. Thirty percent have more than six diagnoses. Virtually all of them have challenging socio-economic conditions in their lives.

To meet the needs of our patients, we have evolved a well-known integrated medical-behavioral care model. What does this look like? A physician and a behavioralist, which is a trained mental health professional, assess all new-to-clinic patients and set the stage for the development of a plan of care by the patient, medical and behavioral provider. Physical, mental and social needs are addressed at each visit. Each patient is treated as a whole person—provided respectful, thorough and cost-effective care. Patients are cared for on-going in a team-based model. For example, the medication management pharmacist may see a patient weekly for a period of time to assist in having an optimal medication regimen that the patient is able to adhere to. The RN Care Coordinator may follow a patient for several weeks between clinic visits. All of these activities are interdependent yet utilize the right person for the right job at the right time.

The medical center's CCDS utilizes a tight network of providers, largely relying on our partnership with the University of Minnesota Physicians for specialty care. All the care and services are managed through the clinic and provided by referral only. Because our patients are enrolled in our CCDS network, we have the opportunity to really manage the care and impact our patients' health for the better.

Let me give you a few examples:

One of our patients is a man with MRSA—an antibiotic-resistant infection that had been very, very difficult and costly to treat and control. The man had been ostracized for his condition, feeling that he didn't belong anywhere. The clinic physician and the behavioral health consultant welcomed him and told him he was to come to the clinic whenever he had concerns. With the medical-behavioral model, staff focused not only on his medical conditions but also his depression and sense of isolation. In one of his many follow-up visits, the patient told our staff that, at the time he first came to the clinic, he had planned to kill himself. Staff asked what made him not carry through with his plan. The patient stated it was because staff cared about him and helped him feel he was worth something.

Another patient in our CCDS is a man with diabetes, chronic pain and chemical dependency issues. He initially came to the clinic seeking pain medications. Through a team medical-behavioral model, staff helped wean the man off his pain meds. Our pharmacist is working with the patient to better control his diabetes. Overall, the man has made significant strides to turn his life around—stopping his chemical use and addressing significant anger management issues. He is now enrolled in school with a goal of eventually becoming a chemical dependency counselor.

There is a woman who was in a cycle of admission and readmission to the hospital—nine times between June and November. This patient was enrolled in our CCDS but never sought primary care. Our CCDS staff reached out to the patient, convincing her to come to the clinic, where the physician and behavioral health consultant helped the patient break the cycle causing the frequent admissions. The patient has remained out of the hospital since November.

I am inspired by these stories and many, many more that demonstrate our care model and our approach is helping our patients. The team we've assembled to serve our CCDS enrollees has done impressive work to build relationships and deliver outstanding clinical care.

We're working hard to quantify our work through quality and cost measures. It's still relatively early, but we have some measures that are very telling. For example, we've seen a steady reduction in ER utilization by our CCDS enrollees throughout the months we've been in the CCDS model.

Looking ahead, we are very supportive of the Medicaid expansion. The expansion will improve access to care statewide, which was a serious issue for individuals covered by GAMC living outside the seven-county metro area.

We're hopeful our learnings in the CCDS structure can be applied to other patient populations and that we can continue to serve the majority of our current CCDS enrollees when they transition to MA on March 1.

In the private insurance market, Fairview has actively pursued shared-savings contracts that align the financial incentives to improve quality and reduce the total cost of care. The CCDS model gave us the flexibility to deliver the right care at the right time to manage the total cost of care. The traditional MA structure lacks flexibility and aligned incentives. We urge the committee to consider innovations in Medicaid that will ultimately improve quality and reduce the total cost of care.

Thank you.