Proposed Outline of the Final Report of the Care Coordination Work Group

1. Executive Summary
2. Background
    a. Overview of new All-Payer model
    b. Explanation of the purpose of this Work Group and our process
3. Broad vision: better care and population health, meeting the All-Payer near-term targets; how care management and coordination can contribute to achieving these goals.
4. The case for improved chronic care and care coordination
    a. Overview of populations in need
        i. Rationale for focus and coordination (data and reason to focus efforts on patients with the greatest needs)
        ii. Key determinants of need (e.g. some mix of medically complex; socially complex; frail, cognitive impairments)
5. Key Elements of Care Coordination
    a. Relationship to broad vision
        i. Tying into other initiatives (CMS, EHR, etc.)
    b. Engaging patients and patient permission
    c. Patient-Centric Health Risk Assessments
    d. Early development of customized, individualized care management plans, including:
        i. Effective hospital discharge planning and strong follow-up
        ii. Attention to improving other transitions of care, including those involving rehab centers and long-term care facilities
        iii. Medication management and patient alerts to danger signals
        iv. Regular face-to-face interaction between care managers and patients
        v. Addressing social determinants of health
        vi. Good nutrition and oral health
        vii. Strong linkages between somatic and behavioral health
        viii. Patient and family involvement in the care plan
6. Existing infrastructure, gaps, opportunities to improve care coordination
    a. What care coordination activities are already underway in Maryland?
    b. What are the gaps and unmet needs that need to be addressed?
    c. Medical
    d. Behavioral Heath
    e. Social services

7. Implementation strategies
    a. Acquiring data in a timely fashion
        i. First priority: acquiring Medicare data through Data Use Agreement with CMS
        ii. Getting such data in a form that permits and facilitates the preparation of individualized care plans
        iii. Obtaining other types of data to support care coordination
        iv. Stratifying likely patient needs and risk
        v. Predictive modeling

b. Developing face-to-face Health Risk Assessments (HRAs) and Individual Care Plans
c. Specifying key areas of focus (e.g. behavioral health integration, LTC transitions, tele-health, other)
d. Identifying infrastructure needs (care management processes, technology needs, work force needs)
    i. What are respective roles for different public and private sector organizations?
e. Determining the locus of new infrastructure (e.g. statewide, regional, local or hospital-specific)
f. Identifying infrastructure financing options
g. Specifying legal and regulatory needs to support care coordination

8. Recommendations (Potential Areas of Recommendations)
    a. The transformation of health care in Maryland will require the creation of common infrastructure enabling the widespread use of best practices in care coordination and management.
    b. An important building block in this infrastructure is a data system that incorporates utilization, cost, and health risk assessment data to identify patients with the most complex medical and social needs and facilitates the creation of patient-centered care plans.
    c. The place to start is with Medicare patients in the fee-for-service system already in a high-use situation.
    d. The next step is to identify a broader range of patients in Maryland who are at-risk and are dealing with poorly managed and frequently multiple chronic illnesses.
    e. Another building block in the infrastructure is an interoperable health information system with timely data sharing among providers across different settings, in a privacy-protected fashion, that is used by physicians and hospitals in real-time as they treat patients in offices, clinics, and at the bedside.
    f. A third building block is collaboration among groups of hospitals, and between such hospitals and physicians, health centers, and community-based organizations, to address common factors that are driving people into the use of high-cost resources (e.g. repeated ED visits, inpatient admissions and readmissions) that are in many cases avoidable with timely care management and prevention strategies.
    g. HSCRC can play a role of convener and catalyst in helping leaders in Maryland State government and the private sector identify public and private-sector investments at the local, regional, and State-wide levels that can lead to repositories of promising care management strategies and specific action steps to carry them out.