Patient-Level Data to Support a Collaborative Care Coordination Initiative: Recommendation of the Care Coordination Work Group

February 3, 2015

Background

The Maryland all-payer agreement commits the State to meeting specific goals to improve care and lower health care spending. Maryland hospitals are bound to the terms of the all payer contract and are all operating under global budget arrangements, which hold them accountable for population-adjusted total hospital spending and key quality metrics.

Success under this new model will require hospitals, community-based providers, long-term care, and post-acute care providers to work together to effectively coordinate patient care, reducing the need for hospitalizations. Maryland's ability to succeed under the new model will require hospitals to embrace a very new and different role – one that is accountable for the total cost of care for the population. To achieve success, all providers will need the ability to understand the health care needs as well as other factors affecting their patients' health, and target their care coordination and patient support efforts to address these needs.

The need for a two-track approach

Access to meaningful, actionable data is one important tool to achieve effective care coordination. A two-track approach for using data to inform and support care coordination is advisable. First, it is important to use information from *existing data sources* that could be used to identify patients with the most complex medical needs. This data would include data currently available through CRISP such as real time Hospital Administrative, Discharge, and Transfer (ADT), hospital inpatient and outpatient data available on a monthly basis through the HSCRC abstract and potentially other clinical data available through CRISP.   Additionally, other sources of data should be evaluated for possible use in these efforts, including: pharmacy data obtained from pharmacy benefit managers (PBMs), Outcome and Assessment Information Set (OASIS) data on home care, Minimum Data Set (MDS) records on nursing home care, and other information sources. It is also important to use clinical data such as prescribed medications, medication lists, problem lists, lab values, and immunization records. *This work could begin immediately, and CRISP could take the lead in this effort.*

Second, moving down a parallel track, *Maryland should take steps as soon as possible to acquire Medicare claims data under its existing CMMI grant.* Medicare data that includes physician encounters as well as skilled nursing facility and other post-acute providers linked with hospital data, clinical data, ADT, and HSCRC abstract data will create a powerful tool for care coordination.

The two complementary efforts will give the delivery system in Maryland an unprecedented opportunity to serve its patients.

Although other types of tools are also needed for care coordination, the focus of this recommendation involves obtaining data following this dual-track approach.

Maryland policymakers, hospitals and other providers are focused on implementing strategies to coordinate the care of patients in the Medicare fee-for-service population. Effective care coordination will require collaboration among hospitals, health systems, independent providers, and community-based organizations.   Most Medicare high- utilizers are using multiple hospitals, multiple doctors and many prescriptions. In most instances a single hospital will not have a comprehensive understanding of a patient's prior utilization, medical conditions, and opportunities to improve care through targeted care coordination initiatives.

The federal government's agreement with Maryland recognizes that providers will need access to patient-level Medicare data to implement strategies that will allow Maryland to meet the goals of the All Payer agreement.[1] Other existing data sources could also provide robust and timely information to support a collaborative care coordination initiative. These data sources include clinical information potentially available through CRISP and timely and comprehensive hospital data for all payers available through CRISP, ADTs, and HSCRC abstract data.

Recommendation

The Care Coordination Workgroup recommends that Maryland develop a carefully coordinated initiative to put data already in hand, or readily available, to use in care coordination. This should be done in an organized, collaborative fashion. A useful place to start is to make best use of data that CRISP is already collecting. It is also important to understand what care coordination initiatives can be planned with data that is not identifiable to specific patients in terms of their names and addresses, but does contain important information about medical conditions and utilization. Such information could be helpful in the care coordination process.

Work can begin now on risk stratification using information already available. We know that a relatively small proportion of patients, particularly in Medicare, accounts for a disproportionately high share of health care spending. High-risk patients can be identified through data on ED use, admissions, readmissions and chronic diseases. As more data is available, risk stratification can become more sophisticated.

Moving down a parallel track, we recommend that Maryland gain access to Medicare data for the purposes of collaborative care coordination.

A plan needs to be developed with sufficient detail to make the case to CMS that Maryland hospitals, physicians, and other providers should be granted access to use confidential Medicare data for care coordination consistent with the goals of the new all payer model, similar to ACOs and numerous other Medicare demonstrations. This plan is also needed in order to share existing data sets among various hospital and other providers for the purpose of care coordination. Medicare will not provide this data

---

[1] Note: The Maryland All-Payer Model agreement allows for the state or its agents to request data that is necessary to achieve the purposes of the Model. Such data could include de-identified (by patient or by provider) data or individually identifiable health information such as claims level data. All such requests for individually-identifiable health information must clearly state the HIPAA basis for requested disclosure. CMS will make best efforts to approve, deny or request additional information within 30 calendar days of receipt. Appropriate privacy and security protections will be required for any data disclosed under this Model.

without specific protections and understanding of its use; we recommend providing such assurances to CMS to facilitate and expedite the delivery of this important data.

The plan must include:

1. Patient protections and data security to ensure protection and appropriate use of health information;
2. The approach to defining patient-provider relationships for the purposes of data sharing to support care coordination;
3. A risk stratification process that identifies high-risk patients;
4. The capability to inform providers of patients who would benefit from care management;
5. The ability to populate care plan tools with information that is needed for effective care planning, including conditions/diagnoses, provider relationships, historic use patterns, etc; and
6. Outcome data collection and analysis for the purpose of continuous improvement.