February 20, 2015

Ms. Donna Kinzer, Executive Director
Maryland Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
Attention: Care Coordination Workgroup

Dear Ms. Kinzer,

I am writing to offer LifeSpan's recommendations to assist the Care Coordination Workgroup on their report.

LifeSpan is the State's largest post-acute care (LTPAC) provider association, representing approximately 250 organizations that care for more than 45,000 Marylanders in various settings throughout the State, including skilled nursing, assisted living, CCRCs, senior housing and community-based providers. Each and every one of LifeSpan's members has much to offer in terms of improving care coordination with their respective hospitals, especially as it pertains to the State's high cost, dual-eligible population.

LifeSpan members understand this population. There are about 28,000 people residing in Maryland skilled nursing facilities. Nearly all are dually eligible. Another 20,000 reside in assisted living facilities in the State. The average age of a Maryland assisted living resident is higher than those in SNFs, so although most may not be Medicaid eligible, they are very likely to become Medicaid eligible as a result of the high cost of care.

With the exception of the CON (Certificate of Need) process, the post-acute care market has evolved well outside of State public policy and health planners, and hospital leaders. While not intentional, there is a lack of awareness of the needs of this medically complex population, who provides the post-acute care, and the inter-relationships of the current support systems. This lack of understanding hinders Maryland's hospitals as they pivot to a global budget, and become accountable for the total cost of care for people in their market.

**We believe that the better State planners and hospital leaders understand the LTPAC market and capabilities, the faster they can identify, scale and adopt new**

**practices. Many of the fundamentals of care coordination and comprehensive patient healthcare management are currently practiced by LTPAC providers.**

On behalf of LifeSpan, we offer the following information and recommendations to assist the workgroup in meeting its stated goals.

> *The purpose of the Workgroup is to provide the HSCRC with senior level stakeholder input on guiding principles for the overall implementation of population-based and patient-centered care coordination, with a focus on strategies and priorities that are timely, scalable and best-practices, and especially focused on the Medicare fee-for-service population.*

**LifeSpan recommends the following guiding principles:**

- **reward LTPAC partners for high quality care;**
- **require proven performance metrics from LTPAC partners;**
- **assure data that is accurate, secure and accessible;**
- **protect patient privacy, dignity, choice and self-determination; and**
- **include the broadest practicable array of community-based post-acute organizations that have a demonstrated ability in effective care coordination.**

> *The workgroup will identify the key ingredients and program elements of successful care coordination strategies.*

**LifeSpan recommends the following care coordination strategies:**

**1. Integrate Staff & Workspace**

- Integrate staff between hospital and LTPAC facility, such as a post acute nurse liaison to reduce readmissions.
- Establish a dedicated hospital contact person available 24 hours/day for LTPAC facility.
- Schedule regular meetings between hospital transition teams and LTPAC staff to establish contacts, go over care transition cases, provide training.
- Have the hospital occupy space (unit, floor, wing) and provide staff at LTPAC facility.
- Have hospital staff perform regular rounds at LTPAC facility.
- Have hospital identify LTPAC facilities that are at a higher risk of sending readmits and provide a physician or nurse to perform rounds at the LTPAC facility.

**2. Share Revenue, Systems, Information**

- Incentivize hospital and LTPAC partners to develop gain-sharing models to share revenue to reduce unnecessary hospitalizations and maintain quality care outcomes.
- Incentivize models that are based on data accuracy, and timeliness of data that is entered and accessible.
- Include hospital staff and/or physician in communications with families of LTPAC residents, prior to admission to reduce family pressure to send patient to hospital.
- Encourage hospitals to share their EHR system with LTPAC partners, or finance system connectivity.

**3. Accelerate Adoption of Information Technology, CRISP Use and Require Standardization of Patient Transfer Data Elements**

- All participating healthcare providers should be required to adopt a Universal Discharge Summary(UDS). The UDS should have an agreed upon limited number of key data elements (and that is in addition to INTERACT).
- State should offer grants to finance the purchase and adoption of Information Technology systems.
- CRISP should collect/include data from home health providers from OASIS and MDS data.
- Have hospitals and LTPAC facilities develop effective processes, including CRISP, to ensure that patient records flow between each with consistency, speed and uniformity.
- Make medication reconciliation a priority capability of shared data systems; and include pharmacy data in CRISP.

*The Workgroup will identify barriers, and how can they be overcome.*

**Care Coordination Barriers**

- Eliminate incentives for gaming – hospitals & LTPAC providers are sometimes are releasing patients too soon or refusing to admit certain patients, and this ultimately results in higher readmission rates.
- Penalize hospitals that abuse the 'observation' status.
- Reduce hospital discharges to LTPAC at night or weekends. This often causes higher readmission rates, because LTPAC facilities staff at a lower level at those times.

- Encourage increased use of transitional settings (rehabilitation units, skilled nursing, assisted living, home health) that offer additional support to high risk post-discharge patients.

**Information Technology Barriers**

- Post-acute providers need assistance in accessing CRISP system and capabilities. They are unaware of CRISP capabilities; don't see the advantage of using the system from a patient care or financial perspective.
- Clinical information contained in CRISP is not real time; or attached to notifications in the ENS.
- With many hospitals running or developing their own systems, CRISP is redundant. Post-acute providers currently have a greater incentive to connect with their hospital's existing electronic systems.
- Most post-acute providers don't have comprehensive EHR systems. They are more likely to have partial electronic systems (for billing or MDS).
- CRISP data is delayed. Data is posted after it becomes final. This creates delays, making the information less useful to providers who would benefit from real time information.
- Post-acute providers are not paid for this activity. There is a lack of reimbursement and/or clear financial incentives to become electronically connected or to use CRISP system.
- CRISP doesn't support all data attributes that are important to post-acute care providers.
- LTPAC providers are unsure about key system issues, such as: Who controls the patient data? Who can access, edit, update data? Who is the hub? How will future system additions, updates be managed, financed? What essential data elements are included/excluded (medications; labs; physician orders)?
- LTPAC providers cannot finance IT connectivity with multiple, competing hospitals and multiple EHR systems.

Thank you for the opportunity to provide input to the workgroup. LifeSpan is fully invested in supporting this effort, and we stand ready to provide further assistance as Maryland moves forward in making the 'triple aim' a reality in this State.

Sincerely,

Isabella Firth
President