Statewide Integrated Health Improvement Strategy (SIHIS)
Hospital Population Health Leader Forum

March 25, 2022
Agenda

• Welcome and Opening Comments
• Overview of Statewide Integrated Health Improvement Strategy (SIHIS)
• Opportunities for Hospital Alignment with State Initiatives
  • Diabetes Initiatives
  • Opioids Initiatives
  • Maternal Health Initiatives
  • Childhood Asthma Initiatives
  • Medicaid Initiatives
  • Maryland Primary Care Program (MDPCP) Initiatives
• Questions & Discussion
Opening Comments
Statewide Integrated Health Improvement Strategy Overview
Statewide Integrated Health Improvement Strategy (SIHIS)

- In December 2019, Maryland & CMS signed a Memorandum of Understanding (MOU) agreeing to establish a Statewide Integrated Health Improvement Strategy.

- This initiative is designed to engage State agencies and private-sector partners to collaborate and invest in improving health, addressing disparities, and reducing costs for Marylanders.

- The MOU required the State to propose goals, measures, milestone and targets in three domains.

- The State submitted its proposal to CMMI in December 2020. CMMI approved the proposal in March 2021.

- The annual report on SIHIS activities for 2021 was submitted in January 2022.

- The proposal, approval memo, and annual report can be found on the HSCRC website. https://hscrc.maryland.gov/Pages/Statewide-Integrated-Health-Improvement-Strategy-.aspx
Domain 3: Total Population Health

Priority Area 1: Diabetes

- Identified as a statewide priority by Maryland State Secretary of Health & the statewide Diabetes Action Plan is now available on MDH website

Priority Area 2: Opioids

- Identified as a statewide priority by Lieutenant Governor through the Maryland Heroin and Opioids Emergency Task Force in 2015
- State of Emergency declared by Governor Hogan in 2017

Priority Area 3: Maternal & Child Health

- Maternal and Child Health identified as a SIHIS recommendation by the Maternal and Child Health Task Force formed by House Bill 520/Senate Bill 406
Statewide Goals Across Three Domains

1. Hospital Quality
   • Reduce avoidable admissions
   • Improve Readmission Rates by Reducing Within-Hospital Disparities

2. Care Transformation Across the System
   • Increase the amount of Medicare TCOC or number of Medicare beneficiaries under value-based care models*
   • Improve care coordination for patients with chronic conditions

3. Total Population Health
   • Priority Area 1 (Diabetes): Reduce the mean BMI for adult Maryland residents
   • Priority Area 2 (Opioids): Improve overdose mortality
   • Priority Area 3 (Maternal and Child Health Priority Area):
     • Reduce severe maternal morbidity rate
     • Decrease asthma-related emergency department visit rates for ages 2-17
Opportunities for Hospital Alignment with SIHIS Initiatives
Diabetes Initiatives

• Partner with providers to increase provider awareness, education, training and referrals to the National Diabetes Prevention Program (National DPP) and Diabetes Self-Management Education and Support (DSMES) programs.
  • Educate the entire clinical team (medical assistants, nurses, etc) on these programs so they can help “sell” the programs.
  • Connect with your hospital’s Regional Partnership on DPP and DSMES, if applicable. https://hscrc.maryland.gov/Pages/regional-partnerships.aspx
• Increase pharmacist awareness of DPPs and their role in patient referrals
• Offer CME’s to providers; have diabetes care teams/specialists in the hospital participate in learning collaboratives with primary care.
• Incorporate food insecurity questions during patient intake and refer patients to programs to access foods.
Opioids Initiatives

- Expand screening, brief intervention, and referral to treatment (SBIRT) and buprenorphine induction.
- Distribute Naloxone to patients who receive treatment in the emergency department (ED) for a non-fatal overdose.
- Connect with your Regional Partnership, if applicable, on plans to expand behavioral health crisis infrastructure in your community. https://hscrc.maryland.gov/Pages/regional-partnerships.aspx
Reverse the Cycle (RTC)

Comprehensive hospital substance use response program

RTC includes:

• Universal screening and peer intervention
• Overdose survivors outreach
• Medication initiation

Components:

On site TA, standardized protocols, modifications to electronic health records, trainings and boosters for all staff
Reverse the Cycle Data

- Screened 80% of patients who presented to ED
- Engaged 62% of overdose patients presenting to the ED with intensive community peer support
- Initiated medication for 63% of opioid-using patients presenting to the ED
- Linked close to 33% of patients who overdosed to treatment after community peer engagement
- Linked 12,917 patients directly from ED to treatment
- Linked 66% of patients after MOUD induction in the ED to MOUD treatment same or next day after discharge
Reverse the Cycle Fidelity Project

- Mosaic Group and the state of Maryland recognize the need for a more powerful response to the opioid overdose crisis

- The Fidelity Project will aim to optimize program performance across the hospital systems who are implementing RTC

- The 21 Fidelity Hospitals are:
  - Ascension Saint Agnes
  - Greater Baltimore Medical Center
  - Johns Hopkins Hospital and Bayview
  - Lifebridge Health – Grace, Sinai, Northwest, and Carroll Hospitals
  - MedStar Health – Union Memorial, good Samaritan, Franklin Square, Montgomery, Southern Maryland, Harbor, and St Mary’s Medical Center
  - Mercy Medical Center
  - Meritus Health
  - University of Maryland- Medical Center, Midtown, and Upper Chesapeake
  - UPMC Western MD
## Background: Select Maternal Health Initiatives*

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<tr>
<th>Life Course Period</th>
<th>Interventions</th>
<th>Potential Outcomes</th>
<th>Links</th>
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<tr>
<td>Prenatal Period</td>
<td>CenteringPregnancy, Group-based Prenatal Care</td>
<td>Reduction in risk of preterm birth, low birth weight and NICU, increased breastfeeding, increased patient satisfaction</td>
<td>Centering Pregnancy</td>
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<td>Expansion Home Visiting (Healthy Families America, Nurse Family Partnership)</td>
<td>Reduce pregnancy complications, reduce low birth weights</td>
<td>HFA NFP</td>
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<tr>
<td>Birthing Period</td>
<td>Doula/Community Birth Worker</td>
<td>Fewer preterm births, cesarean births, increased breastfeeding coordination</td>
<td>Doulas</td>
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<td>Perinatal Quality Collaborative</td>
<td>Evidence-based safety bundles aimed to improve severe maternal morbidity</td>
<td>AIM</td>
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<td>Severe Maternal Morbidity Review Process</td>
<td>Hospital based surveillance, review, and quality improvement process</td>
<td>MDMOMs</td>
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<td>Maternal Opioid Misuse Model</td>
<td>Increased linkage to treatment, addressing social needs</td>
<td>MOM</td>
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<td>Postpartum/Interconception Period</td>
<td>Increased Medicaid coverage for comprehensive medical, dental and other health care services for postpartum individuals from 2 months to 12 month (Medicaid)</td>
<td>Continued coverage to ensure medical care</td>
<td>HealthySteps</td>
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<tr>
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<td>Increased linkage to care, addressing social needs</td>
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*These do not represent all the Maryland programs and policies working to improve maternal health
Maternal Health Initiatives

Medicaid Coverage Initiatives:
• Home Visiting Services (HVS) for high-risk pregnant women and infants
  • Statewide benefit effective 1/13/2022
  • Two evidence-based models are included: Healthy Families America (HFA) and Nurse Family Partnership.
  • HFA and NFP programs may enroll with Medicaid to participate as HVS providers
• Doula services
  • Statewide benefit effective 2/21/2022
  • Includes up to 8 prenatal or postpartum doula visits and birth support during labor & delivery
  • Certified doulas may enroll with Medicaid to participate as providers
Ways to partner - Maternal Health Initiatives

1) **Participate** in the Severe Maternal Morbidity Review Pilot if contacted by the MDMOM team. Contact: Dr. Andreea Creanga at acreang3@jhu.edu

1) **Inform OB** practices about availability of and how to refer patients to home visiting services, Healthy Steps, and Doula program.

1) Ensure hospital policies allow for doulas/birth workers to be present during labor and delivery. Contact: mdh.medicaidmch@maryland.gov.

1) **Connect patients** who would benefit from community-based services, send the PIMR form to the local health department [https://health.maryland.gov/phpa/mch/Pages/postpartum-referral.aspx](https://health.maryland.gov/phpa/mch/Pages/postpartum-referral.aspx). Contact: Mdh.mchb@maryland.gov
Childhood Asthma Initiatives

• Discussions and efforts already underway with several hospitals and systems to expedite referrals from emergency departments and inpatient stays to local health department home visiting programs
  • Contact your local health department or the MDH Environmental Health Bureau for more information on referral programs
• Development underway with CRISP to provide Care Alerts to providers for patients discharged from hospitals, EDs about home visiting program eligibility.
• Community of Practice for asthma – opportunity for providers, stakeholder groups to share best practices, resources.
Medicaid Specific Initiatives

• Diabetes
  • HealthChoice Diabetes Prevention Program (DPP)
  • Continued support to strengthen managed care organization (MCO) infrastructure to implement the HealthChoice DPP

• Opioids
  • Coverage of residential treatment for behavioral health
  • Maternal Opioid Misuse (MOM) Model

• Maternal Health:
  • Expanding postpartum coverage to 12 months
  • MOM model
  • CenteringPregnancy
  • Doulas
  • Home Visiting Services

• Child Health
  • HealthySteps Model
  • Asthma and lead environmental case management home visits
The Maryland Primary Care Program (MDPCP) supports Domain 3 in the following ways:

**CHRONIC CARE MANAGEMENT FOR DIABETES**
- DPP e-Referral Tool
- DSMES Promotion
- Targeted outreach and quality improvement projects

**PREVENTIVE CARE FOR OBESITY AND DEPRESSION**
- Electronic Clinical Quality Measures (eCQM)
- Targeted outreach and technical assistance

**SBIRT IMPLEMENTATION**
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
  - It works! Reduction in ED visits, hospitalizations, health care costs, etc.
  - Strategy to address opioids use

**HEART PAYMENT**
- Health Equity Advancement Resource And Transformation (HEART) Payment
  - Additional support (e.g., social needs referral tools)
  - Improvement in patient health outcomes and cost
  - Health equity
What can hospital-based CTOs do now?

Actionable Steps
• Implement SBIRT if you haven’t already!
• Support partner practices with electronic Clinical Quality Measures (eCQMs)
• Promote DPP & DSMES
• Support use of unique solutions to SDOH
  ○ Push social needs referrals

Resources
• List of CTOs
• List of CTOs providing services in each county
• List of participating practices (PY2022)
• SBIRT Contact: Erin Cosgrove
  ○ ecosgrove@groupmosaic.com
Questions?
Staff Contact Information

• Health Services Cost Review Commission
  • Erin Schurmann, erin.schurmann@maryland.gov
• Diabetes,
  • Pam Williams, pamela.williams@maryland.gov
• Opioids (Opioid Operational Command Center)
  • Marianne Gibson, marianne.gibson@maryland.gov
• Maternal Health (Maternal and Child Health Bureau)
  • Dr. Shelly Choo, shelly.choo@maryland.gov
• Childhood Asthma (Environmental Health Bureau)
  • Dr. Cliff Mitchell, cliff.mitchell@maryland.gov
• Medicaid Initiatives
  • Laura Goodman, laura.goodman@maryland.gov
  • Sandy Kick, sandra.kick@maryland.gov
• Maryland Primary Care Program
  • Alice Sowinski-Rice, alice.sowinski@maryland.gov
  • Raghavi Anand, raghavi.anand@maryland.gov
Appendix
Guiding Principles for Maryland’s SIHIS

• Maryland’s strategy should fully maximize the population health improvement opportunities made possible by the TCOC Model
• Goals, measures, and targets should be specific to Maryland and established through a collaborative public process
• Goals, measures and targets should reflect an all-payer perspective
• Goals, measures and targets should capture statewide improvements, including improved health equity
• Goals for the three domains of the integrated strategy should be synergistic and mutually reinforcing
• Measures should be focused on outcomes whenever possible; milestones, including process measures, may be used to signal progress toward the targets
• Maryland’s strategy must promote public and private partnerships with shared resources and infrastructure
# Reporting Resources

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<th>Domain</th>
<th>Report</th>
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| Hospital Quality (Avoidable Admissions & Readmissions Disparities) | HSCRC Regulatory Reports through CRISP  
  ● Potentially Avoidable Utilization  
  ● Readmissions - Patient Adversity Index Report |
| Care Transformation (Timely Follow-Up) | HSCRC Regulatory Report through CRISP  
  ● QBR - Follow-Up After Discharge |
| Total Population Health               | CRISP Reporting Services (CRS)  
  ● Public Health - Public Health Dashboard  
  ● Public Health - SIHS Directional Indicators Dashboard (Statewide performance)  
  [Maryland Opioid Dashboard](#)  
  [Asthma Dashboard](#) (to be released soon) |
MDPCP Background

Statewide – Practices in every county

Support infrastructure – 24 Care Transformation Organizations

In 2022, MDPCP has:

- **545 practice sites**
  - (508 official participants)
- **374,000 FFS beneficiaries attributed**
- **~2,100 providers in MDPCP**
- Over **4,000,000 Marylanders served**

**545 sites** – 7 FQHC organizations represent 44 site locations
(508 official participants)

*The Annals of Family Medicine, 2012
http://www.annfammed.org/content/10/1/56.full*
# Maternal Health Program Inventory

| Interventions                              | Anne Arundel | Baltimore City | Baltimore County | Caroline | Cecil | Charles | Dorchester | Frederick | Garrett | Harford | Howard | Kent | Montgomery | Prince George’s | Queen Anne’s | Somerset | Talbot | Washington | Wicomico | Worcester | Number Implemented | % Implemented |
|--------------------------------------------|--------------|----------------|------------------|----------|-------|---------|-----------|-----------|---------|---------|--------|-------|------------|------------------|-------------|----------|--------|--------|-----------|----------|-----------|------------------|---------------|
| **Prenatal Period**                        |              |                |                  |          |       |         |           |           |         |         |        |       |            |                  |             |          |        |        |          |          |           |                  |               |
| Centering Pregnancy                       | 3            | 2              |                  |          |       |         |           |           |         |         |        |       |            |                  |             |          |        |        |          |          |           |                  |               |
| Care Coordination at LHDs                  | 1            | 1              | 1                | 1        |       |         |           |           |         |         |        |       |            |                  |             |          |        |        |          |          |           |                  |               |
| Home Visiting (HFA or NFP)                 | 1            | 4              | 1                | 1        |       |         |           |           |         |         |        |       |            |                  |             |          |        |        |          |          |           |                  |               |
| Maternal Opioid Misuse Model               | 1            |                |                  |          |       |         |           |           |         |         |        |       |            |                  |             |          |        |        |          |          |           |                  |               |
| Electronic Prenatal Risk Assessment        | 1            |                |                  |          |       |         |           |           |         |         |        |       |            |                  |             |          |        |        |          |          |           |                  |               |
| **Birth Period**                           |              |                |                  |          |       |         |           |           |         |         |        |       |            |                  |             |          |        |        |          |          |           |                  |               |
| SMM Review Pilots                         | 1            |                |                  |          |       |         |           |           |         |         |        |       |            |                  |             |          |        |        |          |          |           |                  |               |
| Perinatal Quality Collaborative            | 1            |                |                  |          |       |         |           |           |         |         |        |       |            |                  |             |          |        |        |          |          |           |                  |               |
| Implicit Bias Training                     | 2            |                |                  |          |       |         |           |           |         |         |        |       |            |                  |             |          |        |        |          |          |           |                  |               |
| **Postnatal & Interconception Care**       |              |                |                  |          |       |         |           |           |         |         |        |       |            |                  |             |          |        |        |          |          |           |                  |               |
| Home Visiting (see above)                  | 1            |                |                  |          |       |         |           |           |         |         |        |       |            |                  |             |          |        |        |          |          |           |                  |               |
| Healthy Steps (effective 2022)             | 1            |                |                  |          |       |         |           |           |         |         |        |       |            |                  |             |          |        |        |          |          |           |                  |               |
| Maternal Opioid Misuse (See above)         | 1            |                |                  |          |       |         |           |           |         |         |        |       |            |                  |             |          |        |        |          |          |           |                  |               |

*Funds go through Queen Anne’s County

**SFY22- Q2-Draft**