Health Services Cost Review Commission
Care Coordination and Infrastructure Work Group
Agenda

Date: February 27, 2015

Time: 10:00 AM-1:00 PM

Location: HSCRC Offices, 4160 Patterson Ave. Baltimore, MD 21215 410-764-2605

Meeting Objectives:

- **Achieve consensus on a strategy for making timely investments to bring promising care management practices to scale. Approve a proposed budget for financing the new investments. Approve plan for completing the Work Group's report to HSCRC.**

Time	Activities
10:00-10:10	**Welcome - Carmela Coyle and Laura Herrera** • Opening Remarks • Overview of Meeting Objectives
10:10-10:40	**CRISP presentation on ambulatory connectivity** • David Horrocks, CRISP
10:40-10:55	**Suggestions from Dr. Howard Haft**
10:55-12:20	**Facilitated Discussion** • Review Grid of activities / action steps • Seeking consensus to move ahead

12:20-12:45	**Wrap up and next steps** **Process for finishing the writing of the report** • Need for additional meeting • Budget and BRFA • Additional Perspectives • Report draft review process
12:45-12:50	**Closing Comments from Carmela Coyle and Laura Herrera**
12:50-1:00	**Comments from the Public**

Opportunities for Maryland Investment in Care Coordination

Activity	State-level	Regional-level	Local-level	Implementation Strategy
Build/secure a data infrastructure to facilitate identification of individuals who would benefit from care coordination				
1. Combine **existing** data sources for the purpose of identifying individuals who would benefit from care coordination	X			1. Use BRFA funds to fund CRISP to accomplish this activity
2. Secure **new** data sources. Specifically, request the use of Medicare patient-level data for the purpose of identifying individuals who would benefit from care coordination and chronic care management	X			2. MHA to coordinate hospitals to make a special request of CMS for access to Medicare data together with the State
3. Develop procedures and policies to **secure patient consent** for the sharing of data for purposes of care coordination	X			3. Use BRFA funds to secure contractor to develop patient consent process
4. Engage a vendor for the purpose of storing, cleaning and normalizing the Medicare data and other Medicare related data sets Maryland may be able to obtain	X			4. Use BRFA funds to purchase capabilities from an existing qualified vendor
5. Use data to **identify individuals** who would benefit from care coordination and chronic care management	X			5. Use BRFA funds to secure contractor to convene leaders in developing best possible approaches to stratifying patients based on needs for use by hospitals and other providers
Encourage patient-centered care and patient engagement				
1. Standardize patient consent forms	X			1-4. Use BRFA funds to secure contractor to convene providers and create standardized consent forms, health risk assessment, and care plan elements
2. Standardize elements needed in care plans	X			
3. Standardize health risk assessment elements	X			
4. Standardize elements in discharge summaries to aid transitions to LTPAC providers as well as home-based settings	X			

Activity	State-level	Regional-level	Local-level	Implementation Strategy
5. Make key elements easily visualized through CRISP.	X			5-6. Use BRFA funds to have CRISP create easily visualized access to care plan data elements
6. Develop approach to identify patients with care plans through CRISP, together with identification of care managers and providers	X			
7. Develop processes to avoid duplication of resources across provider systems, including coordination of resources for health risk assessments		X		7. Use BRFA regional planning processes to avoid duplication of resources
8. Lead a state-level campaign to encourage individuals to 1) participate in care plans and 2) complete and share medical orders for life sustaining treatment	X			8. Ask HSCRC consumer engagement workgroup to assist in developing a plan and campaign for engaging patients and families in care planning and consents
9. Educate patients about care coordination resources and opportunities			X	9-10. MHA to lead effort for statewide education and coordination of efforts with support of consumer work group
10. For care coordination, first connect patients with providers with whom they have a relationship			X	
Encourage collaboration				
1. Facilitate collaborative relationships among providers, patient advocates, public health agencies, faith-based initiatives and others with a particular focus on resource planning, resource coordination, and training		X		1. Use BRFA funds to provide regional planning resources, including technical resources to support regional planning efforts 1. Work with DHMH to create web-based inventories of community services available in the State

Activity	State-level	Regional-level	Local-level	Implementation Strategy
2. Facilitate somatic and behavioral health integration	X			2. Use BRFA funds to develop approaches that can be deployed on a regional and local level. Improve integration and deployment of community-based resources. Coordinate with dual eligible ACO efforts
3. Facilitate care integration between hospitals and long-term care/ post-acute services		X	X	3. Use BRFA funds to develop approaches that can be deployed on a regional and local level. Coordinate with dual eligible ACO efforts. Develop gain sharing/P4P approach. Develop limited demonstration approach for 3 day waiver.
4. Support practice transformation through technical assistance and dissemination of information on best practices	X			4. Use practice transformation grant funding (applied for)
5. Create standard gain sharing and pay for performance programs	X			5. Use BRFA funds to develop standard approaches to pay for performance and gain sharing opportunities in Maryland. Work in coordination with MHA approach for hospital-based services.
6. Encourage providers to take advantage of new Medicare Chronic Care Management payments	X			6. Use practice transformation grant funding (applied for) and encourage implementation.

Activity	State-level	Regional-level	Local-level	Implementation Strategy
Connect providers				
1. Develop plans to connect community based providers to CRISP	X			1-4. Funding source TBD.
2. Develop plans to connect long term and post-acute providers (LTPAC) to CRISP. Develop approaches to meet needs of LTPAC.	X			
3. Purchase/develop applications to facilitate interoperability among providers' EMRs to make clinically relevant information available to providers	X			
4. Purchase applications to facilitate collection of EMR data to use for population health and outcomes measurement	X			

CRISP

CHESAPEAKE REGIONAL INFORMATION SYSTEM FOR OUR PATIENTS

CRISP Care Management Support

February 2015

7160 Columbia Gateway Drive, Suite 230
Columbia, MD 21046
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www.crisphealth.org

Vision – Mission – Guiding Principles

Our Vision

To advance health and wellness by deploying health information technology solutions adopted through cooperation and collaboration.

Our Mission

We will enable and support the healthcare community of Maryland and our region to appropriately and securely share data in order to facilitate care, reduce costs, and improve health outcomes.

Our Guiding Principles

1. *Begin with a manageable scope and remain incremental.*
2. *Create opportunities to cooperate even while participating healthcare organizations still compete in other ways.*
3. *Affirm that competition and market-mechanisms spur innovation and improvement.*
4. *Promote and enable consumers' control over their own health information.*
5. *Use best practices and standards.*
6. *Serve our region's entire healthcare community.*

General Maryland Strategy

1. Identify the high utilizer and high risk Medicare patients ~ 40,000 beneficiaries through a combination of Case Mix data and Medicare data
   - Using data in a limited way to identify patients at risk, but not yet sharing for care management.
2. Use a methodology to associate these patients to hospitals (Hospital Case Mix data) and to PCPs (Medicare data and ENS panels)

3a. Engage hospitals to provide care management for their associated patients, either at a local level, through regional cooperatives, or through a statewide care management program.
   - Patients will consent to participation in care management.
   - Patient level data may not be shareable until patient consent is obtained.

3b. Engage ambulatory clinicians in the care management process.
   - PCPs could receive $500 from CMS for care management.
   - Financial alignment strategies are needed.

4. Ask clinicians who care for one of the 40,000 to create a sharable Care Profile or Care Plan.
   - A mechanism to share care profiles, summaries, and plans will be needed.
5. Plan for future interventions to benefit a broader group of Medicare patients ~ 200,000 beneficiaries.

Using Health Data

Four venues where information is needed:

1. Statewide reporting services
2. At the point of care
3. Care management
4. Patient engagement

1. Statewide Reporting Services

- CRISP can already create a report of Medicare high utilizing patients, from the Hospital Case Mix data.
  - To distribute these reports, we need a data use policy which will allow sharing of either the patient demographics, or the more complete patient record, presumably after a patient consent.
  - The reports could be added to a monthly schedule for each hospital, regional consortium, or ACO.
  - We could contract with an organization to create more sophisticated risk-scored reports from the hospital Case Mix data.
- Patient relationship identification for hospitals can be done through Hospital Case Mix data and for ambulatory clinicians could be done partially from ENS panels.
  - Currently 2 Million patients are in the ENS provider panels.
- Both activities can be accomplished more accurately and completely if Medicare claims data is eventually obtained.
  - We would need to contract with a firm possessing Medicare data expertise.

Patient Details

Patient ID: C3

Date Range:

This would allow user to look at a different time range in this

Inpatient and Outpatient Hospital Utilization Detail

Inpatient Services

Facility Name	From DOS	Through DOS	Readmit	DRG	DRG Description	PQI	Discharged to LTC
Greater Baltimore Medical Center	2/1/2014	2/5/2014		139	Other pneumonia	Yes	
Johns Hopkins Hospital	3/16/2014	3/21/2014		165	Coronary bypass w/ cath or percutaneous cardiac proc		
Greater Baltimore Medical Center	4/15/2014	4/21/2014	Yes	253	Other & unspecified gastrointestinal hemorrhage		Yes
....							

Observation Services

Facility Name	From DOS	Through DOS	Revisit	DX CCS	Dx CCS Description	PX CCS	PX CCS Description
Greater Baltimore Medical Center	3/15/2014	3/16/2014		7.2.4	Coronary atherosclerosis	16.18	Cardiac stress test
....							

ED Services

Facility Name	From DOS	Through DOS	Revisit	DX CCS	Dx CCS Description	PX CCS	PX CCS Description	From Day	From Time
Greater Baltimore Medical Center	8/3/2014	8/3/2014	Yes	7.2.5	Nonspecific chest pain	16.18	Cardiac stress test	Wed	14:30
Greater Baltimore Medical Center	11/2/2014	11/2/2014		16.8	Contusion			Thu	11:00
Greater Baltimore Medical Center	12/20/2014	12/20/2014		9.12.1	Constipation			Sun	18:10
....									

Chronic Conditions

Condition	Present
Asthma	
Behavioral Health Condition	Yes
Coronary Artery Disease/Angina	Yes
Heart Failure/CHF	
Diabetes	
Hypertension	Yes

Draft Template for Report
For Discussion Purposes Only
Data Sharing Policy will need to be addressed

2. Point of Care

These following are possible extensions of CRISP's existing services to clinicians at the point of care:

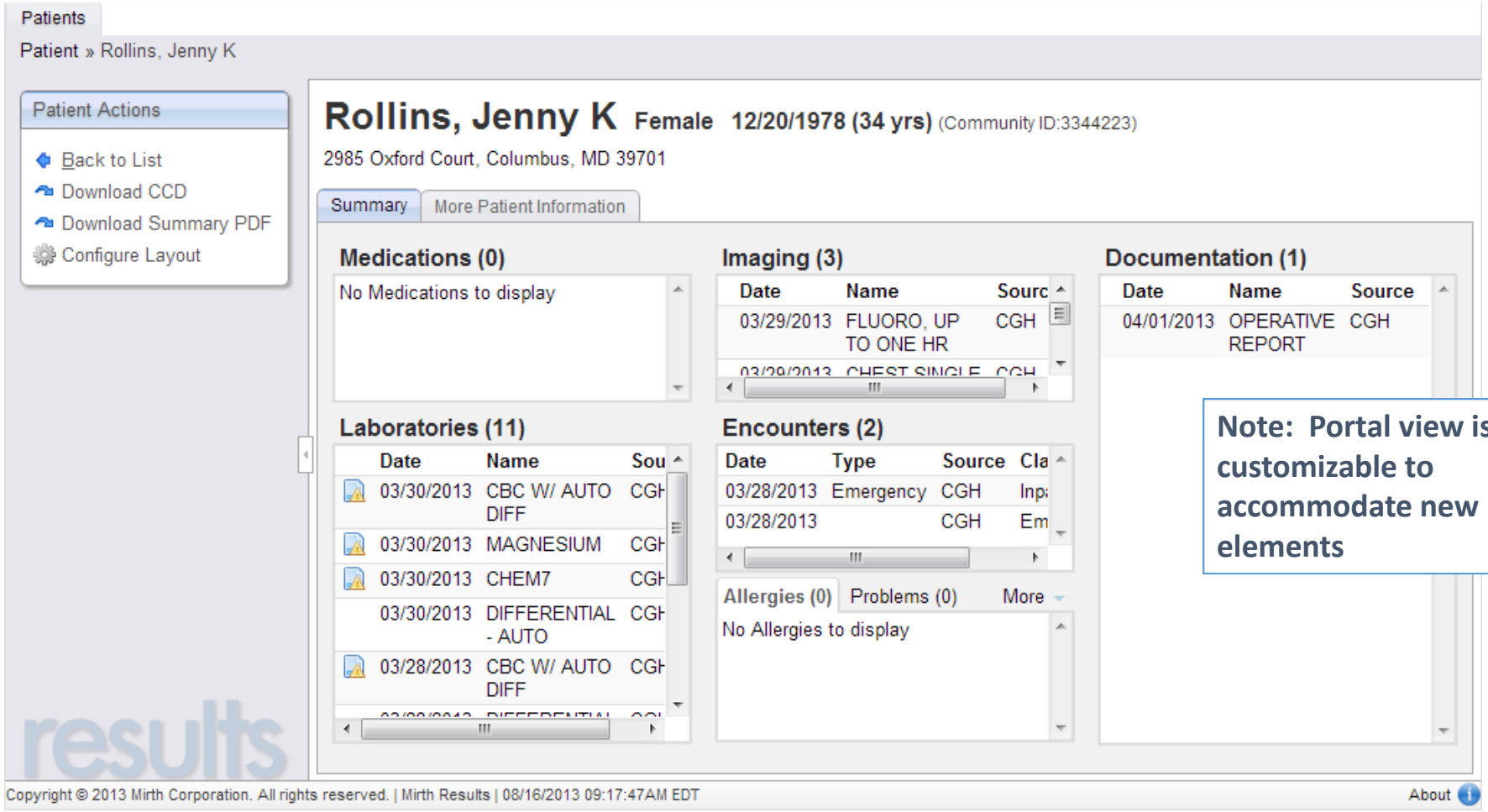
1. Visit List, showing the recent treatment encounters at participating community providers, displayed in the Clinical Portal or fed to the care management systems of individual or regional organizations.
2. Clinician relationship identification, displayed in the Clinical Portal, based on ENS panels or another methodology.
3. Provider Directory, in the Clinical Portal to facilitate communication between providers.
4. Care Profile, standards-based and displayed in the Clinical Portal, in some cases pulled from a more comprehensive Care Plan.
5. In-context alerting mechanism, so providers realize when a patient who presents is under care management, or meets other criteria.

CRISP has already credentialed about 5,000 providers to use the Clinical Portal, and necessary processes for monitoring and managing access already exist.

More complete information requires connecting ambulatory practices to the HIE, and that is no small undertaking.

A patient summary could be augmented by a hospital utilization summary pulled from the Case Mix data.

Existing Clinical Portal



Note: Portal view is customizable to accommodate new elements

3. Care Management

- CRISP does not have existing interfaces to Care Management programs, but such interfaces would allow CRISP to “feed” relevant information to those providing Care Management services. The ability to interface with local or regional tools would have to be determined on a one-by-one basis.
- CRISP could easily customize the existing Clinical Portal to store and view a common Care Profile statement, Patient Summary, or Care Plan document generated by Care Managers. We could also forward new documents to PCPs or Case Managers through ENS.
- A standardized Health Risk Assessment could also be stored and accessed through the existing Clinical Portal.
- The functionality to generate a common Care Profile statement, Patient Summary, or Care Plan document in the various EMRs around the state is not a slam dunk, but it is becoming more realistic with the CCDA document structure.
- The ability to edit a common Care Profile, Patient Summary, or Care Plan does not currently exist and would be difficult to pull off without use of a common tool of some kind. Clinicians have expressed interest in making basic annotations to a care summary.

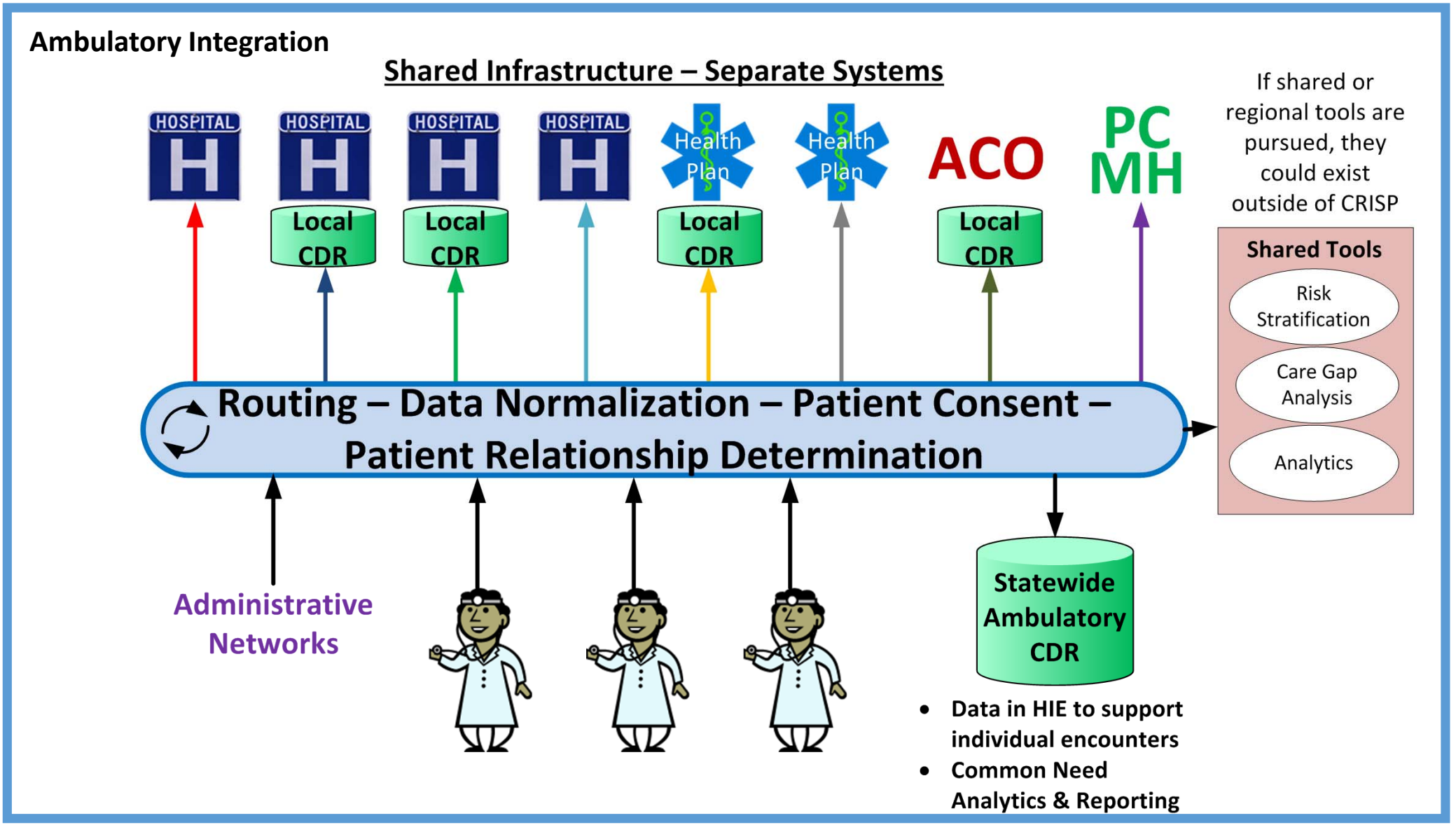
4. Patient Engagement

Other than one small pilot, CRISP has not built any services which directly engage patients. The first concern is not to weaken the patient-provider relationship. A second concern is the difficulty of offering a shared service which consumers would actually value.

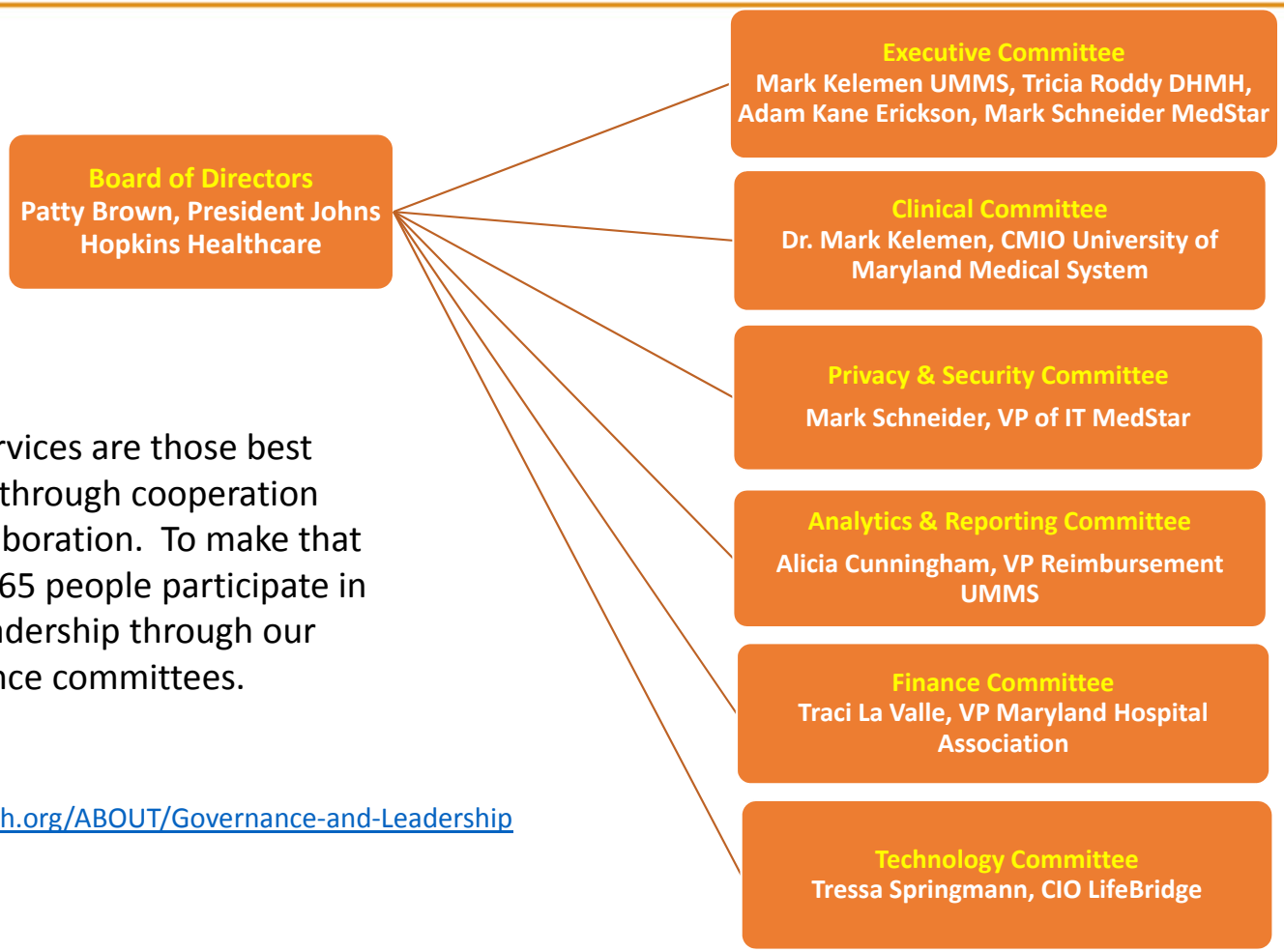
Care management and moving the data to support it will require new patient consent process. CRISP can build on it existing statewide patient consent platforms to meet this need.

Patient engagement for consent management could possibly include a patient portal. To the extent jointly-managed patient engagement tools did become a goal, CRISP would prefer to expose such services through providers' own portals.

Ambulatory Integration



CRISP Governance



CRISP services are those best pursued through cooperation and collaboration. To make that possible 65 people participate in CRISP leadership through our governance committees.

http://crisphealth.org/ABOUT/Governance-and-Leadership

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