Regional Partnership for Health System Transformation

Regional Transformation Plan – Final Report

Due: December 1, 2015

Regional Partner: _____

***Maryland's Vision for Transformation*:** Transform Maryland's health care system to be highly reliable, highly efficient, and patient-centered. HSCRC and DHMH envision a health care system in which multi-disciplinary teams can work with high need/high-resource patients to manage chronic conditions in order to improve outcomes, lower costs, and enhance patient experience. Through aligned collaboration at the regional and state levels, the state and regional partnerships can work together to improve the health and well-being of the population.

***Regional Partnerships*:** In order to accelerate effective implementation, Maryland needs to develop regional partnerships that can collaborate on analytics, target services based on patient and population needs, and plan and develop care coordination and population health improvement approaches. The Regional Partnerships for Health System Transformation are a critical part of the state's approach to foster this collaboration. As referenced in the RFP, the Regional Partnership plan will describe, in detail, the proposed delivery and financing model, the infrastructure and staffing/workforce that will support the model, the target outcomes for reducing utilization/costs and improving quality and the health of the populations targeted, and effective strategies to continuously improve overall population health in the region. In order to fulfill healthcare savings commitments by Maryland to CMS, the initial target populations have been identified as high utilizers such as Medicare patients with multiple chronic conditions and high resource use, frail elders with support requirements, and dual eligibles with high resource needs.

The Care Coordination Workgroup identified these populations as most likely to yield the biggest gains from the Regional Partnerships' efforts. The Workgroup also recommended the development of state-level integrated care coordination resources and in some areas recommended standardization and collaboration. The Care Coordination Workgroup's final report can be found at: http://www.hscrc.state.md.us/documents/md-maphs/wg-meet/cc/Care-Coordination-Work-Group-Final-Report-2015-05-06.pdf.

The Regional Partnership grants will culminate in the development of a regional transformation plan due in December 2015. Given the importance of regional collaboration to meet the goals of the new model, multi-year strategic plans for improving care coordination, chronic care, and provider alignment are required of all Maryland hospitals.

To achieve transformation on a regional and state-level, the following nine domains have been developed. These domains are meant to be a guide to the Regional Partnerships and other Maryland hospitals and serve as action steps during the planning process.

Nine Transformation Domains

1. Clearly articulate the goals, strategies, and outcomes that will be pursued and measured
2. Establish formal relationships through legal, policy, and governance structures to support delivery and financial objectives

3. Understand and leverage currently available data and analytic resources
4. Identify needs and contribute to the development of risk stratification levels, heath risk assessments, care profiles and care plans
5. Establish care coordination people, tools, processes, and technology
6. Align physicians and other community-based providers
7. Support the transformation with organizational effectiveness tools
8. Develop new care delivery models
9. Create a financial sustainability plan

As you utilize this template and develop your Regional Transformation Plan, please refer to the "Transformation Framework" as a reference guide.

Regional Transformation Plan Template

Goals, Strategies and Outcomes
Articulate the goals, strategies and outcomes that will be pursued and measured by the regional partnership.
Describe the target population that will be monitored and measured, including the number of people and geographical location.
Describe specific metrics that will be used to measure progress including patient satisfaction, quality, outcomes metrics, process metrics and cost metrics. Describe how the selected metrics draw from or relate to the State of Maryland's requirements under the new model.
Describe the regional partnership's current performance (target population) against the stated metrics.
Define the data collection and analytics capabilities that will be used to measure goals and outcomes.
List the major areas of focus for year one. (For the completion of this plan, if various areas of focus require different descriptions, please identify each area under the following sections of the plan.)

Formal Relationships and Governance
List the participants of the regional partnership such as hospitals, physicians, nursing homes, post-acute facilities, behavioral health providers, community-based organizations, etc. Specify names and titles where possible.
Describe the governance structure or process through which decisions will be made for the regional partnership. List the participants of the structure/process.
Identify the types of decisions that will be made by the regional partnership.
Describe the patient consent process for the purpose of sharing data among regional partnership members.
Describe the processes that will be used by the regional partnership improved care and the MOUs or other agreements that will be used to facilitate the legal and appropriate sharing of care plans, alerts and other data as described in the process.
Attach the list of HIPAA compliance rules that will be implemented by the regional partnership.

Data and Analytics
Define the data collection and analytics capabilities that will be used to measure goals and outcomes, including specific metrics and measures.
Describe with specificity the regional partnership's plan for use of CRISP data.

Risk Stratification, Health Risk Assessments, Care Profiles and Care Plans
Describe any plans for use of risk stratification, HRAs, care profiles, or care plans. Describe how these draw from or complement the standardized models being developed.
For risk stratification, include the types of patients, risk levels, data sources, accountabilities (who is accountable to do what?)
For HRAs, include the types of screenings, who is accountable for completing, and where information is recorded.
For care profiles and/or care plans, include the key elements that will be included, the systems through which they will be accessible, the people who will have access. Standardized care profiles are anticipated to be developed by the state-level integrated are coordination infrastructure.
Identify the training plan for any new tool identified in this section.

Care Coordination
Describe any new care coordination capabilities that will be deployed by the regional partnership.
Identify the types of patients that will be eligible for care coordination and how they will be identified and by whom.
Define accountability of each person in the care coordination process.
Describe staffing models, if applicable.

Describe any patient engagement techniques that will be deployed.

Physician Alignment
Describe the methods by which physician alignment will be created.
Describe any new processes, procedures and accountabilities that will be used to connect community physicians, behavioral health and other providers in the regional partnership and the supporting tools, technologies and data that will assist provides in the activities associated with improved care, cost containment, quality and satisfaction.
Describe any new value-based payment models that will be employed in the regional partnerships

Organizational Effectiveness Tools
Attach the implementation plan for each major area of focus (**with timelines and task accountabilities)**
Describe the continuous improvement methods that will be used by the regional partnership.
Attach a copy of the metrics dashboard that will be used to manage performance over time with an explanation of associated processes that will be used to monitor and improved performance.
Describe the work that will be done to affect a patient-centered culture.

New Care Delivery Models
Describe any new delivery models that will be used to support the care coordination outcomes. (For instance, tele-visits, behavioral health integration or home monitoring.)
Identify how the regional partnership will identify patients, new processes, new technology and sharing of information.

Financial Sustainability Plan
Describe the financial sustainability plan for implementation of these models.
Describe the specific financial arrangements that will incent provider participation.

Population Health Improvement Plan
Provide detailed description of strategies to improve the health of the entire region over the long term, beyond just the target populations of new care delivery models. Describe how this plan aligns with the state's vision, including how delivery model concepts will contribute and align with the improvement plan, as well as how it aligns with priorities and action plans of the Local Health Improvement Coalitions in the region.