



**Department of Health and Mental Hygiene
and
Maryland Health Services Cost Review Commission**

**Regional Partnerships
Learning Collaborative**

July 16, 2015





**Department of Health and Mental Hygiene
and
Maryland Health Services Cost Review Commission**

**Johns Hopkins
Baltimore City Regional Partnership**

Learning Collaborative
July 16, 2015

Johns Hopkins Baltimore City Regional Partnership

Hospital Partners

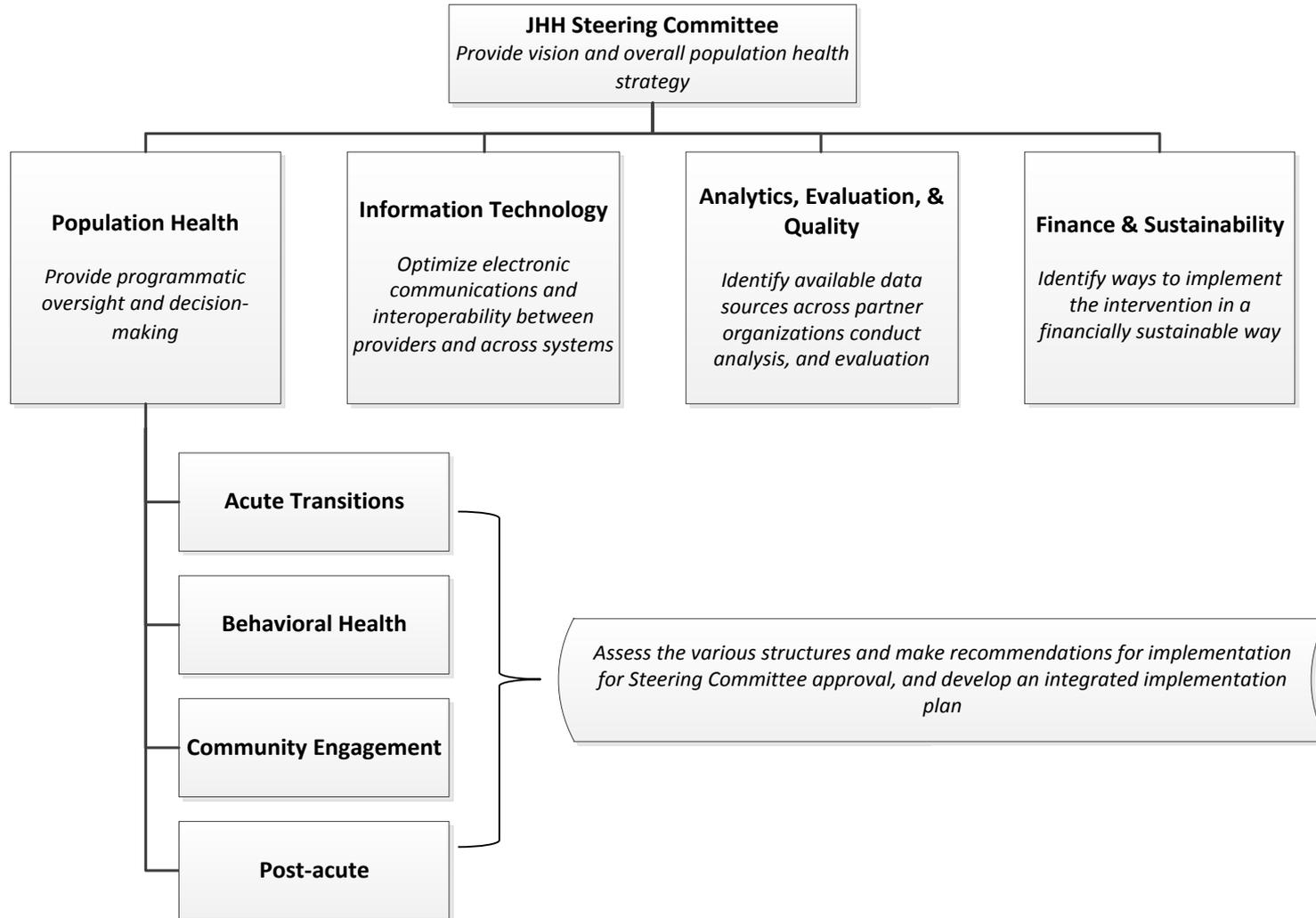
- ▶ The Johns Hopkins Hospital (lead)
- ▶ Johns Hopkins Bayview Medical Center
- ▶ University of Maryland Medical Center
- ▶ University of Maryland Midtown
- ▶ Mercy Medical Center
- ▶ Anne Arundel Medical Center
- ▶ Greater Baltimore Medical Center

Community Partners

- ▶ Health Care for the Homeless
- ▶ Sisters Together And Reaching
- ▶ Esperanza Center



Structure and Aims



Timeline and Milestones

Form Steering Committee,
Taskforces



Hospital
Partners
Meeting

Chairs
Committee
Meeting

ED Patient
& Clinician
Analysis

**Interim
Report**

**Regional
Transformation
Plan**

Workgroup activities
concluded

Taskforce activation:
Population Health
Information and Technology
Analytics & Evaluation
Finance & Sustainability



=

Enhance Patient Experience

Better Population Health

Lower Total Cost of Care



Areas where our team has strong resources:

- ▶ Acute, Post-acute, and Community Processes and Protocols
 - ▶ Risk assessments
 - ▶ Care plans
 - ▶ Transition Guides
 - ▶ Community Workforce
- ▶ Analytics
 - ▶ Data integration
 - ▶ Dashboards
 - ▶ Predictive Modeling
 - ▶ Risk Stratification
- ▶ Evaluation
- ▶ Population Health Conceptual Model
- ▶ Established Steering Committee that includes School of Medicine Dean, Health System President, and President of Johns Hopkins HealthCare

Challenges

- ▶ Sharing patient-level data for high utilizers across hospitals
- ▶ HIPAA compliance rules
- ▶ Communicating and Coordinating with multiple hospitals in an unprecedented level of collaboration
 - ▶ Exciting opportunity with other hospitals that we welcome, but it is challenging to do this work
 - ▶ Exciting opportunity to strengthen relationships with community-based partners to effectively leverage skills and expertise
- ▶ Shifting nature of requirements and data capabilities
- ▶ Summer Schedules

Early Successes

- ▶ Acute cost-savings
- ▶ Community-based partnerships
 - ▶ Neighborhood Navigators
 - ▶ Community Health Workers
- ▶ Trust
- ▶ Patient-staff engagement
- ▶ Infrastructure
 - ▶ Training and assessment tools
 - ▶ Protocols

Questions and Comments?





**Department of Health and Mental Hygiene
and
Maryland Health Services Cost Review Commission**

**Baltimore Health System Transformation Partnership
(University of Maryland Medical Center)**

**Regional Partnerships
Learning Collaborative**

July 16, 2015



Baltimore Health System Transformation Partnership

Names of Core Team Members and Partners:

- AbsoluteCARE
- Baltimore City Health Department
- Baltimore Medical Center
- Bon Secours Hospital
- Chase Brexton
- Comprehensive Housing Assistance, Inc.
- Health Care for the Homeless
- Johns Hopkins Bayview Medical Center
- Keswick Multi-Care Center
- Lifebridge Health
- Maryland Learning Collaborative
- Mercy Medical Center
- Mosaic Community Services
- Park West Medical Center
- The Coordinating Center
- The Johns Hopkins Hospital
- St. Agnes Hospital
- Total Health Care
- University of Maryland Dept. of Medicine
- University of Maryland Medical Center
- UMMC – Midtown Campus

Consultants:

- Andrew Solberg
- Kathryn Whitmore, STS Consulting Group, LLC
- HMA



Structure, Topics and Aims

Health System Infrastructure and Population Health Strategy Workgroup: “The Architects”

- Assess the scope of services/programs within hospitals/providers
- Research evidence-based practices to support planned approaches
 - Provide ongoing clarification and guidance to other workgroups
- Refine the continuum consistent with findings from planning process
- Integrate and coordinate project with hospital/provider programs/resources
 - Function as consultants and advisors
- Lead and coordinate development of the population health strategy

Care Coordination, Chronic Disease Management, and Care Transitions Workgroup

- Research current state
- Complete inventory of existing and planned CC activities and programs
- Research evidence-based approaches
- Create and operationalize CC, care transitions, and behavioral health integration
- Collaborate on development of IT infrastructure
- Consult and advise other groups

Finance, Data, and Quality Workgroup

- Acquire in-depth understanding of goals and objectives and possible programs, and services
- Conduct data collection and evidence-based research
- Collaborate on performance measures and explore capacity
- Conduct analysis on the actual costs, feasibility, and potential health outcomes of model concept

IT and Technology Infrastructure Workgroup

- Evaluate current state technologies
- Assess data-and information-sharing and reporting needs of model concept
- Identify potential system and processes for internal and external data collection and sharing
- Evaluate interoperability potential of existing health IT Systems
- Make future state recommendations for optimizing electronic communications and interoperability
- Coordinate w/CRISP; understand and evaluate data capacity and utility

Provider and Community Engagement Workgroup

- Refine approach for engaging providers and community members
- Craft and collaboratively oversee implementation of the qualitative research approach
- Serve as consultants and advisors to workgroups
- Synthesize and share with findings and research to clarify and/or focus other workgroups
- Engage the community in the Health System Transformation exploration process ancillary to development of the model concept

Alignment:

- Common work between UMMC/JHH Transformation Grants

Baltimore Health System Transformation Partnership

Timelines

2015								
March/April	May	June	July	August	Sept.	Oct.	Nov.	Dec.
<ul style="list-style-type: none"> Partnership Collaborative Established Partnership Meetings Begin 	<ul style="list-style-type: none"> Executive Committee & Committee Chairs Named Meetings Begin 	<ul style="list-style-type: none"> Committees Formed Population Health: Retreat #1 JHH/UMMC Alignment Committee Mtg. – 1st w/External Consultants 	<ul style="list-style-type: none"> HMA Consulting Services Sought to Evaluate Model Concept 	<ul style="list-style-type: none"> Committee Work Resumes Data Analysis of Shared High Risk Populations 	<ul style="list-style-type: none"> Analysis of Current Assets and Gaps 	<ul style="list-style-type: none"> Population Health: Retreat #2 	<ul style="list-style-type: none"> Committee Reports due Evaluation of grant model Beginning of Alignment Implementation 	<ul style="list-style-type: none"> BHSTP Plan Submitted

Areas Where Our Team Has Strong Resources:

- Acute and Post-acute Care
- Analytics/IT/Data Analysis
- Strategic Planning
- Care Coordination
- Community Resource Identification
- Behavioral Health
- Primary Care Modelling / Best Practices
- Alignment Potential

Baltimore Health System Transformation Partnership

Challenges

- Communicating with and balancing multiple interests between hospitals and community providers
- Leveling out the work/avoiding duplication of effort amongst the committees, provider types and consultants
- Scheduling and maintaining the meeting schedule
- Understanding the available data, utilizing it across providers

Early Successes

- Motivation, enthusiasm and will to improve the health of the community
- Coalescence of a diverse group around a common goal
- Identification of network of professional consultants to provide guidance
- Resolution of committee structure and work plans

Questions and Comments?





Alliance Regional Partnership Overview

DHMH and HSCRC Regional Partnership Learning Collaborative

July 16, 2015

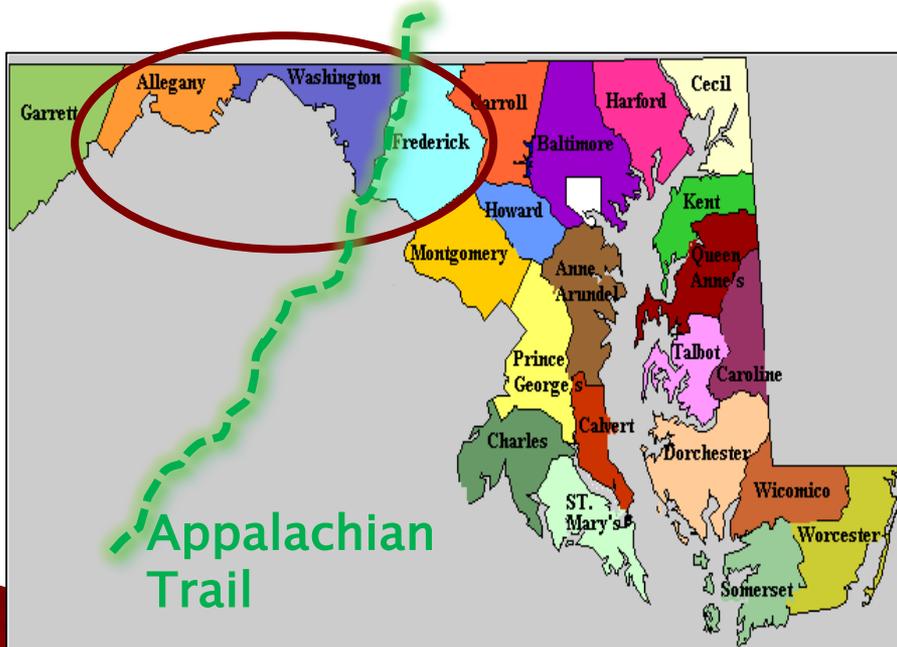
Frederick Regional Health System Hospital
Meritus Medical Center
Western MD Health System

Presenter: Manny Casiano MD MBA
Frederick Regional Health System

Trivergent Alliance Regional Planning Structure: Core Team Members and Partners

Three hospital systems, together as the Alliance, began Regional Care Delivery Transformation planning efforts in April 2015. The core team includes:

- ▶ Frederick Regional Health System Hospital, Frederick
- ▶ Meritus Medical Center, Hagerstown
- ▶ Western MD Health System, Cumberland

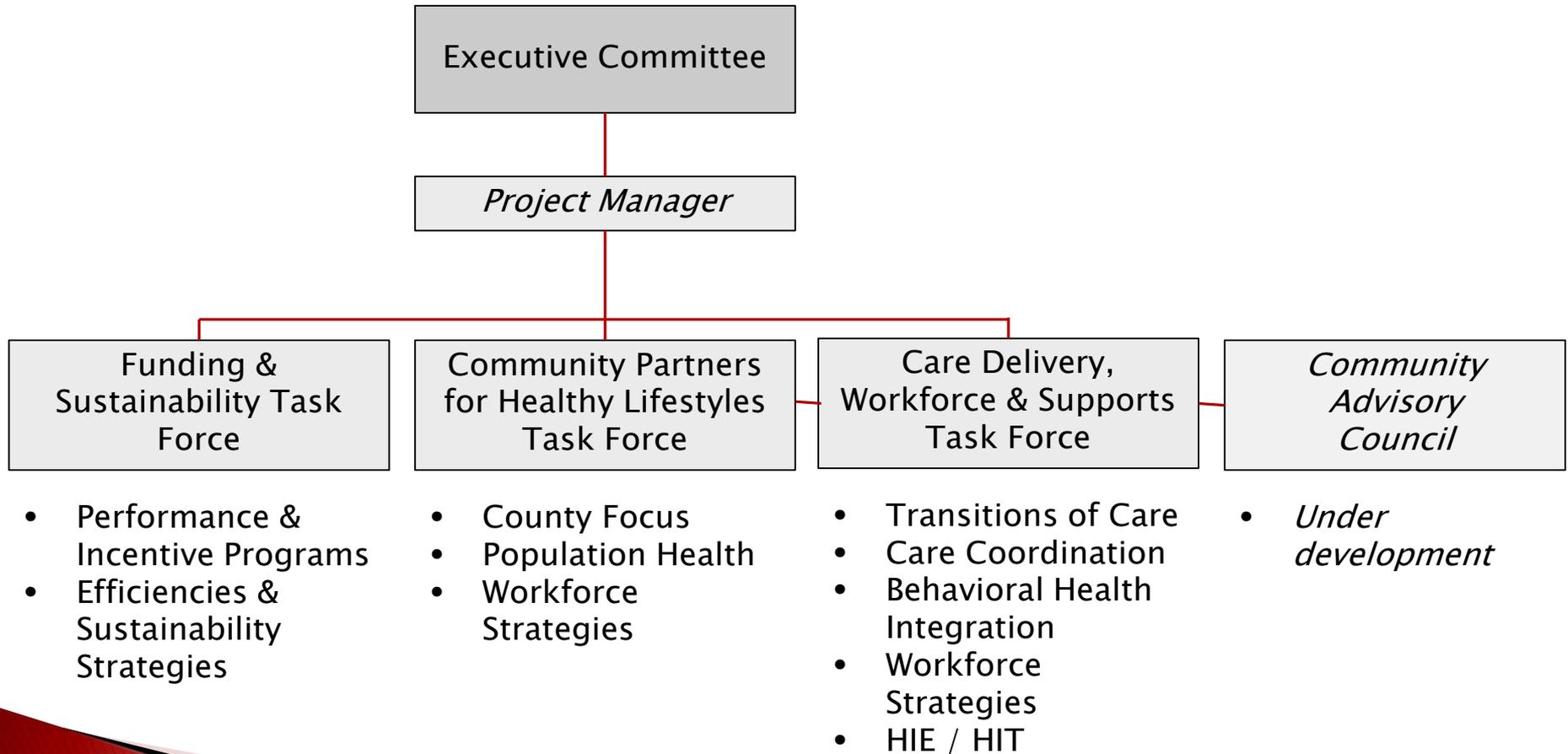


Community Partners:

- ✓ 78 Community Partners wrote Letters of Support for the Alliance's Regional Planning Grant Application
- ✓ *We are currently working to identify membership of a Community Advisory Council*

Alliance Regional Planning Structure

The Regional Planning structure below was developed to enable the Alliance to build our care delivery transformation plan and move forward with focus, efficiency and transparency.



Building Blocks for the Alliance's Regional Care Transformation

The Alliance identified seven essential 'building blocks' to care delivery transformation. This framework will guide our planning phase and our multi-year implementation efforts



Areas of Focus: Alliance Scope and Need and Priorities

Using the Community Needs Assessments below, the Task Forces are currently refining the areas of focus and priority initiatives

	Total Population ¹	Medicare FFS	High Utilizers with Chronic Conditions
Mental health condition – mood disorder (incl. depression)	✓✓✓	✓✓✓	✓✓
COPD	✓	✓✓✓	✓✓
Mental health condition – other (not cognitive or mood disorders)	✓✓		✓✓✓
Lipid disease / Hyperlipidemia	✓	✓✓✓	✓
Arthritis	✓	✓✓✓	✓
Hypertension	✓	✓✓	
Coronary artery / ischemic heart disease	✓	✓✓	✓
Diabetes		✓✓	
Cardiac arrhythmia	✓		

The two leading causes of death in Alliance counties are **heart disease** and **cancer**.

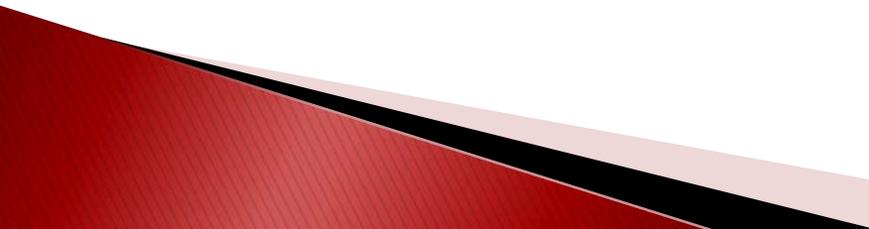
Correlated conditions / risk factors -- congestive heart failure, coronary artery disease, diabetes, **obesity** and **smoking** -- are significant concerns in all three counties.

Draft: Alliance Regional Care Transformation Horizon Map

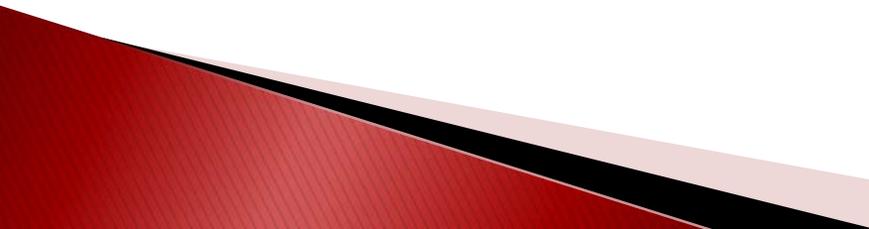
Horizon 1: May – December 2015	Horizon 2: January – June 2016	Horizon 3: July – December 2016
<p>Goals</p> <ul style="list-style-type: none"> • Planning process in place and working • Oversight structure in place • Identify Community Partnership Advisory Council and define goals/charter • Hire project manager • Model of care finalized • Areas of focus / priorities identified • Funding sources identified (implementation monies?) • Build work plan • Define priorities 	<p>Goals</p> <ul style="list-style-type: none"> • 3 programs implemented and training in place • Enabling IT identified (and implemented) • Workforce development underway • Community strategy ready to begin • Develop relationship w/ Medicaid • Strategic plan for other programs – MA, Medicare, Duals • Second generation of ACO discussion ACO metrics integrated 	<p>Goals</p>
<p>Milestones</p> <ul style="list-style-type: none"> • Convert goals into milestones—draft plan in place by August • Interim report to state by Sept 1 • Final plan to state by Dec 1 	<p>Milestones</p> <ul style="list-style-type: none"> • Define work plan milestones 	<p>Milestones</p>
<p>Measures of success</p> <ul style="list-style-type: none"> • Work plan complete • Dashboard of baseline metrics • Viable financial plan 	<p>Measures of success</p> <ul style="list-style-type: none"> • Early outcome measures connected to clinical initiatives • Progress / process measures towards implementation • Utilization measures – early usage effect • Critical mass of committed community partners • ACO measures? 	<p>Measures of success</p>

Under Construction

Strengths of the Alliance Regional Partnership

- ▶ Regional care delivery transformation is natural evolution for Trivergent Health Alliance (MSO formed in January 2014)
 - ▶ Engaged membership and leaders representing all hospitals, financial and care programs
 - ▶ Currently, local care management programs and ACOs in place with early measurable results
 - ▶ TPR lessons learned by two systems being generously shared
 - ▶ Mature local care management infrastructures and activities exist, with documented community partnership successes
 - ▶ Active community health and wellness activities exist, with strong LHIC and other relationships
- 

Opportunities

- ▶ Ensuring all Members have a common understanding of Regional Partnership goals, timeline and deliverables
 - ▶ Clarifying how Task Forces work together on a short timeline
 - ▶ Understanding the primary initial focus -- short term improvements in utilization vs. long term patient outcomes
 - ▶ Learning to think regionally and implementing shared decision-making
 - ▶ Understanding what data is available thru CRISP, and ensuring the right individuals have access to CRISP for planning/implementation purposes
 - ▶ Clarifying the role of existing LHICs and other community partners in the regional planning process (vs implementation)
 - ▶ Clarifying overlap of ACO activities and Regional Planning activities
 - ▶ Engaging independent physicians
- 

Alliance Early Successes

- ▶ Early general consensus on scope and need of region
- ▶ Care Management and other patient engagement activities in member hospitals, including:
 - WMHS Center for Clinical Resources: Focus on chronic care management.
 - Diabetic ED Visits/100K: 2011: 386 2017 Goal: 364 Current: 238
 - Heart Disease ED visits/100K: 2011: 260 2017 Goal: 237 Current: 243
 - Meritus Medical Center:
 - Creation of multi-disciplinary Care Management team, including RN, SW, BH SW, RPh, RD, and Respiratory Therapy
 - Embedding care managers in local PCP practices to improve coordination for care transitions, ED follow up
 - Frederick Regional Health System
 - Establishment of Bridges Program (targeted collaboration with faith-based communities focusing on peer support and education to work with patients with chronic health conditions)
 - Collaboration with NH's (readmit rates: 25% -> 13%, with some in single digits)
 - Joint venture with community mental health providers (eg: Way Station) to achieve low readmission rates (~8-9%)
 - Identification of high utilizers and implementation of ED CREDO care plans

Comments ??
Questions ??





**Department of Health and Mental Hygiene
and
Maryland Health Services Cost Review Commission**

Bay Area Transformation Partnership

**Regional Partnerships
Learning Collaborative**

July 16, 2015



Bay Area Transformation Partnership

Our Core Team:

Anne Arundel County Department of Health

Anne Arundel Medical Center

University of Maryland Baltimore Washington Medical
Center

MedChi Network Services



Aims / Topics / Timeframe

- ▶ Two overlapping projects
 - ▶ Developing an easy, fast, effective way for clinical and nonclinical providers of care to communicate with one another and share “need to know right now” information regarding **vulnerable, chronically ill patients**, *at the point of care*, in order for the best care decisions to be made.
 - ▶ Integrating community resources with physician practices to address non-medical needs of vulnerable, chronically ill patients and also promote strategies that improve overall population health
- ▶ We’ll know we got there when patients’ goals of care are followed and workflows are transformed so that safe and effective alternatives to the “usual” cycle of admission and readmission are provided to our most complex patients.

Areas where our team has strong resources:

- ▶ Appetite for change: our proposal arose from frustrations and solutions voiced by providers and patients and caregivers.
- ▶ Strong participation from health systems and community-based providers
- ▶ Hospitals on same EMR platform; community physicians engaged with CRISP
- ▶ Engaged government and community partners from our LHIC, the Healthy Anne Arundel Coalition
- ▶ Support from MDICS who provide services at both AAMC and UM BWMC as well as area SNFs
- ▶ Initial discussions regarding care coordination were previously undertaken in the County.

Challenges

- ▶ Multiple partners are needed to develop effective workflows and meet patient and caregiver needs, yet larger groups come with their own coordination challenges
- ▶ Tight timeline for developing an implementation plan
- ▶ Tension between “clinical provider” camp and “community-based resource” camp: transformation of care delivery will require integration of both if we are to succeed

Early Successes

- ▶ Encounter notifications through CRISP are supporting transitions of care and workflows have been adopted by community providers.
- ▶ UM BWMC offers a bridge clinic for psychiatric patients who present to the ED to help
- ▶ *A Pediatrician's Toolkit for Behavioral Health Resources* was developed by the Healthy Anne Arundel Coalition. A toolkit for use with the adult population is under development.
- ▶ Reduction of 911 calls, ED visits, admissions and readmissions in AAMC HEZ.

Questions and Comments?





**Department of Health and Mental Hygiene
and
Maryland Health Services Cost Review Commission**

Upper Chesapeake

Regional Partnerships

Learning Collaborative

July 16, 2015



UMUCH & Union Hospital

- ▶ Cecil & Harford County Health Department
- ▶ Cecil & Harford County Offices of Aging
- ▶ Harford EMS
- ▶ Hart to Heart Transportation
- ▶ Amedysis
- ▶ Healthy Harford
- ▶ West Cecil/ Beacon Health (FQHC)
- ▶ Physician Providers from Union and UMUCH
- ▶ Lorien Health

Aims / Topics / Timeframe

- ▶ Agreement on Elements of Risk Scoring across the continuum
- ▶ Connecting community partners to CRISP
- ▶ Interventions, (in-home & Telehealth)
- ▶ High Utilizer Registry

Areas where our team has strong resources:

- ▶ Experience with CRISP
- ▶ Telehealth programs (In-home and CCF)
- ▶ Strong collaboration among government agencies
- ▶ Leadership support

Challenges

- ▶ Multitude of risk scoring/ assessment/ intake forms
- ▶ Determining the most appropriate (and willing!) stakeholder for the in-home intervention
- ▶ Surprisingly varying understanding of what each stakeholder does in the community.

Early Successes

- ▶ **UMUCH Comprehensive Care Center**
 - ▶ High Risk Patients
 - ▶ Post Discharge Visit
 - ▶ RN/ SW Case Management
 - ▶ In-home visits for vulnerable
 - ▶ Connecting patients to FQHC

- ▶ First 180 patients 42% had not ED or Admission activity in the following 90 days.
- ▶ Diagnosed 12 cancer cases
- ▶ Reduced patient charges by average of \$500

Questions and Comments?





**Department of Health and Mental Hygiene
and
Maryland Health Services Cost Review Commission**

Nexus Montgomery

**Regional Partnerships
Learning Collaborative**

July 16, 2015



Nexus Montgomery

Team Members & Partners:

- Montgomery County's 6 hospitals (4 systems)
- 25 senior living communities (IL&AL)
- Community-based health care and social service agencies
- MC Department of Health and Human Services
- Primary Care Coalition
- Technical experts (Discern, LifeSpan, Medical Societies)



Aim: A Financial Model, Operating Model, Governance Structure and Learning System

Operating Model: (designed by 12/1/15)

- ▶ **Health Risk Assessment + Care Coordination**: To improve the care and health status of, and reduce avoidable healthcare utilization by, seniors who are frail and/or have multiple chronic conditions (initially in IL & AL, market rate and subsidized)



Aim: A Financial Model, Operating Model, Governance Structure and Learning System

. . . Continued

Financial Model: *(assumptions defined by 12/1/15)*

- ▶ Aligned across providers to support a cohesive, patient centered approach [longer-term goal: introduce performance measurement model with payments tied to quality and cost]

Governance: (initial MOUs by 12/1/15)

- ▶ Decision-making model for operating and payment decisions across the community collaboration

Learning System: (continual work in progress)

- ▶ Data and communication feedback for continual improvement of models.

Our Team Has Strong Resources

- ▶ Positive experience of H.E.A.L.T.H. Partners: an 'on-the-ground' work group w/3 years experience
- ▶ Track record of successful improvement projects that are focused on the Triple Aim
- ▶ Relationship with VHQC and EMS for data
- ▶ County's commitment to focus on needs of the growing senior population
- ▶ Region already collaborates for health improvement (LHIC/Healthy Montgomery); commitment of key leaders at hospitals & other partner organizations
- ▶ Experienced consulting team

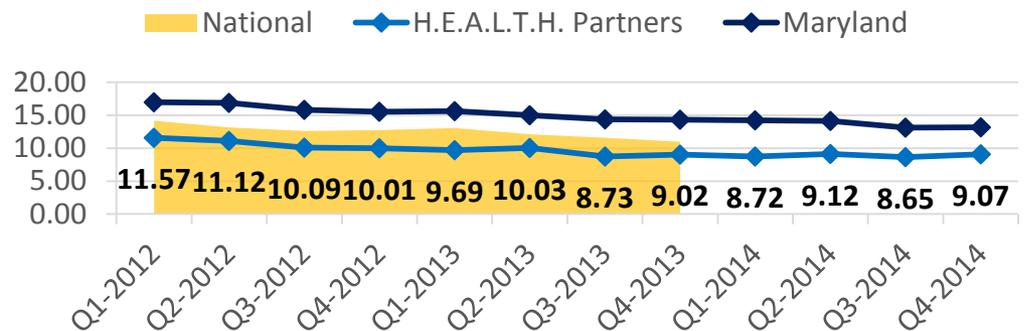
Challenges

- ▶ Identifying a RA methodology that identifies individuals that will benefit from interventions
- ▶ Population health model is a new paradigm
- ▶ Selecting cost effective evidence based interventions
- ▶ Physician engagement & alignment
- ▶ Creating a long term sustainable model
- ▶ Summer vacations & time frame

Early Successes

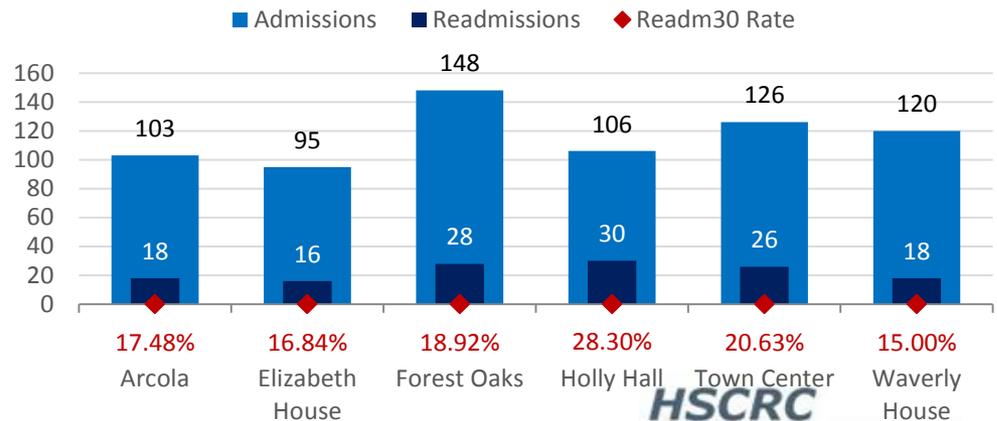
- ▶ Obtained baseline data from VHQC & EMS, data by senior living address

Community Readmissions per 1,000 Beneficiaries



- ▶ Hospital partners are focused on transitions in care

Admits & 30-Day Readmits by Location



Questions and Comments?





**Department of Health and Mental Hygiene
and
Maryland Health Services Cost Review Commission**

Howard County

**Regional Partnerships
Learning Collaborative**

July 16, 2015



Howard County Regional Partnership

- Elizabeth Edsall Kromm, PhD, MSc – Howard County General Hospital
- Kyla Mor – Johns Hopkins HealthCare LLC
- Nikki Highsmith Vernick, MPA – The Horizon Foundation
- Maura Rossman, MD – Howard County Health Department



Chase Brexton
Health Care



Aims

- ▶ July – September: **Six Core workgroups** to assess current state, identify gaps, make recommendations for future state
 1. Community Link to Care
 2. Facility Transitions
 3. Social Needs
 4. Behavioral Health
 5. Pharmacy
 6. Primary to Specialty Care
- ▶ September – November: The **Financial Sustainability** and the **Analytics, Evaluation & IT Subcommittees** will evaluate Core recommendations and work with the Operating Committee to set goals and develop **plans for sustainability and data infrastructure.**
- ▶ September – November: **Operating Committee** will use Core recommendations **to build population health model** with emphasis on Medicare high utilizers
- ▶ November: **Steering Committee** and the **LHIC** to approve model based on **county-wide population health strategy**

Strengths

- ▶ Local Health Improvement Coalition (LHIC)
- ▶ Multidisciplinary working groups
- ▶ Support from Horizon Foundation
- ▶ Active provider engagement – primary & specialty care
- ▶ Applying lessons learned & best practices from pilot interventions & Hopkins initiatives

Challenges

- ▶ Anticipating needs before the model is built
- ▶ Financial sustainability
- ▶ Data and analytic infrastructure
- ▶ Working group adherence to scope of work

Early Successes

- ▶ Engagement with SNF and long-term care
- ▶ Advanced Primary Care Collaborative involvement
- ▶ Patient/consumer voice

Questions and Comments?





**Department of Health and Mental Hygiene
and
Maryland Health Services Cost Review Commission**

Southern Maryland Regional Coalition

**Regional Partnerships
Learning Collaborative**

July 16, 2015



Southern Maryland Regional Coalition

Names of core team members and partners:

Name	Organization
Camille Bash	Doctors Community Hospital
Lisa Goodlett	Dimensions Healthcare System
Marjorie Quint-Bouzid	Fort Washington Medical Center
Susan Dohony	Calvert Memorial Hospital
Dr. George Bone	Southern Maryland Integrated Care
John O'Brien	Community Representative
Robin Nelson	Doctors Community Hospital
Chris Rayi	Capital Cardiology
James Case	KPMG LLP (Partnership Facilitator)

Aims / Topics / Timeframe

- ▶ Our goal is to substantially reduce readmissions and ambulatory sensitive condition (PQI) admissions per capita in Prince Georges County and Calvert County, Maryland
- ▶ The diseases/conditions that are prevalent in Prince Georges and Calvert Counties based on community assessments:
 - ▶ CHF
 - ▶ Asthma
 - ▶ Diabetes
 - ▶ Mental health (prevalent secondary diagnosis)

Areas where our team has strong resources:

- ▶ The team has very strong resources (over 50 participants) in the following areas:
 - ▶ Executive resources at the C-suite level from hospital representatives
 - ▶ A broad set of providers including long-term care, outpatient renal, primary care providers, specialty services, and emergency services
 - ▶ Analytical resources
 - ▶ Community resources including local faith-based communities, NGOs, and the University of Maryland School of Public Health

Challenges

- ▶ There are several challenges facing this group
 - ▶ Experience in working together
 - ▶ Resources to devote to the effort beyond those supplied in the grant funding
 - ▶ Experience in broad care coordination efforts
 - ▶ Information technology resources and knowledge of tools that work

Early Successes

- ▶ The coalition has been successful in the following areas:
 - ▶ Built up substantial trust between partners in the group and a collaborative approach
 - ▶ Assessed available tools for identifying root causes of readmissions and began implementation
 - ▶ Identified and engage community groups in developing solutions

Questions and Comments?



Wrap Up



Wrap Up

- An FAQ sheet is being developed and will be available on Basecamp. Please send any questions to Meghan Kirkpatrick at mkirkpatrick@healthmanagement.com.
- If you have not been added to Basecamp, please contact Meghan.
- Webinar dates have all been scheduled; topics are tentative. Webinars are bi-monthly and conclude on November 12.

Upcoming Webinar Schedule

- July 23: CRISP data tools to expect in the future (Note: This webinar was extended by an hour and will be from 9-11am at MHA. The additional hour will be used for Q&A. Regional Partnerships can attend in person or via webinar).
- August 13: Governance structures and decision-making (tentative)
- August 27: Care coordination – overview of key components and workforce (tentative)
- September 10: Consumer education and outreach (tentative)
- September 24: BH integration models and access (tentative)
- October 8: GBR and shared savings (tentative)
- October 22: Leveraging funding streams (tentative)
- November 12: TBD

Upcoming Learning Collaboratives

- August 6 (all hospitals)
- September 3 (in-person; Regional Partnerships only)
- October 1 (all hospitals)
- November 5 (in-person; Regional Partnerships only)