

Transformation Framework

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-mapsh/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, health 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

Domain 1: Clearly articulate the goals, strategies, and outcomes that will be pursued and measured

Context: To initiate and drive any type of transformational change there needs to be collective understanding and agreement on exactly what is to be accomplished and why it is a focus. Clearly defined and articulated goals, strategies, and outcomes allow for the setting of baseline data and the development of metrics to measure progress as it is achieved. In Maryland, it is important for the goals, strategies, and outcomes to align directly with those that have been set by the demonstration project and associated initiatives.

1. Understand goals associated with Maryland's All Payer Model, ACOs, CMS and the State of Maryland. Evaluate current performance against goals and areas of opportunity.
2. Evaluate current performance against patient satisfaction metrics and identify areas of opportunity.
3. Evaluate quality and outcome metrics associated with Medicare, Medicaid, and commercial programs, and identify areas of opportunity.
4. Develop and articulate satisfaction, quality, outcome, and cost goals and supporting process goals and metrics that will be used for the short-term and long-term.

Domain 2: Establish formal relationships through legal, policy, and governance structures to support delivery and financial objectives

Context: Formal relationships are needed to ensure effective collaboration, planning, and implementation. A formal collaborative arrangement may include partner participation agreements, a memorandum of understanding, legal compliance processes, a leadership structure through which to engage in decision-making (e.g. Executive Committee, etc.), and partnership communication plans that are designed to engage and involve the participating members. To achieve optimal functionality, it is important to clearly define, describe, and communicate partnership roles, responsibilities, expectations, performance measures, monitoring, and mechanisms for holding participants accountable for care, and financial management, arrangements and distributions that are in accord with partnerships roles.

1. Consider including ambulatory physicians, specialists, nurses, nursing homes, skilled nursing facilities, behavioral health practitioners, area hospitals, local health departments, and community-based organizations.
2. Establish a governance board and/or process by which decisions can be made by all types of providers in the partnership.
3. Work with CRISP to understand the evolving legal and policy framework for data sharing and establish complementary contracts, MOUs, or other agreements that facilitate the legal and appropriate sharing of care plans, alerts, and other patient-specific data that facilitates the most comprehensively informed decisions, consults, and treatments of patients across multiple settings and with all providers that encounter that patient in the region.
4. Work with CRISP to understand the patient consent requirements necessary to enable data sharing and implement new requirements.
5. Establish HIPAA compliance rules including appropriate treatment of Maryland specific laws (such as behavioral health).

Domain 3: Understand and leverage currently available data and analytic resources

Context: The Care Coordination Workgroup recommended building or securing a data infrastructure to facilitate the identification of individuals who would benefit from care coordination. The goal is to se-

cure, organize, synthesize, and share data that supports care coordination and enables more robust care management and monitoring.

1. Determine how to best access CRISP's state-level infrastructure and state-level data.
2. Identify readily available data that can be used to understand the needs in the region and the best opportunities for success, as well as how to monitor success.
3. Use existing and new data to encourage setting substantial aims, convene workable coalitions, and monitor and manage progress.

Domain 4: Identify needs and contribute to the development of risk stratification levels, health risk assessments, care profiles, and care plans

Context: The Care Coordination Workgroup recommended encouraging and supporting patient-centered care, including collaborating on best possible approaches to risk stratifying patients, standardizing elements of Health Risk Assessments, and developing a standardized and interoperable format for a patient profile.

1. Determine risk stratification levels necessary for regional care coordination initiatives.
 - a. Understand the state-level risk stratification capability and determine how regional partnerships will leverage it to define high-risk and moderate-risk patients. Work with CRISP to determine needs and priorities for additional risk stratification efforts and determine whether there are any additional algorithms that will be used in addition to state-level risk stratification.
 - b. Agree on other types of patients that may be eligible for care coordination based on ED use, admissions, and other pertinent data.
 - c. Set up accountabilities for receipt of risk-level information and triggers for action.
 - i. From where does data come
 - ii. How are risk levels determined
 - iii. What is presented to whom
 - iv. Can this data be shared and how
2. Work with CRISP on the development of standard Health Risk Assessments (HRAs) and deploy.
 - a. Determine what type of HRAs will be used:
 - i. Screening HRAs
 - ii. Behavioral health risk assessment
 - iii. In-depth assessments
 - b. Agree on elements that will be used in various HRAs.
 - c. Set up accountability for the administration of HRAs and how the results of those HRAs will be recorded for use by all appropriate providers
 - i. Who can and should complete an HRA
 - ii. Where is the information recorded
 - iii. How is HRA data factored into risk levels
3. Work with CRISP to design and develop care profiles to be shared through the state-level infrastructure and facilitate the development of longitudinal care plans.
 - a. Assess the state-level care profile and care plan and determine if it is the appropriate tool or if a modified or regional version of the care profile will be used.

- b. Identify key elements and contribute to development of care profiles and plans, considering key elements.
 - i. Care Profile
 - 1. Problem list
 - 2. Medications list
 - 3. Allergies
 - 4. Specialists
 - 5. Care Team
 - 6. Future appointments
 - ii. Care Plan
 - 1. Identifying treatment goals
 - 2. Assessing and addressing potential barriers to meeting goals
 - 3. Creating a self-management plan that incorporates patient preferences and functional/lifestyle goals
 - 4. Assessing and addressing potential barriers to meeting goals
 - 5. Crisis planning
- c. Establish the systems through which the care profile and the care plan will be accessed, the interoperability of the profile/plan, and who will have access to it.
- d. Set up accountability for use of the care profile and the training needed to establish the accountabilities and processes used to meet requirements.

Domain 5: Establish Care Coordination People, Tools, Processes and Technology

Context: Care coordination and management hold the potential to reduce hospital use by reducing the likelihood and severity of deterioration and complications of chronic conditions. The return on investment in these efforts requires effective use of resources, targeting of initiatives, and leveraging community-based resources. It is important to engage hospitals, primary care providers, and payers in an effort to provide care management at the local level or through regional partnerships. Identifying the necessary workforce and defining roles and processes will be required of collaborative efforts.

- 1. Create mechanisms by which high-risk, moderate-risk, and event-based patients are identified.
- 2. Enroll these patients in care coordination programs so that the provider can check the history of the patient, the care plan, and other pertinent information for the purpose of making well-informed decisions about treatments, settings and the patients' health goals, and to record the patient encounter so that others in the system will have the best information available at the next encounter. Define accountabilities of Care Coordinators and other players:
 - a. Patient education
 - b. Health risk assessment responsibility
 - c. Providing the patient/family/ caregiver access to their individualized care plan
 - d. Implementation of the care plan
 - e. Responding to emergency room ADT alerts
 - f. Transitions of care
 - g. Continuity of care processes
- 3. Hire Care Coordinators

- a. Define care management intensity based on CMS requirements, risk stratification and care management resources
 - b. Define staffing models and ratios (new hires, redeployment, and training)
 - c. Determine who will employ care coordinators and where they will be located (hospital, physician's offices, other)
 - d. Set up tools, processes, and accountabilities for care coordinators
4. Assess the need for and establish a call center, if needed
 - a. Based on the amount of care coordinators needed, determine if a centralized call center is needed
 - b. Assess internal technology, operational, and leadership capabilities
 - c. Assess outsourcers – e.g., a regional contract
5. Assess the need for enhanced in-home services – including physician visits and home care outside of Medicare home health agency and hospice – and including social supports and personal care (housing, transportation, food, caregiver support, homemaker services, and personal care)
6. Establish a Care Coordination Quality Assurance Program
 - a. Deploy methods of monitoring successes, challenges, performance, and deploying strategies to optimize the care coordination model
 - b. Measure, publish, discuss, and improve process and outcome measures
 - c. Deploy methods of evaluating the competencies and performance of care coordinators
7. Develop techniques that encourage patients to enroll, engage, and actively participate in care coordination efforts
 - a. Capitalize on established PCP and specialist relationships.
 - b. Capitalize on care coordination relationships.
 - c. Deploy telephonic, mail, and face-to-face enrollment campaigns.
 - d. Establish hospital-based, CBO-based and other programs to assist in facilitating enrollment.
 - e. Support caregivers.

Domain 6: Align physicians and other community-based partners

Context: The Advisory Council and Physician Alignment and Engagement Workgroup recommended strategies to align the goals of hospitals and non-hospital providers to meet the goals of the new All-Payer Model. Numerous initiatives are underway in Maryland to achieve this, including PCMH, ACOs, as well as other efforts. Medicare's new Chronic Care Management codes also provide an opportunity to align efforts. The State of Maryland will work with stakeholders and CMMI to phase-in strategies to address total cost of care. This phasing strategy is currently unfolding.

1. Establish support services to help various types of providers to achieve effective and efficient care coordination
 - a. Offer care coordination resources that can be leased by providers in the regional partnership
 - b. Set up tight relationships, communications and other processes that will meet CMS criteria for Chronic Care Management at the practice-level or through a centralized care coordination function.
 - c. Assist various providers, PCPs, nursing homes, etc. to hire practice level care coordinators as appropriate.

2. Develop processes, procedures, accountabilities with supporting tools, technologies and data that connect disparate providers in the activities and events associated with care coordination, such as:
 - a. Patients presenting at the ED and patients being admitted by PCPs/specialists
 - i. What information should a PCP office provide to a patient being sent to the ED?
 - ii. What records/history does an ED need to check before admitting a patient?
 - iii. Who should the ED talk to before admitting a patient? Under what circumstances should this happen?
 - b. Transitions of Care
 - i. Who communicates what to whom when a patient is being discharged from the hospital? What? When? How? Who takes follow-up action? How? How does it get recorded?
 - ii. Who communicates what to whom when a patient is moving from a SNF to home? What? When? How? Who takes follow-up action? How? How does it get recorded?
 - iii. Who proactively contacts patients/families for appropriate follow-up care within an appropriate period following a hospital admission or ED visit?
 - c. Coordination of care post-discharge or at PCP/specialty level
 - i. Who is responsible for: When? How? Where? How recorded?
 1. Test tracking and follow-up
 2. Referral tracking and follow-up
 3. Detecting and addressing gaps in care
 - d. Behavioral Health
 - i. What does a PCP or specialist office do when a patient or practitioner identifies a mental health issue? What does a hand-off look like? When does one do a “hand-off,” and when does one work collaboratively or not rely upon a BH specialist? What is the BH specialist responsibility and what is the responsibility of the PCP or others?
 - e. Community-based Services
 - i. What are the community-based services available in the region – what are gaps in supply or quality, or perhaps oversupply inducing utilization (e.g., in nursing homes)?
 - ii. What is the process for coordination of referrals for other necessary services that are not covered services but may address social and non-medical needs, such as supportive housing? Who is responsible? How? How is it recorded?

Domain 7: Support the transformation with organizational effectiveness tools

Context: The concept and tools around continuous quality improvement are the foundation for the changes leading to transformation. Using these tools to create an implementation plan listing the rapid cycles for improvement, milestone action steps, and process and outcome measures monitoring progress along the way for the major areas of care delivery and population health focus are critical to drive the planning into a smooth implementation process.

1. Implementation Planning
 - a. Rapid and incremental implementation with timelines and task accountabilities
 - b. Continuous improvement – learning organization
2. Quality Improvement Processes
 - a. Establishing methods of using data to make and adjust plans based on continuous improvement processes
3. Performance management mechanisms:
 - a. That allow the RP to monitor and improve outcome measures, including state-level and regional targets:
 - i. The all-payer per capita total hospital revenue growth will be limited to 3.58% per year over the five years (plus an adjustment for population growth).
 - ii. Medicare per beneficiary total hospital cost growth over five years shall be at least \$330 million less than the national Medicare per capita total hospital cost growth over five years. This is estimated to represent a savings level of about one-half percent per year under the national Medicare spending growth rate beginning in year two of the model.
 - iii. The aggregate Medicare 30-day unadjusted all-cause, all-site readmission rate will be reduced to the corresponding national rate over five years.
 - iv. An annual aggregate reduction of 6.89% in potentially preventable conditions (PPCs) over five years will result in a cumulative reduction of 30% in PPCs over the life of the model.
 - b. Facilitate the monitoring and improvement of process measures, outcome measures and associated performance
 - i. Establish forums in which key metrics are reviewed and understood and accountabilities are set up for improvement
 - ii. Deploy methods of evaluating and continuously improving the competencies and performance of associates, including care coordinators
4. Establish mechanisms to affect a culture that promotes:
 - a. More communication and collaboration among organizations and individuals within the regional partnerships
 - b. Clarity about how to handle ongoing competition alongside cooperation – how to compete and keep working together
 - c. Patient-centered decisions, processes, and accountabilities
 - d. Aligned incentives

Domain 8: Develop Care Delivery Model Changes

Context: Meaningful short-term impact on commitments to hospital utilization reduction, as well as long-term impacts on population risk, will require system changes in the delivery of care. These are likely to include the strengthening of access to primary care, better connections of hospitals to post-acute care, and new ways to engage patients and families in the defined care goals.

1. Develop programs that were defined in applications such as diabetes, tele-health and chronic care management.
2. Design and establish:

- a. Identification of patients
- b. Processes
- c. Technology
- d. Sharing of information
- e. Workforce development, deployment, and training

Domain 9: Create Financial Sustainability Plans

Context: Decisions on investments in infrastructure, including workforce, process improvements and technology, should include an evaluation of the return on those investments. For example, when developing care coordination staffing ratios, it is important to ask which patients should be eligible for what level of care coordination – one of the driving factors is the ROI that is expected on that patient population based on reduced admissions, reduced readmissions, reduced duplicate testing and adverse drug interactions. Interventions need to pay for themselves at some point.

1. Assess the cost of the intervention over a reasonable period of time
2. Estimate expected savings that will be driven by the intervention based on historical data, literature, and expert advice
3. Determine if there is an ROI and over what period of time
4. Articulate in writing the plan for financial sustainability in terms of:
 - a. Goals that need to be met in order to produce an ROI on the investment and the time scale for achieving it
 - b. Mitigation plans if the goals are not achieved