The Maryland Model

A Bold Initiative to Control Cost Growth, Improve Quality and Make People Healthier
The Big Goal: Better Care
New Model Unique to Maryland

- Individual Health Improvement
- Efficiency & Affordability
- Accessibility & Convenience
- Healthy Communities

Whole Person Care
Model Brings Ambitious Targets

- State at risk for total cost of care for 920,000 FFS Medicare beneficiaries
- Added goals for quality improvement and health gains
<table>
<thead>
<tr>
<th>Key</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Global Hospital Budgets</td>
</tr>
<tr>
<td>2</td>
<td>All-Payer Hospital Rates</td>
</tr>
<tr>
<td>3</td>
<td>Total Care Cost Accountability</td>
</tr>
<tr>
<td>4</td>
<td>Shared Provider Incentives</td>
</tr>
<tr>
<td>5</td>
<td>Population Health Goals</td>
</tr>
<tr>
<td>6</td>
<td>Quality of Care Incentives</td>
</tr>
</tbody>
</table>

- **Global Hospital Budgets**: No incentive to deliver more than needed care
- **All-Payer Hospital Rates**: Cost burdens shared equitably by all payers
- **Total Care Cost Accountability**: Hospitals each responsible for attributed lives
- **Shared Provider Incentives**: Programs designed to align all care partners
- **Population Health Goals**: Care for communities, not just individuals
- **Quality of Care Incentives**: Hospitals rewarded for hitting quality targets
Global Budgets Reward Efficiency

- Incentivizes preventive care to avert hospital use
- Hospitals may reinvest savings in prevention
- Maintains quality controls to uphold performance
Total Care Cost Risk

Promotes keeping people – and populations – well

Encourages partnering for whole-person, longitudinal care

Drives care to most appropriate, least costly settings

- Medicare FFS beneficiaries attributed to hospital
- Target aggregate spend for all Parts A and B services
- Gain/Loss opportunity = 1% of hospital’s Medicare revenue
Shared Incentives Boost Collaboration

<table>
<thead>
<tr>
<th>Finding Hospital Efficiencies</th>
<th>Managing Patients with Chronic Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal</strong>: Drive improvements and cost savings in hospital care</td>
<td><strong>Goal</strong>: Enhance care management and coordination</td>
</tr>
<tr>
<td><strong>Players</strong>: Hospitals and care partners practicing at hospitals</td>
<td><strong>Players</strong>: Hospitals and community-based providers</td>
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<tr>
<td><strong>Benefit</strong>: Physicians may share in efficiency gains</td>
<td><strong>Benefit</strong>: Shared resources and information improve quality and reduce costs</td>
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Hospital Care Improvement Program (eff. July 2017)  
Complex & Chronic Care Improvement Program (eff. July 2017)

<table>
<thead>
<tr>
<th>Connecting Providers to Treat Episodes of Care</th>
<th>Primary Care Doctors Guiding Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal</strong>: Align care across all settings, with focus on care post-discharge</td>
<td><strong>Goal</strong>: Restore focus on primary care</td>
</tr>
<tr>
<td><strong>Players</strong>: Hospitals and care partners across the continuum</td>
<td><strong>Players</strong>: Primary care physicians and some specialists working with supportive organizations</td>
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<tr>
<td><strong>Benefit</strong>: Hospitals may share incentives with efficient partners</td>
<td><strong>Benefit</strong>: Additional resources to support new modes of care delivery and performance improvement</td>
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Episode Care Improvement Program (available Jan 2019)  
MDPCP: Maryland Primary Care Program (available Jan. 2019)
Population Health – Beyond One Patient

- Prevent chronic conditions
  - Diabetes
  - Heart disease
  - …more
- Reduce widespread harms
  - Falls in elderly
  - Opioid overdoses

Promotes hospital investments in community-based care

Motivates integration of physical & behavioral care

Demands attention to social determinants of health
Incentives Aim to Raise Quality of Care

- Hospital incentives apply across all payers
- More than 7% of inpatient revenue at risk

End patient harms occurring in health facilities
Reduce avoidable care … for manageable conditions
Enhance coordination across care settings, and beyond
Engage patients in improving care experience and health
A Systems Approach Is Needed

STATE & COMMUNITIES

- Better job opportunities
- Adequate & affordable housing
- Safer communities
- Stronger education
- Family & social supports
- Improved transportation

HEALTH SYSTEM

- Partnerships across care continuum
- Resources for modernization
- Aligned incentives
- Robust, inclusive workforce
- Integrated behavioral and physical care
- Actionable healthcare management information

Maryland Hospital Association
Our Success Demands Collective Effort

Healthier People & Economically Sustainable Health System
CalvertHealth CARES Program

Making a PACCT to CARE

Leveraging Community Resources to Educate, Engage and Empower Patients

Karen Twigg, BSN, RN, CMCN
karen.twigg@calverthealthmed.org
CalvertHealth Medical Center is a 74 bed independent, not-for-profit, community hospital

Located in beautiful Prince Frederick, MD, CHMC provides inpatient and outpatient general medical / surgical and psychiatric care

Founded in 1919, CHMC has been taking care of Southern Maryland families for almost 100 years
• In FY 2018:
  – 39,353 patients visited our emergency room
  – We had 5,457 inpatient admissions & 3,018 observation stays
  – Our physicians performed 1,306 inpatient & 7,263 outpatient surgeries

• Approximately 230 active & consulting physicians representing over 40 different specialties

• Approximately 1,200 dedicated employees help CMH provide the very best for our patients, with more than 200 volunteers helping to add those "special touches"

• In addition to our main hospital campus, 4 satellite medical office buildings ensure that quality care is no more than 15 minutes from anywhere in Calvert County
Measuring Our Success

All-cause, non-risk adjusted inter-hospital readmission rate

- > 14% prior to beginning our CARES journey in 2013

- Program inception Q1 FY14 readmission rates:
  - Total = 12.4%  - Medicare = 19.6%  - SNF = 23%

- We were at our best Q2 FY17
  - Total = 5.5%  - Medicare = 8.5%  - SNF = 9.1%

- Q4TD FY18 (thru May) shows declining volumes and LOS impact
  - Total = 7.5%  - Medicare = 8.5%  - SNF = 9.1%

- Q4TD FY18 (thru May) intra-hospital readmission rate = 10.16%
Measuring Our Success

All-cause, risk-adjusted **intra-hospital** readmission rate
- FY17 = 7.49%
- Q4TD FY18 (thru May) = 9.21%

CARES Clinic FY18 all-cause, non-risk adjusted intra-hospital admission rate
- Includes admissions and readmissions = **2.5%** !!

CRISP pre- / post- panel for CARES Program care coordination
- Excludes those patients only receiving care through the clinic
- Approximately 180 high and rising risk patients
- January to June 2018 cost reduction = **$615K**
- 45% reduction in total cost of care
How are we doing it? Through patient, caregiver, community and team collaboration.

CalvertHealth CARES!!

Collaborative Activation of Resources and Empowerment Services
• **Initiative**  CalvertHealth’s CARES is a free “community benefit” program which takes a multi-faceted approach to meet the post-discharge needs of patients by assisting patients at moderate to high risk for readmission or emergency department overuse.

• **Team**  Physician, Nurse, Social Worker, Pharmacist

• **Target Population**  Bridging the gap for patients who:
  - Are unable to schedule a follow up physician appointment within 5 days post-discharge from ED, observation stay or inpatient admission
  - Lack a primary care provider
  - Can’t afford essential medications and/or those who need assistance managing multiple medications
  - Need assistance securing transportation to health care appointments
  - Can benefit from access to an array of post-acute care resources

**Interventions**  Phone calls, patient portal, community outreach, active listening with coaching, home visits, CARES clinic, financial guidance and assistance

*It’s all about the relationship.....*

*Consistency, Collaboration, Communication = TRUST*
Together, We Can Cross the Bridge to Wellness
# PACCT Charter

**Partners in Accountable Care Collaboration and Transitions**

## Committee Purpose

PACCT's purpose is to facilitate and promote collaboration between our community health care partners, with the goal of eliminating care fragmentation, while fostering an environment of collegiality, networking and resource sharing focused on enhancing our efficiency and effectiveness in optimizing patient outcomes.

## Goals / Key Result Areas:

1. **Goals:**
   1. Improve the patient centered experience by ensuring patient's receive the right care in the right setting, as evidenced by the reduction of avoidable admissions, all cause readmissions, emergency department visits and outpatient observations stays at CalvertHealth Medical Center and in the Southern Maryland region.
   2. Improve synergy (consistency, efficiency, and effectiveness) of patient centered disease specific care planning, education and medication management provided by our community health care partners.
   3. Improve communication flow and patient centered care coordination between our community health care partners, as evidenced by the development and implementation of post-acute pathways and protocols. *Target initiative:* Mental health pathway that navigates a specific population.

## Strategies:

1. **Strategies:**
   1. Improve patient engagement: develop motivational interviewing initiative & begin targeted synchronization of education - same tools / different methods
   2. Improve networking between community partners
   3. Enhance information / strategy sharing
   4. Mobilize CalvertHealth CARES Program; including Transitions to Home, Project Phoenix, Medication Therapy Management
   5. Optimize engagement with / use of community resources
   6. Optimize use of technology
   7. Explore incentivization methods to engage PACCT members and community providers; ex.: lunches, communication, networking, professional growth
   8. Brand our collaborative and publicize what we are doing / why / outcomes
   9. Leverage our collective to increase our access to resources and capabilities and explore ways to share risks and benefits ($)

## Key Result Measures:

1. **Key Result Measures:**
   1. Reduction in all cause readmission rate to < 8% (in Maryland intra and inter hospital rate)
   2. Reduction in nursing home readmission rate to < 14%
   3. Reduction in Medicaid readmission rate to < 12%
   4. Reduction in Medicare patient readmission rate to < 12%
   5. Reduction in avoidable hospital based utilization (PQI) < 4%

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Revised 10/19/17
Program Return on Investment
Due to Improvements in:

- Health care spend per beneficiary
  - through reduced utilization and readmissions
- Safer patient environment
  - through reduced exposure to hospital associated conditions due to reduced hospital utilization
- Overall patient health
  - through provision of services in the patient home, care coaching, referrals to partnering service providers and discharge CARES clinic services .....

Through state incentive programs and grant opportunities
(HSCRC and Rural Maryland Prosperity Investment Fund)
CalvertHealth Medical Center has been awarded
≈ $2.6M over the past 4 years

The CalvertHealth CARES Program has received state and national recognition as a best practice
Lions, and tigers, and bears...OH MY!
A Multidisciplinary Collaborative Approach to Chronic Disease Management

The Well Patient Program®
The Well Patient Program®

Goals

1. To create and maintain a multidisciplinary approach to Chronic Disease Management.

2. Decrease Emergency Department utilization by patients who can be managed in a more appropriate health care setting.

3. Identify and assist individuals in the community who have a high level of utilization of health care services. These individuals may have chronic medical conditions, limited family support, limited financial resources or poor coping mechanisms which lead them to a higher level of medical services than necessary to meet their perceived needs.

4. Decrease the Potentially Avoidable Utilization Rate by 20%
The Well Patient Program®

Description

• GRMC High needs patients will be *enrolled* in the GRMC **Well Patient Program®**
  – To develop a comprehensive plan in collaboration with the patient, family, PCM Department and PCP in order to assist them with navigation through the health care continuum and ensure a favorable outcome.
• The **Well Patient Program®** is staffed by the Patient Care Management Department (MSWs and Nurse Navigator)
• Assess patient strengths, as well as identify barriers to a positive outcome
• Educate patients on their disease process
• Reinforce a multi-disciplinary approach to chronic disease management
• Reinforce patient engagement in health care management to empower patients to make effective choices
• Patients are referred to the appropriate resources for their disease condition (Sub Acute/Rehab, Home Health, Wound Care Clinic, Cardiac Pulmonary Rehab program, diabetes education, Hospice or Behavioral Health Services)
The Well Patient Program®
High Needs Patient Target Population

GRMC High needs patients will be identified by a review of the following criteria:

– Diagnosis Based – reflecting Potentially Avoidable Utilization criteria, as well as other known reasons for increased utilization of costly hospital services
  • Inpatient/Observation
  • Emergency Department
– 10 ED/OBS/Inpatient encounters within 6 months
– Inpatient Readmissions within 30 days
The Well Patient Program®

Stakeholders and Collaborative Partners

- **GRMC**
  - Cardiac and Pulmonary Rehab, Wound Care, Sub Acute, Diabetes Education, Cancer Care Nurse Navigator
- **GCHD**
  - Home Health, Adult Evaluation Services, Behavioral Health Services
- **Western Maryland ACO with MedChi support**
  - TCM and CCM code assistance
- **Mountain Laurel FQHC- Case Management**
- **Nursing Homes and Assisted Living Facilities**
- **Hospice**
- **Community Action**
  - Area Agency on Aging, Transportation, Medicaid Waiver, MAP Program, Housing, Energy Assistance, Homemaker Services
- **Garrett County Light House**
  - Psychiatric Rehabilitation Program, Safe Harbor, Case Management
- **Other Equivalent Agencies in our geographic service area**
The Well Patient Program®
Patient Care Management Nurse Navigator Role
Reducing Readmission and ED Utilization

• Face to face intervention with ED high needs patients as appropriate to assessed needs.
• Follow up with ED high utilisers with medical issues via telephone.
• Assists identified high-risk patients during the transition from hospital stay to home by:
  – Attending daily interdisciplinary discharge planning meetings
  – Establishing rapport with patient/family via quick face to face meeting prior to discharge
  – Ensuring follow up appointment made with PCP prior to discharge
  – Performs timely post discharge follow up telephone calls to:
    1. provide telephone reinforcement of the discharge plan,
    2. follow-up appointment, transportation and medication considerations,
    3. assess effectiveness of discharge plan
The Well Patient Program®

Role of the PCP

• Assist in the development of the Treatment Plan for each patient.
• Engage the patient in a more closely monitored preventative/maintenance of care model and follow
• Review the patients’ faxed ER summaries.
• Educate the patient on the appropriate utilization of health care services, such as ED usage.
The Well Patient Program®

IT Infrastructure

• Implementation of the Dimensional Insight IT platform. This product integrates clinical, financial, and administrative data to provide an analysis of patients who are at high risk for readmissions or return care.

• IT infrastructure support to upload care plans and coordination tasks into CRISP to support continuity of care among all providers with which the patient may come into contact.
Garrett Regional Medical Center

HSCRC Risk Adjusted Readmission Rate Comparative for all Maryland Hospitals CY 17

Adjusted Readmission Rate

Hospital

GRMC
Garrett
Ft. Washington
UMMC
UMRMC
UM - Upper Chesapeake
Washington Adventist
UM - Charles Regional
Shady Grove
Atlantic General
GRMC
UM - St. Joe
McKee
Frederick
PC Hospital
UM - Eastern
Anne Arundel
UM - Chestertown
Howard County
UM - Harford
Sinai
S rolne
Peninsula
MedStar St. Mary's
Carroll
German
d Suburban
Levindale
Meritus
MedStar Montgomery
Holy Cross
UM - BWMC
Northwest
St. Agnes
HC - Germantown
Laurel Regional
MedStar Good Samaritan
MedStar Union Memorial
Mercy
MedStar Fr. Square
Johns Hopkins
MedStar Harbor
HC - Baltimore
UMMC
UMMC - Midtown
Bon Secours
Maryland Hospital Acquired Conditions

GRMC Maryland Hospital Acquired Conditions Scores January-June CY2018
Preliminary

State Avg. 0.64

POSITIVE
At the end of 2017, GRMC has the lowest TCOC per Medicare Beneficiary:

- MD State: $11,596
- US Avg: $9,795
- GRMC: $9,327
Peninsula Regional Health System
Region’s Oldest Most Experienced Healthcare Team

Offers Full Scope of Services
- ED/Trauma
- Open Heart Surgery
- Designated STEMI (Rt. 404 South)
- Special Care Nursery Level II
- Robotic Surgery
- Stroke Center
- Orthopedics
- Neurosurgery
- Spine Center
- Comprehensive Cancer Center
- Behavioral Health
- Community/ Population Health
- Joint Ventures
- Surgery Centers
- Ambulatory Care
- Primary Care Offices

- Located In Salisbury, Maryland
- 281 Licensed Beds – 8th Largest in State
- Service Area > 480,000
- Provides Health Services to Three States
  - Maryland
  - Delaware
  - Virginia
- Predominately Rural with Urban Influence in Greater Salisbury
- Popular Retirement Destination (Retirees from Annapolis, Washington D.C., Philadelphia, Baltimore, New York and the State of New Jersey continue to move into this geographic region)
Our Service Area

Primary Service Area
Wicomico 101,614
Worcester 51,713
Somerset 26,252
179,579

Secondary Service Area
Sussex 211,254
Accomack 33,409
Dorchester 32,896
277,359

Total 456,938
Smith Island, Maryland

Population 195 in 2016; average age 53.8
Smith Island Telemedicine

• Grant-funded initiative between PRMC, McCready Health, and Crisfield Clinic

• Goals
  • Increase access to care
  • Ensure appointments for residents within 48 hours of the need being identified
  • Reduce use of ED for non-emergent care
Program Overview

• PRMC employs 1.5 CHW’s to staff two clinics (one on each island)

• Crisfield Clinic provides telemedicine equipment and some medical supplies, and a provider at Crisfield Clinic sees patients via telemedicine

• McCready Health has a PA who visits the island every two weeks except in the winter months
  • Sees patients who need or want an in-person visit with a provider
  • Draws labs onsite to save residents a trip
Role of the CHWs

• Hired two CHWs (Medical Assistants/EMTs)
  • Make appointments with Provider and facilitate the secure visit
  • Serve as an extension of the Provider
  • Run the equipment (BP, stethoscope, EKG, etc)
  • Provide clinical services (suture removal, dressing changes, flu shots, etc)
• Provide education and screenings to the community
  • Blood pressure & diabetes screenings
  • CDSME – CHW’s have had training – will soon be Master Trainers!
• Follow discharged patients to ensure the best outcomes
Program Update

- 5% reduction in use of McCready’s ED in the first year
- Approximately 50% of the total population of Smith Island has utilized the program in some form
- Collaborative Health Fair held on Smith Island (PRMC, McCready, Somerset County Health Dept)
- Exercise Equipment has been placed
- Walking Clubs being formed
- Additional PCP’s to see patients via Telemedicine
- Specialists (Endocrine, Pulmonary, Nephrology) will be added soon
October 18, 2018

Total Cost of Care

Innovative Programs in St Mary’s County

Presenter: Lori Werrell, MPH, MCHES
Director, Population and Community Health
MedStar St. Mary’s Hospital
Transportation

• **AccessHealth (CHWs and RNs)**
  – Began with our HEZ project
  – Shuttle bus running loop
  – Moved to individual transport
    • 2 minivans (one with HEZ funds, one with RMC funds)
    • Repurposed police car donated by county
    • In yr 4 of HEZ 383 patients touched with 210 few visits to hospital and 420K savings to system in the 6 months post intervention

• **Wheels to Wellness**
  – New demonstration project with Tri-county Council, CalvertHealth, Arc of Southern Maryland and The Center for Life Enrichment
  – 92 rides in first month, 118 rides in second month of operation

October 18, 2018
Medical Respite

• 20 participants to date
• 19 now in permanent housing
• 1 readmission
• Three Oaks Shelter, DSS & MSMH
• IDT meetings for residents
• VA, CareFirst and partner staff funding
Transition Programs

Nancy Bedell, RN MBA
Regional Director, Care Coordination
ED Care Coordination Program
- Expanded coverage of case managers & social workers to 7 days/16 hrs.
- Function as gatekeepers.
  - Reduce inappropriate/unnecessary admissions
- Develop individual care plans for ED high utilizers.
- Develop protocols with Post Acute/Hospice/Home Care for us to diagnose, initiate treatment then redirect.

Telemedicine
- Currently: Psychiatry, Palliative Care, Specialty consults. Always looking to expand.
Refocus the Care Team

Shift the focus from getting the patient out of the hospital to keeping them out.

“Readmissions Matter” video series by senior leadership.

Think beyond this discharge. Are they on the cusp of needing a different discharge plan?

Increase referrals to community agencies like Maryland Access Point & Mobile Integrated Health Care

Start application for assistance, discuss options with families

Launching a major initiative to improve the discharge process.
Medication Optimization Program

50% of readmissions are due to medication issues.

- Identify medications that require preauthorization or have high co pays & resolve issues pre discharge.
- Provide physicians ability to e-prescribing.
- Pharmacist consults at bedside & in home when appropriate.
  - SRH Transition Pharmacist provides telepharmacy consults for MIHC Meds to beds program.

- Resolve issues related to Medication Reconciliation.
  - Training video for all caregivers
  - Trialing having a Pharmacy Tech in the ED to improve accuracy of home medication capture.
Reduce readmissions: high risk

Transitional Nurse Navigators.

Follow patients from the hospital into the community.

- Minimal contact: weekly phone call.
- Liaison with the PCP & other caregivers in the community
- Ensure transportation for appointments, medications are obtained.
- As needed, visit patients in post acute facilities & at home
- Work with community agencies to get modifications to homes, friendly visits for socialization,

Transition to a Health Coach model
Address End of Life Issues
- Working with primary care to increase the percentage of people with advanced directives.
- Increase consults to the Palliative Care Team
- Opened a Palliative Care outpatient clinic.

Establish partnerships with post acute, home care, community & physician practices.
- Routine meetings
- Point Rite system: financial & quality data on our patients that go to post acute facilities.
- Allowing access to the patient's medical record.
Transformational Care

Changing the Culture of Healthcare and the community......

Searching for a way to educate the community to the changes that we have introduced and those to come......

Shifting the hospital from the center of healthcare delivery to the option of last resort......

Looking for the answer to a question that is being asked more and more by members of the healthcare team......how far does healthcare's accountability go?