Care Coordination Workgroup

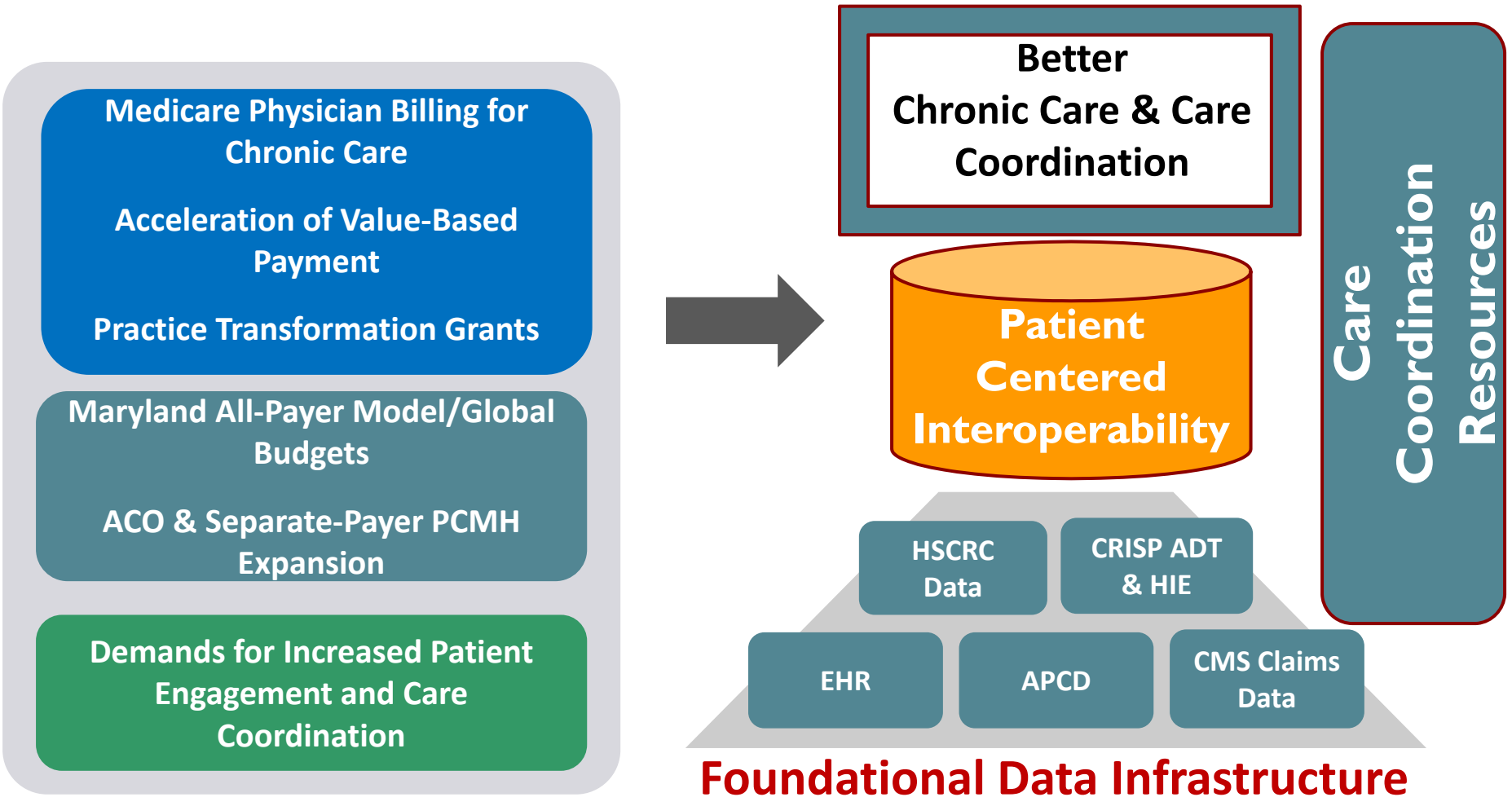
Care Coordination to Support
Integrated Value-Based Patient-Centered Care

April 2015

Care Coordination Workgroup

- Established to offer advice on how stakeholders can work together on effective care coordination to accelerate efforts underway that support the Triple Aim under the Maryland All-Payer model
- Workgroup focus:
  - Promote acceleration of care coordination models and efforts already underway, focusing on opportunities to align providers, patients, and communities
  - Recommend strategies and priorities for statewide approaches and investments, building on investments already made, to accelerate timely, scalable, effective implementation
- The Workgroup
  - met six times November 2014 - March 2015.
  - Completed assignment on the identification of key work to be done at the state-level

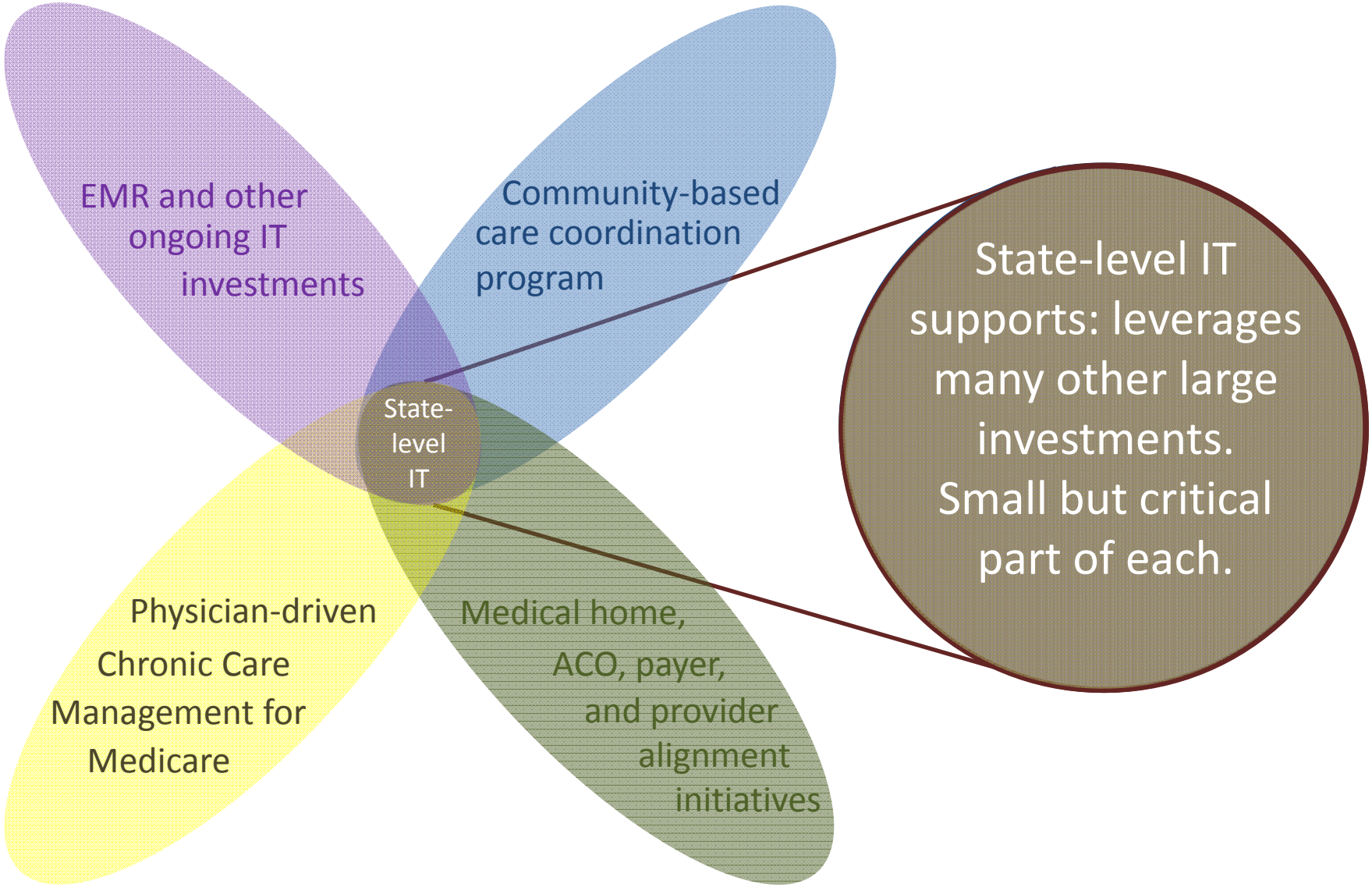
Workgroup Focus:
How to Accelerate Care Coordination



Major Findings

- Numerous care coordination initiatives underway in Maryland
- Smart public investments can support promising initiatives and bring them to scale
- Shared tools are needed to accomplish a three-step sequence to care coordination:
  - effective risk stratification to identify people with complex medical and social needs
  - health risk assessments to ascertain patients' needs
  - patient-driven care profiles and plans addressing the medical and social needs of patients
- Care coordination will focus on accelerating initiatives for high-needs patients in the Medicare fee-for-service system – the highest cost/ highest utilizers in Maryland
  - 2/3 of high utilizers and dollars are Medicare or Dual eligible
    - 40k high needs patients
    - 280k chronically ill Medicare patients with 4+ chronic conditions
- Partnerships are critical to effective care coordination. The challenge is to create opportunities to cooperate even while healthcare organizations compete in other ways
- Ultimately, goal is all-payer, all population care coordination with flexible approaches to operate within different payer and provider organizations while leveraging common IT to share structured care profiles and other information

Enhanced State-Level IT Infrastructure Supports Current Investments



Build/secure a data infrastructure to facilitate identification of individuals who would benefit from care coordination

High-level goal: To secure, organize, synthesize, and share data that will support care coordination.

- **Develop procedures and policies to secure patient consent** for the sharing of data for purposes of care coordination, building on existing resources and processes
- **Combine existing data sources** for the purpose of identifying individuals who would benefit from care coordination.
- **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.
- **Engage CRISP to contract with a qualified vendor(s)** to store, clean, and normalize the Medicare data and other Medicare-related data sets Maryland may be able to obtain for this purpose.
- Use data to **identify individuals who would benefit from care coordination** and chronic care management; use alert mechanisms to connect these patients to the physicians and hospitals who care for them (e.g. alerts to PCPs when their patients are in the ED or admitted to the hospital. The alerts are set in motion by enrolling providers in the CRISP ENS system)

Encourage Patient-Centered Care

High-level goal: Identify standard elements of care profiles that can be shared; propose future standards for the creation of Individualized Care Profiles.

- Provide resources to design basic patient care profiles that are standardized and interoperable; make these profiles readily viewable across the continuum of care: Restated, care profiles should be “doable and viewable” after establishment, to facilitate implementation and ongoing use.
- Standardize health risk assessment elements.
- Standardize elements in discharge summaries to aid transitions to long-term and post-acute care (LTPAC) providers as well as home-based settings.
- Develop approach to identify patients with care plans through CRISP, together with identification of care managers and providers. Set up process for learning, monitoring, and managing the system to determine the effectiveness of this effort over time, and make needed adjustments.
- Lead a state-level campaign to encourage individuals to participate in care plans.
- Educate patients about care coordination resources and opportunities.

Encourage Collaboration

High-level goal: Regional and local care coordination should be based on local needs and environment, with focus on some common requirements and best practices.

- Facilitate somatic and behavioral health integration.
- Facilitate care integration between hospitals and long-term care/ post-acute services.
- 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.
- Develop processes to avoid duplication of resources across provider (and payer) systems.
- Support practice transformation through technical assistance and dissemination of information on best practices.
- Create gain sharing and pay for performance programs.
- Encourage providers to take advantage of new Medicare Chronic Care Management payments.

Connect Providers

- Accelerate efforts to connect community-based providers to CRISP.
- Expand efforts to connect long-term and post-acute providers (LTPAC) using HIE and telehealth. Develop approaches to meet needs of LTPAC.
- Purchase/develop applications to facilitate interoperability among providers' EMRs to make clinically relevant information available to providers.
- Coordinate the effort to use Medicare data with initiatives to use EMR data, information on high-needs patients in Medicaid and private plans for population health and outcomes measurement.

Care Coordination Cost Summary:

Common State Level Support + Regional Planning

Start-up Cost: $51m ($41m is IT/data)	Annual Operating Cost: $8m (low) to $28m
• $8.5m Build/secure data infrastructure (includes analytics) • $4.2m Data sharing (patient-centered care/engagement) • $7m, Collaboration (training, support, TA) ($4m regional planning & support) • $31m Provider Connectivity (ambulatory and LTCF EMR interfaces)	• $3.7m Data analytics/infrastructure • $0.6m Data Sharing • $1m QA/QI staff (including training/support/TA) • $1.5m Provider Connectivity • $1m Profile of common care plan elements

A sophisticated method is needed to assess, scope and decide on the best approach to IT, analytics and connectivity. An expert committee of CRISP should work expeditiously to address these technical implications and select vendors.

Immediate Next Steps

1. **Engage Maryland Healthcare Leadership**
2. **Develop Specific Budget Estimates and Implementation Plans**
3. **Initiate data process**
4. **Tap CRISP to organize data**
5. **Build data infrastructure and identify target populations**
6. **Designate CRISP to identify consistent information that can be shared among provider and support different care management platforms**
7. **Design standardized care profiles**
8. **Establish consumer outreach strategy**
9. **Develop Care coordination programmatic efforts**
10. **Develop plan for sustainability of care coordination infrastructure**