Maryland Health Services Cost Review Commission

Interim Reports Summary
Regional Partnerships for Transformation

September 9, 2015

Regional Partnerships Overview

- The 8 Regional Partnerships have each been given 60 hours of individual consulting time. Each RP has a "Point of Contact" who serves as a guide and resource to help RPs identify areas of need for use of their 60 hours and to bring in subject matter experts as needed. Each RP also has a point of contact assigned from CRISP.
- In addition to individual TA, the Regional Partnerships and all hospitals have been invited to participate in a series of bi-weekly, topic-specific webinars and an interactive Learning Collaborative. Six webinars have been given so far specific to the framework for transformation:
  - Kick-off to the framework needed for transformational change
  - Understanding data resources and performance metrics and electronic tools for coordination (three individual webinars around these topics)
  - Governance structures
  - Care coordination
- Regional Partnerships have also been invited to participate in a three-part, in-person Learning Collaborative hosted at MHA. Two have already been held in June and August.

Highlights from the TA Points of Contact

- The Points of Contact have helped with relationship building and served in a general communication role, aiding regional partnerships with connectivity, understanding and the building of their plan as driven by the HSCRC and DHMH planning process grant
- Most common technical assistance needed from RPs:
  - Governance structure development
  - Aid in strategic initiatives and infrastructure development
  - Research and summaries of best practices, i.e., care coordination models, BHI models, transitions of care
  - Financial and incentive modeling
  - Providing other specific resources of information

Interim Report Themes

Number and Type of Meetings Held

- The organization and structures vary among Regional Partnerships. Number and types of meetings depend on complexity of planning structure.
- Common elements include:
  - Core Project Team to manage and drive the planning process, at least bi-weekly meetings
  - Advisory or Steering Committee, at least bi-monthly meetings
- Additional meetings (depending on RP):
  - Board meetings: 3-7 meetings
  - Topic-specific Task Forces or Subcommittees: 2-6 meetings. Topics include care coordination, data, community and provider engagement, model design, pharmacy, behavioral health, sustainability
  - Provider Focus Groups
  - Planning Retreats

Organizations and Person Involved in Planning Process

- Hospital Partners – generally leading the planning process
- County Representatives - Health Departments, LHIC, Social Services, Office on Aging and Disability Services
- Provider groups – MedChi, Emergency Medicine reps
- Community partners are frequently engaged in planning activities, with representation on Advisory Committee and/or sub-committees.
- Consultants – data analysis, project management, payment modeling
- State Technical Assistance – CRISP, HMA

Data Reviewed to Help in Decision-Making Process

- Community Health Needs Assessment - Disease prevalence and burden within region
- CRISP and Hospital systems - High-utilizer data, population and patient level data.
- Additional Data Sources:
  - Qualitative data from clinicians through focus groups, MedChi and Medical Society surveys, EMS
  - Medicare data from VHQC, MSSPs, and other sources
  - Office on Aging and Disability case load and trend data
  - SHIP

Briefly Describe the Planning Process Thus Far

- Building the culture and working relationships needed for a true regional partnership to function – working together to first align multiple hospitals and build trust, then community partner expansion
- Identifying fundamental aspects of shared work, overlap and efficiencies
- Creating organizational committee structures for planning process and for long-term

List of Decisions Made Related to Delivery and Financing Model

- Create strategy for physician engagement in first phase and implementation of physician alignment through initiatives and incentives
- Need marketing plan for care management model to patients
- Clear method to track saving generated and use part for sustainable program funding
- Identification of vendors for care coordination or build yourself and use of CCM process and payment- understanding the relationships and connectivity

What Gaps/Barriers Have Been Identified, if Any

- Sharing patient level data across hospitals and other partners
  - Compliance with HIPPA, creating DUAs, BAAs
  - Access and timeliness of data
  - Obtaining data from non-hospital partners
- Timeline for building new partnerships and resources needed to ensure effective collaboration and completion of plans due
- Ability to achieve financial and practice alignment across partners, especially with PCP and other physicians

Next Steps – RPs Plans for Implementation

- Explore and formalize governance structures
  - Include and expand coalition to new partners
- Develop and implement operational plans addressing staff resources and needed infrastructure
- Modify existing care management models in place or secure care management vendors
- Seek additional revenue and funding streams that will support RP and service lines
- Future plans for RPs to engage:
  - Patients and family care-givers
  - Additional community physicians and county social service agencies

Next Steps – Ongoing Technical Assistance

- Routine communications, ongoing guidance and technical assistance continues to be offered for the regional partnerships as needed.
- Five more topic specific webinars coming over the next few months. Upcoming webinar schedule:
  - Consumer Education and Outreach: September 10
  - Behavioral Health Integration Models: September 24
  - Physician Alignment: October 8
  - October 22 and November 12: Topics TBD
- The last Learning Collaborative is scheduled for Nov. 5.

Appendix: Additional Detail from Interim Reports

Additional Detail from Interim Reports

Key Stakeholders/ Community Partners

- The Coordinating Center
- Provider Groups – EMS, Assisted Living Facilities, SNFs, CHCs/FQHCs, Community physicians, home health care, behavioral health
- County Service and Transit
- Partnership for Children, Youth, and Families
- CBOs – Esperanza Center, Health Care for the Homeless, Sisters Together Reaching
- NGO/Faith-based organizations

Additional Detail from Interim Reports

Progress and Decisions Made Thus Far for Planning

- Understanding and working with CRISP on areas to help with data and tools
- Identifying overlap of provision of services and efficiencies
- Building trust and expanding coalition
- Defined clear scope of work and SMART goals
- Decision on structural governance needed
- Changes in interventions and approach based on realizations of shared patients across hospitals and need for collaboration
- Best practices and spread models identified
- CRISP as the engine for new levels of communication
- Data and incorporating social determinants of health
- Physician focus groups to test interventions
- More clearly defined target high utilizer population

List of Decisions Made Related to Delivery and Financing Model

- Development of transition and chronic disease clinic
- Care management bonus based on enrolling and follow-up management of patients and ultimately outcomes (reducing readmissions)
- Engage ED and community-based physicians to decrease PAUs
- Expanded use of CRISP
- Use of CCM code/fee and creating the infrastructure to perform
- Use of Behavioral health as part of care management strategy

Additional Detail from Interim Reports

What Gaps/Barriers Have Been Identified, if Any

- Physician engagement – PCP, ED physicians and specialty providers
- Data capabilities
  - Alignment with and across EMRs
  - Risk assessment and care plans
  - Identification of providers working with specific patients
- Lack of coordination and leveraging of existing care management/coordination across partners
- Timeframe challenging particularly in light of evolving information and data capabilities

Plans for Implementation

- Continue regular meeting schedule in place during planning process to review cases, metrics, report cards and identify opportunities for expansion across partners
- Focus on provider and physician engagement
- Invest in behavioral health expansion and capacity
- Seek consultation and TA as needed
- Continue to identify and problem-solve regarding gaps and barriers
- Standardize processes and workflows across partners
- Maintain current decision making advisory committee structures in place
  - Include any new partners identified in existing structures

Monitoring Maryland Performance

Financial Data

Year to Date thru July 2015

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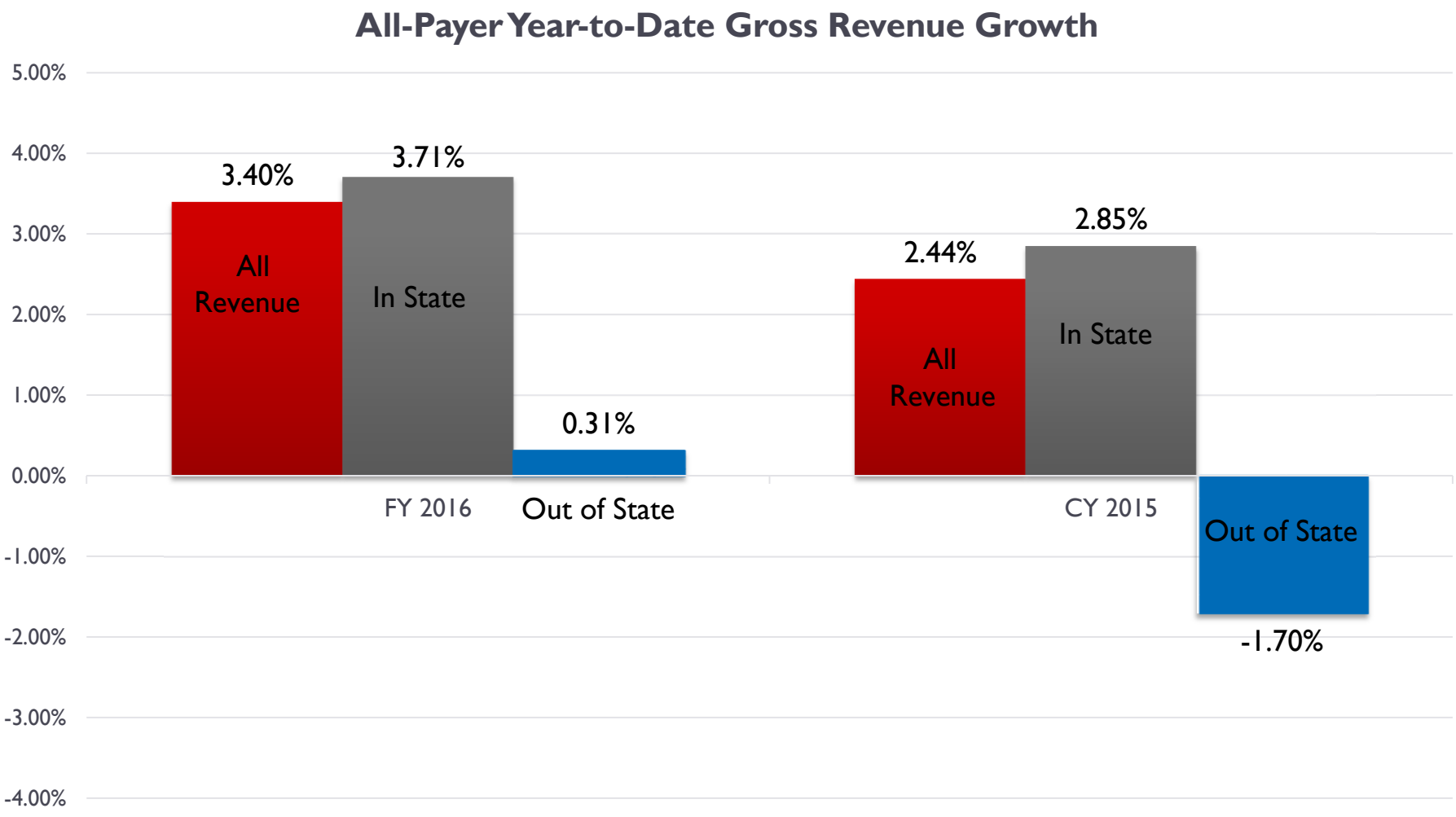
Gross All Payer Revenue Growth

Year to Date (thru July 2015) Compared to Same Period in Prior Year



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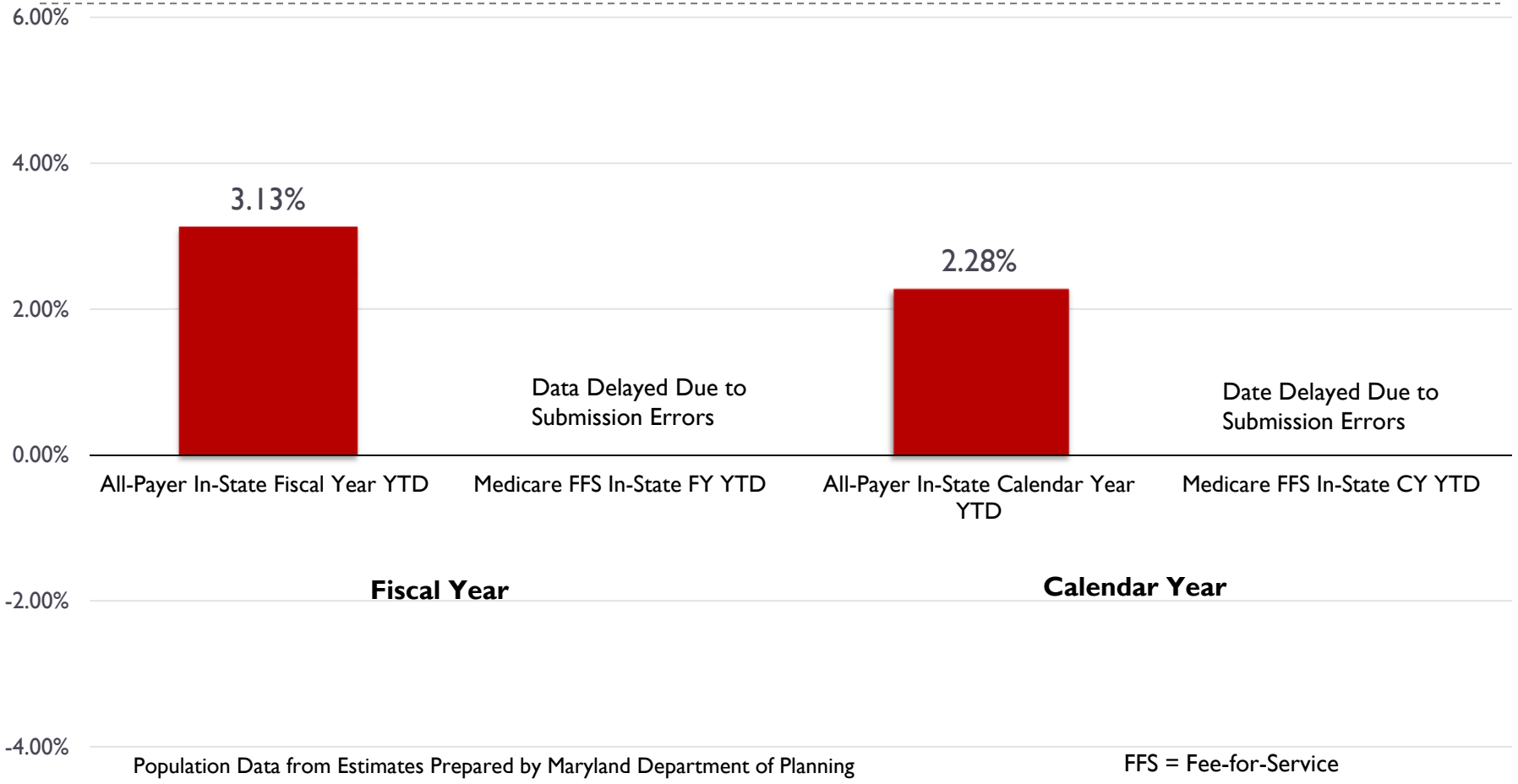
Per Capita Growth Rates
Fiscal Year 2016 and Calendar Year 2015



- **Calendar and Fiscal Year trends to date are below All-Payer Model Guardrail for per capita growth.**

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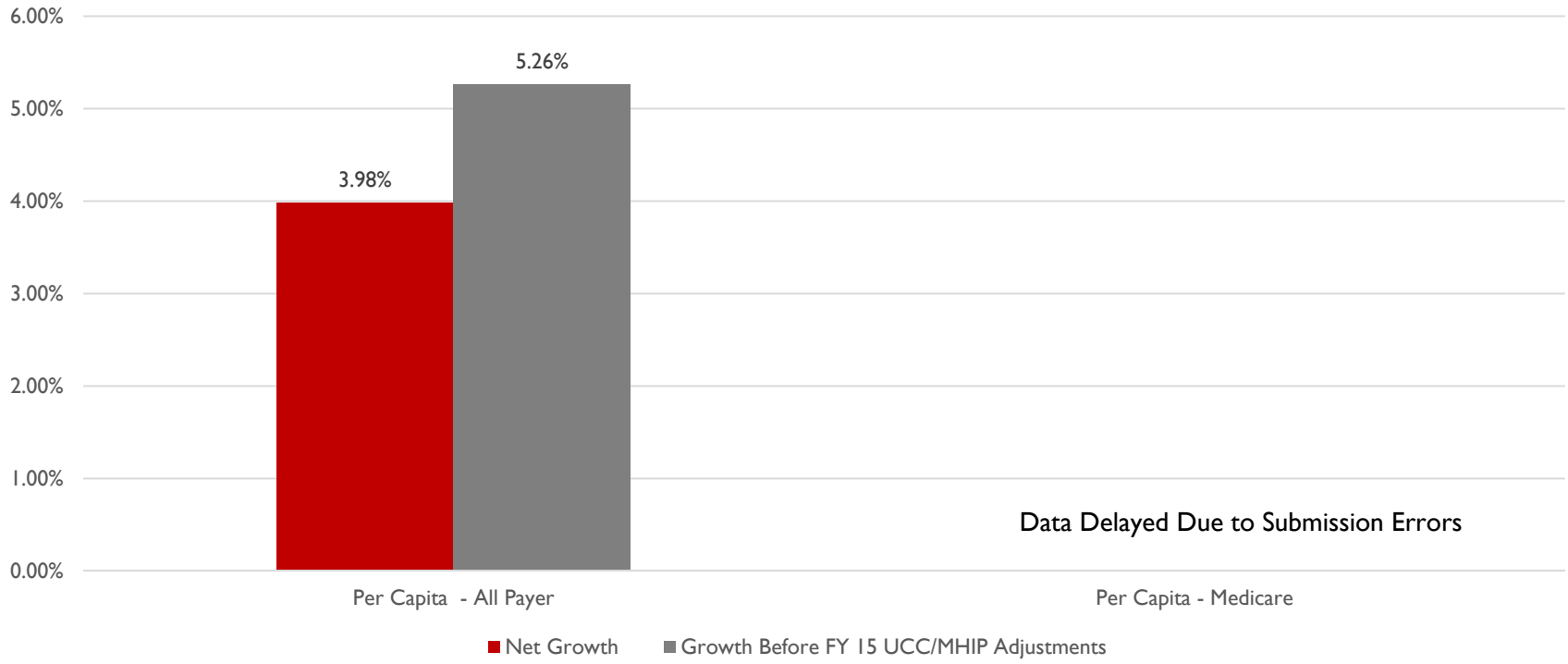
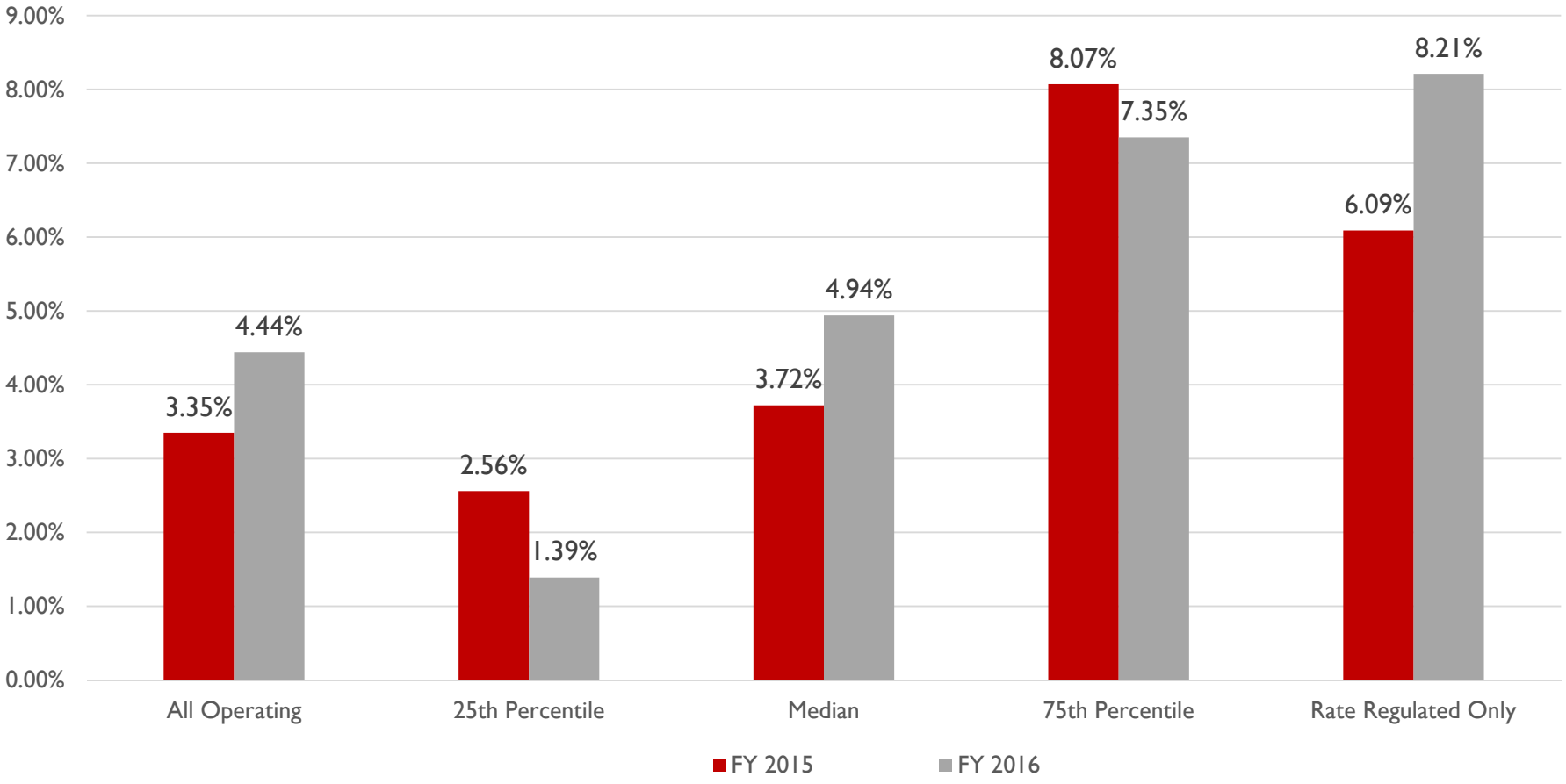
Per Capita Growth – Actual and Underlying Growth

CY 2015 Year to Date Compared to Same Period in Base Year (2013)



- Two year per capita growth rate is well below maximum allowable growth rate of 7.29% (growth of 3.58% per year)
- Underlying growth reflects adjustment for FY 15 & FY 16 revenue decreases that were budget neutral for hospitals. 1.09% revenue decrease offset by reduction in MHIP assessment and hospital bad debts in FY 15. Additional 1.41% adjustment in FY 16 due to further reductions to hospital bad debts and elimination of MHIP assessment.

Operating Profits: Fiscal 2016 Year to Date (July) Compared to Same Period in FY 2015



- Year to date FY 2016 unaudited hospital operating profits improved compared to the same period in FY 2015.

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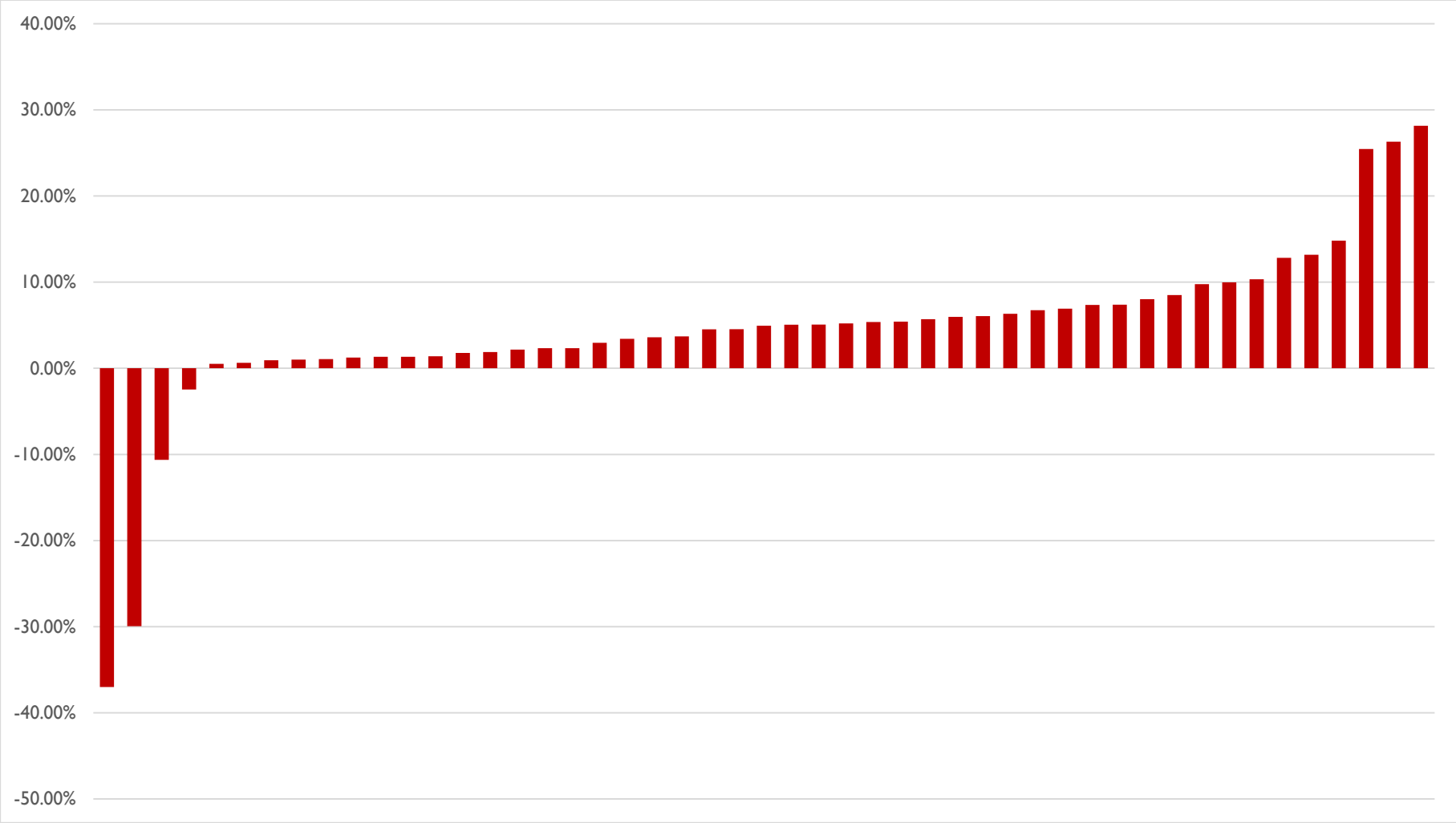
Operating Profits by Hospital

Fiscal 2016 Year to Date (July)



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Purpose of Monitoring Maryland Performance

Evaluate Maryland's performance against All-Payer Model requirements:

- **All-Payer total hospital per capita revenue growth ceiling** for Maryland residents tied to long term state economic growth (GSP) per capita
  - 3.58% annual growth rate
- **Medicare payment savings** for Maryland beneficiaries compared to dynamic national trend. Minimum of $330 million in savings over 5 years
- **Patient and population centered-measures** and targets to promote population health improvement
  - Medicare readmission reductions to national average
  - 30% reduction in preventable conditions under Maryland's Hospital Acquired Condition program (MHAC) over a 5 year period
  - Many other quality improvement targets

Data Caveats

- Data revisions are expected.
- For financial data if residency is unknown, hospitals report this as a Maryland resident. As more data becomes available, there may be shifts from Maryland to out-of-state.
- Many hospitals are converting revenue systems along with implementation of Electronic Health Records. This may cause some instability in the accuracy of reported data. As a result, HSCRC staff will monitor total revenue as well as the split of in state and out of state revenues.
- All-payer per capita calculations for Calendar Year 2015 and Fiscal 2016 rely on Maryland Department of Planning projections of population growth of .56% for FY 16 and .56% for CY 15. Medicare per capita calculations use actual trends in Maryland Medicare beneficiary counts as reported monthly to the HSCRC by CMMI.

Monitoring Maryland Performance
Preliminary Utilization Analytics

FY2013-FY2015

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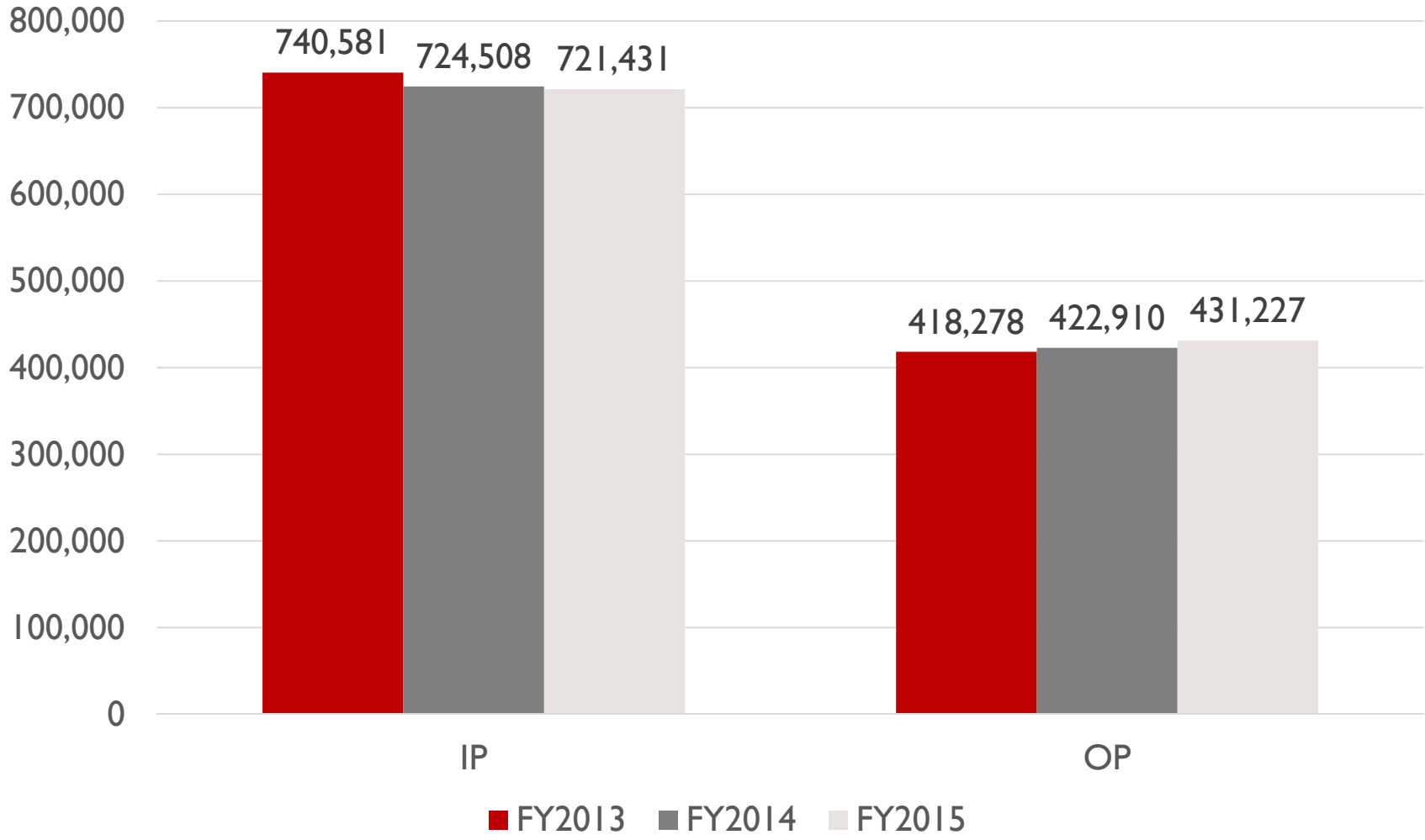
Utilization Analytics

- Utilization as measured by Equivalent Case-mix Adjusted Discharges (ECMAD)
  - 1 ECMAD Inpatient discharge=1 ECMAD Outpatient Visit
- Observation stays with more than 23 hour are included in the inpatient counts
  - IP=IP + Observation cases >23 hrs.
  - OP=OP - Observation cases >23 hrs.
- Preliminary data, not yet reconciled with financial data
- Careful review of outpatient service line trends is needed
- Tableau Visualization Tools

All-Payer Inpatient(IP) and Outpatient (OP) ECMAD Trend



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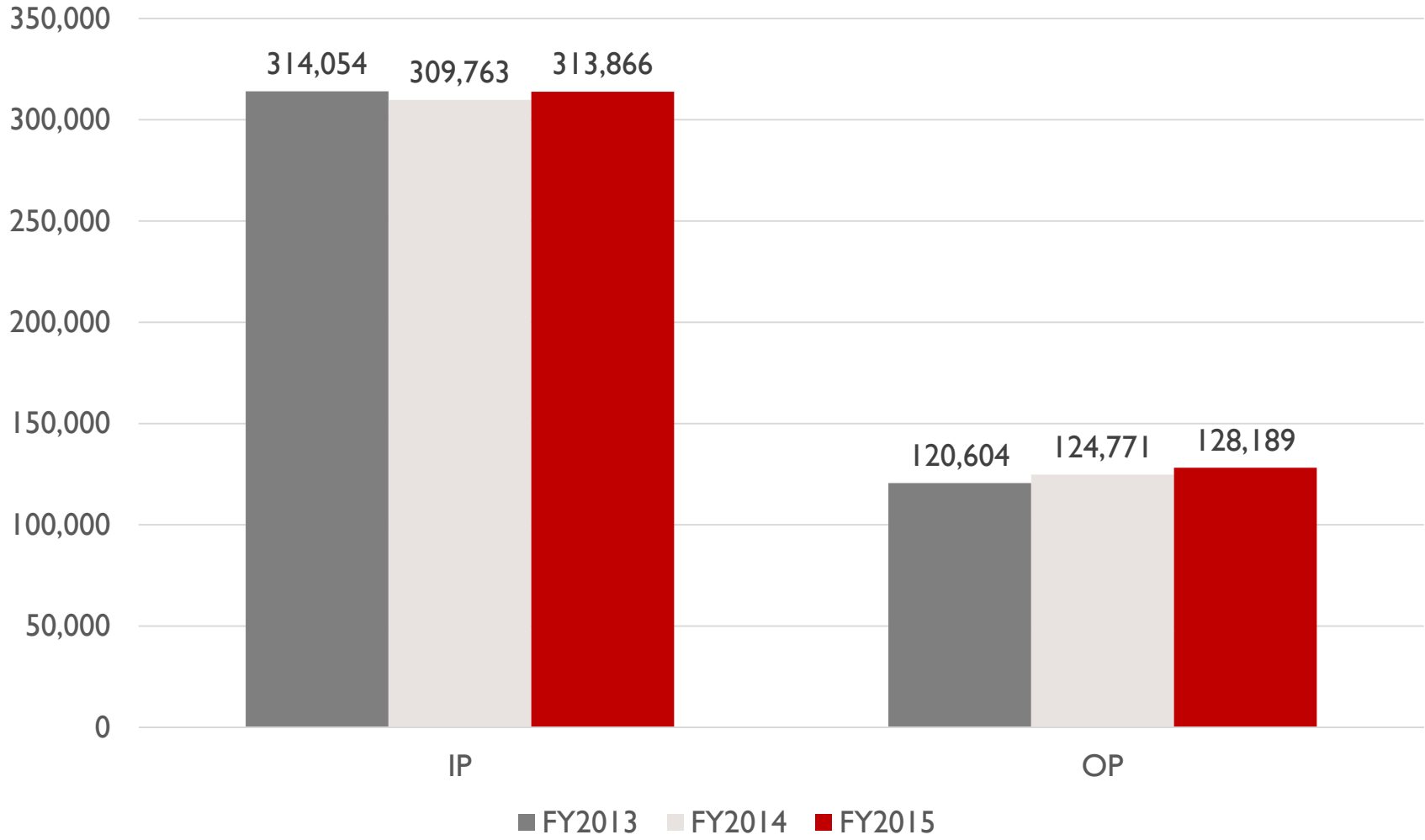
Medicare All-Payer Inpatient(IP) and Outpatient (OP) ECMAD Trend



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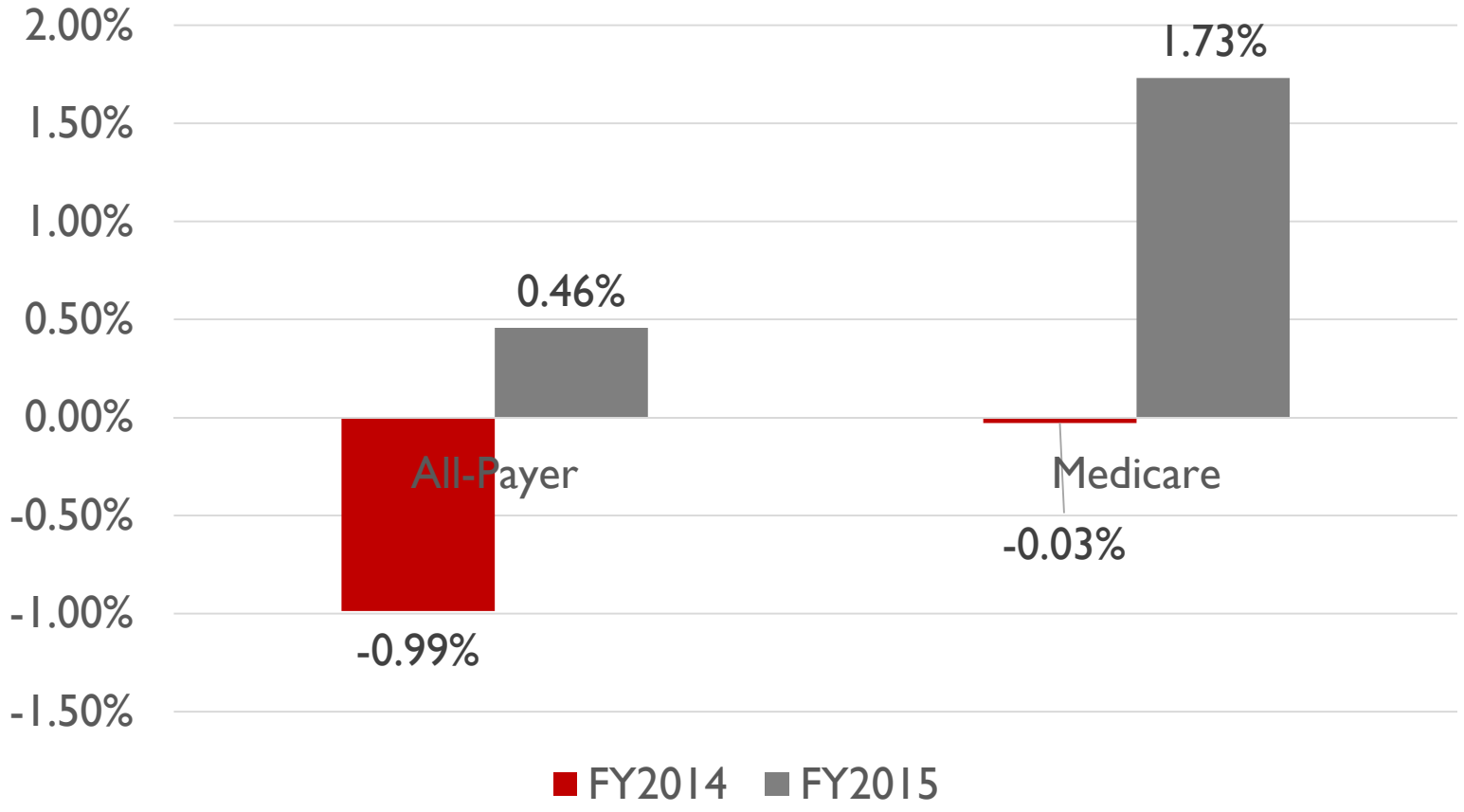
Annual Percent Growth Rate-Total ECMAD



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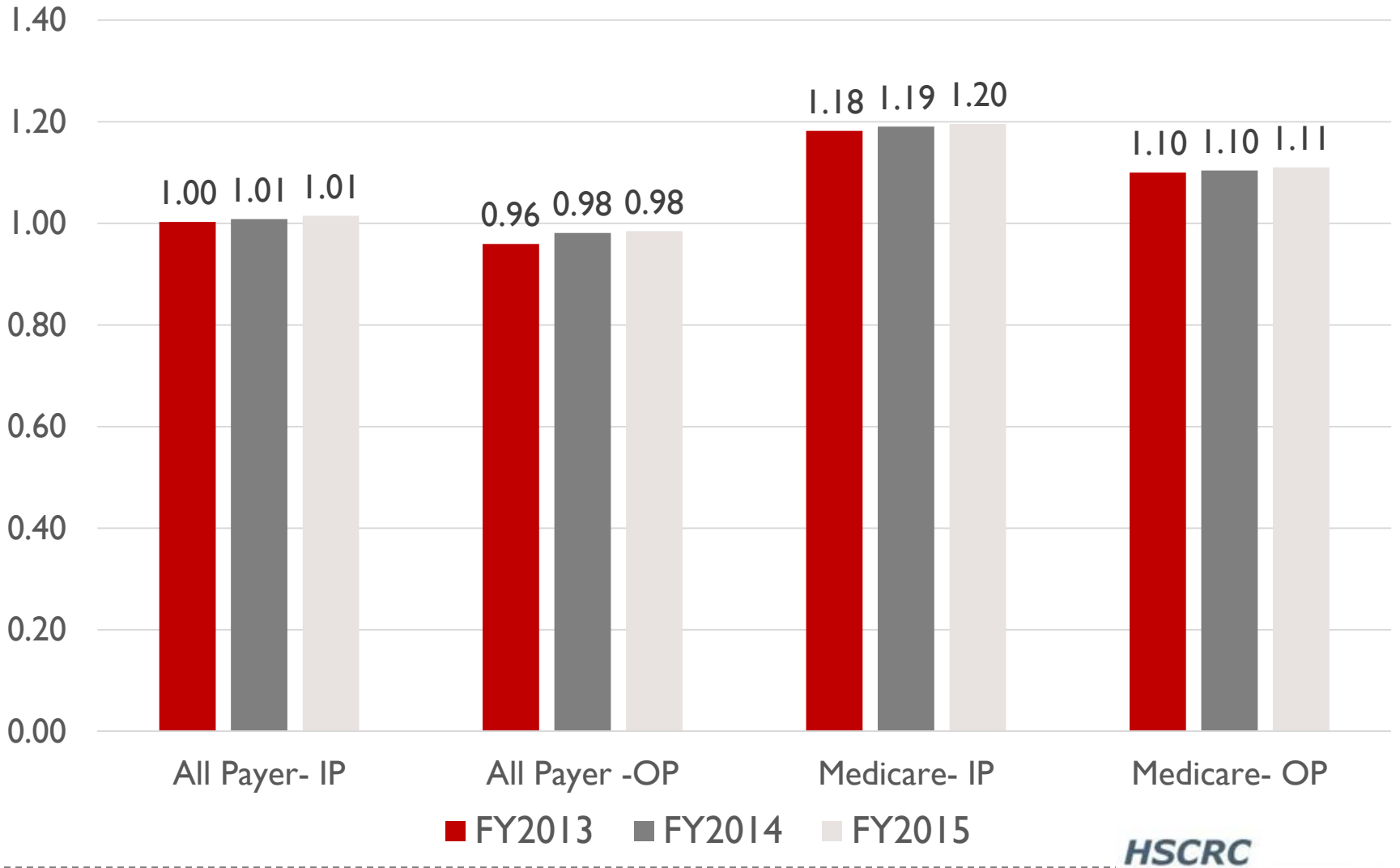
Case-mix Index Trends by Payer



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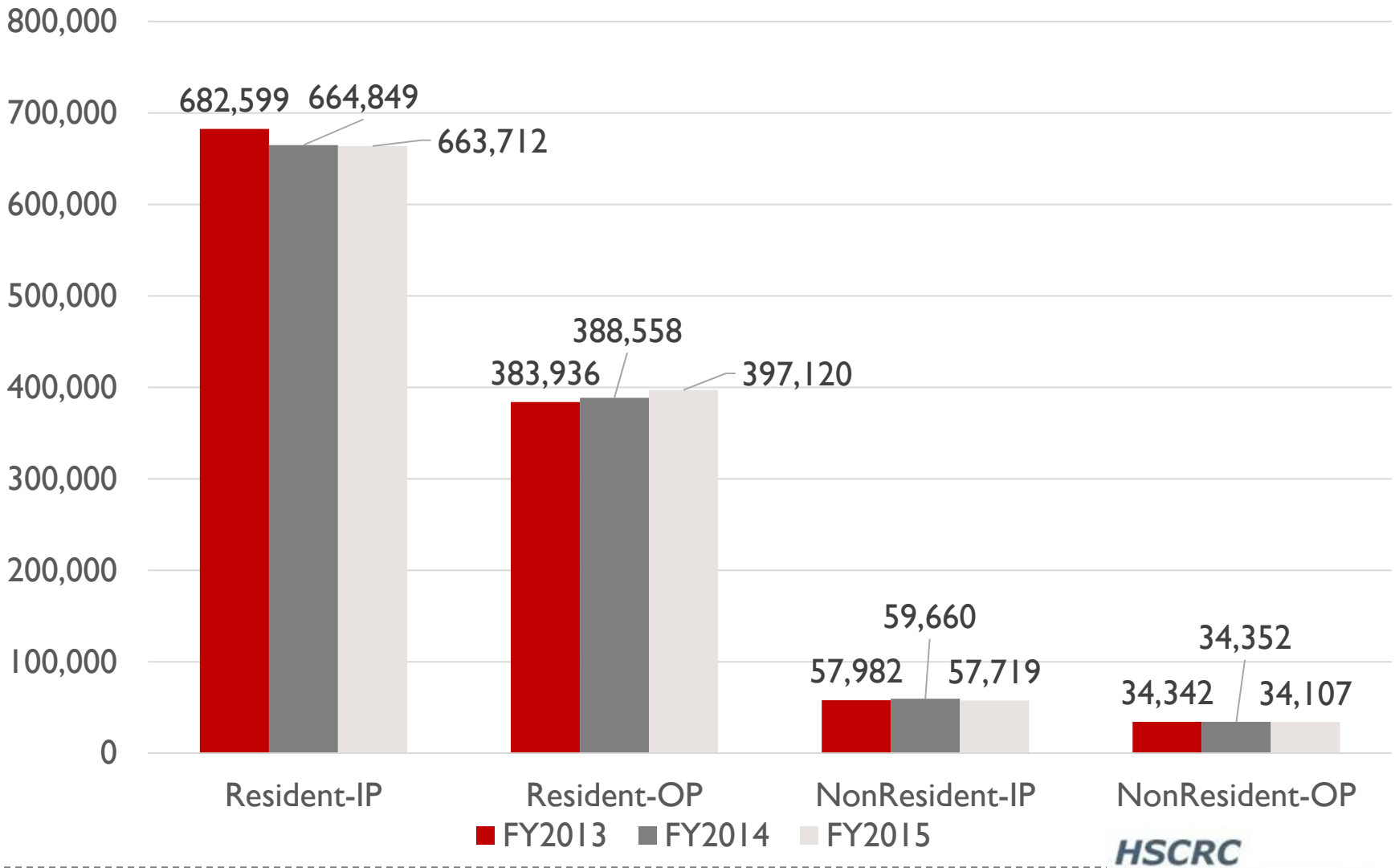
All-Payer ECMAD Trends by Resident Status



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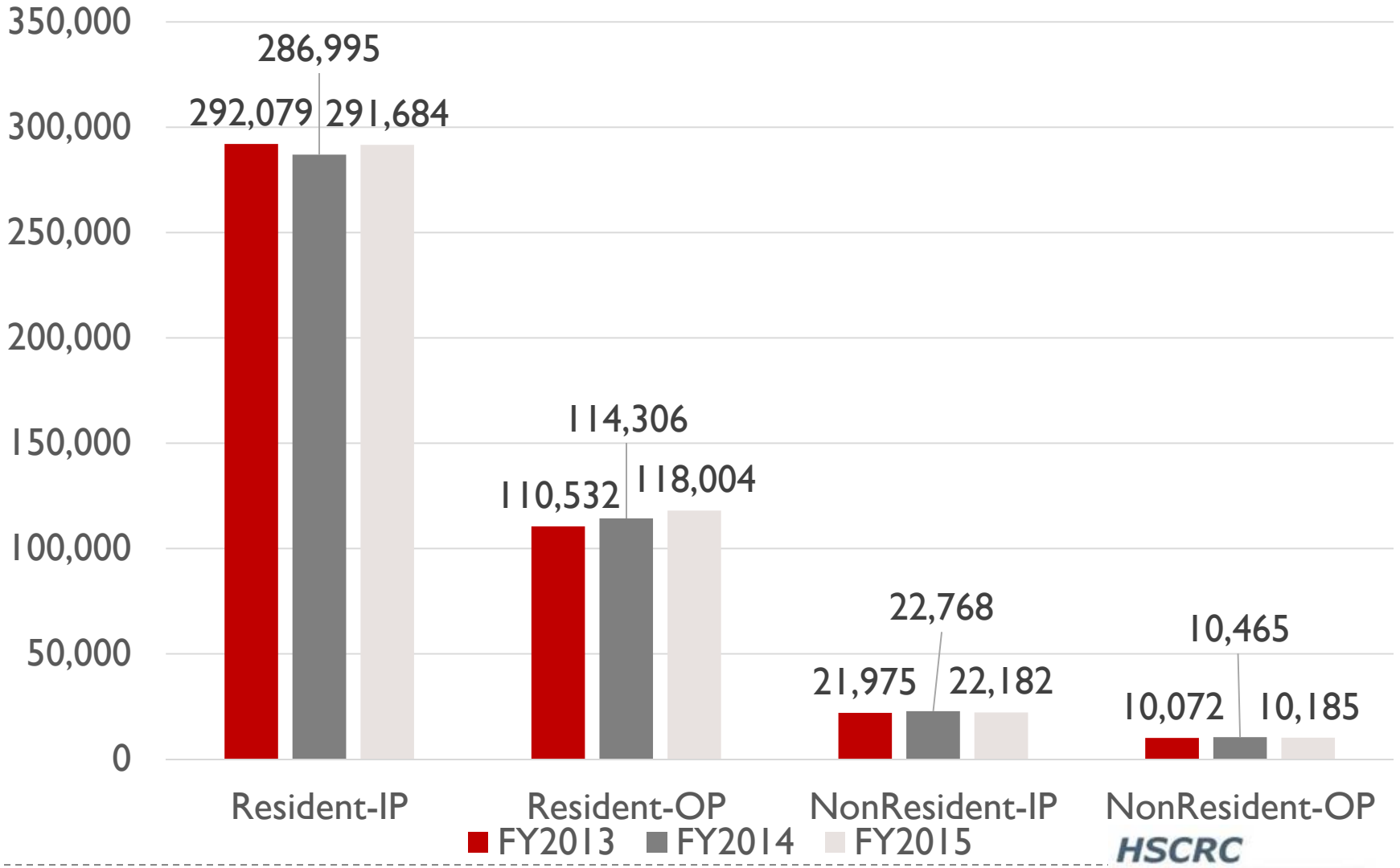
Medicare ECMAD Trends by Resident Status



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Service Line Definitions

- Inpatient service lines:
  - APR DRG to service line mapping
  - Readmissions and PQIs are top level service lines (include different service lines)
- Outpatient service lines:
  - Highest EAPG to service line mapping
  - Hierarchical classifications (ED, major surgery etc)
- Market Shift technical documentation

All Payer MD Resident Inpatient Service Line Distribution

Rank	Service Line	FY2015 ECMAD	% Total ECMAD
1	Readmission	90,377	8%
2	Orthopedic Surgery	89,403	8%
3	General Surgery	55,793	5%
4	PQI	51,112	4%
5	Obstetrics/Delivery	43,783	4%
6	Infectious Disease	36,593	3%
7	Gastroenterology	31,628	3%
8	Neurology	24,922	2%
9	Pulmonary	24,192	2%
10	Cardiothoracic Surgery	21,311	2%
11	Cardiology	18,642	2%
12	Psychiatry_IP	18,150	2%
13	Neonatology	16,908	1%
14	Ventilator Support	14,918	1%
15	Invasive Cardiology	14,015	1%
16	Categorical Exclusions_IP	13,263	1%
17	Neurological Surgery	11,655	1%
18	Rehabilitation	11,176	1%
19	Oncology_IP	11,101	1%
20	Newborn	9,607	1%

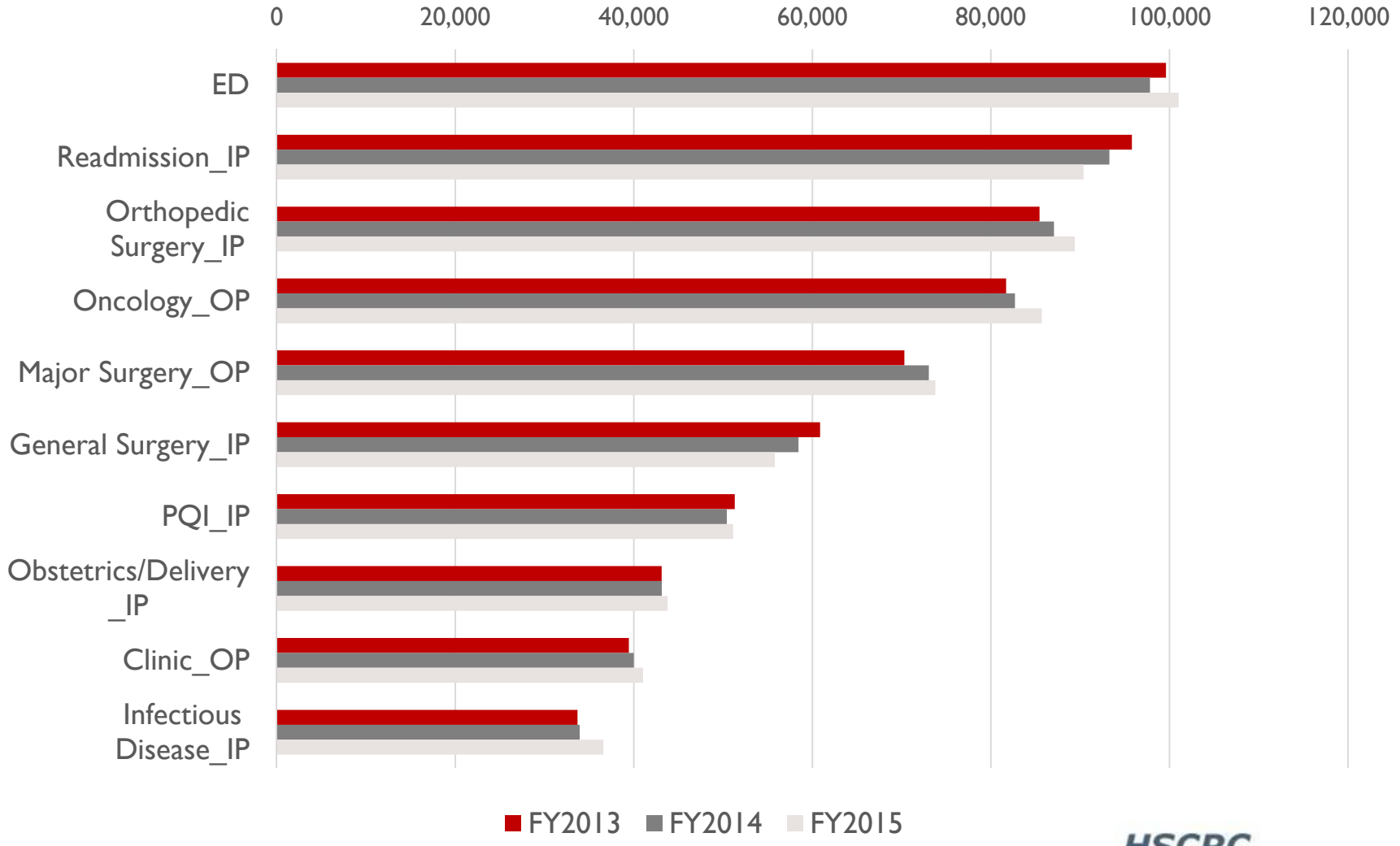
Inpatient Service Lines-Continued

Rank	Service Line	FY2015 ECMAD	% Total ECMAD
21	Vascular Surgery	9,492	1%
22	Nephrology	9,075	1%
23	General Medicine	9,050	1%
24	Spinal Surgery	8,967	1%
25	Urological Surgery	6,632	1%
26	Gynecological Surgery	5,664	0%
27	Hematology	5,606	0%
28	Endocrinology Surgery	5,417	0%
29	Thoracic Surgery	5,242	0%
30	Trauma	5,218	0%
31	Orthopedics	5,013	0%
32	Endocrinology	4,360	0%
33	Myocardial Infarction	3,713	0%
34	Rheumatology	3,647	0%
35	EP/Chronic Rhythm Mgmt	3,434	0%
36	Substance Abuse	3,296	0%
37	Otolaryngology	3,234	0%
38	ENT Surgery	3,177	0%
39	HIV	2,385	0%
40	Other Obstetrics	2,180	0%
41	Injuries/complic. of prior care	2,046	0%
42	Dermatology	1,934	0%
43	Urology	1,513	0%
44	Gynecology	725	0%
45	Unassigned_IP	493	0%
46	Dental	427	0%
47	Diabetes	402	0%
48	Ophthalmology	381	0%
49	Ophthalmologic Surg	148	0%

All Payer MD Resident Outpatient Service Line Distribution

Rank	Service Line	FY2015 ECMAD	% Total ECMAD
1	ED	101,018	9%
2	Rad/Inf/Chemo	85,694	7%
3	Major Surgery	73,774	6%
4	Clinic	41,033	4%
5	Cardiovascular	27,943	2%
6	Radiology	26,419	2%
7	Minor Surgery	24,473	2%
8	Other	13,884	1%
9	CT/MRI/PET	10,894	1%
10	Psychiatry	8,637	1%
11	Rehab & Therapy	7,835	1%
12	Lab	4,806	0%
13	Drugs	2,228	0%
14	Unassigned	1,522	0%
15	Pathology	1,067	0%

All-Payer MD Resident Largest 10 Service Line Trends



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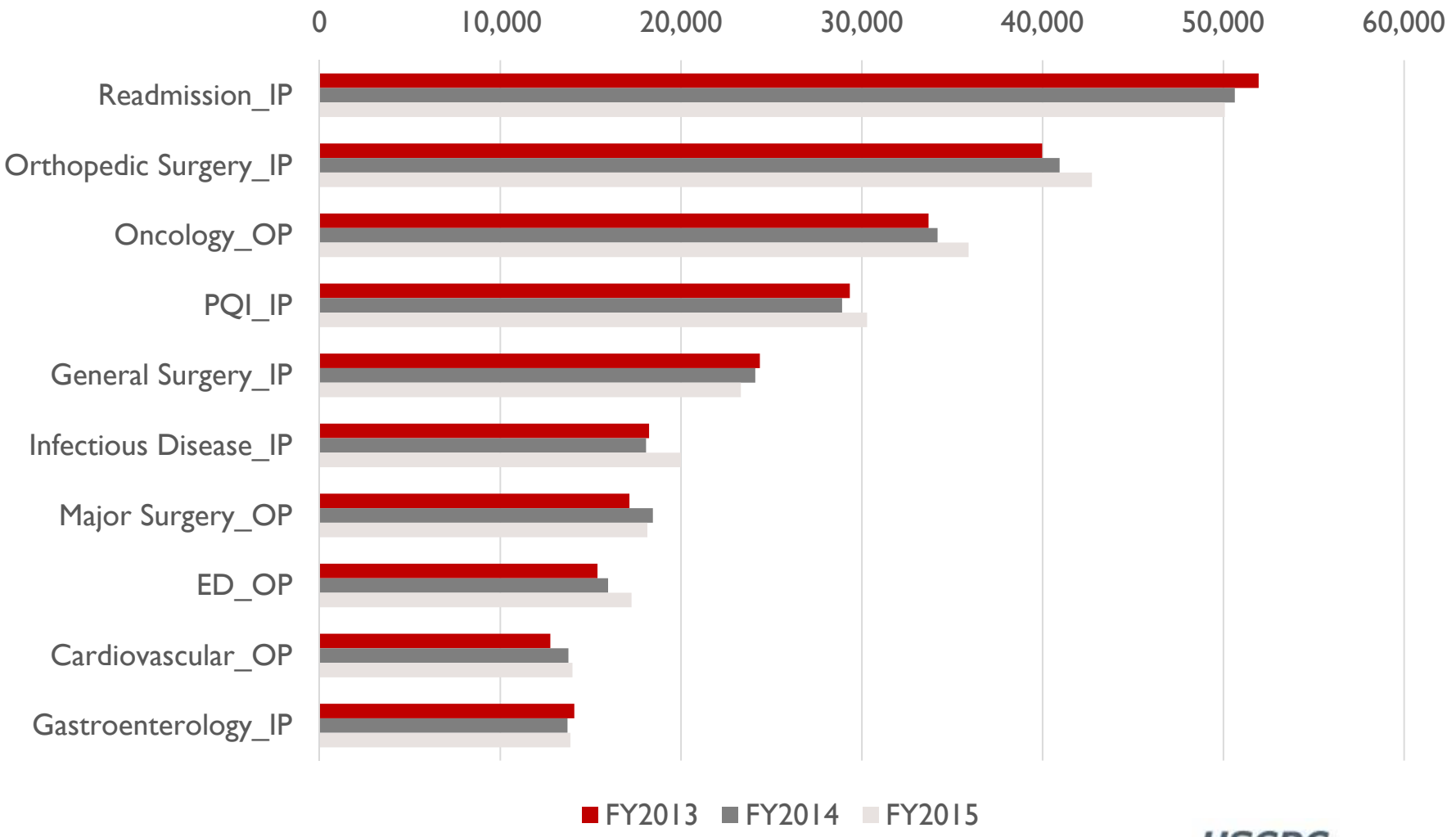
Medicare MD Resident Largest 10 Service Line Trends



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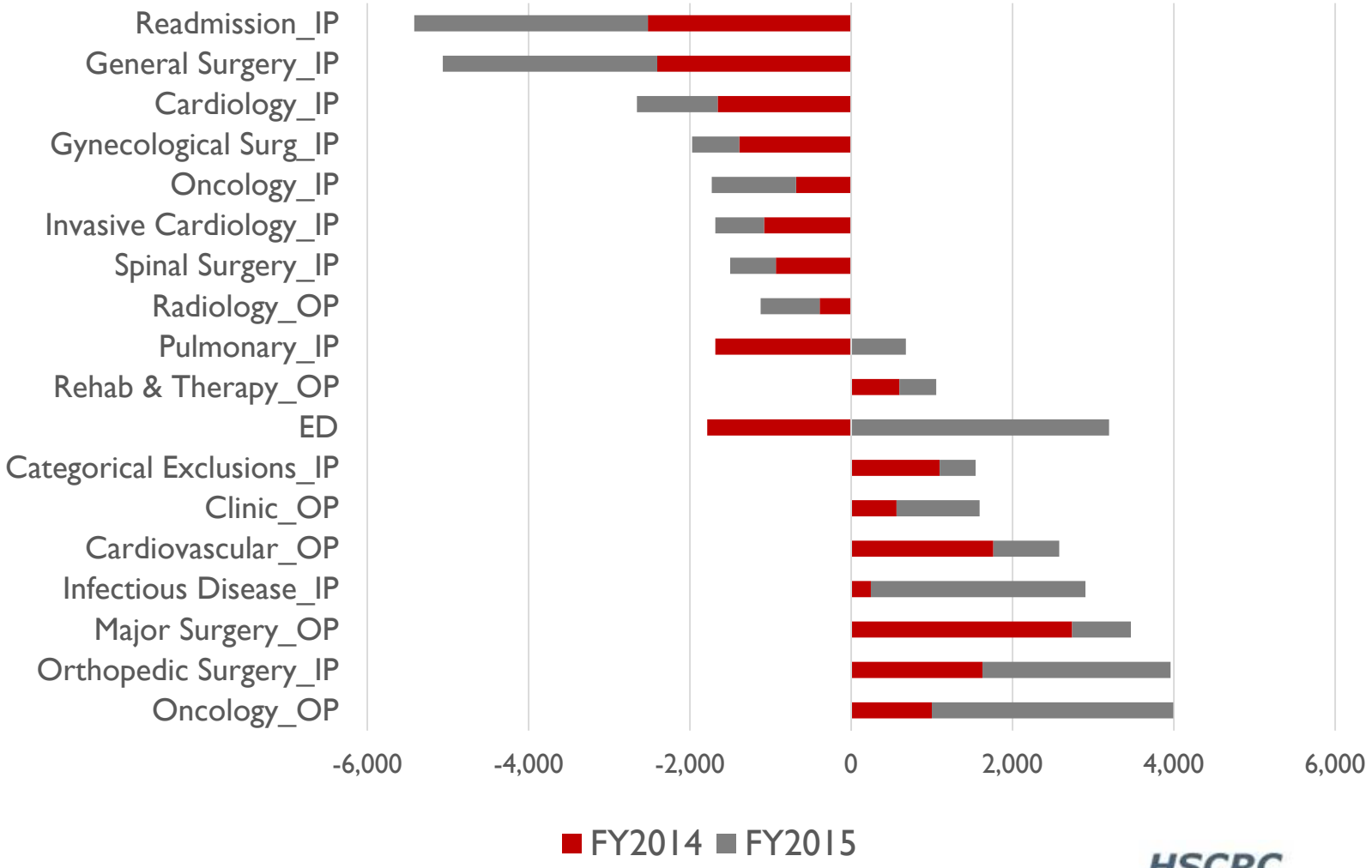
All-Payer MD Resident Service Lines with Largest Net Changes FY15 vs FY13



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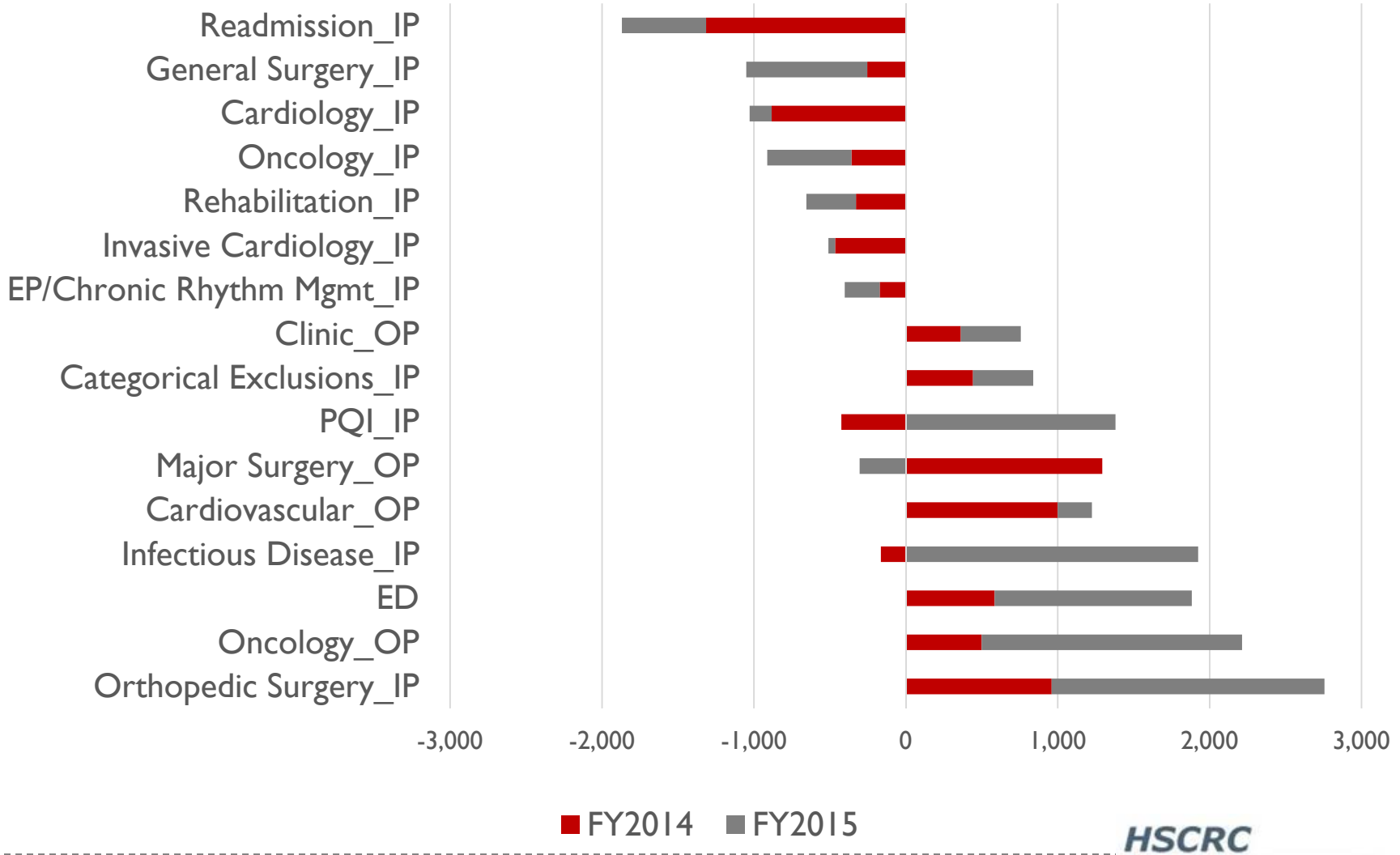
Medicare MD Resident Service Lines with Largest Net Changes FY15 vs FY13



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Partial Rate Application for Capital

September 9, 2015

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Partial Rate Application for Capital

- **What it does:**
  - Allows a hospital that is undertaking a major capital project to request an increase to rates to finance a portion of the project

- **Who is eligible?**
  - Any hospital that has filed a Certificate of Need (CON) request with the Maryland Health Care Commission (MHCC)
    - The project must be a major renovation or relocation, defined as having a total project cost that is at least 50% of the hospital's total approved revenue for the year

Partial Rate Application for Capital

- **Why is it allowed?**
  - As part of the CON process, the HSCRC must comment on the financial feasibility of the project
    - The feasibility may be dependent on the HSCRC's approval of rate increases at the time of the project's completion
    - Allows HSCRC to review and approve future increases so that the feasibility may be better estimated

Partial Rate Application for Capital

- **What is used?**
  - Blended Reasonableness of Charges (ROC) Methodology, adopted June 2010, with modifications
    - Incorporates outpatient charge per visit (CPV) with inpatient charge per case
    - Hospitals are divided into peer groups:
      - Urban
      - Non-urban teaching hospitals
      - Suburban and rural non-teaching hospitals
      - Special Hopkins & University Group

Partial Rate Application for Capital

- **Adjustments included in the Modified ROC:**
  - Compares the hospital with its peer group standard, comprehensive charge target (CCT) adjusted for the following:
    - **Mark-up**: Commission approved markups over costs that reflect the payer differential and uncompensated care built into each hospital's rate structure
    - **Direct Strips** (Direct Medical Education, Nurse Education, and Trauma): Remove partial costs of resident salaries, nurse education costs and incremental costs of trauma services of hospitals with trauma centers
    - **Labor Market**: Adjustment for differing labor costs in various markets
    - **Case Mix**: Adjustment accounts for differences in average patient acuity across hospitals
    - **Capital**: Costs for a hospital are partially recognized
    - **Indirect Medical Education**: Adjustment for inefficiencies and unmeasured patient acuity associated with teaching programs
    - **Disproportionate Share**: Adjustment for differences in hospital costs for treating relatively high number of poor and indigent patients

Partial Rate Application for Capital

- **Normal adjustments to convert to the Inter-hospital Cost Comparison (ICC)**
  - Remove regulated profit percent
  - Remove additional 2% productivity adjustment (not done as part of the Partial Rate Application for Capital)
  - Peer group average becomes the standard

Partial Rate Application for Capital

- **Adjustments to the standard**
  - Same as those made for each hospital when developing standards
    - Disproportionate Share
    - Indirect Medical Education
    - Capital
    - Case Mix
    - Labor Market
    - Direct Strips
    - Mark-Ups

Partial Rate Application for Capital

- If the adjusted standard is **less than** the current approved:
  - The percentage difference is offset to the future capital adjustment

- If adjusted standard is **more than** the current approved:
  - No additional amount is added to the calculation of future capital adjustment

Partial Rate Application for Capital

- **Future adjustment allowed for capital:**
  - 50% of the hospital's depreciation and interest (D&I) as a percentage of total cost (after addition of project D&I)
  - 50% of the peer group's average depreciation and interest as a percentage of total cost

Partial Rate Application for Capital

- **Example:**

	D&I	Total Cost	% D&I
Hospital's current depreciation and interest	$7,000,000	$100,000,000	7.00%
Hospital's project depreciation and interest	$6,000,000	$6,000,000	
	$13,000,000	$106,000,000	12.26%
Peer group depreciation and interest as a percentage of total cost			9%

Allowed % for Capital	50%	x	12.26%	=	6.13%
	50%	x	9.00%	=	4.50%
					10.63%

Partial Rate Application for Capital

- **Example:** Final adjustment
  - Allowed Capital % 10.63%
  - Current Capital % - 7.00%
    - Difference 3.63%
  - Adjustment from ICC (minus only) 0%
  - Final Capital % 3.63%

  - Approved revenue for current period $115,000,000
  - Additional capital adjustment $4,174,500

This amount will be added to rates when the project is completed and the hospital begins to record additional depreciation and interest

Future Issues

- Volume Growth
  - Previously reimbursed actual volume growth at 85% Variable Cost Factor (VCF)
  - Current policy only provides 50% VCF on market shift and population/demographic growth

- Other Avenues for Financing Major Capital Projects
  - Cash from operations (prior, future)
  - Philanthropy
  - Sale of bonds- how much and how do we finance?

Future Issues

- Efficiency of Prices
  - Previous ROC and ICC adjusted for only differences in prices, which were considered reasonable or necessary to compare one hospital to another

- Efficiency Bands Around Prices, which should consider:
  - Quality measures
  - Per capita efficiency levels
  - Potentially Avoidable Utilization

Maryland Health Services Cost Review Commission

Market Shift Adjustments Update
09/09/2015

Market Shift Adjustments

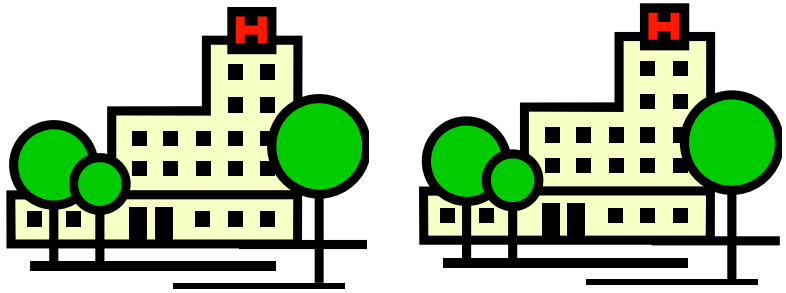
- Market shift adjustment should not undermine the incentives to reduce avoidable utilization

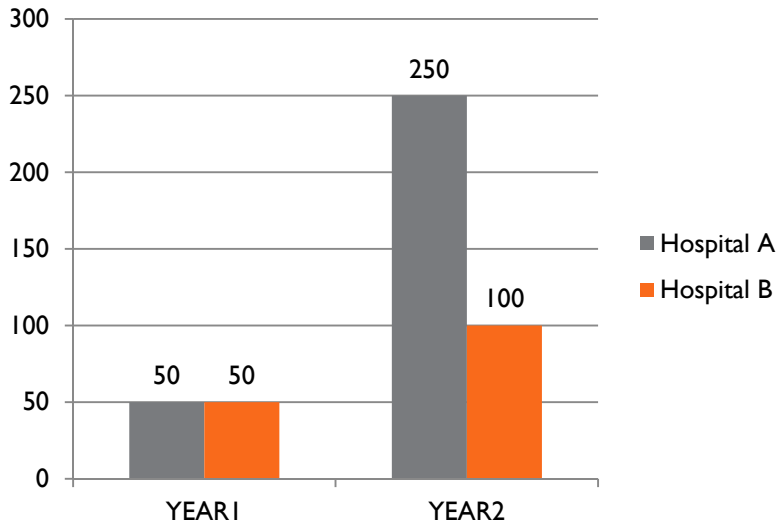
- Market shift adjustment should provide necessary resources for services shifted to another hospital

- Calculations are based on
  - 66 inpatient and outpatient service lines
  - Zip codes and county level
  - Excludes Potentially Avoidable Utilization (Readmissions and PQIs*)
  - Hospital service line average charge per ECMAD**
  - 50% variable cost factor applied

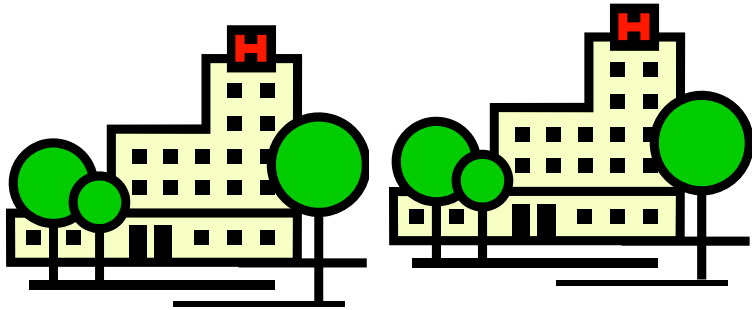
*AHRQ Prevention Quality Indicators
**Equivalent CaseMix Adjusted Discharges

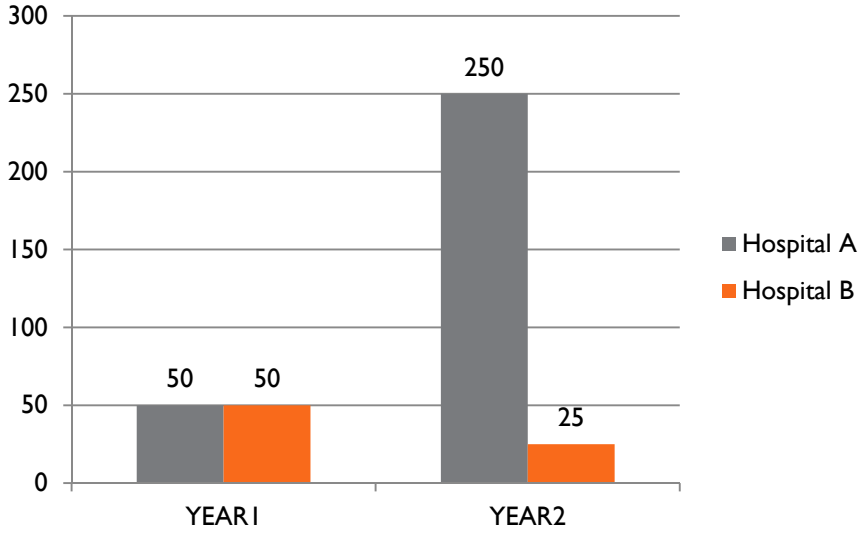
Market Share vs. Market Shift





Market Shift Adjustment=0





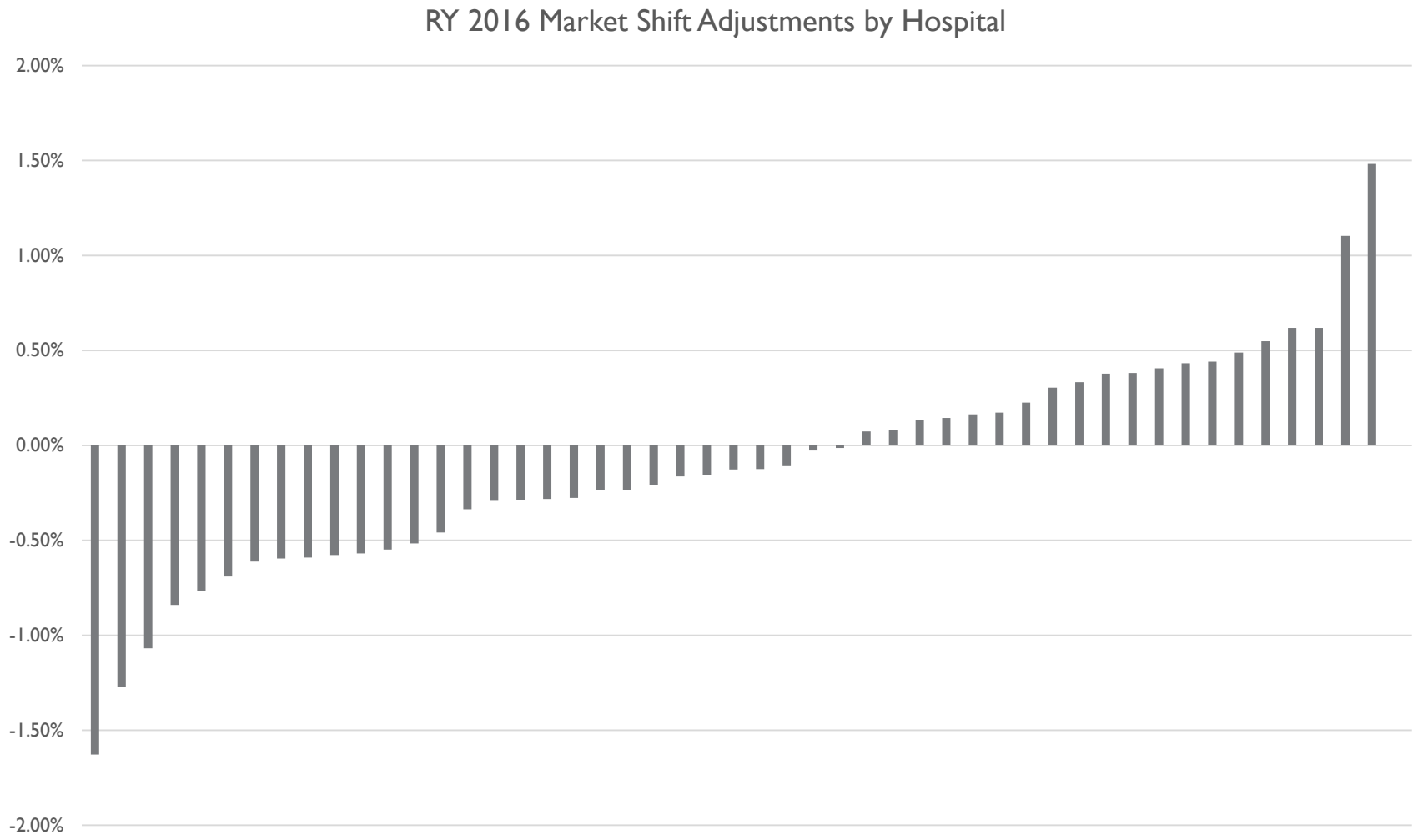
Market Shift Adjustment=25

RY 2016 Statewide Impact*

Statewide Impact	FY 16 Market Shift Adjustment Results
A	B
Grand Net Total	**$756,341**
Positive Adjustment Total	$27,741,411
Negative Adjustment Total	-$28,497,752
Absolute Adjustment Total	$56,239,163

*excludes oncology/radiation therapy/infusion service line and other manual adjustments

RY 2016 Hospital Level Impact as % of Revenue



Technical Report and Reference Materials

http://www.hscrc.state.md.us/gbr-adjustments.cfm

Infusion/Chemotherapy/Radiation Therapy

- Consolidated billing creates a challenge to measure unit of service
- HSCRC staff aggregated records for the same patients at a single hospital into a single measurement unit
- Assignment of highest EAPG* and weights are under review

*3M Enhanced Ambulatory Patient Grouping System

Health Jobs Opportunity Program

Health Services Cost Review Commission

September 9, 2015

Maryland Hospital Association

Health Jobs Opportunity Program

- What is being proposed?
- Why it is needed?
- How it is funded?

Health Jobs Opportunity Program

What is it?

- Up to 1,000 hospital based jobs
- Targeted at high unemployment and poverty zip codes in Baltimore City and throughout state
- Entry level positions with opportunity for advancement
- Includes support services and job readiness training

Health Jobs Opportunity Program

Why is it needed?

- Recent civil unrest in Baltimore City highlighted the sense of hopelessness in disadvantaged communities based on lack of employment opportunities
- Poverty contributes to poor health; improving the economic stability of certain communities will improve the health of the population hospitals serve

Health Jobs Opportunity Program

Role of the hospitals

- Hospitals are the largest private sector employers in the Baltimore City and in many counties throughout the state
- Hospitals are capable of large scale hiring, particularly for entry level positions; hope that other major employers will follow our lead
- Hospitals will serve as model for other industries

Health Jobs Opportunity Program

Targeted Hospital Workforce Development

- Community Health Workers
- Certified Application Counselors
- Peer Recovery Support Specialists

Health Jobs Opportunity Program

Applications must:

- Demonstrate that additional positions are needed and are incremental
- Detail a plan to recruit employees from designated high poverty and unemployment zip codes
- Include proposed competitive wages, benefits and education and enrichment opportunities
- Describe existing or planned programs for employees to improve work skills
- Describe the role new positions will play in meeting goals of the waiver
- Detail job readiness and skills training necessary to prepare individuals for successful employment
- Detail employee retention strategies
- Other requirements to be developed by HSCRC staff

Health Jobs Opportunity Program

Funding

- Capped at 0.25% of statewide revenue ($40m)
- HSCRC develops criteria for proposals
- Hospitals voluntarily submit application to HSCRC
- Our view: Awarded funds will be collected by hospital through permanent rate increases

Health Services Cost Review Commission

Consumer Engagement Task Force: Final Report

September 9, 2015

Leni Preston, Task Force Chair
Hillery Tsumba, Task Force Member

Task Force Members

Task Force:

- Leni Preston, Chair – Maryland Women's Coalition for Health Care Reform
- Linda Aldoory, Herschel Horowitz Center for Health Literacy, University of Maryland
- Barbara Brookmyer, Frederick County Health Officer
- Kim Burton, Mental Health Association of Maryland
- Tammy Bresnahan, AARP
- Michelle Clark, Maryland Rural Health Association
- Shannon Hines, Kaiser Permanente
- Donna Jacobs, University of Maryland Medical System
- Michelle LaRue, CASA DE MARYLAND
- Karen Ann Lichtenstein, The Coordinating Center
- Susan Markley, HealthCare Access Maryland
- Suzanne Schlattman, Health Care for All!, MCHI
- Novella Tascoe, Keswick Multi-Care
- Hillery Tsumba Primary Care Coalition of Montgomery County
- Gary Vogan, Holy Cross Hospital

Staff: Dianne Feeney & Steve Ports, HSCRC; Theressa Lee, MHCC; & Tiffany Tate, Consultant

HSCRC Consumer Engagement Task Force
January – September 2015

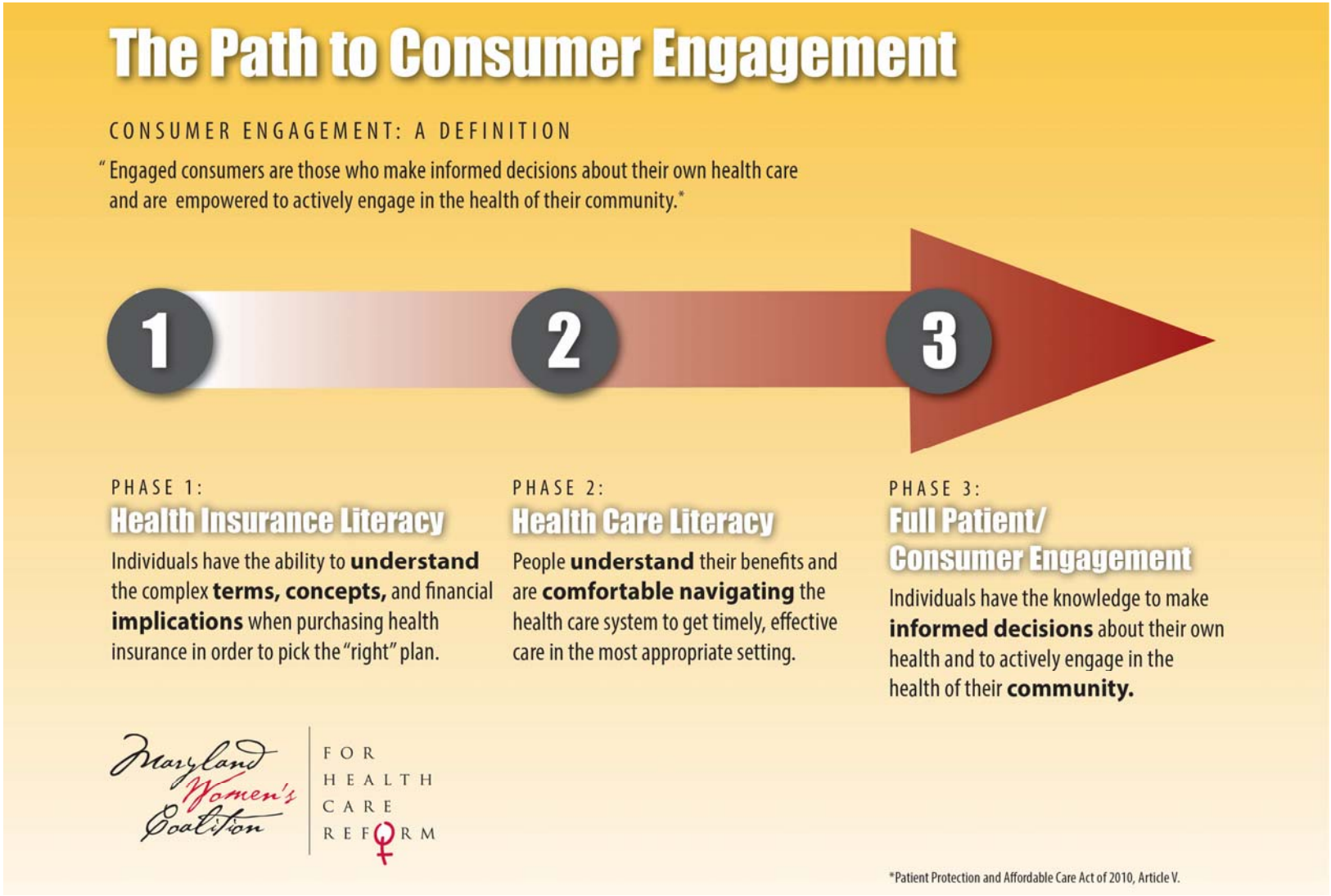
Charge 1

- Provide rationale for health literacy and consumer engagement within the context of the New All-Payer Model (NAPM)
- Define audiences, identify messages, and propose engagement strategies as appropriate, including:
  - Systemic adjustments
  - Education and communication strategies

Charge 2

- Advise decision-makers, regulators, etc. on the impact of system transformation on individual and community health issues
- Provide guidance for ensuring an appropriate and consumer-friendly communications process
- Make recommendations for enhanced ways for consumers to provide feedback and for hospitals to act on that input

Consumer Engagement – Get It!



Consumer Engagement: Benefits to Consumers & the Community

Engaged consumers may experience:

- Improved understanding about their health condition, related treatment options, & how to access the appropriate services to optimally manage their health
- Improved relationships with health care providers
- Improved experience and satisfaction with their health care
- Personal sense of value, ownership, and influence in health care decision-making
- High quality health care
- An informed, responsive, and more efficient, health care system

Consumer Engagement: Benefits to Health Care Providers & Institutions

Providers & institutions that meaningfully engage the consumer can experience:

- Patients' improved understanding of their medical condition(s) and treatment options resulting in improved outcomes and more efficient use of resources.
- Greater confidence that their programs meet the needs of consumers and communities, including those with unique cultural or social needs
- Improved relationships and cooperative partnerships with the individuals and communities they serve
- Streamlined processes for receiving information and insight from the community and applying the insights to inform policy decisions

Consumer Engagement: Recommended Mission

Foster a health care system driven by a culture of robust and meaningful consumer engagement that addresses the Triple Aim:

- improving the patient experience, including quality and satisfaction
- improving health of populations
- reducing per capita cost of health care

Consumer Engagement: Themes

- Clear call to action – at the right time, in the right place and from the right person
- Engagement is dependent on individual's input and perception that their actions have an impact
- Individuals' motives are different than institutions' – identifying the motivating factors is key for both groups
- Health care information should be disseminated and consumer engagement activities should be led by sources that consumers trust
- Sensitivity to diversity and the multitude of cultural differences is critical
- Requires extraordinary commitment from health care leadership at all levels
- Ideally, consumers should be engaged, both prior to, and at the point of contact with the health care system
- A more robust and consumer-friendly feedback process (i.e. concerns, complaints and commendations) is needed
- Advanced directives planning is indicative of consumer engagement

Consumer Engagement: Strategic Communications Goals

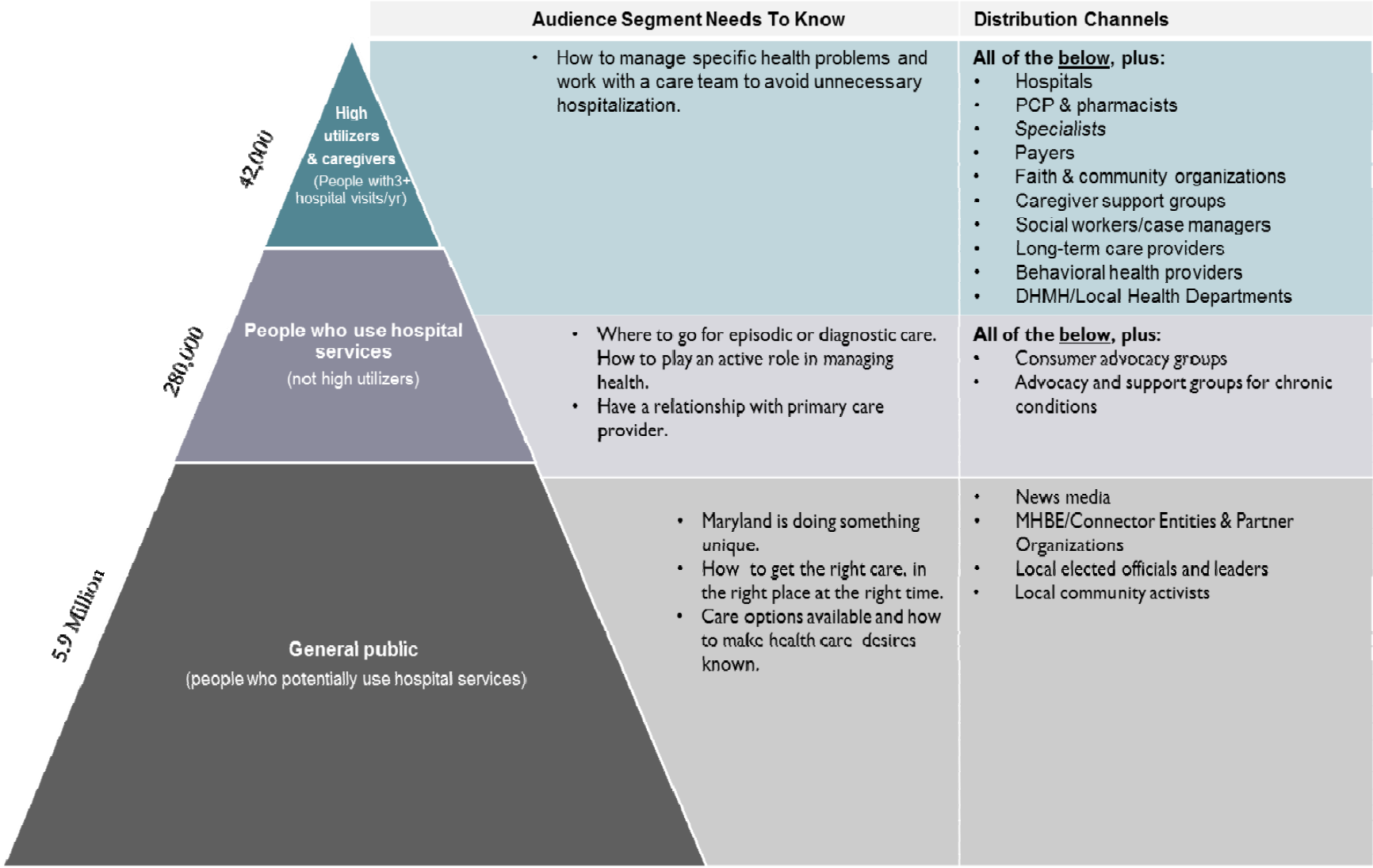
Goal #1

- Establish a person-centered health care delivery system with an ongoing role for consumers to participate in the design and implementation of policies and procedures at all levels.

Goal #2

- Engage, educate, and activate people who use, or are potential users of, hospital services in their own health care in order to promote efficient and effective use of the health care system

Audiences & Messengers



Task Force Recommendations

1. Allow for meaningful, ongoing role for consumers at the HSCRC through continued representation of Commissioner(s) with primary consumer interest, and through a newly created standing advisory committee with diverse representation.
2. In collaboration with key stakeholders, develop a statewide public education campaign specific to the NAPM that is part of a broader campaign to promote health and wellness.
3. Convene an interagency task force, with consumer representation, to oversee the public education campaign including the development of related consumer-oriented information.

Task Force Recommendations

4. Provide options and opportunities that support regular, longitudinal and effective consumer engagement in the development of policies, procedures, and programs by hospitals, health care providers, health care payers, and government.
5. In coordination with the SAC, the MHCC and other key stakeholders, consider development of a Consumer Gold Star system for hospitals based upon consumer engagement standards.
6. Define Community Benefit dollars to include consumer engagement initiatives and promote these dollars for this use, particularly for those supporting vulnerable populations.

Task Force Recommendations

7. Continue to encourage and incentivize independent and collaborative approaches to support people who are at risk of becoming high utilizers.
8. Encourage hospitals to provide current, consistent, and transparent information on average procedure costs using the data made readily available by the Maryland Health Care Commission (www.marylandqmdc.org) and new pricing transparency tools being created, and make this available on NAPM and/or other appropriate website(s).
9. Include discussions about patient and family decision-making and preferences about advanced directives in the context of consumer engagement and educating consumers.

Measuring Consumer Engagement

- Currently few validated metrics or tools that could directly and comprehensively evaluate the impact of consumer engagement on health outcomes, patient experience or satisfaction, provider satisfaction, improved program design decision-making, access, or utilization.
- Propose an initial non-exhaustive set of measures which could be adopted from currently available resources:
  - Existing data sources (e.g., Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), Medicare claims, CRISP encounter information),
  - Suggested some that are not currently collected (e.g., the Communication Climate Assessment Toolkit (C-CAT)).
- Propose others where there are currently measurement gaps, for example:
  - HSCRC Standing Advisory Committee
  - Patient Family Advisory Committees at hospitals

Multi-Agency & Multi-Stakeholder Engagement: HSCRC Role

True consumer engagement promises tremendous benefit to the people who use health services as well as health care providers and institutions. Successful consumer engagement requires proactive and committed leadership. It is imperative that the HSCRC embraces a continued leadership role to promote a coordinated, collaborative and person-centered health care system.

Questions

- Leni Preston, Maryland Women's Coalition for Health Care Reform leni@mdchcr.org
- Hillery Tsumba, Primary Care Coalition of Montgomery County
- hillery_tsumba@primarycarecoalition.org

Consumer Outreach Taskforce Report

Maryland Citizens' Health Initiative Education Fund, Inc.
Vincent DeMarco
September 2015

Rationale

- Marylanders are unaware of the state's unique and long-standing status as an all-payer state or of the new state/federal agreement that is further transforming the health system in Maryland.
- Consumer engagement in these efforts is crucial to make Maryland's new system a success.

Task force members

Tresa Ballard, AARP
Tammy Bresnahan, AARP
Darren Brownlee, National Association of Health Services
Carmela Coyle, MHA
Vincent DeMarco, MCHI
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Susan Markey, HCAM
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Gerald Stansbury, NAACP
Terry Staudenmaier, Abell
Tiffany Tate, Consultant
Nikki Highsmith Vernick, Horizon Foundation
Rev. Fred Weimert, Central Maryland Ecumenical Council

Forums

- Format
  - Welcome from host
  - Presentation by HSCRC/MHA
  - Local panel of stakeholders
  - Presentation of Faith Community Health Network concept
  - Q&A
  - Evaluations

Forums

Number of forums	11	
Number of participants	800+	
Evaluation response rate	42%1	
Presenters	• HSCRC • Local Health Improvement Coalitions • Hospitals and health systems • Community health providers	• Health Departments • Faith communities • MCHI • Foundations
Attendees	• Consumers • Government agencies • Community groups • Providers/provider groups	• Hospitals/health systems • Faith-based • Civic organizations • Union Members
Constituents of Attendees	• Diverse populations/minorities • Seniors • Low-income populations • Immigrants • Chronically Ill	• Children • Families • Caregivers • Parishioners • Healthcare providers and workers

1 Excluding Lower Easter shore, which did not have evaluation forms.

Consumer Feedback

- Consumers are eager for more information
  - **Timely**
    - Prior to hospitalization
    - Design phase/launch of care coordination programs
  - **Consistent**
    - Esp. in areas with competing providers
  - **Available in multiple formats**
    - Primary care providers, faith leaders
    - Traditional news outlets
    - Social media

Recommendations

- Periodically convene stakeholders and consumers to provide updates on the progress of health system transformation
- Continue to give consumers a voice in the transformation of Maryland's health system
- Encourage local leaders to develop and join a dynamic Faith Community Health Network
- Collaborate to educate primary care providers on—and engage them in—health system transformation
- Maximize communications with consumers via traditional and new media

Thank you!

Vincent DeMarco, President

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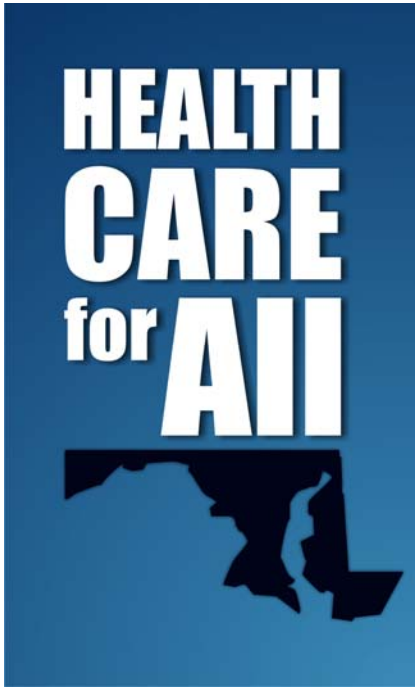


HSCRC
2014 CBR Findings

Steve Ports, Principal Deputy Director

Findings from FY 2014 Summary Report

- FY14 – total of 52 hospitals: 46 acute and 6 specialty hospitals
- FY13 – total of 47 hospitals: 46 acute and 1 specialty hospital

- Reported Total Community Benefits
  - FY 14 – $1.5 billion
  - FY 13 – $1.5 billion

- CBR Dollars as a Percentage of Hospital Operating Expenses
  - FY 14 –10.62% - Ranging from 2.61% to 27.46% with an average of 10.47%
  - FY 13 –11.05% - Ranging from 3.12% to 24.06% with an average of 11.12%

- Staff Hours Dedicated to CB
  - FY 14– Average 1514 hours
  - FY 13 – Average 1699 hours

Offsetting Charity Care, DME, and NSPI

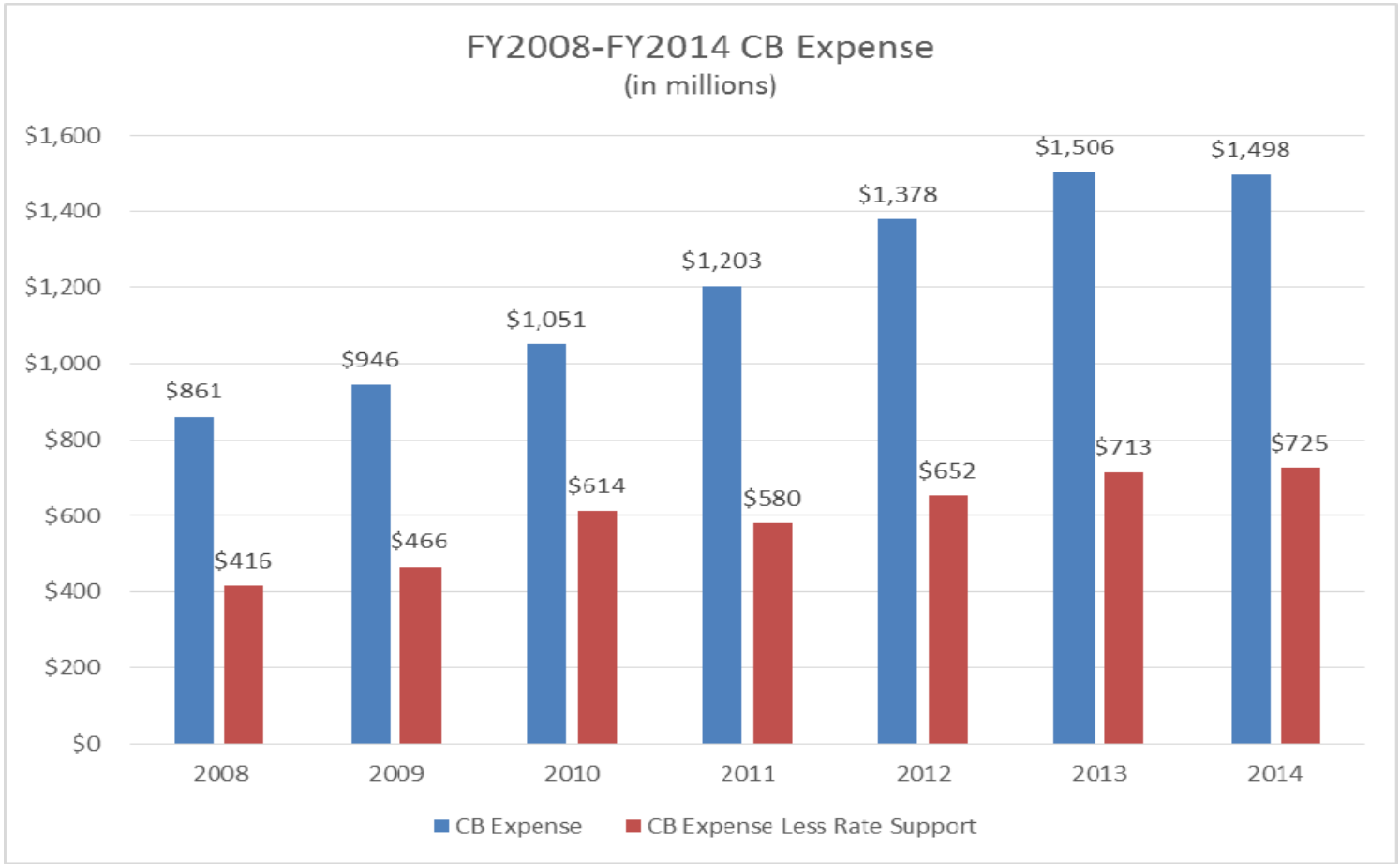
- 2014 Charity Care DME and NSPI Rate Funding:
  - Charity Care - $463.9 million
  - DME - $294.4 million
  - NSPI - $15.1 million

- Total Net Community Benefit Expenditures
  - 2014 - $724.7 million (5.14% of expenses)
  - 2013 - $712.4 million (5.23% of expenses)

- In FY 14 Hospitals provided $19.9 million more in charity care than was provided in rates – down from $54.6 million in FY13.
  - Due to increase in insured population?

FY2008-FY2014 Community Benefit Expenditures

- Increase from $861 million to $1.5 billion



Narrative Highlights

- Top Health Needs to be addressed by hospitals - Identified through CHNA process:
    - Heart Disease
    - Obesity
    - Behavioral/Mental Health/Substance Abuse
    - Diabetes
    - Access to Care
    - Cancer

- Prevalent unmet health needs identified but not to be addressed by hospitals.
    - Behavioral/Mental Health/Substance Abuse
    - Transportation
    - Cancer
    - Safe Housing
    - Dental Health

Observations

- Dollars and effort toward CB has continued to grow but the total amount has appeared to level off in FY 2014 (however net CB continues to grow)
- Reductions in the percentage of charity care may impact the total amount invested in CB
- The quality of the narrative reporting is getting better but still room for improvement
  - Describing information gaps impacting ability to assess needs of community
  - Describing process and methods to conduct CHNA's
  - Prioritizing community needs with criteria
  - Explanation of unmet needs
- Strategic transformation planning and partnerships will likely provide more information to address these issues in future