

Regional Partnership for Health System Transformation

Regional Transformation Plan – Final Report

Totally Linking Care in Maryland, LLC*



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Prepared by TLC-MD Grant Writing and Advisory Committees

December 6, 2015

*Representing the health care delivery systems of Prince George's County, Calvert County, and St. Mary's County.

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Regional Partnership for Health System Transformation

Regional Transformation Plan – Final Report

Due: December 1, 2015 (revised to December 7, 2015)

Regional Partner: Totally Linking Care in Maryland, LLC (TLC-MD) – (formerly Southern Maryland Regional Coalition) anchored by Doctors Community Hospital, Ft. Washington Medical Center, Laurel Regional Hospital, Prince George’s Hospital Center, Bowie Medical Center, and Calvert Memorial Hospital. Since the original planning grant was approved, MedStar St. Mary’s and MedStar Southern Maryland hospitals joined TLC-MD. TLC-MD has deemed the Prince George’s County as the northern sector, and the Calvert and St. Mary’s counties as the southern sector. At times reports and interventions may be study by northern and southern or by total TLC-MD.

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-maphs/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

As you utilize this template and develop your Regional Transformation Plan, please refer to the “Transformation Framework” as a reference guide.

Goals, Strategies and Outcomes

Articulate the goals, strategies and outcomes that will be pursued and measured by the regional partnership.

Goals:

Primary Goal: Reduce the frequency and severity of high utilization of hospital-based services.

TLC-MD plans to reduce of frightening or unstable health-related situations for persons living with serious or advanced illnesses and disabilities. By doing so, the goal is to improve the patient experience, the health of the population and to reduce the need to resort to the hospital. Our quantitative goals are given in the section on data and analytics, and they are closely aligned with the goals for Maryland.

Strategies:

Strategy #1 – Screen all admissions to our hospitals and implement layered care coordination.

Initially utilizing CRISP notifications of past utilization and local clinician screening tools, for those at high risk of instability and repeated utilization will be offered eQHealth care coordination unless another care coordination program is available. All high-risk patients who do not have a care coordinator will be offered eQHealth care coordination services including home visits, patient and caregiver education, medication reconciliation, navigation for primary and specialty care and supportive services, care planning, and communication with physicians. We will track the effectiveness of this approach by monitoring readmission rates, total cost of care, and root cause analysis of readmissions and preventable hospitalizations. Patient satisfaction and engagement will be critical and regular surveys will be conducted to receive patient (and caregiver/family) feedback.

Strategy #2 – Reinforce the care coordination with special focus on medication management. For patients who are at risk of medication problems, each hospital will provide the enrolled patient with a 30-day supply of medications at discharge.

We will track and monitor the effectiveness with subset analysis of these patients and a comparison group of those with similar needs without the medication management component. A second approach would include testing an electronic home medication administration technology that alerts the eQHealth care coordinator when and if the patient is adherent /compliant. This technology is a proven improvement initiative at one MedStar facility. Both medication management approaches as an offered service are adjunct to care coordination, allowing patients and caregivers who cannot move to full self-care to have the support of a programmed administration kit. We will test these approaches with patient-level reporting and aggregate utilization.

Strategy #3 – Support physician practices that deal with these high-needs patients.

We have initiated outreach and education opportunities with our physicians to (1) track primary physician and practice involved in Root Cause Analyses (RCA) of readmissions, and (2) recognize the high-volume physicians for individualized approaches. In addition to these opportunities, we have developed a spreadsheet that will enable physician practices to estimate revenue potential from the newer Medicare codes*. With the care plans from eQHealth and the CRISP information, we will work with willing physician practices to enable use of these enhanced practices that generate Medicare revenues. A gain sharing arrangement will be developed, when permissible, using hospital savings to invest in highly productive community practices. In addition, we are actively investigating implementing a 24/7 on-call service to mobilize physician services to the home. As a part of support provided to physicians, these services will wrap around current services offered by local physician and patients' care plans would be readily available as a bonus. Prominent physician representation from each county already exists on our Advisory Board and we will institute working groups on Medicare services and billing, gain sharing, and coverage in the coming year.

*(See <http://medicaring.org/2015/10/26/potential-revenue-from-new-medicare-billing-codes/> which is being updated with the advance care planning codes that start January 1, 2016).

Strategy #4 – Cultivate a highly reliable learning organization.

TLC-MD aims to collaborate actively in developing services that are honest and supportive to patients and families, efficient to payers, highly valued in our communities and serve as a model for Maryland. To that end, we have adopted a strategy of testing interventions in a subset of our population, often in one or two hospitals first, and learning the effectiveness and the cost-effectiveness of strategies. As we become more familiar with data sources and analyses, our governance structure can support a strong staff effort to guide the monitoring and management of our multi-county system with insight and alacrity. Furthering work to date and advancing the current momentum of TLC-MD, we plan to hire a director with substantial experience in practical improvement activities and to back that person up with a coalition that is invested in successfully serving our communities better and in a more cost effective manner. TLC-MD continues to pride itself on its evolution as a learning organization and is excited to test promising interventions beyond those listed above (which will be detailed in the full grant application.) We expect that one of the high priorities for the TLC-MD Advisory Group will be to debate and advise on the priorities of our improvements to test, improvements to spread and sustain, and data needed to guide the critical decision. A full list of proposed interventions can be found on page 16.

Outcomes:

The full array of quantitative goals is given with the table of outcome measures below, pages 7-10. In summation, we aim to:

- Hold total hospital charges and total health care costs per capita for our hospital service areas and for our counties below the 3.58% growth target and below the targets set in future years.
- Reduce the hospitalizations per capita and the readmissions per capita in our hospital service areas and our counties to less than the national average within two years.
- Reduce ER use and short observation stays in our hospital service areas and our counties by 2% per year.
- Reduce potentially avoidable hospitalizations by 15% per year for two years.
- Improve the transition-related HCAHPS score and the overall HCAHPS rating of 9 or 10, in both our hospital service areas and our counties, to close half of the gap between our weighted average and the national average each year.

Describe the target population that will be monitored and measured, including the number of people and geographical location.

Our target population consists of the high-needs patients in our area. We have three nested populations as formal targets:

1. Those identified as high-needs patients when they use our hospitals (High Needs Population);
2. Those who live in our hospital service areas (the area for each hospital from the 2014 HSCRC Community Benefits report) (HSA Population), and
3. Those who live in our counties (Counties Population). (For a visual representation, see Appendix C: Maps and Population)

Our strongest and earliest impacts will be on the first category, and without impacts in this population, we will not show impacts in the larger populations. However, we expect to have substantial measured effects upon the quality and efficiency of health care and the level of health in our service areas and counties. The high-needs patients can live anywhere, but nearly all do live in our hospitals' service areas (based on Berkley Research Group (BRG) analyses and root cause analyses completed during the planning period). The hospitals' service areas cover more than three-quarters of the ZIP codes in the counties, and only a few of these HSA Population ZIP codes fall outside of our counties, so the HSA Population and the Counties Population are

nearly co-extensive and which one to use will depend upon data organization and participant preferences.

Many residents of the adjacent counties use one another's health care resources. Similarly, our geographical location in a densely overlapping urban area ensures that many of our counties' residents use health care resources in Washington, DC; Anne Arundel County; Montgomery County; and Baltimore. Also, we have a strong commitment and outreach effort to include Charles County and its University of Maryland Charles Regional Medical Center in future projects that are of shared interest and opportunity. Thus, we will establish a conscious, ongoing effort to work with these neighbors toward interoperability, standardization of processes and forms, continuity of care, and high performance standards across the region.

We started with restricting the scope of intervention to persons with specific illnesses and Medicare coverage. We quickly found, using our Root Cause Analysis, availability of patients, and the aggregate data analyzed by BRG that we have very many persons with high needs who are under 65 and our high-needs patients have quite an array of diagnoses. So, we are now including all payers and all diagnoses.

Working with Mary Pohl of CRISP, the following data helps to shape our work plan. Obviously, most of our readmissions are in Medicare patients (see Table 1 below)

Table 1: The Number of Unique Hospitalized Patients with Residence in TLC-MD Counties

The Number of Unique Hospitalized Patients with Residence in TLC-MD Counties during September 2014 thru August 2015 using the 2014 Community Benefits Zip Codes Source: CRISP	
	Total
Total Unique Patients seen in the TLC-MD Coalition	
Medicare FFS and Managed Care	5,089
All other payers	4,841
Total Patients	<u>9,930</u>
Total Unique Patients seen in the TLC-MD Coalition with 1 or more readmission	
Medicare FFS and Managed Care	2,185

We looked at this population from various perspectives, including diagnosis. Remarkably, there were 369 unique Medicare beneficiaries who had all of six major chronic illnesses diagnoses: Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, Hypertension, Diabetes, Heart Failure, and hyperlipidemia. They generate bills over \$30,000,000 in just one year. There were just another 87 people with the same panoply of diagnoses but who had some other payer. We certainly aim to have all 456 such high-needs patients living more comfortably and confidently and yet doing so while needing hospital services much less often. These data show the concentration of very high cost patients in Medicare coverage in our area, and about half are younger than 65 years old.

Describe specific metrics that will be used to measure progress including patient satisfaction, quality, outcomes metrics, process metrics and cost metrics. Describe how the selected metrics draw from or relate to the State of Maryland’s requirements under the new model.

For all data provided by HSCRC and CRISP, TLC-MD will request aggregate data and data splits between Prince George’s County (northern sector) and the combination of Calvert, Charles, and St Mary’s Counties (southern sector), since otherwise gains in the more rural counties (Calvert and St. Mary’s and often Charles) will be overwhelmed by the large numbers in Prince Georges County. Similar data splits will be conducted with data generated by the coalition. Although Charles County is not an official participating partner of the coalition, TLC-MD recommends including Charles County’s data within the coalition data pulls, for the following reasons: first, because patients and residents traverse the county boundaries, especially from Charles to St. Mary’s County; second, the Charles County population is small and will not obscure surrounding improvements; and, third, ultimately TLC-MD hopes that Charles County providers will work with the coalition on future projects.

Not only will the aggregate population need to be determined for both the southern and northern sections within the coalition, but TLC-MD will usually need to be able to separate Medicare, Medicaid, and dual-eligible populations from one another and from commercial populations. In addition to monitoring the overall effect of the programs, we will need to track utilization experience of adults (1) identified and enrolled as High Needs Population, (2) identified and refused, and (3) not targeted. In order to see the effects on the hospital service areas, TLC-MD requests that most data elements be tracked for each hospital’s service area. Although TLC-MD has procured eQHealth for care coordination services and has established a working partnership with VHQC, the quality improvement organization and health care assessment network for Maryland and Virginia; CRISP recommends that all data runs through them when possible, rather than any other vendor. We will comply with this request, though some QIO data may have to come directly to the providers involved.

Finally, data will have to be consistent and recurrent in order to enable proficient and effective management. For some metrics, the frequency will be monthly and for others, the data will probably only be available quarterly. For data that is available into the past, we will request data for the last three years (2013-2015) in order to be able to establish seasonal variation and a rough baseline, as well as requesting reasonably prompt data through the future work. Some of this will be displayed on the CRISP dashboard, which we will study and use, but we also want to be able to download the raw data if CRISP and HSCRC reporting do not promptly construct useful process control charts for the interventions we implement. We understand from CRISP that they will have data from dual-eligible beneficiaries first, then probably Medicare Parts A, B, and D. Once the core data are all coming in quickly after billable events, other quality measures will become possible. For example, we expect that screening our patients for quality issues such as Beers criteria medications in elderly persons or screening and preventive tests would be very helpful in galvanizing the coalition and raising the standard of care. Having current Medicare administrative data would also allow tallying success in use of the new CMS billing codes.

Table 2: CORE OUTCOME MEASURES – from the RFP, with TLC-MD goals and specifications

Measure	Definition	Goals	Source	Population	Baseline Data
Total Hospital charges per capita	Hospital charges per person (monthly)	Growth <3.58% from CY 2013 in 2015; meeting state goals in ensuing years	HSCRC case-mix data	HSA and Counties Populations	Will be developed for 12/21/15
Total Hospital Admissions per capita	Admissions & Observation patients >24hr per 1000/month	< national average N/1000/month for Medicare within two yrs.	HSCRC Case-mix data	HSA and Counties Populations	Will be developed for 12/21/15

Measure	Definition	Goals	Source	Population	Baseline Data
ED visits per capita	ED visits per thousand/month	2% per year decrease	HSCRC Case-mix data	HSA and Counties Populations	Will be developed for 12/21/15
Readmissions	All-cause readmissions within 30 days, both as N/1000/month and as N/discharges	< national average N/1000/mo for Medicare within two years	CRISP	HSA and Counties Populations	Will be developed for 12/21/15
Potentially avoidable utilization	As per HSCRC specifications	Reduction of 15% per year for two years	PAU Patient Level Reports – HSCRC and CRISP	HSA and Counties Populations	Will be developed for 12/21/15
Patient experience	% rating 9 or 10 overall	Close half of the gap between current average and national average each year (consider splitting factors in other ways)	HCAHPS, reported to each hospital	Weighted average of our hospitals	Will be developed for 12/21/15

Table 3: CORE PROCESS MEASURES – from the RFP, with TLC-MD goals and specifications

Measure	Definition	Goal	Source	Population	Baseline Data
Use of encounter notification alerts	% of inpatient discharges that result in an encounter notification system alert going to a physician	50% of inpatient discharges of high needs patients meet criterion within a year, then closing half of the remaining each year thereafter; goal metrics for all discharges the same, but lagged by a year	CRISP	Discharges of High-Needs Population; then all hospital discharges	Will be developed for 12/21/15
Completion of health risk assessments	% of high utilizers with completed HRAs (in hospital record or linked care coordination record)	50% within a year, then closing half of the remaining each year thereafter	Aggregation of reports from coalition hospitals, merged with reports from care coordination contractors	High-Needs Population	0
Established longitudinal care plan	% of high utilizers with completed care plan	50% within a year, then closing half of the remaining gap each year thereafter	Reports from care coordination contractor and sampling of hospital records on high utilizers	High-Needs Population	0
Shared Care Profile	% of high-utilizers with care profiles shared through CRISP	25% in the first year available, 50% in the second, and closing half of the gap each year thereafter	CRISP (when available)	High Needs Population	0

Measure	Definition	Goal	Source	Population	Baseline
Portion of target population with contact with an assigned care manager	% of high utilizers with contact with an assigned care manager	80% of persons consenting to care management, refusal rate <25%	Aggregation of reports from the hospitals and eQHealth	High-Needs Population	Will be developed for 12/21/15

Table 4: Metrics Specific to this Coalition’s Work in Year One

Measure	Definition	Goal	Source	Population	Comments	Baseline
Rate of readmissions of patients who are already in care coordination program	N readmitted within 30 days /N enrolled and followed for >30 days after discharge, or until readmission or death	<10%	eQHealth, monthly	High Needs Population	eQHealth has a case closure report which shows those members whose case was closed because they readmitted to the hospital. We’ll combine with CRISP reports of readmissions of our targeted population, once that system is operational.	Unknown, because denominator population does not yet exist
Medication management need identified and met	N for which a medication management problem was successfully addressed as reported by the care coordinator /N for which medication problem or high risk identified	>80%	eQHealth, monthly	High Needs Population	Denominator is Modified Morisky scale or First Databank review finding a problem, or with >8 medications, or with anticoagulants or Beers criteria ¹ medication in an elderly person	Unknown, because denominator population does not yet exist
30-day readmissions within the coalition reviewed by shared Root Cause Analysis	Among those admitted and readmitted in the coalition, N reviewed jointly	>90%	CRISP for denominator population, RCA for numerator	High Needs Population	RCA to be modified to address communications between teams in ER, before ER, and during admission	Unknown, denominator population does not yet exist

Measure	Definition	Goal	Source	Population	Comments	Baseline
Social support need identified and met	N who got the services needed/N identified as needing services involving transportation, housing, food, or caregiver support	>90%	eQHealth, monthly	High-Needs Population	from Plan of Care report	Unknown, will establish baseline after 90 days of pilot data.
Palliative/hospice care need identified and met	N with preferences for CPR and hospitalization documented and with surrogate identified (or documented that there is no surrogate)/ N high-needs patients	Closing half of the gap between past performance and 90% each year	Coalition hospitals	High Needs Population	High needs patients defined by CRISP or eQHealth (see Table 1) Numerator estimated by chart review sample of patients discharged alive. Subset of patients from settings required to offer MOLST.	Unknown, will establish baseline after 90 days of pilot data.
Vitamin D	N with initial Vitamin D assay/N high-needs patients admitted; N prescribed Vitamin D in the hospital and at discharge/N with low Vitamin D	70% for each	Hospital records	High-needs population, while hospitalized	To start later in Year 1 - When these rates are high and stable, then test correction of Vitamin D levels in follow-up and then test measures of effectiveness in improving outcomes	Very nearly 0% - will establish baseline when this test starts.

¹ American Geriatrics Society 2015 Beers Criteria Update Expert Panel. American Geriatrics Society 2015 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. Retrieved from <http://geriatricscareonline.org/toc/american-geriatrics-society-updated-beers-criteria-for-potentially-inappropriate-medication-use-in-older-adults/CL001/>. Criteria for Potentially Inappropriate Medication Use in Older Adults. Retrieved from <http://geriatricscareonline.org/toc/american-geriatrics-society-updated-beers-criteria-for-potentially-inappropriate-medication-use-in-older-adults/CL001/>.

Describe the regional partnership's current performance (target population) against the stated metrics.

We understand that our TLC-MD partnering hospitals have incredible opportunities to improve, and the creation of the coalition provides the platform to facilitate this improvement. Having a lower utilization on the Medicare data from CRISP might reflect some utilization in Washington, DC, our younger than average population, and the blend of patients between the northern and the southern sectors. Looking only at Medicare patients, but with a database that captures Maryland residents using hospitals anywhere in the country (from VHQC), TLC-MD Medicare Fee-for-Service patients had an admission rate of 67 to 70 per thousand per quarter in the last year, which was just under Maryland's rate and tracked the national average closely. Per VHQC readmissions for, Prince George's County ran between 13.3 and 14.7 readmissions per thousand per quarter, which was about one per thousand per quarter more than the Maryland average, which in turn was about one per thousand per quarter above the national average. The combination of Calvert, St. Mary's, and Charles Counties was a little lower than the Maryland average and a little higher than the national average. Since we know that some parts of the country report Medicare admission rates around 52/1000/quarter and readmission rates around 9/1000/quarter, we can aim to move to rates of hospital utilization for Medicare fee-for-service beneficiaries much lower than current rates. The VHQC data also highlights an important adverse characteristic to monitor in watching for an increase in observation stays. At present, the national average for observation stays is in the 12 to 13 per thousand per quarter range. Prince George's County residents have a rate about 3 per thousand per quarter higher, and Calvert, St. Mary's, and Charles Counties together are showing about 5 per thousand per quarter higher.

Based on the above data, we understand that our coalition has a substantial opportunity to improve. Since September 2015, TLC-MD has implemented two strategies to start coalition shared learning and to begin the process of shared improvement: Root Cause Analysis (RCA) of readmissions and other avoidable utilizers at each hospital and a Pilot of the Care Transition/Coordination using the eQHealth Professional and Data contract.

Table 2 demonstrates progress to date on TLC-MD's outcomes measurements. Work completed as part of the planning grant has moved TLC-MD's strategies towards our overall goals; however, the time needed to demonstrate the scope of impact on population metrics is still in process. We have data available that supports processes and expect to have data to support outcomes with the assistance of CRISP during the next few months. Tables 3 and 4 show the process metrics and the initial plans for measures to monitor our interventions.

Root Cause Analysis (RCA):

Each hospital in TLC-MD, except the two MedStar hospitals that recently joined the coalition, has implemented the RCA tool and documents findings into a common data base. Recently, the staff at MedStar St Mary's and MedStar Southern Maryland Hospital went through training on the TLC-MD RCA tool. Weekly, the Case Management Department documents results in the TLC-MD Base camp (a shared communication tool) and bi-weekly, the TLC-MD Advisory Committee discusses results, possible follow up actions, and plans for new or revised interventions.

As of November 2015, 174 RCA forms were completed across the hospitals for patients readmitted within 30 days. Ninety-four percent (94%) of the patients readmitted were not planned, and 79.4% had been previously

discharged to their home. However, 88.2% said they were pleased with their facility and 83.1% said they were pleased with their physician. This gives TLC-MD the opportunity to help with care transition from hospital to home and provide care coordination to stay healthy at home.

The top specified major problems for the readmission were CHF, COPD, and Diabetes complications. Fifty four percent (54.9%) of the patients were 55 years and older with 46.6% having Medicare coverage. Sixty-two percent (62.4%) said that their illness from the last admission got worse.

Eighty percent (80.3%) of the patients said they were able to fill their discharge prescriptions from the prior admission, 58.9% on the same day. Nineteen percent (19.2%) were taking their medicines 5 days or less a week, which TLC-MD considered non-compliant. This presents an opportunity to develop an understanding as to the reasons for the non-compliance and to offer offering medication adherence tools to which alert the patient and TLC-MD care coordinator on missed medication.

Next, the RCA focused on the PCP or specialist visit after discharge. Only 23.7% saw their physician within a week of discharge, and 69.6% never visited a physician prior to readmission. This again shows an opportunity for TLC-MD care coordination among patients and their providers.

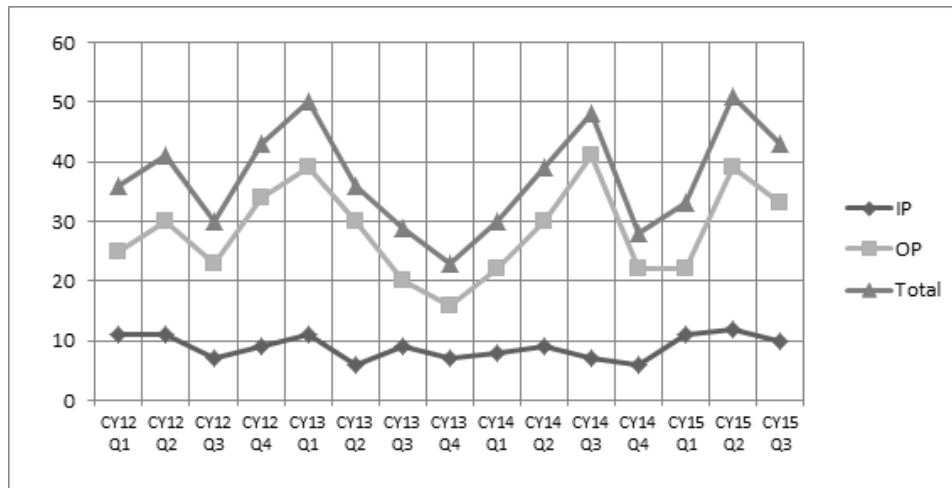
Finally the RCA focused on the home environment of diet, transportation, in-home assistance, selection of palliative care or hospice, SNF care, and access to care. For the most part, the majority of patients needed assistance getting and even understanding these services.

Only 7.1% saw a physician between their first and ensuing admissions, half of those within 3 days. Only 30% said they had a follow-up appointment set before discharge from the first hospitalization. The care coordination nurse was of the opinion that 47% of the readmissions were potentially preventable.

The RCA process was valuable in learning how to have such disparate teams work together and share data and insights, as well as shaping some of our initial priorities. Confirming the BRG analyses, our area has a much younger population that is seriously ill and covered by Medicare than would be expected nationwide. Our high-utilizing patients (and probably their physicians) are used to using the hospital and find it comfortable and reassuring. Taking more direct responsibility for health and being more reliably adherent to optimal self-care will require substantial re-orientation of these patients and their social connections and will require physician education and engagement which has been successfully piloted during TLC-MD's planning grant phase. We plan to continue to do RCA in targeted and sampled strategies to support and inform our interventions.

CRISP staff produced the first report on TLC-MD patients that validated our RCA tool we identifying patients with high-utilization, while we await the predictive modeling tool. Here are a few comments on the CRISP data from Alice Wang. Our first 37 patients had 560 encounters in hospitals in the TLC-MD coalition.

Table 5: TLC-MD Patients 12 month look back in CRISP database



Care Transition/Coordination Pilot:

TLC-MD has contracted with eQHealth for professional and data support of care coordination for high-needs patients. The eQHealth RN visits patients in the participating hospitals that the clinical staff has identified (in part using the RCA tool) as fragile high-needs hospitalized patients who might benefit from more support after discharge. This service is contracted to the Coalition to manage many aspects of care for the high-needs patients who are not in another care coordination program and to provide targeting and data assistance to the coalition hospitals. By the time this proposal is submitted, we will have worked out the interfaces for the participating hospitals to submit information from their admission records to eQHealth in order to have predicted high-needs patients identified the same day. While we have the portals and agreements ready, we will start this screening process with this proposed grant’s initiation. Additional patients identified by the hospital staff will be added to the care coordination targets in each hospital and, as needed, referred back to eQHealth for intensive care management after discharge. The eQHealth services include nurse-led in-home self-care education, medication reconciliation, referral to social services, and care planning, as well as ongoing telephone contact. At this point, the services are available only during usual business hours, but TLC-MD is exploring how to move to 24-hour coverage with care plan and how to expand to have in-home medical care (which will require further testing, monitoring, and evaluating). Four of our hospitals are now using this service, and initial reports from patients are positive.

eQHealth also provides predictive modeling using the Johns Hopkins product. Upon grant approval, TLC-MD will contract to electronically share all patients with eQHealth to identify patients who are or could be high-risk utilizers. Listed below is the variety of services that eQHealth can perform for our coalition.

Figure 1: eQSuite Software Options and Flows

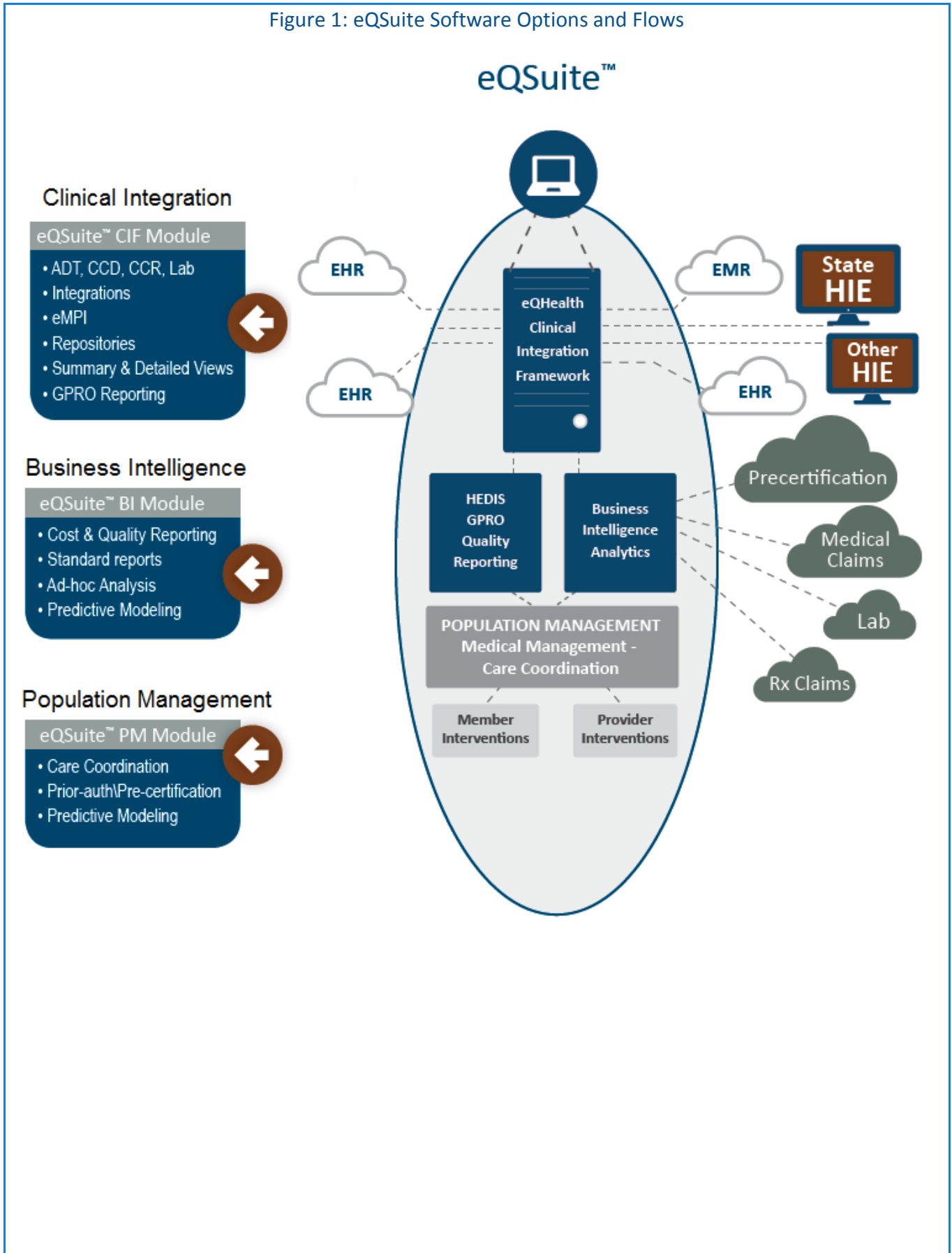


Table 5 has three sections: a summary of the pilot started in September 2015 of patients enrolled in TLC-MD care transition/care coordination program as of November 30, 2015, measurement: 30-day readmissions within the coalition reviewed by shared RCA, and measurement: Rate of readmissions of patients who are already in care coordination program.

Table 6: Metrics Specific to this Coalition’s Work in Year One

Month	CC/CT	Readmitted	Percent
Sep-15	6	0	0%
Oct-15	23	4	17%
Nov-15	47	1	2%
	<u>76</u>	<u>5</u>	<u>7%</u>

Measurement: 30-day readmissions within the coalition reviewed by shared RCA

Enrollment & Referral Summary for Period

- + Enrollments 76
- + Active Enrollments 50
- + Enrollments Closed 26
 - + Completed 4
 - + Did Not Complete 22
 - + Re-Admit 5

Measurement: Rate of readmissions of patients who are already in care coordination program.

September thru November 29, 2015

These are high-risk utilizers of all payers.

Five (5) readmitted and 76 thru program or 5/76 equals 7%.

Early insights: Patients are generally accepting of the services with an apparent positive effect. Moving forward, in partnering with the hospitals, eQHealth has determined a way to screen all admissions with a predictive algorithm. This algorithm will create the anchoring list of high-needs patients and to which a few patients will be added by clinical evaluation alone.

Define the data collection and analytics capabilities that will be used to measure goals and outcomes.

The coalition intends to hire a dedicated staff person to lead analytic and data collection work on behalf of the coalition. We will use the available data provided by CRISP and HSCRC reports as a base, and collaboratively work with VQHC on coalition-building and care transition as needed. VQHC have agreed to provide routine and custom data analyses especially for Maryland Medicare data (Part A, B, and D). Collectively, this would eventually allow a more complete estimation of medication utilization or Beers criteria drug use, as well as a better estimation of total health care costs. For a few monitors, we need to do chart reviews, root cause analyses, and patient/family interviews. We will review progress each month, using process control charts for data with enough data points to establish upper and lower control limits and thereby closely monitor the changes.

List the major areas of focus for year one. (For the completion of this plan, if various areas of focus require different descriptions, please identify each area under the following sections of the plan.)

As described on pages 4-5, the focus of TLC-MD will be the provision of successful intervention of layered care coordination within the context of developing a highly-efficient regional learning organization model. We are also committed to improving medication management and physician alignment. In addition, TLC-MD has generated a list of enhanced services to test in the care coordination sphere, beyond the 24/7 on-call by care coordinators and in-home physician services that are expected to be selected and negotiated in early December 2015. These include the following:

- Self-Care Activation Approach- Our care management program at present includes patient and family education which we are dedicated to bolstering as a full-bodied self-care activation approach.
- Hospice and Palliative Care Utilization. The area has a low utilization of hospice, palliative care, and advance care planning, so testing improvements in utilization of these services are of interest to TLC-MD.
- Optimizing clinical communications over time. CRISP will shortly be able to provide notifications, care profiles and other information to eQHealth care managers, so optimizing that clinical communications work over time will also be a shared set of tests.
- Post-hospital clinic and nurse call-in line. Calvert Memorial Hospital has sponsored a post-hospital clinic and a nurse call-in line, which TLC-MD will evaluate and test for possible replication or shared services among coalition members.
- Vitamin D Levels. We are aware of the compelling data showing major deficiencies in Vitamin D in African-Americans and especially in persons living with chronic illnesses – and showing the substantial correlation of Vitamin D deficiency with mortality.² The effectiveness of a strategy of supplementation is less well-established. However, Vitamin D supplementation is so inexpensive and free of side-effects that TLC-MD will plan to test the costs and effects of a strategy of testing Vitamin D levels on admission to the hospital and providing supplementation through hospitalization and thereafter.
- Enhancing behavioral health options for our high-needs patients, in conjunction with Mosaic and local practitioners. We will test matching identified needs with available resources and working toward enhanced availability where shortages are identified. For example, older persons with multiple chronic conditions and depression or anxiety might best be supported with enhanced skills in their primary care physician practice, while persons living with substance abuse disorders might need us to try more ready availability of detoxification and supportive environments. We aim to develop this plan of testing and adoption during the first year.

² Harris SH. Vitamin D and African Americans. *J Nutr.* 2006;136(4): 1126-1129

Formal Relationships and Governance

List the participants of the regional partnership such as hospitals, physicians, nursing homes, post-acute facilities, behavioral health providers, community-based organizations, etc. Specify names and titles where possible.

Hospitals	Attendees	Phone	Email addresses	TLC-MD Committee
Doctors Community Hospital and Affiliates – Lead hospital	Philip B. Down, President/CEO	301-552-8028	pdown@dchweb.org	Executive Committee
Doctors Community Hospital and Affiliates	Camille Bash CFO	301-552-8085	cbash@dchweb.org	Executive Committee TLC-MD, Chair All Committees
Doctors Community Hospital and Affiliates	Sunil Madan, MD CMO	301-552-8630	smadan@dchweb.org	Executive Committee
Doctors Community Hospital and Affiliates	Robin Nelson Dir. Case Management	301-552-8590	rnelson@dchweb.org	Clinical Care Committee, RCA leader
Doctors Community Hospital Foundation	Sherri Moore Development Officer	301-552-8218	smoore@dchweb.org	Grant writer
Doctors Community Hospital Foundation	Robyn Webb-Williams VP Foundation	240-965-3681	rwebb-williams@dchweb.org	Grant Writer
Ft Washington Medical Center – hospital	Victor Waters, MD, CMO & President/CEO	301-203-2200	vwaters@FortWashingtonMC.org	Executive Committee
Ft Washington Medical Center – hospital	Marjorie Quint-Bouzid CNO	301-203-2210	mquint-bouzid@FortWashingtonMC.org	Executive Committee Clinical Care Committee, Chair All committees
Ft Washington Medical Center – hospital	Joe Tucker CFO	301-203-2210	jbtucker@fortwashingtonmc.org	Executive Committee Grant Writer Budget Committee
Ft Washington Medical Center – hospital	Patricia H. Gerbracht Director Case Management	301-203-2210	pgerbracht@FortWashingtonMC.org	Clinical Care Committee

Ft Washington Medical Center – hospital	Lisa Boyd Case Management	301-203-2210	lboyd@FortWashingtonMC.org	Clinical Care Committee RCA liaison
Dimensions – hospitals	Neil Moore, President/CEO	301-618-2109	neil.moore@dimensionshealth.org	Executive Committee
Dimensions – hospitals	Lisa Goodlett SVP, CFO	301-583-4033	lisa.goodlett@dimensionshealth.org	Executive Committee Budget Committee, Chair All committees
Dimensions – hospitals	Michael Jacobs VP Comm Relations	301-617-8606	Michael.jacobs@dimensionshealth.org	Grant writer
Dimensions – hospitals	Steve Twaddle Exec Dir, DHA	301-583-4033	Steven.Twaddle@Dimensionshealth.org	Advisory Committee
Dimensions – hospitals	Carl Jean-Baptiste Senior Vice President & General Counsel	301-583-4050	Carl.Jean-Baptiste@Dimensionshealth.org	Executive Committee Governance Committee
Dimensions – hospitals	Valarie Barnes Director Case Management	301-583-4033	valarie.barnes@dimensionshealth.org	Clinical Care Committee RCA liaison
Calvert Memorial – hospital	Dean Teague, President/CEO	410-535-8324	dteague@cmhlink.org	Executive Committee
Calvert Memorial – hospital	Bob Kertis (Kelly Malone), CFO	410-535-4000	rkertis@cmhlink.org;kmalone@cmhlink.org	Executive Committee All committees
Calvert Memorial – hospital	Karen Twigg Case Management	410-535-4000	ktwigg@cmhlink.org;	Executive Committee
Calvert Memorial – hospital	Melissa Carnes, CFRE Development Coordinator	(410)535-8348	mcarnes@cmhlink.org;	Grant writer
So Maryland Hospital	Wray, Christina CEO	410-933-2375	Christine.Wray@medstar.net	Executive Committee
So Maryland Hospital	Talbot, Kathy VP Reimbursement	410-933-2375	Kathy.a.talbot@medstar.net	Executive Committee Budget Committee

	MedStar			
So Maryland Hospital	Yvette Johnson-Threat CMO	410-933-2375	Yvette.C.Johnson-threat@medstar.net	Executive Committee Clinical Care Committee
So Maryland Hospital	Dan Feeley CFO	410-933-2375	daniel.m.feeley@medstar.net	Budget Committee
So Maryland Hospital	Angela Thomas Executive Director, Health Services Research Administration	202-244-9843	Angela.d.thomas@medstar.net	Grant Committee Data and Utilization Committee
St Mary's Hospital	Wray, Christina CEO	410-933-2375	Christine.Wray@medstar.net	Executive Committee
St Mary's Hospital	Talbot, Kathy VP Reimbursement MedStar	410-933-2375	Kathy.a.talbot@medstar.net	Executive Committee Budget Committee
St Mary's Hospital	Lori Werrell, MPH, MCHES Director of Health Connections	301-475-6195	Lori.K.Werrell@medstar.net	Grant writer

Post-Acute Providers	Attendees	Phone	Email addresses	TLC-MD Committee
Genesis – SNF	Marsha Butler VP Sales & Mktg	410-371-4558 (cell)	Marsha.Butler@genesishcc.com	Advisory committee
Genesis – SNF	Ferris, Terri RN		Terri.Ferris@GenesisHCC.com	Advisory committee Clinical Care Committee
DaVita – Dialysis	David Chernov VP	301-788-2237 (cell)	David.Chernov@davita.com	Advisory committee IT Implementation, Chair
DaVita – Dialysis	Daniel Rueda Posada Dir.Corp Development	434-996-7198	Daniel.rueda@davita.com	Advisory committee

Professional Healthcare Resources	Joseph Shannon Dir. Sales & Mktg	443.900.1160	jshannon@phri.com	Advisory committee Clinical Care Committee
DI LLC – Radiology Group	Ben Stallings, MD Managing Partner	301-552-8118	BHOKIE@aol.com	Advisory committee
DRCC – Cancer Treatment	Jack Nyiri Executive Director	615-491-8597	jnyiri@drcnet.com	Advisory committee
Walgreens	Debbie Gundlach	443-520-7777	Debbie.Gundlach@walgreens.com	Advisory committee

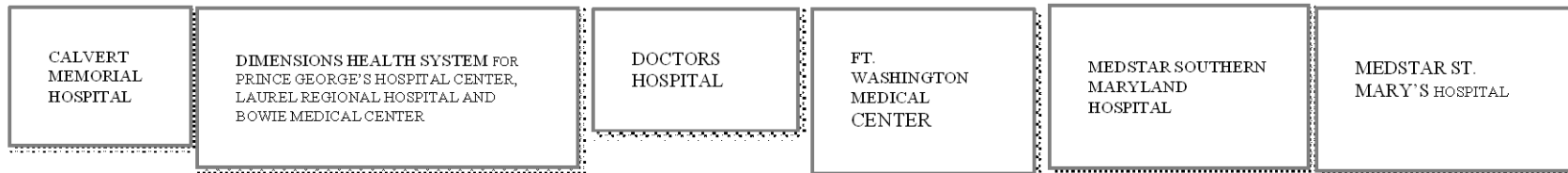
Analytics	Attendees	Phone	Email addresses	TLC-MD Committee
KPMG - contracted facilitator and project leader	James Case	410-949-8895	jcase@KPMG.com	Facilitator Advisory committee All committee
Dixon Hughes Goodman LLP	Richard Coughlan	240.403.3727	Rich.Coughlan@dhgllp.com	Advisory committee Grant writer - maps
Miles & Stockbridge PC – organization structure for collaborative	Pete Parvis	410-823-8165	pparvis@milesstockbridge.com	Governance, Chair
Maryland Center for Health Equity, School of Public Health, University of Maryland	Stephen B. Thomas, PhD, Director, Professor Health Service Admin	301-405-8859	sbt@umd.edu	Advisory committee Data and Utilization Committee, Co-Chair Clinical Care Committee
Maryland Center for Health Equity, School of Public Health	Susan Passmore, PhD, Project Director		spassmor@umd.edu	Advisory committee Clinical Care Committee
Neustra	Chris Rayi Administrator	901-734-6992	Chris@neustra.com	Advisory committee Data and Utilization Committee Software Selection, Chair

Community	Attendees	Phone	Email addresses	TLC-MD Committee
Prince George's Health Department	Pam Creekmur	301-883-7879	pbcreekmur@co.pg.md.us	Advisory committee
Prince George's Health Department	Dr. Ernest Carter	301-883-7879	elcarter@co.pg.md.us	Advisory committee
Prince George's Health Department	Donna Perkins, MPH	301-883-3108	drperkins@co.pg.md.us	Advisory committee
Calvert County Health Department	Thru Calvert Hospital staff		Working on this with Mr. Kertis and Susan Dohony	Advisory committee
Area Agencies on Aging Office, Prince Georges	Taylor Ferguson	301-265-8450	teferguson@co.pg.md.us	Advisory committee
Area Agencies on Aging Office, Calvert	Thru Calvert Hospital staff		Working on this with Mr. Kertis	Advisory committee

Describe the governance structure or process through which decisions will be made for the regional partnership. List the participants of the structure/process.

OWNERS:

Ownership interests are in direct relation to the amount of contributed capital to the total of all contributed capital, based on net proceeds from grant monies put in hospital revenue Managers



Board of Managers consists of the following votes per member, voting as a block. Each Member appoints its own managers:

2 5 2 2 2 2

UNANIMOUS MEMBER VOTES REQUIRED FOR: CHANGE IN GOVERNING DOCUMENTS, CAPITAL OTHER THAN PASS THRU OF HSCRC ADDED REVENUE, TRANSFER OF OWNERSHIP, ADMISSION OR REMOVAL OF NEW MEMBERS, STRATEGIC PLAN, CREATION OF SUBSIDIARY, ANY DEBT OR LIABILITY

TLC-MD, TOTALLY LINKING CARE IN MARYLAND, LLC

COALITION

ADVISORY COMMITTEE: The Advisory Committee of TLC will coordinate the (i) identification and development of Company projects and related annual work plans and goals, (ii) identification and communication of project issues to the Board, (iii) provision to the Board of ongoing status reports for project implementation, including the submission of periodic progress reports regarding the attainment of Board-established project goals, (iv) such other project development matters as the Board may delegate from time to time; and (v) serve as the sounding board for input and communication of the views and needs of the community. Meets at least quarterly. Cannot exceed 35 members (excluding governmental entities and affiliates) without Board approval.

EXECUTIVE COMMITTEE: Each Member appoints a representative to the Executive Committee which can act between scheduled meetings of the Board who can vote the Member's voting block on issues presented.

BUDGET AND COMPLIANCE COMMITTEE: Can be created and can include individuals other than Member representatives

See Appendix D for the Operating Agreement and Charter

Identify the types of decisions that will be made by the regional partnership.

"To be successful, peer support interventions need to be well-designed with clear and realistic program goals, adequate training and support for peers, clear evaluation benchmarks, and sufficient overall organizational support for the program" (Heisler, 2006, p. 35). The Coalition began with clear objectives for the eQHealth Pilot program, discussed the Coalition's plan with physicians and post-acute service providers, and the Coalition then utilized Pilot program results to develop interventions and best practices for short-term and long-term goals, as well as realistic revenue sources.

Here are some future decisions:

1. The review of results and the selection of new or revised interventions need to be incorporated into the eQHealth process, such as technology to assist patients with medicine adherence and other disease management.
2. The selection of the behavioral health strategies to serve our patients.
3. The selection of the pharmaceutical management process – University of Maryland is the number one choice at this point.
4. The implementation of the hospital's admissions into eQHealth's predictive modeling tool.
5. The decision on how to contract with each county to support the unique characteristics and priorities of each county.
6. The decision to offer CCM for a fee to our local physicians.
7. The use of data from eQHealth and CRISP (when available).
8. The selection of TLC-MD staff.
9. The agreement of procedures to run TLC-MD, i.e. which hospital will pay the vendors and produce monthly financial reports.

Describe the patient consent process for the purpose of sharing data among regional partnership members.

Hospitals have a Business Associations Agreement (BAA) with eQHealth. For hospitals that perform care coordination for other hospitals during the Pilot phase, BAAs were exchanged.

At the inpatient introduction set up by a hospital's Case Management Department, eQHealth explains the 90-day program and provides to the patient our TLC-MD pamphlet while discussing the initial assessment. The patient then decides to not join or join the program. For those interested in enrolling in the program, An appointment is made for follow-up in the home. As of November 2015, all patients have opted into the 90-day program. The pamphlet is attached in Appendix B.

Describe the processes that will be used by the regional partnership improved care and the MOUs or other agreements that will be used to facilitate the legal and appropriate sharing of care plans, alerts and other data as described in the process.

The following will occur prior to the grant application and as each new provider or hospital join our coalition after 12/21/2015.

1. TLC-MD will have an Operating Agreement signed by all the Hospital Members.
2. TLC_MD will have all advisory committee members sign a Charter.

The VHQC requires a charter, so the TLC-MD charter was updated to incorporate their requirements.

Attach the list of HIPAA compliance rules that will be implemented by the regional partnership.

The Corporate Compliance Directors of each hospital will lead this process. For now, the BAA agreements between the hospitals and TLC-MD and TLC-MD and eQHealth exist. As TLC-MD gets involved with a behavioral health organization, updates to this process will be developed and implemented.

Data and Analytics

Define the data collection and analytics capabilities that will be used to measure goals and outcomes, including specific metrics and measures.

Please reference section “Goals, Strategies and Outcomes” on page 15 as this question is closely aligned.

Describe with specificity the regional partnership’s plan for use of CRISP data.

TLC-MD will use CRISP data for the purposes identified in Tables 2, 3 and 4. As more capabilities are identified and CRISP has more administrative or clinical data, we will look to expand our data use to make use of these opportunities.

Risk Stratification, Health Risk Assessments, Care Profiles and Care Plans

Describe any plans for use of risk stratification, HRAs, care profiles, or care plans. Describe how these draw from or complement the standardized models being developed.

As previously mentioned, eQHealth Professional and data collection contract will meet risk stratification, HRA, Care Profiles and Care Plans. After the grant is provided, the risk stratification will be implemented, which uses the Johns Hopkins model. Each hospital will submit admissions for evaluation. The hospitals’ CIOs are currently developing this process thru an existing module required by Meaningful Use. In the meantime, we are anticipating CRISP to offer risk stratification and will make further decisions when that service becomes available.

If a hospital wants to use this stratification or another tool, TLC-MD will work to understand the benefits of each option. Comparative studies will be documented.

The hospital case management staff performs RCA on all readmitted patients, unless the patient has another care coordination program available. Otherwise these patients are assigned to eQHealth. Once the risk prediction model in place, then new admissions with high risk will also join the High Risk Population pool and have care coordination.

The eQHealth RN prepares the care plan by assembling data from all the patients’ providers and performing a health risk assessment.

In the future, pharmaceutical management, adherence, and other medical equipment will be provided to patients and monitored.

Data gathered from all of these and other interventions will be used to update the care coordination/care transition model.

For risk stratification, include the types of patients, risk levels, data sources, accountabilities (who is accountable to do what?)

eQHealth offers a proprietary risk stratification tool, but during the TLC-MD pilot the hospitals’ inpatient care coordinators and their use of the RCA tool identified high-risk patients. After this pilot, the intent is to use the

eQhealth predictive modeling with the RCA results; however, some hospitals may want to use another model, such as their own or the CRISP model, and TLC-MD will do studies to compare results and learn what the best is for the enrollees.

eQSuite[®] Population Health Management uses sophisticated software to identify high-risk, high-cost members, categorizing and prioritizing them by illness, severity of illness and identifying any gaps in care. Through predictive modeling, we are able to take your claims and other data to identify members whose health, functional ability and use of health services suggest they are good candidates for care coordination, and provide the platform to guide you to care for those members. (From eQHealth materials)

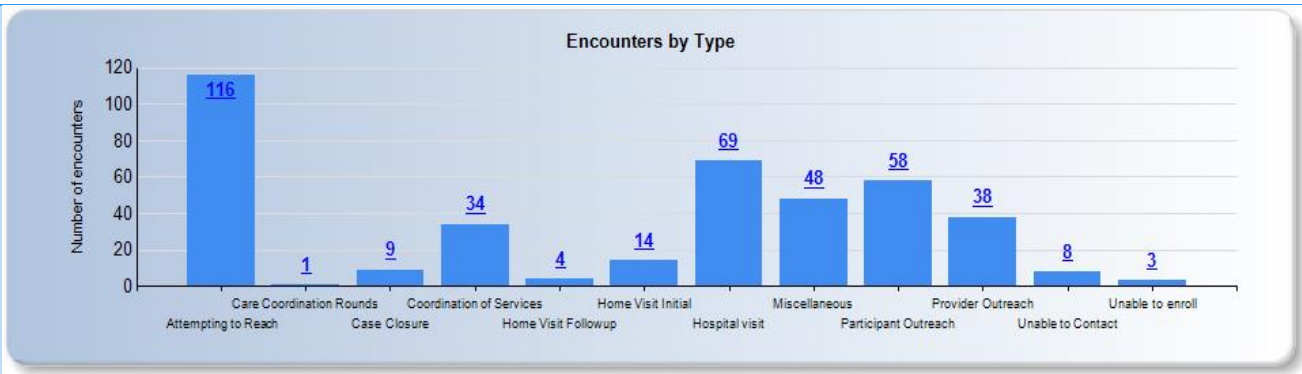
TLC-MD, through its Executive Director and committees, will decide how to work with the results of predictive modeling over time, maximizing impact within its budgetary constraints. At present, the targeted population is highest risk hospitalized patients. We recognize that, over time, we will continue to optimize the targeted with any shifts or changes.

Another tool that TLC-MD has budgeted for is the eQHealth Business Intelligence, resource for current population and network trends (possibly add potential impact here). The TLC-MD Executive Director and the Advisory Committee will recommend changes of the strategies to the Executive Committee.

eQSuite[®] Business Intelligence gives you the ability to take an immediate in-depth look at current population and network trends and drill down into the details. This helps you determine what factors are driving the quality of care and healthcare costs, and you are able to generate custom reports on any data metric desired. (From eQHealth materials)

For HRAs, include the types of screenings, who is accountable for completing, and where information is recorded.

The Health Risk Assessment is being performed by the care coordination nurse of eQHealth as part of generating the eQHealth Care Plan. The Advisory Committee will study the results provided and the RCA results to learn how to provide the high-risk patients the tools and communication to meet the Triple Aim. By the end of November, our pilot program has had 426 identified interventions to improve the care of the 76 enrolled patients. We are studying the reported interventions to improve our offerings to our enrollees. Some of the most frequent have been communicating with the patient and family to enable smooth care transitions, providing a disease specific assessment and education on the basis of the HRA and clinical records, arranging for care transitions visit with primary care physicians, and education about red flags indicating a need to contact the PCP or the care coordinator. The rest are scattered over a remarkable array of interventions, customized to the patients' situations. The graphic below shows the relative rate of various kinds of encounters.



For care profiles and/or care plans, include the key elements that will be included, the systems through which they will be accessible, the people who will have access. Standardized care profiles are anticipated to be developed by the state-level integrated care coordination infrastructure.

eQHealth will generate, store, and appropriately share the care profiles and care plans. Both the eQHealth RN and the case management staff at each hospital will have access to the software to document activity within TLC-MD. eQHealth utilizes national disease state HRA tools in preparing the care plans.

Identify the training plan for any new tool identified in this section.

eQHealth provides all training to their staff and the hospital staff as necessary. There is an integrated IT Operations Implementation Team focused on developing interoperability between the hospitals’ admissions records and eQHealth. The Hospitals’ CIOs or designees are members of the IT team that is led by a member of the Advisory Committee.

Care Coordination

Describe any new care coordination capabilities that will be deployed by the regional partnership.

Engaging the hospitals’ care coordination staff in root cause analyses and contracting with eQHealth to start the pilot are both new endeavors for the Coalition. The addition of medication management and behavioral management is still under review, with an anticipation of agreements signed for implementation with the grant approval. These programs will also be documented in eQHealth, with one data source of capture and storage. We are also examining the possibility of contracting for 24/7 medical coverage, including at home, to cover for physician practices that otherwise send patients to the ER. This service would tap into our care plans and profiles.

Identify the types of patients that will be eligible for care coordination and how they will be identified and by whom.

- All readmitted patients have an RCA performed by the hospital’s case manager.
- High-risk patients are assigned to eQHealth.
- After grant is approved, the predictive modeling tool in eQHealth will be used to perform risk stratification, so that eQHealth will identify patients for hospital’s to approve to be invited into the program, based on budgetary constraints.
- Eventually, the risk stratification may be done by CRISP.

Define accountability of each person in the care coordination process.

Process:

- Hospital Case Managers work with the patients to do the RCA and discuss eQHealth opportunity.
- eQHealth RN speaks with the inpatient before and after discharge.

Accountability:

- The hospital case managers will review the submission of patients and ensure that the RN starts with the care transition while the patient is in the hospital.
- The Care Coordination Committee, chaired by a hospital Member, reviews results with the committee bi-weekly to learn new interventions for improvements.
- Advisory Board hears results and works on additional interventions or changes to existing interventions.
- The hospital Executive Committee will review results at least quarterly, including approving the annual budget to support care coordination interventions.

Describe staffing models, if applicable.

- For Care Transition – one RN to 100 patients – the HIGH level of risk assessment
- For Care Coordination – one RN for 200 patients – the lower levels of risk assessment that may only require medical technology and coordination with other providers.
- TLC-MD will require an Executive Director, a data analyst, and an administrative assistant hired as soon as the grant is approved.

Describe any patient engagement techniques that will be deployed.

Patients (and their families, as appropriate) will meet with the eQHealth RN and other professionals with contracts with TLC-MD, such as

1. Medication management for high-risk medication plans
 2. Behavioral health clinicians as we initiate addressing integration of behavioral health services.
- Some patients and their families will be invited to sit on the Advisory Committee to discuss improvements in the care coordination/care transition programs. Patient feedback will be obtained through surveys and information will be a critical component to the decision making process for investment in future interventions, educational opportunities for physicians and staff, and overall enhancements to the work process and outcomes of TLC-MD.

In an effort to promote outreach, public education, and engagement of civic and community leaders, we have reached out to an array of community-based and faith-based organizations to both guide the work alongside the providers and to assure that the community understands the aims and methods and sees them as positive improvements rather than disconcerting changes. TLC-MD realizes the benefit of utilizing existing community resources when possible and engaging local partners when possible to further our goals in an effective and efficient manner.

Physician Alignment

Describe the methods by which physician alignment will be created.

Currently:

- 1) The hospitals' Chief Medical Officers (CMO) are part of the Advisory Committee and many hospitals may include them on the Executive Committee.
- 2) An ACO President is a member of the Advisory Committee
- 3) MedChi assisted TLC-MD in presenting our care coordination/care transition program to local physicians. Another education meeting is scheduled for January 20, 2016 and further education opportunities being planned.
- 4) The Chronic Care Management tool is available in eQHealth. TLC-MD is working to make this tool available to physicians. At this time, TLC-MD is assessing who needs assistance with this process to meet the billing requirements.

TLC-MD is eager to work with the physicians most often responsible for patients living with advanced illnesses in developing gain sharing incentive programs that complement those of the dominant payers in the area and help to achieve our outcomes goals. Work on this awaits information that some gain sharing will be permitted in Maryland. In the meantime, we are working with our physicians to make it easier to provide excellent medical care to complex patients, seeing that as a strong incentive to physicians to align with the work described herein.

Describe any new processes, procedures and accountabilities that will be used to connect community physicians, behavioral health and other providers in the regional partnership and the supporting tools, technologies and data that will assist providers in the activities associated with improved care, cost containment, quality and satisfaction.

- 1) The possibility of the CCM tool being enabled through eQHealth is one of the first offers from TLC-MD. Decisions are still being made as to how this will be offered.
- 2) Contracting to provide pharmacist consultation for persons with complicate or risky medication management challenges, perhaps with the University of Maryland's pharmacy school will be another tool to test to support physicians.
- 3) The use of gain sharing will be discussed and a program with incentives set, once the State of Maryland and HSCRC allows this program.
- 4) For the first year, monthly CME educational programs offered by MedChi and TLC-MD will keep the TLC-MD programs in front of the providers.
- 5) We will continue to sponsor the TLC-MD Clinical Committee, chaired by the CNO of Ft Washington, which focuses on ancillary ambulatory services and will help to link those providers to this program. TLC-MD is considering testing community health workers on the model now in use in the Health Enterprise Zone in Prince George's County under the Department of Public Health. If this is helpful to patients and physicians, some CHWs might join this committee.

Describe any new value-based payment models that will be employed in the regional partnerships

The Chronic Care Management software and professional services are available with eQHealth. TLC-MD is deciding how to offer it to the physicians. At this time, TLC-MD is assessing who needs assistance with this process to meet the billing requirements. We expect that the VBP gain sharing that TLC-MD would offer will be developed in conjunction with the physicians and may be especially responsive to our younger seriously ill population, with incentives for after-hours management, care plan generation, and moving to a Patient-Centered Medical Home where possible.

Other concepts are still under discussion, such as offering TLC-MD services to insurance companies for a fee.

Organizational Effectiveness Tools

Attach the implementation plan for each major area of focus (with timelines and task accountabilities)

(See the current draft in Appendix A, which is still under active development)

Describe the continuous improvement methods that will be used by the regional partnership.

Having seven hospitals gives TLC-MD the opportunity to pilot test interventions in a couple and compare progress with other facilities. Since Calvert Memorial Hospital started its transformation prior to joining TLC-MD, we have a unique opportunity to learn from previously tested improvement activities.

We will hire an Executive Director with substantial experience and skills in leading QI work. We recognize the discipline needed in order to test and evaluate, always thinking ahead to sustainability and grow. TLC-MD will also hire a data analyst either as an employee or a contracted consultant. The data from eQHealth, RCA, and CRISP will be studied and reported to the Advisory Committee to continuously update our strategies.

Attach a copy of the metrics dashboard that will be used to manage performance over time with an explanation of associated processes that will be used to monitor and improved performance.

See Tables 2, 3, and 4 above (pages 7-10).

Describe the work that will be done to affect a patient-centered culture.

In conjunction with the patient and the family, each high-risk patient will have a care plan that is patient-driven and negotiated. All enrolled patients will have a care plan available through eQHealth within the Coalition. Upon implementation of care coordination services through CRISP, that data may be available elsewhere in Maryland. We aim to have high compliance with care plans and profiles and eventually to build metrics that reflect patient-driven care planning and that evaluate and provide feedback on the adequacy of the care planning.

TLC-MD's Advisory Committee will include patients, family members, and other laypersons. We also value the participation of persons and organizations that focus on enabling citizen input into the process, such as HealthCare for All! Coalition and the Local Health Ministry Network.

New Care Delivery Models

Describe any new delivery models that will be used to support the care coordination outcomes. (For instance, tele-visits, behavioral health integration or home monitoring.)

The major new delivery model is layered care coordination, though we will be testing a sequence of enhancements to that work, starting with medication management. Some of the new approaches TLC-MD will be bringing to our communities, include:

- 1) Medicine adherence through a cloud based tool used to alert the patient and eQHealth when a patient does not comply with medicine guidance.
- 2) UM behavioral health or Mosaic behavioral health programs, once one or more programs are tested and established.
- 3) County case workers and community health workers assisting with social-economic needs as identified by patients in their HRA.
- 4) Other home-monitoring tools to monitor weight, falls, blood pressure and other indicators which inform physicians and care coordinators.

Identify how the regional partnership will identify patients, new processes, new technology and sharing of information.

- 1) TLC-MD will identify patients through RCA and/or the eQHealth predictive modeling. If other providers identify prospective patients, TLC-MD will consider if the patient is appropriate for the program.
- 2) New processes will be identified by the eQHealth, RCA, and CRISP data. Results will be reported to the Advisory Committee to recommend updates of strategies to the Executive Committee.
- 3) TLC-MD expects new technology to be reviewed by the Clinical Committee and IT Committee before presenting to the Advisory Committee and then the Executive Committee. This will include a review of each hospital's current existing IT infrastructure.
- 4) The sharing of information is through the eQHealth system and the CRISP system.

Financial Sustainability Plan

Describe the financial sustainability plan for implementation of these models.

The current plan is to fully utilize HSCRC/DHMH's grant dollars to successfully operate the coalition's work until December 2018, and to enable the program to yield substantial reductions in utilization. As savings occur at each hospital in the reduction of regulated unnecessary utilization, the variable savings could be shared with the counties, the hospitals, the providers who affected change, and HSCRC.

As the program develops, TLC-MD members will be seeking financial investments from other interested parties who share the mission of TLC-MD and who want to see patients remain healthy at home (such as The Harry and Jeanette Weinberg Foundation, other granting foundation, and community partners such as Wal-Mart, Giant, Walgreens and other businesses who invest in the population health needs of their communities.)

Describe the specific financial arrangements that will incent provider participation.

- 1) For Hospitals, the intent is to receive the Temporarily Restricted HSCRC/DMHM grant to grow the coalition and its programs.
- 2) For other ancillary providers, the incentive is keeping patients healthy at home with their services, such as home health, hospices, pharmaceuticals, etc.
- 3) For community physician providers, the incentive is more organized and effective office visits and fewer disruptive hospital visits.
- 4) For all ambulatory providers, TLC-MD anticipates sharing some of the shared variable savings in a gain sharing program.

Population Health Improvement Plan

Provide detailed description of strategies to improve the health of the entire region over the long term, beyond just the target populations of new care delivery models. Describe how this plan aligns with the state's vision, including how delivery model concepts will contribute and align with the improvement plan, as well as how it aligns with priorities and action plans of the Local Health Improvement Coalitions (LHICs) in the region.

- 1) The target population, 2014 Community Benefits data for each hospital, is the first step; however, all patients in the three represented counties can join the program at any time, up to the budgetary limits of TLC-MD.
- 2) The first step is to focus on Medicare patients, but all patients are encouraged to enroll in the program, again depended on budgetary limits. Patients will be screened and referred to available benefit providers, charity care programs, etc. as available.
- 3) TLC-MD's eQHealth offers a lot to history and tools that could support our counties and the entire state. We have already introduced eQHealth leadership to CRISP leadership to help develop the CRISP tools, by considering component outsourcing.
- 4) The LHICs are members of the Advisory Committee and through their identified needs; TLC-MD will see how it can assist.
- 5) Under the direction of TLC-MD, Prince George's County will coordinate one Community Health Needs Assessment, as is done in Calvert and St Mary's counties

Appendix A: Implementation Timeline

Appendix B: TLC-MD Pamphlet

Appendix C: Maps and Population of TLC-MD

The maps below show the service areas of the seven Coalition hospitals which provided inpatient services to Prince George's, Calvert and St. Mary's County residents in FY 2014.

The data for this map was obtained from the Maryland Health Services Cost Review Commission (HSCRC) at the following website:

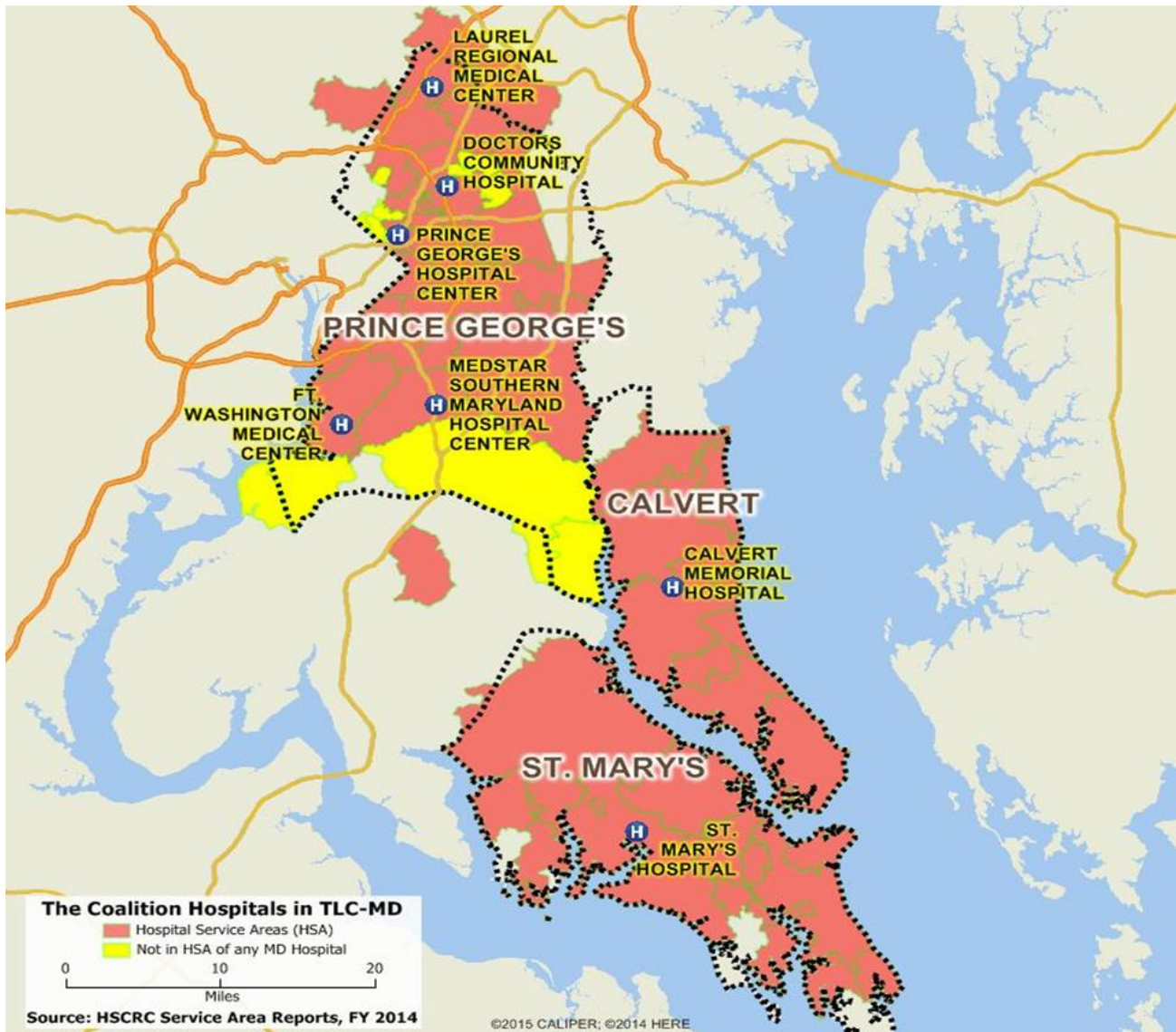
http://www.hscrc.state.md.us/documents/HSCRC_Initiatives/CommunityBenefits/DataCollectionTools/2015/Acute-PSA-FY2014.xlsx

The zipcode areas shown for each hospital are not mutually exclusive, i.e., that a zipcode area can only be listed in the service of one hospital. Because several zipcodes were listed in the service area of more than one Maryland hospital, the map includes twenty-one (21) "overlapping" zipcode areas³. The combined service areas of the Coalition hospitals are shown **red**. One zipcode area of MEDSTAR Southern Maryland Hospital Center's Service Area (20602) is located in Charles County. Portions of Laurel Regional Medical Center's Service Area are located in Anne Arundel, Montgomery and Prince George's Counties.

There are nine (9) zipcode areas located in Prince George's County that were not included in the service areas of any Maryland hospital⁴. These are zipcode areas with very small, sparsely populated and/or unique resident populations, for which the total number of hospital discharges from that area to any one Maryland hospital was not sufficiently large to qualify it as a service area zipcode. For example, zipcode area 20742, the campus of the University of Maryland College Park, is populated with a uniquely younger resident population, for which the number of hospital discharges to any one Maryland hospital is so small relative to other zipcode areas and populations that it did not qualify as being a service zipcode area by the HSCRC. These nine unique zipcode areas are shown in **yellow**.

³ These include: 20703, 20748, 20792, 20775, 20721, 20731, 20774, 20737, 20738, 20770, 20785, 20743, 20744, 20745, 20746, 20747, 20784, 20791, 20753, 20757 and 20706.

⁴ These include: 20607, 20613, 20608, 20722, 20712, 20781, 20769, 20771 and 20742.



Appendix D: Operating Agreement and Charter