Frederick Integrated Healthcare Network
MDCTO-0089
Summary Information

Maryland Primary Care Program, 2018 Application Cycle

CTO Overview

CTO Information	
Application ID Number	MDCTO-0089
Status of the Proposed CTO	The proposed CTO is owned and operated by a healthcare organization and is currently in existence.
Organization Site Name	Frederick Integrated Healthcare Network LLC
DBA Name	Frederick Integrated Healthcare Network
Website (if applicable)	fihnaco.org
Ownership & Legal Structure	
Owned by Health Care Organization	Yes
Name of Parent Organization	Frederick Regional Health System
Legal Structure	Non profit 501c3 LLC
Service Area	
Counties Served	Frederick County
Partnerships	
Formal Partnerships	Frederick Co. Health Department, Frederick Co. Health Care Coalition (LHIP), Trivergent Regional Partnership for Healthcare Transformation, Advanced Health Collaborative, Mental Health Association, Agency on Aging, Asian American Center, UZURZ Transport, Frederick Community Action Agency (FQHC), Coordinating Center, Wahlgreens, Whitesells, Right At Home, Amada, Maryland Prescription Assistance Program, FMH Home Health and Hospice, MHP Dental Clinic, Meals on Wheels, SNAP.
Informal Partnerships	N/A
Services Offered	
Tele-diagnosis	Planned for future
Tele-behavioral health	Planned for future
Tele-consultation	Planned for future
Remote Monitoring	Currently in place
Other	Currently in place
HIT	
CRISP Connectivity	We currently educate and support practices on the use of services from the State-Designated Health Information Exchange (CRISP).; We assist practices in establishing electronic health information exchange with CRISP or a community-based health information exchange network.; We use CRISP to view data.; We send administrative encounter data to CRISP on a regular basis.; We send clinical data (CCDAs or QRDAs) to CRISP on a regular basis.

HIT Vendor	Integra Connect	NextGen Healthcare	eClinical Works, LLC	Aprima Medical Software Inc	Athenahealth, Inc
HIT Product Name	Mastermind EHR	NextGen Ambulatory EHR	eClinicalWorks	Aprima PRM 2015	Athena Clinicals

Care Team Members

Category	Currently in place: How many?	Planned for future: How many?
Administrative Support	1	N/A
Behavioral Health Counselor	2	N/A
Billing/Accounting Support	N/A	1
Care Managers - RNs	5	N/A
Care Managers - Medical Assistants	N/A	N/A
Care Managers - LPN	1	N/A
Community Health Workers	N/A	N/A
Data Analysts	1	N/A
Health IT Support	2	N/A
Licensed Social Workers	3	N/A
Nutritionist	1	N/A
Pharmacists	2	N/A
Practice Transformation Consultants	2	N/A
Psychiatrist	N/A	N/A
Psychologist	N/A	N/A
Other	N/A	N/A

Vision

The CTO will support practices in achieving transformation in the following areas depending upon practice specific needs and Program Tracks: Care Management, Data Analytics, Connectivity and Information Sharing, Practice Workflow improvement, Linkage to Agencies and non-traditional care providers and assistance with meeting care transformation and reporting requirements. Care managers in the CTO will work with care team members and patients to develop patient specific plans of care that focus on the patient's needs, barriers, lifestyle and set realistic expectations for self-management that meet that patient's desired goals. Care Managers provide coaching between clinical visits and linkage between providers and community agencies to maximize efficient use of available resources. The Frederick Integrated Healthcare Network (FIHN) MSSP ACO 2492 has care managers embedded into Primary Care and select Medical Specialty practices in Frederick County serving 10,500 Medicare beneficiaries. Serving as a CTO for MD PCP will allow continuity of care management for the physician practice and patients. The FIHN approach to Care Management has been successful in improving quality and reducing avoidable utilization and costs for Medicare. This has created community momentum for change due to shared goals and incentives. FIHN works across communities with our partners participating in the Regional Grant for Care Transformation with the Trivergent hospitals to our west. We plan to supplement CTO functions through economies of scale by collaborating with other systems in the Advanced Health Collaborative (coalition of 5 Maryland hospitals) to reduce the cost of CTO supporting tools such as telemonitoring, behavioral health telemedicine and other initiatives. The ACO Analytics Team makes use of Medicare claim, EHR data, CRISP tools and Care Management screening tools to risk stratify patients and prioritize work starting with the highest risk population. We produce dashboards to monitor progress and provide patient specific actionable data for care managers and practices. The IT Analysts visit practices and educate staff on workflows for integrating data into discreet EHR fields for ease of reporting, quality improvement tracking and daily huddle reports to reduce gaps in care. They also provide support to link to CRISP connectivity and utilize hospital encounter notifications to provide transitional care. FIHN has trained Practice Transformation Specialists who assist with practice workflows, LEAN process development and working at the top of license to increase quality of outcomes and efficiency. The Transformation Specialists participated in best practice training through our local CMS QIO that trained practices under the Maryland Primary Care Medical Home initiative. The FIHN medical directors review population level reports by practice with physicians and discuss performance and priorities quarterly. Our teams look forward to expanding current efforts using best practice CPC + Program tactics to develop practice specific transformation plans. CTOs participating in the MD PCP will help continue to transform primary care delivery from a reactive, illness based, episodic process to a proactive community based service thru which the unique needs of more beneficiaries will be met by expanding capacity and improving value based care. The use of analytic tools will allow for the proactive identification of population based needs and smart use of limited practice resources. The Program will enable practices to remain viable and independent in a sustainable fashion that reduces overutilization and the total cost of care in Maryland. We are excited about this opportunity to improve care for patients and continue to support our local independent physician partners.

Approach to Care Delivery Transformation

The Frederick Integrated Healthcare Network has 3 years of experience working with practices to transform. Our approach has evolved over time as we tested new methods, continued our education and listened to patients and practices. Our strategy begins with the foundation of the right leadership team. Those include our medical directors, practice transformation specialists, IT analysts, care management teams, CHWs, practice managers, EHR superusers, engaged community physician leaders and Medicare beneficiaries on our Board. We conduct quarterly educational group and practice specific meeting focused on review of current quality and service metrics, best practices for improvement and actionable patient specific reports. Each practice requires a roadmap for success based on their needs and differences in their population. We envision furthering our work using best practice tactics identified in the CPC+ program. This team has demonstrated their value to practices and patients through reducing avoidable utilization metrics such as Emergency Room Visits/1000, Readmissions/1000 and Admissions/1000. We have seen year over year improvement of our quality scores now at 96% and assisted practices in making meaningful use of data and targeting populations for quality improvement. Medical teams adopted 10 evidence based pathways for chronic conditions and several practices report to registries to measure compliance. A physician recently commented at an ACO All Provider Meeting, "if you told me 3 years ago what the care manager in my office would mean to our staff and patients I never would have believed you, now I don't know what we'd do without her." These testimonials are common and treasured. This is hard work, particularly for many solo practices in our community where transformation would be nearly impossible without the assistance of ACO/CTO resources. This approach works and we are excited to expand upon our experience.