MSLLC
MDCTO-0105
Summary Information

Maryland Primary Care Program, 2018 Application Cycle

CTO Overview

CTO Information			
Application ID Number	MDCTO-0105		
Status of the Proposed CTO	The proposed CTO will be owned and operated by a healthcare organization and does not yet exist.		
Organization Site Name	Management Solutions LLC		
DBA Name	MSLLC		
Website (if applicable)	www.managementsolutionsllc.com		
Ownership & Legal Structure			
Owned by Health Care Organization	No		
Name of Parent Organization	N/A		
Legal Structure	Limited Liability Company		
Service Area			
Counties Served	All 24 Counties: Allegany County; Anne Arundel County; Baltimore County; Baltimore City; Calvert County; Caroline County; Carroll County; Cecil County; Charles County; Dorchester County; Frederick County; Garrett County; Harford County; Howard County; Kent County; Montgomery County; Prince George's County; Queen Anne's County; Saint Mary's County; Somerset County; Talbot County; Washington County; Wicomico County; Worcester County		
Partnerships			
Formal Partnerships	N/A		
Informal Partnerships	Baltimore County Department of Health; Department of Social Services; Baltimore County Social Services Department; Baltimore Social Services Department; Community Assistance Network Baltimore Maryland; Prince George's County Department of Health		
Services Offered			
Tele-diagnosis	Planned for future		
Tele-behavioral health	Planned for future		
Tele-consultation	Currently in place		
Remote Monitoring	Planned for future		
Other	N/A		
HIT			
CRISP Connectivity	We use CRISP to view data.		
HIT Product Name	CompleteConnect. Web-based app integrates geographic, clinical, census, etc	Management Assessment & Improvement Priorization Model. Web-based survey	WebOPUS. Proprietary web-based Electronic Case Management Reporting System
HIT Vendor	Integra Service Connect (Health IT Tool)	Management Solutions (Health IT Tool)	Manged Care Advisors (Health IT tool)

Care Team Members

Category	Currently in place: How many?	Planned for future: How many?
Administrative Support	1	5
Behavioral Health Counselor	N/A	2
Billing/Accounting Support	N/A	5
Care Managers - RNs	65	5
Care Managers - Medical Assistants	N/A	N/A
Care Managers - Other	N/A	N/A
Community Health Workers	N/A	N/A
Data Analysts	7	5
Health IT Support	20	5
Licensed Social Workers	N/A	N/A
Nutritionist	N/A	N/A
Pharmacists	N/A	N/A
Practice Transformation Consultants	3	5
Psychiatrist	N/A	N/A
Psychologist	N/A	N/A
Other	N/A	N/A

Vision

Management Solutions, LLC Care Transformation Organization (MSLLC-CTO) comprises three partner-organizations namely: Management Solutions, LLC, Integra Service Connect (Integra), and Managed Care Advisors (MCA). MSLLC-CTO will support Maryland Primary Care Program (MDPCP) practices by providing an end-to-end care management solution-- pulling from our internal (and extended) resources. MSLLC-CTO will provide support via care management personnel, additional infrastructure, and technical assistance to our partner practices. Our service offerings are grouped under two main categories of CTO services: A) Care Coordination Services, B) Management Support Services. Our care Coordination Services are further categorized into Care Management Services and Community Care Services. MSLLC-CTO will provide Care Managers, Community Health workers, other healthcare providers, and supporting care coordination tools to support practice care teams with care coordination, standard beneficiary screening, and care transition support. Resources will be embedded at the request of the practice, and/or provide services to patients in the community to enhance the practices' capacity to provide care management services. We will support partner practices with the following: 1. Care Coordination a. Patient Empanelment & Risk Stratification: 1)Empanel patient & Assign PCP 2)Assign care team in EHR (Including Lead Care. Mgr.) 3)Define role of care team members 4)Risk-stratify & Screen empaneled patients b. Proactive Longitudinal Care Management: 1) Identify patients that need care management services based on risk 2)Established a team-based approach with dedicated clinically trained staff working closely with practitioner 3)Develop & use patient-centered care plan for high-risk patients 4)Identify & assign additional care team members (e.g. dietician, nutritionist, etc.) 5)Maintain regular check-in & follow up 6)Identify & close care gaps 7)Use EHR/stand-alone registry to track patients in care management 2. Standard Beneficiary Screening a)Use and integrate a health-related social need screening tool that will identify community and social service needs b)Refer beneficiaries with social needs to community services organizations and public health agencies c) Inventory and maintain/access a current database of community and social services d)Track and measure success rates of linkages to community resources 3. Care Transition Support a. Referral Management: 1)Identify high-volume and/or high-cost specialist serving attributed patient population 2)Establish collaborative care agreements (with hospitals, EDs, Community-based organizations) 3)Ensure post-discharge care includes plan for practice-based care and medication management 4) Systematically integrate information from referrals into care plan c. Episodic Care Management (across transitions) 1)Identify patients with recent discharge/ED visit 2)Provide transitional care services such as: Care transition planning and follow up; Ensure diagnosis and discharge plans are understood by patient and families; Conduct medication reconciliation 3)Document encounter and next steps in EHR MSLLC-CTO's management support services (technical assistance services) include: Program Management, Systems/Process Improvement Services, and Data Management Services. These services will support practices in streamlining their workflows and meeting their connectivity and data sharing requirements. To ensure a high-level of professionalism and accountability, MSLLC-CTO has identified a functional management structure to provide quality services consistently across the board. As we work closely with our practice partners to enhance their capacity for care transformation, we will be working internally to review our ongoing services and continually improve and adjust to meet the evolving needs of our partner practices. Our management structure also ensures that we stay compliant with all requirements & meet our goals.

Approach to Care Delivery Transformation

MSLLC-CTO understands that no two practice transformation implementation will be the same; as all practices have unique capabilities & opportunities for improvement. We'll meet partner practices where they are & work closely with them on their terms to engage in & facilitate innovative approaches that result in value-based care delivery. The MDPCP model will be new to most of our practices; our goal is to keep things simple & uncomplicated. MSLLC-CTO's approach involves 4 iterative steps: Step 1: Partner Practice Assessment, Step 2: Plan for Change, Step 3: Implement Change, & Step 4: Sustain Change. Step 1: MSLLC-CTO (in collaboration with practices) will conduct a practice assessment using our customized assessment tool to assess practices' level of transformation across key primary care functions & drivers. If an assessment report already exists, we'll review the baseline data to inform our assessment. In Step 2 MSLLC-CTO will develop a recommended practice-specific implementation plan that includes the approach & roadmap for care transformation outlining people, process, technology & the integration/handoffs between partner practice staff & MSLLC-CTO staff. Step 3, MSLLC-CTO will provide care management resources to support practices with implementing change and participate in actions groups & affinity groups. If additional CTO services are needed such as change management & process improvement, MSLLC-CTO will support with implementing tests of change using PDSA & other QI methodologies. We'll leverage (as needed) our proprietary health IT tools to develop actionable dashboards/reports. Step 4, MSLLC-CTO would work hard to sustain positive change. We'll work closely with our partner-practices to help maintain a culture of improvement. We'll participate in required practice team huddles/review sessions. We'll provide weekly/monthly updates on care management (& other support) services to review care delivery standards using actionable data.