MARYLAND
Department of Health
Larry Hogan, Governor · Boyd Rutherford, Lt. Governor · Dennis Schrader, Secretary

Care Transformation Organizations Environmental Scan: A Summary

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Section 1- General Questions

Question 1: Describe the legal structure of your organization.

Legal structure is an important component of an organization's ability to function as a Care Transformation Organizations **(**CTO). The organizations were delineated into six categories:

1. health systems/ medical accountable care organization (ACO) [13];
2. ACO [1];
3. health systems [3];
4. health department [2];
5. health care coalition [1];
6. Area Health Education Center [1].

A total of 21 organizations responded to the survey. Respondents included large health systems, the majority of which are nonprofit, 501(c)(3)s, who service all Maryland counties. Among the other respondents, 21 out of 23 counties in Maryland, plus Baltimore City, were listed as active service areas. Respondents that were the ACO portion of larger organizations reported setting up a separate limited liability corporations (LLC) to operate this part of their business. Additionally, most of the organizations established independent governance for their hospitals and ACOs, including physician led boards.

Question 2: If your organization participates in a Medicare Accountable Care Organization, describe your current track level and model.

Of the 21 responses, 14 organizations reported current participation in an ACO. Over half of the respondents either participated in or managed a Track 1 Medicare Shared Savings Plan (MSSP) ACO. Only one respondent noted being in a Track 3 ACO. The length of

involvement ranged from as early as 2012 to as recent as 2017.

Question 3: Provide an overview on the population that you serve (i.e., numbers, patients served, demographics, payors, and health status).

Most respondents reported a population that included every age, socioeconomic strata, payor type, and health status. Hospital system and ACO respondents indicated they had between 100,000 to one million patients. A few of the respondents specified that they served rural, underserved or low income populations.

Question 4: Describe the nature of your contact with patients and providers (i.e., care management, hospital follow-up, social service connections, health education, etc.).

The vast majority of respondents responded affirmatively that their organization has experience with supporting practices to address high and rising need patients. A few of the organizations directly addressed health education for providers and patients, as well as providing practice transformation supports. Organizations listed a variety of services that they are experienced in delivering including:

- services to the high-risk Medicare fee-for-service population;
- social service connections;
- behavioral health navigation;
- practice transformation supports;
- integrated technology platforms to address gaps in care;
- hospital and embedded care management, as well as care transition programs; and
- multi-disciplinary care teams including community health workers, social workers, and behavioral health providers.

Section 2 - Staffing and Partnerships

Question 1: Does your organization work directly with practices? If so, what services do you currently provide?

The least amount of support was reported by government organizations and more by ACOs and health systems. Most of the ACOs and health systems provided the same level of support for practices, including partnering with physicians to improve patient care, and quality and efficiency, as well as developing innovative ways to implement best practices for patient-centered care, including strategies for population health, coordinated community-based care, and multidisciplinary support. Some organizations specifically mentioned helping practices with:

- telehealth;
- reporting to Meaningful Use;
- Physician Quality Reporting System (PQRS);

- connecting to Chesapeake Regional Information System for our Patients (CRISP) or other health information exchange/registries; and
- a technology platform to effectively manage their patient populations.

Question 2: Specifically, identify and describe team members (e.g., Registered Nurse, Community Health Worker, Social Worker, Behavioral Health Specialist, Pharmacist, etc.) employed by your organization who perform the activities in the domains listed above. If applicable, describe your ratios of staff to beneficiaries as it relates to the domains.

Team members included registered nurses, registered dieticians, care managers, care coordinators, community health workers, social workers, behavioral health providers, respiratory therapists, process improvement managers, data analysts, and pharmacists. Staffing ratios varied by type of team member. Most organizations only had one pharmacist. Care managers and nursing ratios varied from 1:30 to 1:150.

Question 3: Describe how your organization collaborates with social service and community organizations to promote holistic health management.

Organizations reported collaborating with home health, hospice, outpatient physical and occupational therapy, behavioral and mental health services, public housing authorities, meal providers, local advocacy groups and the faith-based community.

Section 3 - Data and Quality Management

Question 1: Does your organization:

a. *Use electronic health records (EHRs) to manage care and report quality? If so, provide the name of the EHR system.*

Respondents reported using electronic health record (EHR) platforms in both inpatient and outpatient environments to manage care and for quality metrics reporting. Many of the multi-site, multi-facility organizations connected disparate vendor systems through a central data quality management system for internal analysis, quality improvement, and population health. Non-clinical organizations were also using EHRs for services provided to clients.

b. *Educate and support practices on the use of services from the State-Designated Health Information Exchange (CRISP)?*

Organizations responded that they have integrated and were actively using CRISP services like encounter notification service (ENS), care alerts, query portal, and CRISP Reporting Services. Level of connectivity (Tier) with CRISP is not immediately clear.

c. *Assist practices in establishing electronic health information exchange with CRISP or a community-based health information exchange network?*

See summary above.

d. Use risk stratification to identify patients for care management?

The majority of respondents discussed using risk stratification methodologies or scores to inform their care processes. Some organizations talked about specific tools or reports that they used to identify patients for care management.

e. Collect, report, and interpret quality metrics?

Most organizations reported collecting, reporting, and interpreting quality metrics for the ambulatory providers, and consistently providing feedback to providers regarding performance. Among the metrics reported are ACO and value-based purchasing measures, often from a dedicated unit.

Question 2: How do you utilize data to facilitate quality improvement in the practices that you currently support? Describe the data that you collect and the manner that you use the data to inform your quality improvement initiatives.

Respondents reported using data to risk-stratify patients (for appropriate interventions and resources), and they also reported on individual clinician and aggregate performance on health equity, safety/risk, meaningful use, quality, patient experience, and efficiency metrics. Multiple data sources (e.g., payor, hospital, SureScripts, CRISP, EMR, and patient-reported data) were integrated. The organization leveraged this data to identify gaps in care, process improvement opportunities, and care management needs. The organization then works closely with physicians and their staff to make the necessary workflow changes to improve quality outcomes and reduce the total cost of care. Hospital organizations had a significant focus on acute utilization with their ambulatory providers.

Question 3: Describe the technical infrastructure in place to share data with practices, CRISP, and other entities on cost, utilization, and quality at regular intervals (e.g., quarterly).

Practices were able to access data for their populations directly through portals. Organizations reported the provisions of data systems that display daily, weekly, and monthly dashboards on utilization, cost, and quality. Hospitals and other organizations were at various stages in terms of integrating data feeds into CRISP for care management to include care plans and care alerts.

Section 4 - Practice Transformation and Technical Assistance

Question 1: Describe the role of your organization in providing health education and trainings.

Most of the organizations offered services and programs for patient education, including support groups, health screenings, and informative seminars, to help individuals make healthier choices and lifestyle changes. Many of the organizations offered coaching and education to partner practices, such as regular meetings, weekly visits, and trainings, to support better care at lower costs. Organizations also offered best practice education focused on specific diseases such as chronic obstructive pulmonary disease, congestive heart failure, and diabetes.

Question 2: Do you provide behavioral health support within a provider setting? If so, please describe.

Most organizations reported offering behavioral health support within a provider setting. Offerings ranged from having a full-time psychiatrist on staff available for provider consultation, to care manager support, and to embedded behavioral health specialists. Some respondents leveraged telehealth services for behavioral health.

a. *Does your organization promote the use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs?*

Six of the organizations confirmed the use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.

Question 3: What support for social services (i.e., referrals, application assistance, etc.) and core needs (i.e., food insecurity, transportation, housing instability, etc.) do you provide?

The majority of organizations provided services to arrange for assistance with benefit applications and core needs to include food, clothing, shelter, safety, and medication assistance. One organization provided access to discretionary funds to support short term immediate access to resources, such as transportation or temporary housing.

Question 4: Do you work with practices that provide care to high and rising needs patients with substantial hospital utilization? If so, describe the support that you provide.

All but one organization provided support for practices to provide care to high and rising needs patients with substantial hospital utilization to reduce avoidable and unnecessary utilization. The organizations provided support to practices to identify and manage their high risk patient through chronic care management, transitional care management, responsible management of referrals and many other methods.

Question 5: What kind of consumer and patient engagement services does your organization provide?

Most of the organizations provided consumer and patient engagement services, including access to a patient portal, a Community Advisory Board, a Patient Engagement Council, and a Community Patient Engagement Team. A few offered patient and family advisory committee (PFAC) meetings to test new ideas and gather feedback on the best methods to promote services to patients. Most of the organizations reported on specifically training staff how to empower patients to take ownership of their health and health care.

Question 6: Does your organization deliver targeted engagement solutions to disengaged and engaged patient populations?

Most organizations delivered targeted engagement solutions for both disengaged and engaged patient populations. Some reported that PFAC members are chosen to represent disengaged populations. The organization used the input of the PFAC members to refine its outreach strategy for those individuals.