State Innovation Models (SIM) Award: Community Integrated Medical Home

Laura Herrera, MD MPH
Deputy Secretary for Public Health
Maryland Department of Health & Mental Hygiene

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State Innovation Models (SIM) Grant Solicitation

- Released by Center for Medicare & Medicaid Innovation (CMMI) at CMS
- Purpose: Develop, implement, and test new health care payment and service delivery models at the state-level
- Maryland received "Model Design" award
  - $2.37 million
  - 6-month planning grant (April 1 – September 30, 2013) to develop "Community-Integrated Medical Home"
  - Opportunity to apply for "Model Testing" award for up to $60 million to fund implementation over a 4 year period.

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Community-Integrated Medical Home

- Integration of a multi-payer medical home model with community health resources
- 4 pillars:
  1) Primary care
  2) Community health
  3) Strategic use of new data
  4) Workforce development
- Goal is for CIMH to be an umbrella program with certain programmatic standards that allows for innovations across payers

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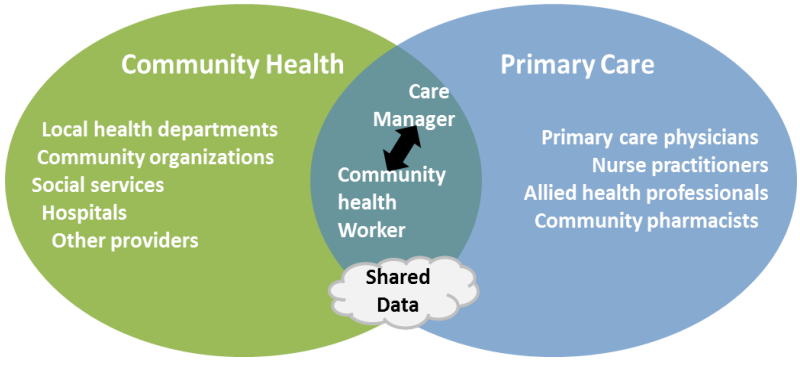
Community-Integrated Medical Home



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Planning Process

- Two parallel stakeholder engagement processes
  1) Payers and Providers
  2) Local Health Improvement Coalitions
- All-stakeholder summit near the end of 6-month period to review recommendations from both processes and make final recommendations
- Health Quality Partners will manage planning process and provide content expertise

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Meeting Schedule

- **Payer/Provider Group** *(201 Preston Street)*
  - May 9, 12:30 - 5pm (L-1)
  - June 5, 12:30 - 5pm (L-3)
  - July 9, 12:30 - 5pm (L-1)
- **Local Health Improvement Coalition (LHIC) Group** *(201 Preston Street)*
  - May 17, 8:30am - 1pm (L-1)
  - June 18, 12:30 - 5pm (L-1)
  - July 16, 12:30 - 5pm (L-1)
- **Stakeholder Summit** (members of both groups): July 31, 8:30am - 5pm: *Location TBD*
- All meetings open to the public

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Payer and Provider Engagement Process

- Develop a governance structure for CIMH program
- Establish a public utility to administer payment and quality analytics processes
- Set programmatic standards, such as
  - Criteria for practice inclusion
  - Quality metrics
  - Analytics
  - Shared savings methodology
- Hilltop Institute and Optumas will conduct actuarial modeling of health costs to demonstrate savings expected from CIMH

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Local Health Improvement Coalition (LHIC) Engagement Process

- Complement medical care by linking high-need patients with wrap-around community-based health services
- Capacity of LHICs will be strengthened
  - Develop new models to carry out population health activities (e.g., 501(c)3, integration with LHD, etc.)
- More Definition Around Community Health Worker role
  - Define responsibilities and required skills/education for CHWs
  - Develop pathways through which they will be connected to practices
- Use new data and mapping resources to "hot-spot" high utilizers and bring them into CIMH
  - Review and provide feedback on prototypes

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New Data Resources

- CRISP developing mapping tools for "hot-spotting"
  - Real-time hospital admissions data
  - CHWs and care managers would use to reach out to high utilizers in the community
  - LHICs and local health departments can use to monitor population health and develop targeted interventions
  - Monitor progress on community-based interventions
- DHMH will expand Virtual Data Unit
  - Warehouse of social and economic determinants, population health, outcomes, and other data
  - Will help LHICs with CIMH work as well as SHIP measures
- Maryland Health Care Commission to assess and plan expansion of All-Payer Claims Database
  - Envision APCD as supporting provider measurement on cost and quality and clinical decision-making.

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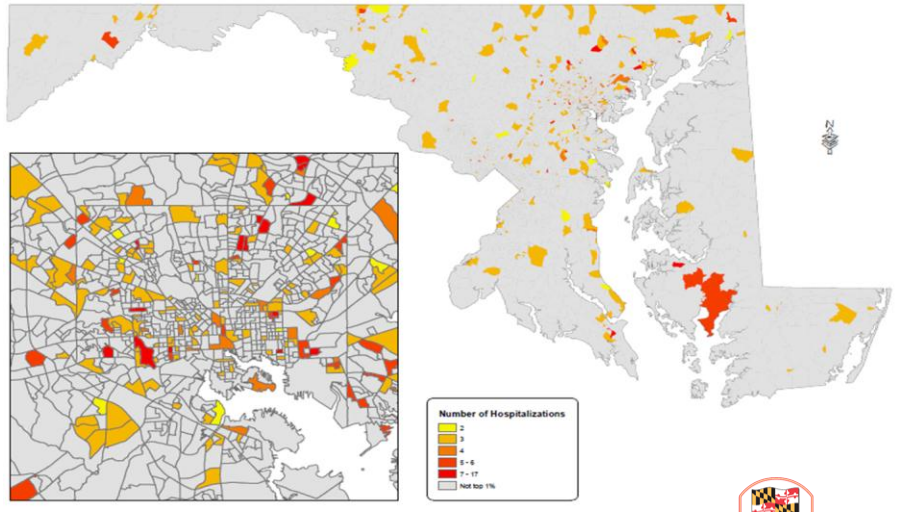
Sample Hot-Spotting Map



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Workforce Development and CIMH Readiness

- Conduct background research to inform Community Health Worker development
  - Inventory of training programs and CHW models
  - Identify best practices for integration of CHW into medical practices and broader health care system
  - Will present findings at LHIC stakeholder engagement process
- Technical assistance and CIMH readiness
  - Identify various ongoing TA and develop recommendation for streamlining
  - Convene TA providers and chart path forward
  - Identify and describe quality improvement efforts in local communities
  - Assist in scaling up of promising QI models

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Major Deliverable

- "State Innovation Plan" that articulates the CIMH model in detail.
  - Must show how CIMH integrates with other state delivery and payment reforms
- Will form the basis for Model Testing application to CMMI

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Health Quality Partners

- Ken Coburn, MD, MPH: CEO and Medical Director (Senior Consultant)
- Sherry Marcantonio: Senior Vice President (Program Manager)

Role of Stakeholder Input: State Innovation Model Planning

Ken Coburn, MD, MPH
Health Quality Partners

1

Role of Stakeholders

- Stakeholder input key to informing design
- Major ways stakeholders can contribute
  - Creativity: Help us identify new and better approaches
  - What would it take to align and leverage DHMH initiatives with yours to achieve maximum signal strength and economies of scale?
  - Help us identify and troubleshoot potential areas of disjuncture
  - Teach us what you've learned that we should know

2

Nature of Stakeholder Input

- Stakeholder input is advisory in nature
  - No group consensus is expected or required
  - All inputs will be considered and documented
  - May be iterative; we may need to outreach to you for more input and clarification
- Your input is highly valued and will be used to inform design
  - Crucial to creating a model that is widely supported, well utilized, effective and sustainable

3

Key areas of input from this group

- Governance
- Public resource for data management and advanced analytics
- Program standards
- Evaluation measures
- Sustainability

4

Means of Stakeholder Input

- Stakeholder meetings
  - 3 for each stakeholder group + 1 joint summit
- As project facilitator for Maryland, Health Quality Partners (HQP) encourages and accepts stakeholder input outside of meetings
  - Confidentially if preferred and clearly indicated
  - By email, phone
  - All input will be brought to the attention of the core project team at Maryland DHMH

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Conduct of Stakeholder Meetings

- Framing information for topics will be followed by open discussion, brainstorming, exchange of ideas
- Meetings will be recorded and transcribed
- Balanced participation across all attendees will be sought
- Respectful demeanor at all times

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Contacting HQP to Offer Additional Input

- Ms. Sherry Marcantonio, Senior Vice President, Chief Program Architect
- Office Phone: 267-880-1733 ext. 27
- Email: marcantonio@hqp.org

- Thank you – Questions? Suggestions?

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Guiding Principles and the Conceptual Approach to Operational Design

K Coburn, MD, MPH
Health Quality Partners

1

Design Process

- Vision
- Aims
- Principles
- High-level design specifications
  - Mappings, schemas, visualizations
- Detailed design specifications
  - Further informed by measurable performance goals / times
- Testing, Measuring, Evaluating

- Good design is an iterative process requiring multiple revisions, discussions, inputs, new insights, and testing leading to increasing effectiveness

2

CIMH Aims
Improve health and lower cost

- Create new or strengthen existing community interventions esp. for high-risk populations
- Extend capabilities of PCMH with greater access to and use of community interventions
- More effectively use information and analysis
- Create a framework for sustainability

3

Advantages of Community Deployed Interventions

- Increased accessibility to and engagement with high-risk populations
- Greatly increases identification of and ability to intervene on non-medical (environmental, social, behavioral, cognitive, etc.) determinants of health
- Increased person-centeredness
- Resource allocation often more efficient than office practice or institutional deployment

4

Evidence that Community-based services can lower health care costs and utilization

- Mixed
  - Some models shown to be effective
  - Quality of codification and evaluation varies greatly
- Maturing
- Promising area for R&D / new development
- Highlights need for disciplined design, implementation, and evaluation

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CIMH Guiding Principles

- Person-centeredness improves care
- The CIMH should be as "payer agnostic" as possible from the provider point of view
- Community interventions and medical care should be integrated
- New community capabilities need to be developed
- More effective transformation of data into information and advanced analytics is critical to the effectiveness of the CIMH
- Administrative efficiency and ease of use will increase adoption
- A "healthy balance" between standardization and flexibility will best enable broad implementation

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Thoughts, suggestions, additions, deletions, changes to the guiding principles of the CIMH?

7

Future Discussion: Heading toward high-level design specifications

- Selecting target populations
- Goodness of fit between target populations' modifiable risks and proposed interventions
  - Largely determines estimated savings

- Who will we serve?
- How will we care for them differently?
- What evidence exists that doing so improves health or reduces cost?

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Beyond the Operational Design

- Success and sustainability of entire model is heavily dependent on the effectiveness of key infrastructure;
  - Governance
  - Quality standards
  - Program performance measurement
  - Information technology
  - Financing / business model

Overview of Maryland's Patient Centered Medical Home Programs

Ben Steffen

May 9, 2013

Maryland Program History

Studies in 2009 showed

- Tools to enhance primary care are limited in Maryland law
- Higher payment for primary care alone would be inadequate

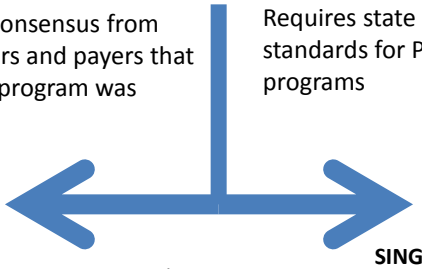
Legislation in 2010 established

- Authority of the state to launch a PCMH program
  - Exemption for a cost-based incentive payment tied to PCMH
  - Authority for carriers to establish single carrier PCMH programs with incentive-based reward structure (shared savings) and data sharing

2010 PCMH Legislation

Broad consensus from providers and payers that a state program was needed

Requires state to establish standards for PCMH programs



MULTIPAYER

- Exercises state action exemption
- Requires large private payers to participate
- Mandates an evaluation

Patient protections on participation and information sharing

SINGLE CARRIER

- MHCC authorizes a carrier to implement a single carrier PCMH program that conforms with the principles of the patient centered medical home as adopted by a national coalition and standards adopted by MHCC

3

PCMH model

- ACCESSIBLE
- COMPREHENSIVE WHOLE PERSON CARE
- CONTINUOUS
- COORDINATED AND INTEGRATED

- ACCOUNTABILITY
- PERSON AND FAMILY-CENTERED CARE

4

State Role: Multipayer

- Convene stakeholders to form multi-payer Patient-Centered Medical Home (PCMH) program: state action exemption to Federal anti-trust
- Develop standards and approval process for single payer PCMH programs (2 programs recognized as of March 2013)
- Participation in multi-payer: 5 commercial and 6 Medicaid MCOs
- 250,000 patients in multi-payer program
- 330 Physicians & NPs
- TRICARE will join multipayer in July 2013

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Multi-payer PCMH Program

Program Administration
Maryland Health Care Commission

Practice Transformation Maryland Learning Collaborative	Innovative Payment	Program Evaluation
• Engage in organizational change • Obtain NCQA PCMH recognition • Redefine roles • Develop care manager • Broaden the scope of care	• Upfront investment (Fixed Transformation Payments) • Shared savings based on difference between expected and actual total costs of care	• Can the model achieve savings? • Does the model increase satisfaction for patients/providers? • Can PCMH reduce disparities?

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State Role: Single Payer

- Establish application and approval process in September 2011
  - CareFirst approved in 10/2010 for program start in 1/2011
  - Cigna approved in 2/2013 for program start in Spring 2013
- Programs report summary information on program participation, shared savings results, complaints, practice departures.
- 1.1 million in single payer programs
- 2,500 physicians and NPs

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Putting it all together: who is involved

- 1.3 million of roughly 5.6 million residents
- 2,800 primary care physicians and nurse practitioners actively engaged of about 4,500 primary care physicians and NPs
- All major private payers, 6 MCOs in multi and single carrier payer programs
- 3 largest health systems JHU, Medstar, University, and many others
- Federal, state employee programs, and TRICARE

Other related programs

- 15 FQHCs in the CMS FQHC Advanced Primary Care Demo
- 9 ACOs, many practices are also in PCMH programs

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Balancing the programs

⁎Maryland single payer & multi-payer programs sunset in 2015

Multi-payer – formal pilot ends in July 2014

- Practice allegiance may be higher
- Consistent shared savings model; similar to one-sided ACO model
- More likely to:
  - align quality metrics across initiatives
  - link reward structure to broader state improvement goals
- Carriers with small market share can participate
- Build trust in All-Payer Claims Database (attribution and shared savings) foundation of the utility
- … but resource intensive, not as easy to scale

Balancing the programs

⁎Maryland single payer & multi-payer programs sunset in 2015

Single payer

- Allows for payer innovation now and more rapid cycle time
- Easier to implement for larger carriers
- Little new state infrastructure and less statutory change
- May allow greater flexibility for practice participation, i.e. “PCMH light”
- …but operational challenges for practices are higher and many inconsistent programs will not add value

Observation: Value from a mix of consistency and innovation

Key Considerations

Sustaining Practice Transformation

- External practice transformation support is critical
- Transformation team embedded in the state
- Ongoing funding is key

Care Coordination

- Providers have opportunity to define the mix and should be held accountable for results
- Combination of provider-based, payer-based, and community-based support may work best
- Ongoing funding is key

Electronic Health Technology essential to success

- Recognition programs presume electronic health records
- Standardized carrier data feeds needed
- Link PCMH practices to Health Information Exchange (HIE) initiatives and encourage HIEs to develop tools to support new care models
- Ongoing funding is key

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Opportunities for alignment
Less to more alignment

- Structure
  - Practice transformation approach
  - Recognition process
- Quality measurement
  - Measures
  - Thresholds
- PCMH operations (i.e., approach to care management)
- Reimbursement strategy

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Challenge of alignment: the bilateral example

- 7 of the Maryland Multi-payer measures are core or alternate under the Office of the National Coordinator (ONC) meaningful use;
- 8 Multi-payer PCMH measures are among the 33 ACO measures
- 8 Multi-payer PCMH measures are used in CF single carrier program
- 8 Multi-payer PCMH measures are used in Cigna single carrier program

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Greater Challenge of Alignment
Of 33 ACO Measures, 1 measure aligned in ACO, MMPP, CF, Cigna programs

Measures in ACO, MMPP, Cigna, and CF Programs		
NQF Number	**Measure Title**	**Alignment**
0275	Ambulatory Sensitive Conditions Admissions: COPD or Asthma in Older Adults	CF,Cigna
0277	Ambulatory Sensitive Conditions Admissions: Heart Failure	CF,Cigna
n/a	Percent of Primary Care Physicians who Successfully Qualify for an EHR Program Incentive Payment	CF
0041	Influenza Immunization	MMPP
0043	Pneumococcal Vaccination for Patients 65 Years and Older	MMPP
0421	Body Mass Index (BMI) Screening and Follow-Up	MMPP
0028	Tobacco Use: Screening and Cessation Intervention	MMPP
0034	Colorectal Cancer Screening	MMPP,CF,
0031	Breast Cancer Screening	MMPP,CF,,Cigna
0059	Diabete Mellitus: Hemboglobin A1c Poor Control	MMPP,Cigna
0018	Hypertension: Controlling High Blood Pressure	MMPP
0075	Ischemic Vascular Disease: Complete Lipid Panel and LDL Control	MMPP,Cigna
0066	Coronary Artery Disease Composite: ACE Inhibitor or ARB Therapy - Diabetes or Left Ventricular Systolic Dysfunction	CF
0074	Coronary Artery Disease Composite: Lipid Control	Cigna
0075	Ischemic Vascular Disease: Complete Lipid Panel and LDL Control	MMPP,Cigna
0275	Ambulatory Sensitive Conditions Admissions: COPD or Asthma in Older Adults	CF, CIgna
0277	Ambulatory Sensitive Conditions Admissions: Heart Failure	CF,Cigna

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Challenge of Alignment (continued)
2 measure aligned in MMPP, CF, Cigna programs

Measures in ACO, MMPP Cigna and CF Programs		
NQF Number	**Measure Title**	**Alignment**
0421	Body Mass Index (BMI) Screening and Follow-Up	MMPP
0729a	Diabetes Composite: Hemboglobin A1c Control	Cigna
0729b	Diabetes Composite: Low Density Lipoprotein Control	Cigna
n/a	Percent of Primary Care Physicians who Successfully Qualify for an EHR Program Incentive Payment	CF
n/a	Percent of Primary Care Physicians who Successfully Qualify for an EHR Program Incentive Payment	CF
0002	Appropriate Testing for Children with Pharyngitis	MMPP,CF,Cigna
0036	Use of Appropriate Medications for People with Asthma	MMPP,CF,Cigna

Findings consist with an NQF sponsored study of measures in 16 AF4Q initiatives: No measure was used in all 16 programs[1]

Diane Stollenwerk, Quality Measurement: Adventures in Alignment, NQF presented at the National Association of Health Care Organizations, October 24, 2012 referenced at https://www.nahdo.org/sites/nahdo.org/files/conference_sessions/Quality%20Reporting_Stollenwer_2012.pdf

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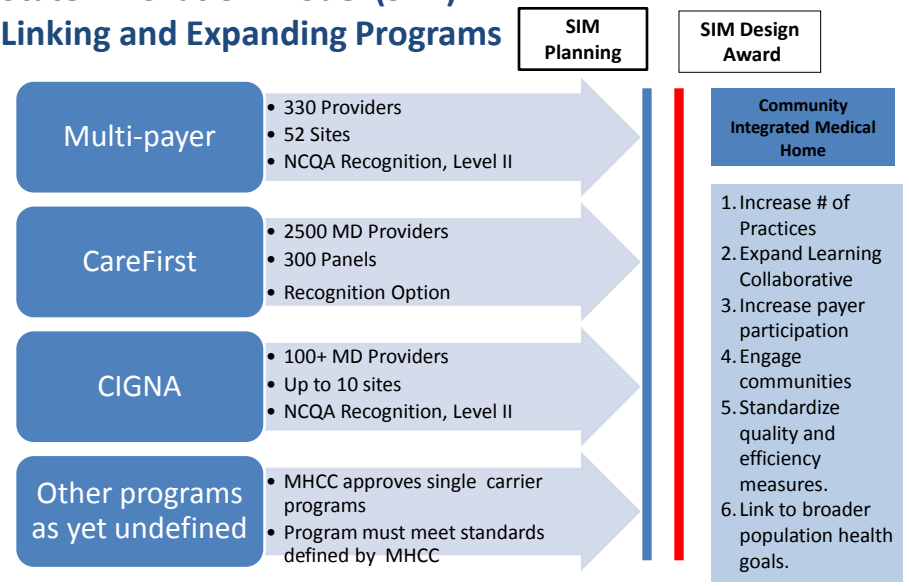
State Innovation Model (SIM)- Linking and Expanding Programs



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There is a lot to be done!

You must retain faith that you will prevail in the end, regardless of the difficulties.

AND at the same time…

You must confront the most brutal facts of your current reality, whatever they might be.

Formal portrait of Rear Admiral James B. Stockdale in full dress white uniform

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MD's State Health Improvement Process (SHIP)

Accountability Framework
&
Local Health Action

Karen Matsuoka, PhD
Director, Health Systems and Infrastructure Administration

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State Health Improvement Process (SHIP)

- Established in September 2011
- Goal
  - To provide a Framework for shared accountability
  - And resources (financial and data)
  - To Catalyze Local Action at the community-level
  - And integrate Efforts of
    - Public Health
    - Hospitals and Health Care Providers
    - Community Groups
    - Health Benefits Exchange
  - To Improve Population Health and Reduce Health Disparities

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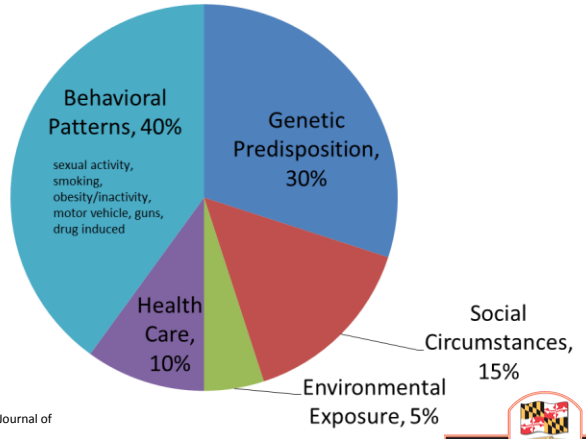
Proportional Contribution to Premature Death



Source: Steven A. Schroeder, New England Journal of Medicine, Sept 20, 2007

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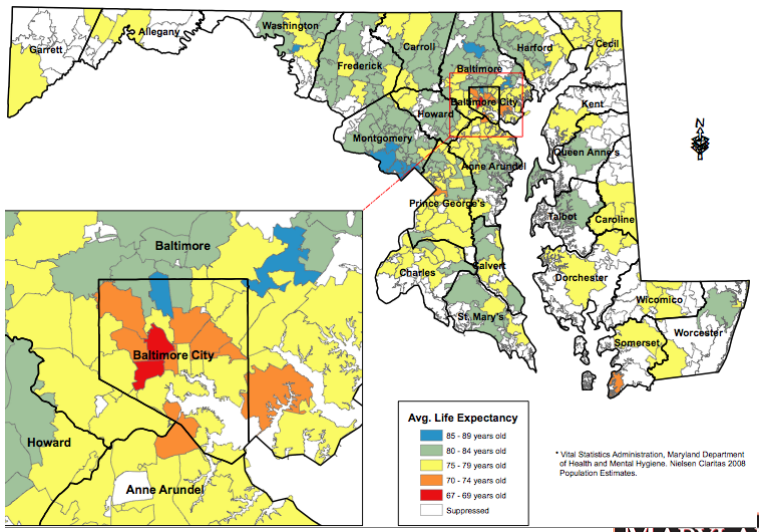
Maryland Average Life Expectancy



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Aligned Action in 6 Focus Areas to Increase Life Expectancy

- **Healthy Babies**
- **Infectious Disease Reduction**
- **Healthy Social Environments**
- **Prevent and Control Chronic Disease**
- **Safe Physical Environments**
- **Improve Health Care Access**

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Governance/Structure

- State and Local Accountability
  - 39 measures: health outcomes and determinants
  - State and county baselines and 2014 targets
  - Racial/ethnic disparity information
- 18 Local Health Improvement Coalitions covering the state
  - Typically Co-Chaired by Hospital and Public Health leaders and include cross-section of community leaders
    - Community members
    - BH leaders
    - Schools, veteran, aging and social services providers
    - Businesses and faith leaders
    - Safety and built environment planners
  - Maximum flexibility with regard to community interventions; standardization around core metrics and population definition

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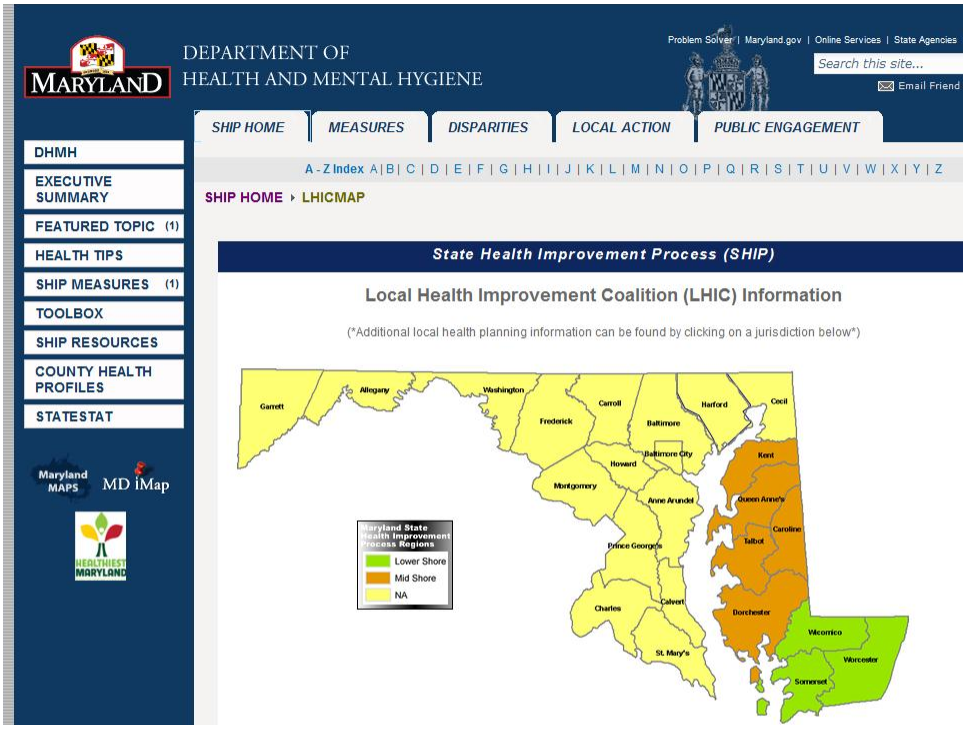

Data and Analytics

- For planning: to assist in priority-setting around identified community health needs
- For performance monitoring:
  - To assist in continuous quality improvement
  - To identify best practices through comparative analysis
- DHMH data sources repurposed in a privacy-protective manner

SHIP County Profiles

High Impact Objectives

Figures in RED/GREEN represent when the county baseline is WORSE/BETTER than the state baseline.

Obj #	SHIP Measure (County Baseline Source)	County Baseline	Maryland Baseline	Maryland 2014 Target
High Morbidity Impact				
17	Rate of ED visits for asthma per 100,000 population (HSCRC 2010)	535.3	850.0	671.0
27	Rate of ED visits for diabetes per 100,000 population (HSCRC 2010)	258.1	347.2	330.0
28	Rate of ED visits for hypertension per 100,000 population (HSCRC 2010)	183.7	237.9	225.0
34	Rate of ED visits for a behavioral health condition per 100,000 population (HSCRC 2010)	1,085.2	1,206.3	1,146.0
High Mortality Impact				
25	Rate of heart disease deaths per 100,000 population (age adjusted) (VSA 2007-2009)	227.6	194.0	173.4
26	Rate of cancer deaths per 100,000 population (age adjusted) (VSA 2007-2009)	189.3	177.7	169.2
Multiple Impact Objectives (those objectives with a high rate of return on investment)				
3	Percentage of births that are LBW (VSA 2007-2009)	7.0%	9.2%	8.5%
6	Percentage of births where mother received first trimester prenatal care (VSA 2007-2009)	86.0%	80.2%	84.2%
11	Percentage of students who graduate high school four years after entering 9th grade (MSDE 2010)	91.1%	80.7%	84.7%
30	Percentage of adults who are at a healthy weight (not overweight or obese) (BRFSS 2008-2010)	30.5%	34.0%	35.7%
31	Percentage of youth (ages 12-19) who are obese (MYTS 2008)	9.4%	11.9%	11.3%
32	Percentage of adults who currently smoke (BRFSS 2008-2010)	18.6%	15.2%	13.5%
33	Percentage of high school students (9-12 grade) that have used any tobacco product in the past 30 days (MYTS 2010)	25.8%	24.8%	22.3%

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SHIP Year 2 Progress

Vision Area	39 SHIP Objectives	2012 Update	Local Data Displays
Healthy Social Environments	7. Reduce **child maltreatment**	🔴	Map Graph & figures
	8. Reduce the **suicide** rate	🟢	Graph & figures
	9. Decrease the rate of **alcohol-impaired driving fatalities**	🟢	Graph & figures
	10. Increase the % entering **kindergarten ready to learn**	🟢	Map Graph & figures
	11. Increase the percent of students who **graduate high school**	🟡	Map Graph & figures
	12. Reduce **domestic violence**	🟢	Map Graph & figures

SHIP Progress Summary Key	
🟢	The updated measure on track to meet/ met the Maryland 2014 Target
🟡	The updated measure is moving toward the Maryland 2014 Target
🔴	Updated measure is not moving toward the Maryland 2014 Target
⏳	Data for update is pending

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LHIC Funding Sources 2011

- LHICs received $2.71 million in financial support, including $1.6 million from the State and $800,000 from hospitals
- We are working to line up the following Federal funding to support LHICs
  - CDC Community Transformation Grant
  - CDC Chronic Disease Grant: State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity, and Associated Risk Factors and Promote School Health
  - CMS State Innovation Model (SIM) Model Testing Award

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CONNECT TO SHIP AND LOCAL COALITION HEALTH ACTION

SHIP website links to 18 coalitions' websites
http://dhmh.maryland.gov/ship/SitePages/Home.aspx

Sign on to the SHIP List Serve (go to SHIP website)

Follow us on Twitter http://twitter.com/MarylandSHIP

Friend us on FB http://www.facebook.com/MarylandSHIP

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Health Quality Partners
Designing Advanced Preventive Services

Overview – HQP Background & Work, Framework for Design, Program Description, Results, Lessons for the Maryland CIMH Model

Ken Coburn, MD, MPH
CEO & Medical Director

Health Quality Partners (HQP)
Who we are and what we do

- Dedicated to Research and Development
- Non-profit, 501c3, founded in 2000
- Approach: use disciplines of public health, systems design & analysis, and quality improvement
- Mission: design, test, and spread new models of care that improve the health of populations, and the quality and experience of health care

Ken's background and experience prior to HQP

- Team-based AIDS Care
  - Executive Director of Montefiore AIDS Center (Bronx, NY), a NYS Designated AIDS Center
- Quality Improvement in a Medicaid HMO
  - Medical Director for Quality Improvement; Health Partners
- Disease Management in an academic health system
  - Large primary care practice network of academic medical center (Associate Medical Director, University of Pennsylvania Health System)
- Population Health Care Management – commercial / Medicare
  - SVP, Exec Med Director, Chief Quality Officer of 11-hospital consortium with 120,000 lives under risk contract with Aetna

Current Work at HQP

- Medicare Coordinated Care Demonstration (CMS)
- Medicare Advantage (Aetna)
- Maryland State Innovation Model; facilitating design and planning
- Consultant\collaborators for urban Medicaid ACO (Camden Coalition of Healthcare Providers)
- Comprehensive Primary Care Initiative (Princeton Health Care Medical Associates)
- Health Systems Redesign
  - Improving Systems Initiative (Doylestown Hospital)
  - Cancer care coordination model (Clinical Cancer Center at Froedtert & the Medical College of Wisconsin)

HQP's Framework for Program Design

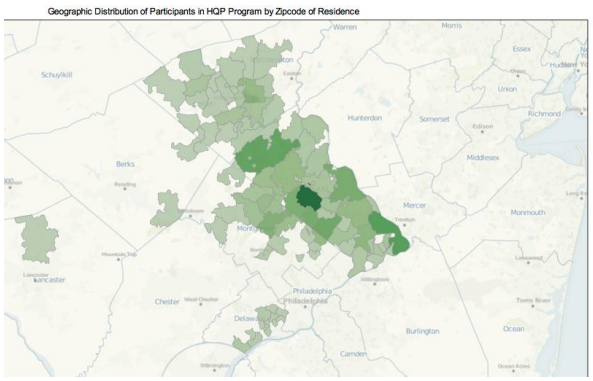
- Define
  - Target population and *root cause determinants of health*
- Design
  - Assemble several evidence-based preventive interventions into a coherent portfolio
  - Standards, protocols, procedures, communication loops
  - Team roles, work flows, staff training, mentoring and monitoring
- Deploy
  - Community-based nursing with extensive collaborations and data sharing
  - Frequent participant contacts (1:1, group, phone)
  - Very longitudinal (absent significant, durable shift in participant risk status)
  - Case finding, outreach, engagement, individualized (person-centered)
  - Service data capture and advanced program analytics

High reliability

- Refine
  - Ongoing improvement guided by performance analytics, outcomes, staff observations, participant feedback, collaborator feedback

Population Served

- Traditional Medicare and Medicare Advantage
- Chronically ill with heart failure, coronary heart disease, diabetes, chronic lung disease
  - Other risks as well; prior admission or high risk score
  - Median age 81 years



Collaborating with 100+ physician practices and 7 health systems

Mode and frequency of contacts with patients

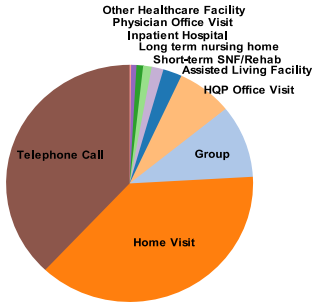
In one year (1/22/2012-1/23/2013):

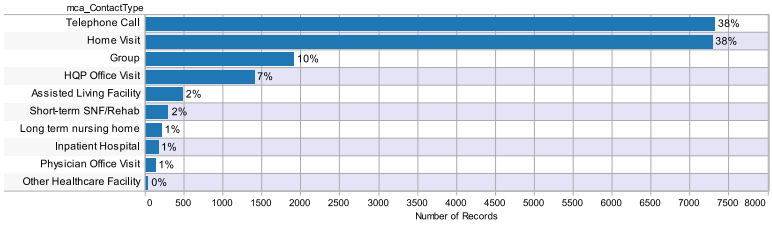
With approx. 660 active patients

Contacts = 19,240 contacts, avg 29/person/yr

In-person = 11,926 (62%)

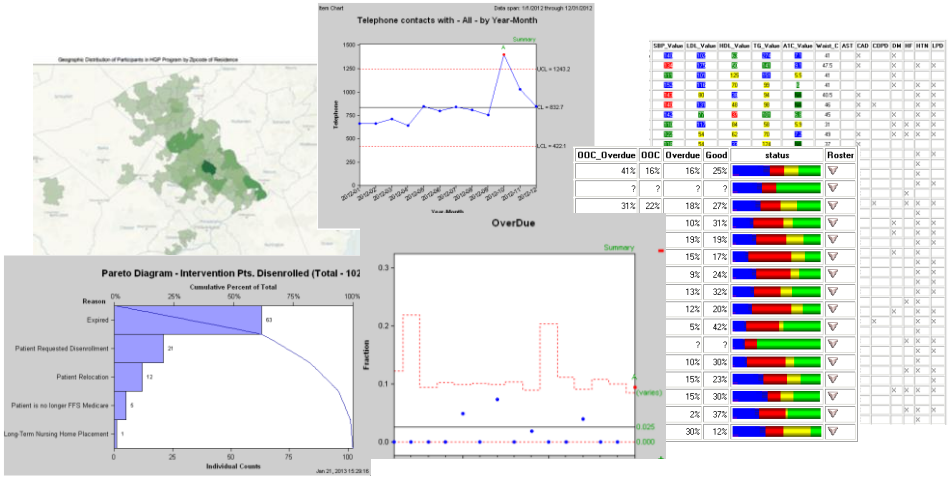
At-home = 7,289 (38%)





Advanced Analytics are KEY

- Separating the Signal from the Noise
  - Prioritize individuals with dynamically changing risk profiles
  - Identify variation in service delivery performance to direct root cause analysis, organizational learning, and management corrective actions



HQP Advanced Preventive Service Outcomes

Population	N	Control PPPM	Deaths	Hospital admissions	ER visits	Part A&B expenditures; excl prgm fees	Part A&B expenditures; incl prgm fees	SNF cost
Medicare Coordinated Care Demonstration (randomized, controlled trial versus usual care)								
All risk levels (low, mod & high)	1,464			-14%		-14%**	Neutral	
	1,721	$731	-25%**	-7%		-4%	+9%	
Higher-risk 1	502	$900	-30%**	-29%**		-20%**		
Higher-risk 2	248	$1,441	-18%	-39%**	-37%**	-36%**	-28%**	-64%**
Higher-risk 3	695	$1,108		-25%**		-20%**	-10%	
Higher-risk 4	273	$1,363		-33%**		-30%**	-22%	
Aetna Medicare Advantage (difference-in-differences analysis trended over time against a like comparison group; multiple eval. cycles)								
	N			Hospital adms			Hospital cost	
Higher-risk 5	1,200			-20%, 17%,			-18%, 16%,	

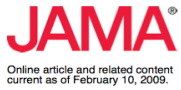
**P≤0.05, *P≤0.1
°Statistics not reported

Higher-risk 1: based on geriatric HRA
Higher-risk 2: (HF, CAD, or COPD) AND ≥1 hospitalization in prior year
Higher-risk 3: HF, CAD, or COPD
Higher-risk 4: (HF, CAD, or COPD) AND ≥1 hospitalization in prior year] OR (diabetes, cancer (not skin), stroke, depression, dementia, atrial fibrillation, osteoporosis, rheumatoid arthritis/osteoarthritis, or chronic kidney disease) AND ≥2 hospitalizations in the prior 2 years]
Higher-risk 5: (HF, CAD, COPD, asthma, or diabetes) AND ≥2 minimum cut-point on Aetna proprietary risk score

Abbreviations: PPPM=per person per month, ER=emergency room, SNF=skilled nursing facility, HRA=health risk assessment, HF=heart failure, CAD=coronary artery disease, COPD=chronic obstructive pulmonary disease

Third Report to Congress, Deborah Peikes, et al., Jan 1, 2008, Mathematica Policy Research, Inc. (MPR)
Fourth Report to Congress, Jennifer Schore, et al., March 2011, MPR
PLoS Medicine, Ken Coburn, et al., July 2012, 9(7): e1001265. doi:10.1371/journal.pmed.1001265
JAMA, Deborah Peikes, et al., Feb 2009;301(6):603-618 (doi:10.1001/jama.2009.126)
MPR report shared with HQP with CMS permission, 2011 (unpublished)
Health Affairs, Randall Brown, et al., June 2012, 31, no.6:1156-1166
Aetna Medical Economics Team Reports 2011, 2012 (press releases)

Publications



Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries: 15 Randomized Trials

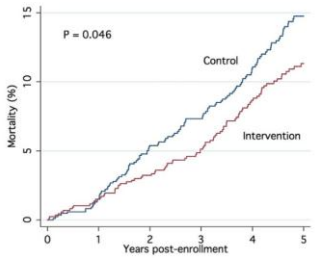
Deborah Peikes; Arnold Chen; Jennifer Schore; et al.

JAMA. 2009;301(6):603-618 (doi:10.1001/jama.2009.126)

http://jama.ama-assn.org/cgi/content/full/301/6/603

"… HQP, also showed promise, … for this subgroup [highest severity cases] both differences were large (-29% for hospitalizations and -20% for expenditures) and statistically significant (P=.009 and P=.07, respectively)."

"… Health Quality Partners, reduced hospitalizations by 30 per 100 beneficiaries (33 percent; *p*=0.02)"
" … The demonstration program with the largest effects, at Health Quality Partners, was very data-driven, tracking care coordinators' performance and continually assessing the effectiveness of newly introduced interventions component and refinements to existing ones …"



Effect of a Community-Based Nursing Intervention on Mortality in Chronically Ill Older Adults: A Randomized Controlled Trial

Kenneth D. Coburn*, Sherry Marcantonio, Robert Lazansky, Maryellen Keller, Nancy Davis
Health Quality Partners, Doylestown, Pennsylvania, United States of America

"… Overall, a 25% lower relative risk of death (hazard ratio [HR] 0.75 … the adjusted HR was 0.73 (95% CI 0.55-0.98, *p*=0.033)."

Aetna has renewed & expanded HQP contract through 2015

Washington Post
April 28, 2013

The nurse's house call:

If this were a pill, you'd do anything to get it

AMANDA VOISARD FOR THE WASHINGTON POST

DELIVERING CARE: **Patty Graefe, a nurse with Health Quality Partners, makes her weekly visit to Paul and Betty Bradfield at their home near Doylestown, Pa.**

BY EZRA KLEIN

When Ken Coburn has visitors to the cramped offices of Health Quality Partners in Doylestown, Pa., he likes to show them a graph. It's not his graph, he's quick to say. Coburn is not the sort to take credit for other's work. But it's a graph that explains why he's doing what he's doing. It's a graph he particularly wishes the folks who run Medicare would see, because if they did, then there's no way they'd be threatening to shut down his program.

The graph shows the U.S. death rate for infectious diseases between 1900 and 1996. The line starts all the way at the top. In 1900, 800 of every 100,000 Americans died from infectious diseases. The top killers were pneumonia, tuberculosis and diarrhea. But the line quickly begins falling. By 1920, fewer than 400 of every 100,000 Americans died from infectious diseases. By 1940, it was less than 200. By 1960, it's below 100. When's the last time you heard of an American dying from diarrhea?

"For all the millennia before this in human history," Coburn says, "it was all about tuberculosis and diarrheal diseases and all the other infectious disease. The idea that anybody lived long enough to be confronting chronic diseases is a new invention.

So why is Medicare **shutting down one of the most revolutionary** health-care experiments in the country?

COBURN CONTINUED ON G6

2 Flavors of Innovation; Unintended Variation impedes both

- Innovation
  - Flavor 1: Dissemination of established interventions – into new settings, usually requires judicious local adaptation (intentional controlled variation)
  - Flavor 2: Experimentation – trying a new, promising, but relatively untested/unproven intervention
  - Both thrive on disciplined design/codification, reliable implementation, and rigorous evaluation
- Variation
  - Significant unintended, uncontrolled sources of variation undercut both types of innovation
    - Often due to lack of process specifications, lax implementation

Standardization / Flexibility

- Philosophy guiding this work: to the degree possible, key processes should be "standardized" (thoughtfully defined with explicit specifications and reliably executed)
  - Dissemination of established interventions
  - Experimentation of new interventions
- Flexibility in the form of nimble intentional modifications that are explicitly specified and consistently and reliably implemented can be great
- 'Flexibility' due to lack of defined process specifications or implementation standards leads to uncontrolled variation

Relevance to Maryland SIM / CIMH

- We hope that the lessons and experience derived from HQP's other engagements can help the CIMH successfully implement community interventions that improve health and lower cost

Stakeholder Input Session: Governance

Ken Coburn, MD, MPH
Facilitating

1

What would governing the CIMH entail?

- Who's in – partcipation inclusion criteria and standards
- Analytics – Utility capable of providing real-time operational data (case-finding/outreach, event triggers); cost, savings, and quality impact analyses, service delivery reports, 'hot-spotting' high-risk communities; program evaluation
- Quality Assessment – Setting standards including minimal requirements for continued participation, eligibility for potential shared savings
- Sustainability – Mechanism(s) to equitably distribute savings between payers, providers, and the community (eg through shared savings methodologies, "wellness trusts," etc.)
- For discussion: OTHER?? DIFFERENT??

2

A few examples of governance models others are using

3

Michigan's Primary Care Consortium

- Large collaborative partnership with diverse stakeholder membership, now in a 501(c)3 structure
- Started as public/private partnership funded by Michigan Dept of Community Health
- Convening, consensus building, and advocacy
  - "to improve the primary care delivery system with regard to disease prevention, health promotion, and chronic disease services in primary care throughout Michigan. In addition, align existing quality improvement initiatives, address accessibility gaps, and engage in problem-solving strategies to assure a patient centered medical home for everyone. MPCC's strategic focus is to improve primary care accessibility and quality."

4

Maine Health Management Coalition

- 501c3 structure, serving as a "neutral vehicle" for health system transformation "… a purchaser-led partnership among multiple stakeholders working collaboratively to maximize improvement in the value of health care services delivered to MHMC members' employees and dependents."
- Tracking health care costs, promoting value over volume, new payment and incentive reforms, standardized performance measures, transparency, and public reporting

5

State Innovations Model (SIM) governance is newer & seems to lean more on state agencies

- SIM governance and management still being developed across states – new, evolving
- Comparatively more focus on Medicaid, CHIP, Medicare/Medicaid dual eligible, and state employee coverage
- In some states governance resides within one or more state agencies with varying degrees and methods of ongoing external stakeholder advisory input
  - Presumably due to the tighter coupling of services provided through or reporting to state agencies in the SIM

6

Arkansas

- Governance of specific elements of the SIM is divided between state agencies, each with its own mechanism for consumer/stakeholder engagement
  - Population-based care interventions
    - Medical Home (PCMH)
    - Health Home (state resources)
  - Episode-based care delivery

7

Oregon

- Care Coordination Organizations – regional entities implementing the Coordinated Care Model including provider (PCPCH) + community service collaboration; “global budgets”
- Some degree of flexibility to design local payment and delivery reforms
- State-coordinated Transformation Center; learning systems
- Oregon Health Authority (OHA) – consolidates state health care purchasing, integrates and oversee all aspects of health reform
- Oregon Health Policy Board – oversight and advisory to OHA

8

Given the scope of governance needed to support the Maryland CIMH

- What kind of entity best serves this role?
  - Public, private, public-private collaboration
  - Advisory or decision-making
  - Staffing
- Who should serve?
  - Number
  - Composition
- Key charter elements?