AGENDA

- Vision and goals of project
- Purpose of Workgroup
- Maryland Landscape
  - All-Payer Model
  - CRISP
- Discussion
MARYLAND’S STATE INNOVATION MODEL

- DHMH was awarded a CMS State Innovation Model design grant Dec 2014.
  - This grant is funding the State to engage in tasks related to the development of a new model, one similar to an Integrated Delivery Network (IDN) or an Accountable Care Organization (ACO), for dual eligibles.

- The State is working on a single transformation effort with multiple related projects rather than multiple initiatives each in a silo.

- The focus on dual eligibles reflects that new models of care for these beneficiaries had not yet been identified or designed as part of larger reform efforts.

- Maryland is interested in assessing the development of a strategy to integrate care delivery for Maryland's dually-eligible.
  - It is in the State’s and duals’ interest to design one strategy for the current FFS duals instead of piloting several approaches.
The SIM grant is multifaceted, and includes:

- Dual eligible strategy development
- Support for CRISP’s efforts to expand connectivity among additional providers
- Development of care plans and predictive modeling tools to help with care coordination for high needs patients
- Design of the Plan for Improving Population Health—a strategy that sets population health goals for the All-Payer Model

All aspects of the SIM grant support one another and provide additional groundwork for transformation in the All-Payer Model
MARYLAND’S ALL-PAYER MODEL

- Maryland has been engaged in delivery system innovation, most recently with the implementation of the All-Payer Model beginning January 2014.

- The SIM grant complements the All-Payer Model by allowing the state to focus on:
  - The challenges associated with serving the high-cost and largely-unmanaged dual eligible population;
  - The work of the state-designated Health Information Exchange (HIE), CRISP, to expand connectivity among providers;
  - The development of a population health strategy; and
  - High-needs individuals across the state through the development of care plans and predictive modeling to support care coordination.
VISION AND GOALS OF THE PROJECT

DHMH’s focus on dual eligibles is based on the consensus that was achieved through the Advisory Council and multiple workgroups that full duals should be a top priority.

- The SIM project is integrated into the planning efforts already underway as part of the All-Payer Model.
- Maryland stakeholders have identified dual eligibles as a population with substantial health and social support needs who are largely unmanaged in the current delivery system.
- The focus on duals reflects the fact that new models of care for these beneficiaries have not been systematically identified.
WORKGROUP MEMBERS

- Alzheimer Association, Maryland
- Amerigroup
- CareFirst BlueCross BlueShield
- CRISP
- Dorchester County Addictions Program - National Council on Alcoholism and Drug Dependence
- Erickson Living
- Health Facilities Association of Maryland
- Johns Hopkins HealthCare
- Maryland Department of Aging
- Maryland Health Care for All Coalition
- Maryland Hospital Association
- Maryland Learning Collaborative
- MedChi

- MedStar Health
- Mental Health Association of Maryland (MHAMD)
- Mid-Atlantic Association of Community Health Centers
- Mid-Atlantic Healthcare
- Mosaic Inc.
- Schwartz, Metz & Wise
- Talbot County
- The Coordinating Center
- Towson University
- University of Maryland
- Way Station Inc./Sheppard Pratt Health Systems
PROPOSED STAKEHOLDER ENGAGEMENT STRUCTURE

DHMH

Advisory Council

Partnership Activities
Multi-Agency & Stakeholder Work Group

New:
Alignment
Infrastructure

Duals Care Delivery

HSCRC Commissioners & Staff

HSCRC Functions/Activities

Payment Models
Performance Measurement
DHMH selected EBG Advisors, through a competitive procurement, to work with and track the developments of the HSCRC and their contractors—as well as our partners at CMMI—as the State moves forward with the Phase 2 approach to the All-Payer Model through CY 2016.

DHMH and EBG Advisors will continue to develop a Duals Care Delivery strategy in collaboration with other state and federal partners by inviting them into the stakeholder process and continuing to hold joint leadership meetings. The work will include:

- The governance model.
- The beneficiary attribution process.
- The provider attribution/alignment process.
- Accounting for total cost of care.
- Development of quality metrics and incentives.
WORKGROUP’S PURPOSE

The purpose of the Duals Care Delivery Workgroup is to facilitate multi-stakeholder discussions regarding efficient and effective implementation of the dual eligible program design that supports CMMI’s goals and DHMH’s goals. They are:

- Improve the patient experience, improve the health of populations, and reduce the growth in per capita costs of health care
  - Alignment: Promote value-based payment
  - Care Delivery: Increase integration and coordination
  - Health Information Exchange and Tools: Support providers
MARYLAND LANDSCAPE

ALIGNMENT WITH CURRENT INITIATIVES
HEALTH SERVICES COST REVIEW COMMISSION (HSCRC)

- Donna Kinzer, Executive Director
Maryland’s All-Payer Model: Patient-Centered Delivery System Transformation

February 18, 2016
Overview

- The Evolving Health Care Landscape & Maryland’s All-Payer Model
- All-Payer Model Implementation
- Person-Centered Delivery System Transformation
The Evolving Health Care Landscape & Maryland’s All-Payer Model
Context: Health Care System Challenges

Current System

- Aging, Sicker Population
- Fragmentation & Variation
- High Costs
- Coverage & Access
- Health Disparities
- Consumer Demands

More Ahead...

- Changes in Demographics and Expenditures

<table>
<thead>
<tr>
<th>Year</th>
<th>Age 65+</th>
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<tbody>
<tr>
<td>2010</td>
<td>40 million</td>
</tr>
<tr>
<td>2020</td>
<td>55 million</td>
</tr>
<tr>
<td>2030</td>
<td>72 million</td>
</tr>
</tbody>
</table>

- Federal Budget & Health Care Spending
  - More Entitlements, Fewer Contributors
Health Services Cost Review Commission (HSCRC)

- Leads implementation of Maryland’s All-Payer Model
- Oversees hospital rate regulation in Maryland with broad statutory authority
- Responsible for all-payer rate setting in Maryland, which provides considerable value to patients, hospital and the State
  - A Medicare waiver, allowing HSCRC to set hospital rates for Medicare, was granted in 1977 and renewed under a different approach in 2014
  - State Medicaid plan pays HSCRC rates
  - State law requires health insurers, managed care organizations, and others to pay HSCRC rates
  - Limits cost shifting--all payers pay their fair share, including funds for uncompensated care and graduate medical education
Unique New Model: Maryland’s All-Payer Model

- Maryland is implementing an All-Payer Model for hospital payment
  - Approved by Center for Medicare and Medicaid Innovation (CMMI) effective January 1, 2014 for 5 years
  - Modernizes Maryland’s Medicare waiver and unique all-payer hospital rate system

Key provisions of the new Model:
- Hospital per capita revenue growth ceiling of 3.58% per year, with savings of at least $330 million to Medicare over 5 years
- Patient and population centered measures to promote care improvement
- Payment transformation away from fee-for-service for hospital services
- Proposal covering all health spending due at the end of Year 3 for 2019 and beyond
All-Payer Model Implementation
Year 1 Approach

Initiate payment reform (Hospital global budgets and value-based performance requirements)

Focus policies on reducing potentially avoidable utilization through care improvements

Engage stakeholders

Build regulatory infrastructure
Maryland’s Current Situation & Future Focus

**Years 2-3 Focus (Now)**

- Work on clinical improvement, care coordination, integration planning, and infrastructure development
- Partner across hospitals, physicians and other providers, post-acute and long-term care, and communities to plan and implement changes to care delivery
- Alignment planning and development

**Years 4-5 Focus**

- Implement changes, and improve care coordination and chronic care
- Focus on alignment models
- Engage patients, families, and communities
- Focus on payment model progression, total cost of care and extending the model
2014-2015 All-Payer Model Results

- All hospitals adopted global budgets, encompassing ~95% of revenues, ahead of schedule

- All Payer hospital revenue growth was contained to 1.47% per capita, compared to the 3.58% per capita ceiling; Medicare hospital savings of $116 million were achieved toward the $330 million five year requirement.

- Quality measures for hospital acquired conditions were achieved and readmissions were reduced.

- Overall hospital volumes have been contained in 2015. In contrast, national estimates show substantial all payer hospital volume growth.
Person-Centered Delivery System Transformation
Deliver Care Based on Person-Centered Needs

- **Healthy**
- **Chronically ill but under control**
- **Chronically ill but at high risk to be high need**
- **High need/complex**

**A**
Care plans, support services, case management, new models, and other interventions for individuals with significant demands on health care resources

**B**
Address modifiable risks and integrate and coordinate care, develop advanced patient-centered medical homes, primary care disease management, public health, and social service supports, and integrated specialty care

**C**
Promote and maintain health (e.g. via patient-centered medical homes)
# Stakeholder-Driven Strategy for Maryland

Aligning common interests and transforming the delivery system are key to sustainability and to meeting Maryland’s goals.

<table>
<thead>
<tr>
<th>Focus Areas</th>
<th>Description</th>
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</thead>
</table>
| **Care Delivery**                             | • Encourage integration and coordination of clinical care  
• Support provider-driven plans for improving care for complex patients and improving chronic care  
• Support enhancement of primary care practices and models  
• Promote consumer engagement through shared decision-making and state & local outreach efforts |
| **Health Information Exchange and Tools**     | • Enhance capabilities of CRISP (Maryland’s Health Information Exchange) to support providers, ACOs, and payers  
• Connect providers in addition to hospitals (physicians, long-term care, etc.)  
• Develop shared tools (e.g. common care profiles)  
• Bring additional electronic health information to the point of care |
| **Alignment**                                 | • Promote value-based payment systems, focused on improved outcomes  
• Develop alternative payment models and other transformation opportunities  
• Build on private payer medical home models, Accountable Care Organizations formed by providers, and emerging Medicare Advantage plans |
The Next Steps Needed for Maryland’s Transformation

- Develop approach to care transformation that improves care and also reduces avoidable hospitalizations
- Fully implement care coordination to scale, first for complex and high needs patients
  - Intense focus on Medicare and dual eligible, where supports are immature
- Organize and engage primary care, long-term care, and other providers in care coordination and chronic care management
  - Intense focus on Medicare, where models do not exist or are immature, in Maryland
  - Build on growing PCMH and ACO models, global budgets, and Medicare and Chronic Care Management fees
- Develop financial alignment programs between hospital and non-hospital providers, and get data and waivers needed for implementation
- Optimize acute/post-acute
- Engage other providers
Thank you for the opportunity to work together to improve care in Maryland

Questions?
CHESAPEAKE REGIONAL INFORMATION SYSTEM FOR OUR PATIENTS (CRISP)

- David Horrocks, President
What is CRISP

CRISP is a regional health information exchange organization that services Maryland and the District of Columbia.

Our Guiding Principles

1. **Begin with a manageable scope and remain incremental.**

2. **Create opportunities to cooperate even while participating healthcare organizations still compete in other ways.**

3. **Affirm that competition and market-mechanisms spur innovation and improvement.**

4. **Promote and enable consumers’ control over their own health information.**

5. **Use best practices and standards.**

6. **Serve our region’s entire healthcare community.**
### Annual Focus Areas and Theme Setting

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<tr>
<th>Year (Fiscal)</th>
<th>Theme</th>
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<tbody>
<tr>
<td>2009 - 2010</td>
<td>Developing Infrastructure (Governance, People, Technology)</td>
</tr>
<tr>
<td>2010 - 2011</td>
<td>Creating Connectivity</td>
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<tr>
<td>2011 - 2012</td>
<td>Driving Utilization</td>
</tr>
<tr>
<td>2012 - 2013</td>
<td>Creating Value for Participants</td>
</tr>
<tr>
<td>2013 - 2014</td>
<td>Achieving Sustainability</td>
</tr>
<tr>
<td>2014 - 2015</td>
<td>Critical Infrastructure</td>
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</tbody>
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Technical Overview

1. Mirth Connect
   - Initiate MPI

2. Repositories
   - Query Portal
   - CRISP Landing Page

3. ENS
   - Inbound Adapter
   - ENS Core
   - Notification Engine

4. CRS
   - Transactional Database
   - Reporting Database

5. Clinical Feeds
   - LAB
   - RAD
   - PDMP
   - CCDA

6. EID Updates
   - EID to MRN Table
   - Patient Rosters

7. ADT Feed
   - ADT for MRN Match
   - EID Updates

8. HSCRC Hospital Visit Data

9. Unique ID Linking
   - Readmission & Pop Health Reports
1. Clinical Query Portal
   - Includes Maryland Prescription Drug Monitoring Program (PDMP)
   - Search for your patients’ prior hospital and medication records
   - Monitor the prescribing and dispensing of drugs that contain controlled dangerous substances

2. Encounter Notification Service (ENS)
   - Includes Direct Secure Messaging capabilities
   - Be notified in real time about patient visits to the hospital
   - Use secure email instead of fax/phone for referrals and other care coordination

3. CRISP Reporting Services
   - Use CRISP Data for patient identification, performance measurement and service coordination
Patient Identity Management

The Challenge:
Because no Unique Patient ID exists, CRISP must accurately and consistently link identities across multiple facilities to create a single view of a patient.

A near-zero tolerance of a false positive match rate with a low tolerance of a false negative match rate.

Effective Master Patient Indexing is a foundational concept to any population health oriented payment or delivery reform initiatives.
The query portal allows credentialed users to search the HIE for clinical data.

Users can search for patients using last name/DOB or the medical record number from your practice or a hospital.

The initial query returns information from the past 6 months and allows the user to query data as far back as June of 2012 (depending on when a given data sending went live).

While a great tool, there are workflow challenges.

There are currently roughly 115,000 queries per month.

Types of data available:

- Patient demographics
- Lab results
- Radiology reports
- **PDMP Meds Data**
- Discharge summaries
- History and physicals
- Operative notes
- Consults
Single Sign-On (SSO) is an approach to enable faster and more efficient access to the query portal through the EHR.

By securely sending a local user’s credentials and the current patient medical record number (or other demographics), CRISP can send the user directly to the patient summary screen.
CRISP currently receives information pertaining to **ER visits and inpatient admissions** in real-time:

- All Maryland hospitals
- Most D.C. hospitals (1 remaining currently working through on-boarding)
- All Delaware hospitals and most Northern Virginia hospitals

Through ENS, CRISP has the ability to communicate this information, in the form of **real time hospitalization alerts** to PCPs, care coordinators, and others responsible for patient care.

We are current routing roughly 700,000 notifications per month.

Roughly 30 hospitals are “auto-subscribing” so they can be alerted when one of their past discharges is being readmitted within 30 days.
Additional ENS Access Points
CRISP Key Performance Indicators

**Portal Queries**
- Total: 107,698

**ENS Notifications Sent**
- Total: 735,230

**Monthly CRISP Portal Users**
- Active Clinician user accounts*
- Unique Users who logged in during month
- Active User Accounts
- Monthly Queries

*Active User Accounts*
Rules of the Road

• Patient Privacy policies are foundational to Health Information Exchange

• CRISP operates under a combination of:
  • Federal laws – HIPAA, 42 CFR Part 2
  • State laws and regulations – CMRA, MHCC Regulations
  • Stakeholder agreements – Participation Agreement
  • Data use agreements – HSCRC, MHBE, DHMH

• All participating organizations are required to
  • Update their HIPAA Notice of Privacy Practices to include a paragraph on their participation with CRISP
  • Make CRISP brochures and opt-out forms available at intake areas.

• Patients who do not want to participate must opt-out, by contacting CRISP by phone, online, or by mail.
• Patients have the right to contact CRISP and ask for a list of users who have accessed their information.
• All participating organizations are required to update their HIPAA Notice of Privacy Practices to include a paragraph on their participation with CRISP.

• All participating organizations are required to make CRISP brochures and opt-out forms available at intake areas.

• Patients are responsible for completing and submitting the opt-out form to CRISP. They may also opt-out by phone or online.
Agreements and Policies

PREPARE FOR THE FUTURE of healthcare

POLICIES AND APPROVED USE CASES

Approved Use Case - Cross-Facility Patient-Level Data Sharing Policy - Wednesday, September 23, 2015

HIE Policies and Procedures - Thursday, April 17, 2014
CRISP HIE Policies and Procedures.

Approved Use Case - Access to Query Portal for Health Plans - Wednesday, December 10, 2014

Approved Use Case - Reporting Service - Monday, June 4, 2012

Approved Use Case - Notification Service - Thursday, October 24, 2013
HIE Policy for Encounter Notification System (ENS). Effective October 24, 2013

Approved Use Case - Cancer Registry - Friday, September 7, 2012

Approved Use Case - Query Portal Access Outside CRISP Service Area - Wednesday, September 11, 2013

PARTICIPATION AGREEMENTS

CRISP Participation and Direct Agreement - Wednesday, July 30, 2014
CRISP Participation and Direct Agreement.
Regional Coordination and Planning

Cross Hospital Use

Unique Patients 63,837

Footnotes:
- HSCRC Casisma data and CRISP EIDs
- HSCRC Casisma data includes all inpatient discharges and outpatient hospital observation visits greater than 24 hours from any hospital in Baltimore City.
- Observation visits greater than or equal to 24 hours is identified using Casisma rate center 60 with rate center unit 1.24 and rate center changes 10.
- Unique patients are identified using CRISP EIDs.
- Zip code is the zip code of the patient's residence at the time of discharge as reported in HSCRC Casisma data.
- Baltimore City is defined by HSCRC's zip code to county SAS mapping.
- Report currently contains all IP casisma data updated until August 2015.
### Analysis of Pre and Post Metrics based on Enrollment Date

The analysis is based on discharges before and after the enrollment date. Please select the number of months, number of hospitals to show and the types of visit to include in the analysis.

#### Overall Charges

<table>
<thead>
<tr>
<th></th>
<th>Before</th>
<th>After</th>
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<tbody>
<tr>
<td>Charges - Before</td>
<td>$1,403K</td>
<td></td>
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<tr>
<td>Charge - After</td>
<td>$1,009K</td>
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#### Total Visits - Before

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<tr>
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<th>Total Visits</th>
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<tbody>
<tr>
<td>Total Visits - Before</td>
<td>568</td>
</tr>
<tr>
<td>Total Visits - After</td>
<td>361</td>
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#### Charges at Outside Hospitals

<table>
<thead>
<tr>
<th></th>
<th>Before</th>
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<tbody>
<tr>
<td>Charges - Before</td>
<td>$38,642.60</td>
<td>$86,339.69</td>
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<tr>
<td>Charge - After</td>
<td>$47,676.48</td>
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<td>$47,274.13</td>
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<td>Charge - After</td>
<td>$28,275.70</td>
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<td>Charges - Before</td>
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<td>$92,023.89</td>
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#### Total Charges at Outside Hospitals

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<td>Charges - Before</td>
<td>$123,788.06</td>
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<tr>
<td>Charge - After</td>
<td>$466,874.37</td>
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#### Total Visits to Outside Hospitals

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<tr>
<td>Total Visits - After</td>
<td>47</td>
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#### Visits to Outside Hospitals

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<td>Total Visits - Before</td>
<td>28</td>
<td>36</td>
</tr>
<tr>
<td>Total Visits - After</td>
<td>21</td>
<td>31</td>
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#### Total Visitors

<table>
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<td>309</td>
<td></td>
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<tr>
<td>Total Visits - After</td>
<td>234</td>
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# Readmission Analysis

## Service Line Readmission Analysis

### Hospital Utilization - Select a service line to see top DRGs

<table>
<thead>
<tr>
<th>Service Line</th>
<th>Eligible Discharges</th>
<th>Readmissions</th>
<th>Readmit Ratio</th>
<th>Readmit Rate</th>
<th>Intra Readmissions</th>
<th>Intra Readmit Rate</th>
<th>Inter Readmissions</th>
<th>Inter Readmit Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burns</td>
<td>10,214</td>
<td>1,804</td>
<td>1.04</td>
<td>17.86%</td>
<td>1,051</td>
<td>10.29%</td>
<td>753</td>
<td>7.37%</td>
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<tr>
<td>Cardiology - Invasive</td>
<td>1,105</td>
<td>199</td>
<td>1.00</td>
<td>18.01%</td>
<td>114</td>
<td>10.32%</td>
<td>55</td>
<td>7.69%</td>
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<tr>
<td>Cardiology - Open Heart Surgery</td>
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<tr>
<td>Dental</td>
<td>404</td>
<td>63</td>
<td>0.78</td>
<td>15.59%</td>
<td>41</td>
<td>10.15%</td>
<td>22</td>
<td>5.45%</td>
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<tr>
<td>Dermatology</td>
<td>1,244</td>
<td>232</td>
<td>1.08</td>
<td>18.65%</td>
<td>149</td>
<td>11.98%</td>
<td>83</td>
<td>6.67%</td>
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<tr>
<td>Endocrinology</td>
<td>754</td>
<td>109</td>
<td>1.07</td>
<td>14.46%</td>
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<td>9.02%</td>
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<tr>
<td>ENT Surgery</td>
<td>463</td>
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<td>0.98</td>
<td>11.23%</td>
<td>36</td>
<td>7.78%</td>
<td>16</td>
<td>3.46%</td>
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### Statewide

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<th>Service Line</th>
<th>Eligible Discharges</th>
<th>Readmissions</th>
<th>Readmit Ratio</th>
<th>Readmit Rate</th>
<th>Intra Readmissions</th>
<th>Intra Readmit Rate</th>
<th>Inter Readmissions</th>
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<tr>
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### Initial Discharge - Select initial DRG to see top 5 resulting readmit DRGs

#### Initial APR Code 363 APR DRG Value

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<th>Eligible Discharges</th>
<th>Readmissions</th>
<th>Readmit Ratio</th>
<th>Readmit Rate</th>
<th>Intra Readmissions</th>
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### Readmit Discharge - Select readmit DRG to see top 5 resulting final DRGs

#### Readmit APR Code 383 APR DRG Value

<table>
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<tr>
<th>Readmit APR Code</th>
<th>APR DRG Value</th>
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<tr>
<td>363</td>
<td>CELLULITIS &amp; OTHER BACTERIAL SKIN INFECTIONS</td>
<td>463</td>
<td>KIDNEY &amp; URINARY TRACT INFECTIONS</td>
<td>720</td>
<td>SEPTICEMIA &amp; DISSEMINATED INFECTIONS</td>
<td>468</td>
<td>OTHER KIDNEY &amp; URINARY TRACT DISEASES, SIGNS &amp; SYMPTOMS</td>
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<td>204</td>
<td>SYNOCOPE &amp; COLLAPSE</td>
<td>383</td>
<td>CELLULITIS &amp; OTHER BACTERIAL SKIN INFECTIONS</td>
<td>720</td>
<td>SEPTICEMIA &amp; DISSEMINATED INFECTIONS</td>
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<td>100</td>
<td>SIGNS, SYMPTOMS &amp; OTHER FACTORS INFLUENCING HEALTH STATUS</td>
<td>197</td>
<td>PERIPHERAL &amp; OTHER VASCULAR DISORDERS</td>
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<tr>
<td>861</td>
<td>POISONING OF MEDICAL AGENTS</td>
<td>720</td>
<td>SEPTICEMIA &amp; DISSEMINATED INFECTIONS</td>
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<td>197</td>
<td>PERIPHERAL &amp; OTHER VASCULAR DISORDERS</td>
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Three Purposes of CRS:
1. Patient Identification
2. Performance Measurement
3. Coordination of Services
Upcoming CRS Reports

Patient Identification
- Risk stratification tools/methodologies applied
- Enhancements to Patient Total Hospitalizations reports
- Admission and discharge analysis

Performance Measurement
- Core metrics dashboard
- Panel-based trends and utilization reports
- Benchmarking for regions and providers

Coordination of Services
- Regional and cross-hospital patient utilization mapping
- Population-based Preventive Quality Indicator dashboards
Prior to providing individual user access, CRISP will work with the hospital to complete the following:

- Review and sign the CRISP Participation Agreement
- Established VPN and route outbound HL7v2 (ADT, Lab, Rad, Documents); CCD if possible
- Validate CRISP developed interface
- Update existing Notice of Privacy Practices to inform patients of the hospital’s participation with CRISP and their right to opt out
Visit [http://onboarding.crisphealth.org](http://onboarding.crisphealth.org). The registration process takes approximately 30 minutes. You may save your application at any time and return to it later.

Please have the following identifying information available:

- An electronic copy of a government or employer ID
- Personal (non-shared) email address
- If applicable, license, DEA, NPI, and CDS numbers.

You will also need to complete the following steps:

- Sign PDMP Memorandum of Understanding
- Watching CRISP Portal/PDMP training video
- If obtaining access to clinical data, you will also need to be verified by organization Point of Contact
Integrated Care Network Infrastructure Project

Why: The all-payer waiver and GBR will motivate new population-health efforts and care management initiatives...

And: Stakeholders will need new infrastructures and access to data to support these activities...

It follows that: Elements of these infrastructure could be shared, i.e. pursued cooperatively, both to avoid duplication of costs and to give care managers more complete data...

And if so: CRISP was chartered and is governed to be the place where health IT solutions are deployed through cooperation and collaboration.
Maryland’s Strategic Transformation Roadmap

Transform care delivery to support person centered care, coordinated across primary care, behavioral health, long term and other settings

State-Level Infrastructure (leverages many other large investments)
- Create and Use, Meaningful, Actionable Data
- Develop Shared Tools (Patient Profiles, Enhanced Notifications, Care Needs, Others)
- Connect Providers

Alignment
- Medicare Chronic Care Management Codes/Medical Homes
- Gain Sharing & Pay for Performance
- Integrated Care Networks & ACOs Including Dual Eligibles
- Accelerating All-Payer Opportunities Moving Away From Volume

Care coordination & integration (locally-led)
- Implement Provider-Driven Regional & Local Organizations & Resources (Requires Large Investments And Ongoing Costs)
- Support Provider-Driven Regional/Local Planning
- Technical Assistance

Consumer Engagement
- State & Local Outreach Efforts
- Develop Shared Tools For Engaging Consumers

Year 2 Implementation Focus
- Clinical Improvement Focus:
  - Chronic Care
  - Care Coordination
  - High Needs Patients
- Alignment

From HSCRC presentation
1. AMBULATORY CONNECTIVITY
The project aims to achieve bi-directional connectivity with ambulatory practices, long-term-care and, other health providers. Multiple methods of connectivity will be employed, including HL7 interfaces, CCDA exchange, and administrative networks.

2. DATA ROUTER
A key concept of the infrastructure effort is to send relevant patient-level data to the healthcare organizations who can use it for better care management. The data router will receive and normalize health records, determine a patient-provider relationship, verify patient consent, and forward the records where they should go in near real time.

3. CLINICAL PORTAL ENHANCEMENTS
The existing clinical query portal will be enhanced with new elements, including a care profile, a link to a provider directory, information on other known patient-provider relationships, and risk scores.

4. NOTIFICATION & ALERTING
New alerting tools will be built such that notification happens within the context of a provider’s existing workflow. So for instance, if a patient who is part of a specific care management initiative shows up at the ER, an in-context alert could inform the clinicians that the patient has a care manager available.

5. REPORTING & ANALYTICS
Existing reporting capabilities, built on Tableau and Microsoft Reporting Services, will be expanding and made available to many more care managers. Will also plan for a potential new solution to support thousands of ambulatory practices.

6. BASIC CARE MANAGEMENT SOFTWARE
The current scope is for planning only, as the advisors help us determine an appropriate path.

7. PRACTICE TRANSFORMATION
The current scope is for planning only, as the advisors help us determine an appropriate path.
CRISP services are those best pursued through cooperation and collaboration. To make that possible 65 people participate in CRISP leadership through our governance committees.
Questions?
SUMMARY AND NEXT STEPS

- **Summary**
  - Vision and goals of the project
  - All-Payer Model Overview
  - CRISP Overview

- **Next steps**
  - **In-person Duals Care Delivery Workgroup Meeting**
    - Monday, February 29—1:00-4:00
    - DHMH Room L-3
  - Full meeting schedule on next slide
### DUALS CARE DELIVERY WORKGROUP MEETINGS

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Subject Matter and Goals</th>
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</table>
| 2) Feb 29 | - Review, at high level, other states’ approaches to duals’ care coordination  
- Discuss existing MD infrastructure and ongoing projects touching dual eligibles, which may aid or limit options for a new program  
- Outline concepts and parameters for improving duals’ care coordination |
| 3) Apr 4 | - Present and discuss refined vision for a duals care coordination program encompassing delivery organization, payment, quality concepts, and information infrastructure (include options that do and don’t include hospital services affected by all-payer rate model) |
| 4) May 2 | - Present pre-final program concept reflecting feedback from Apr 4 meeting  
- Explain any waivers needed to implement program |
| 5) Jun 1 | - Present final program concept  
- Describe key elements of any waiver application |
| 6) Jun 29 | - Further discuss any waiver application |