University of Maryland Capital Region Health to Prince George's County Council as Board of Health

The Maryland Medicare Waiver, Global Based Revenue (GBR) Model, and Population Health

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February 13, 2018

Six Keys to Patient Care Success in Prince George's County

UNIVERSITY of MARYLAND MEDICAL SYSTEM

UNIVERSITY of MARYLAND CAPITAL REGION HEALTH

Outline

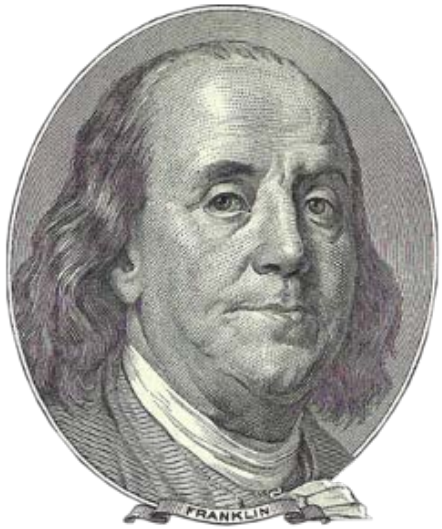
1. Maryland Medicare Waiver and Global Based Revenue

2. What is Population Health?

3. Collaborative Care to Patients and Families in Prince George's County

4. Discussion


PRINCE GEORGE'S HOSPITAL CENTER



"An ounce of prevention is worth a pound of cure."

Benjamin Franklin

University of Maryland Capital Region Health FY18 Annual Operating Plan

Mission

Enhance the health and wellness of our patients and communities

Vision

To be the healthcare system of choice

Values

Dignity
Excellence
Accountability
Quality
Communication
Innovation
Safety

Goals

Quality
Laxton/ Connerney/ Hall/ Ehrlich

1.1 Improve quality & patient experience
LRH- HCAHPS 0.15 (QBR score)
PGHC- HCAHPS 0.15 (QBR score)
BHC ED -HCAHPS 62% (top box)

1.2 Reduce harm
LRH- MHAC 0.75; Harm Index -7.5%
PGHC-MHAC 0.60; Harm Index-7.5%

1.1.1 Achieve sustained compliance with regulatory bodies
1.1.2 Improve HCAHPS top box performance
1.1.3 Achieve patient and family centered care goals
1.1.4a-b: Improve certification standing in Chest Pain and Stroke
1.1.4c-e: Achieve requirements for Trauma and NICU programs re-designation and LRH TJC accreditation
1.1.4f-j: Improve clinical outcomes in Orthopedics, Behavioral Health, Cardiac Surgery, Critical Care, and Women's Health
1.1.5 Improve Hospital Throughput
1.1.6 Implement Nursing Strategic Plan Year 1
1.1.7 Execute IT initiatives, upgrades and training needs to achieve AOP goals
1.2.1 Reduce hospital acquired complications and harm events

Integration
Sullivan/ Hall/ Ehrlich

2.1 Decrease readmissions
LRH- 12.24% risk adjusted rate
PGHC-10.66% risk adjusted rate

2.2 Achieve 0 CMS rate penalties related to MACRA/MIPS

2.1.1 Execute Community Health Needs Assessment work plans
2.1.2 Integrate with UMMS Quality Care Network (Clinically Integrated Network)
2.1.3 Implement system based re-engineered discharge and case management models including end of life care
2.1.4 Expand telehealth appointment options for patients seeking primary and/or specialty care
2.1.5 Develop clinical analytics and data warehouse for quality and clinical integration
2.2.1a-d: Expand chronic disease management initiatives: Diabetes, Hypertension, COPD, and Mobile Integrated Health
2.3.1 Implement improvements to achieve MIPS performance targets

Market
Johnson

3.1 Build acute, primary, and ambulatory care network

3.2 Expand unregulated revenue to $29.8M

3.1.1 Complete UMMS / DHS transaction and integrate shared services
3.1.2 Achieve Year 1 Objectives of the Laurel Regional Hospital Strategic Transformation Plan
3.1.3 Execute Year 1 Medical Staff Development Plan
3.1.4 Complete Ambulatory Care Network Development Plan and Achieve Year 1 Objectives
3.1.5 Develop 3 Year Strategic Plan: Focus 2020
3.1.6a-e: Develop and implement business and marketing plans for select service lines: Cancer, Cardiovascular, Orthopedics, Surgery, and Women's Health
3.1.7 Complete PGRMC detailed design phase and initiate construction
3.2.1 Develop Collaborative and Joint Venture Relationships with Physician Partners, Payers and other Providers
3.2.2 Achieve DHA operational/revenue target

Workforce
Ford

4.1 Reduce voluntary turnover to <14%

4.2 Improve culture of safety

4.1.1 Execute system wide hiring plan, including Laurel workforce transition
4.1.2 Execute system wide recognition and retention plan
4.1.3 Negotiate new collective bargaining agreement
4.1.4 Improve employee, medical staff, and volunteer communication
4.1.5 Implement evidence based leadership development curriculum
4.2.1 Achieve Year 1 Plan for Patient Safety Certification through Maryland Patient Safety Center

Finance
Brosius

5.1 Achieve operating income of $6.4M

5.2 Enhance philanthropy (donation revenue) to $625K

5.1.1a-d: Achieve PI targets for revenue cycle, supply chain, labor management & contracts
5.1.2 Increase financial reporting and management skills among middle leadership and above
5.1.3 Implement procure to pay work plans
5.2.1 Implement Year 2 Fundraising Plan (traditional, special appeals & fundraising programs)
5.2.2 Implement Year 1 RMC Capital Campaign Plan


METABOLIC SYNDROME
HIV behavioral Health
food insecurity
cancer
education
employment
housing
stroke
POVERTY
diabetes
obesity
asthma
heart disease
access to health insurance
healthcare providers
residents knowledge to use resources
behavioral Health
HIV
7

Seven Key Assumptions About the Future Maryland Operating Environment

1. Most providers—whether hospitals or physician groups—will need to focus on **scale**, **skill** (new competencies), scope (continuum of care) and **reach** (geographic dispersion and access).

Expect Further Consolidation of the Maryland Healthcare Marketplace

2. Integrated health systems will continue to pursue economies of scale and achievement of quality outcomes at a lower cost

Expect Maryland's "Big Three" Healthcare Systems to Dominate the Market

Seven Key Assumptions About the Future Maryland Operating Environment

3. Health systems, not payors, will place an increasing emphasis on "health care" vs. "sick care." Payors (public and private) will shift more risk for the cost of medical care to individual subscribers.

Inpatient Admissions Will Continue
To Decline in Maryland

4. Consumers and patients will expect better access, clinical results, convenience and affordability.

High Deductible Health Insurance Plans
Are Here to Stay

Seven Key Assumptions About the Future Maryland Operating Environment

5. The Current Maryland Medicare Waiver will continue into a second phase at least through 2023.

The HSCRC will continue its move toward value based payment methodologies that focus on population health.

6. Little net financial value will accrue to health systems unless they accept **insurance risk for the management of care.**

Providers will need to move up the "premium food chain" to capture the financial benefits of successful care management.

Seven Key Assumptions About the Future Maryland Operating Environment

7. The demand for healthcare services in Maryland will continue to grow; however at a slower pace.

Future financial performance will be strongly driven by improving quality, the patient experience and efficiency.

HSCRC History and Background

- **Health Services Cost Review Commission (HSCRC) regulates Maryland hospital rates**
- **Seven Member Commission appointed by the Governor and established in 1971**
- **Founding Legislative Mandate**
  - Contain hospital costs
  - Maintain solvency of efficient and effective hospitals
  - Set rates in a fair and equitable manner
  - Insure access to hospital care
  - Disclose information to the public on hospital costs and finances

HSCRC History and Background

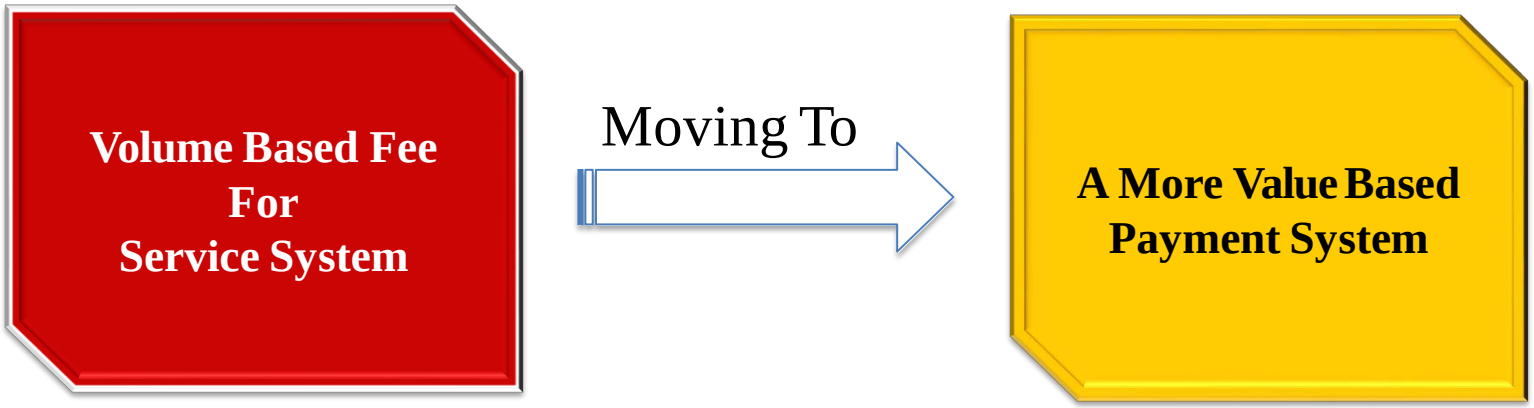
- **Broad authority and flexibility to accomplish its mandate**
- **Regulatory Jurisdiction**
  - Inpatient hospital services as defined by Medicare
  - Outpatient hospital services "at the hospital"
  - 46 Acute care hospitals; 3 Chronic hospitals; 3 Private Psychiatric hospitals
- Does not regulate physician professional fees, nursing homes or home care
- **Each Maryland Hospital has unique HSCRC established rates**

Key Benefits of the HSCRC

- Equitably finances Uncompensated Care
- Eliminates “Cost-Shifting” (from one payor to another) occurring in other States
  - Allows for enhanced federal payments for inpatient and outpatient hospitals services
- Affords a high level of predictability and stability in hospital revenue streams

Maryland is the only State to retain is Waiver

The New Medicare Waiver Focuses On A More Value Based Hospital Payment System



Where rewards and penalties are provided for:

- Cost containment on a per capita basis
- Demonstrated quality
- Management of patient care across various health care delivery settings (population health)

The Value-Based System Emphasizes The Triple Aim

Better Care	Better Health	Reduced Costs
• Enhance care transitions	• Reduce unnecessary admissions and ED visits	• Reduce overuse of diagnostic testing
• Sustain high physician participation	• Reduce health disparities	• Reduce the rate of growth of health care costs on a per capita basis
• Broaden engagement in innovative model of care	• Increase sharing of data through State Health Information Exchange	• Meaningful savings for all payors
• Improve quality of care	• Improve health status	
• Increase patient satisfaction		

The New Waiver Will Be Implemented In Two Phases

Phase	Time period	Main Financial Focus
I	Calendar Years 2014-2018	Controlling and reducing the rate of growth in ***per capita hospital expenditures*** for Maryland residents
II	Calendar Years 2019* and Beyond	Controlling and reducing the rate of growth in ***total per capita health care expenditures*** for Maryland residents

**Potential Year Delay*

The HSCRC Has Moved To A Global Based Revenue (GBR) System A Fixed Annual Approved Revenue Amount. . .

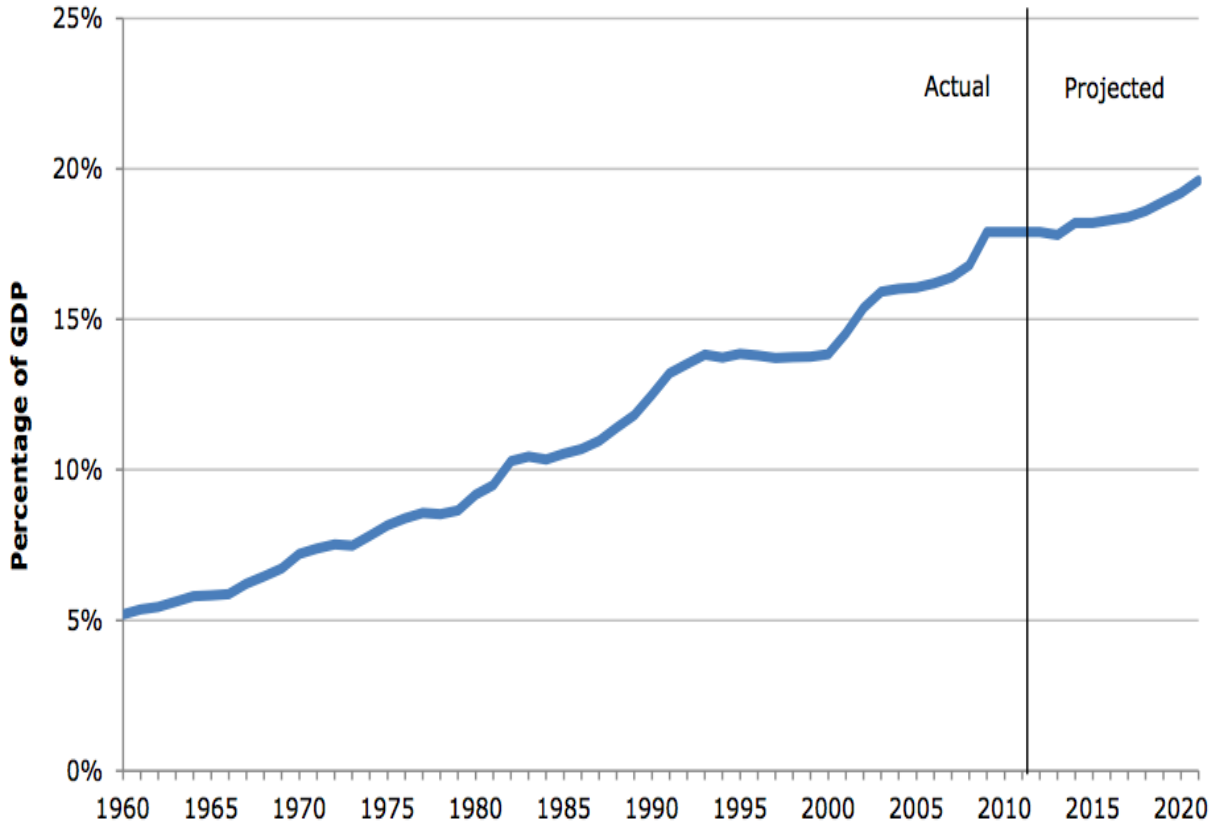
- ❑ Rewards hospitals for reducing/eliminating avoidable hospital-based care
- ❑ Penalizes growth in avoidable hospital-based care
- ❑ Increases incentives and penalties for quality
- ❑ Funds inflation (or at least a high percentage)
- ❑ Provides seed funding to invest in population health infrastructure cost
- ❑ Adjusts for shifts in market share

What is Population Health Management?

The design, delivery, coordination, and payment of comprehensive healthcare services to achieve improved health outcomes and lower healthcare costs for a population or group of individuals.

Why Population Health Management?

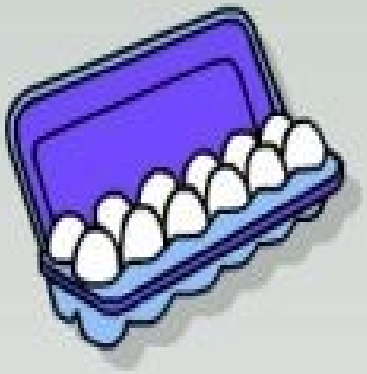
Figure 2: U.S. National Health Expenditures as a Share of GDP, 1960-2021



Source: Centers for Medicare and Medicaid Services.

The Cost of Health Care
How does it compare?

If other prices had grown as quickly as healthcare costs since 1945…



a dozen eggs
would cost
$55

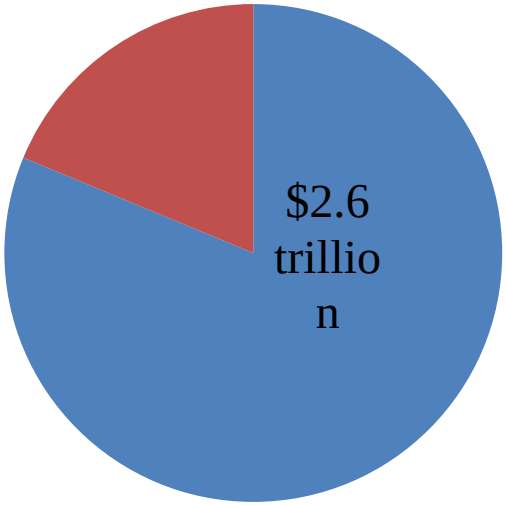
a gallon of milk
would cost
$48

a dozen oranges
would cost
$134

- Source-Washington Post

Chronic Conditions Drive 85% of Healthcare Spending

2017 total health expenditures = $3.2 trillion



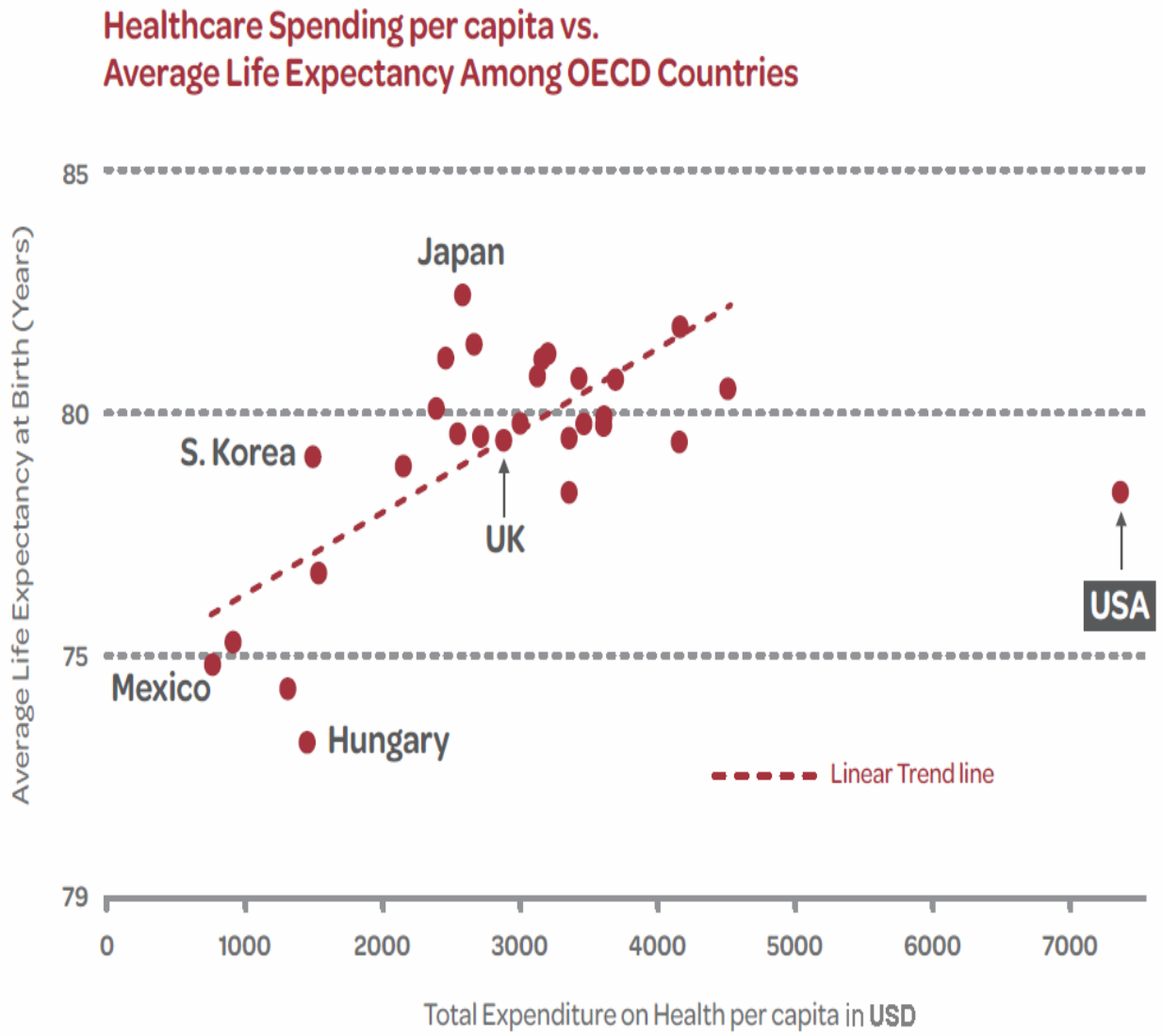
Chronic Conditions

- Congestive heart failure
- Asthma
- Diabetes

Associated Behaviors

- Tobacco use
- Physical inactivity
- Poor nutrition

High Healthcare Spending, but Lower Life Expectancy than Countries that Spend Less

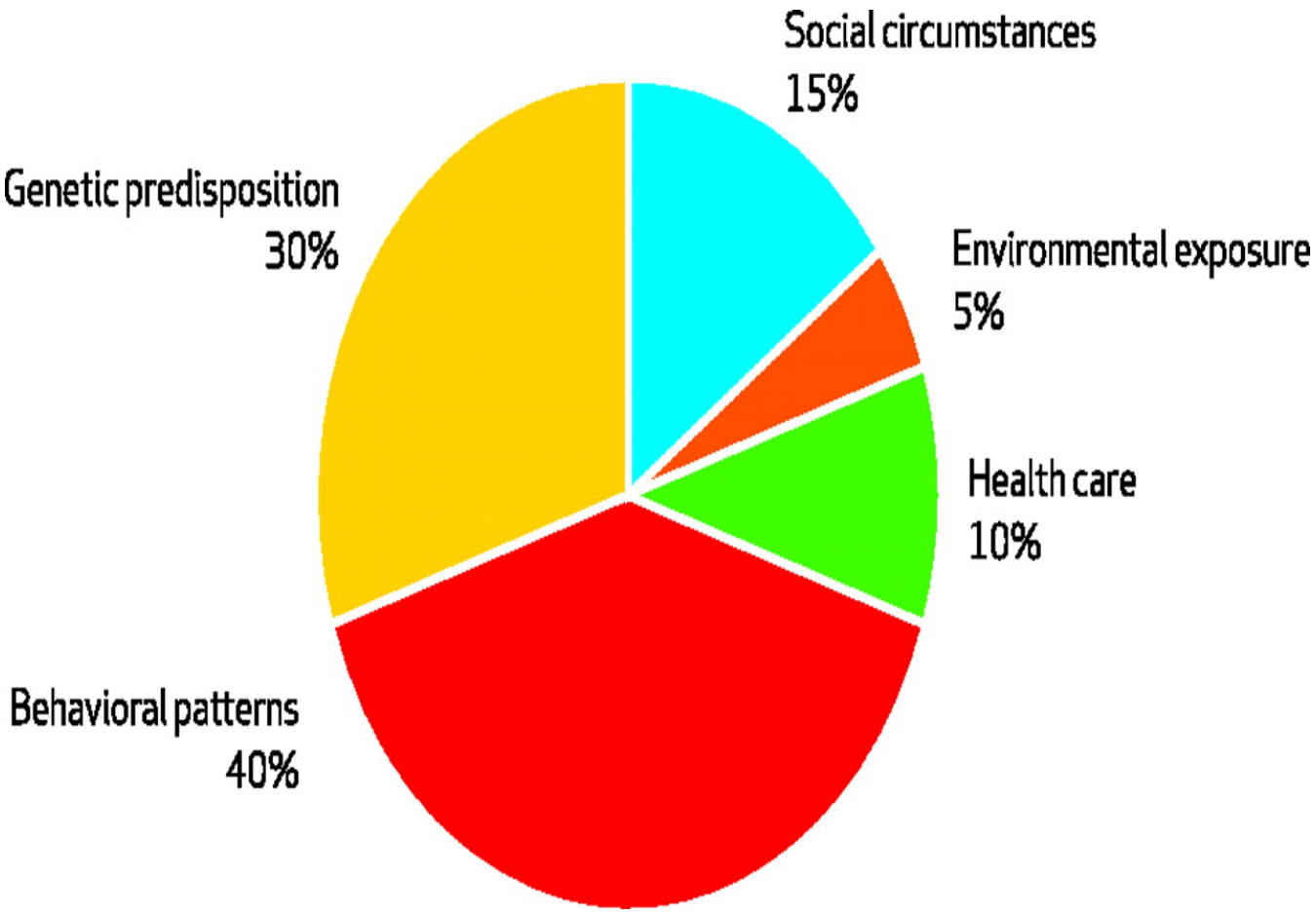


New Waiver Rewards Population Health Management

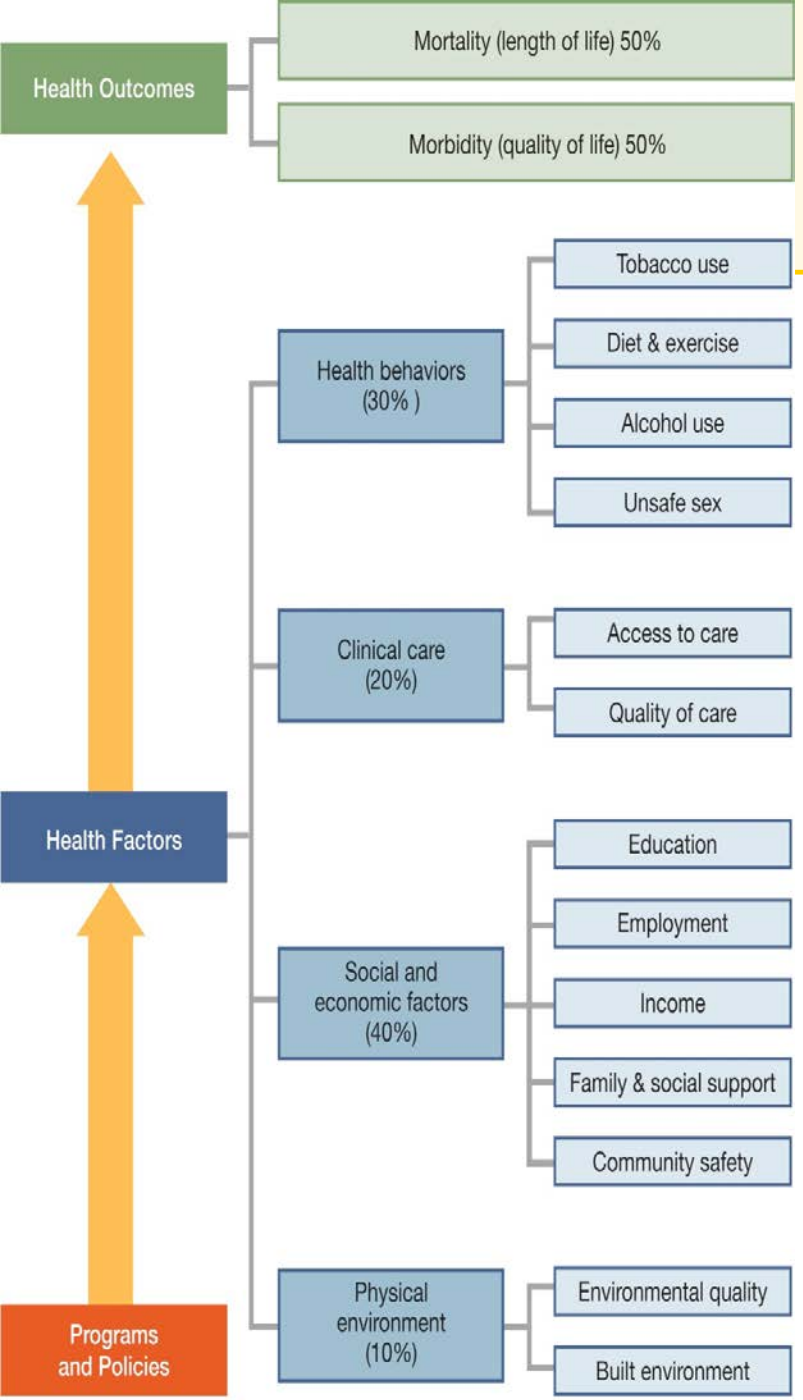
The new Medicare waiver provides incentives for hospitals to…

- Provide comprehensive care for people and communities, rather than treating individual illness at any given point in time, and
- Invest in the provision of the right care in the right place (i.e. lowest cost setting) at the right time.

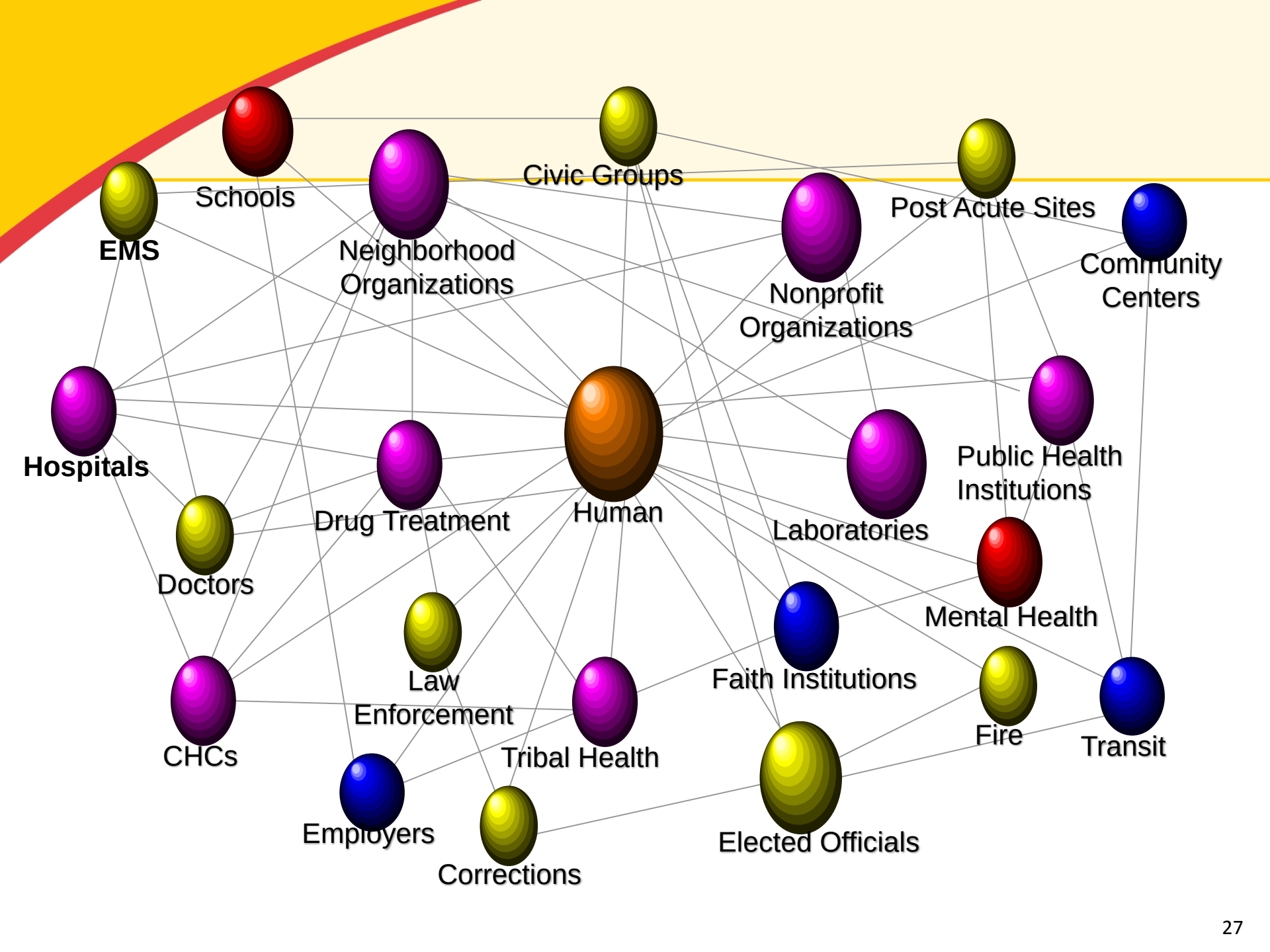
Comprehensive Healthcare Services Address All Determinants of Health



Source: McGinnis, JM, Foege, WH. Actual causes of death in the United States. JAMA 1993; 270:2207-2212



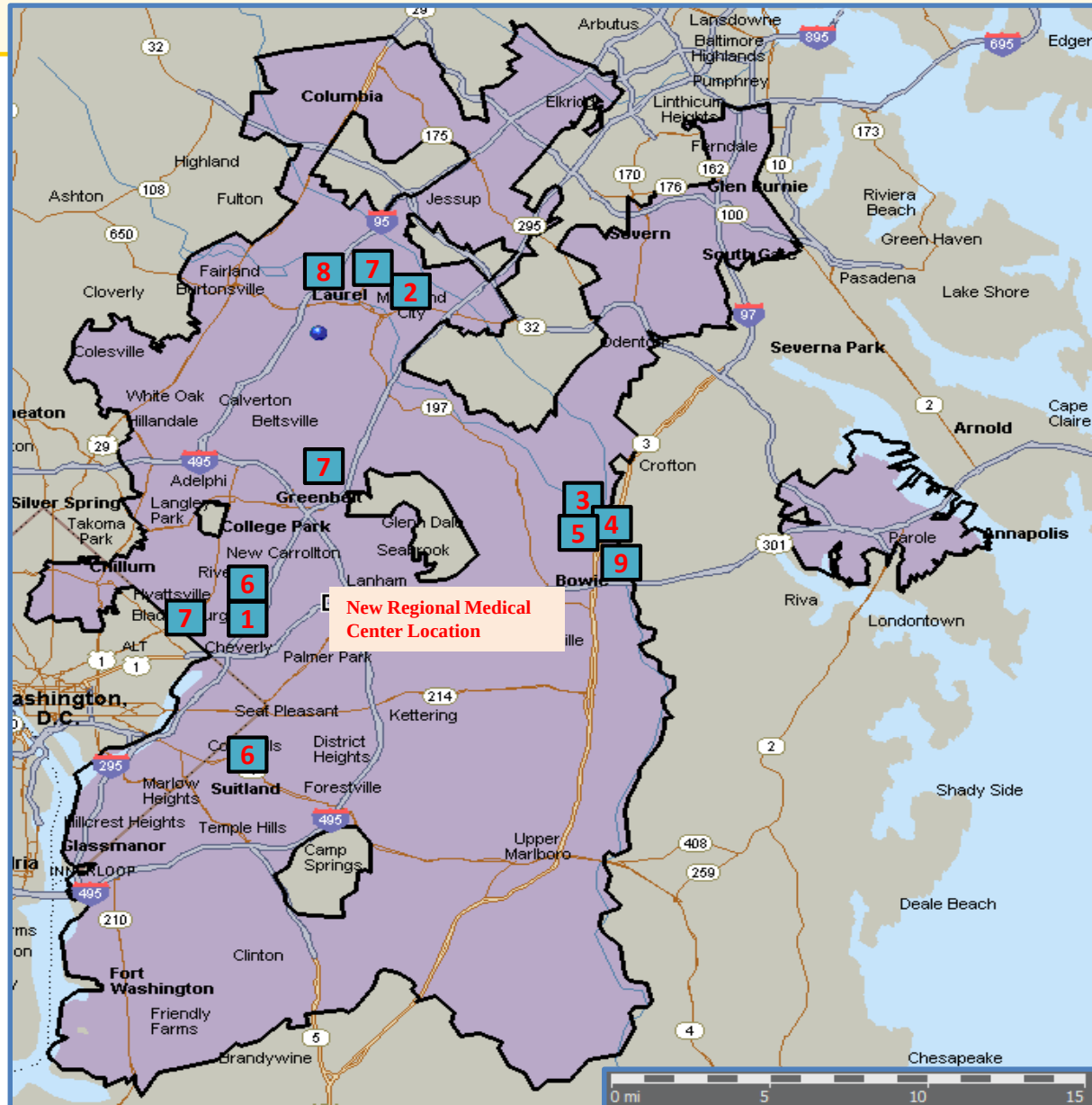
County Health Rankings model ©2010 UWPHI


Schools
Civic Groups
EMS
Neighborhood Organizations
Post Acute Sites
Nonprofit Organizations
Community Centers
Hospitals
Drug Treatment
Human
Public Health Institutions
Laboratories
Doctors
Mental Health
Law Enforcement
Faith Institutions
CHCs
Tribal Health
Fire
Transit
Employers
Elected Officials
Corrections

UM Capital Region Health Service Area & Facility Locations

Map Key

1. **UM Prince George's Hospital Center**
2. **UM Laurel Regional Hospital**
3. **UM Bowie Health Center (Freestanding ED)**
4. **UM Capital Region Surgery Center (Freestanding ASC)**
5. **Larkin Chase Center - Skilled Nursing Facility (JV with Genesis Eldercare)**
6. **UM Family Health & Wellness Centers**
7. **Other physician/ambulatory sites**
8. **Wound Care Center**
9. **Mullikin Medical Office Building**



Ambulatory Practice Site Locations

- Cheverly
  - Internal Medicine
  - Family Medicine
  - Pulmonary
  - OB/GYN and MFM
  - Nurse Midwifery
  - Infectious Disease
  - GI
  - Vascular
  - Ortho/Trauma Follow Up
- Laurel
  - Internal Medicine
  - Pain Management
  - Pulmonary
  - OB/GYN and MFM
- Greenbelt
  - Plastic and Reconstructive Surgery
  - OB/GYN
- Bowie
  - Vascular (Q1 2018)

Ambulatory Practice Site Locations

- Suitland
  - Internal Medicine
  - Family Medicine
  - Pulmonary
  - OB/GYN and MFM
  - Nurse Midwifery
  - Dentistry
- Capital Heights
  - Pulmonary
  - MFM
  - Infectious Disease

UM Capital Population Health Management Strategic Objectives

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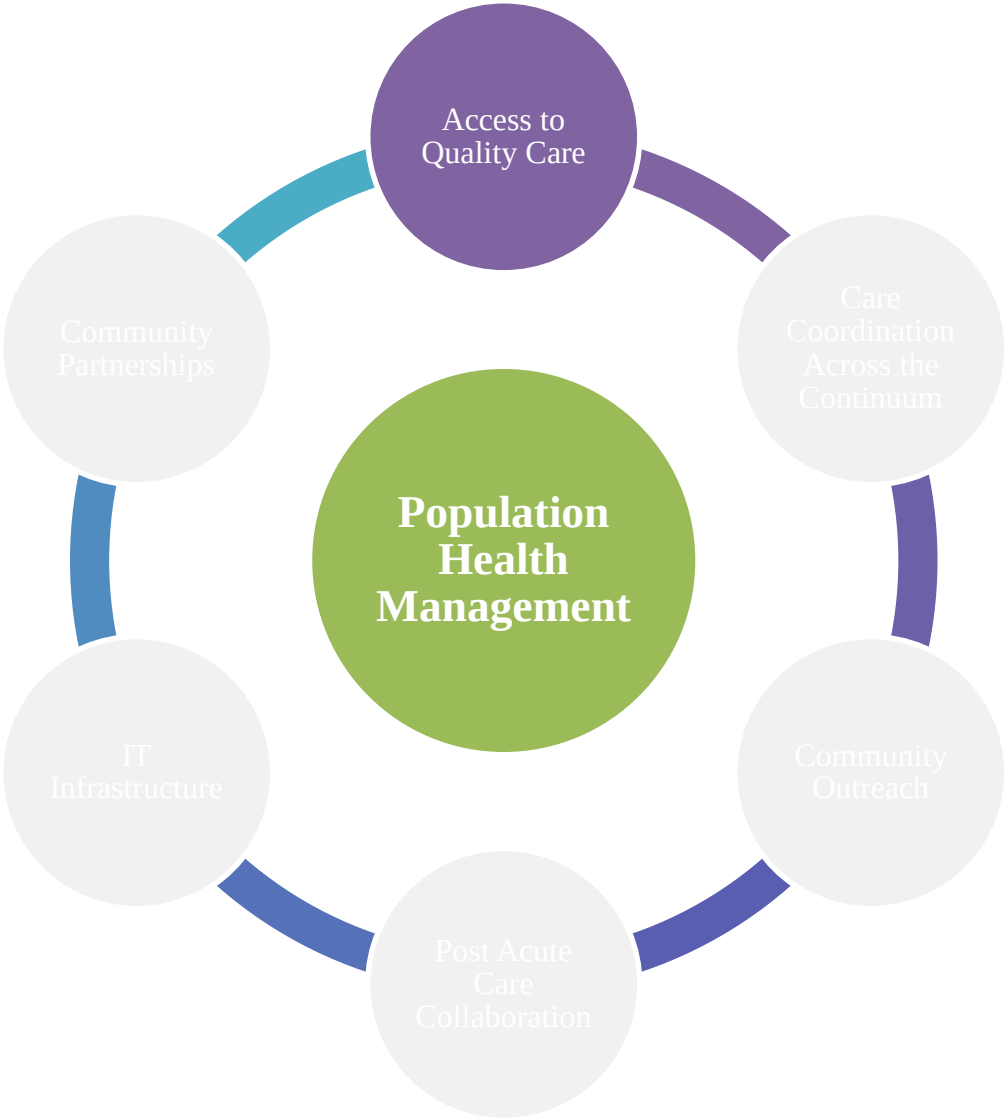


Access to Quality Care

- Improvements
  - Additional Specialties and Locations
    - Opened Capital Heights
    - Pulmonary and Vascular Specialties
    - Expanded Hours
    - Eligibility Services
  - Team infrastructure realigned to support clinical and operational improvement
  - Patient engagement/Satisfaction Survey Implemented
  - Focused on clinician and staff training to improve quality

Access to Quality Care

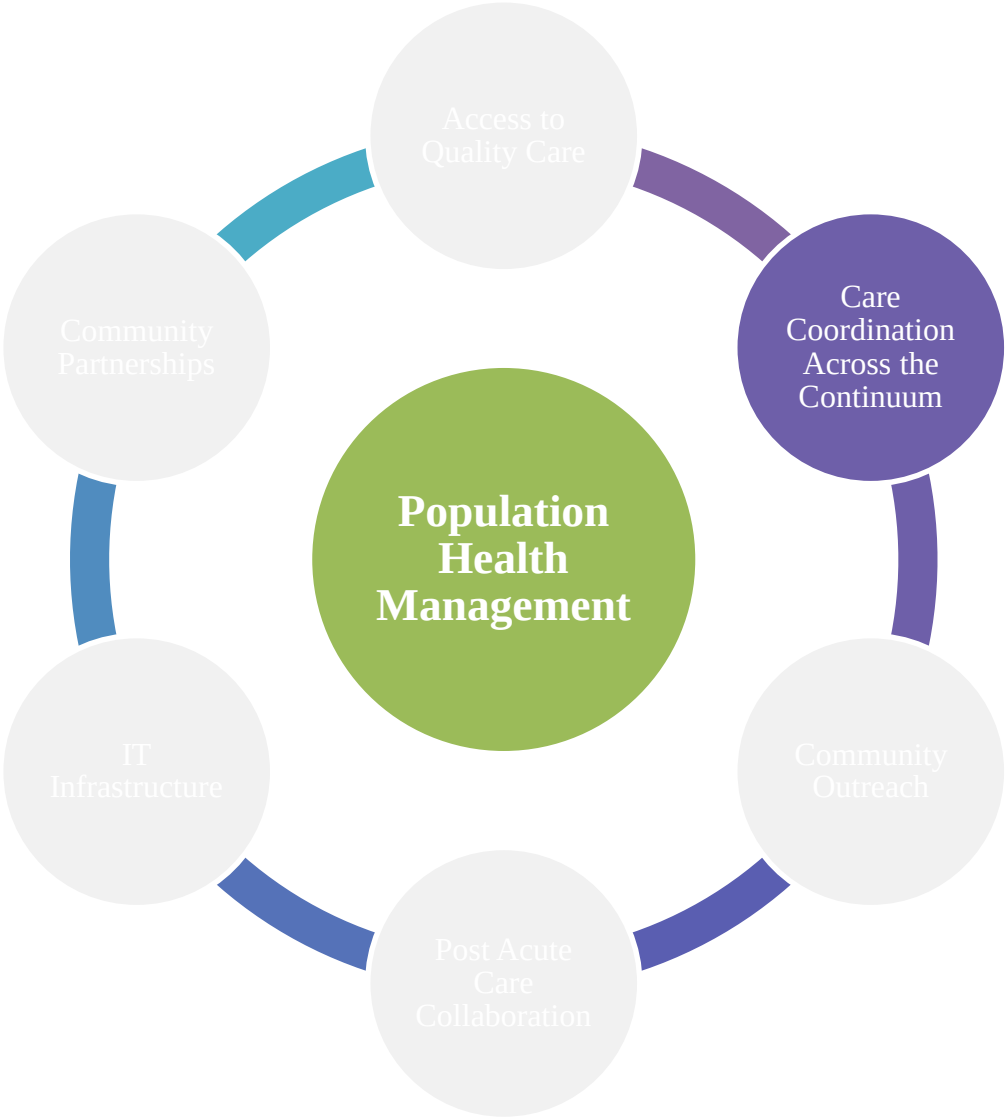
- Mobile Health Opportunities
  - Mama Baby Bus
  - https://www.nbcwashington.com/news/local/Mama-_-Baby-Bus-Kicks-Off-Winter-Stops_Washington-DC-471615783.html?appVideoHub=y

Access to Quality Care

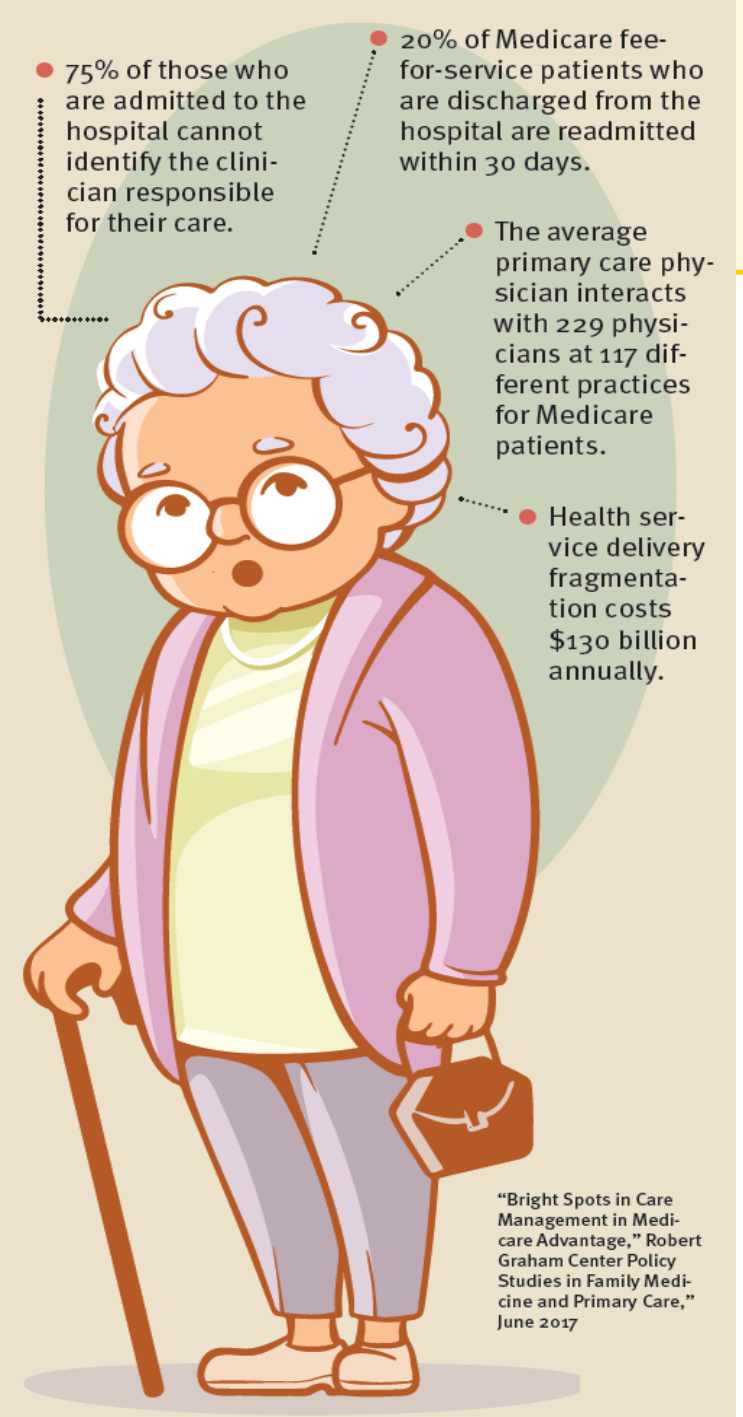
2015	2016	2017
Quality (Calendar Year)		
4% downward adjustment	0% adjustment/neutral	TBD
Low quality and low cost	Average quality and low cost	TBD
All cause readmission-15.56%	All cause readmission-15.07%	TBD
Visits (Fiscal Year)		
20,352	22,548 10.8% growth	25,616 13.6% growth

- 38% increase in hemoglobin A1c tests ordered for patients managing type 2 diabetes
- 88% of patients managing type 2 diabetes receive blood glucose testing at every visit

UM Capital Population Health Management Strategic Objectives



Care coordination is a function that helps ensure that the patient's needs and preferences for health services and information across people, functions, and sites are met over time. Coordination maximizes the value of services delivered to patients.



The average Medicare patient sees seven physicians across four different practices

Care Coordination

Care Coordination

Assessment

- Completed on Day 1
- Patient identified as “at risk” for additional ED visits and or hospitalizations
- Confirm primary care physician (PCP) or preference

Coordinated Referrals

- Appropriate programs/services identified for patient
- Referrals and appointments made and information communicated to patient and care taker
- Information shared with PCP

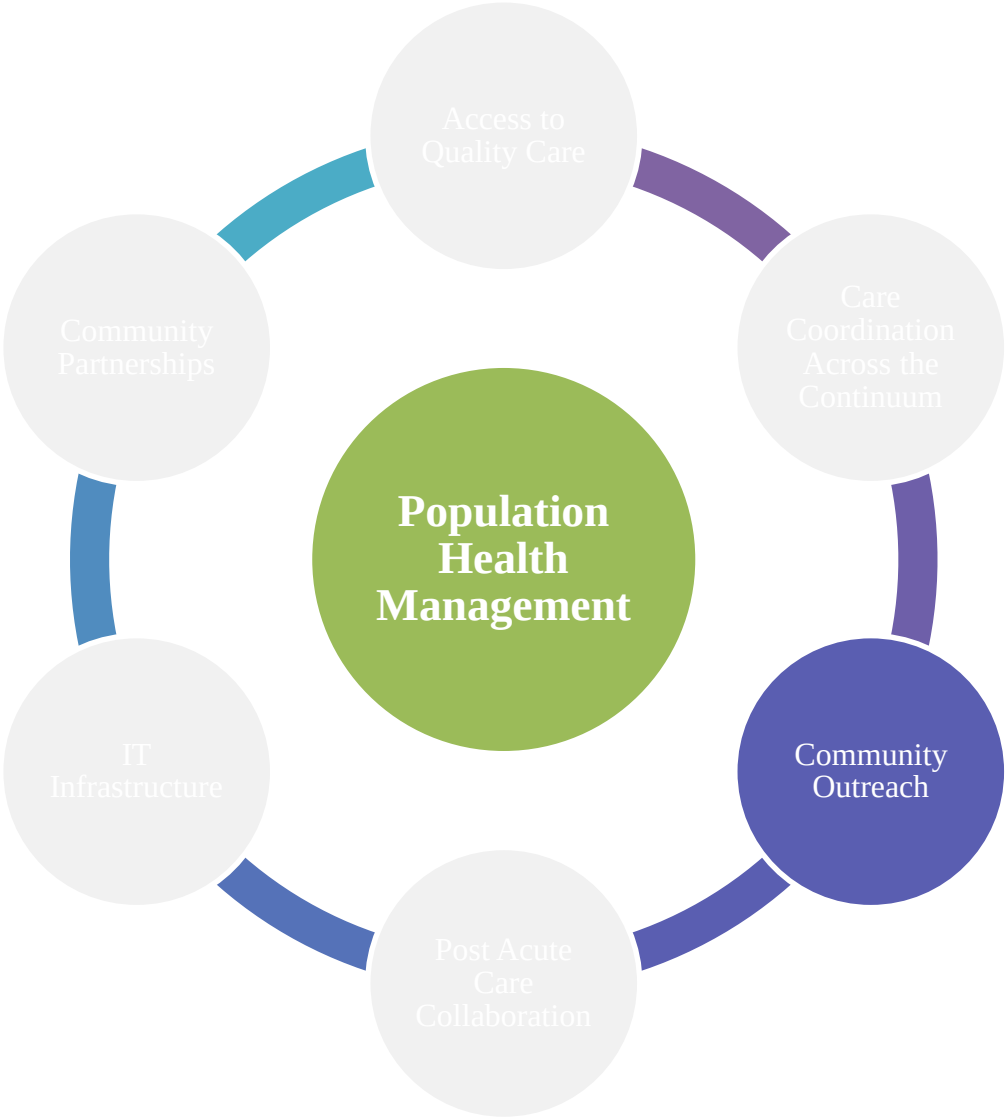
Monitoring

- Continued communication with patient: discharge phone calls, outpatient visits
- Review of databases to track readmission and patient progress

Care Coordination

- Re-Engineering Discharge Priority Areas:
  - Follow up appointments at discharge
  - Take home medications provided at discharge
  - Easy to Understand and Follow After Hospital Care Plans
  - Develop a referral/tracking system
  - Readmission Reviews

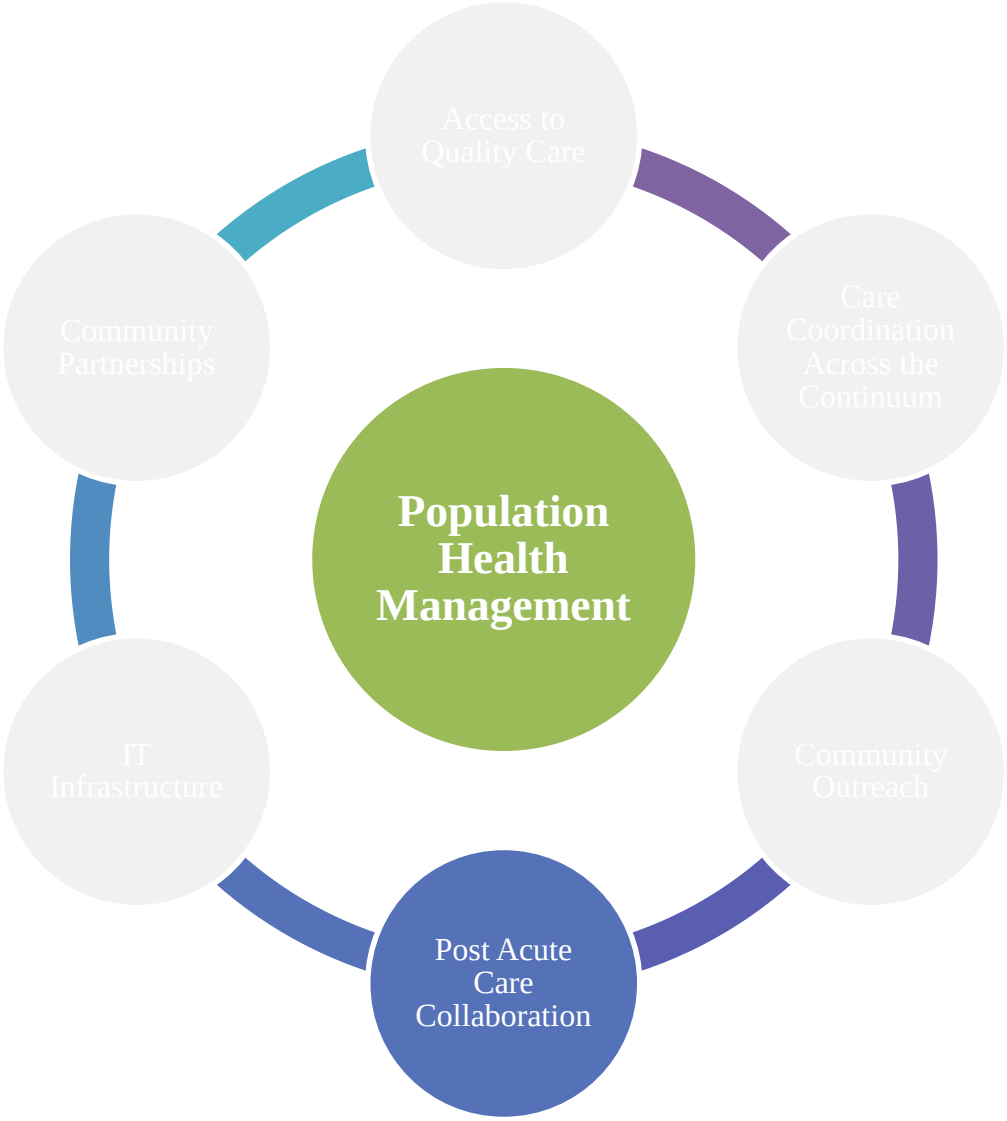
UM Capital Population Health Management Strategic Objectives



Community Outreach

- Community Screening
  - *Participation in a number of events with various partners to provide free screening throughout the community. Currently blood pressure and some POS testing offered.*
- Community Health Improvement Plan Initiatives
  - *Diabetes*
  - *COPD*
  - *Hypertension*
  - *Chronic Disease Self Management*

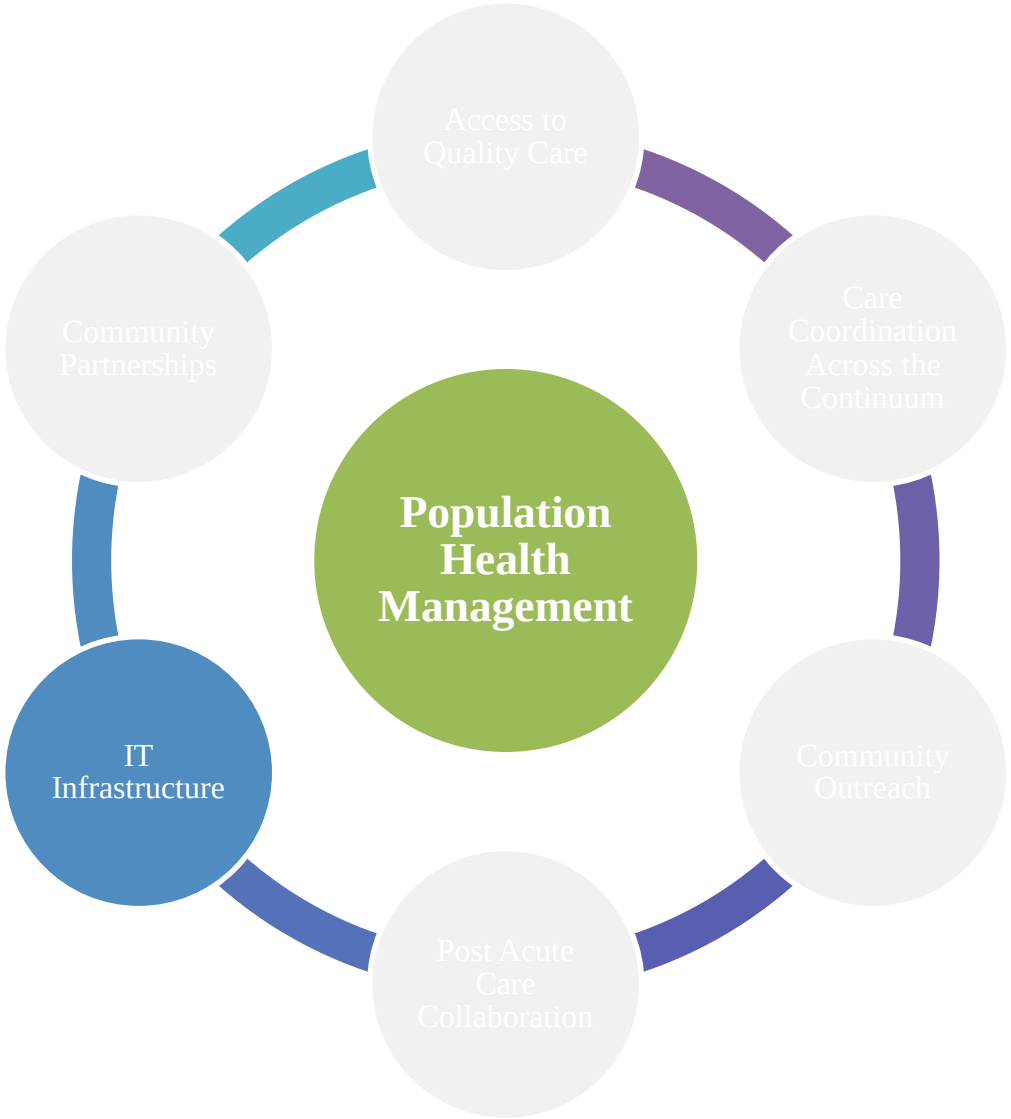
UM Capital Population Health Management Strategic Objectives



Post Acute Care

- Build Effective Network of PAC Providers
  - *Rehab*
  - *Home Health*
  - *Hospice*
  - *Palliative Care*
- Palliative Care Referral Improvement
  - *Capture "missed" opportunities*
  - *Percentage of providers trained on appropriate selection of post-acute care setting*
  - *Number of complaints from PCPs regarding unclear post-discharge instructions*

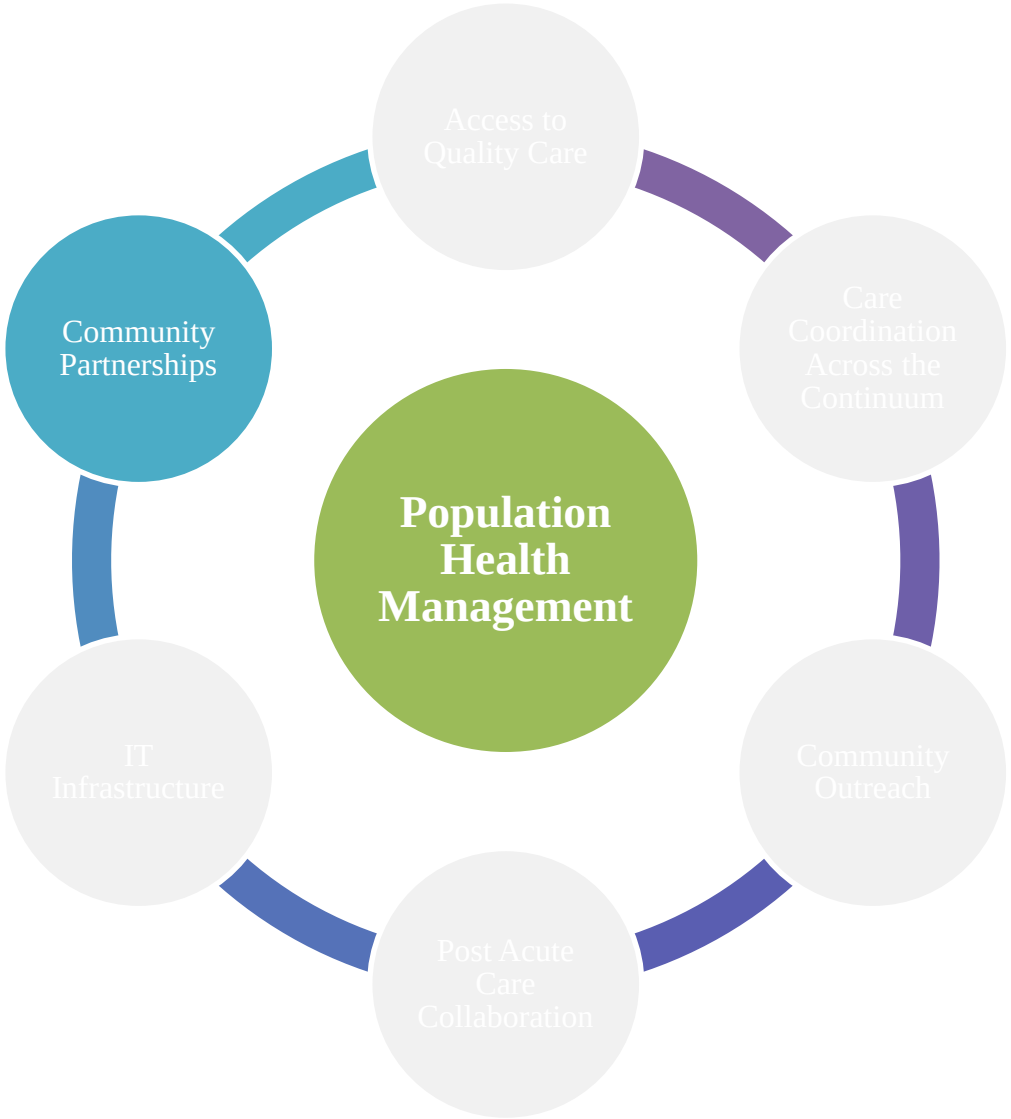
UM Capital Population Health Management Strategic Objectives



IT Infrastructure

- Patient portals
- Secure messages with providers
- Online scheduling and payments
- Medication refill requests

UM Capital Population Health Management Strategic Objectives



Community Partnerships

- Totally Linking Care-MD (TLC-MD)
  - *Network of providers, health departments, community organizations and hospitals working together to help patients coordinate medical care.*
    - *HSCRC Regional Transformation Grant*
      - eQHealth-patient care coordination
      - Blue-tooth Monitoring
      - *Medication, Diabetes, blood pressure, CHF*
      - Blue Bag Program
- Community Care Coordination Team (Prince George's County Health Dept.)
  - *ED Community Health Workers*

Community Partnerships

- Partnership with *Access to Wholistic and Productive Living Institute* to assist with breast and cervical diagnostic appointment follow up.
- Inter-professional Care Transition Clinic (ICTC) at UM Prince George's
  - *Partnership with UM Baltimore School of Pharmacy*
  - *Team-based approach to assist high utilizer patients*
  - *Nurses, Social Workers, Pharmacists and Law Clinic*
  - *Additional location:*

Community Partnerships

- Mary is an ICTC Patient
  - 67 years old
  - Frequent ED utilizer with a history of hospitalizations
  - Connected with ICTC in July after another discharge
  - Mary disclosed social and financial concerns that impacted her ability to pay for medication and was at risk of being homeless
  - Mary received support to help her manage her needs including pharmacy assistance, housing assistance and link to primary care
  - Since July Mary has been connected to a PCP and has had 2 follow up visits. She has had no additional ER visits or inpatient hospitalizations


HIV behavioral Health
food insecurity
METABOLIC SYNDROME
education
employment
housing
access to health insurance
healthcare providers
residents knowledge to use resources
POVERTY
stroke
diabetes
obesity
cancer
heart disease
asthma
behavioral Health
HIV
food insecurity