UNIVERSITY of MARYLAND
SCHOOL OF MEDICINE

Welcome

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UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE

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MARYLAND PATIENT CENTERED MEDICAL HOME

Value Based Care Model

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Associate Professor Family and Community Medicine
University of Maryland School of Medicine

Acknowledgements

- **Department of Health and Mental Hygiene**
  - ✓ DHMH Center for Tobacco Prevention and Control
  - ✓ Medicaid
  - ✓ Community Health Resources Commission – Initial Funder of the Maryland Learning Collaborative
  - ✓ Maryland Health Care Commission
  - ✓ DHMH Center for Chronic Disease Prevention
  - ✓ Howard County Local Health Improvement Coalition
- **Commercial Carriers – Aetna, CareFirst, CIGNA, Coventry, United Health Care, Maryland MCOs**
- **Tricare**
- **Plan Sponsors**
  - ✓ State of Maryland Employee Health Plan
  - ✓ Federal Employee Health Program
  - ✓ Maryland Health Insurance Program
- **Maryland Learning Collaborative- Practice Transformation Leaders and Advisors**
  - ✓ Dept of Family and Community Medicine , University of Maryland School of Medicine
  - ✓ University of Maryland School of Nursing
  - ✓ Johns Hopkins Community Physicians and Guided Care at Johns Hopkins
- **Health IT Adoption and Optimization – CRISPHEALTH**
- **Pharmaceutical Sponsors**
  - Abbott
  - Teva Respiratory
  - Novo Nodisk
- **Outreach**
  - ✓ Societies of Family Medicine, Pediatrics and Hospital Medicine, Maryland Chapter ACP, MedChi
  - ✓ Mid-Atlantic Business Group on Health
  - ✓ Merck & Co., Inc.
  - ✓ Pfizer Inc.
  - ✓ Sanofi-Aventis
- **Consultants**
  - ✓ Remedy Health Care Consulting – Practice Transformation
  - ✓ IMPAQ International, LLC – Evaluation Consultant
  - ✓ NCQA – Recognition
  - ✓ Discern Consulting LLC – Payment Development
  - ✓ Social and Scientific Systems – Data Aggregation and Attribution

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SCHOOL OF PHARMACY

A special thank you to our distinguished Biostatistician team

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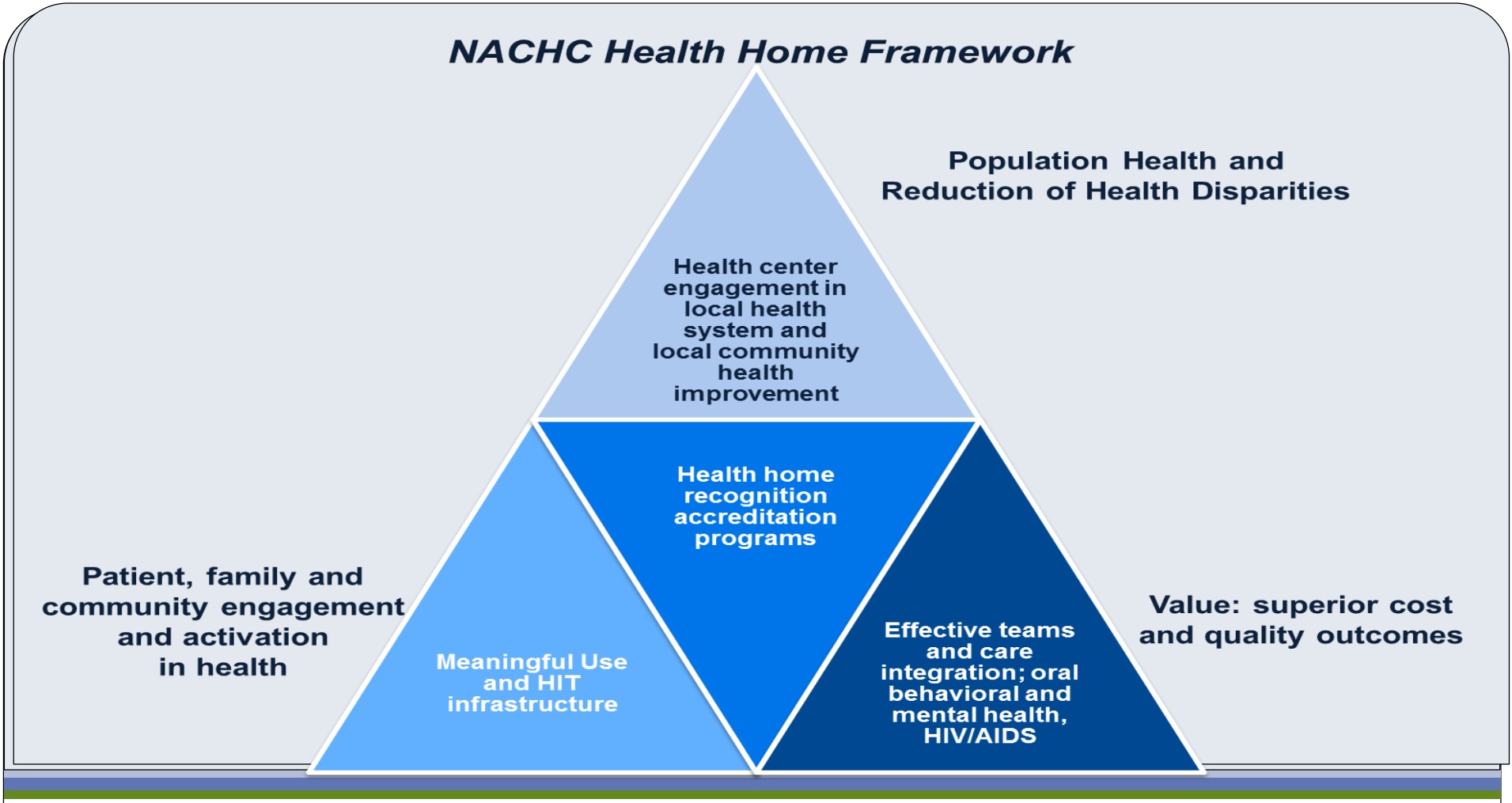
What is Value Based Care Model?

Value Based Care

Patient Centered Medical Home

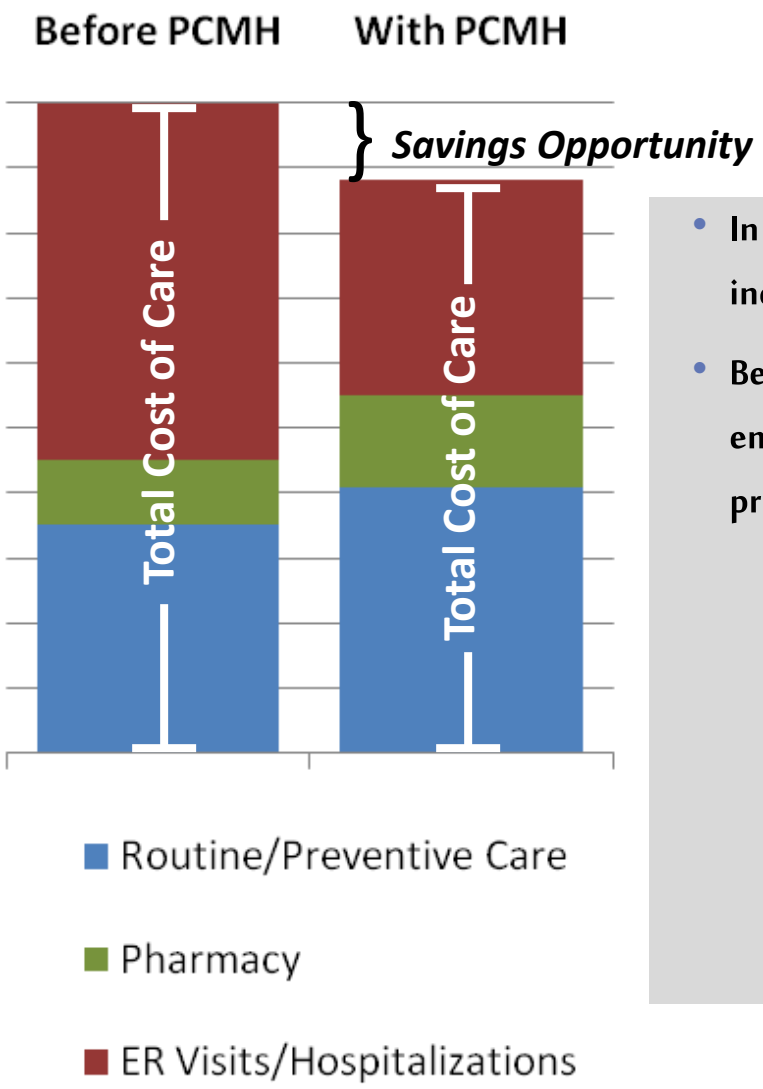
Risk Based Reimbursement



Patient Centered Care Delivery

http://www.nachc.com/PatientCenteredMedicalHome.cfm

VBCD Financial Model – Overview



- In VBCD, primary care services and pharmacy utilization increase
- Better patient management and outcomes reduce emergency room (ER) visits and hospitalizations, producing net savings

Patient centered, integrated care delivery model
based on:

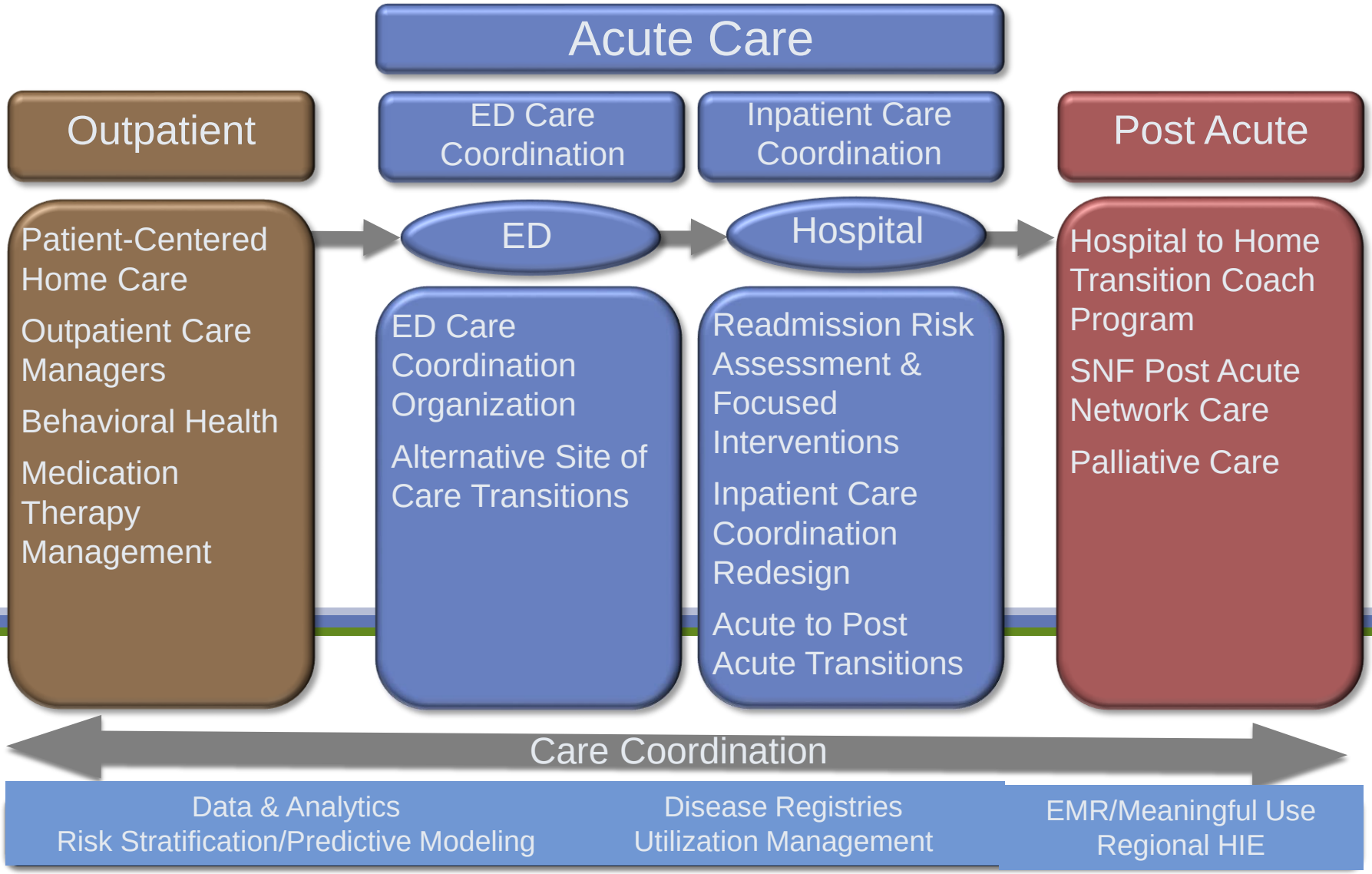
- Aligned incentives
- Coordinated, collaborative processes
- Evidence-based prevention and disease management protocols
- Seamless sharing of information

Supported by **wellness and continuity care** programs that focus on:

- Patient engagement
- Community integration
- Prevention and health promotion

Driven by analytics to support quality outcomes and value-based accountable reimbursement for population health

Leading Teams Across the Continuum



Integrated Systems of Care are necessary for Population Health and Value Based Care Delivery

COMMUNITY INTEGRATED MEDICAL HOME ESTABLISHED BY THE HCHD/HEALTHY HOWARD/HCGH/HORIZON FOUNDATION

~COMMUNITY CARE TEAM

~ADVANCED PRIMARY CARE LEARNING COLLABORATIVE

Our goal is to move knowledge into community and people

Questions?

"To him who devotes his life to science, nothing can give more happiness than increasing the number of discoveries, but his cup of joy is full when the results of his studies immediately find practical applications."
~Louis Pasteur

Howard County
Value-Based Care Delivery

Program and Initiatives

Maura J. Rossman, MD

February 25, 2016

Howard County
Community Integrated Medical Home

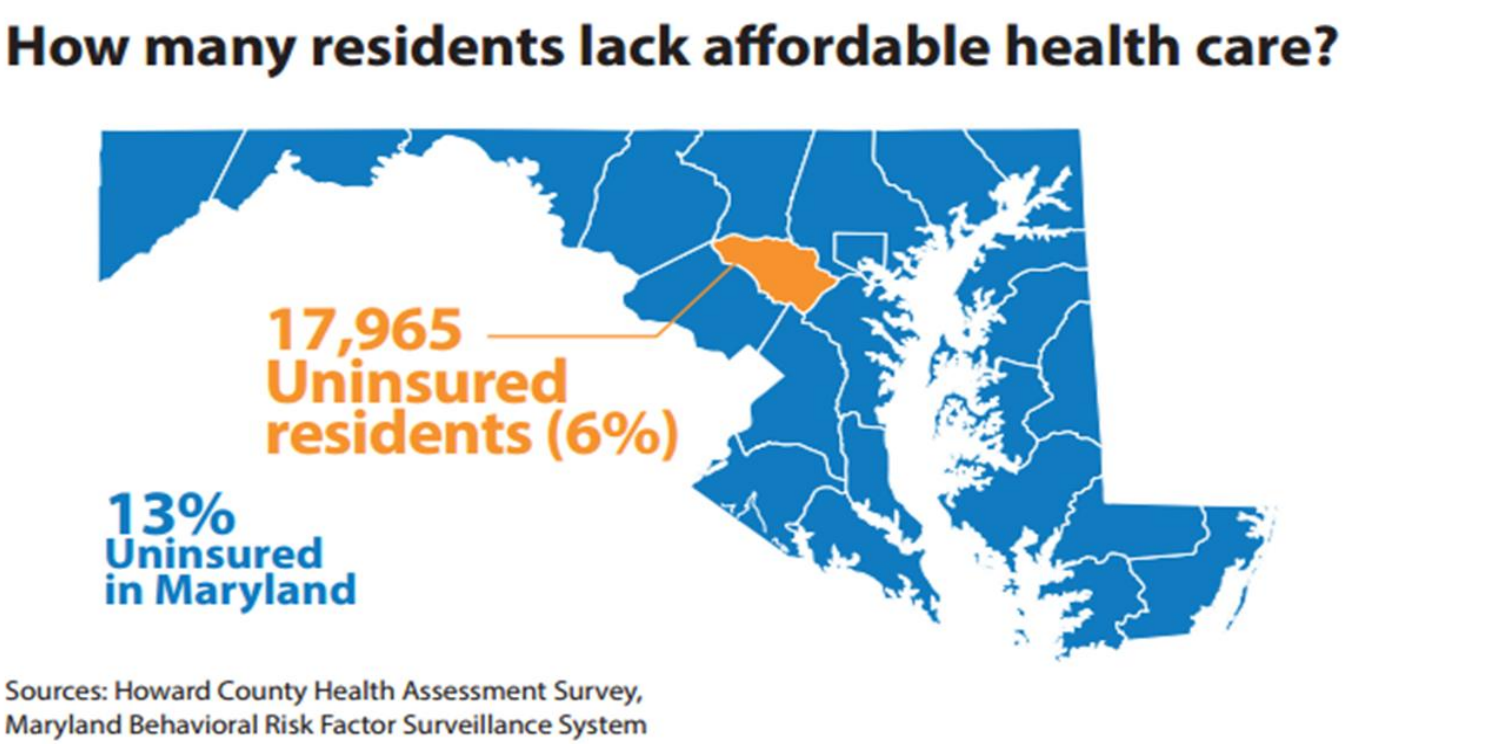
A model that uses data, evidenced based practices, diverse resources, outcome measurements, partnerships and collaboration to improve the health of Howard County residents and create healthcare delivery efficiencies.

Howard County Health Department

Drivers

- Affordable Care Act
  - New “Patient’s Bill of Rights” gives the American people the stability and flexibility they need to make informed choices about their health.
- Modernization of Maryland's all-payer system
  - Initiative will update Maryland’s 36-year-old Medicare waiver to allow the state to adopt new policies that reduce per capita hospital expenditures and improve health outcomes.
- State Innovation Model
  - Led by Centers for Medicare and Medicaid.
  - The State Innovation Models Initiative supports the development and testing of state-based models for multi-payer payment and health care delivery system transformation.

Uninsured Residents



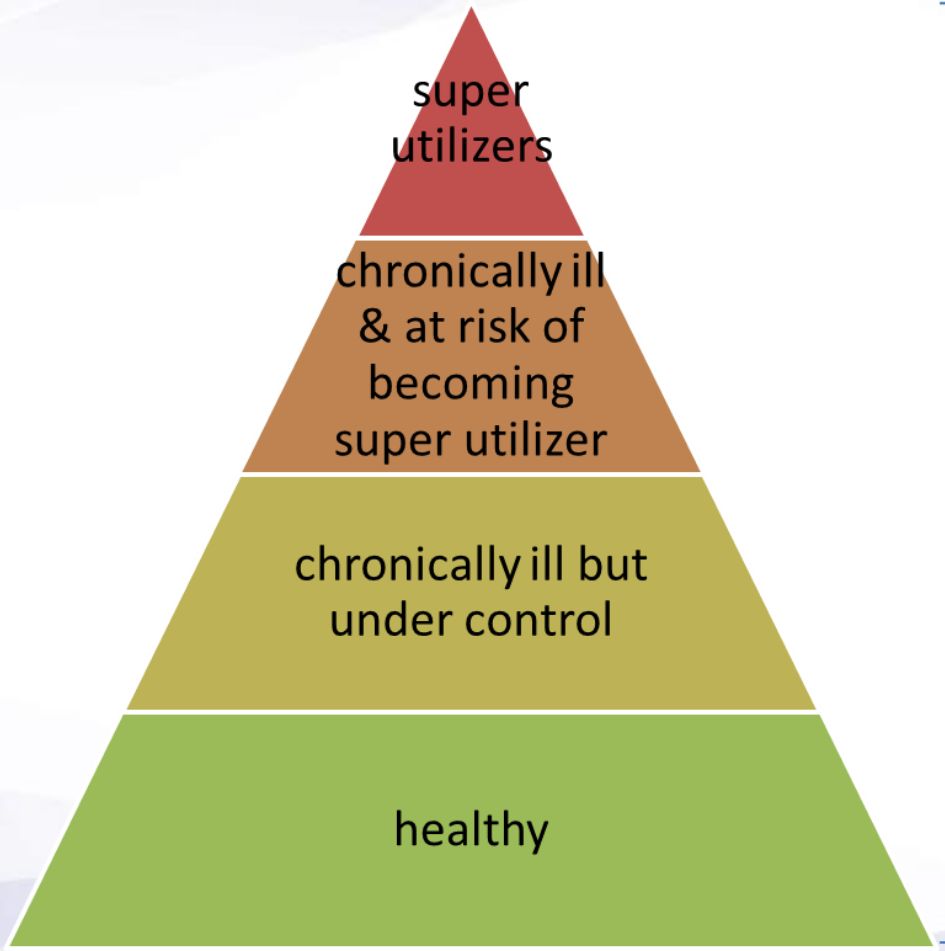
Howard County Health Department

Essential Components

- Strategic use of data – hotspotting
- Community Care Team
- Transformation of Primary Care Practices

Howard County Health Department

Population Health Improvement at All Levels of Health Need



A

Promoting and Maintaining Health through the Built Environment, Structured Choice & Effective Primary Prevention

B

Secondary Prevention and Effective Care Coordination

C

Equal focus on medical as well as social, behavioral, environmental determinants of health

Howard County Health Department

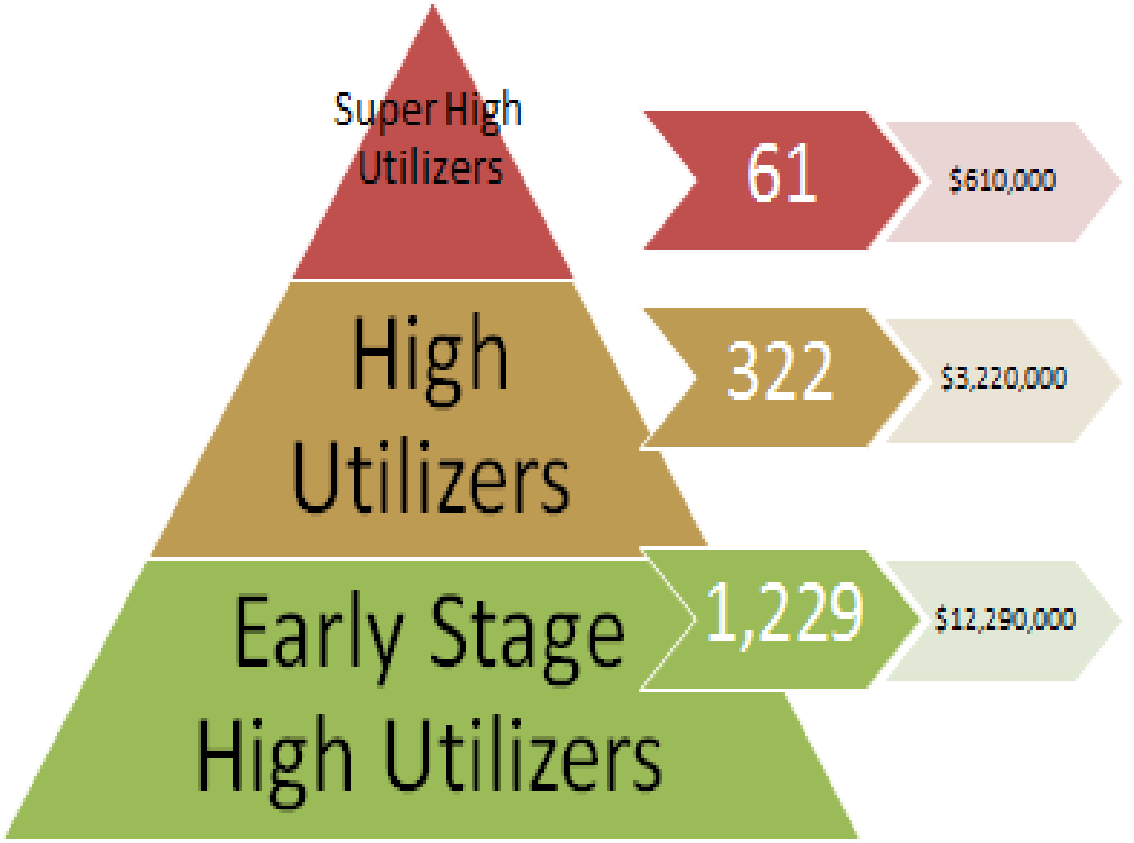
Howard County General Hospital Admissions Data 2012

	Year	One Timers	Low ED Utilizers	High ED Utilizers	Early Stage High Utilizers	High Utilizers	Extreme High Utilizers
Median IP vistis (year)	2012	0	0	0	2	3	6
Median ED visits (year)	2012	1	2	4	1	2	4
Unique Patients	2012	30,318	6,099	600	1,229	322	61
TotalCharges	2012	$81,821,126	$16,712,643	$4,166,706	$29,330,377	$15,541,161	$4,591,567
% of Total UniquePatients	2012	78.49%	15.79%	1.55%	3.18%	0.83%	0.16%
Charges (% Total)	2012	53.77%	10.98%	2.74%	19.28%	10.21%	3.02%
Median Total Charges per patient	2012	$718	$1,375	$3,962	$18,761	$38,466	$69,214
% ED Avoidable	2012	7%	8%	15%	5%	6%	8%
% ED Mental Mealth / Substance A..	2012	13%	15%	30%	23%	33%	54%
% IP 0-60 Day Readmissions	2012				29%	48%	67%

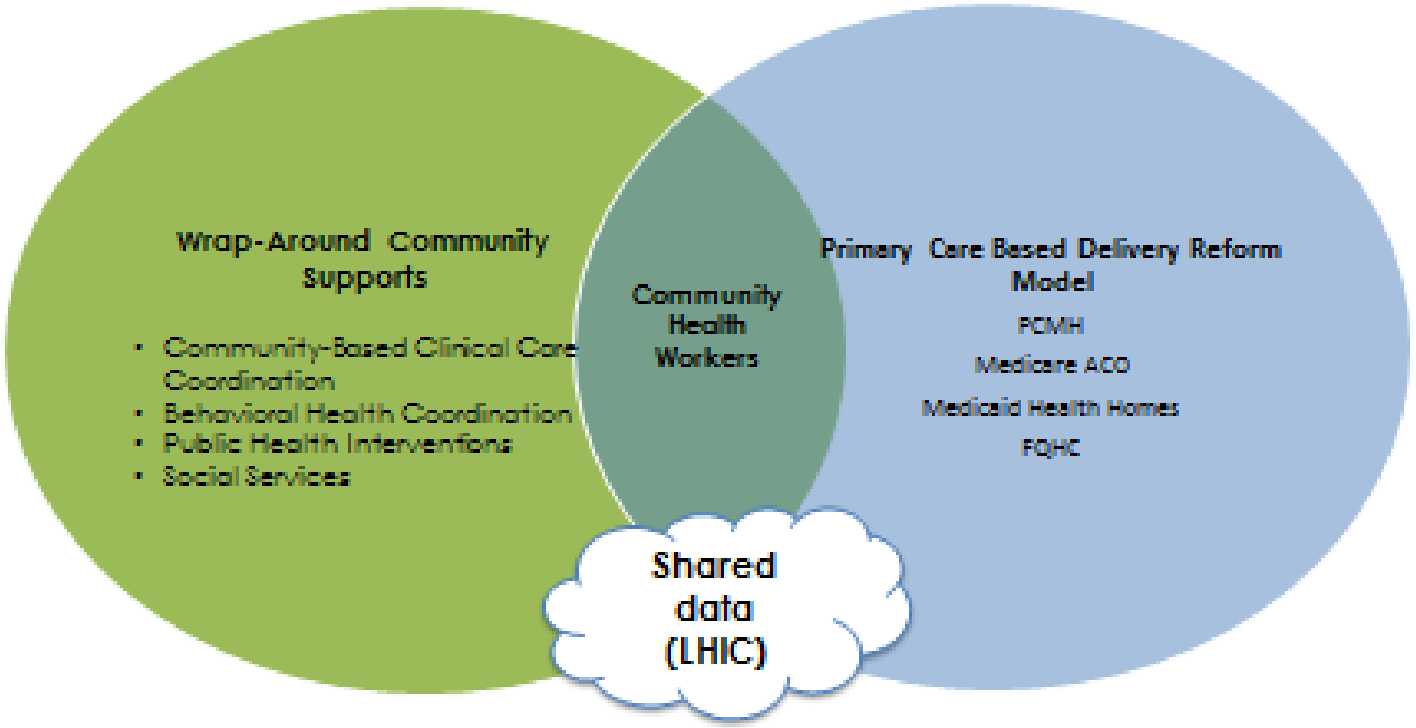
Howard County Health Department

	Year	Early Stage High Utilizers	High Utilizers	Extreme High Utilizers
Median IP Visits (year)	2012	2	3	6
Median ED Visits (year)	2012	1	2	4
Unique Patients	2012	1,229	322	61
Total Charges	2012	$29,330,377	$15,541,161	$4,591,567
% of Total Unique Patients	2012	3.18%	0.83%	0.16%
Charges (% Total)	2012	19.28%	10.21%	3.02%
Median Total Charges Per Patient	2012	$18,761	$38,466	$69,214
% ED Avoidable	2012	5%	6%	8%
% ED Mental Health/Substance Use	2012	23%	33%	54%
% IP 0-60 Day Readmissions	2012	29%	48%	67%

Potential Savings



Howard County Health Department



Howard County Health Department

Goals

- Increase access to health care services

- Access to care was identified as a priority by the Local Health Improvement Coalition (LHIC,) a coalition of local organizations addressing the diverse health needs of Howard County residents.

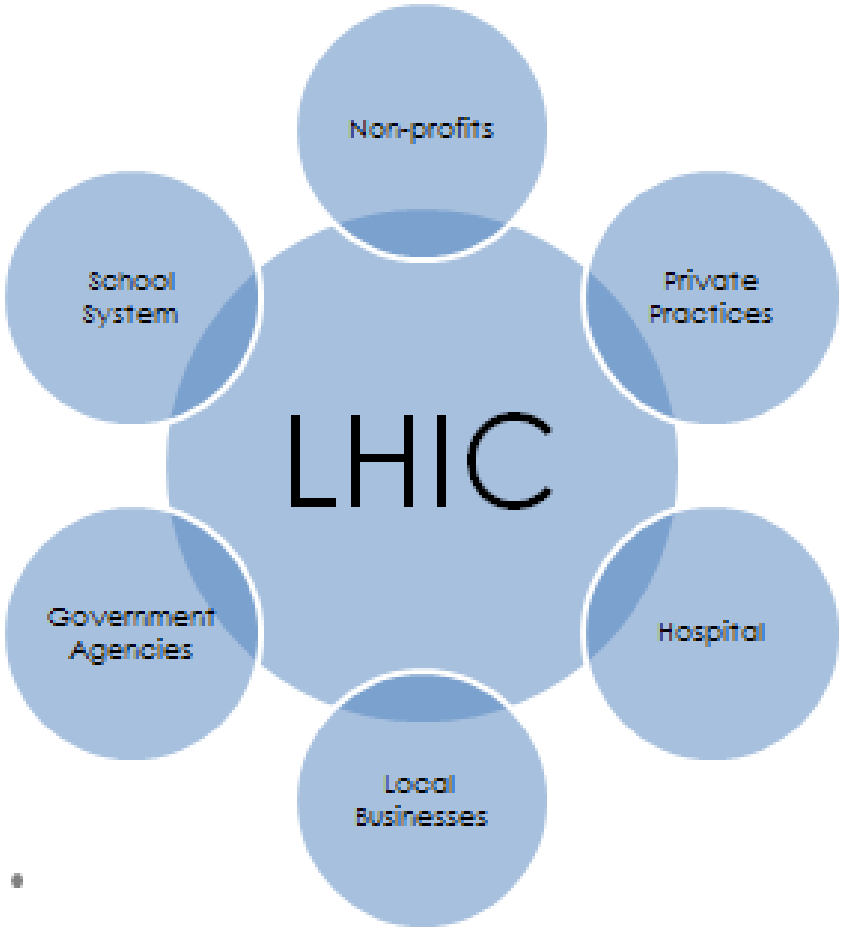
Howard County Health Department

Local Health Improvement Coalition (LHIC)

- A coalition of local organizations addressing the diverse health needs of Howard County residents
- Developed as a part of the State Health Improvement Process (SHIP)
- Currently four priority areas:
- Access to Care
- Behavioral Health
- Healthy Weight
- Healthy Aging
- Priorities aligned with hospital's Community Health Needs Assessment

Howard County Health Department

LHIC Members



2014/2015 Membership

- 47 Participating Organizations
- 9 New Organizations
- More than 100 Individuals

Patient Centered Medical Home

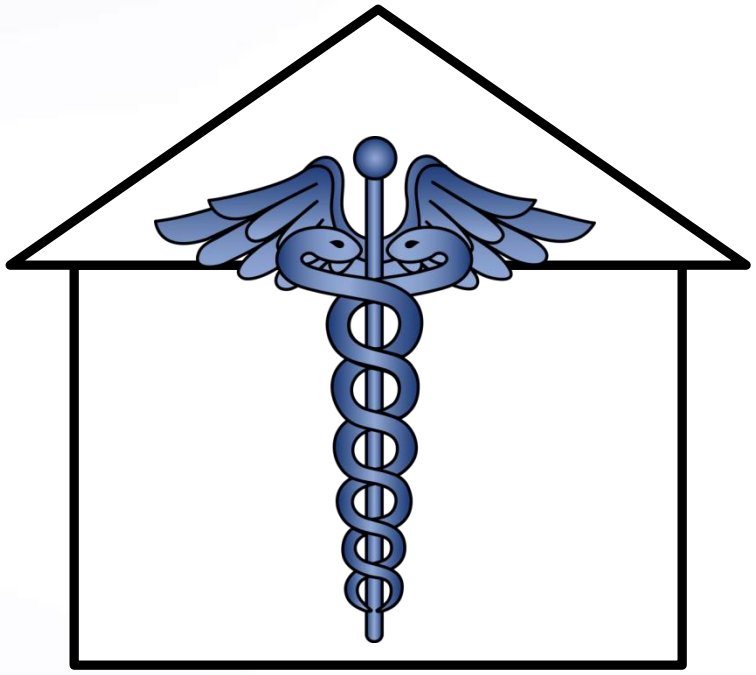
Howard County Health Department

Patient-Centered Medical Home (PCMH)

- Goal
  - Promote primary care practice redesign across Howard County to implement principles of the PCMH model
- Rationale
  - Howard County has disparities in access to health care services
  - Loss to follow up among patients can lead to poor outcomes and hospitalizations
  - Patient-centered care coordinates services, increases follow up, and improves patient outcomes

Howard County Health Department

PCMH Intervention



- Pilot: May-Dec 2014
- Focus on Phase 1: Practice Transformation Readiness Assessment
- Recruitment of primary care practices
- CME Workforce training sessions for other interested practices

Howard County Health Department

PCMH Expected Outcomes

Immediate:

- Primary care practices become patient-centered
- Continuity of Care
- Increased patient adherence
- Enhanced Care Transitions

Long-term:

- Increased access to health services
- Decreased barriers to accessing care
- Decreased hospitalization rates

Howard County Health Department

Practice	# of Patients Served	# of Physicans	# of NP/PAs	Approximate % of Practice Payer				
				Medicaid	Medicare	Carefirst	SFS or Self-Pay	Total Commercial
Centennial Medical Group	15,000	4	3	0%	25%		0%	75%
Chase Brexton Health Care	9,240	7	1	43%	8%		27%	23%
Columbia Medical Practice*	20,000	10	2	2%	20%		0%	78%
Desai Medical Center								
Evergreen Health Care	2,000	2	2	20%	0%		2%	70%
Maryland Primary Care Physicians	56,392	8	0	0%	25%		0%	75%
MedPeds, LLC (Ho Co Patients)	3,771	5	3	9%	3%		0%	88%
Millennium Family Practice								
Personal Physician Care	2,500	2	3	0%	85%		0%	15%
Well Being Medical Care	646	1	0	0%	15%		0%	85%
Totals	109,549	39	14	9%	23%		4%	64%

Howard County Health Department

Thank You

- Healthy Howard
- Howard County General Hospital
- Horizon Foundation
- Howard county Government
- Maryland Community Health Care Resources Commission

Howard County Health Department

ZaneNet: *Expanding equitable access to healthcare through technology, communication and services*

ZaneNetConnect

MSO
Maryland State Designated

EHNAC
ACCREDITED
MSOAP

Certified by:

CRISP

MHCC
MARYLAND
HEALTH CARE
COMMISSION

ZaneNetConnect

Healthcare Providers

We work with primary care, specialists, long term care facilities, clinics and hospitals (with an emphasis on medically underserved areas) to transform their practice with technical assistance.

New Approaches to Care

We help clinicians explore new systems of care, quality improvement programs, health information technologies and payment structures that are appropriate to their practice.

Incentives Programs

We help practices qualify and report measures in order to fulfill obligations of various federal and state incentive programs (Meaningful Use, State Payor Program, PCMH and PQRS).

Connected Care

We connect healthcare providers within their medical neighborhood through technologies such as HIEs and by the promotion of connected, coordinated care models.

CERTIFICATIONS

- Accreditation by the Maryland Health Care Commission to serve as a Management Service Organization (MSO) -2018
- Nationally certified by EHNAC- Electronic Healthcare Network Accreditation Commission-2017
- Certified by SBA as an 8(a), woman-woman owned company and by Maryland as an MBE certified company

Honoring Minority and Women Entrepreneurs
TOP 100 MBEs

Montgomery County
Department of Economic Development
Small Business
Awards
Celebrating Small Business Success

AWARDS:

2014 Top 100 MBE Companies in Maryland

2014 Frost and Sullivan Top CIO Award (for CCIN Project)

2013 Small Business of the Year Award Montgomery County (11-50 employees category)

CIO IMPACT awards

SAMPLE CLIENTS

ZaneNetConnect

- CRISP
- Capital Clinical Integrated Network (CCIN)
- Dept. of Health and Mental Hygiene
- Dimensions Healthcare System
- DC Primary Care Coalition
- Fort Belvoir Community Hospital
- Fort Meade Kimbrough Ambulatory Care Clinic
- Howard University Hospital
- Ingleside Nursing Home
- Lions Center for Rehabilitation and Extended Care
- Mary's Center for Maternal and Child Care
- Medical Home Development Group
- MedChi – The Maryland State Medical Society
- Minority Organ Tissue Transplant Education Program (MOTTEP)
- National Hispanic Medical Association,
- National Medical Association,
- University of Maryland Learning Collaborative,
- St. Agnes/Seton Medical Group

MEDICAL REVENUE CYCLE SPECIALISTS LLC
Your Practice Transformation Partner

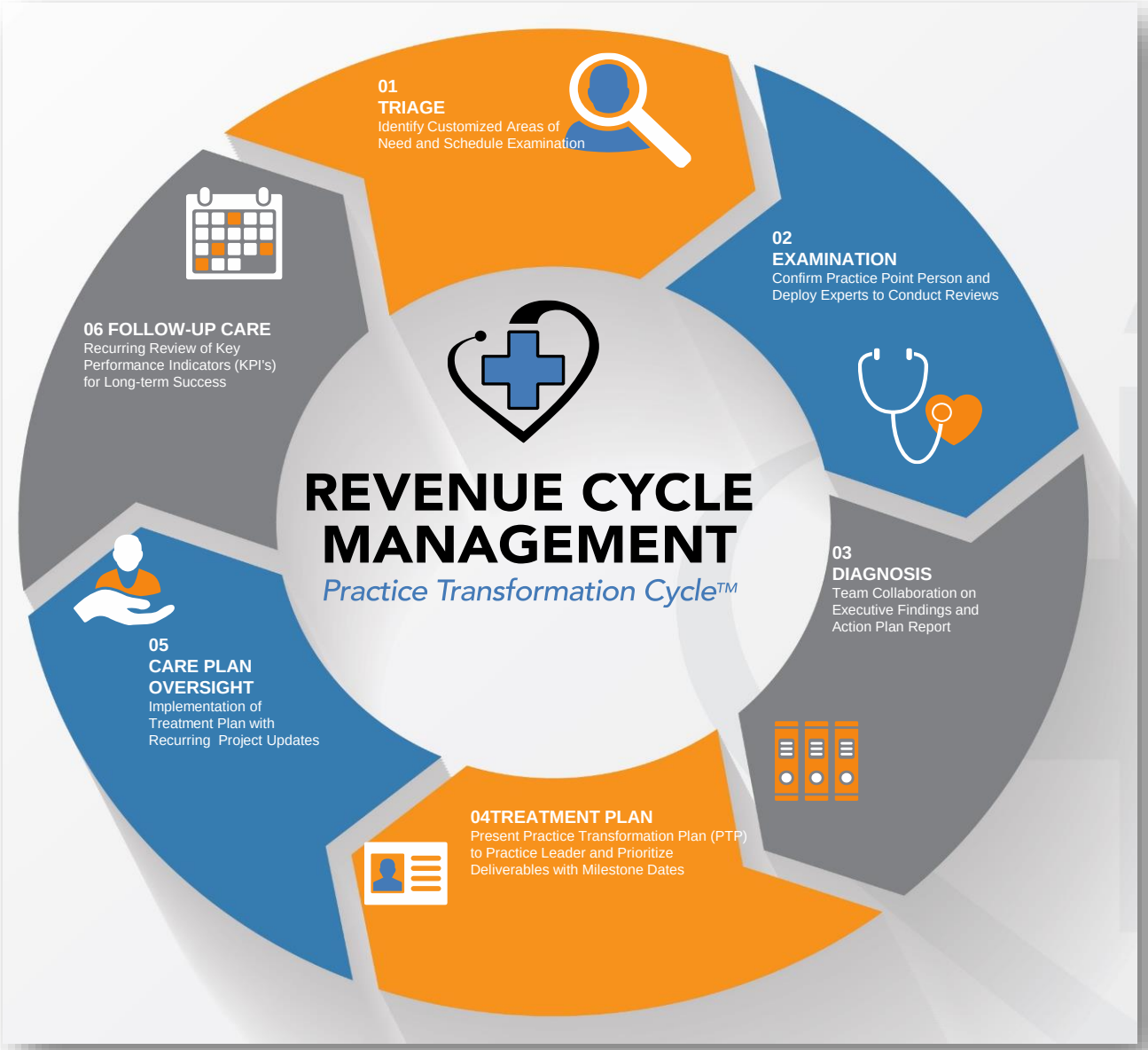
HOW WE HELP PRACTICES TRANSFORM

ZaneNet's *Practice Transformation Partners* help practices to:

- ***Optimize EHR use*** and qualify for incentive programs
- Connect to the state's ***Health Information Exchange***
- ***Report PQRS and other measures*** correctly and in a timely manner to avoid costly cuts in reimbursement from CMS
- ***Improve revenue cycle***, compliance and staff development to optimize coding and enhance credentialing, provide fee schedule analysis and payer contract negotiation and improve processes.
- ***Comply with value-based care practices*** such as: Chronic Care Management, Behavioral Health Assessments and Transition of Care revenue
- Evaluate the benefits from ***new care delivery model programs*** – Patient Centered Medical Homes, Accountable Care Organizations, State Innovation Models and the Million Hearts Campaign

Implementing Value Based Care Delivery (VBCD) in 9 Steps

Improving the Revenue Cycle



Chronic Care Management Support

- Interface of CCMS platform and CRISP
- Practice participates with HIE and subscribes to ENS
- LPN provides non face-face 20 minutes service monthly
- Document Care Plan in CCS
- Bill CPT 99490 through Practice Certified EHR

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ZaneNetConnect