Maryland Health Care Commission

Thursday, April 21, 2016

1:00 p.m.

MARYLAND HEALTH CARE COMMISSION

AGENDA

1. **APPROVAL OF MINUTES**

2. **UPDATE OF ACTIVITIES**

3. **PRESENTATION**: Follow-up to March Update - Hospice Services in Maryland and Implementing the State Health Plan

4. **ACTION:** State-Designated Health Information Exchange – Re-Designation of CRISP and Approval of Agreement

5. **PRESENTATION:** Final Report on Telehealth Round One Applicants

6. **OVERVIEW**: Legislative Actions Affecting the Commission
   - HB 1385 "Public Health – Advance Directive – Procedures, Information Sheet, and Use of Electronic Advance Directives"
   - SB 707 "Freestanding Medical Facilities – Certificate of Need, Rates, and Definition"

7. **Overview of Upcoming Initiatives**

8. **ADJOURNMENT**

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MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

Follow-up to March Update - Hospice Services in Maryland and Implementing the State Health Plan

(Agenda Item #3)

MARYLAND HEALTH CARE COMMISSION

Update on Hospice Services and Implementation of State Health Plan

Linda Cole

April 21, 2016

Issues Raised at March Meeting

- Availability of Hospice Services:
  - Where are hospices authorized to serve?
  - Where do they serve?
- State Health Plan Process:
  - Plan development and promulgation
  - Plan implementation–CON
- Determination of Unmet Need
- Variations by Race and other Variables
- Next Steps

Where are hospices authorized to provide care?

- Each jurisdiction is served by at least one general hospice
- 14 served by single provider (12 have one authorized provider and 2 served by single provider)
- Single provider jurisdictions have small population size

Hospice Services by Jurisdiction

Jurisdiction	Number of Hospices Authorized to Serve	Number of Hospices Having Served at least 10 Patients in 2014
Allegany	1	1
Anne Arundel	8	5
Baltimore County	9	8
Baltimore City	8	6
Calvert	1	1
Caroline	1	1
Carroll	4	4
Cecil	3	2
Charles	1	1
Dorchester	1	1
Frederick	3	3
Garrett	1	1
Harford	7	4
Howard	7	4
Kent	1	1
Montgomery	7	6
Prince George's	8	7
Queen Anne's	1	1
Somerset	1	1
St. Mary's	1	1
Talbot	2	1
Washington	2	1
Wicomico	1	1
Worcester	1	1

Where do Hospices Provide Care?

- 7 hospices provided services to less than 10 clients in authorized jurisdictions
- 17 instances where jurisdictions have at least one authorized provider with no substantial level of service provided
- One hospice served 2 out of 8 jurisdictions authorized; one served 2 out of 7 jurisdictions authorized

Hospice Services by Provider

Hospice	Number of Jurisdictions Authorized to Serve	Number of Jurisdictions where 10+ patients served in 2014
Seasons Hospice	9	9
Gilchrist Hospice	8	8
Community Hospice	8	2
Joseph Richey Hospice	7	2
Stella Maris Hospice	6	4
Heartland Baltimore	5	4
Amedisys Hospice	4	3
Coastal Hospice	4	4
Compass Regional Hospice	4	4
Professional Healthcare Resources of Baltimore	4	3
Carroll Hospice	3	3
Holy Cross Hospice	3	3
Heartland Beltsville	2	2
Hospice of Frederick Co	2	1
Hospice of the Chesapeake	2	2
Calvert Hospice	1	1
Capital Caring Hospice	1	1
Hospice of Charles Co	1	1
Hospice of Garrett Co	1	1
Hospice of St. Mary's Co	1	1
Hospice of Washington Co	1	1
Jewish Social Services Hospice	1	1
Montgomery Hospice	1	1
Talbot Hospice	1	1
Western Maryland Health Systems Hospice	1	1

What was the Process for Updating the State Health Plan?

- Plan Development:
  - Hospice Work Groups
  - Meetings on Hospice Education and Outreach
  - Senate Finance Committee Briefings
  - Public Comment Periods
- Plan Implementation:
  - Plan effective 2013
  - Delay implementation to 2015
  - Delay implementation to 2016
  - Publish CON Review Schedule

How is Unmet Need Determined?

- Base year death rate is calculated by dividing base year population deaths by base year population
- Target year deaths forecasted by multiplying this death rate by the target year population
- Target year need (potential use) is determined by multiplying the target year use rate (MedPAC) by the target year population deaths
- Target year capacity (projected use) is calculated by applying CAGR (last 5 years of hospice deaths) extrapolated over 5 years from base year to target year
- Net need is derived by subtracting projected use from potential use for each jurisdiction
- If net need exceeds volume threshold, there is unmet need

How Does Hospice Use Vary by Race?

Jurisdiction	Proportion of Hospice Patients who are African American, 2014	Proportion of Total 35+ Population that is African American	Total 35+ pop	2014 Jurisdictional Use Rate
Allegany	3%	6%	42,059	22%
Anne Arundel	15%	15%	300,930	49%
Baltimore City	57%	65%	307,632	25%
Baltimore Co.	22%	24%	452,816	56%
Calvert	11%	14%	50,533	37%
Caroline	6%*	14%	18,175	27%
Carroll	3%	3%	97,126	50%
Cecil	5%	6%	56,871	46%
Charles	28%	41%	81,219	29%
Dorchester	14%	25%	19,507	20%
Frederick	5%	8%	132,425	46%
Garrett	0%*	1%	18,182	23%
Harford	7%	11%	139,631	51%
Howard	12%	17%	166,017	49%
Kent	12%	15%	12,122	46%
Montgomery	14%	17%	559,018	47%
Prince George's	60%	69%	455,805	28%
Queen Anne's	7%	7%	29,804	49%
Somerset	26%	32%	13,490	25%
St. Mary's	13%	14%	56,402	47%
Talbot	7%	12%	24,666	37%
Washington	3%	8%	84,168	57%
Wicomico	14%	23%	50,915	46%
Worcester	11%	12%	33,649	40%
MARYLAND	21%	29%	3,202,462	43%

* Indicates fewer than 10 African American patients served

How Does Hospice Use Vary by Urban/Rural Location?

Variable	2000	2011	2012	2013	2014
All Beneficiaries	22.9%	45.2%	46.7%	47.3%	47.8%
Location:					
Urban	24.3%	46.6%	48.0%	48.5%	48.6%
Micropolitan	18.5%	41.4%	43.4%	44.3%	44.7%
Rural Adjacent to Urban	17.6%	40.2%	42.2%	42.9%	43.2%
Rural, nonadjacent to urban	15.8%	35.9%	37.7%	38.0%	38.7%

Source: Report to Congress: Medicare Payment Policy, March 2016
Note: Allegany, Anne Arundel, Baltimore, Baltimore City, Calvert, Carroll, Cecil, Charles, Frederick, Harford, Howard, Montgomery, Prince George's, Queen Anne's, St. Mary's, Somerset, Washington, Wicomico, Worcester are classified as urban. Dorchester and Talbot are classified as micropolitan. Caroline, Garrett, and Kent are classified as rural adjacent to urban.

Upcoming MHCC Steps

- Publish updated hospice need projections in *Maryland Register* and post on MHCC website
- Develop and publish CON Review Schedule
- Continue FY 2015 hospice data collection

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ACTION:

State-Designated Health Information Exchange – Re-Designation of CRISP and Approval of Agreement

(Agenda Items #4)

Briefing

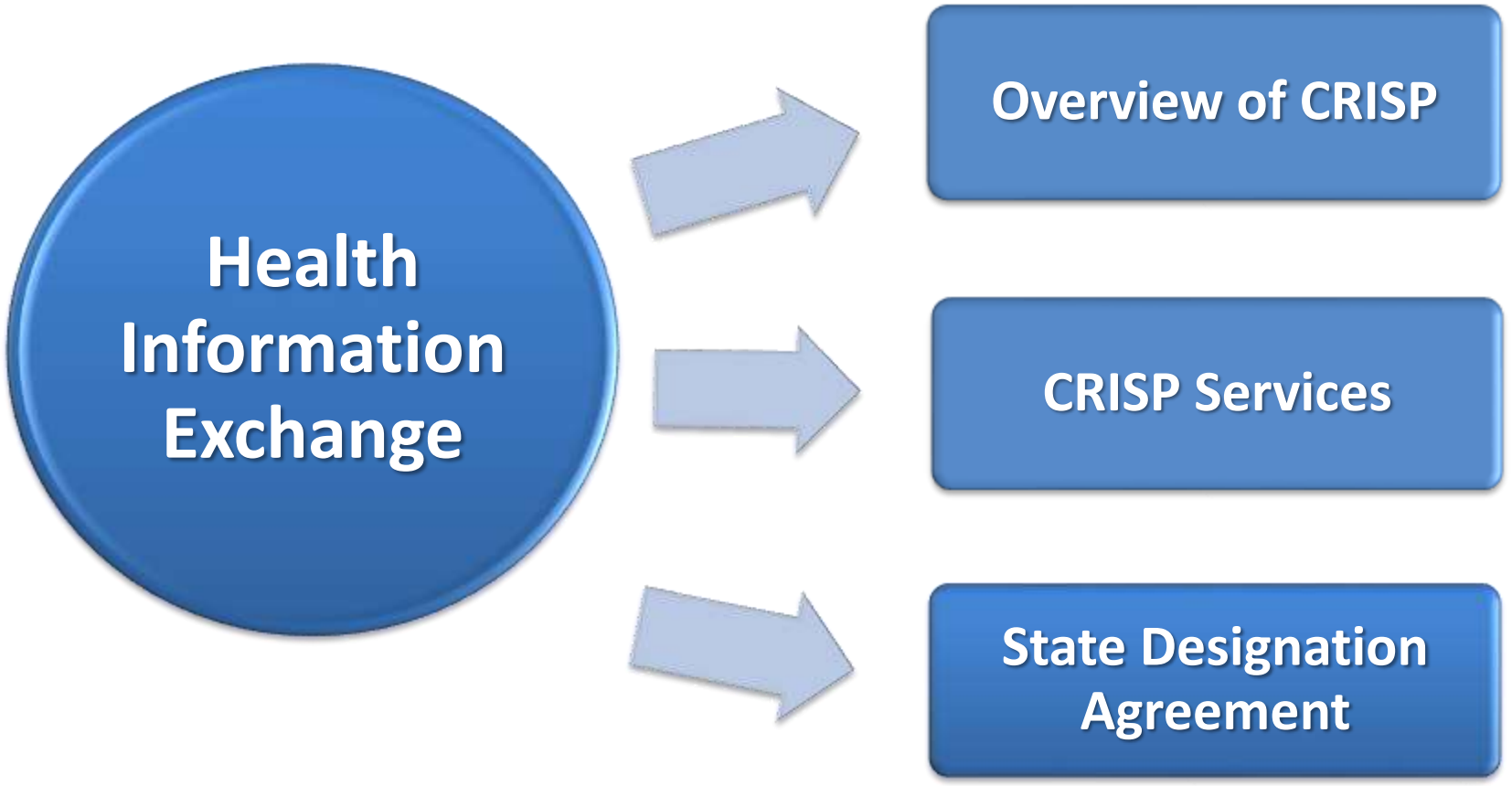
Health Information Exchange

The State-Designated Health Information Exchange
&
Overview of the Designation Agreement

April 21, 2016

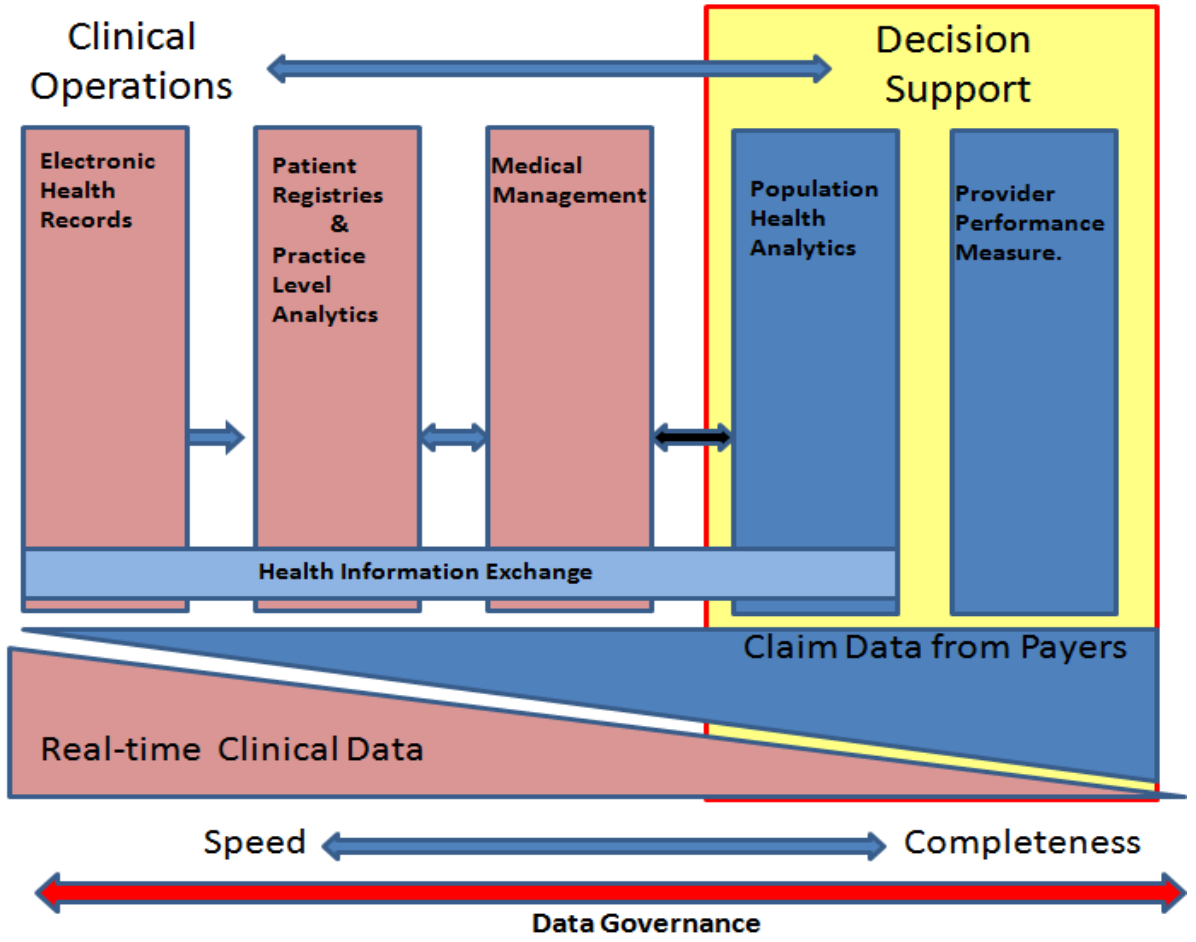
The MARYLAND
HEALTH CARE COMMISSION

Discussion Points



Our Role

The MHCC is responsible to advance a strong, flexible health IT ecosystem that can appropriately support clinical decision-making, reduce redundancy, enable payment reform, and help to transform care into a model that leads to a continuously improving health system. In addition, foster innovation in a way that balances the need for information sharing with the need for strong privacy and security policies



Health Information Exchange

Background

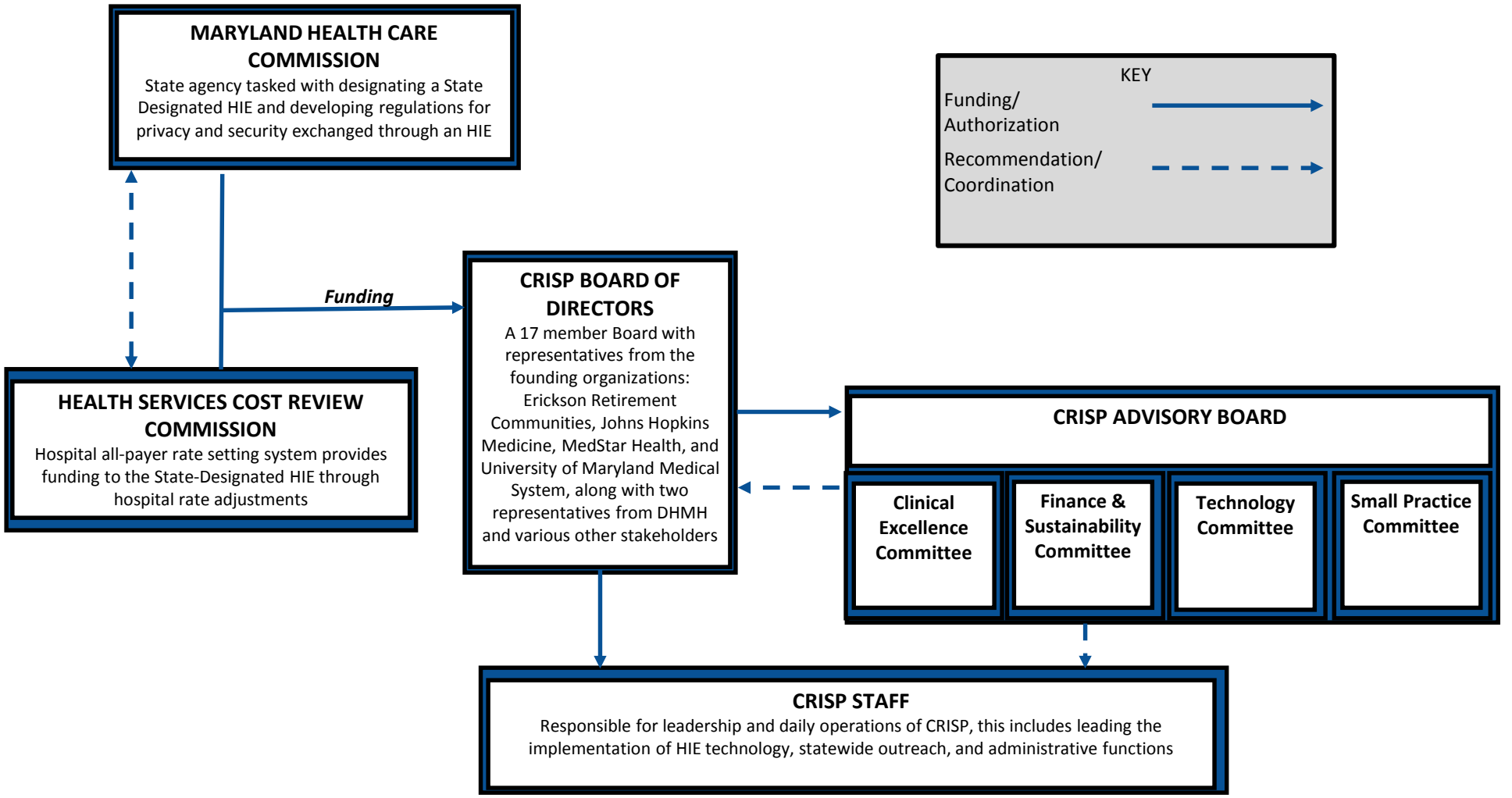
- In 2005, MHCC initiated the development of guiding principles for an interoperable and secure statewide clinical data sharing utility, or health information exchange (HIE)

- In 2008, MHCC and the Health Services Cost Review Commission (HSCRC) funded two multi-stakeholder groups to develop competing approaches for developing a statewide HIE

- In August 2009, MHCC designated the Chesapeake Regional Information Systems for our Patients (CRISP) as the State-Designated HIE

  - CRISP is a 501(c)(3) independent nonstock Maryland membership corporation; members include: the Johns Hopkins Health System; MedStar Health; University of Maryland Medical System; Erickson Retirement Communities; and Erickson Foundation

CRISP Governance Structure



Board Structure

- 9 appointees of original members
- 2 payer representatives
- 2 Secretary of DHMH appointees
- 2 community representatives
- 2 small practice representatives

Leading Services

- Query Portal
  - Allows providers the ability to securely look up patient information through the Internet
- Direct Secure Messaging
  - Enables secure point-to-point messaging among providers with Direct accounts (similar to other secure email systems)
- Encounter Notification Service
  - Notifications to providers when their patients have an encounter at any hospital in Maryland
- Encounter Reporting System
  - Monthly reports to each hospital on its inter-hospital readmissions for those patients discharged from the hospital
- Prescription Drug Monitoring Program (PDMP)
  - CDS dispensers electronically submit information on drugs dispensed to patients in Maryland and this information is securely stored and disclosed to appropriate users through the CRISP Query Portal

Key User Performance Metrics (2016)

At a Glance						
HIE Category	**Dec**	**Jan**	**Feb**	**Total[a] #**	**Total[b] %**	**Growth Rate[i]**
Ambulatory Practice Data Consumption *(# of organizations)* N=5,099[c]						
Signed participation agreements - CRISP Portal	24	19	24	721	14.1%	3.1%
CRISP portal live	12	7	13	501	9.8%	2.0%
Direct message accounts live	51	16	22	729	14.3%	4.9%
Encounter notification service live	37	6	28	468	9.2%	4.9%
Hospital Data Submission *(# of hospitals)* N=47						
Laboratory reports	1	0	0	42	89.4%	1.2%
Radiology reports	0	0	0	46	97.9%	0.0%
Transcribed reports	0	0	0	44	93.6%	0.0%
Continuity of care documents	0	0	0	14	29.8%	0.0%
Long Term Care Data Consumption *(# of organizations)* N=233[f]						
Signed participation agreements - CRISP Portal	1	1	1	106	45.5%	1.0%
CRISP portal live	1	5	1	78	33.5%	4.1%
Encounter notification service live	11	3	0	53	22.7%	16.6%
CRISP Portal Participation and Usage						
Single-sign on live in Maryland hospitals	0	2	0	14	29.8%	8.0%
Users in Prescription Drug Monitoring Program[g]	-14	-60	105	6,875	9.4%	-0.5%
CRISP Portal queries[h]	91,259	96,880	106,286			7.9%
Consumer Metrics						
Number of Consumers Opting Out	327	304	245	5,864	0.04%	5.9%
Unique Consumer Identifiers (MPI)	491,331	211,416	366,799	15,014,141	99.96%	2.4%

Notes:

[a] Totals are cumulative since service was started

[b] Represents the total percentage of providers utilizing specific CRISP services

[c] 2012-2013 Maryland Board of Physicians Licensure data file

[d] Edward McCready Memorial Hospital has no plans to submit radiology reports to CRISP

[e] Edward McCready Memorial Hospital and Garrett County Memorial Hospital have no plans to submit transcribed reports to CRISP

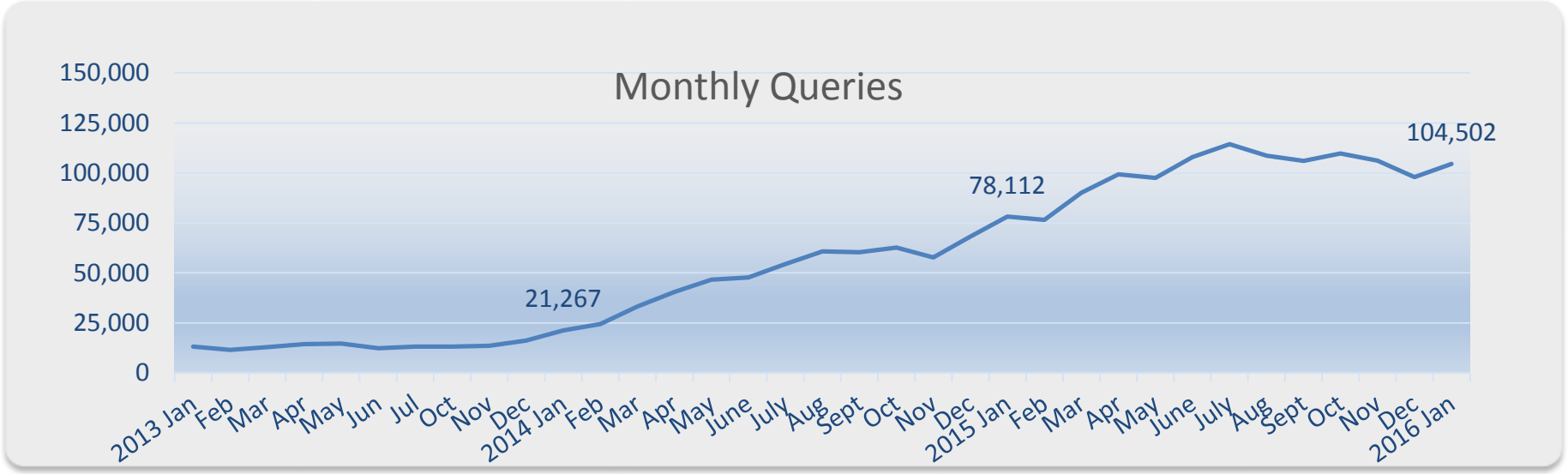
[f] 2013 Annual Long Term Care Survey data

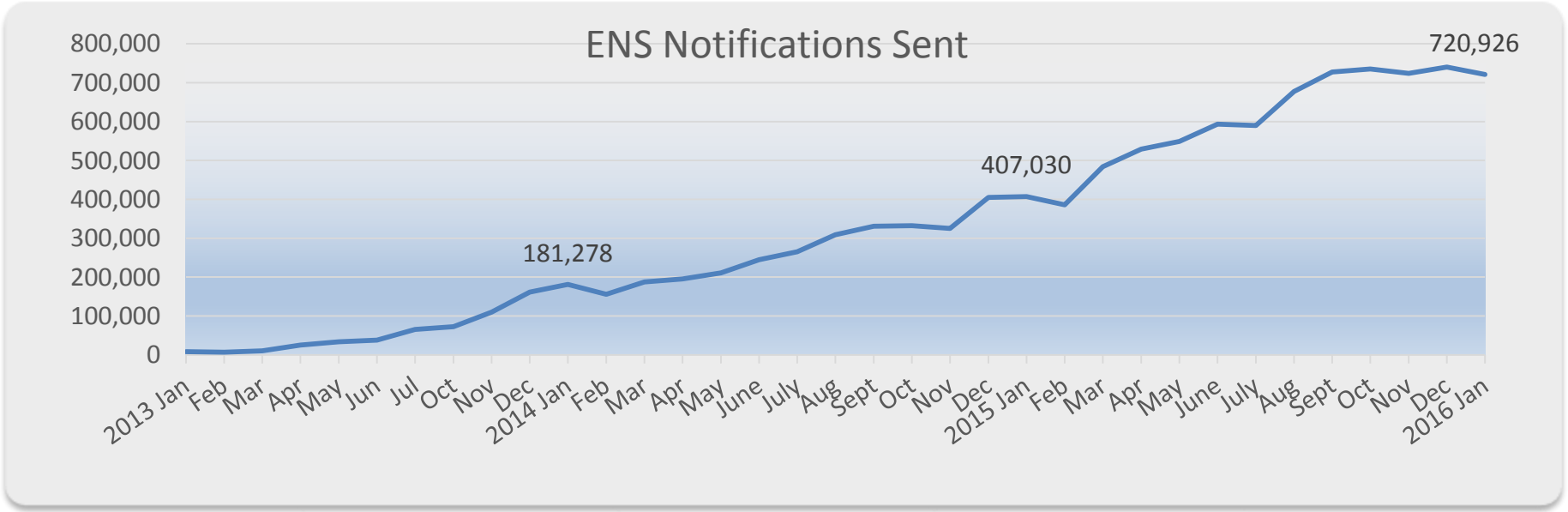
[g] Periodic deactivation of 90-day-inactive users accounts may result in lower user totals

[h] Number of CRISP Portal queries not listed in Total # and Total % columns because CRISP Portal queries are not calculated based on a cumulative total over time

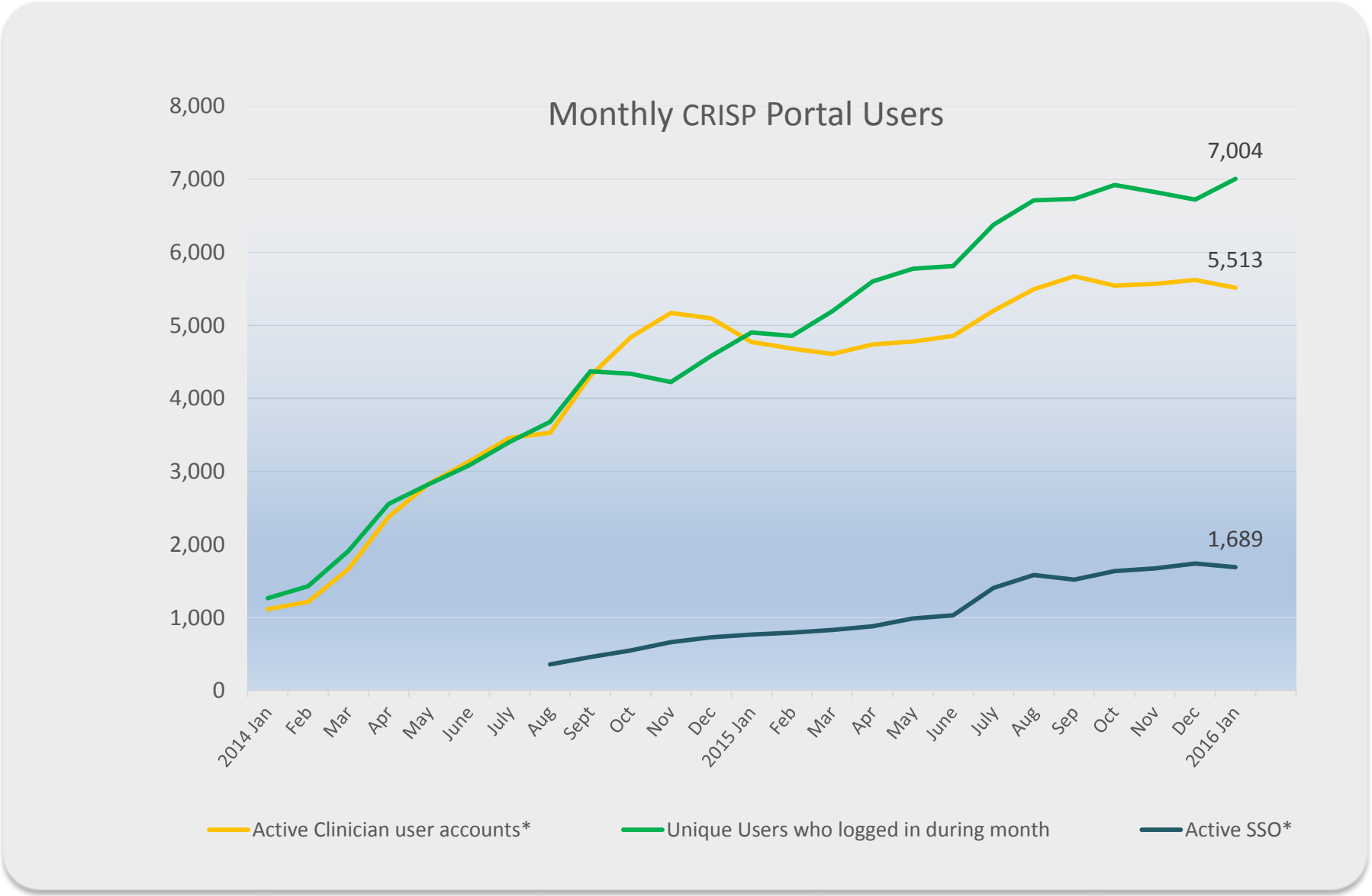
[i] Growth rate is calculated based on the totals between months shown above

Trends – Queries & Alerts





Trends - Portal



Trends - Financial

FY17 Budget & Look Back ($$)

2017	*2016*	*2015*	*2014*	*2013*
31,024,000	23,720,000	14,661,000	11,169,989	5,611,000

Note: The 2017 budget amount has not been finalized and is subject to change.

CRISP Collaboration

- Behavior Health Administration – serves as the access point for clinical providers, including prescribers, pharmacists, and other licensed health care practitioners to the PDMP database
- Department of Health and Mental Hygiene (DHMH) – technology/connectivity assistance for portions of its Syndromic Surveillance, Immunization Registry, and Reportable Lab programs
- Maryland Health Benefit Exchange – Manages the interface for the provider directory
- Medicaid – provides support to eligible providers under the federal meaningful use EHR Incentive Program
- MHCC – link electronic advance directives submitted through MyDirectives to the Query portal, and assign the enterprise identification number to carrier eligibility files for the All Payor Claim Database

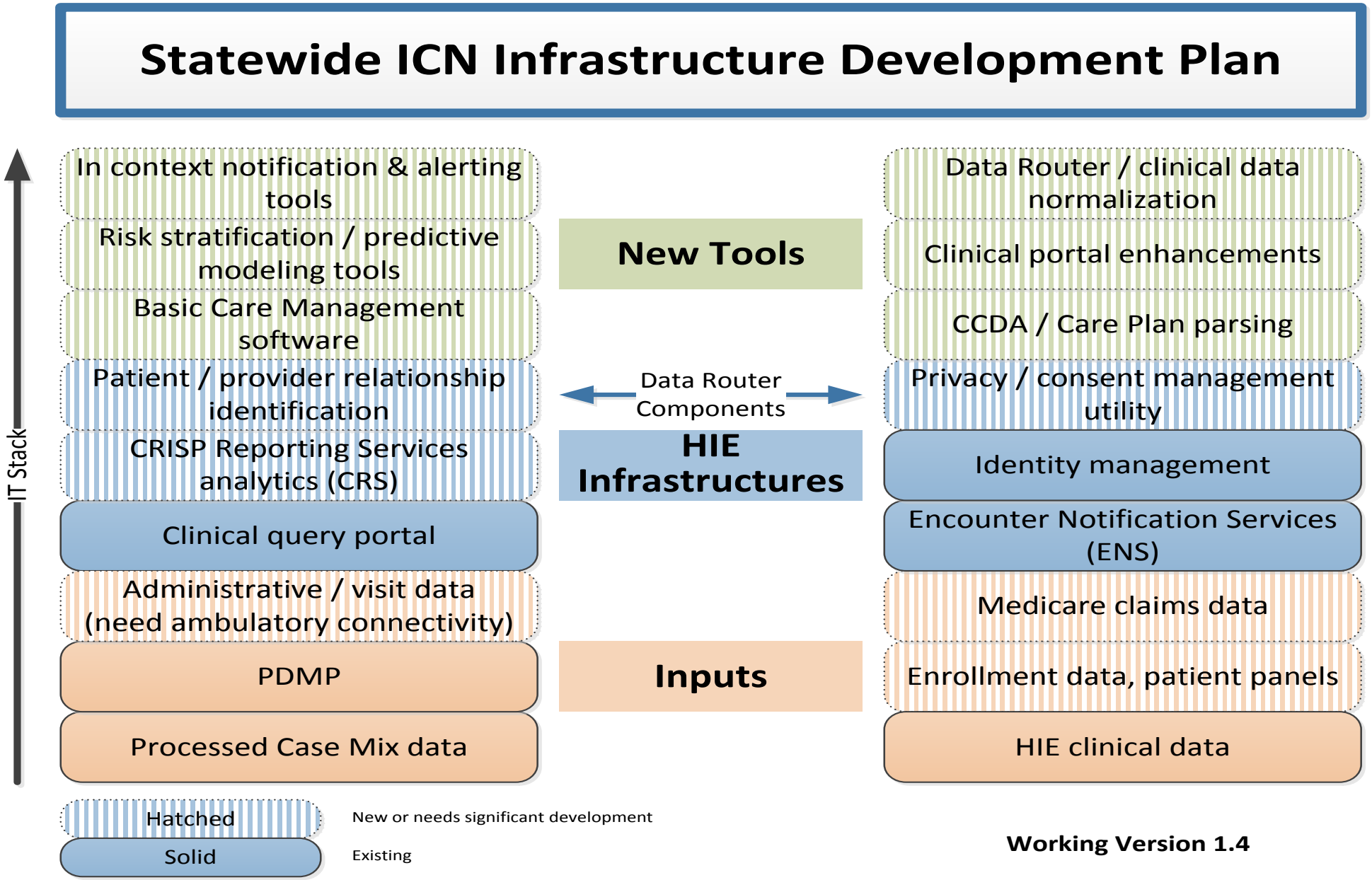
CRISP Expansion Activities

- CRISP is developing an Integrated Care Network (ICN) infrastructure to support care coordination and care management efforts that will lead to enhanced patient care, improved health outcomes, and lower costs

- The ICN is being developed through new efforts and by building on the existing HIE platform that has evolved over the last seven years; the ICN will support Maryland's All-Payer Hospital System Modernization activities

- CRISP organized the ICN infrastructure build out into seven work streams:

ICN Infrastructure Concept



Working Version 1.4

Key Elements

CRISP
HIE Designation Agreement

A Word About the Proposed Agreement

- The State-Designated Health Information Exchange Designation Agreement (Agreement) sets forth the conditions of CRISP's designation as Maryland's State-Designated Health Information Exchange

- The 2016 Agreement is for three-years and marks the beginning of the seventh year of CRISP as the State-Designated HIE

- The State-Designated HIE is responsible for building and maintaining a technical infrastructure that can support the exchange of electronic health information

New Items in the Proposed Agreement

- Develop a cybersecurity plan within 120 days of executing the Agreement that addresses the core components of the *National Institute of Standards of Technology Cybersecurity Framework*
  - The Framework enables organizations – regardless of size, degree of cybersecurity risk, or cybersecurity sophistication – to apply the principles and best practices of risk management to improving the security and resilience of critical infrastructure
- Establish a disaster recovery and business continuity plan within 120 days of executing the Agreement to ensure the continuity of core operations during a declared disaster
- Report annually on initiatives aimed at minimizing the false positive outcomes and in reducing to near-zero the false positive correlations in the Master Patient Index (MPI)
- Ensures that Maryland HIE priorities remain a priority for CRISP as they expand into other states

CRISP Oversight

- CRISP Bylaws
  - Must comply with the amended Bylaws from November 15, 2012, where Board membership was expanded to include two designees of the Secretary of DHMH
  - Board composition cannot be modified without formal MHCC approval
- CRISP Advisory Committees
  - MHCC staff can participate in CRISP advisory committees and advisory boards
- Bond or Appropriate Assurances
  - Provide to MHCC's Executive Director to assure electronic health information is maintained in HIE's core infrastructure is either destroyed or securely transferred
- Investment in major technology requires approval by MHCC

Reports to MHCC

- An annual plan that sets forth how CRISP plans to increase connection to the core infrastructure by payors and ambulatory practices
  - Identifies CRISP's education and outreach strategies
  - Identifies current and planned activities to secure potential revenue sources
- Monthly performance reports
- An annual budget approved by the CRISP Board, along with monthly updates on the budget
- An annual report approximately 120 days after the end of their fiscal year assessing performance to the CRISP Annual Plan

Privacy and Security

- CRISP must meet all current and industry standards and best practices regarding system performance, business processes, technical resources, and system security

- CRISP must comply with all applicable federal and State laws concerning the privacy and security of health information and COMAR 10.25.18, Health Information Exchanges: Privacy and Security of Protected Health Information

- MHCC may require CRISP to later obtain national accreditation from an organization recognized by MHCC

Annual Independent Audits

- **Financial – A review of the financial statements as of June 30th, and the related statements of activities and cash flow activities for the year that ended**

  - **Assess internal control over financial reporting and compliance with the provisions of laws, related to major programs and express an opinion on compliance with federal statutes, regulations, and the terms and conditions of federal awards that could have a direct and material effect on each major program in accordance with the Uniform Guidance**

- **Technology – A privacy and security review of patient data processed, transmitted, and stored by CRISP and its vendors**

  - **Assess compliance with Health Insurance Portability and Accountability Act (HIPAA)/Health Information Technology for Economic and Clinical Health (HITECH), State level requirements, and cybersecurity risk**

Changes to the CRISP Organization

- Sale, Merger, or Lease
  - CRISP must submit a plan that assures for the destruction of electronic health information contained in the HIE's core infrastructure, or the secure transfer to an MHCC-approved entity at least six months prior
  - The State and each organization with an existing Participation Agreement with CRISP may choose the continuation by CRISP of critical services during a transition
- Closure
  - As soon as CRISP has information regarding its ability to continue to operate as the State-Designated HIE, and not less than six months prior to closure it must provide written information to MHCC along with a plan that addresses data destruction or transfer, compliance with State or federal grants, and provide participants with notice of the closure
  - CRISP must support critical services during the selection of a new State-Designated HIE where possible

Cooperation

- CRISP will make connectivity available at a reasonable cost for each HIE recognized by MHCC
- CRISP will participate on any health information technology-related workgroup convened by MHCC
- CRISP will collaborate with MHCC staff, consumers, and stakeholders, concerning the development, implementation, and sequencing of new use cases

Requested Commission Action

Staff recommends that the Commission re-designate CRISP and approve the proposed Agreement

Thank You!

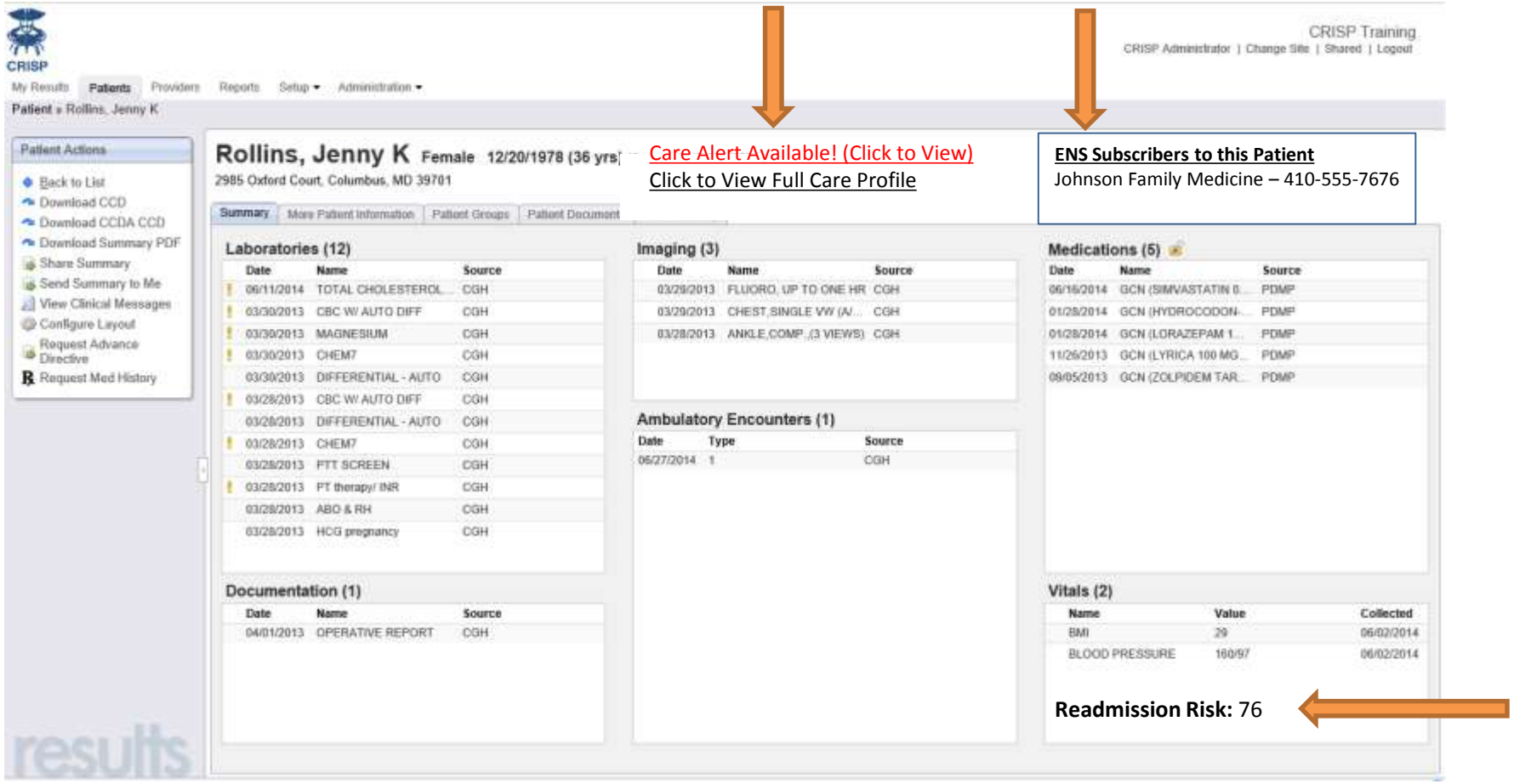
The MARYLAND
HEALTH CARE COMMISSION

Appendices

Terminology

	Definition
 **Clinical Query Portal Enhancements**	Improvements to the existing clinical query portal including approaches to simplify access, incorporating new content such as access to care profiles, and displaying the patient's providers.
 **In-Context Notifications and Alerting**	Inclusive of a range of alert types sent to the point-of-care or to a care manager, in a manner consumable with their workflow. Alerts may pertain to critical information about a patient, identify care gaps, indicate post-discharge follow-up care has not occurred, etc.
 **Care Profile View**	The care profile provides, in one readily viewable place, the key characteristics of a patient and their current medical status. Key elements in the care profiles could include patient demographics, most recent clinical alerts, summary of recent hospital encounters – diagnoses and procedures, visit dates, subscribing providers, and the existence of a current care plan.
 **Data Router**	The router is a service that includes key functionality to support connectivity, consent management, data routing to other services or data consumers, and patient-provider relationship determination. The approach may rely on connectivity through a health system, through a hosted EHR, directly to the practice, or via an administrative network.
 **Standardized Risk Stratification Tools**	Deployment of one or more centralized risk stratification methodologies to support stratification of patients initially using HSCRC case mix data housed in CRS but expanding to include broader data sets. Predictive risk score will be shared through a range of tools, including the query portal and ENS.

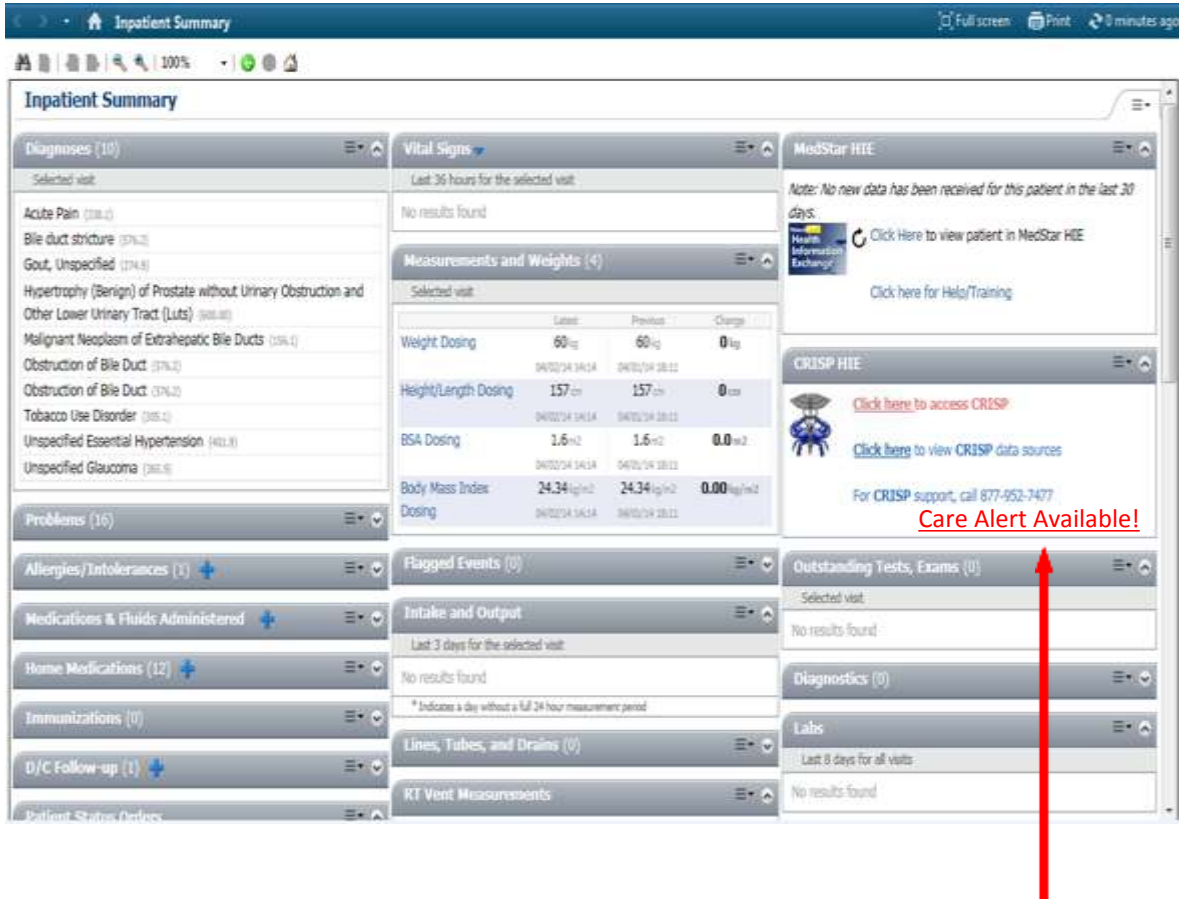
Clinical Query Portal Enhancements



Clinical Query Portal Enhancements – Improvements to the existing clinical query portal including approaches to simplify access, incorporating new content such as access to care profiles, and displaying the patient's providers.

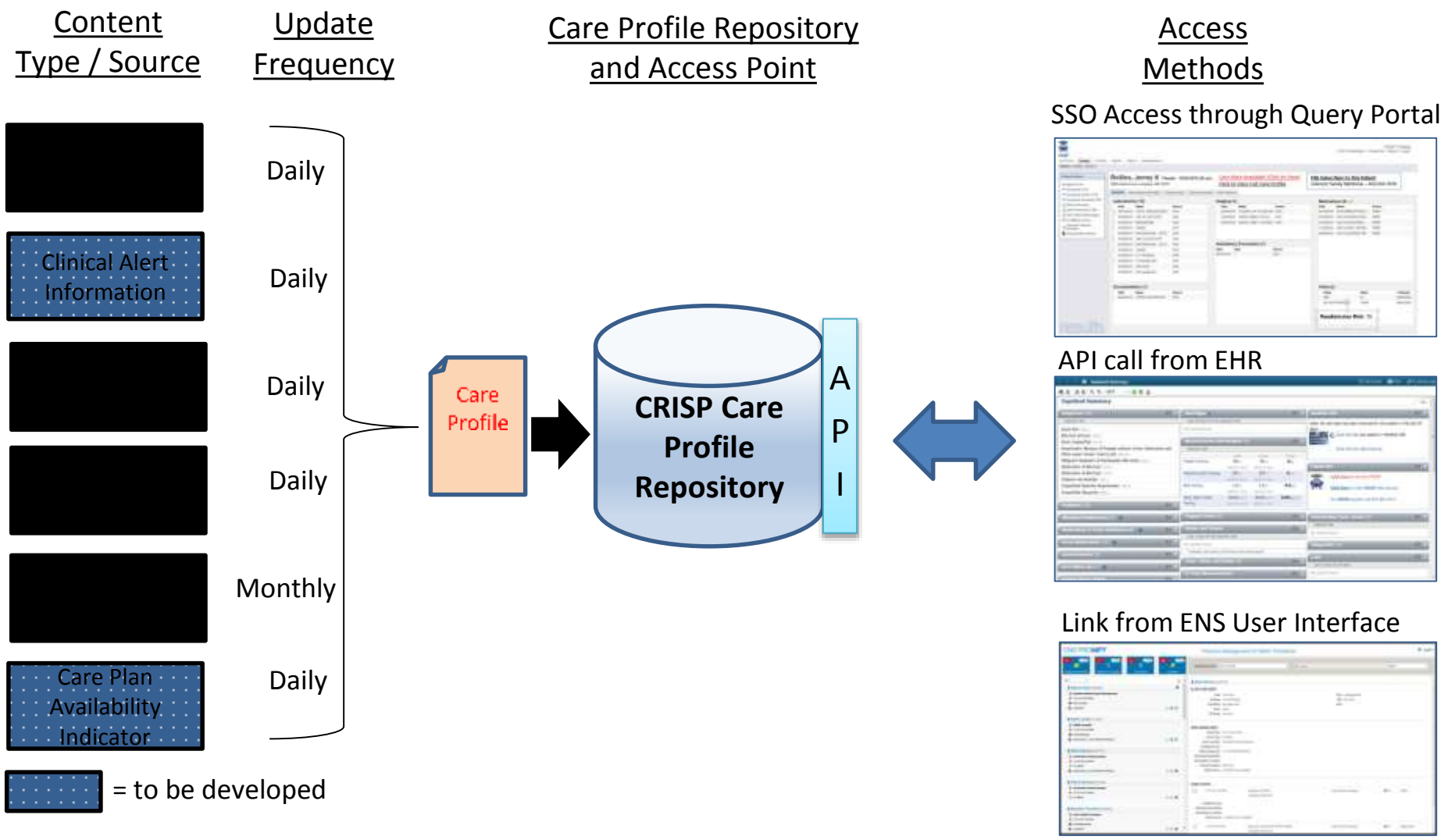
In-Context Notifications and Alerting

- In-context alerting is intended to provide key information to clinical decision makers at the most effective point in their clinical workflows.
- An example of an in-context alert is pushing information to a hospital ER when a patient is registered indicating if a care plan is available in CRISP.
- In this in-context alert use case, a pre-defined method to access the care plan (or just key sections such as the care alert) would be established between CRISP and the receiving organization.



In-Context Notifications and Alerting – inclusive of a range of alert types sent to the point of care or to a care manager that pertains to critical information about a patient, identifies care gaps, indicates post-discharge follow-up care has not occurred, etc.

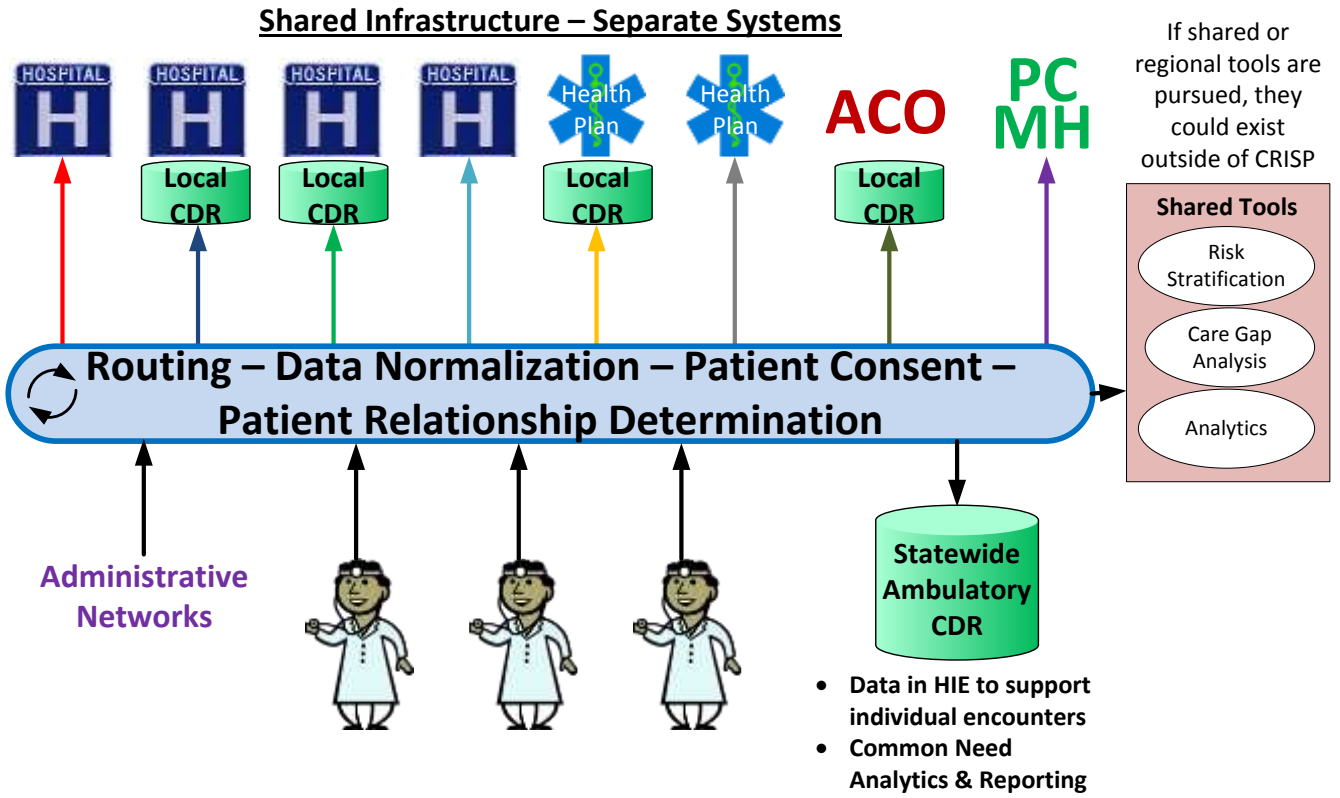
Care Profile View



Data Router and Non-Hospital Connectivity

Key Functions include:

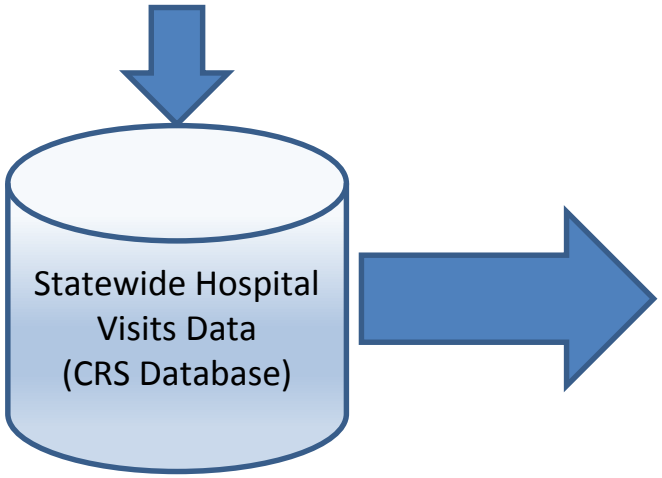
- Consent management
- Data normalization
- Data routing
- Patient-provider relationships determination and management



- The router is a service that includes key functionality to support connectivity, consent management, data routing to other services or data consumers, and determine patient-provider relationships
- These approaches may rely on connectivity through a health system, through a hosted EHR, directly to the practice, or via an administrative network

Standardized Risk Stratification Tools

Risk Stratification Methodology

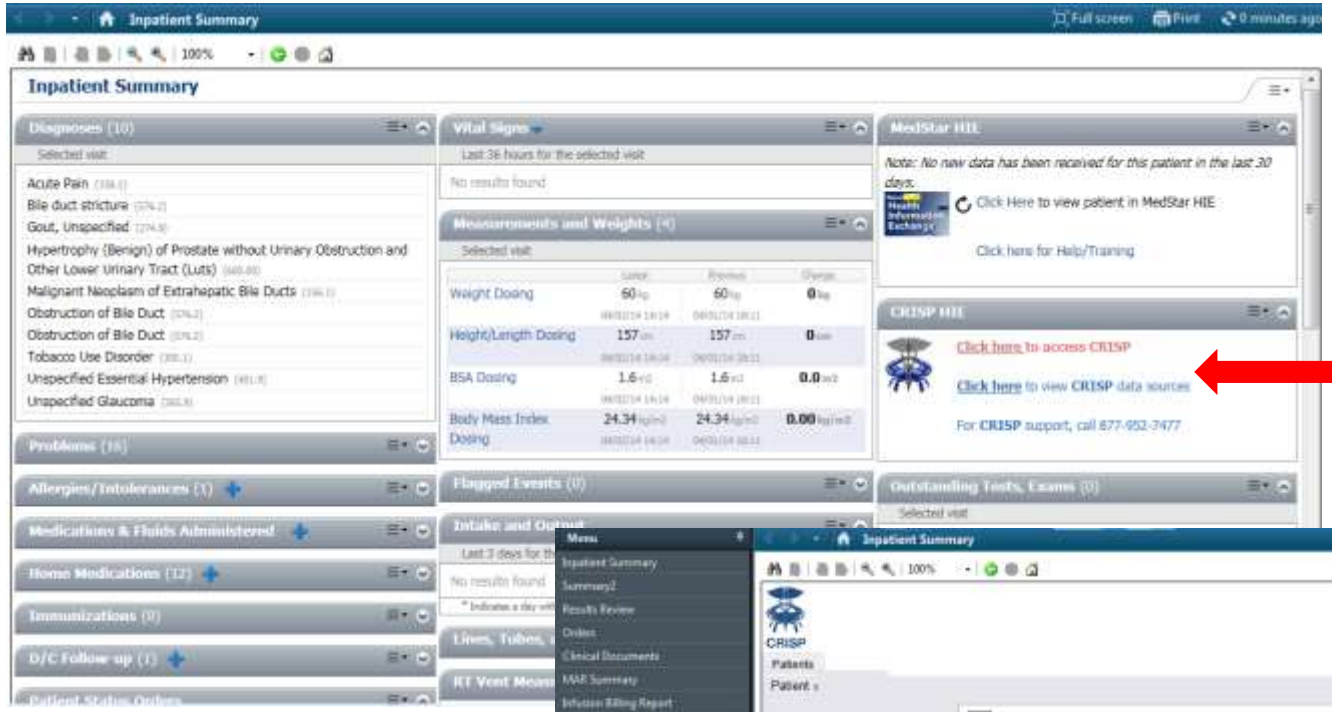


Note: Over time, additional data, such as Medicare claims data, can supplement the currently available hospital case mix data.

- **Standardized and shared risk stratification and predictive modeling tools**
- **Supporting common understanding high risk patients**
- **Data feeds to provider care management systems**
- **Risk scores available through broader set of CRISP tools**

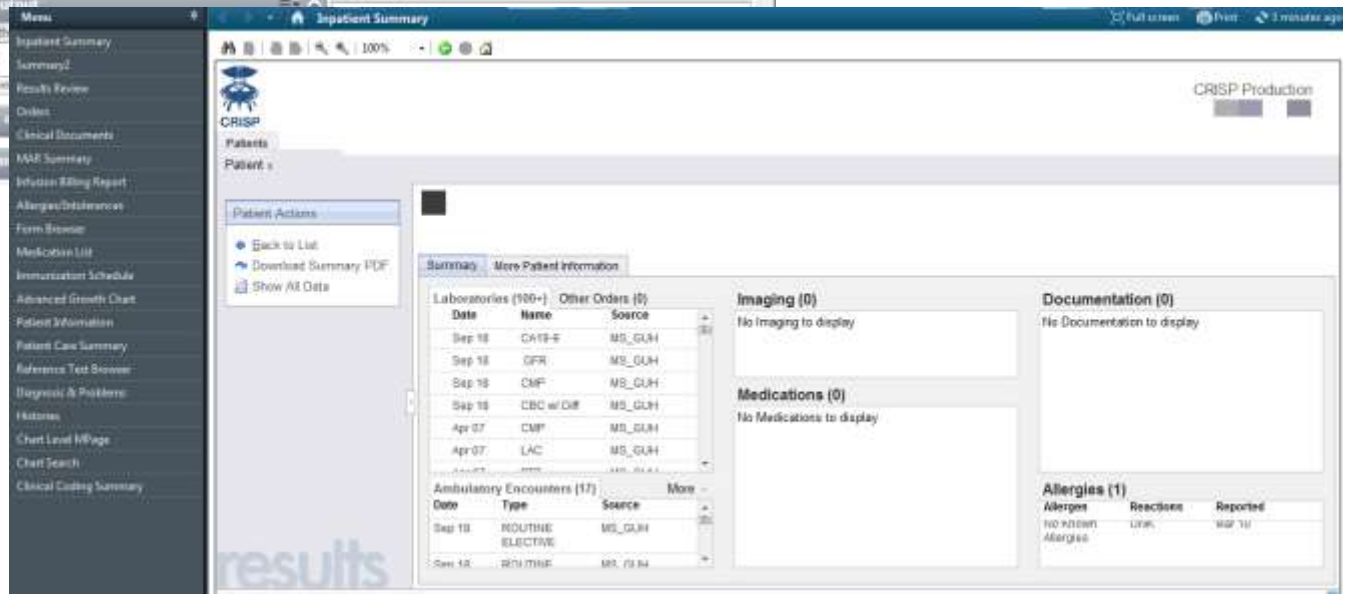
- Standardized Risk Stratification Tools - deployment of one or more centralized risk stratification methodologies to support stratification of patients initially using HSCRC case mix data housed in CRS but expanding to include broader data sets
- Predictive risk score will be shared through a range of tools, including the query portal and ENS

Clinical Query Portal & Single Sign-on

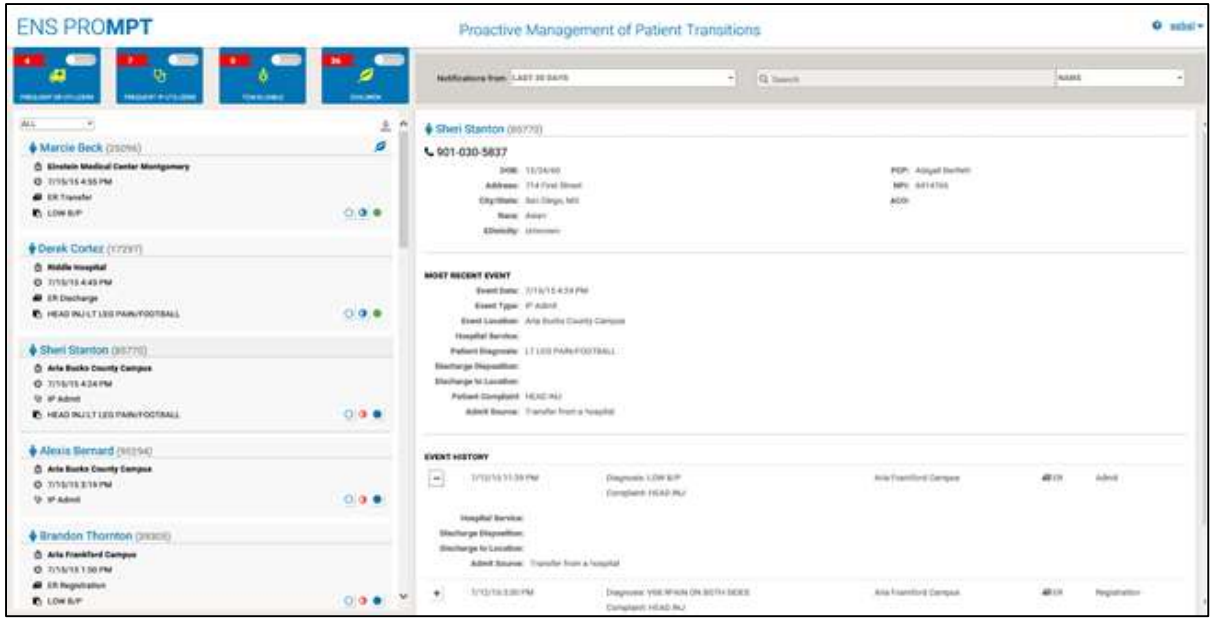


Single Sign-On (SSO) is an approach to enable faster and more efficient access to the query portal through the EHR.

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.



Encounter Notification Services

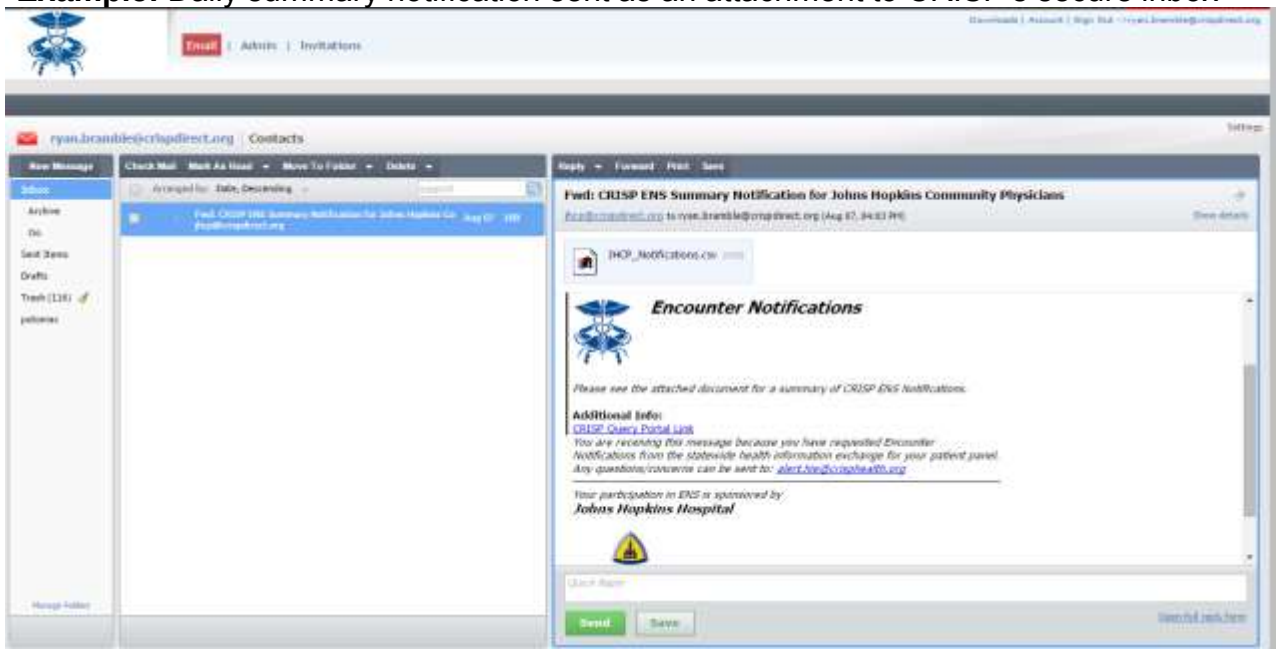


- Subscribers submit a patient panel to CRISP and identify which types of alerts they would like to receive
- Phase 1 notifications included only demographic information and the event types; Phase 2 included chief complaint and discharge diagnosis; Phase 3 includes a CCDA summary of care
- Hospitals can auto-subscribe to 30-day real-time readmission alerts

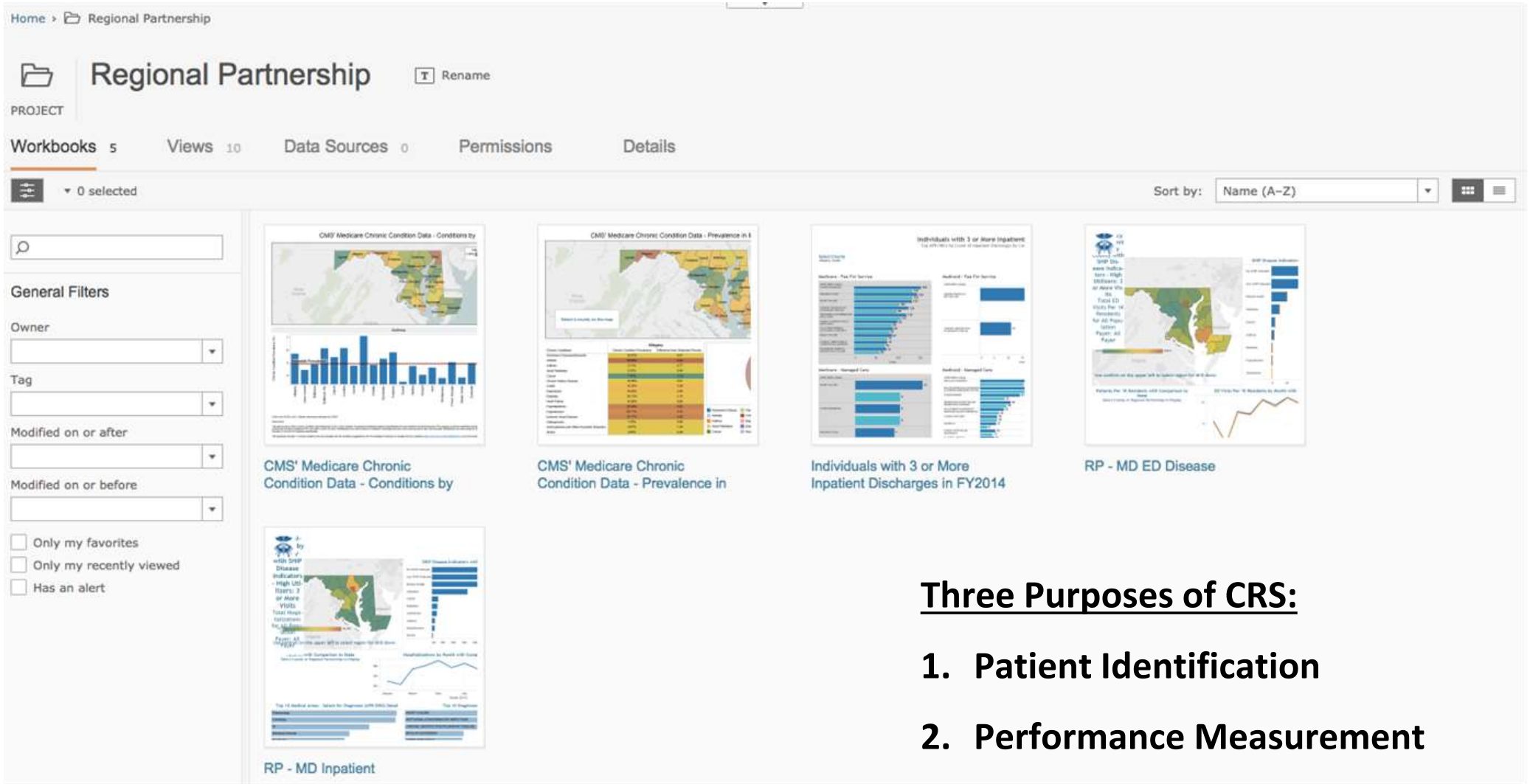
Methods to Receive Notifications

- Currently, ENS recipients can choose to receive real-time or a daily (or twice daily) summaries of the prior 24 hours of hospitalizations
- Most notifications are sent via CRISP secure direct messaging tool (shown below)
- Some ENS subscribers choose to integrate notifications into their EHR by receiving the notifications in the form of an ADT

Example: Daily summary notification sent as an attachment to CRISP's secure inbox



CRISP Reporting Services (CRS)



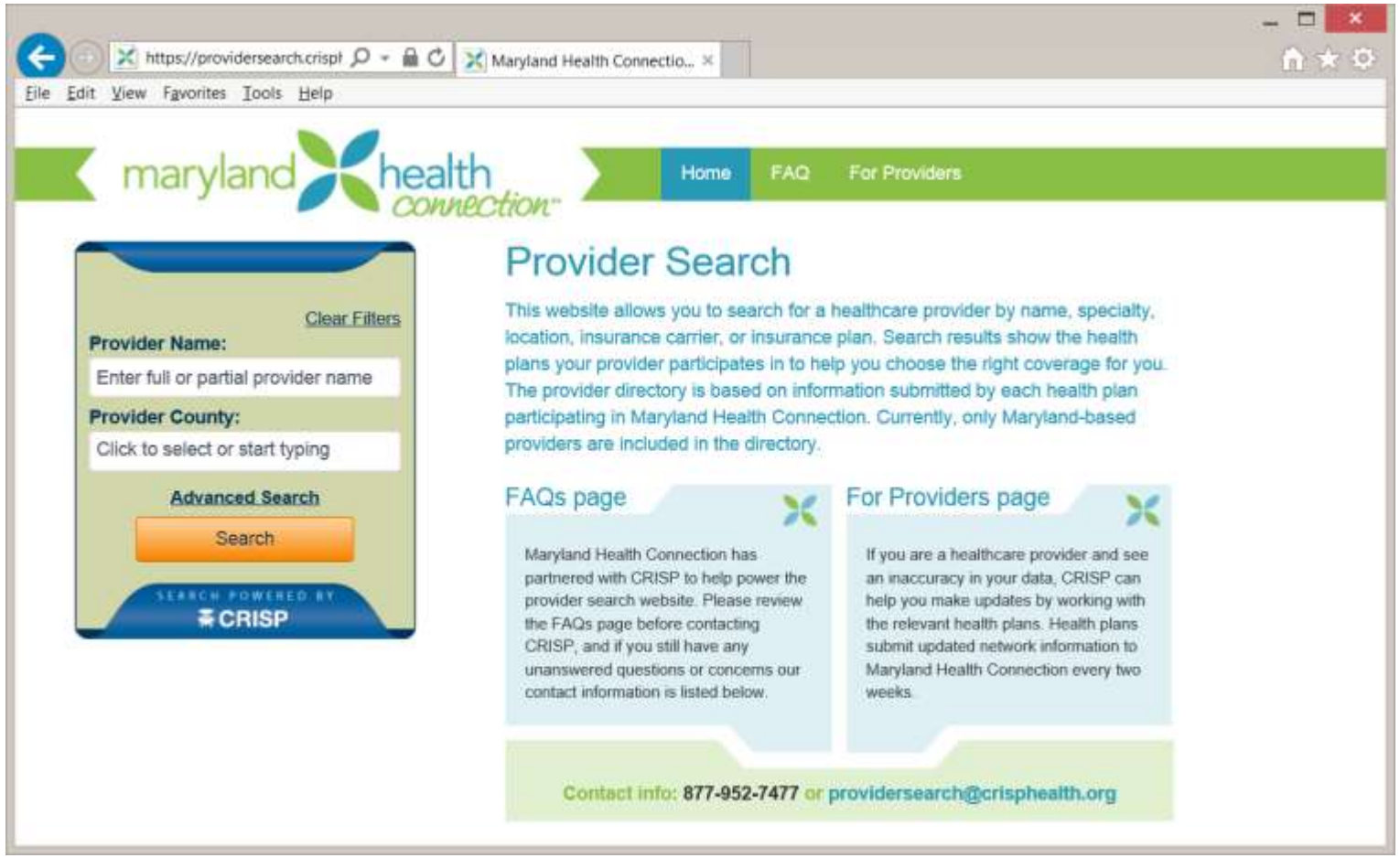
Three Purposes of CRS:

1. **Patient Identification**
2. **Performance Measurement**
3. **Coordination of Services**

CRISP Services

In support of Maryland's Health Benefit Exchange, CRISP operates a provider directory for individuals choosing an insurance plan

http://providersearch.crisphealth.org



HIE Hospital Fee Calculation

- Hospital Fee calculation methodology borrowed from an MHCC process:

FY2011 User Fee Methodology

Hospitals and Special Hospitals - 31%

½ of the total user fee assessment ($3,193,839.48) times the ratio of the admissions of each facility to the total admissions of all facilities:

$$(\$1{,}596{,}919.74) \times \frac{\text{individual facility admissions}}{\text{total admissions of all facilities}} \quad (720{,}007)$$

then adding,

½ of the total user fee assessment ($3,193,839.40) times the ratio of gross operating revenue of each facility to the total gross operating revenues of all facilities:

$$(\$1{,}596{,}919.74) \times \frac{\text{individual facility revenue}}{\text{total revenues of all facilities}} \quad (\$13{,}407{,}964{,}865.00)$$

The calculated sum of (a) and (b) above is the FY2011 user fee assessment for each facility.

****

MARYLAND HEALTH CARE COMMISSION

AGENDA

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3. **PRESENTATION**: Follow-up to March Update - Hospice Services in Maryland and Implementing the State Health Plan

4. **ACTION:** State-Designated Health Information Exchange – Re-Designation of CRISP and Approval of Agreement

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   - HB 1385 "Public Health – Advance Directive – Procedures, Information Sheet, and Use of Electronic Advance Directives"
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7. **Overview of Upcoming Initiatives**

8. **ADJOURNMENT**

MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

Final Report on Telehealth Round One Applicants

(Agenda Item #5)

MHCC Telehealth Grants

Round 1 - Brief

April 2016

The MARYLAND
HEALTH CARE COMMISSION

MHCC Authority and Current Projects

- Maryland law, established in 2014, authorizes MHCC to directly award grants to non-profit organizations and qualified businesses
- Current Projects Assessing the Impact of Telehealth
  - Round One (Oct. 2014-Oct. 2015) – coordinate care delivery between a long term care (LTC) facility and a general acute care hospital using video consultation
  - Round Two (June 2015 – Nov. 2016) – demonstrate the impact of remote patient monitoring on hospital readmission in various settings
  - Round Three (Dec. 2015 – May 2017) – demonstrate the impact of telehealth to improve the patient experience and overall health of patients with chronic conditions living in underserved rural and minority communities

The Value of Telehealth Grants

- Diverse use cases provide an opportunity to test the effectiveness of telehealth with various technology, patients, providers, clinical protocols, and settings
- Challenges and successes from each round of projects are shared with the next – building on successes
- Lessons learned from these projects will inform
  - Better practices and industry implementation efforts
  - Potential policies to support the advancement of telehealth
  - The design of larger telehealth programs and projects across the State

Round 1 - Telehealth Projects

- Twelve-month telehealth projects funded by MHCC
- Goal: Demonstrate the impact of using telehealth on coordinating care delivery between LTC facility and a general acute care hospital
- Grantees
  - Atlantic General Hospital in partnership with Berlin Nursing and Rehabilitation Center (Berlin)
  - Dimensions Healthcare System in partnership with Sanctuary of Holy Cross and Patuxent Health and Rehabilitation Center
  - University of Maryland Upper Chesapeake Health in partnership with the Bel Air facility of Lorien Health Systems

Project Lessons

- **Technical Considerations**
  - Assessment of the bandwidth and Wi-Fi signal strength at LTC facilities was necessary to ensure maximum functionality of the telehealth audio-video consultations.
  - Staff training and frequent opportunities to test the use of the telehealth equipment is important to ensure successful telehealth encounters and continued use
- **Engagement of Consumers and Staff**
  - Education of families and patients prior to the use of telehealth increases acceptance and willingness to use telehealth
  - Early identification and ongoing involvement of physician and nurse champions is essential to the success of a telehealth project

Project Lessons

- Liability Coverage
  - Professional liability insurance carriers' coverage of telehealth practices may not be clearly outlined in the policy language
  - Physicians need to consult with their malpractice carrier to determine under what conditions, if any, they are covered for telehealth
- Integration of Data
  - Integration of data collected through telehealth technology with CRISP and existing EHRs is challenging and requires additional resources to implement

Cost Savings and Sustainability

- The projects reported a reduction in hospital encounters for patients whose non-emergency conditions were being monitored remotely, and estimated cost savings as a result of using telehealth
- Hospitals agreed to pay for physician telehealth services through the hospital's operating budget
- Hospitals anticipate that the All-Payer Global Budget Revenue Model will help support the telehealth program because of the savings and improved care that the telehealth program generates
- All three programs are expanding their telehealth programs

Impact on the Industry

- **The MHCC's telehealth programs are having a positive impact on the diffusion of telehealth**
  - **MHCC 2015 and 2016 telehealth symposiums were well attended and well received by stakeholders**
  - **CareFirst based its $3 million telehealth grant initiative, in part, on the recommendations in the *MHCC's Teleheath Taskforce Report***
  - **Staff has been invited to present on the value of telehealth at various conferences statewide**

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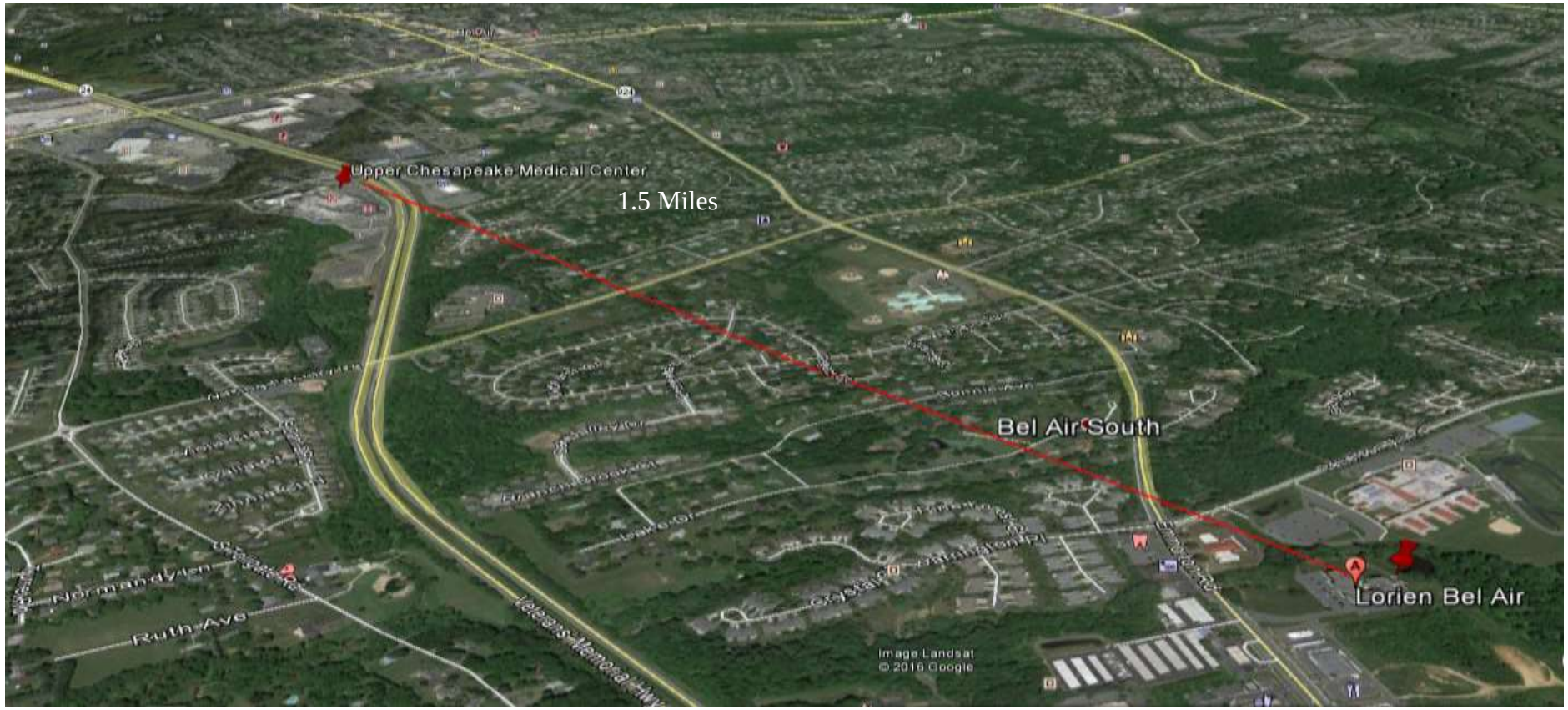
Telehealth Program

Presenter: Colin Ward, VP Population Health & Clinical Integration
University of Maryland – Upper Chesapeake Health

Telehealth Participants

- University of Maryland Upper Chesapeake Health (UMUCH)
- Lorien Bel Air
- Maryland Emergency Medicine Network (MEMN)
- LifeBot/ Citrano Labs



General Description

A Remote Patient Evaluation process for Skilled Nursing Patients at Lorien Bel Air

- ICU Level Monitoring
- Basic Point of Care Testing
- Medications matched to UMUCH ED inventory
- On-demand ED physician consultation using two-way video

Goal: Maintain treatment in the most appropriate location and reduce avoidable utilization

Impact on Quality

Measure	Numerator/Denominator	Baseline Data 10/1/2013-9/30/2014	Goal	11 Months	Final Rate	
30-day Readmissions	Number of patients that were admitted from an ACH to Lorien Bel Air and were re-admitted to an ACH within 30 days of hospital discharge date	83		48		
	Number of patients that were admitted to Lorien Bel Air from an ACH	610		536	**9.0%**	**34%**
	Percent	13.6%	10.2%			
Hospital Admissions	Number of patients that were admitted to an ACH from Lorien Bel Air	105		83		
	Total number of resident days for the month at Lorien Bel Air	24,743		23,034	3.6	**15%**
	Rate	4.2	3.2			
ED Transfers	Number of residents that were transferred via ambulance to an ACH	168		126		
	Total number of resident days for the month at Lorien Bel Air	24,743		23,034	5.5	**19%**
	Rate	6.8	5.1			

- Program resulted in 42 avoided trips to the UMUCH ED
- Patient and Provider satisfaction measured

Impact on Cost

UMUCH finance team estimates hospital expense savings of:

- $128 for each ED visit avoided
- $445 for each patient day avoided

(incremental reductions in imaging, labs, patient care staff hours)

- Projected Expense Avoidance of $70,000

Pilot team estimates payer cost savings of ALS Transport of:

- $650-$750 per Ambulance Trip avoided
- Approximate payer savings of $25,000

Plan for Sustainability

- Partnership is expanding to two remaining Harford County Lorien locations – Riverside and Havre de Grace
- UMUCH & Lorien sharing the capital cost
- MEMN – UMUCH agreed to payment process that allows providers to prioritize “virtual patients” as equals to patients physically in the ED

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UPPER CHESAPEAKE HEALTH

Video- Telehealth Program

UMUCH and Lorien Lifebot Telehealth

Presenter: Colin Ward, VP Population Health & Clinical Integration
University of Maryland – Upper Chesapeake Health

Atlantic General Hospital
Telehealth Project

A collaborative effort between Atlantic General Hospital and Berlin Nursing & Rehabilitation Center with the focus of implementing telehealth services to prevent avoidable transfers, admissions and readmissions.

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BERLIN
NURSING & REHABILITATION CENTER

Vision

ATLANTIC GENERAL HOSPITAL
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Atlantic General Hospital

Implementation

- Administrative commitment
- Physician champions
- Comprehensive assessment of transfer and admission patterns
- Substantial wireless infrastructure
- Collaborative efforts among all stakeholders
- Clearly defined goals, protocols and guidelines

Project Goals/ Metrics

- Reduce admissions from BNRC to AGH
- Reduce 30-day readmissions from BNRC to AGH
- Reduce total transfers from BNRC to AGH for skilled patients with COPD, CHF, DM, and HTN
- Decrease E.D. utilization by directly admitting BNRC patients requiring higher level of care

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Approach

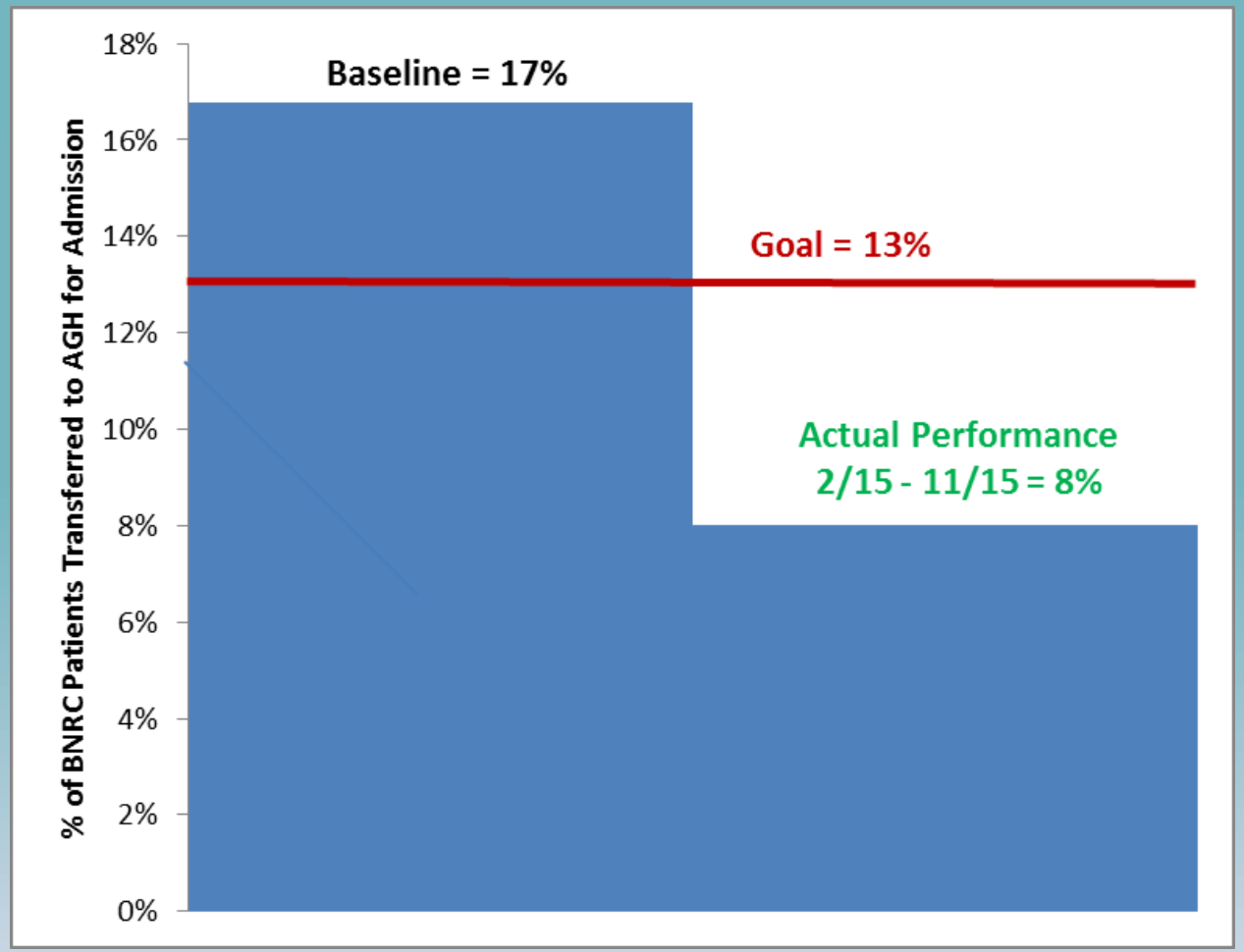
Strategies

- Community partnerships
- Information technology
- Selection of equipment
- Legal, credentialing, malpractice, consents, bi-directional policies
- Interact pathways
- Medical / clinical staff education
- Interact pathways

Results/ Outcomes

%BRNC Patients Admitted to AGH

As a % of BNRC Avg Daily Census



Notes:
Baseline data reflects 12 months ending November 2014

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Results/ Outcomes

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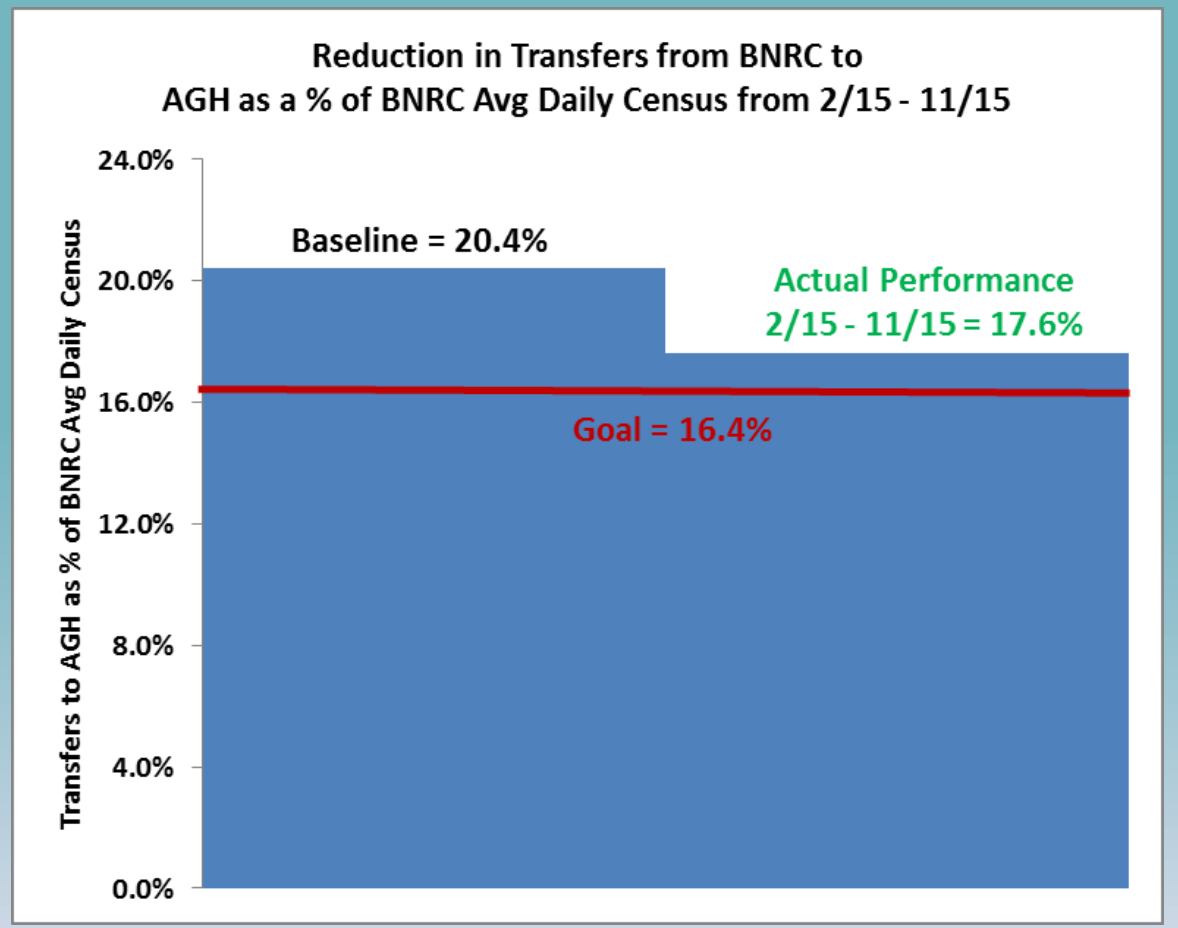
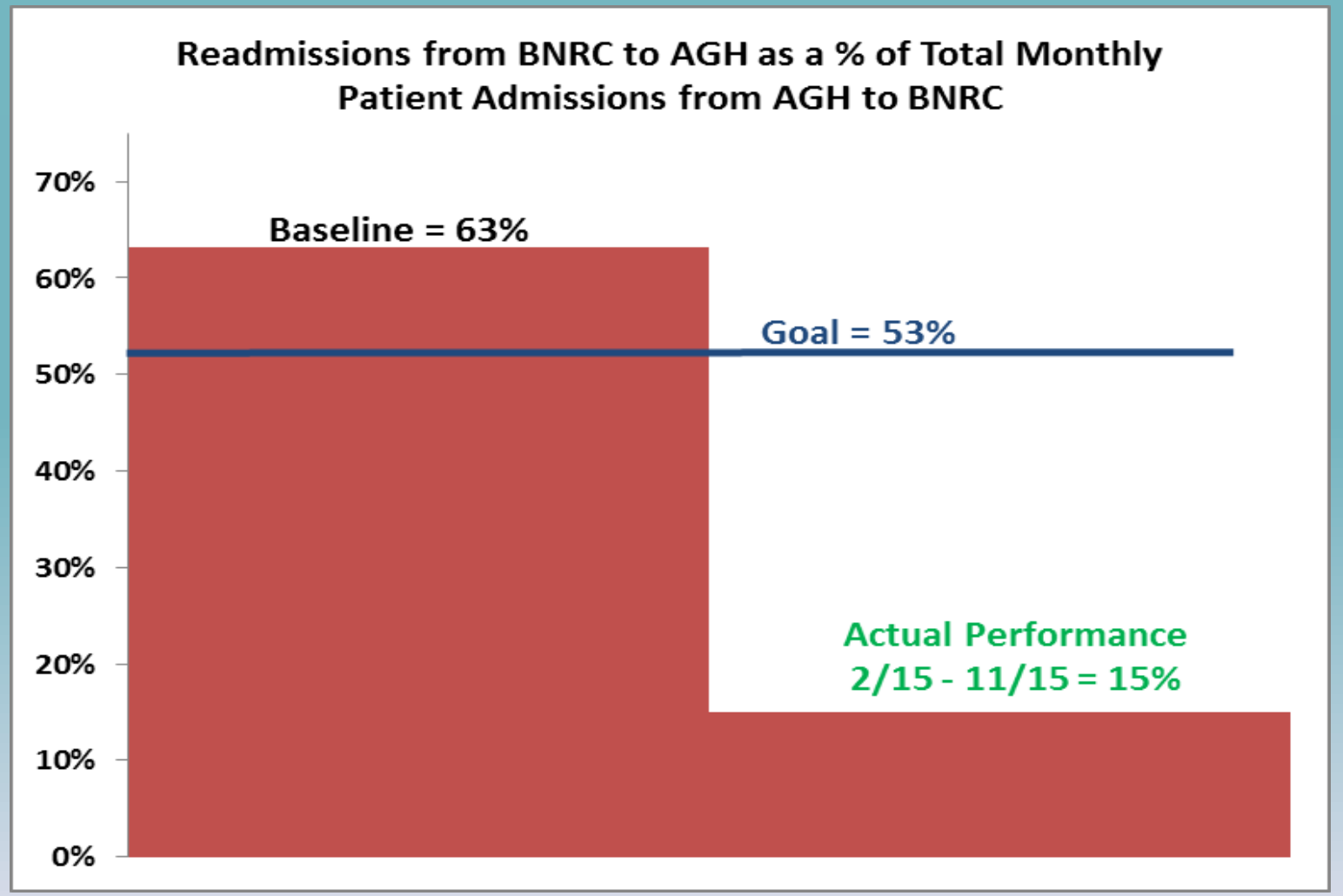
Reduction in Total Transfers from BNRC to AGH



Notes:
Reasons for Transfers include: ER Visits, Hospital Observation, Acute Care Admission, etc.
Baseline data reflects 12 months ending November 2014.

Results/ Outcomes

Re-Admissions to the Acute Care Hospital



Notes:
Baseline data reflects 12 months ending November 2014

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Estimated Cost Reduction

Hospital Estimated Costs / Savings

- The 9% reduction translates into a reduction of 30 transfers over the 12-month period.
- The reduction in admissions from BNRC resulted in a decrease of 11 admissions per month. An estimated cost of $14,313 per admission results in a savings $157,400 per month savings or 1.9 million over the 12-month period.
- The 42% reduction in 30-day re-admissions translates to a decrease of 4 readmissions per / month at a a savings of $57,300 or $687,000 over the 12-month period.

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Sustainability

The Maryland "Waiver" Program for Acute Care Hospital Payment

- **The new "Global Budget Revenue" system with the HSCRC in Maryland creates the incentives for hospitals to create programs like this telehealth initiative.**

<u>Additional Means to Sustain Telehealth Services:</u>

- **Reimbursement / billable services for physicians in Maryland**
- **Further extension of services into primary care, long-term care and assisted living facilities**
- **Grant funding**

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Thank You!

Open Forum / Discussion

INTEGRATING VIRTUAL VISITS AND REMOTE MONITORING TO IMPROVE TRANSITIONS OF CARE BETWEEN DIMENSIONS HEALTHCARE SYSTEM FACILITIES AND COMPREHENSIVE CARE FACILITIES

Carnell Cooper, M.D., FACS
Chief Medical Officer
Dimensions Healthcare System

Dimensions Healthcare System

Participating Partners

Dimensions Healthcare System

- Integrated, not-for-profit healthcare system in Prince George's County, Maryland, serving approximately 180,000 patients annually

Maryland Emergency Medicine Network

- National leader in academic and community-based emergency medicine Affiliated with the University of Maryland Medical System

UNIVERSITY of MARYLAND
SCHOOL OF MEDICINE

DEPARTMENT OF EMERGENCY MEDICINE

Participating Partners

Comprehensive Care Facilities

SANCTUARY AT HOLY CROSS

A Trinity Senior Living Community

Hillhaven

Assisted Living, Nursing and Rehabilitation Center

SavaSeniorCare

Patuxent River Health and Rehabilitation Center

Genesis HealthCare®

Crescent Cities Center

Participating Partners

ZaneNet
Expect Excellence

- Certified 8(a) Company and Small and Woman-Owned Disadvantaged Business (SDB); Maryland MBE Certified woman owned SBD registered in the District of Columbia
- Accreditation by the Maryland Health Care Commission to serve as a Management Service Organization (MSO)
- Certified Professionals in Health Information Technology (CPHIT)

Clients:

The DHS project

The DHS project involved two telehealth interventions.

- Post-discharge e-visit between the CCF and a DHS hospital to track a patient's status during the first 30 days of discharge

- Pre-transfer e-visit between the CCF and a DHS hospital emergency department to determine if emergency transfer is necessary or provide support to the CCF to avoid emergency transfer

Purpose

The Long Term Care/Hospital Telehealth Project Pilot was designed to reduce hospital admission and 30-day readmissions for patients at comprehensive care facilities (CCF) by:

- (1) improving care transitions for Medicare, Medicaid and dually eligible patients who were admitted to hospital and transferred to the CCFs or who are at risk for readmission to the hospital from the CCFs
- 2) reducing unnecessary emergency department visits for Medicare, Medicaid and dually eligible residents of the CCFs

Implementation

- The pilot integrated virtual visits to improve transitions of care between two DHS acute care facilities (PGHC and) and two CCFs, Sanctuary and Patuxent. Additional CCFs were added during the pilot.

- Patient data were exchanged among DHS and CCF providers via the HouseCall e-vist platform which permitted virtual consultations and virtual encounters and image capture

- The pilot served patients who are Medicaid, Medicare or dually eligible beneficiary residents of the CCFs and who are at risk for admission or readmission within 30 days or at risk of transfer to a hospital emergency room

Workflow Integration

- The committee developed Telehealth Workflows for the post-discharge intervention and the ED Intervention
- A group of DHS (at PGHC) physician advisors was trained on the telemedicine tool and to manage the post-discharge intervention process
- Zane Networks took the lead in training the hospitals' staff and providers as well as CCF staff and providers on the use of the telemedicine equipment and software
- Hospital case managers and/or CCF staff explained the pilot to patients and families and obtained informed consent from interested patients prior to their being discharged from hospital or upon their (re)admission to the CCF

Expected outcomes

- Reduction in the hospitalization rate for Medicare, Medicaid and dually eligible CCF residents
- Reduction in the 30-day readmission rate for CCFs
- Reduction in the emergency department transfer rate for Medicare, Medicaid and dually eligible patients who are CCF residents
- Improvements in patient experience

Hardware: Surface Pro Tablets

- Surface Pro 3 Tablets and IPADs were considered as hardware options
- Surface Pro 3 Tablet was selected because it provides full widows desktop capabilities along with the versatility of a tablet
- Surface Pro 3 USB port can support future integration of devices (Stethoscope, examination camera, BP cuff, etc.)

Hardware: JACO Carts

- The JACO Cart was chosen for mobility and ease of use for end users.
- The Surface Pro 3 tablets can be mounted to the JACO carts, providing greater security for the hardware.
- With the JACO Cart clinicians can easily navigate between patients rooms to conduct Tele-Health visits.

Software: HouseCall

- HouseCall created by ZaneNetworks, a Maryland State Designated Management Service Organization
- HouseCall is a cloud-based software service, hosted in a HIPAA certified Data center
- TeleHealth Calls are encrypted and sent through the internet, securely
- HouseCall is provider-centered and supports provider-to-provider Video conferencing
- ZaneNetworks currently developing direct integration to allow providers to send Direct Messages with documents using HouseCall

CRISP ENS and Direct Messaging

- CRISP ENS delivered to participating providers secure emails with real-time alerts of their patients' hospitalization status during the hospital stay and at the time of discharge

- Providers could retrieve more detailed patient information such as discharge summary, labs, medications prescribed if documented and available from the hospital information system

- The pilot leveraged EHRs, HIE and Telehealth to allow hospital-based and CCF telehealth practitioners to schedule, manage and conduct video consults with patients; collect clinical data such as images and provider notes; exchange health information with other providers via DIRECT or through the portal; and import data into their EHR

- The integration of telehealth and ENS increased coordination between the hospital and CCFs and enhanced the quality and accessibility of clinical information needed to inform quality care

Results

Table 1: DHS Long Term Care Hospital Telehealth Project Evaluation Findings						
Measures	**Patuxent CCF**			**Sanctuary CCF**		
	Baseline Rate (Jan-March, 2015)	Goal	Endpoint Rate (April – Oct, 2015)	Baseline Rate (Jan – June 2014)	Goal	Endpoint Rate (Jan– Sept 2015)
Hospital Admissions **Numerator =Number of patients that were admitted to an ACH from the CCFP** **Denominator= Total number of resident days for the month at the CCF**	.44%	.36%	.41%	1%	0.70%	.38%
30 day Readmissions **Numerator= Number of patients that were admitted from the CCF to an ACH and were re-admitted to an ACH within 30 days of hospital discharge date** **Denominator Number of patients that were admitted to the CCF from an ACH**	66.6%	50%	18%	15.3%	12.5%	11.38%
ED visit rate **Numerator=Number of residents that where transferred via ambulance to any ACH from the CCF** **Denominator= Total number of resident days for the month at the CCF**	.52%	.42%	.29%	.24%	.19%	.42%

Lessons Learned

- Consistent communication between the acute care hospital and the CCF results in a more in depth assessment of the resident's condition and facilitates on site interventions that eliminate transfers
- Telehealth champions are critical to maximize the utility of telehealth among the physician and nursing staff
- There must be ongoing training and engagement of physician and facility staff to sustain provider and staff enthusiasm for the project and to integrate telehealth interventions and protocols as a natural part of the clinical workflow.
- Telehealth programs must include education for patients and their families regarding the benefits of telehealth intervention
- Clinical support and staffing resources must be available to ensure that the effective and efficient clinical management of patients

Sustainability

- To sustain a telehealth program, investment of additional resources for hardware, capital improvements and dedicated personnel to implement a more comprehensive telehealth program is required

- To be viewed as cost effective, to the hospitals and CCFs, there must be a quantifiable return on investments (ROI). Specifically, there must be appropriate reimbursement for telemedicine services as one element of the ROI. An effective program would also like result in definitive hospital savings and better healthcare outcomes for participants

- Telemedicine programs must be integrated into the daily work processes of the acute care hospitals and CCFs to ensure broad utilization. Staff must be trained on the benefits of the programs and utilization of the tools

- Internal resources in the form of dedicated staff and IT support must be part of the program. Additionally, to expand CCFs' capacity to care for sick patients through collaboration with acute care hospitals, there must be a nurse champion at each CCF and strong commitment by the CCF administration to provide the training and support needed by staff to expertly care for patients

Questions

On the Horizon

- Work with stakeholders to increase telehealth adoption where use case development is informed by the findings from round one projects
- Continued collaboration with round two and three grantees
- Award a fourth round of telehealth grant(s); the use case focuses on advance practice transformation and alignment with value base care models
  - 6 proposals have been submitted to MHCC for review by evaluation panel
  - Recommended awards to be presented to Commission on May 19th
- Provide support to round two grantees as they assess program performance to include in their final report, due at about six months; the use cases focus on remote patient monitoring of patients with chronic conditions in December 2016

Thank You!

The MARYLAND
HEALTH CARE COMMISSION

MARYLAND HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

OVERVIEW:

Legislative Actions Affecting the Commission

HB 1385 “Public Health – Advance Directive – Procedures, Information Sheet, and Use of Electronic Advance Directives”

SB 707 “Freestanding Medical Facilities – Certificate of Need, Rates, and Definition”

(Agenda Item #6)

Legislative Update

Erin Dorrien
Chief, Government and Public Affairs
April 21, 2016

MHCC | MARYLAND HEALTH CARE COMMISSION

Presentation Outline

- Requirements Due to Enacted Legislation
  - Advanced Directives
  - Hospital Conversion & a Rural Health Study
- Other Requirements/ Responsibilities
  - Self-Referral
  - Clinically Integrated Organizations

HB 1385 Public Health- Electronic Advance Directives- Witness Requirements, Information Sheet, and Repository

- Requires MHCC and DHMH to approve an electronic advanced directive service that will connect with CRISP
- Requires payers and Maryland Health Benefit Exchange to notify enrollees of the electronic advanced directive service

SB 707 Freestanding Medical Facilities- Certificate of Need, Rates and Definitions

- Requires MHCC to establish regulations for freestanding medical facility conversions.
- Regulations must address public notification process.
- Regulations will be incorporated into the current draft Freestanding Medical Facilities Chapter of the State Health Plan
  - Track 1 – Establishment of a FMF through CON **(work underway)**
  - Track 2 – Conversion of an existing general hospital to an FMF via an exemption
- Staff expects significant stakeholder interest in developing the exemption process

SB 707 -Rural Health Workgroup

- Members
  - General Assembly Members
  - Secretary of DHMH
  - CEOs of several rural hospitals
  - Providers, consumers, local government, business, labor
- Purpose
  - Examine special challenges for delivering health care in the five county Mid-Eastern Shore
  - Review policy options developed under the study
  - Make recommendations to the General Assembly on approaches for effectively meeting health care needs

SB 707- Rural Health Study

- Examine challenges in Health Care delivery in the five county region in the Mid-Eastern Shore
- Examine the economic impact of hospital closure or conversion.
- Identify opportunities created by telehealth and the Maryland all-payer model
- Develop policy options for addressing the health care needs and delivery system in the five county region

Other Requirements

- Self Referral
  - MHCC will continue to work with stakeholders on provider alignment and collaboration ideas. MHA has agreed to convene the groups.
  - Legislative leaders will gather groups to discuss oncology pilot programs.
- Clinically Integrated Organizations
  - MIA will convene stakeholders.

MARYLAND HEALTH CARE COMMISSION

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7. **Overview of Upcoming Initiatives**

8. **ADJOURNMENT**

MARYLAND HEALTH CARE COMMISSION

Overview of Upcoming Initiatives

(Agenda Item #10)


ENJOY THE REST OF
YOUR DAY