Maryland Health Care Commission

Thursday, April 20, 2017

1:00 p.m.

MARYLAND HEALTH CARE COMMISSION

AGENDA

1. CLOSED SESSION

2. APPROVAL OF MINUTES

3. UPDATE OF ACTIVITIES

4. **OVERVIEW:** Legislative Wrap Up

5. **ACTION:** Approval of Release of APCD Data – University of Massachusetts

6. **ACTION:** Certificate of Need – Kaiser Foundation Health Plan of the Mid-Atlantic State, Inc., d/b/a Kaiser Permanente Gaithersburg Medical Center (Docket No. 17-15-2390)

7. **ACTION:** Proposed Regulations – COMAR 10.24.11 – State Health Plan for Facilities and Services – General Surgical Services

8. **ACTION:** Final Regulations – COMAR 10.25.02 – User Fee Assessment of Health Care Practitioners, and COMAR 10.25.03 – User Fee Assessment of Payers, Hospitals, and Nursing Homes

9. **UPDATE:** Maryland Health Care Quality Reports Website

10. **PRESENTATION:** Health Information Technology Grant

- Findings from Round 2
- Shore Regional (telehealth) and Johns Hopkins Pediatrics at Home (mHealth) Go Live Demo

11. Overview of Upcoming Initiatives

12. ADJOURNMENT

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OVERVIEW:

Legislative Wrap Up

(Agenda Item #4)

Legislative Wrap Up

Erin Dorrien

Chief, Government and Public Affairs

April 20, 2017

MHCC | MARYLAND HEALTH CARE COMMISSION

Presentation Overview

- Budget and Budget Reconciliation and Financing Act (BRFA)
- Passed Legislation
- Failed Legislation
- What We Expect/ Our To Do List

Budget and BRFA

- Budget
  - $15.1 Million Appropriation – includes an additional $600,000 in indirect costs assessed by DHMH.
- BRFA
  - Established a permanent statutory indirect cost ceiling of 30.5%, up from 18%
  - Increased our assessment cap from $12 million to $16 million

Passed Legislation

- SB 369/HB 403 Maryland Patient Referral Law- Compensation Arrangements Under Federally Approved Programs and Models
- HB 188 Public Health- Advance Directives- Witness Requirements, Advance Directives Services, and Fund
- SB 571 Maryland Health Insurance Coverage Protection Act

Failed Legislation

- HB 1053 Integrated Community Oncology Reporting Program,
  - MHCC staff suggested language passed House 139-0,
  - Voted out of Senate Education, Health & Environ. Affairs Committee 8-2, but no Senate Floor vote
- SB 1020 Maryland Health Care Regulatory Reform Act of 2017
- HB 736 Workgroup to Recommend Possible Reforms to Maryland's Health Care System

What We're Expecting/ Our To Do List

- MHCC is required to approve advance directive services in accordance with House Bill 188
- A letter from the Health Committee chairs requesting a study of CON is forthcoming
- Monitor work of Maryland Health Insurance Coverage Protection Commission

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MARYLAND HEALTH CARE COMMISSION

ACTION:

Approval of Release of APCD Data
University of Massachusetts

(Agenda Item #5)

MCDB Data Release

University of Massachusetts Amherst, School of Public Health and Health Sciences

April 20, 2017

Dr Kimberley Geissner, Assistant Professor is the applicant for release of the 2015 MCDB

MARYLAND HEALTH CARE COMMISSION

Overview

- Review and vote on application for the MCDB Data by the University of Massachusetts, School of Public Health and Health Sciences
- Criteria for evaluation of application
- UMass SPHHS application details

Framework Criteria

Appropriate use of data

- Is it a permitted use?
- Is the data appropriate for the project?

Qualified user

- Does the applicant have expertise with this type of data?
- Does the applicant have expertise with the specified analyses/projects?

Data Security / Data Management Plan

- Is there an appropriate plan for securing the data?
- Is access restricted to qualified users?
- Adherence to limitations on re-release and reporting of data?

University of Massachusetts,
School of Public Health and Health Sciences Application

Data request is for Commercial data for CY 2015

MCDB Standardized Research Identifiable file contains eligibility records and claims files (professional services, institutional and pharmacy)

- No direct identifiers in the data such as name, SSN, birthdate, address
- Indirect identifiers include gender, age at the end of the reporting year, patient zip code and dates of service
- Member ID's are encrypted by the payer and re-encrypted by SSS to permit linking across MCDB files
- DUA prohibits linking beyond MCDB files at the member level
- DUA prohibits re-identification of members
- No individual payor identification

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Chesapeake IRB Waiver of Informed Consent

"Effects of Utilization Patterns and Coordination of Care on Outcomes" was determined to not constitute human subject research and thus does not require IRB oversight

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(Agenda Item #7)

Maryland Surgical Service Trends

Hospitals and Non-Hospital Surgical Facilities

2008 - 2015

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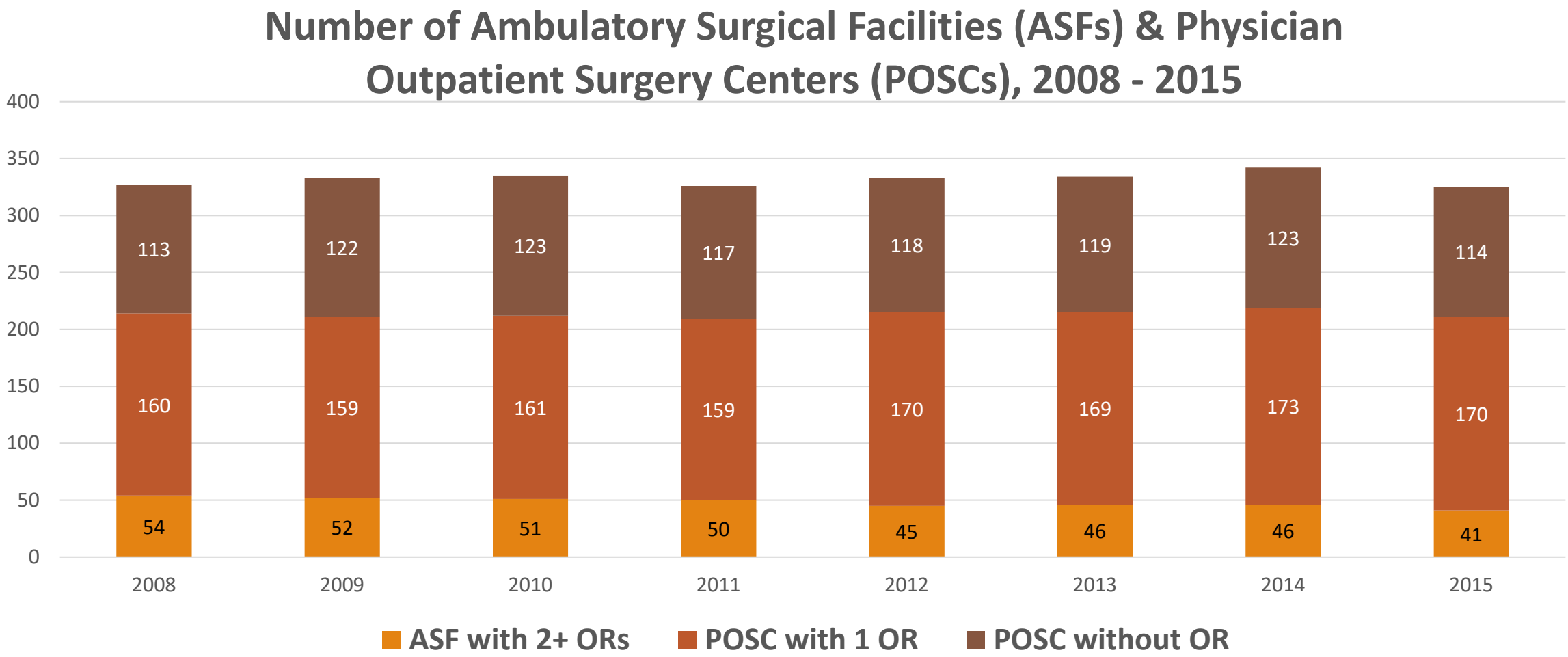
Contents

- Surgical Facilities
- Use of Surgical Facilities
- Surgery Use Rates
- Surgical Case Mix
- Payer Mix for Surgery

Data Sources

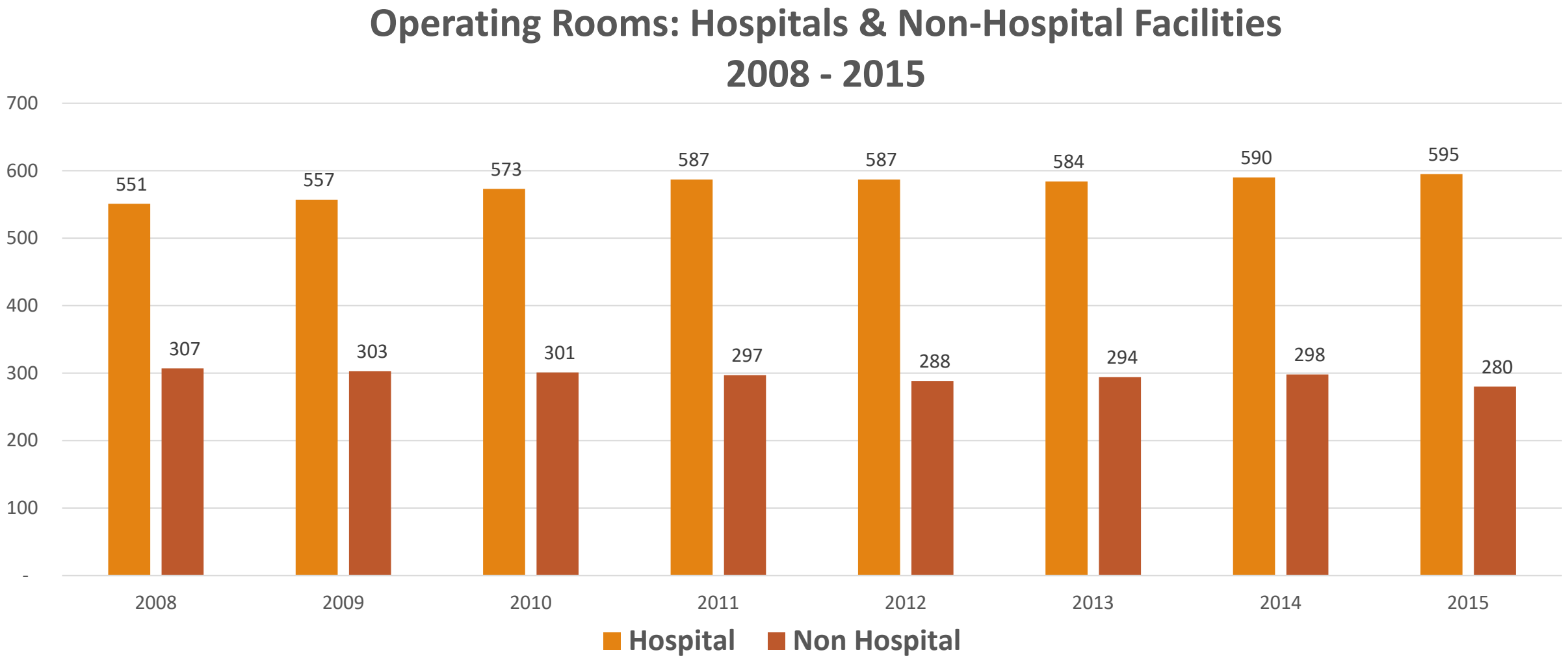
- HSCRC Inpatient Files
- HSCRC Outpatient Files
- MHCC Annual Ambulatory Surgery Survey
- MHCC Annual Hospital Supplemental Survey
- U.S. Census Bureau Population Estimates

Surgical Facilities



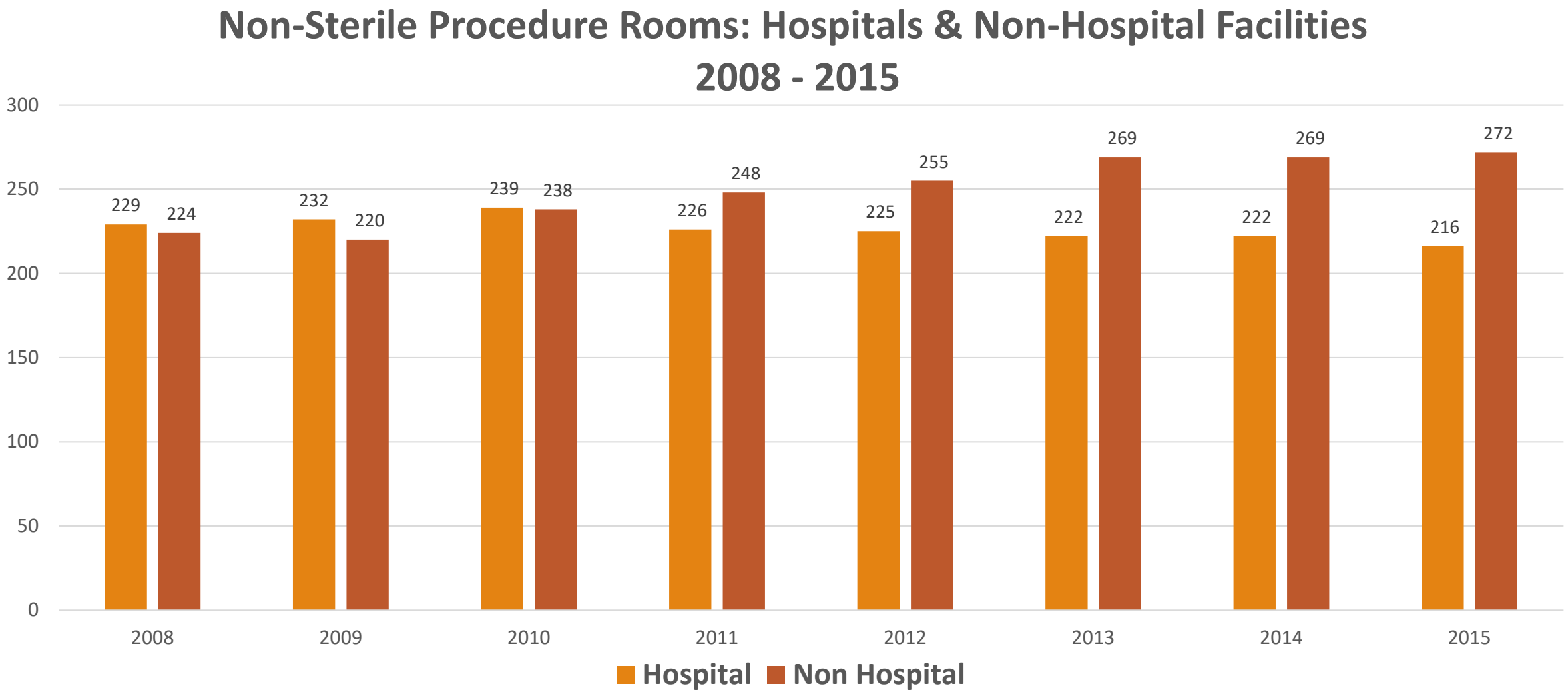
46-47 general hospitals providing surgery in Maryland during this time period.

Operating Rooms (ORs)



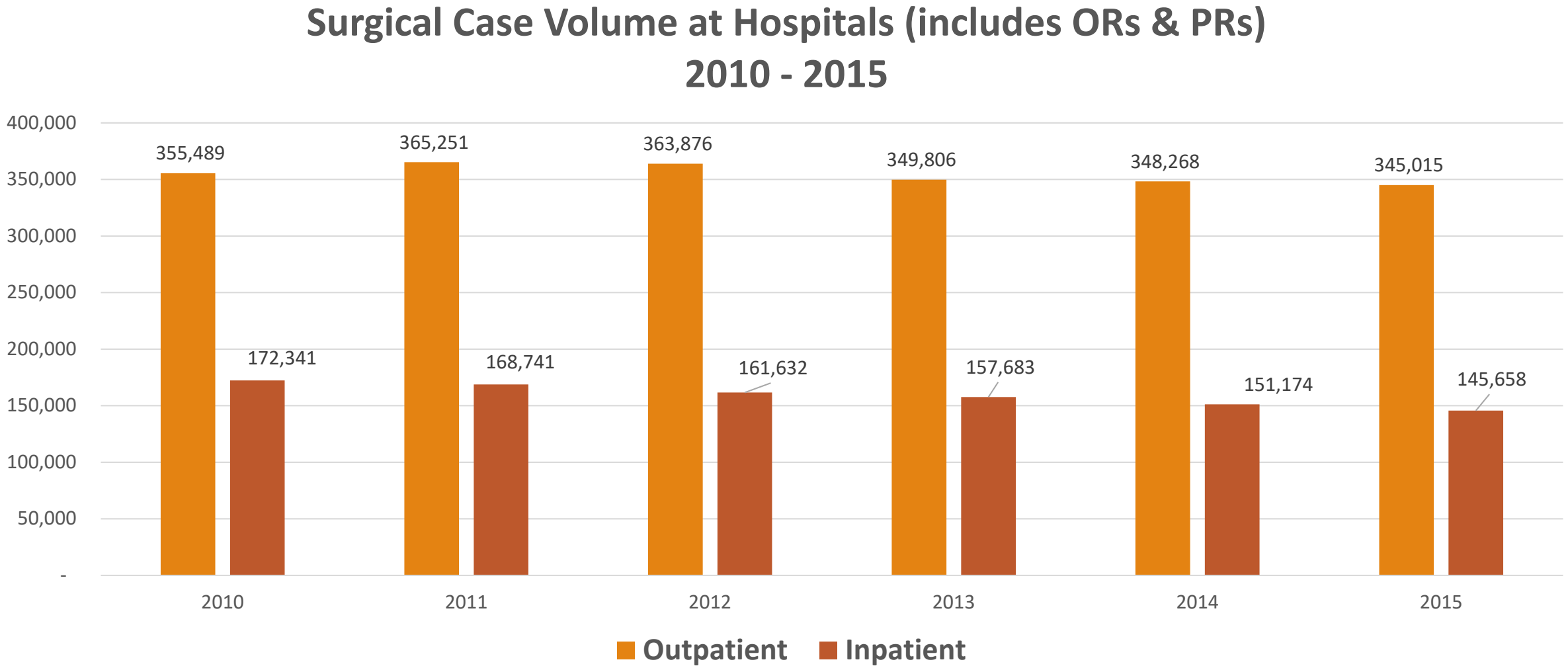
OR supply in hospitals and in non-hospital settings with 2+ ORs is regulated.

Procedure Rooms (PRs)



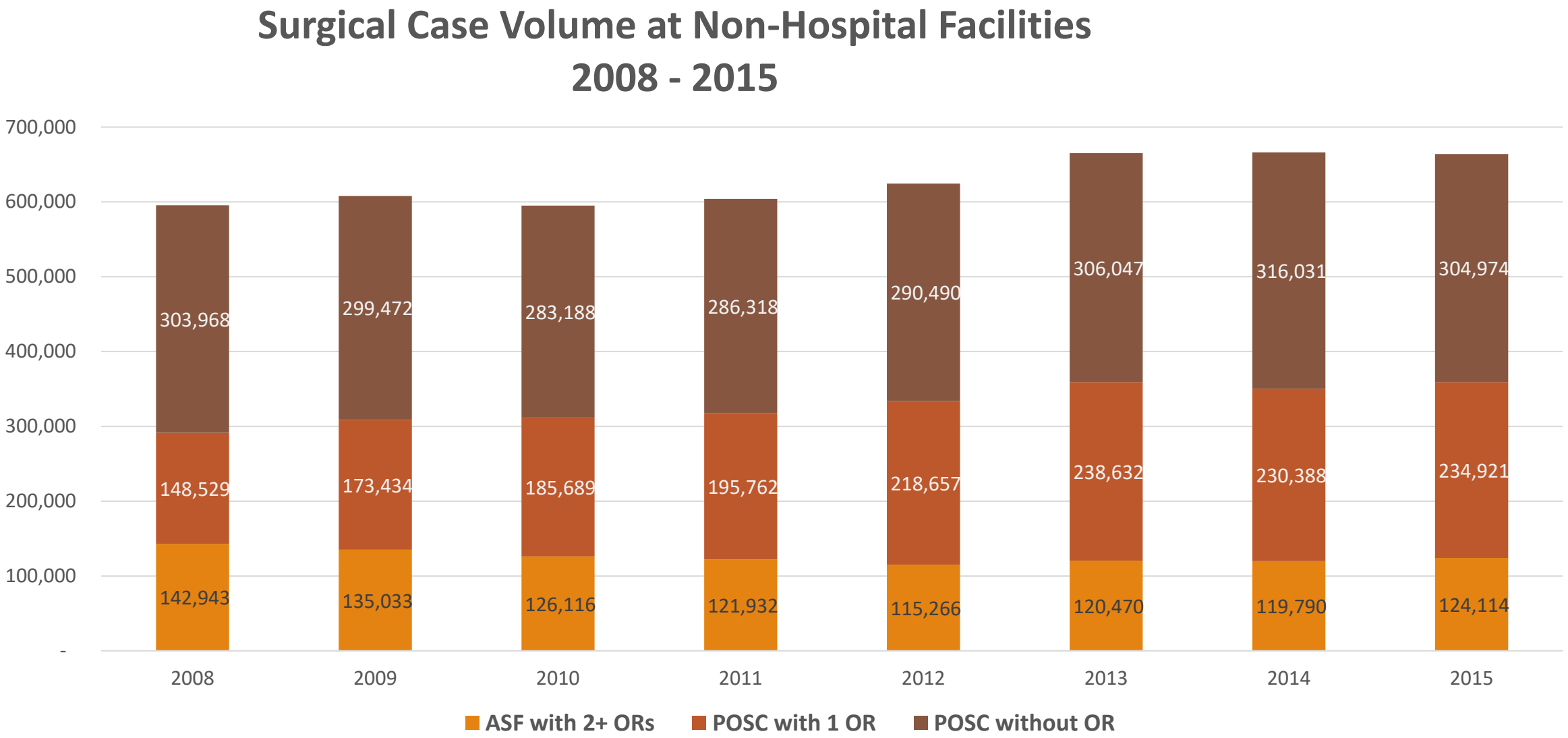
MHCC does not regulate the supply of procedure rooms.

Case Volume at Hospitals

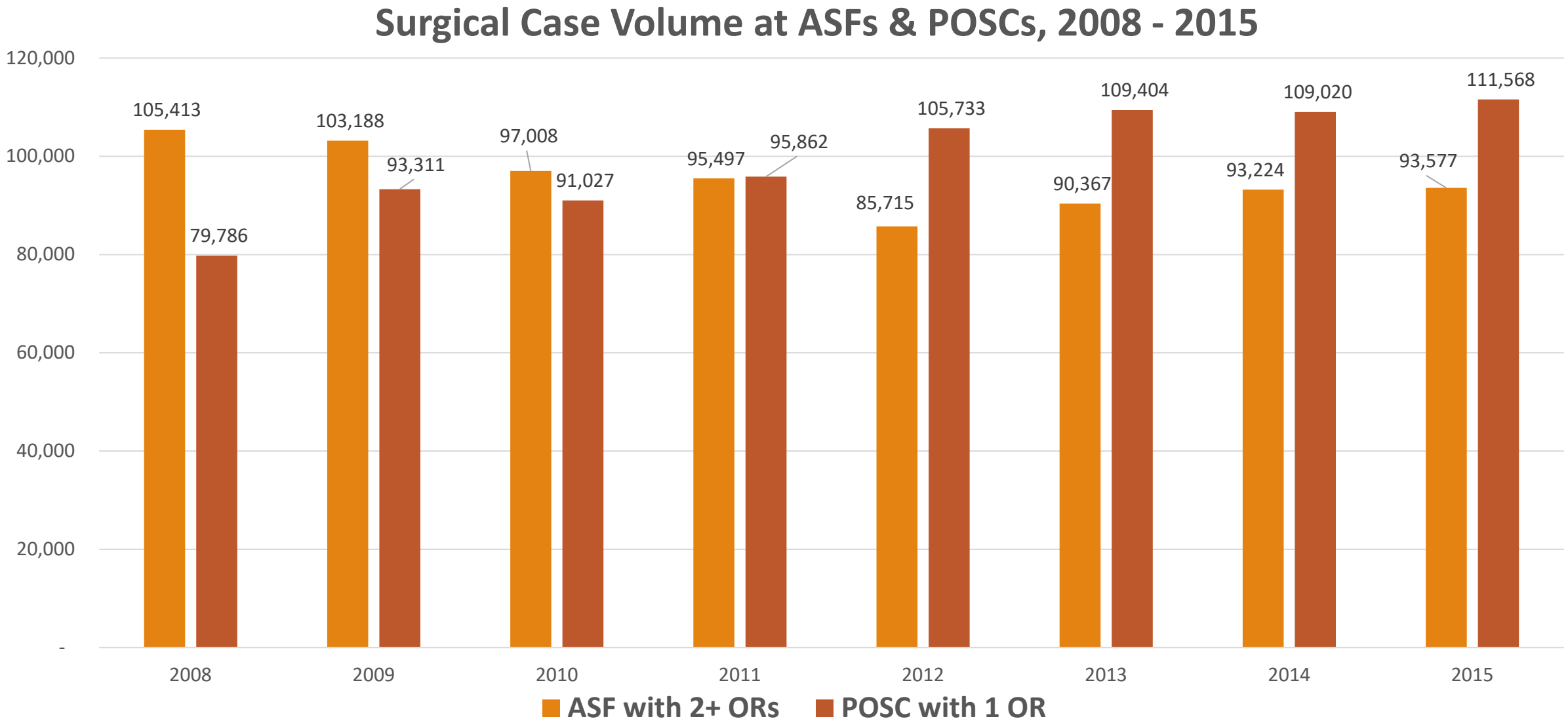


Count of cases with an "operating room" rate center charge.

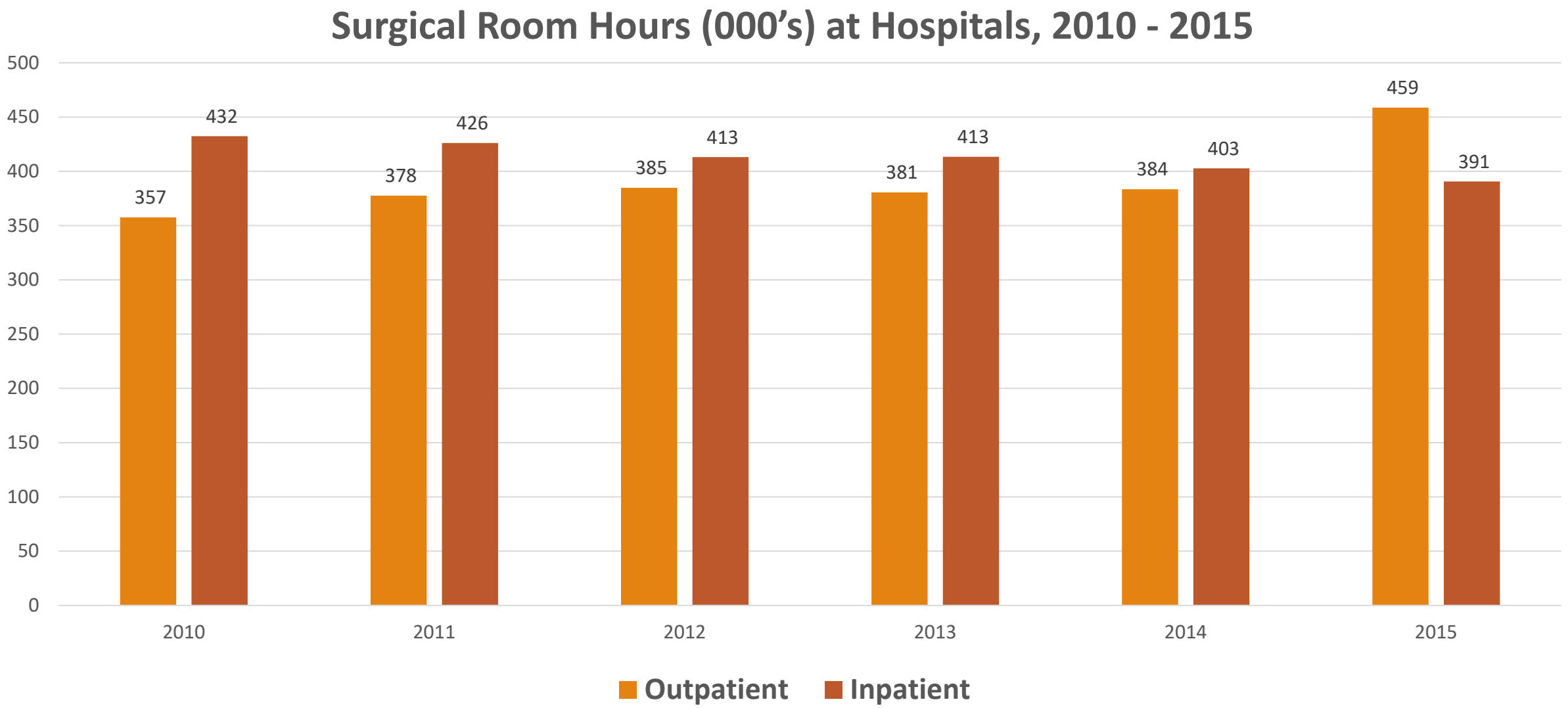
Case Volume at Non-Hospital Facilities



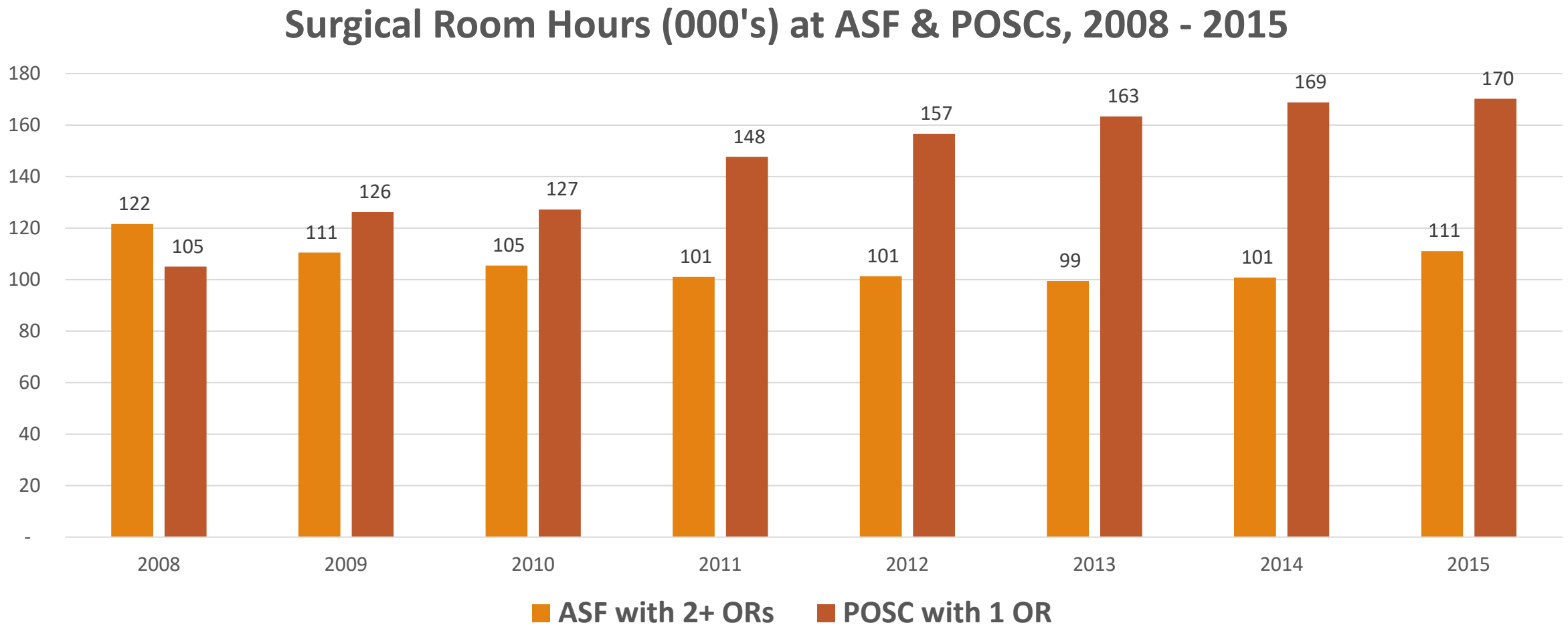
Operating Room Case Volume at ASFs and POSCs



Total OR/PR Hours at Hospitals

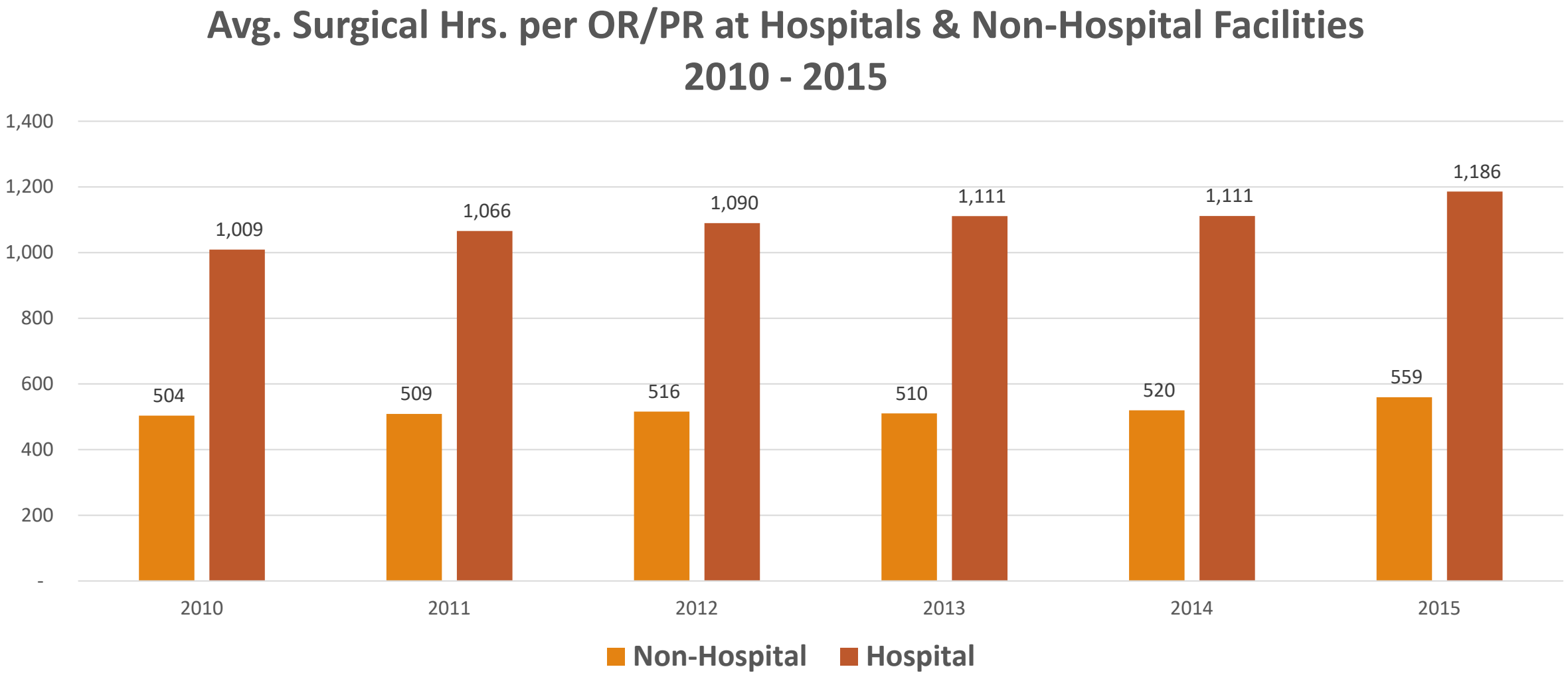


Total OR/PR Hours at ASFs and POSCs

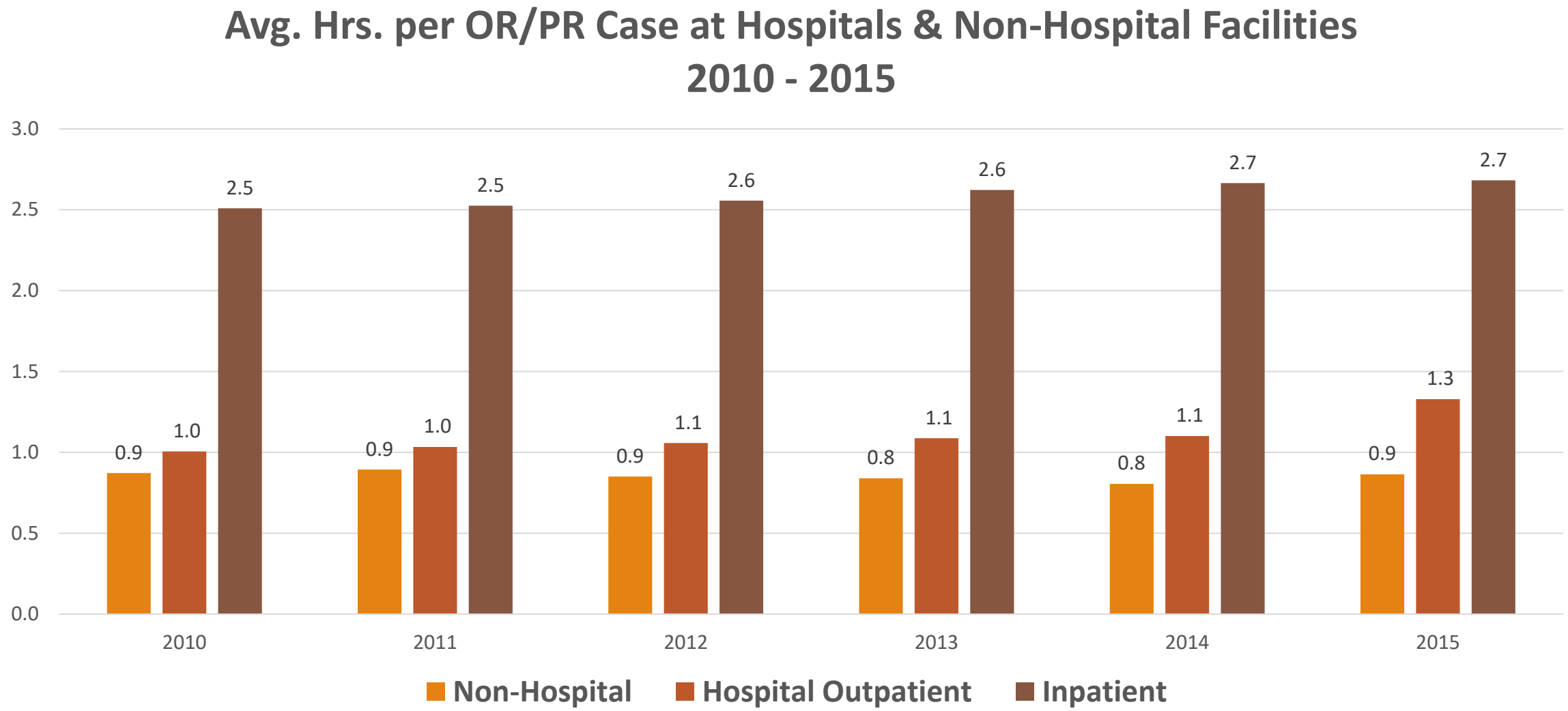


About 5% of facilities with extreme outlier values excluded.

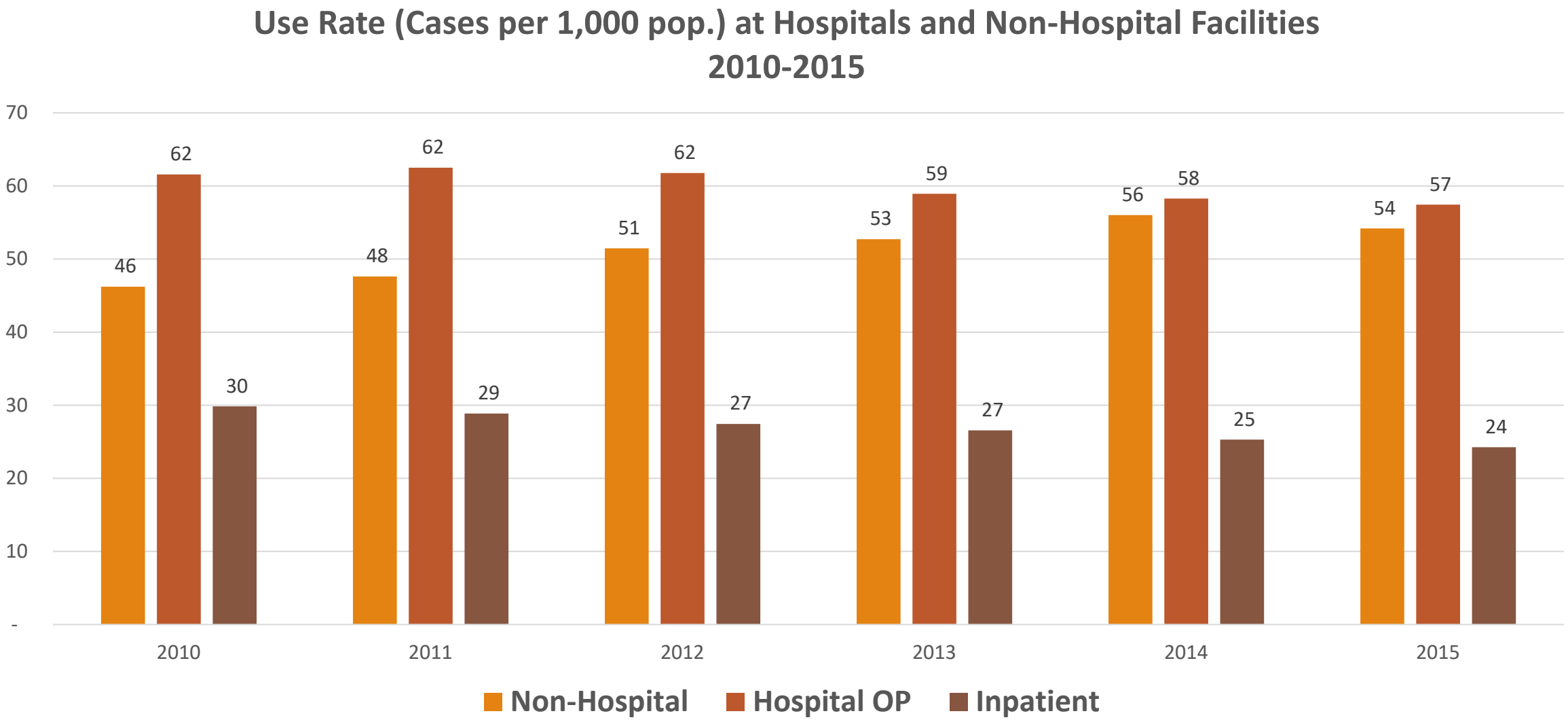
Average Surgical Hours per Room



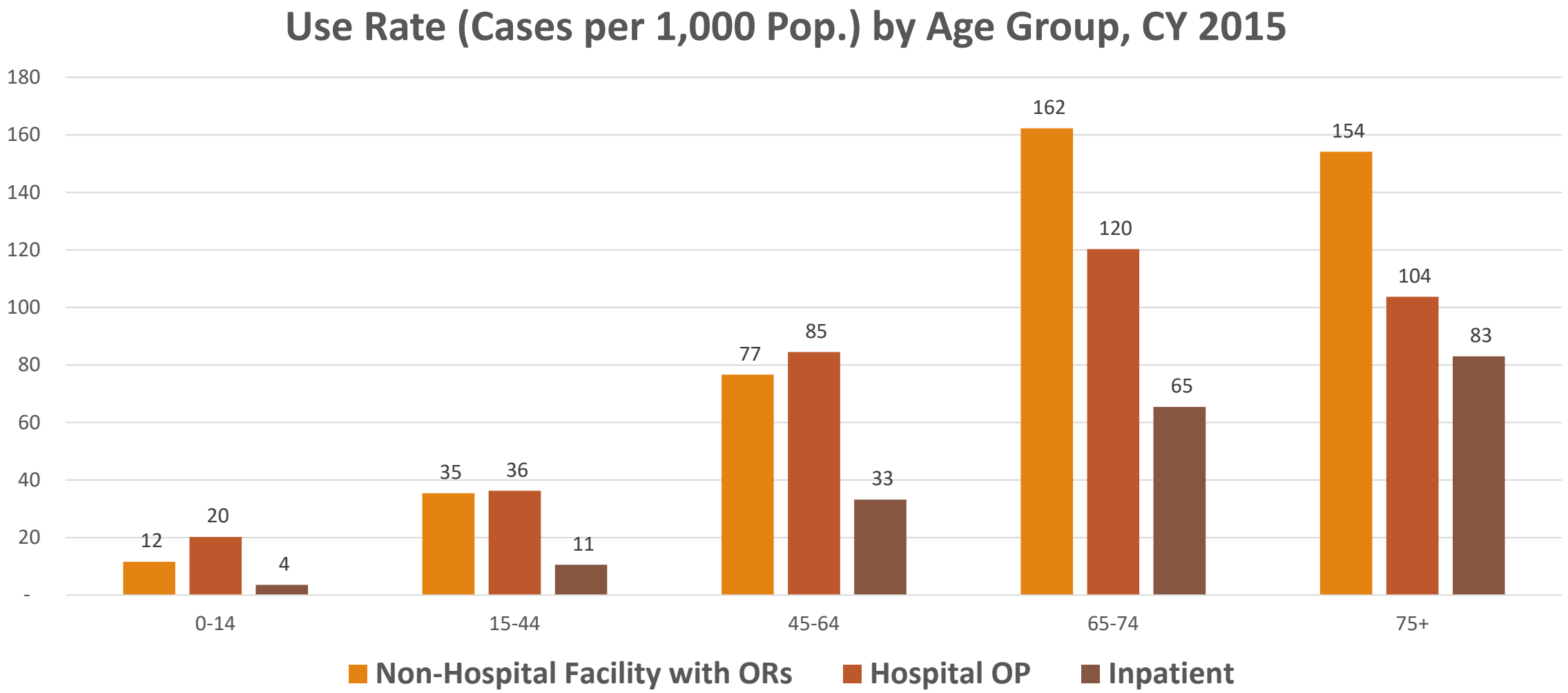
Average Surgical Hours per Case



Surgical Use Rate (includes ORs and PRs)

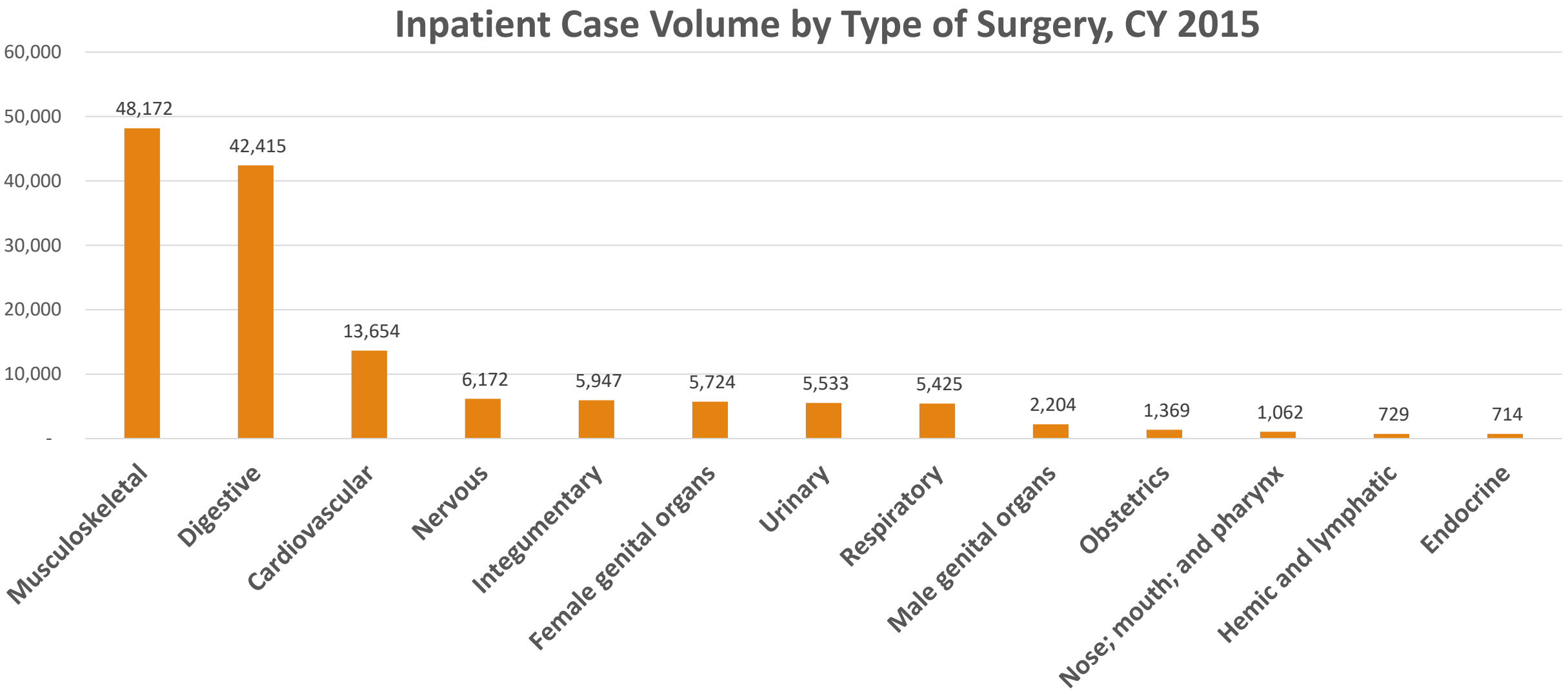


Surgical Use Rate by Age (includes ORs and PRs)



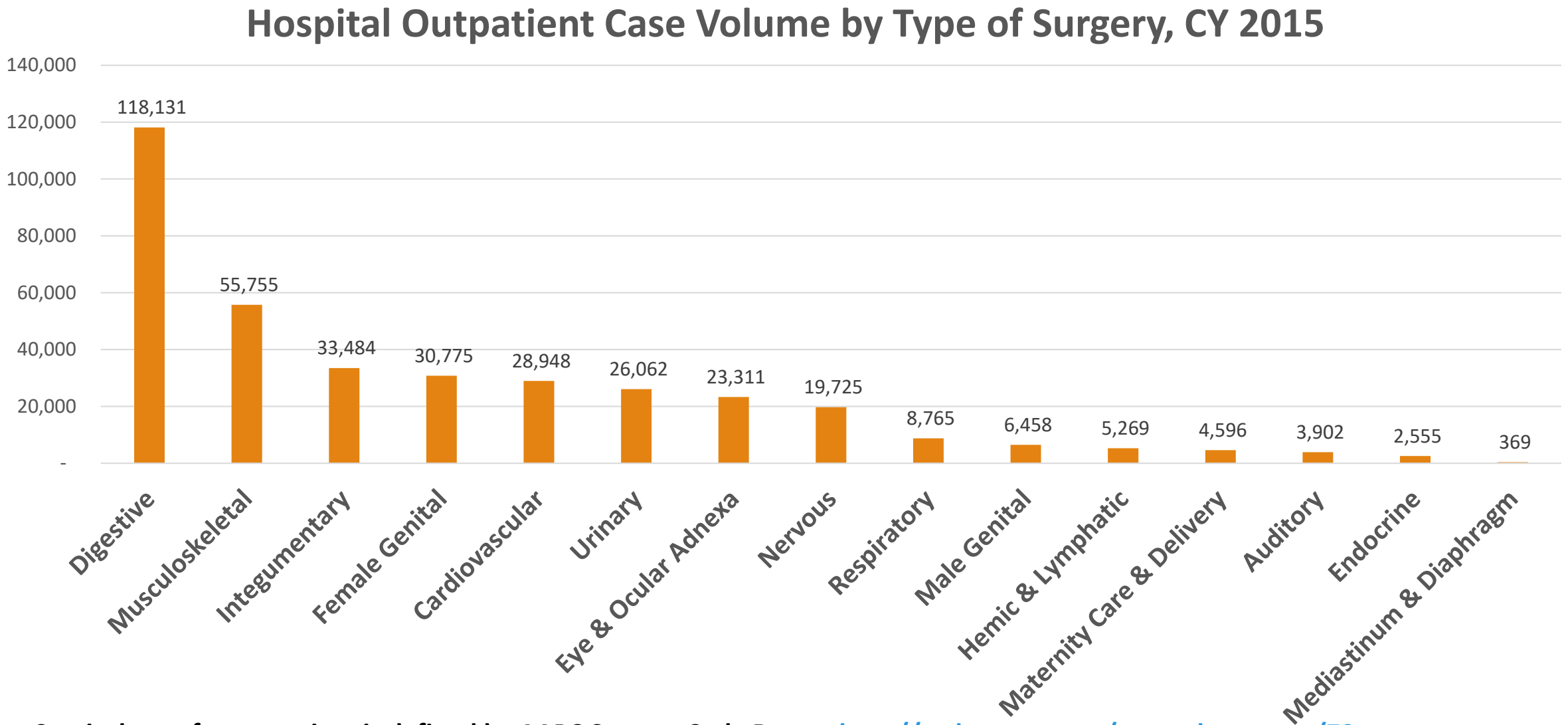
About 43% of non-hospital cases are PR cases; PR proportion of hospital cases unknown.

Surgical Case Mix – Inpatient



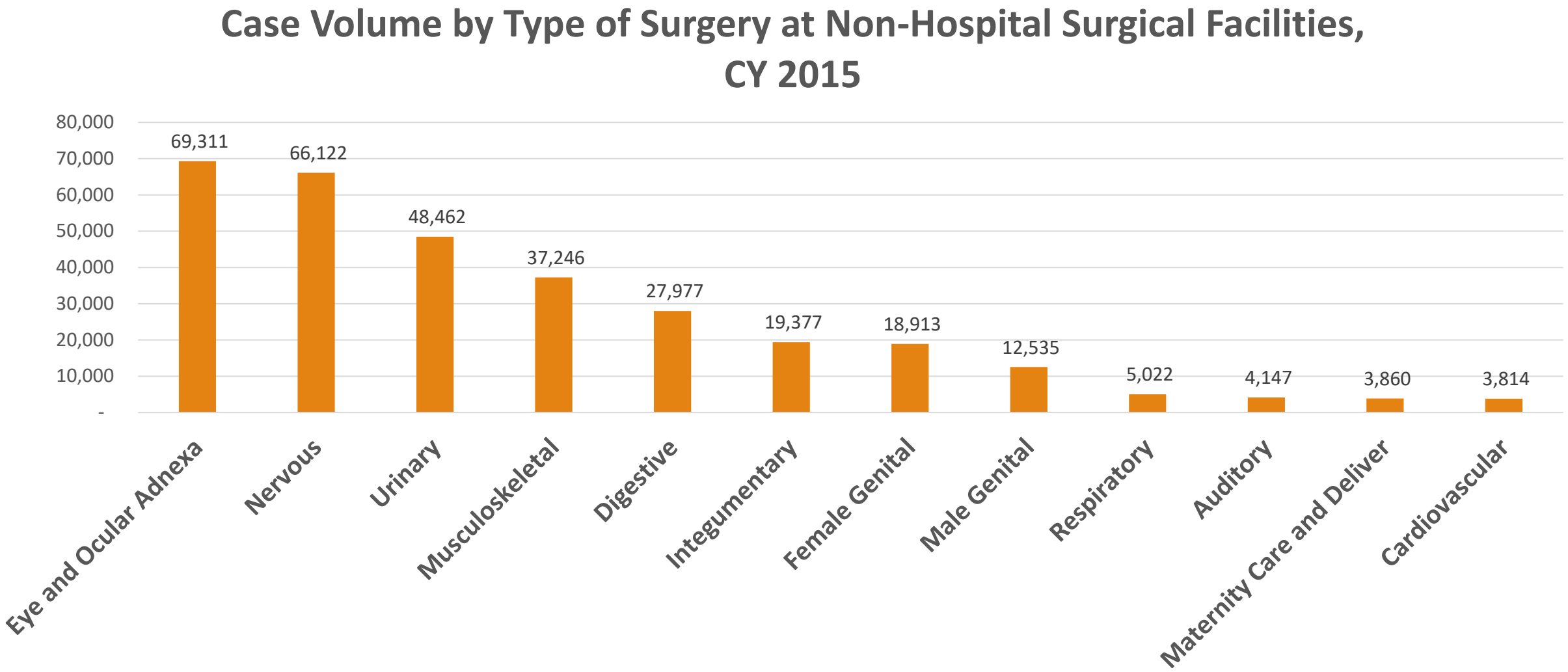
Surgical type for inpatient is defined by HCUP Clinical Classifications Software for ICD 9 and ICD 10 procedure codes.

Surgical Case Mix – Hospital Outpatient



Surgical type for outpatient is defined by AAPC Surgery Code Range: http://coder.aapc.com/cpt-coders-range/79

Surgical Case Mix – Non-Hospital



Based on reported 30 most frequently occurring principle CPT codes. (Includes facilities with ORs only)

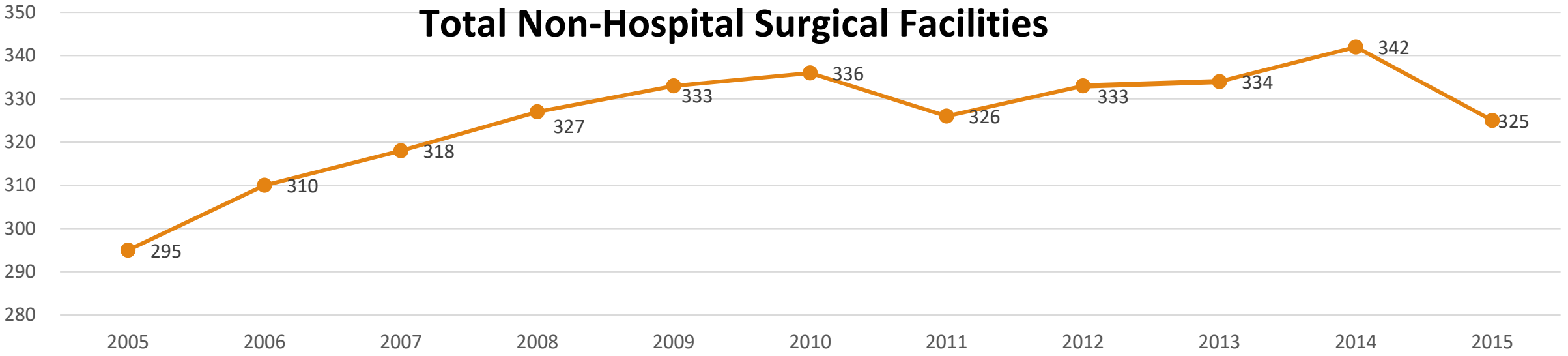
Self-Reported Facility Specialties at ASFs and POSCs

Specialty	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Total Cases	501,893	522,612	560,473	595,255	607,939	594,993	604,012	623,413	665,149	666,209	659,008
Gastro, Colon and Rectal	40%	43%	41%	41%	38%	37%	38%	37%	38%	36%	35%
Pain Management	10%	11%	13%	14%	17%	17%	17%	18%	18%	20%	19%
Ophthalmology	10%	10%	10%	10%	10%	11%	11%	11%	11%	11%	12%
Urology	14%	12%	12%	13%	12%	11%	12%	11%	11%	10%	11%
Orthopaedic	5%	6%	5%	5%	5%	6%	6%	6%	6%	6%	7%
Top 5 Specialties	80%	82%	82%	83%	82%	81%	83%	84%	84%	84%	83%

Includes all facilities, with and without operating rooms.

Number of Non-Hospital Surgical Facilities by Type of Facility

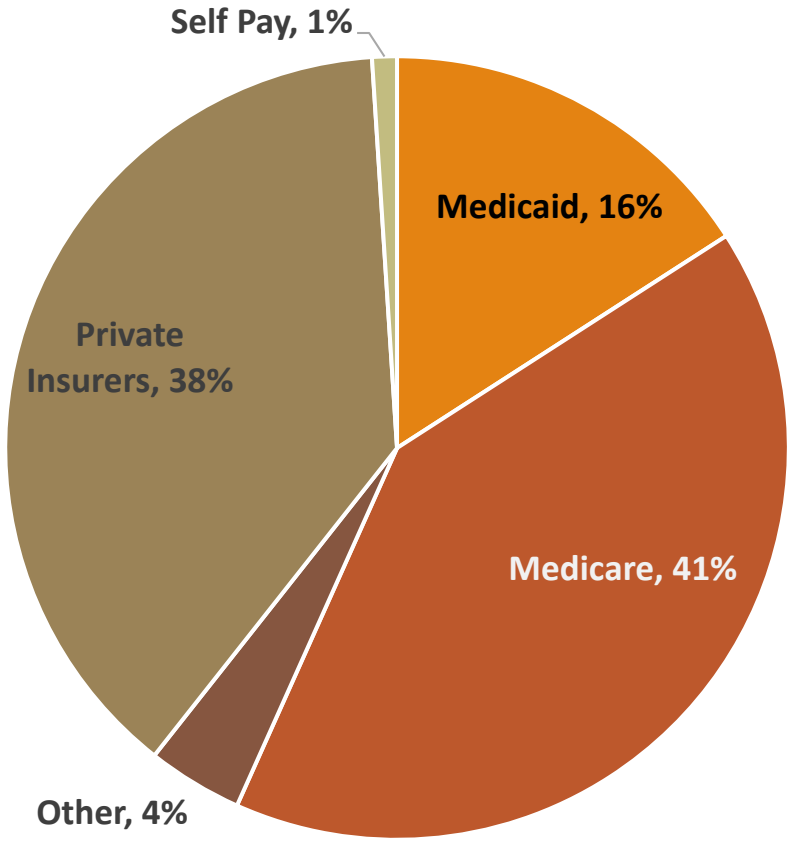
Type of Specialty	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Single Specialty	226	240	247	253	257	258	247	250	246	253	237
Limited Specialty	36	34	31	35	32	30	24	28	29	30	34
Multi-specialty	33	36	40	39	44	47	55	54	59	59	54
Total	295	310	318	327	333	335	326	332	334	342	325



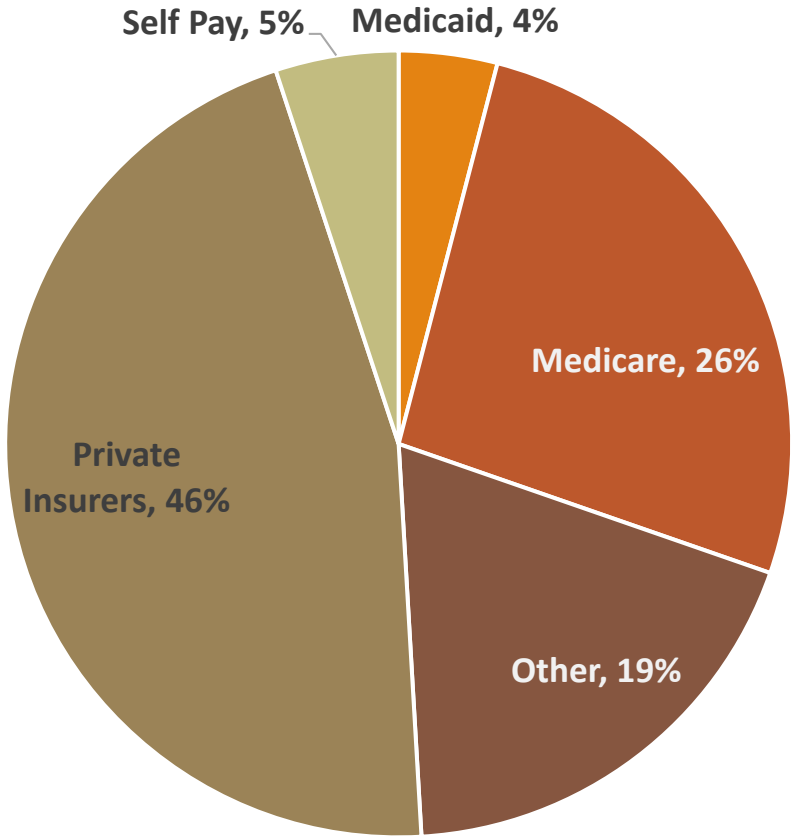
Limited specialty: 2-3 specialties reported; Multi-specialty: 4+ reported.

Payer Mix

Percent of Total Charges at Hospitals, CY 2015



Percent of Total Net Revenue at Non-Hospital Surgical Facilities, CY 2015



Includes all facilities, with and without operating rooms.

Hui Su, Methodologist

Paul Parker, Director

Center for Health Care Facilities Planning & Development

hui.su@maryland.gov

paul.parker@maryland.gov

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MARYLAND HEALTH CARE COMMISSION

Draft State Health Plan Chapter for General Surgical Services (COMAR 10.24.11) for Consideration as Proposed Permanent Regulations

Maryland Health Care Commission
April 20, 2016

Informal Comments Received

Organizations

- Anne Arundel Medical Center (AAMC)
- Johns Hopkins Medicine (JHM)
- Maryland Ambulatory Surgical Association (MASA)
- Maryland Hospital Association (MHA)
- Maryland Society of Anesthesiologists (MSA)
- MedStar Health (MedStar)
- University of Maryland Medical System (UMMS)

Individuals

- Mark Artusio, M.D.
- Donald Bartnick
- Steven J. Brand, M.D.
- Tina Dimarino
- Hae Lin Retz, B.S.N.
- Bert Williams, M.D.
- Ravi Yalamanchili, M.D.

Exemption from Certificate of Need Review for Establishment of an Ambulatory Surgical Facility

Comments on .06A Applicability

- AAMC, MHA, and MedStar Health proposed that a hospital be allowed to relocate two operating rooms (ORs) from a hospital to an unregulated ambulatory surgical facility (ASF) through a CON exemption process.
- MedStar Health expressed concern that physician outpatient surgery centers (POSCs) could double their OR capacity resulting in greater inefficiencies because of spreading surgical cases over a larger number of ORs.

Recommendation

Staff recommends no changes in response to these comments.

Exemption from Certificate of Need Review for Establishment of an Ambulatory Surgical Facility

Other Comments on .06A Applicability

- UMMS commented that a hospital converting to an FMF that seeks an exemption to establish an ASF should be allowed to file at any time before a hospital converting to an FMF actually closes.

Recommendation

Staff recommends modifying the language in .06A(3) to allow some flexibility as requested by UMMS.

.06A Applicability

Revised standard (new text underlined):

(3) A general hospital that seeks to convert to a freestanding medical facility may be issued an exemption that permits it to establish an ambulatory surgical facility with two operating rooms on the same campus as the freestanding medical facility or immediately adjacent to the freestanding medical facility, if it seeks such an exemption ~~in conjunction with an exemption to convert to a freestanding medical facility~~.:

(a) In conjunction with an exemption to convert to a freestanding medical; or

(b) After the issuance of an exemption to convert a general hospital to a freestanding medical facility and prior to the closure of the general hospital.

Exemption from Certificate of Need Review for Establishment of an Ambulatory Surgical Facility

Comments on .06C(1) Need

- JHM proposed eliminating this standard.
- MASA, MHA, AAMC, and Mr. Donald Bartnick proposed greater flexibility in the way that optimal utilization is evaluated.
- MedStar Health did not comment directly on this standard, but it expressed concerns about creating inefficiencies by giving POSCs the opportunity to add a second OR through an exemption process.

Recommendation

Staff recommends revisions to .07A(1)(b) to allow for some flexibility in the capacity assumptions used for dedicated outpatient general purpose operating rooms.

.07A(1)(b) Dedicated Outpatient General Purpose OR

Current Standard:

(i)Is expected to be used for a minimum 255 days per year, 8 hours per day;

(ii)Has full capacity use of 2,040 hours per year, which includes the time during which surgical procedures are being performed and room turnaround time between surgical cases; and

(iii) Has optimal capacity of 80 percent of full capacity, which is 1,632 hours per year, which includes the time during which surgical procedures are being performed and room turnaround time between surgical cases;

.07A(1)(b) Dedicated Outpatient General Purpose OR

Revised Standard (underlined text is new):

(iii) Has optimal capacity of 80 percent of full capacity, which is 1,632 hours per year, which includes the time during which surgical procedures are being performed and room turnaround time between surgical cases; unless an applicant demonstrates that a different optimal capacity standard is applicable based on:

1. Economies of scale available for two or more dedicated general purpose outpatient operating rooms;

2. An analysis of the cost-per case of operating at a range of utilization levels that includes the applicant's proposed optimal capacity standard, the standard described in .07A(1)(b)(iii), and utilization levels between these two standards, and that explains the basis of each assumption used in the analysis; and

3. The ability of the ASF to maintain patient safety and quality of care at the proposed optimal capacity standard.

Exemption from Certificate of Need Review for Establishment of an Ambulatory Surgical Facility

Comments on .06C(3) Location

- UMMS recommended that greater flexibility be allowed for the location of an ASF established in conjunction with a hospital conversion to a freestanding medical facility.

- MHA expressed support for the standard.

Recommendation

Staff recommends allowing slightly greater flexibility in the location of an ASF established in conjunction with a hospital conversion to a freestanding medical facility.

.06C(3) Location

Revised standard (new text is underlined):

An applicant proposing to establish an ASF by adding an OR to the applicant's existing POSC may only locate the proposed ASF:

(i) At the current location or an immediately adjacent location; or

(ii) If an applicant demonstrates that it is not feasible for the proposed ASF to be established at its current ~~or immediate~~ location~~, then~~ or at an immediately adjacent location, it may propose establishment of the proposed ASF at a nearby location, as defined in Regulation .08 of this Chapter.

- Nearby, as defined in Section .08, means a site that can be reached from the reference site by crossing no more than one public thoroughfare.

.06C(5) and .05B(7)(b) Construction Costs

- Commission staff recommends modifying the standard for evaluating construction costs of an ASF for CON exemption requests and CON reviews.

- The Marshall Valuation Service (MVS) standards would apply only to new construction. MVS standards would not be used for evaluating the reasonableness of the costs of renovation or fitting out space.

Certificate of Need Standards: Comments and Recommendations

Comments on .05A(3) Charity Care Policy

- MHA and UMMS recommended that hospitals only be subject to the requirements of HSCRC.
- MedStar commented that any duplicative regulatory requirements for charity care should be deleted.

Recommendation

Staff recommends no changes in response to these comments.

Certificate of Need Standards: Other Staff Recommendations

Quality of Care - COMAR 10.24.11.05A(4)

Staff recommends modifying this standard to allow for consideration of performance standards publically reported other than those used by the Centers for Medicare and Medicaid.

The following new language has been proposed:

(iii) A provider of quality services, as demonstrated by its performance on publicly reported performance measures, including quality measures adopted by the Centers for Medicare and Medicaid Services.

Request for Approval

Staff requests that the Commission adopt draft COMAR 10.24.11, the General Surgical Services Chapter of the State Health Plan, as proposed permanent regulations and repeal current COMAR 10.24.11, contingent on proposed COMAR 10.24.11 becoming effective.

MARYLAND HEALTH CARE COMMISSION

AGENDA

1. CLOSED SESSION

2. APPROVAL OF MINUTES

3. UPDATE OF ACTIVITIES

4. **OVERVIEW:** Legislative Wrap Up

5. **ACTION:** Approval of Release of APCD Data – University of Massachusetts

6. **ACTION:** Certificate of Need – Kaiser Foundation Health Plan of the Mid-Atlantic State, Inc., d/b/a Kaiser Permanente Gaithersburg Medical Center (Docket No. 17-15-2390)

7. **ACTION:** Proposed Regulations – COMAR 10.24.11 – State Health Plan for Facilities and Services – General Surgical Services

8. **ACTION: Final Regulations – COMAR 10.25.02 – User Fee Assessment of Health Care Practitioners, and COMAR 10.25.03 – User Fee Assessment of Payers, Hospitals, and Nursing Homes**

9. **UPDATE:** Maryland Health Care Quality Reports Website

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    - Findings from Round 2
    - Shore Regional (telehealth) and Johns Hopkins Pediatrics at Home (mHealth) Go Live Demo

11. Overview of Upcoming Initiatives

12. ADJOURNMENT

MARYLAND HEALTH CARE COMMISSION

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Final Regulations – COMAR 10.25.02 – User Fee Assessment of Health Care Practitioners, and COMAR 10.25.03 – User Fee Assessment of Payers, Hospitals, and Nursing Homes

(Agenda Item #8)

Final Regulations – COMAR 10.25.02 – User Fee Assessment of Health Care Practitioners, and COMAR 10.25.03 – User Fee Assessment of Payers, Hospitals, and Nursing Homes.

April 20, 2017

INTRODUCTION

Senate Bill 786 – "Department of Health and Mental Hygiene – MHCC –Modifications and Clarification" passed during the 2001 Legislative Session requires the Commission, every four years, to study and make recommendations on the appropriate funding level for the Commission and user fee allocation among those currently assessed by workload;

- Remove from statute, industry allocations, and incorporate into regulation;
- Adopt regulations to permit a waiver of the fee to certain health care practitioners who earn an average hourly wage substantially below that of

  other health care practitioners

The Workload Study was presented and approved at the December, 2016 Commission meeting.

BACKGROUND OF ASSESSMENT MECHANISM

Current Allocations

- Payers – 28%
- Nursing Homes – 17%
- Hospitals/Special Hospitals – 33%
- Health Occupational Boards – 22%

Based on Re-allocation of Costs for each industry outlined in the Workload Study Report submitted to the Legislature in January, 2017:

- Payers – 26%
- Nursing Homes – 19%
- Hospitals – 39%
- Health Occupational Boards – 16%

- The amount of an individual entity's assessment is derived differently for each group assessed.

BACKGROUND OF AVERAGE ANNUAL WAGE – Waiver Process – Health Occupation Boards

The average annual wage as determined in the Workload Study was:

$38,629/grade 14 on salary scale

The following health care practitioners are currently assessed:

Chiropractors; Dietitians/Nutritionists, Occupational Therapists, Social Workers, Speech Language Pathologists, Nurses, Podiatrists, Physical Therapists, Physicians, Psychologists, Pharmacists, Optometrists, Professional Counselors and Therapists, Dentists, Massage Therapists, and Acupuncturists

The following health care practitioners remain excluded from the assessment:

Occupational Therapist Assistants, Social Worker Associates, LPNs, Nurse Psychotherapists, Nurse Assistants, Physical Therapy Assistants, Psychology Associates, Dental Hygienists, Psychiatric Assistants, and Dental Assistants

Staff Recommendations

- COMAR 10.25.02 – User Fee Assessment of Health Care Practitioners and COMAR 10.25.03 – User Fee Assessment of Payers, Hospitals and Nursing Homes were published in the Maryland Register on February 3, 2017 with the Public Comment period ending on March 3, 2017.

  There were no comments received

  Staff recommends approving COMAR 10.25.02 AND COMAR 10.25.03 as final regulations.

MARYLAND HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

UPDATE:

Maryland Health Care Quality Reports Website

(Agenda Item #9)

MARYLAND HEALTH CARE COMMISSION

AGENDA

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12. ADJOURNMENT

MARYLAND HEALTH CARE COMMISSION

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Health Information Technology Grant

a. Findings from Round 2

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(Agenda Item #10)

MHCC Telehealth Grants

Round 2: Remote Patient Monitoring

Brief

April 20, 2017

The MARYLAND
HEALTH CARE COMMISSION

Telehealth Projects

- Eighteen-month projects with a combined total of $80,000 and required a 2:1 match
- Grantees
  - Crisfield Clinic (Somerset) - used mobile devices to help school aged patients manage chronic health conditions (e.g., asthma, diabetes, obesity, etc.)
  - Lorien Health Systems - used RPM to provide 24/7 access to care to patients that were discharged from the skilled nursing facility to home with chronic heart failure, hypertension, and uncontrolled diabetes
  - Union Hospital of Cecil County - used mobile tablets and peripheral devices to monitor patients with chronic health conditions post discharge to reduce prevention quality indicators (PQI)

Key Learning Lessons

Patient Engagement

Continued education and support is required to ensure patients can effectively use RPM technology. Patient are less likely to decline RPM participation when they are engaged prior to discharge. RPM technology that includes patient personal content increases the likelihood of ongoing engagement. RPM is more impactful when monitoring occurs 24/7. School-aged children present unique challenges around participation; family engagement is key. Program adherence screening criteria should be included in patient selection.

Internet Connectivity

The RPM patient selection process should include an assessment of Internet availability and reliability at a patient's home. RPM programs need to consider options for patient monitoring when Internet connectivity challenges emerge. The absence of data collection during Internet outages hinders providers' ability to make clinical decisions. Staff alerts when patient connectivity is lost is essential to monitoring patients; Internet restoration issues can sometimes be addressed by staff.

Technology Selection

RPM is more accepted by providers when implemented as an integral part of care delivery, as opposed to standalone technology. Provider dashboards based on select performance indicators can help accelerate care delivery. Key elements in selecting RPM technology include video conferencing capabilities, integration of information into an EHR, support for clinical workflows, and inclusion of reporting and data analytics. Prioritizing technology attributes in evaluating technology is essential for providers.

Care Management

Relationship building between the patient and provider is important for patient acceptance of RPM. Gaining patient buy-in to use the technology depends largely on the provider's level of comfort with the technology. When patients see providers struggling to use the technology, it can cause uncertainty in patients about its value in care delivery.

Sustainability

Lorien plans to fund their program through a self-pay option for patients. Crisfield expects to fund their program through billable services to Maryland Medicaid and private payors. UHCC intends to fund their program through its operational budget, and will expand it under the Health Services Cost Review Commission's Regional Transformation Grant program.

CHRONIC HEALTH CONDITION MANAGEMENT IN THE SCHOOL-AGE POPULATION USING MOBILE HEALTH (M-HEALTH) DEVICES

Crisfield Clinic – Crisfield, Maryland

Dr. Kerry Palakanis

PROGRAM OVERVIEW

- Project Goal - To utilize mobile health devices in an effort to develop patient data metrics, minimize school absentees, limit emergency room visits, and establish a positive correlation between patient's and their health.
- Targeted population- School aged children with Asthma, Obesity, Diabetes and mental health conditions (ADHD, Depression)
- Community Health Worker (CHW) Role-
  - Communicate with patients
  - Initiate compliance
  - Reduce resource barriers
  - Collect and analyze data from mobile devices
  - Contact patients if data is not within normal range.

PARTICIPANT PROFILES

- Participants = 33
- Gender
  - Male = 17
  - Female = 16
- Diagnosis
  - Asthmatic = 9
  - Behavioral Health = 10
  - Obesity = 14
- Age range = 7-18
- Length of time in program = 12-18 months

COMMUNITY HEALTH WORKER

- Frontline public health workers who have a close understanding of the communities they serve
- The "Bridge Builder" between professional and personable in a healthcare environment
- Provide outreach, education, referral and follow ups, case management, advocacy and home visiting services to those who need an advocate to help them navigate the healthcare system
- Assist individuals and families in developing the necessary skills and resources to improve their health status and self-sufficiency
- Works to break the barrier limiting the children from complete compliance

PROGRAM OUTCOMES – ESTIMATES

- Asthma
  - 57% of patients maintained or improved their peak expiratory flow rate
  - 42% of patients maintained or reduced their rescue inhaler use
- Obesity
  - 71% of patients maintained or improved their BMI
- Mental Health
  - 70% of patients maintained or improved their depression symptoms
  - 100% of patients maintained or improved their medication compliance
- ED visits
  - 100% of patients reduced their ED visits
  - Unknown - patients would have not visited the ED absent the intervention

LESSONS LEARNED

- Have a back up plan
- Individualize approach
- Low interest level in teens
- Parent participation = success
- School System/Telehealth Legislation
- Syncing/Connectivity Important
- Recruiting and retaining participants
- Lack of public exercise facilities
- Funding

QUESTIONS

Utilizing Telehealth to Manage Hospital Prevention Quality Indicators

Presenter: Jim Hummer – VP Home and Community Based Services
– Lorien Health Systems

Program Overview

- **Objective**
  - Combine treatment protocols, care coordination and telehealth technology to reduce re-admissions and admissions to acute care post discharge from a short-term Skilled Nursing Facility stay.

- **Target Specific Diagnosis**
  - Uncontrolled Diabetes
  - Chronic Heart Failure
  - Hypertension

LORIEN AT HOME
Family caring for Families

Program Outcomes

- **Uncontrolled Diabetes**
  - *97% of clients were able to maintain and/or improve their A1C lab values*
  - *52.8% of clients not only maintained their baseline but had A1C lab values below their baseline demonstrating improvements*
  - *It is likely that less than 50% of clients would have maintained and/or improved their A1C lab values absent the intervention*

- **CHF**
  - *96.5% of clients maintained or improved upon their baseline classification score*
  - *It is likely that less than 50% of clients would have maintained or improved upon their baseline classification score absent the intervention*

- **Hypertension**
  - *84% of clients were able to maintain or improve upon their classification score*
  - *32% of clients improved upon their baseline blood pressure scores*
  - *It is likely that less than 50% of clients would have maintained or improved on these indicators absent the intervention*

LORIEN AT HOME
Family caring for Families

Program Outcomes

84% of patients would have not had a re-admission absent the intervention

Hospitalization Rates

- Related-Cause 30 day re-admission rate 0%
- All-Cause 30 day re-admission rate 4.5% (95.5% no re-admission)
- Admission rates:

	Acute Admissions Rates	
	Prior to Telehealth Program	On Telehealth Program
Number of Clients	22	22
Number of Acute Admissions prior 12 months	50	17
Measurement Period – months	12.0	9.8
Annualized factor	0%	81%
Acute Admission Rate Per Year Per Client	2.27	.95
		58% decline

LORIEN AT HOME
Family caring for Families

Program Outcomes

30 Day Re-Admissions	State Average	Telehealth Program	Change
Rate	15.9%	4.5%	-11.4%
Re-Admissions for 22 Clients	3.5	1	-2.5
Charges per Hospital Admission at $10,352	$36,232	$10,352	$25,880
Cost of Telehealth Program $300 PMPM	$0	$6,600	$6,600
Medicare Expenditures	$36,232	$16,952	-$19,280
			-53.21%
Average Annual Hospital Admissions	**Client History**	**Telehealth Program**	**Change**
Rate per client	2.3	1	-1.3
Admissions for 22 Clients	50	22	-28
Charges per Hospital Admission at $10,352	$517,600	$227,744	-$289,856
Cost of Telehealth Program $300 PMPM	$0	$79,200	$79,200
Medicare Expenditures	$517,600	$306,944	-$210,656
			-40.70%

LORIEN AT HOME
Family caring for Families

Lessons Learned

- Client acceptance and use strategies
  - Client and family engagement
  - Client and family education
- Equipment installations in variety of settings
- Value of real time alerts and intervention
- Client and Care Manager relationship
- Utilization of CRISP Query and ENS
- Primary Care engagement

LORIEN AT HOME
Family caring for Families

Questions?

UNION HOSPITAL

Our Values

Caring & Compassion • Integrity • Leadership • Shared Learning

Project Scope

- Patients were selected based upon clinical and utilization indicators
  - Chronic conditions
    - Congestive heart failure
    - COPD
    - Diabetes mellitus
    - Wounds
    - Medication management
  - Utilization indicators
    - ED usage
    - Unscheduled physician office visits
    - Three or more hospitalizations/year
    - Recent stays in comprehensive care facility

Outcomes

- Patient outcomes
  - 30 Day Telehealth Patients readmission rate*= 0.02%
  - 30 Day Hospital Patients readmission rate =10.94%
- CRISP utilization increased
- *Positive patient satisfaction scores*

Outcomes (continued)

- Financial impact
  - 44 potential 30 day readmissions avoided as a result of this program.
  - It is likely that no patient would have avoided a readmission absent the intervention
  - Average PAU cost = $7000.
  - UHCC spent $60,000 to implement and manage the program.
  - Potential avoidable utilization cost as a result of this program is $248,000 [$7000x44-$60,000].
  - Participation in the program helped patients gain valuable information about how to manage their medical condition(s). This may be particularly true for patients with COPD as only nine of them were readmitted to the hospital after the program completion.

Lessons Learned

- Patients needed to be in the program for at least 60 days in order to more effectively incorporate the technology in their daily routines;
    - Patients in the program less than 30 days had a higher readmission incidence;
    - Patients began to understand how to minimize the impact of their medical condition through monitoring their vital signs and weight;
- The caregiver portal provided the transition of care case managers with almost real-time information about the patients allowing them to contact the patient and primary care givers in a timely manner;
- The utilization of blue-tooth enabled kitted devices resulted in a more efficient on-boarding process;
- Successful administration of the program could have benefited with at least three full time staff;


why
when
what
QUESTIONS
who
how
where
?

Thank You!

The MARYLAND
HEALTH CARE COMMISSION

MARYLAND HEALTH CARE COMMISSION

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(Agenda Item #10)

Telehealth Palliative Care and Mental Health: Technology Demonstration

April 20, 2017

The MARYLAND HEALTH CARE COMMISSION

Project Review

- Awarded to University of Maryland Shore Regional Health (UMSRH)
- Telehealth Palliative Care
  - Project: Implement telehealth to provide palliative care services to patients within University of Maryland Shore Medical Center at Chestertown (UMSMC-C) and Shore Nursing and Rehabilitation Center at Chestertown
  - Goals: Increase access to palliative care services while decreasing preventable hospital encounters
- Telepsychiatry
  - Project: Via telehealth, provide ED psychiatric services at UMSMC-C and Shore Regional Emergency Center at Queen Anne's and inpatient psychiatric consultations at UMSMC-C
  - Goals: Increase access to psychiatric services and decrease ED wait times or transfers for psychiatric assessment

Demonstration of Telehealth Technology

Thank You!

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(Agenda Item #10)

mHealth Technology Live Demonstration

April 20, 2017

The MARYLAND HEALTH CARE COMMISSION

Project Review

- Awarded to Johns Hopkins Pediatrics at Home
  - Partnered with Quantified Care to develop the mHealth Technology
- Uses a mobile, multimedia software platform to manage 75 inner city pediatric asthma patient receiving care at East Baltimore Medical Campus
- Technology enables secure communication between a patient and nurse, regular health assessments, and real-time clinical, motivational, and education feedback
- Supports weekly check-in assessments, nurse monitoring, daily/weekly notifications, ongoing education, and real-time care support
- Facilitates the use of the patient's Asthma Action Plan to identify actions and risk factors on a per-patient basis

Demonstration of mHealth Technology

Thank You!

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MARYLAND HEALTH CARE COMMISSION

Overview of Upcoming Initiatives

(Agenda Item #11)


ENJOY THE REST OF
YOUR DAY