State Innovation Models (SIM) Initiative: Community Integrated Medical Home

Briefing to the Health Care Reform Coordinating Council
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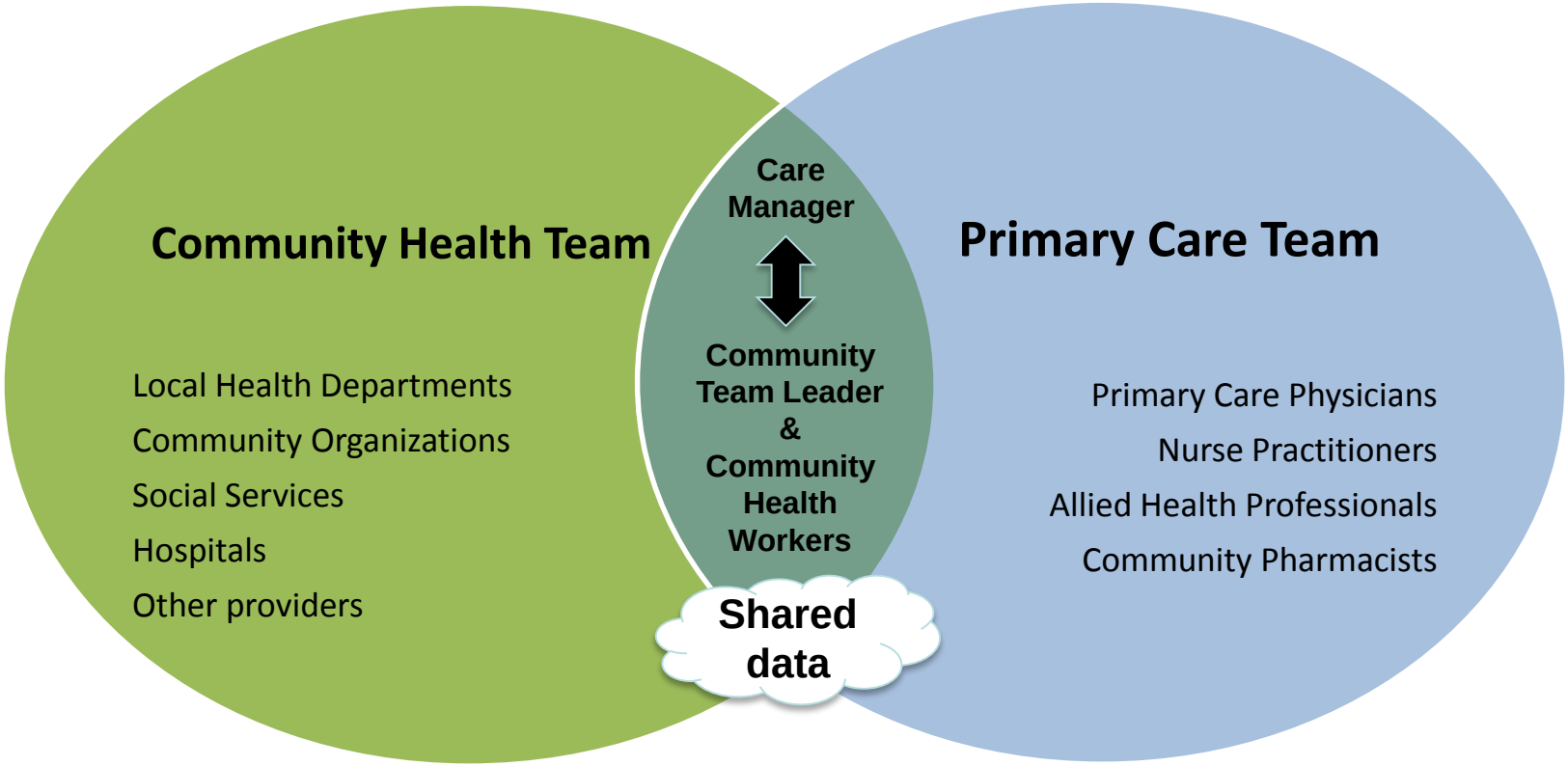
MARYLAND
DEPARTMENT OF HEALTH & MENTAL HYGIENE

Community-Integrated Medical Home



State Innovation Models (SIM) Grant Solicitation

- Released by Center for Medicare & Medicaid Innovation (CMMI) at CMS
- Purpose: Develop, implement, and test new health care payment and service delivery models at the state-level
- Maryland received "Model Design" award
  - $2.37 million
  - Planning grant to develop "Community-Integrated Medical Home"
  - Opportunity to apply for "Model Testing" award for up to $60 million to fund implementation over a 4 year period.

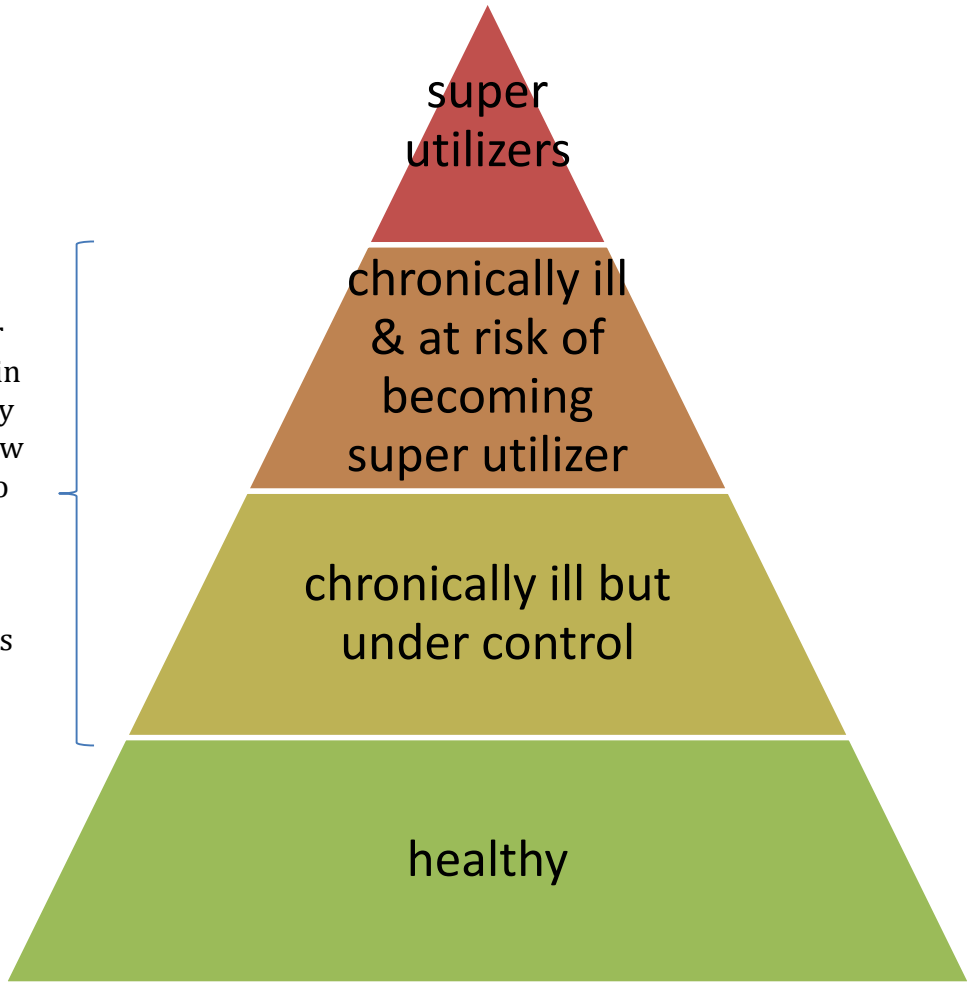
SIM Planning Process

- Two parallel stakeholder engagement processes
  1) Payers and Providers
  2) Local Health Improvement Coalitions
- All-stakeholder summit held on September 10 to review recommendations from both processes and make final recommendations
- Health Quality Partners managing planning process and providing content expertise
- Additional funding to Maryland Health Care Commission to expand All-Payer Claims Database and to CRISP to develop hot-spotting data tools

Population Health Improvement at All Levels of Health Need

A

Secondary Prevention and Effective Care Coordination – Aim for 80% PCP participation in medical home (currently at 50%)--including a new state-certified PCMH--to cover 80% of Marylanders. Enhanced community-based preventive interventions in collaboration with PCMH



6 Million Marylanders

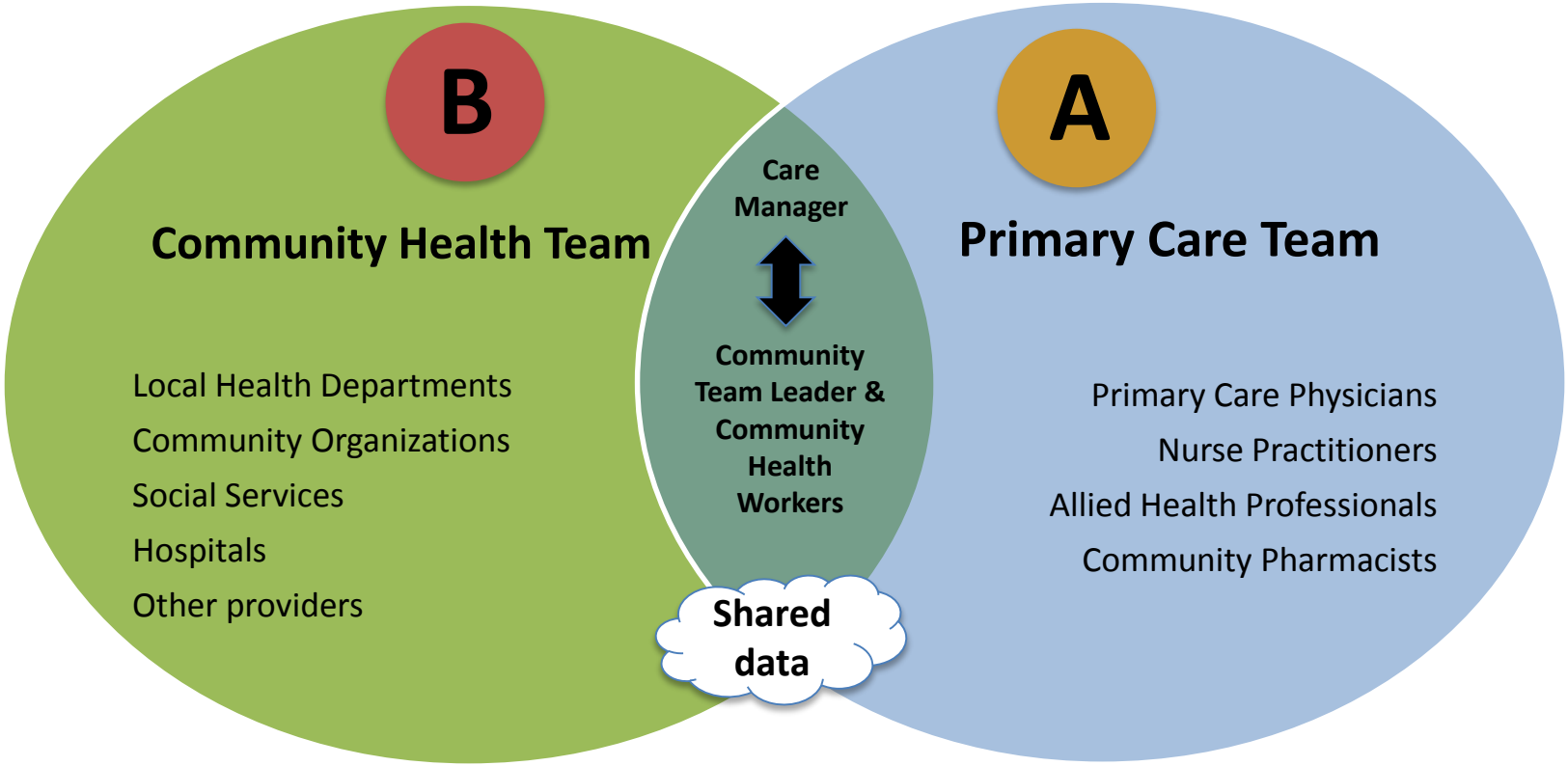
B

"Hot Spotting" – Deploying effective complementary community-based supports that "wrap around" the primary care medical home; patient assessment determines range of services offered

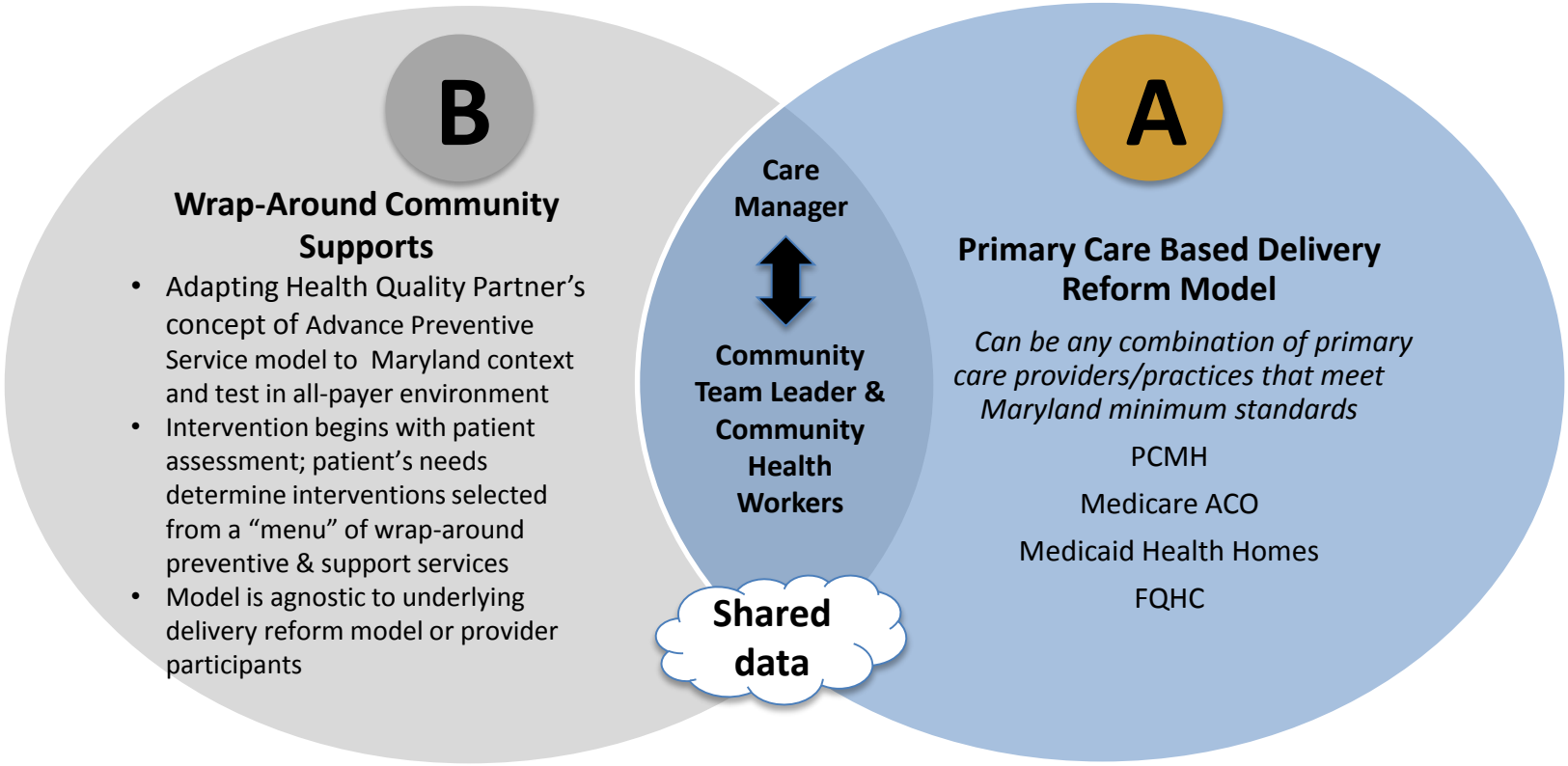
C

Promoting and Maintaining Health through the Built Environment, Structured Choice & Effective Primary Prevention – Aim for 80% uptake of USPSTF grade A/B preventive services. Make the healthy choice the easy choice by creating defaults through effective town planning and other behavioral economic approaches.

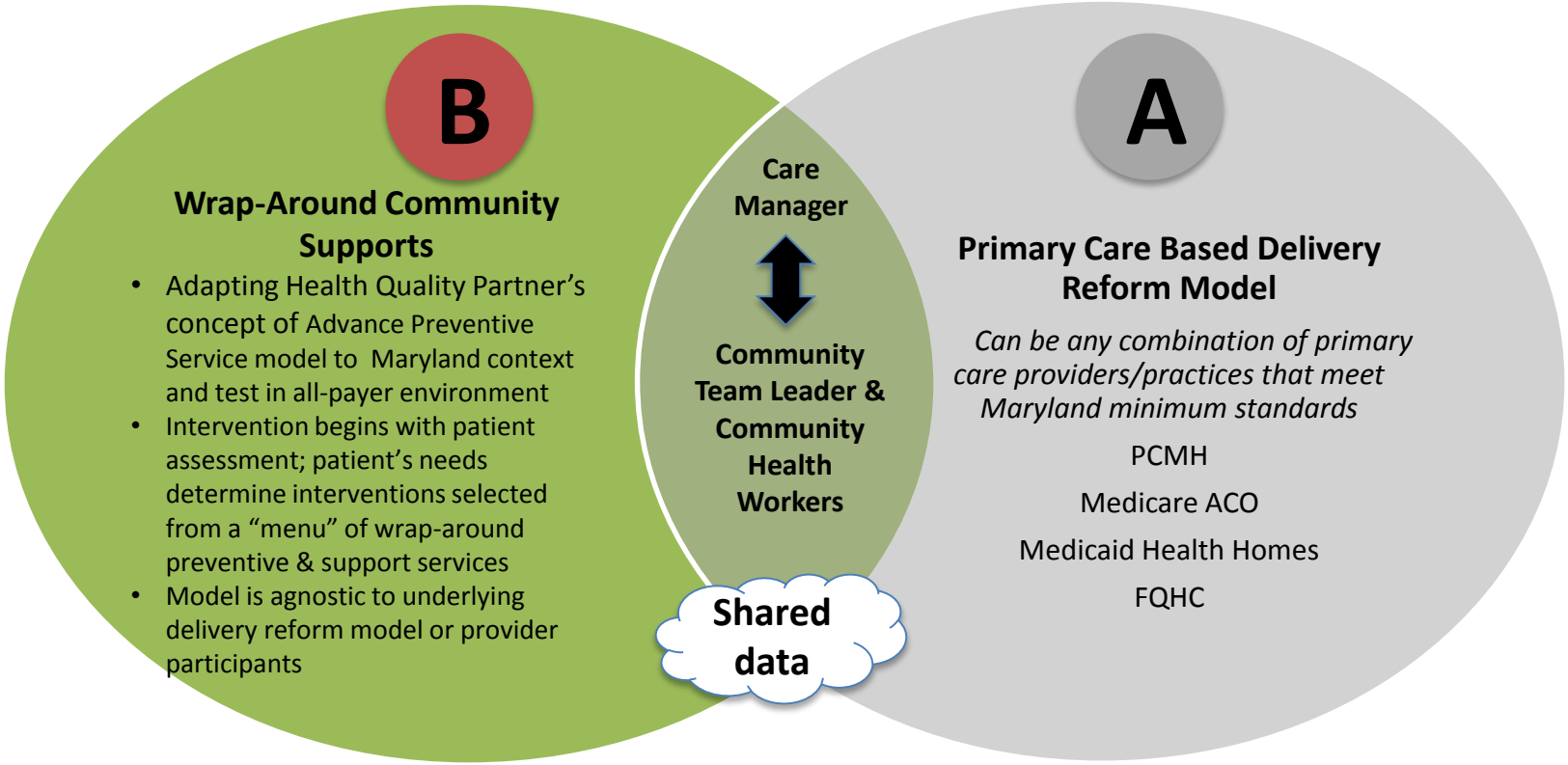
Community-Integrated Medical Home



Community-Integrated Medical Home Model



Community-Based & Clinically-Integrated Hot Spotting Model



Public Utility

DHMH Secretary
Deputy Secretary for Public Health

Governor-Appointed Commissioners

Health Systems and Infrastructure Administration
Office of Population Health Improvement
Office of Workforce Development

Maryland Health Care Commission

Public Utility

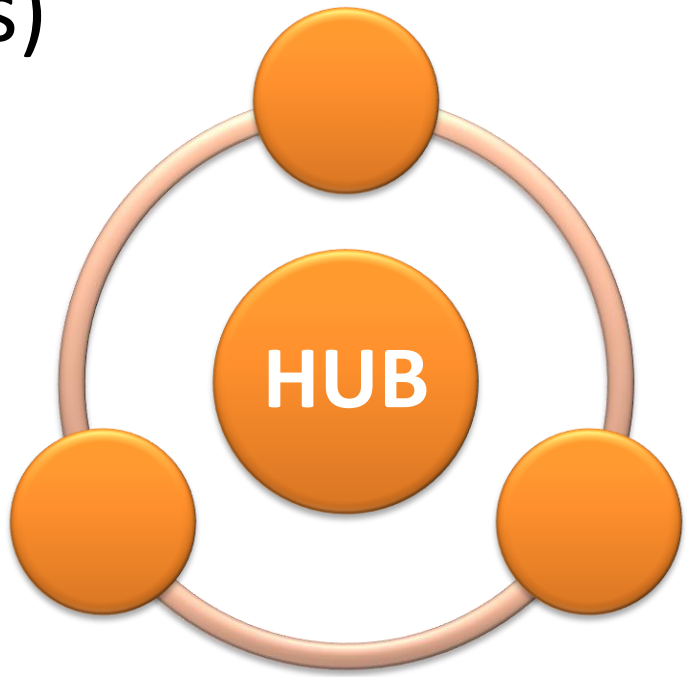
Community-Based

- Certification of Local Health Improvement Coalitions
- Performance measurement & feedback at the population-level
- Oversight of community-based services
  - Quality assurance metrics
  - Standards and training for community health workers

Practice-Based

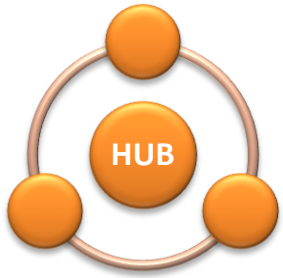
- Certification of practices
- Performance measurement & feedback at the practice-level
- Oversight & monitoring
  - patient attribution: a virtual common roster
  - Validation of payer or practice-generated aggregate data

Regional Community Health Hubs (CHHs)



- HUBs will be established in MD through an RFP process to deploy community wrap around interventions for defined target populations – “hot spotting”.
- HUB entities may include: *Local Health Departments (LHD), Hospital, LHIC, 501c3 community based organization, or a collaborative partnership.*
- HUBs will be established based on need; depending on population density HUBs will vary in size and one HUB could serve more than one jurisdiction not to exceed a geographic radius of 45 miles.
- The Community-Based Public Utility will provider oversight and technical assistance to the HUB.

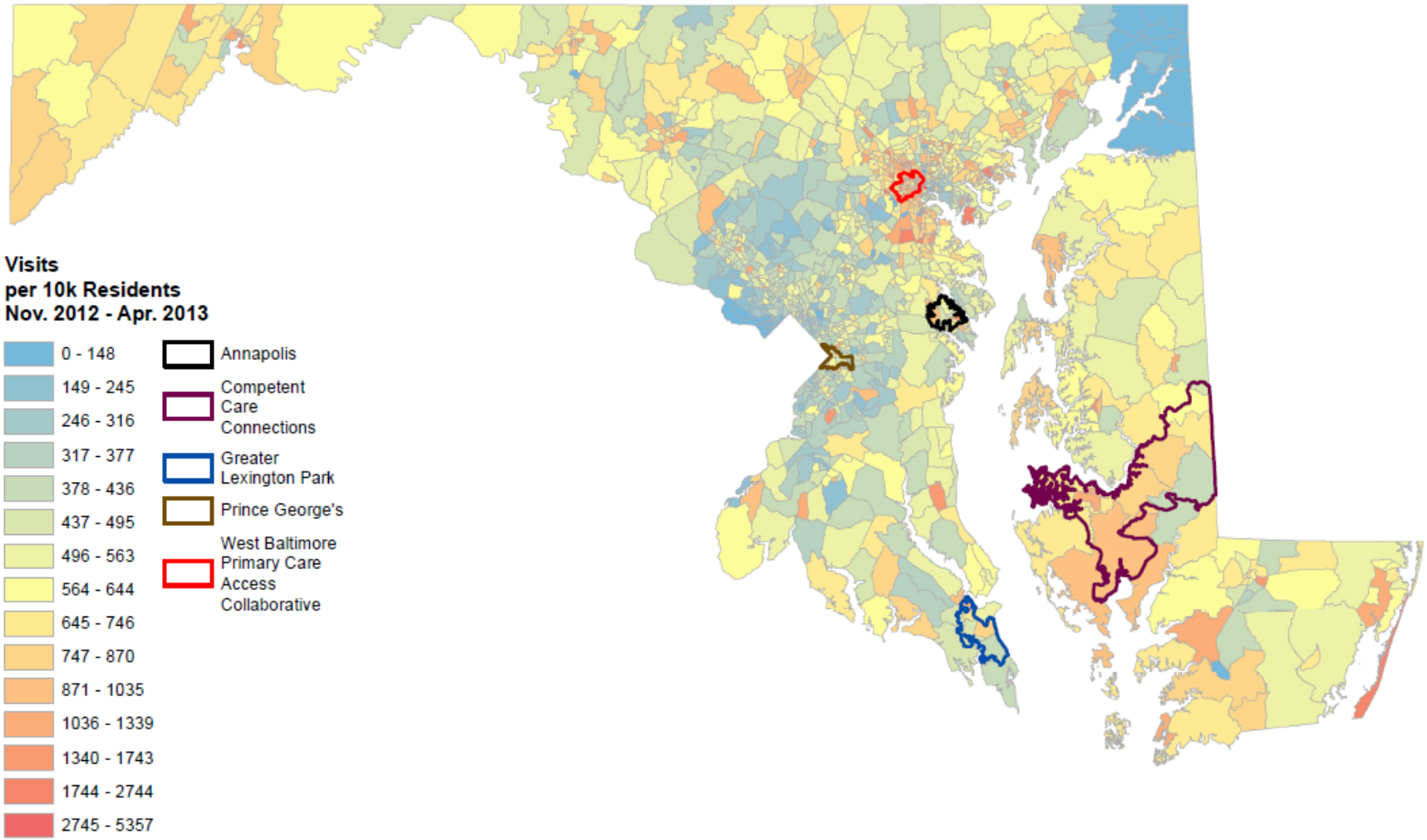
HUB Role/Responsibilities



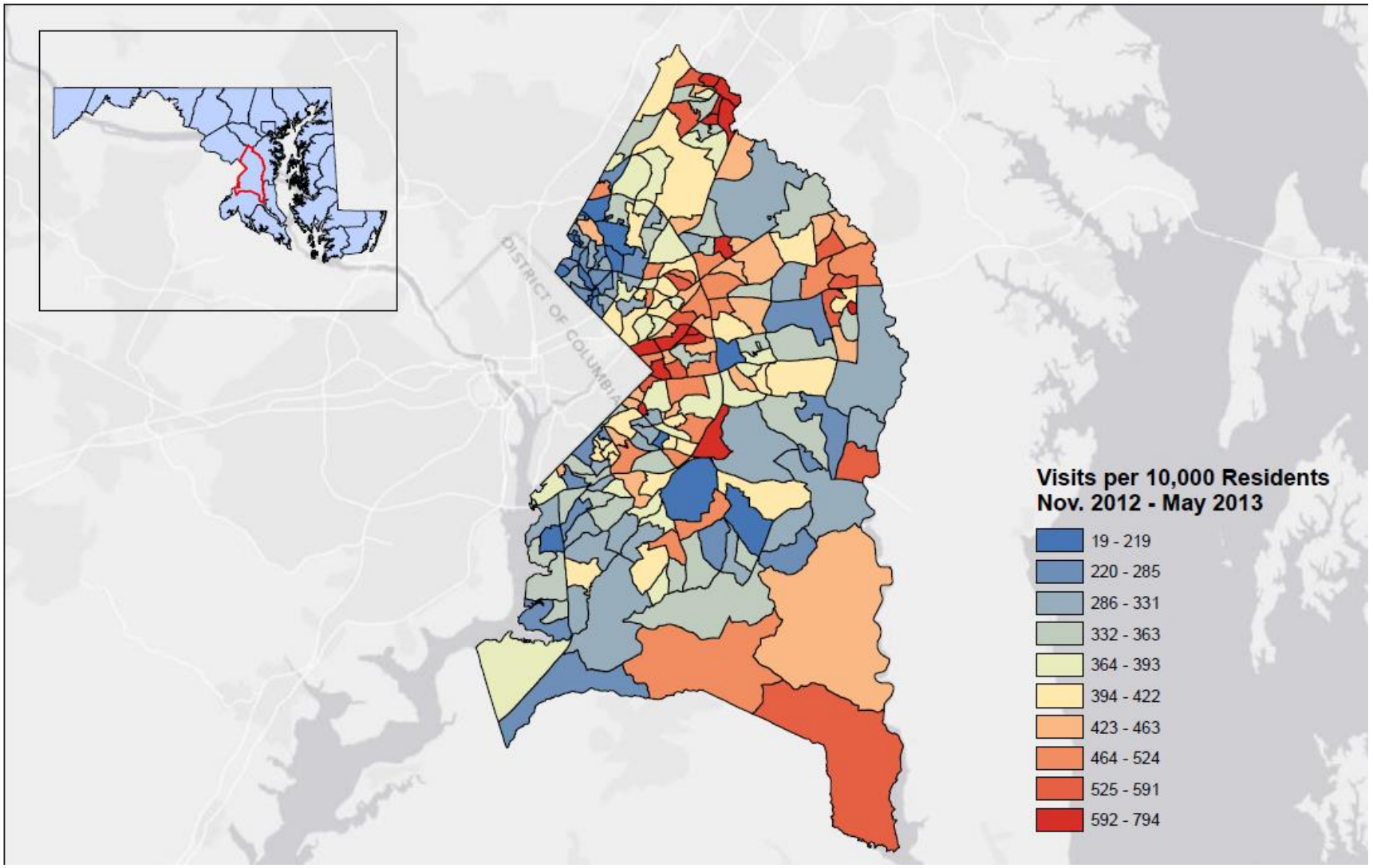
- Deploy “Hot Spotting” Intervention
- Oversight/management staff
- Ensure Fidelity to Intervention Model
- Quality Assurance/Quality Improvement
- Data Monitoring /Tracking/Reporting
- Collaborate with Local Health Improvement Coalitions that will act in an Advisory Capacity to the HUB (advisory committee)
- Participate in HUB learning system to share data and improve processes

Inpatient Utilization by Census Tract

Chesapeake Regional Information System for Our Patients



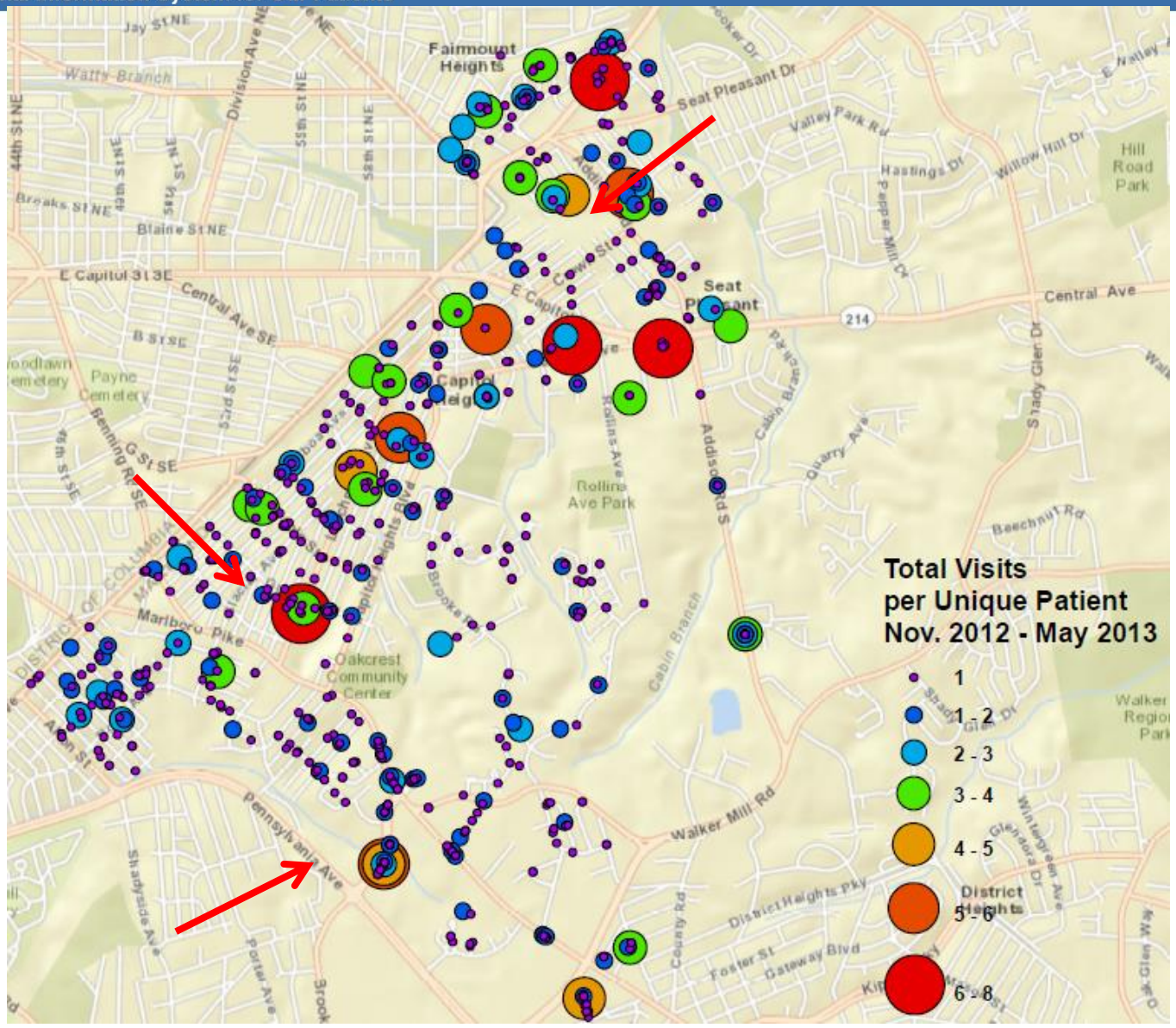
Inpatient Utilization, Prince George's



Inpatient Utilization

Capitol Heights Area (Obscured Data)

Chesapeake Regional Information System for Our Patients



Payment Model for Community-Based Intervention

- Like a public utility, all those deriving benefit from the operation of the CIMH would help pay for it
- Risk-adjusted per capita surcharge levied on payers to cover cost of the intervention
- Medicare currently pays for HQP's community-based intervention using a similar approach

ROI – Return on Investment

- ROI is the net result of
  - CHI price
  - CHI effectiveness reducing acute care costs
- Pricing – based on operational implementation and ROI analyses for each CHI and target population pair
  - Lower pricing is not better if it adversely impacts program effectiveness
  - Evidence of CHI effectiveness is extremely important as is cautious, thoughtful estimation of same where gaps in evidence exist
- An active learning system will help hone both CHI price and effectiveness over time; improving ROI

Timeline

- **December 31**: “Innovation Plan” due to CMS
- **January 2014**: Model Testing funding announcement released
- **Spring 2014**: Model Testing application due
- **Summer/fall 2014**: Model Testing period begins
  - 6 month ramp-up period, followed by 3 years of funding

Example Intervention: Asthma

ELIGIBILITY & ENROLLMENT

CRISP

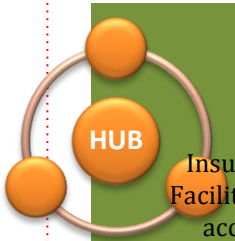
CRISP generated list of eligible children

Hospital Admission or 3rd ER visit in 6 months

PCP or School Nurse referral

COMMUNITY-INTEGRATED INTERVENTION

COMMUNITY INTEGRATED SERVICES



COMMUNITY HEALTH HUB
(Team: RN, CHW, AEC)

Promoting Access to Care
Insurance enrollment (if appropriate)
Facilitate access to PCP/Medical Home & accompanies patient to PCMH appt

Wrap-Around Services
Intake Assessment
Menu of 24 evidence-based interventions including
environmental assessments and self-management education

SCHOOLS
School based services/supports
Asthma Friendly Schools

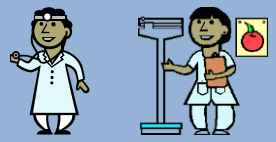
SPECIALISTS
Asthma specialists (pulmonologist/allergist), dietician, behavioral health, etc.

LHICs to FACILITATE ACCESS TO OTHER COMMUNITY RESOURCES
(Extermination, legal, landlord/tenant mediation, social services, contractor for home remediation, etc)

PRIMARY CARE TEAM

MEDICAL HOME
PCP practice/SBHC that meets all PCMH requirements

- Medication management
- Ongoing assessment of control
- Step therapy based on NHLBI guidelines
- Care plan development
- Care coordination
- Follow-up



END-POINT

PRIMARY CARE TEAM

Based on provider judgment

- sustained asthma control
- High level of compliance with medications

RE-ENROLLMENT

PCP or School Nurse referral

Hospital Admission