Maryland Primary Care Program (MDPCP)

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MDPCP Transformed Primary Care across Maryland coordinated with the State’s role in Population Health

Key elements of Maryland’s new system of care
• Investing in primary care practices to build a strong, statewide infrastructure to prevent and manage chronic disease
• Aims to reduce avoidable hospitalization (AH), emergency department (ED) visits, and overall healthcare expenditures
• Innovative hospital/provider partnerships
• **Respond to the Coronavirus pandemic**

MDPCP expansion
• Federally Qualified Health Centers – application period open in 2020
• CareFirst Blue Cross/Blue Shield joined as aligned payer in 2020 > 1200 practices
• Medicaid Chronic Health Homes (planned) and Dual-Eligible entry into MDPCP (current)
“Under this Model, CMS and the State will test whether **statewide health care delivery transformation**, together with population-based payments, improves population health and care outcomes for individuals while controlling the growth of Medicare Total Cost of Care”

- Reduce Medicare expenditures by an annual run rate of $300m by 2023
- Innovate hospital/provider partnerships
- Gain credit for improving overall population health
- Build a strong, effective primary care delivery system inclusive of medical, behavioral and social needs

Source: Maryland Model Contract
Big Picture – Setting an Example for the Nation with a Multipayer Statewide Program

- Reduce avoidable hospital and emergency department utilization
- Coordinated response to public health crisis
- Make strategic, evidence-based investments in expanding primary care services
- Address the social determinants of health
- Integrate Behavioral health into the broader delivery system
MDPCP Creates a System of Care for Marylanders
### PARTICIPANTS

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2020</th>
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<tbody>
<tr>
<td>Providers in MDPCP</td>
<td>1,500+</td>
<td>2,000+</td>
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<tr>
<td>Fee-for-service Beneficiaries Attributed</td>
<td>220,000</td>
<td>330,000</td>
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<tr>
<td>Marylanders Served</td>
<td>2,000,000 – 3,000,000*</td>
<td>2,700,000 – 3,800,000*</td>
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* The Annals of Family Medicine, 2012 [http://www.annfammed.org/content/10/5/396.full](http://www.annfammed.org/content/10/5/396.full)
Program Year 2

476 Practices Participating

- 330,000 attributed Medicare beneficiaries
- 3,000,000+ patients in practices
- ~ 2,000 Primary Care Providers
- ~ 40% employed by hospitals
- All counties represented
- 24 Care Transformation Organizations (min 6/county)
  - 16 of 24 are hospital-based

Dual-Eligible Population in MDPCP:
- more than 50% of state now in practices today
- growing to 88% of non-institutionalized
MDPCP Priorities

Capabilities:
• Expanded Access - Telemedicine prepared and executing now
• Risk Stratified Care Management - knowing and reaching out to vulnerable
• Behavioral Health Integration (BHI) - remote support through Collaborative Care
• Use of CRISP tools – to identify those in need
• Social Needs screening and referrals
• Advanced Care Planning

Outcomes:
• Reduced Prevention Quality Indicators (PQIs)
• Improved management of diabetes, hypertension and substance use disorders (SUD)
• Ability to respond in a coordinated and directed manner in crisis
MDPCP is Building Key Capabilities

Primary Care Functions:

Planned Care for Health Outcomes
- Advanced Health Information Technology
- Continuous Quality Improvement

Beneficiary & Caregiver Experience
- Patient and Family Advisory Council

Comprehensiveness & Coordination
- Behavioral Health and Social Needs Medication Management

Access & Continuity
- Expanded Access
- Alternative Visits

Care Management
- Risk-Stratified Care Management
- Transitional Care Management
Big Changes = Big Impact

For a big impact there must be a large, comprehensive program with sufficient support:

• Statewide program supporting the TCOC Model
• Program Management Office supports all aspects of the program
• Care Transformation Organizations created to assist practices with staffing and support
• Extensive coaching support to practices to assure prompt transformation
• All practices share data across the continuum of care using state health information exchange (HIE) services (CRISP)
# Program Management Office

Coordinates and leads critical operational work and infrastructure building to support Practices

## State Unique Contributions to the MDPCP Program

<table>
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<tr>
<th>CTOs</th>
<th>CRISP</th>
<th>Contractors</th>
<th>State Coaches</th>
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</table>
| • Furnish care coordination services  
• Support care transitions  
• Provide data and analytics support to practices  
• Assist with practice transformation | • Central place to report Quality Measures to CMMI  
• Has portal to access claims data reports  
• Provides SDoH screening tools and resource directories  
• Offers PDMP, Query Portal, Secure Messaging, ENS Services  
• Has Preventable Hospital Utilization Tool integrated into Claims Reports | • Implement Provider Leadership Academy and staff training academies  
• Provide educational materials on complex program issues  
• Develop and conduct Behavioral Health Integration webinar series  
• Offer SBIRT assistance  
• Help optimize EMRs  
• Billing and Coding guidance | • Facilitate escalation process to CMS  
• Offer strategies to reduce administrative burden  
• Deliver hands-on in-person assistance and support  
• Encourage quality improvement  
• Assist with HIE tool implementation |
Support for Practices

Care Transformation Organizations (CTO)

On request – helping practices meet care transformation requirements

Services Provided to Practice:
- Care Coordination Services
- Support for Care Transitions
- Data Analytics and Informatics
- Standardized Screening
- Assistance with meeting Care Transformation Requirements

Examples of personnel:
- Care Managers
- Pharmacists
- LCSWs
- Community Health Workers
Social Needs Workflow in MDPCP

Data

Social Needs Identified

Social Needs Addressed

CRISP

CRISP HIE

Practice Data

Practice Dashboards

Pre-AH Tool

Practice Interventions and Referrals

Care Team and Screening

Patient Communication and Services

Referrals to meet needs over HIE

CBOs

State Agencies

Housing, LHDs

Meals on Wheels

Transportation

Other

CRISP

CRISP HIE

Practice Data

Practice Dashboards

Pre-AH Tool

Practice Interventions and Referrals

Care Team and Screening

Patient Communication and Services

Referrals to meet needs over HIE

CBOs

State Agencies

Housing, LHDs

Meals on Wheels

Transportation

Other

Maryland

DEPARTMENT OF HEALTH
Prevent Avoidable Hospital Events Tool (Pre-AH): Combining the Power of Data, AI, and the State HIE

- Simple practice care team dashboards on HIE –
  - Identifies risk of avoidable hospital events
  - Reveals underlying reasons for risk, incl. State Dept of Health (SDoH) reasons for risk
  - Allows efficient use of targeted care management resources

- First of its kind – designed specifically for MDPCP participants to improve outcomes and predict unnecessary hospital visits in the state

- Uses databases, including those linked to environmental and non-medical factors, to predict avoidable event risk

- Dashboard integrated with MDPCP reports on CRISP
Drill Down on Patient – Reasons for Risk

Likelihood of Avoidable Hospital Event: 96.97%

Distribution of Risk by Reason Category

- Prior avoidable hospitalizations: 23.11%
- Risk related to chronic obstructive pulmonary disease (COPD) and bronchitis: 4.55%
- High risk prior hospital admission: 68.05%
- Number of primary care visits (high or low numbers): 1.25%
- Risk related to heart failure: 68.05%
- Polypharmacy: 1.25%
- Risk related to diabetes: 4.55%
- Risk related to hypertension: 68.05%
- Risk related to tobacco use: 1.25%
- Risk related to arrhythmia: 4.55%
- Discontinuous primary care with several different providers: 68.05%
- Uses insulin: 1.25%

Primary Reasons for Risk

- Category
  - Utilization
  - Condition
  - Pharmacy
  - Demographic

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Electronic referral: workflow – Screening and Referral Integrated into HIE

Practices
- **Outbound**: e-referral completed in CRISP HIE tab
- **Inbound**: Clinical provider is notified of enrollments and status by partner programs

Non-clinical Partner Orgs
- **Inbound**: Receives a secure email with the referral request
- **Outbound**: On a monthly basis, entry of patient/client outreach as Care Alert into CRISP for Practice to view
COVID-19 Response
MDPCP Responds to COVID-19

- 476 MDPCP/health practice partnerships already in place
- 2,000+ providers serving 2-3 million patients statewide
- Imperative to quickly provide providers with accurate and complete information and care guidance

Daily Webinars
- MDPCP launched its first COVID-19 information webinar March 12
- Holding daily weekday webinars since then covering:
  - Identifying and contacting at-risk patients
  - Screening
  - Testing
  - Communications
  - Care
  - Safety
MDPCP Responds to COVID-19

Communication
• Daily email updates and information to PCPs
• Ongoing coach support to practices
• Ongoing updated postings and links on the MDPCP website

State leadership and coordination
• Central leadership through Md Department of Health and the Program Management Office
• Integrated into the State’s response

Alternative care approaches accelerated
• Telemedicine established in some PCPs with support provided for more to scale up
Key Takeaways

• PCPs are on the front line against COVID-19 in Maryland
• PCPs are uniquely positioned to identify these at-risk populations, provide important social distancing information to them, and serve their healthcare needs through telemedicine
• Encouragement - No one can do this better than you!
EXAMPLE: Today’s Key Updates for Maryland

• COVID-19 continues to spread in Maryland, overwhelmingly through community transmission

• Statistics (as of early 3/25/20)
  • 7000+ tested; 2000-3000 processed in lab so far
  • 423 confirmed cases of COVID-19 infection had been identified total across all regions of the State; 74 new cases since yesterday and the biggest increase so far in one day
  • 67 hospitalized
  • 4 deaths
  • More information at https://coronavirus.maryland.gov/
Example: Key Messaging

• Elective and non-emergent medical procedures
• Test Reporting – timely done by the testing labs
• Testing Priority
• Personal Protective Order Conservation
  • Extended use – PPE may be used after the expiration date
  • Reuse - is permitted in some circumstances
  https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html
• Prioritize facemasks
• High-risk providers – avoid treating high-risk patients
Example: What’s Important Now (WIN)

• Identify and proactively contact high-risk patients
• Maximize non-face-to-face visits using telemedicine
• Maximize access to care
• Identify appropriate candidates for testing
• Clinical management of patients
• Stay current, stay safe
Thank you!

Updates and More Information:
https://health.maryland.gov/MDPCP

Questions: email Howard.Haft@Maryland.gov