COUNCIL ON CLINICAL & QUALITY ISSUES

Maryland
Hospital Association

April 13, 2021

Join Zoom Meeting

Maryland
Hospital Association

COUNCIL ON CLINICAL & QUALITY ISSUES

Tuesday, Apr. 13, 2021, 9:30 – 11:30 a.m.

Join Zoom Meeting

AGENDA

9:30 a.m.	Welcome and Consideration of Feb. 9 Meeting Minutes ***(Tab 1)***	Mitchell Schwartz, M.D., Chair
9:33	Meeting Objectives	Traci La Valle, Senior Vice President, Quality & Health Improvement
9:35	Future of the Maryland Model: Securing a Favorable Evaluation ***(Tab 2)***	Traci La Valle
10:25	Future of the Maryland Model: Accountability ***(Tab 3)***	Nicole Stallings, Senior Vice President, Government Affairs & Policy
10:55	MHA's Commitment to Racial Equity: REaL Data Collection ***(Tab 4)***	Brian Sims, Director, Quality & Health Improvement Sherita Golden, M.D., Vice President, Chief Diversity Officer Johns Hopkins Medicine
11:20	Hospital Discharge Protocols for Youth with Intensive Needs ***(Tab 5)***	Erin Dorrien, Director Government Affairs & Policy
11:27	Next Steps	Traci La Valle
11:30	Adjourn	

Maryland Hospital Association

COUNCIL ON CLINICAL & QUALITY ISSUES

Membership Roster
Fiscal Year 2021

Mitchell Schwartz, M.D., Chair
Chief Medical Officer & President of Luminis Health Clinical Enterprise
Anne Arundel Medical Center
Annapolis

Carrie Adams, Pharm.D
Vice President & Chief Quality/ Transformation Officer
Meritus Health, Hagerstown

John Chessare, M.D.
President & CEO
Greater Baltimore Medical Center
Baltimore

Gail Cunningham, M.D.
Vice President of Medical Affairs & Chief Medical Officer
University of Maryland St. Joseph Medical Center, Towson

Griffin Davis, M.D.
Senior Vice President & Chief Medical Officer
Adventist HealthCare Fort Washington Medical Center, Oxon Hill

Renee Demski
Vice President, Quality
The Johns Hopkins Hospital & Health System, Baltimore

Patricia Ercolano
Vice President, Quality Management
University of Maryland Medical System
Baltimore

Terry Fairbanks, M.D.
Vice President Quality and Safety
MedStar Health, Columbia

Kathryn Fiddler, DNP
Vice President of Population Health
TidalHealth Peninsula Regional Health System, Salisbury

Michelle A. Gourdine, M.D.
Interim Chief Medical Officer & Senior Vice President, Population Health & Primary Care
University of Maryland Medical System
Baltimore

Heather Kirby
Vice President, Integrated Care Delivery
Frederick Health, Frederick

Stuart Levine, M.D.
President, MedStar Franklin Square Medical Center
Senior Vice President, MedStar Health
Baltimore

Stephen Michaels, M.D.
Chief Operating Officer & Chief Medical Officer
MedStar St. Mary's Hospital
Leonardtown

Yancy Phillips, M.D.
Chief Quality Officer
Holy Cross Health, Silver Spring

Brent Reitz
President, Post-Acute Care Services
Adventist HealthCare Rehabilitation
Rockville

Wilma Rowe, M.D.
Chief Medical Officer/Senior Vice President, Medical Affairs
Mercy Medical Center, Baltimore

Nitza Santiago
Assistant Vice President, Quality & Patient Safety
Sinai Hospital of Baltimore
Baltimore

Rahul Shah, M.D.
Vice President, Chief Quality & Safety Officer
Children's National Health System
Washington, D.C.

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COUNCIL ON CLINICAL & QUALITY ISSUES
MEETING DATES

2021

June 8

August 10

October 12

December 7

All meetings will take place from 9:30 to 11:30 a.m.
Advance notice of all meetings and materials will be provided.
Please mark your calendars accordingly.

Maryland
Hospital Association

COUNCIL ON CLINICAL & QUALITY ISSUES

Tuesday, Feb. 9, 2021, 9:30-10:30 a.m.
MINUTES

ATTENDANCE

Members	***Present***	***Absent***
Mitchell Schwartz, M.D., Chair	X	
Carrie Adams	X	
Nancy Adams	X	
John Chessare, M.D.	X	
Gail Cunningham, M.D.	X	
Griffin Davis, M.D.	X	
Renee Demski	X	
Patricia Ercolano	X	
Terry Fairbanks, M.D.	X	
Kathryn Fiddler, DNP	X	
Michelle Gourdine, M.D.	X	
Heather Kirby	X	
Stuart Levine, M.D.	X	
Stephen Michaels, M.D.	X	
Yancy Phillips, M.D.		X
Brent Reitz	X	
Wilma Rowe, M.D.	X	
Nitza Santiago	X	
Rahul Shah, M.D.		X

Guests
Bonnie DiPietro, Maryland Patient Safety Center; Blair Eig, Maryland Patient Safety Center; Colleen Hadigan, M.D., NIH Clinical Center; Jonathan Patrick, MedStar Health

Attending MHA Staff
Bob Atlas, Shamonda Braithwaite, Brian Burkhalter, Erin Dorrien, Katie Eckert, Ahmed Elsayed-Ahmed, Amy Goodwin, Traci La Valle, Meghan McClelland, Brett McCone, Maansi Raswant, Laura Russell, Brian Sims, Nicole Stallings, Amanda Thomas, Vidhya Tirumalaraju

CALL TO ORDER AND APPROVAL OF MINUTES

Chair Mitchell Schwartz called the meeting to order at 9:31 a.m. The minutes of the Dec. 1 Council meeting were reviewed and approved.

MEETING OBJECTIVES

Traci La Valle, MHA senior vice president, Quality & Health Improvement, outlined the meeting objectives:

- Obtain guidance on how to demonstrate large-scale, substantive change in hospital quality and care transformation
- Share legislative updates

Future of the Model

Outcome

Members described programs to move care from acute to lower cost settings. Strategies varied by hospital, but common themes included a focus on patients with chronic medical conditions, no stable medical home, a history of preventable exacerbations, or the need for additional support. The approach is similar across all hospitals, though the operational details are different. The collective theme is stretching the global budget outside the hospital walls to create sustainable interventions.

Main Points of Discussion

- Maryland hospitals can demonstrate success in improving care for vulnerable patients by measuring the change in spending across settings of care, i.e., shifting from acute to ambulatory, delving into pre- and post-intervention data with the CRISP tool, and with Care Transformation Initiatives (CTI). Narratives describing interventions can expand on the quantitative findings.
- CCQI members also said they take responsibility for how care is delivered in non-hospital settings, such as ambulatory practices and post-acute settings
- The accountability and sustainability of interventions outside the hospital is what will differentiate Maryland from other states
- To build on existing efforts, hospitals need claims data from other payers whose populations they're managing and movement toward more payment models or demonstrations that are less dependent on volume for non-hospital practitioners

MHA Next Steps

MHA to summarize narrative and spending trends that tell the story of accountability and care delivery change in hospital and non-hospital settings and share preliminary results at the next meeting.

ADJOURNMENT

There being no further business, the council adjourned at 10:31 a.m.

THESE MINUTES HAVE BEEN APPROVED BY THE COUNCIL ON CLINICAL & QUALITY ISSUES

Maryland Hospital Association

Council on Clinical & Quality Issues

April 13, 2021

Topic	**Future of the Maryland Model: Ensuring a Favorable Evaluation**
Objective	To understand the Council's views on Maryland's current state of care transformation and goals for the future
Discussion Questions	1. Does the summary of care transformation activity represent your experience of change that has occurred as a result of the Model? 2. What does mature transformation look like in Maryland? 3. What are your top one or two strategies or opportunities to advance health in the community setting?

As part of its 2023 evaluation, the Centers for Medicare & Medicaid Services' (CMS) contractor will evaluate the extent to which the Maryland Model (Model) spurred transformation of care. To better understand the current state of transformation, MHA engaged Health Management Associates (HMA) to gather and summarize hospital-led activity, strategies, progress, and challenges. HMA reviewed hospitals' Care Transformation Initiative (CTI) submissions, Regional Partnership evaluations and awards, and other documents. MHA and HMA staff also interviewed leaders from 10 health systems.

Care Transformation

Maryland hospitals are building on activities that began under the All-Payer Model; engaging more partners in ambulatory and post-acute settings, and working with additional community-based organizations. Care management and coordination has become more sophisticated. Hospitals have routinized analyses and standardized reports to identify high-risk patients and monitor processes and outcomes. Many implemented chronic disease pathways for post-hospital care. Some integrated data from hospital and ambulatory practices. Integration with post-acute settings is slower—often hindered by frequent turnover in post-acute facility clinical staff.

In the community, hospitals led growth of more meaningful relationships with community organizations, often catalyzed by a joint approach to the Community Health Needs Assessment. Consequently, better relationships with faith-based, or issue-oriented community leaders, led patients to trust that hospitals act in the community's interest.

In the interviews, hospital leaders shared how hospitals team up with others to build community resources. Most often, hospitals address inadequate or unstable housing through a variety of mechanisms that allow people to stay in their home or in housing so that their health needs can be managed. Others mentioned expanding access to health care through creative means such bringing health services into a community center, low-income housing, or house of worship. Health Services Cost Review Commission (HSCRC) staff say personnel at the Center for

Medicare and Medicaid Innovation (CMMI) believe bolstering community resources is a part of care transformation and they expect to see examples in Maryland. We want to hear more from Council members about the top strategies and opportunities to support communities as a means to better health.

MHA's Role

MHA will amplify hospitals' care transformation accomplishments through a strategic communication aimed at top officials in the Maryland Department of Health and HSCRC. The intent is to make these stories better known and to gain advocates for Maryland hospitals and the Model in a way that indirectly influences federal officials involved in decisions about the future of the Model.

MHA is analyzing Medicare spend over time and across categories of service and working with HSCRC to understand CTI trends. MHA will also analyze utilization data and explore other mechanisms to quantify the impact of hospitals' efforts. This will be a topic for a future meeting.

MHA's aim is to ensure all available resources and are brought to bear on efforts that will make the most difference in time for the September 2023 evaluation. In addition to packaging the message of the good work the hospital field has accomplished, we may need to boost action in communities. This could entail expansion of existing efforts or catalyzing new partnerships.

Prepared by: Traci La Valle, Senior Vice President, Quality & Health Improvement

Attachment: Future of Maryland Model: Securing a Favorable Evaluation

FUTURE OF THE MODEL: SECURING A FAVORABLE EVALUATION

Council on Clinical & Quality Issues

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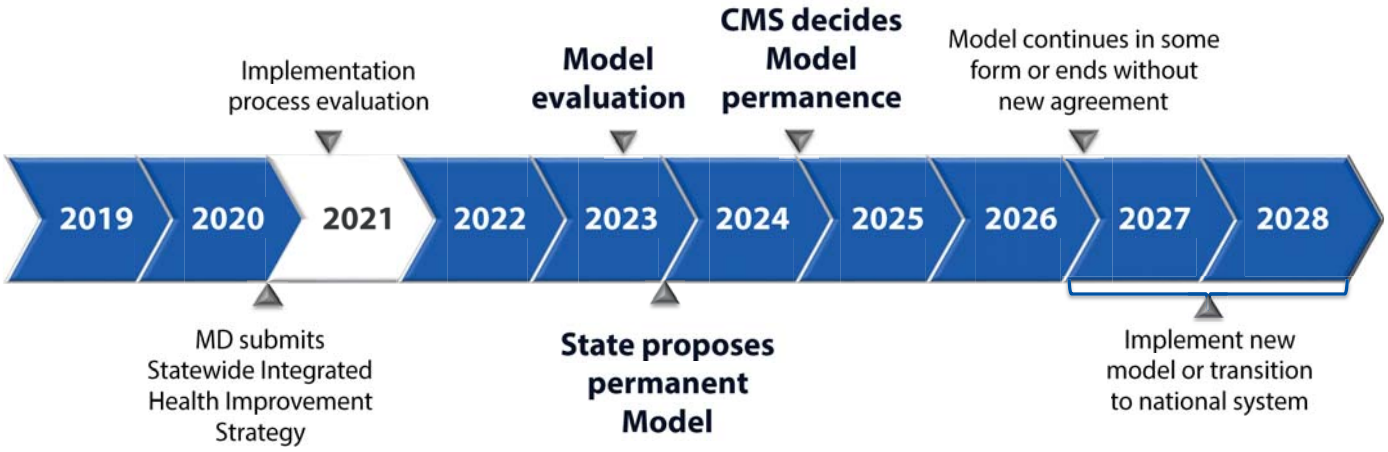
AGENDA

- TCOC evaluation in 2023
- Focus on care transformation category
- Early assessment and MHA role
- Themes from interviews with hospitals
- Hospitals' role in population needs and neighborhood revitalization
- Next steps

TOTAL COST OF CARE MODEL TIMELINE



COMPONENTS OF CMMI EVALUATION

EVALUATION SCORECARD (OTHER THAN SAVINGS)

	Hospital Quality	Care Transformation	Population Health
SIHIS	Avoidable admissions	Follow-up after discharge	Diabetes
			Opioid mortality
	Readmission disparities	Participation in downside risk models (CTIs, MDPCP, Care Redesign Programs)	Severe maternal morbidity
			Asthma in children
Other	Patient experience	MDPCP outcomes	
	Hospital-acquired infections	**Care Transformation Spectrum**	

KEY: Good performance Needs MDH and others' contributions Needs improvement

CTI = Care Transformation Initiatives MDPCP = Maryland Primary Care Program MDH = Maryland Department of Health

HSCRC TRANSFORMATION SPECTRUM

Care Transitions *42 Hospitals*

All hospitals participate in care transformation initiatives

CTI are 'traditional' episode-based care

Primarily extensions of hospitals readmissions reductions programs

Primary & Post-Acute Care *29 Hospitals*

A smaller number of hospitals are developing integrated primary care strategies

Primarily based around ACO or MDPCP networks

The State must demonstrate a small number of community health interventions

Community Health *2-3 Hospitals*

Instituting Specific Care Transformation

- BPCI-A
- Community Based Care Transitions Program

Integration Across the Delivery Systems

- ACO Models
- CPC+
- Comprehensive ESRD Care
- Reduce & avoid hospitalization among nursing facility residents

Community-Based Interventions

- Independence at home
- Accountable Health Communities

Population Health Interventions

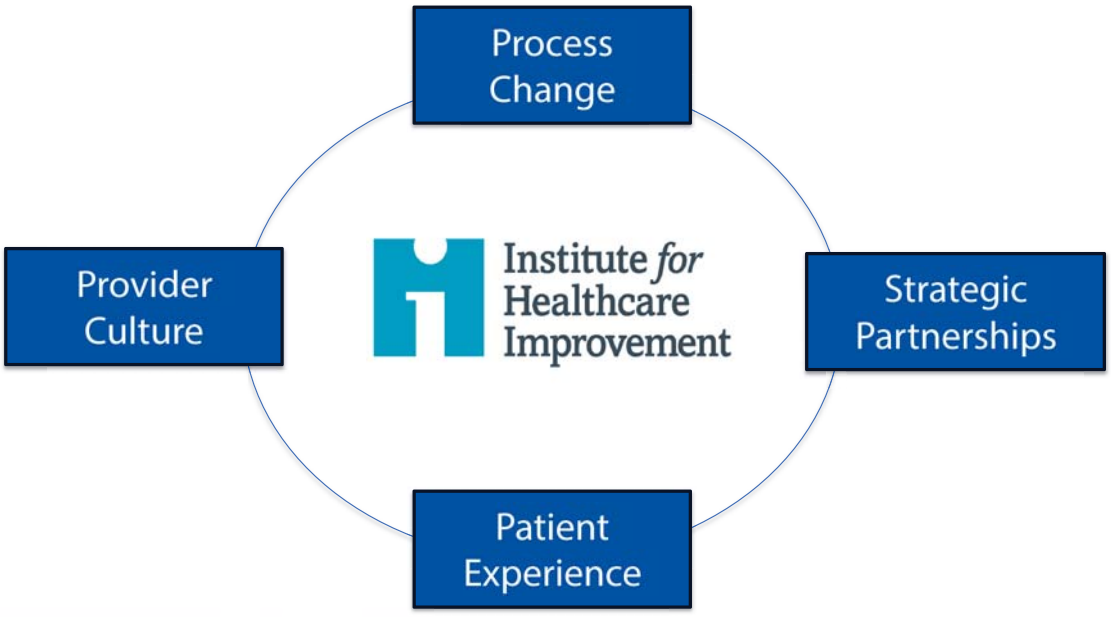
Source: HSCRC. (2021). Demonstrating 'Innovation' in Maryland slide deck. See original in Appendix.

CARE TRANSFORMATION EXAMPLES: HSCRC/CMMI VIEW

Care Transitions/Care Management: Interventions that originate in the hospital setting and are coordinated mostly by the hospital	Primary and Post Acute: Shared interventions between providers to address patient needs throughout the care continuum	Community Health: Interventions not deployed by a medical provider that address social needs	Population Health: Statewide health objectives led by the Maryland Department of Health
1. Disease-specific clinics 2. Disease management education 3. Post-discharge follow up	1. Integration of behavioral health screening into primary care 2. Value-based physician arrangements 3. Conducting care team rounds in SNFs	1. Community-based mobile integrated health 2. Embedding geriatricians in senior living facilities 3. Expanding or improving access to safe, affordable housing	1. Diabetes prevention 2. Prenatal risk assessment and care coordination 3. Maternal Opioid Misuse Model

* List of interventions is not intended as a comprehensive list

TRANSFORMATIVE HOSPITAL PRACTICE



THEMES FROM HOSPITAL INTERVIEWS

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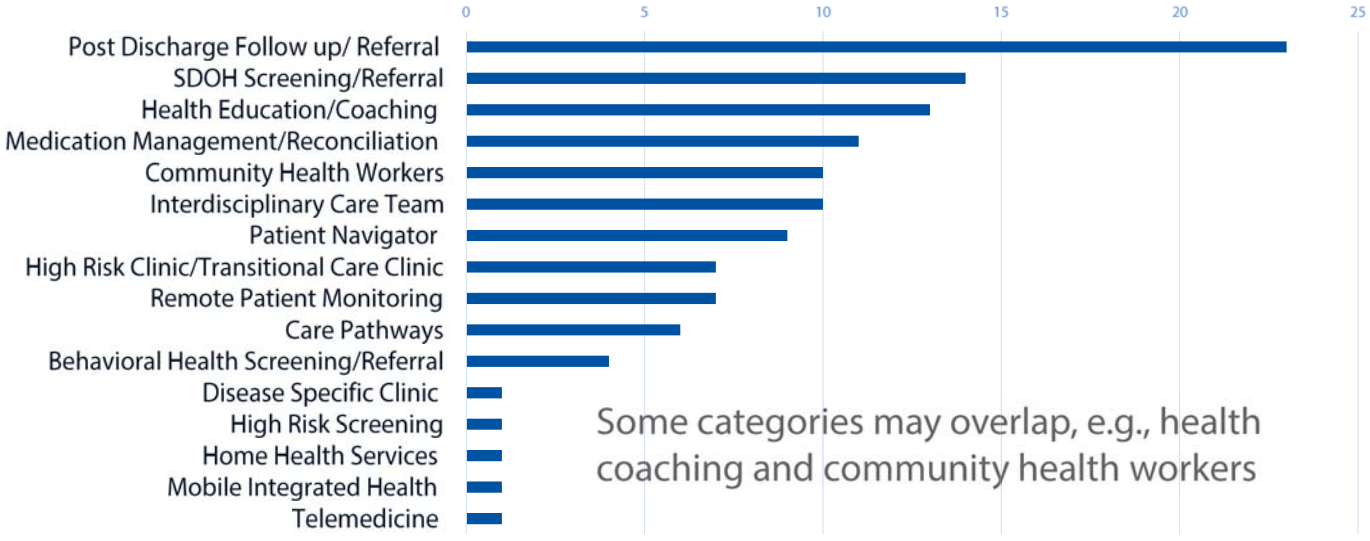
RESULTS: CARE TRANSITIONS

n = 41



Source: CTI Intake Forms

POST-ACUTE ACTIVITIES

- Communication on transfers to/from ED, electronic form in CRISP
- Clean collaborative, ECHO
- Resource nurse for real-time coaching
- Hospital-employed medical director
- Clinical management via telehealth

THEMES FROM INTERVIEWS WITH HOSPITALS

Process Change	Provider Culture	Patient Experience	Strategic Partnerships

- Hospitals expanded data collection and information sharing with ambulatory practices through CRISP and other platforms
- Hospitals increased the use of predictive analytics and risk stratification to identify priority populations for care transformation initiatives
- Hospitals are at different stages in expanding the collection, sharing, and use of standardized SDOH data to address root causes of avoidable utilization
- Some hospitals entered into value-based contracts
- Most hospitals engaged in or catalyzed cross-sector and cross-hospital collaboration on Community Health Needs Assessments and implementation plans

THEMES FROM INTERVIEWS WITH HOSPITALS

Process Change	**Provider Culture**	Patient Experience	Strategic Partnerships

- Maryland Primary Care Program (MDPCP) funded needed infrastructure to connect hospitals to ambulatory care providers
- Care Transformation Organizations (CTO) enhanced and centralized care management and coordination
- Some hospitals created or expanded Clinically Integrated Networks (CIN)

THEMES FROM INTERVIEWS WITH HOSPITALS

Process Change	Provider Culture	**Patient Experience**	Strategic Partnerships

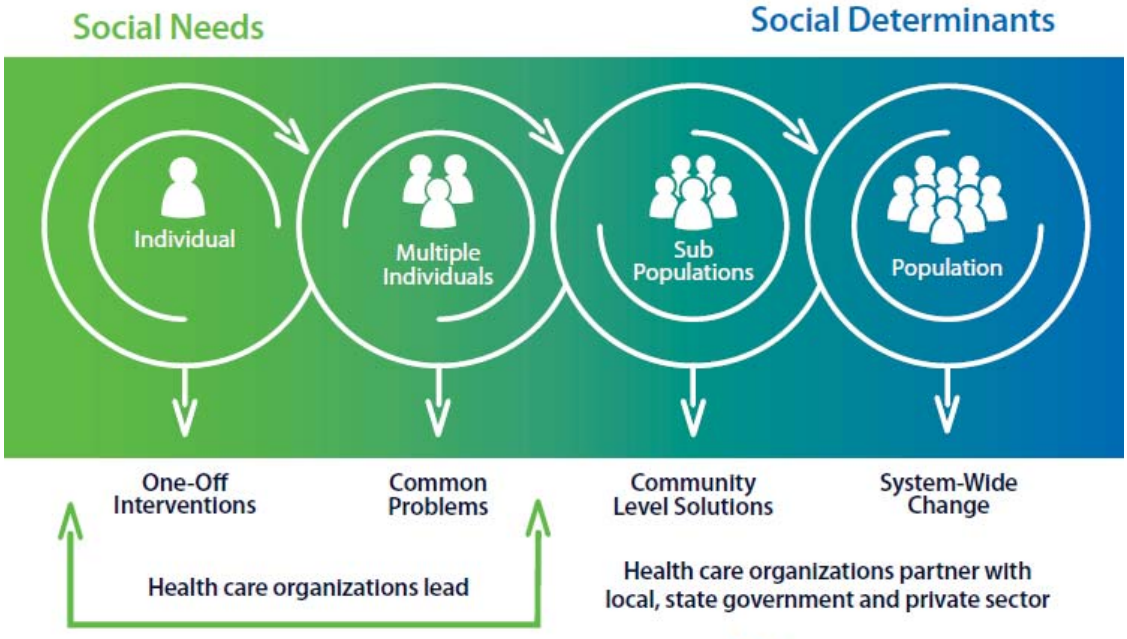
- All hospitals expanded their peer workforces
- Most hospitals address social determinants of health for a subset of patients and for a limited set of social needs
- Some hospitals are expanding access to community-based care
- Some hospitals created tailored care pathways to standardize support models for common high-cost conditions

THEMES FROM INTERVIEWS WITH HOSPITALS

Process Change	Provider Culture	Patient Experience	Strategic Partnerships

- All hospitals have strategic community partners
- External referral and care coordination processes vary in stages of development
- Hospitals reported positive experiences with cross-hospital partnerships

Individual needs vs population-based approaches to address social determinants of health



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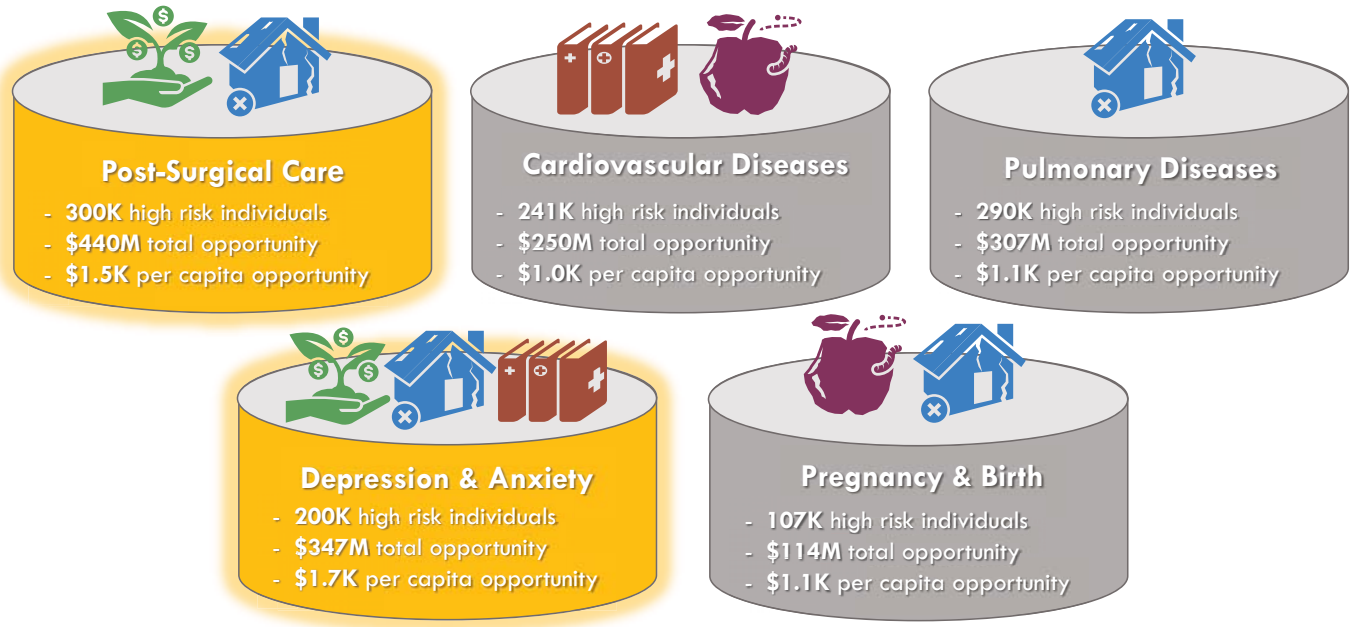
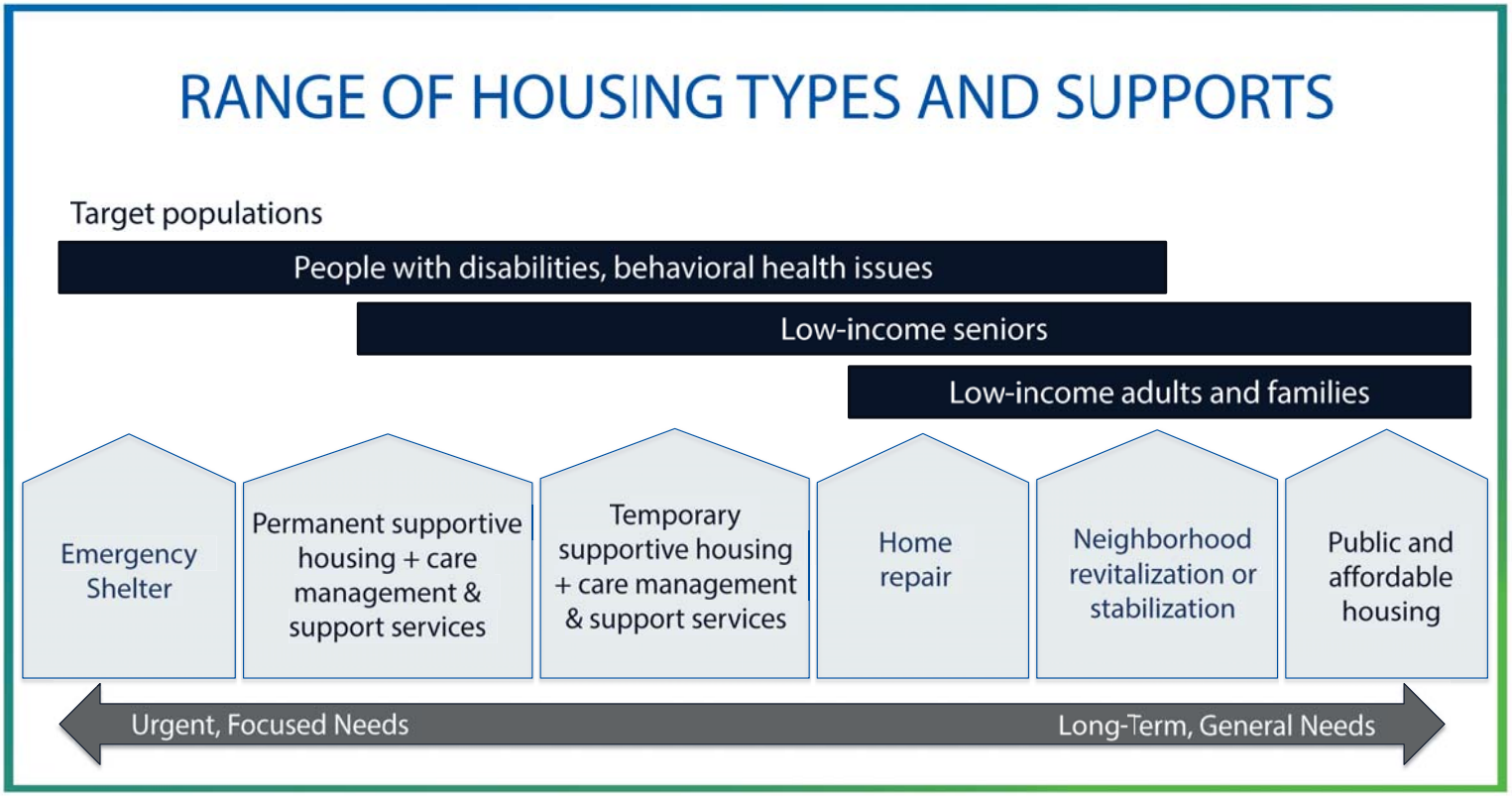
Selection of Socio-Clinical Clusters for Deeper Analysis



RANGE OF HOUSING TYPES AND SUPPORTS



Adapted from SixEightFour.blogspot Housing continuum, Health Research & Educational Trust. (2017, August). *Social determinants of health series: Housing and the role of hospitals*. Chicago, IL: Health Research & Educational Trust. Accessed at www.aha.org/housing

MARYLAND EXAMPLES

Permanent support

- LifeBridge ICCH
- MedStar medical care at home
- 10 Baltimore hospitals and Baltimore City

Temporary support

- UMMS TRI Center
- Tidal Health
- Luminis
- Nexus Montgomery (behavioral health)

Home repair

- Adventist
- LifeBridge
- JHHS

Neighborhood revitalization

Bon Secours

Adapted from SixEightFour.blogspot Housing continuum, Health Research & Educational Trust. (2017, August). *Social determinants of health series: Housing and the role of hospitals.* Chicago, IL: Health Research & Educational Trust. Accessed at www.aha.org/housing

CARE TRANSFORMATION: MEASURING PROGRESS

Care Transitions

- Readmissions
- PQIs
- ED visits
- CTI TCOC
- Pre-Post tool

Primary Care and Post Acute

- Readmissions
- Return to home
- ED visits
- Episode costs
- MDPCP cost and quality metrics

Community Health

- Readmissions
- PQIs
- ED visits
- 911 calls
- TCOC trend

APPENDIX

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HMA EVALUATION

The process included a thorough review of available documents as well as interviews with leaders from the following health systems:

- Adventist HealthCare
- Frederick Health
- Holy Cross Health
- Johns Hopkins Health System
- LifeBridge Health
- Luminis Health
- MedStar Health
- Meritus Health
- TidalHealth
- University of Maryland Medical System

Maryland Hospital Association

Council on Clinical & Quality Issues

April 13, 2021

Topic	**Future of the Maryland Model: Accountability**
Objective	To receive guidance on opportunities and priorities to enhance alignment and establish accountability in support of the Maryland Model
Discussion Questions	1. What are the immediate opportunities to enhance alignment and establish accountability with payers, providers, and state agencies? What are the longer-term opportunities? 2. How would you prioritize engagement of state agencies?

MHA's Council on Legislative & Regulatory Policy is identifying opportunities to engage payers, non-hospital providers, and state agencies to promote alignment toward the goals of the Maryland Model (Model) and to hold these stakeholders more accountable for achieving the goals. Payer- and provider-focused initiatives could include policy and regulatory changes or waivers, enhanced reporting and data-sharing, risk sharing arrangements, and more. There has been some progress in discrete areas, yet MHA and the Health Services Cost Review Commission (HSCRC) recognize more needs to be done to bring payers and non-hospital providers into the fold.

The Council on Legislative & Regulatory Policy concluded that many Maryland legislators and state agency leaders lack full appreciation of the Model and its benefits to Maryland. This work is considered as foundational to any attempt to get greater alignment and accountability among various stakeholders and has already begun. MHA's Executive Committee asked staff also to identify high impact opportunities to serve as a convener and a catalyst to enhance alignment and accountability.

The State's December 2020 Statewide Integrated Health Improvement Strategy (SIHIS) set an immediate path for intensive and sustained effort across state agencies to meet population health goals related to diabetes, opioids, maternal health, and childhood asthma. At this meeting of the Council on Clinical & Quality Issues, MHA is seeking guidance on prioritization of agency investments and accountability to advance the aims of the SIHIS. Key considerations include:

- **Efforts should be informed by local government and community partnerships:** Examples of hospitals' collaborations with local governments may serve to illustrate success and other opportunities. Top challenges hospitals identified in Community Health Needs Assessments may inform opportunities for partnerships across hospitals and regions.

- **HSCRC and Medicaid play key roles:** HSCRC needs to communicate the value of the Model to other state partners, such as the Maryland Insurance Administration, to spur accountability among commercial payers. The Council on Legislative & Regulatory Policy's subgroup on payer and provider alignment notes a focus on Medicaid is central to any community or population health improvement activity.
- **Opportunities to leverage multiple state agencies exist:** Through participation in the Secretary's Vision Group (SVG), MHA has begun to push for broad engagement of state agencies beyond the Maryland Department of Health (MDH) via the cabinet or public meetings. In addition, MHA continues to convene the Stakeholder Innovation Group under the auspices of the SVG and to recommend opportunities for community-based alignment toward SIHIS goals.

  MHA also is supporting legislation to establish a multi-agency commission to craft a statewide plan to advance health equity. This commission will recommend ways to facilitate coordination between the state's health and human services, housing, transportation, education, environment, community development, and labor departments to improve the health of all residents. Simply put, policies that support health equity support the Model.

Prepared by: Nicole Stallings, Senior Vice President, Government Affairs & Policy

Attachment: Future of the Model: Accountability

FUTURE OF THE MODEL: ACCOUNTABILITY

Council on Clinical & Quality Issues

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SUCCESS UNDER SIHIS AND FUTURE MODEL

Where do we create accountability?

State Agencies & Public Health	Non-Hospital Care Partners	Commercial Payers & Medicaid

SIHIS GOALS REACH BEYOND HOSPITAL WALLS

Hospital Quality	Care Transformation	Population Health
• Avoidable admissions • Readmission disparities	• Coordination of care for patients with chronic conditions • Participation in models having downside risk	• Diabetes • Opioid use disorder • Asthma in children • Severe maternal morbidity

SIHIS = Statewide Integrated Health Improvement Strategy

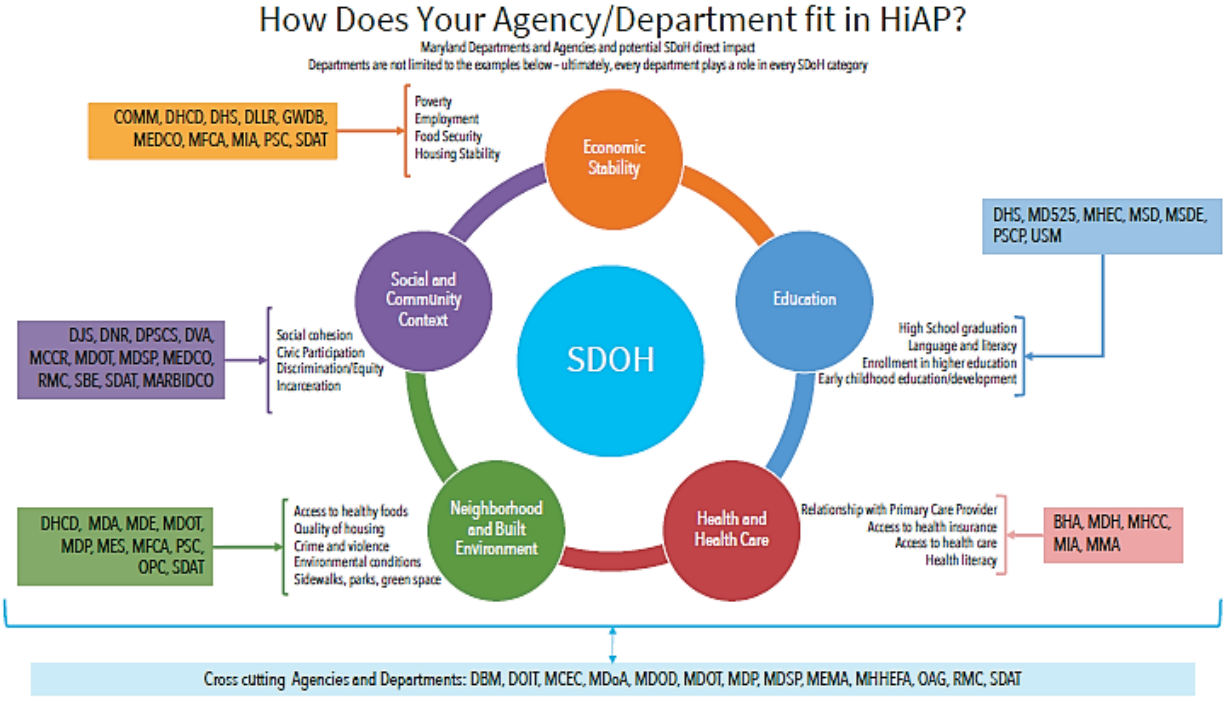
COUNCIL ON LEGISLATIVE & REGULATORY POLICY DISCUSSION

- How do other stakeholders benefit from our Model?
- What levers exist at state and federal levels for alignment/accountability?
- What is current level of alignment and efficacy?
- What policy changes or investments are needed to increase alignment? To create accountability?

COUNCIL FEEDBACK: SIGNIFICANT OPPORTUNITY WITH STATE AGENCIES & LEGISLATORS

- **Opportunity**: Total Cost of Care Model requires sustained investment, interventions to address social determinants of health (SDOH)
- **Current State**: Most state agencies are not aware or not actively working to support Model aims

STATE AGENCIES' LINKS TO SDOH



SDOH = Social Determinants of Health, HiAP = Health in All Policies

SHORT-TERM STATE AGENCY ENGAGEMENT STRATEGY

Educate
- Inform state agency leadership, legislators about Model goals, local examples of partnerships
- Statewide meetings, cabinet meetings, regional legislative briefings

Leverage
- Aligned initiatives, CHNA priorities, existing resources
- Secretary's Vision Group, Stakeholder Innovation Group, MD Commission on Health Equity, departmental meetings, legislative committee briefings

Launch
- Develop/fund targeted initiatives for priority focus areas
- Governor's budget & agency-led efforts/legislation

SHORT-TERM CARE PARTNER ENGAGEMENT STRATEGY

Educate
- Care partners (traditional and non-traditional) on SIHIS goals
- CMS on need to include MD in new payment models, as appropriate

Leverage
- Ability to create new alignment models & request CMS waivers
- MDPCP & Partnership Grants to help align primary care and post-acute care partners
- State agency oversight of other provider groups

Launch
- Pilot programs and collaboratives
- Shared data reporting and transparency

SHORT-TERM PAYER ACCOUNTABILITY STRATEGY

Educate

- Agencies with insurance oversight on TCOC goals, value of Model
- Legislature on need to improve insurer transparency and reporting to measure insurer savings

Leverage

- Available data-sharing opportunities, creating more unified approaches
- Legislative workgroup value-based arrangements with commercial payers*

Launch

- Value-based initiatives across payers
- Coverage of supplemental benefits

*Based on legislation CareFirst introduced that was withdrawn at request of MHA and state medical society

Maryland Hospital Association

Council on Clinical & Quality Issues

April 13, 2021

Topic	**MHA's Commitment to Racial Equity: REaL Data Collection**
Objective	To inform members of strategies and lessons learned related to hospital efforts to improve collection of race, ethnicity and language (REaL) data
Discussion Questions	1. What barriers or challenges prevent adoption of best practices to improve REaL data collection? 2. How can MHA help address these challenges?

In December 2020, members reviewed the equity performance measures created to track fieldwide progress on the priorities outlined in MHA's Commitment to Racial Equity. The group expressed concern regarding the accurate capture of patient race, ethnicity, and language (REaL) data in case mix. Members agreed it would be helpful to hear how their peers improved data collection and organizational efforts to support this work.

MHA recently completed an engagement with deliverables that included an assessment of REaL data elements in case-mix and a comprehensive validation framework that can be used by individual hospitals or statewide data. MHA plans to share that information with hospitals in the coming weeks. Accurate and consistent patient demographic data are imperative to identify disparities and opportunities for improvement. Better collection of these elements ensures confidence in the use of these data for payment policies, such as the readmissions disparity policy. Health Services Cost Review Commission staff said they will continue to seek additional opportunities to incentivize disparity reduction through payment policy.

Dr. Sherita Golden, vice president and chief diversity officer at Johns Hopkins Medicine, led efforts at the Johns Hopkins Health System to identify gaps in the validity and accuracy of patient demographic data and improve these processes. Dr. Golden and Tina Tolson, senior director of operations for international patient services and language service at Johns Hopkins Health System, will share best practices, lessons learned, and achievements over the course of this journey.

Council members should come prepared to share their organizations' similar efforts and to ask questions to tailor potential solutions for their institutions.

Prepared by: Brian Sims, Director, Quality & Health Improvement

Attachments
- MHA REaL CaseMix Validity Assessment slide
- Johns Hopkins REaL Data Collection Process Improvement Slides (material to be provided at the meeting)

MHA REAL CASEMIX VALIDITY ASSESSMENT

100% of Maryland hospitals took the #123 for Equity Pledge to Act from the American Hospital Association to advance health equity

As part of the Pledge, Maryland hospitals committed to improving REaL data in order to better identify health inequities

At the January HSCRC Public Meeting, MHA was asked to assess the field's improvements to date in collecting valid REaL data

Our Project Objectives

As part of our health equity commitment, we've partnered with KPMG to validate the HSCRC IP case-mix REaL data:

- Research and recommend a best-practice validation framework for assessing REaL data
- Research and document REaL validation efforts performed to date by MHA, CRISP, HSCRC and hospital field
- Apply the validation framework to assess current state
- Make recommendations for next steps

Maryland Hospital Association

Council on Clinical & Quality Issues

April 13, 2021

Topic	**Hospital Discharge Protocols for Youth with Intensive Needs**
Objective	To share state-developed hospital discharge protocols and identify any questions for follow-up
Discussion Questions	1. What pain points, if any, have you identified related to the discharge and/or transfer of children or transition age youth? 2. What actions and/or services would you like to see from state agencies to facilitate the discharge of youth to appropriate settings?

In response to advocacy by MHA, the Maryland Health Secretary's Vision Group identified difficult hospital discharges for complex patients as a priority for policy action. Dr. Jinlene Chan, assistant secretary at the Maryland Department of Health, was charged with convening two post-acute care work groups—one focused on adults and the other on children and transition age youth. The groups are tasked with proposing solutions to address finances, policies, practices, and resource development. The groups were also charged with developing protocols for discharging patients with complex health needs to the appropriate and least restrictive community placement.

During the 2020 legislative session, a bill introduced by Del. Brooke Lierman would have mandated a prescriptive approach to the issue of hospital overstays for foster youth—a topic which roused the attention of legislators. While the legislation did not pass, advocates were convened to discuss potential solutions.

Last year, the Governor's Children's Cabinet contracted with Uma Ahluwalia, principal at Health Management Associates, to further the recommendations made by the post-acute care work groups, related to children and youth in the Department of Human Services' care. Ms. Ahluwalia will join the meeting to share and answer questions regarding protocols developed for hospitals and local care teams.

Council members are asked to identify a staff person with expertise to review the hospital discharge protocols for foster youth and attend a future meeting to provide feedback to the state.

Prepared by: Erin Dorrien, Director, Policy & Government Affairs
Jane Krienke, Legislative Analyst, Government Affairs

Attachments
- Hospital Discharge Protocols for Youth with Intensive Needs slides
- Universal Hospital Discharge Planning Protocol

HOSPITAL DISCHARGE PROTOCOLS FOR YOUTH WITH INTENSIVE NEEDS

Council on Clinical & Quality Issues

April 13, 2021

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Hospital Association

BACKGROUND AND CONTEXT

- MHA and partner hospitals study behavioral health discharge delays
- Study identifies patient groups, including elderly, children and youth, as more difficult to discharge from emergency department or inpatient units
- At request of Secretary's Vision Group, MDH convenes post-acute work group to identify discharge barriers
- In 2020 legislative session, proposed legislation would impose prescriptive and troubling requirements for discharging foster youth
- Governor's Children's Subcabinet convenes stakeholders to discuss options, create discharge *protocols* for state and local care teams, and propose discharge framework for hospitals

HEALTH MANAGEMENT ASSOCIATES

Hospital Discharge Planning Protocols

MARYLAND HOSPITAL ASSOCIATION
April 13, 2021

GOALS OF THE PRESENTATION

- ✓Review the revised hospital discharge planning protocol for certain populations
- ✓Review the expectations for different partners in the process
- ✓LCT as the point of entry for youth in acute hospital setting
- ✓Share relevant links to important documents

WHAT OUR SCAN REVEALED:

- Children are experiencing overstays in hospital for several reasons including:
    - Confusion of Process and who has responsibility for what
    - Timelines are not well set and/or adhered to
    - There is not a well-defined system of care that effectively provides step-down in appropriate and effective treatment services to children, youth and their families in less restrictive and community-based settings using a robust treatment continuum
    - There is also inconsistency of regulations and processes across agencies
- The Children's Cabinet has been working on these issues for almost a year and have attempted to improve the situation on many fronts addressing, protocols and workflows, service menu and improved coordination.

This presentation is focused on Hospital Discharge Coordination Protocols for hospital discharge planners and the Local Care Teams

WHAT IS THE LOCAL CARE TEAM AND WHAT FUNCTIONS DOES IT PERFORM:

In accordance with Maryland Statute (Human Services §8-407), a Local Care Team shall:

1. Be a forum for:
    1. Families of children with intensive needs to receive assistance with the identification of individual needs and potential resources to meet identified needs; and,
    2. Interagency discussions and problem solving for individual child and family needs and systemic needs;
2. Refer children and families to:
    1. Care management entities when appropriate; and,
    2. Available local and community resources;
3. Provide training and technical assistance to local agency and community partners;
4. Identify and share resource development needs and communicate with the care management entity, local core service agencies, provider networks, local management boards, and other local care teams in surrounding jurisdictions; and,
5. Discuss a request for a voluntary placement agreement for a child with a developmental disability or a mental illness under §5-525 of the Family Law Article.

LOCAL CARE TEAM STREAMLINED TO DO THE FOLLOWING:

- ✓ Single point of contact for youth in acute hospital settings – Consent should be sought from parent to send packet to LCT as part of the discharge planning process
- ✓ Promotes increased collaboration with hospitals
- ✓ Timely, Effective and Coordinated discharge planning

CATEGORIES OF YOUTH IMPACTED BY THIS DISCHARGE PROTOCOLS:

Child/Youth comes to a hospital emergency department for behavioral health needs or is admitted to the hospital and has an assessment that determines residential care is the most appropriate plan, and one or more of the criteria below applies to the child/youth:

- ✓Has multiple emergency department visits for behavioral health needs;
- ✓Has two or more hospital admissions in the past 90 days;
- ✓Has a hospital emergency department stay of 5+ days without an inpatient admission;
- ✓Is responsible for/suspected of fire-setting;
- ✓Is/was suspected of being a human trafficking victim;
- ✓Has diagnosed developmental disabilities and/or Autism with psychiatric features;
- ✓Demonstrates sexually-reactive behaviors;
- ✓Has complex medical needs with or without psychiatric features; and/or,
- ✓Has unique placement challenges.

PROTOCOLS DEFINING THE RULES OF ENGAGEMENT:

Discharge planning should begin on the date of admission.

a. If a youth is in the **custody of the Department of Human Services (DHS) or Department of Juvenile Services (DJS),** the agency should be **involved on the date of admission** as well as **resource (pre-adoptive, foster, kinship) parents** as applicable.

Note: DHS recommends that all discharge planning start with the local Department of Social Services (DSS) case worker, if the youth is receiving services from DSS. If there are concerns, the first point of escalation should be to the local DSS Director.

b. If a youth is not in the custody of DHS or DJS, then the **youth's family and/or guardian(s) should be assessed** to determine what services, if any, are needed to support the youth at home, including coordinating services from any other public agency with whom the youth and family are involved.

EXPECTATIONS OF HOSPITAL DISCHARGE PLANNING STAFF:

Hospitals acknowledge the Local Care Team (LCT) as the first point of contact if the above protocol conditions are met.

- ✓ If above conditions are met, the hospital discharge planner or designee completes the LCT referral form and sends it electronically to the LCT coordinator in the youth's county of residence.
- ✓ The referral will also contain the hospital discharge recommendations and the psychosocial summary.
- ✓ The LCT coordinator will respond to the referral timely
- ✓ The hospital discharge planner or designee will participate in the LCT meeting.

FACTORS IMPACTING A SMOOTH DISCHARGE PLANNING PROCESS:

- ✓ There are bed capacity and staffing limitations that will impact any established process. **Communication and accountability between hospital personnel, participating agencies, and the youth and family is the key to success.**
- ✓ As part of the communication effort, **all parties should be informed of placement outreach efforts (group homes, foster care placements, etc.) and responses in a timely manner.**
- ✓ This coordination will **build trust and eliminate duplicate placement related efforts.**

QUESTIONS

Universal Hospital Discharge Planning Protocol
for Youth with Intensive Needs
December 16, 2020

Protocol for Hospital Personnel:

1. Youth comes to a hospital emergency department for behavioral health needs or is admitted to the hospital and has an assessment that determines residential care is the most appropriate plan, and one or more of the criteria below applies to the youth:
    a. Has multiple emergency department visits for behavioral health needs;
    b. Has two or more hospital admissions in the past 90 days;
    c. Has a hospital emergency department stay of 5+ days without an inpatient admission;
    d. Is responsible for/suspected of firesetting;
    e. Is/was suspected of being a human trafficking victim;
    f. Has diagnosed developmental disabilities and/or Autism with psychiatric features;
    g. Demonstrates sexually-reactive behaviors;
    h. Has complex medical needs with or without psychiatric features; and/or,
    i. Has unique placement challenges.
2. Discharge planning should begin on the date of admission.
    a. If a youth is in the custody of the Department of Human Services (DHS) or Department of Juvenile Services (DJS), the agency should be involved on the date of admission as well as resource (pre-adoptive, foster, kinship) parents as applicable.
        i. DHS recommends that all discharge planning start with the local Department of Social Services (DSS) case worker, if the youth is receiving services from DSS. If there are concerns, the first point of escalation should be to the local DSS Director.
    b. If a youth is not in the custody of DHS or DJS, then the youth's family and/or guardian(s) should be assessed to determine what services, if any, are needed to support the youth at home, including coordinating services from any other public agency with whom the youth and family are involved.
3. Hospitals acknowledge the Local Care Team (LCT) as the first point of contact if the above protocol conditions are met.
4. If above conditions are met, the hospital discharge planner or designee completes the LCT referral form and sends it electronically to the LCT coordinator in the youth's county of residence. The referral will also contain the hospital discharge recommendations and the psychosocial summary. The LCT coordinator will respond to the referral in accordance with the Children's Cabinet directive.
5. The hospital discharge planner or designee will participate in the LCT meeting.

Factors Impacting a Smooth Discharge Planning Process:

- There are bed capacity and staffing limitations that will impact any established process.
- Communication and accountability between hospital personnel, participating agencies, and the youth and family is the key to success.
- As part of the communication effort, all parties should be informed of placement outreach efforts (group homes, foster care placements, etc.) and responses in a timely manner. This coordination will build trust and eliminate duplicate placement related efforts.

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