



Health Services Cost  
Review Commission

Meeting Agenda  
**Consumer Engagement Taskforce**  
June 30, 2015 \* 9:30 a.m. to 12 p.m. \* HSCRC

**Meeting Objectives:**

- Continue education about various consumer engagement-related activities in Maryland and beyond
- Refine Communication Strategy
- Prepare for Report to Commission

I. Welcome and Introductions

II. Review and Approval of Minutes from May 29 Taskforce Meeting

III. HSCRC Workgroup and Initiative Updates

- Performance Measurement Workgroup
- Regional Health System Transformation Partnership Grants

IV. Review and Refine CETF Communications Strategy

V. Taskforce and Subgroup Updates

- Consumer Outreach Taskforce
- Consumer Outreach & Engagement Subgroup
- CETF Charge #1-2 Subgroup

VI. Review of Proposed Outline for CETF Report to Commission

VII. Action Items and Next Steps

VIII. Public Comment

Meeting Minutes  
**Consumer Engagement Task Force**  
May 29, 2015 \* 9:30 a.m. to 12 p.m. \* HSCRC

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**Scribe:** Tiffany Tate

**In Attendance:**

Tammy Bresnehan (p), Barbara Brookmeyer, Kim Burton, Teressa Lee, Dianne Feeney, Shannon Hines (p), Michelle Larue (p), Donna Jacobs, Steve Ports, Leni Preston, Suzanne Schlattman, Tiffany Tate, Hillery Tumba, Gary Vogan

Guests: Becky Jones, Mary Jane Joseph

**I. Welcome and Introductions**

Leni welcomed the members and guests.

**II. Review of Minutes**

The minutes from the April 10 taskforce meeting were approved.

**III. Presentations: Successes and Lessons Learned in Patient Engagement**

Becky Jones, Nurse Program Manager from the Worcester County Health Department, presented about their Community Integrated Diabetes Care Management Program and how patients are engaged to have an active role in their care through this three-hospital, multidisciplinary initiative.

Mary Jane Joseph from the Primary Care Coalition of Montgomery County presented about their HEALTH Partners program, a multi-stakeholder collaborative that aims to improve care transition for dual-eligibles.

Shannon Hines from Kaiser Permanente discussed their use of Health Navigators and shared decision-making as resources to engage patients.

There was discussion about the scope, sources of funding, and outcomes for the various projects. There were questions about the extent to which the presenters use CRISP and employ health literacy principles in their work.

**IV. Taskforce and Subgroup Updates**

**Consumer Outreach Taskforce**

Suzanne Schlattman reported that they had two forums in late April that were very successful. There are four remaining forums.

### **CETF Charge 1-2 Subgroup**

Leni reported on the recent activities of the subgroup. She shared that the most recent meeting featured several presentations about the how the consumer complaint process is handled in various healthcare settings. She noted that these presentations introduced several tools that may be helpful in the work of the taskforce.

Hillery led the group in a review and discussion of a refined version of the communication strategy. The group appreciated the more focused approach. Feedback is due to Hillery by June 3.

### **Consumer Outreach and Engagement Subgroup**

Tiffany reported that at the last meeting, the group noted that the following trends are emerging from the forum evaluations:

- Consumers want to hear about the New All-Payer Model from the healthcare providers and community leaders
- Consumers like the idea of various types of providers working together to keep them healthy
- Consumers desire information about how they can be more engaged in their own healthcare

## **V. Update on Regional Health System Transformation Grants**

Steve Ports delivered a presentation on the planning grant initiative and the grant recipients. He stated that the purpose of the initiative is to encourage collaboration between hospitals and community-based organizations. Steve mentioned that \$40M might be made available early next year to support implementation of projects striving for the triple aim of the NAPM. He noted that the opportunity would be available to all hospitals and collaborations, not just those funded for the planning grants.

The group discussed how the taskforce might support the grantees in their work. It was suggested that the taskforce might provide consumer engagement guidance for the RFP that will be released for the implementation projects.

## **VI. Miscellaneous Discussion**

- There was discussion about the possible use of the term “No wrong door” (a single entry point for both health and social services) in promotion of the philosophy of the NAPM. The group decided that it should not be used if the NAPM is not fully implemented and hospitals and community providers are not fully integrated.
- Suzanne shared insights from the focus groups conducted by Health Care for All regarding consumers’ desires to control their own health records.



**Maryland Health Services Cost Review  
Commission: Measuring Consumer  
Engagement**

Consumer Engagement Task Force  
Meeting

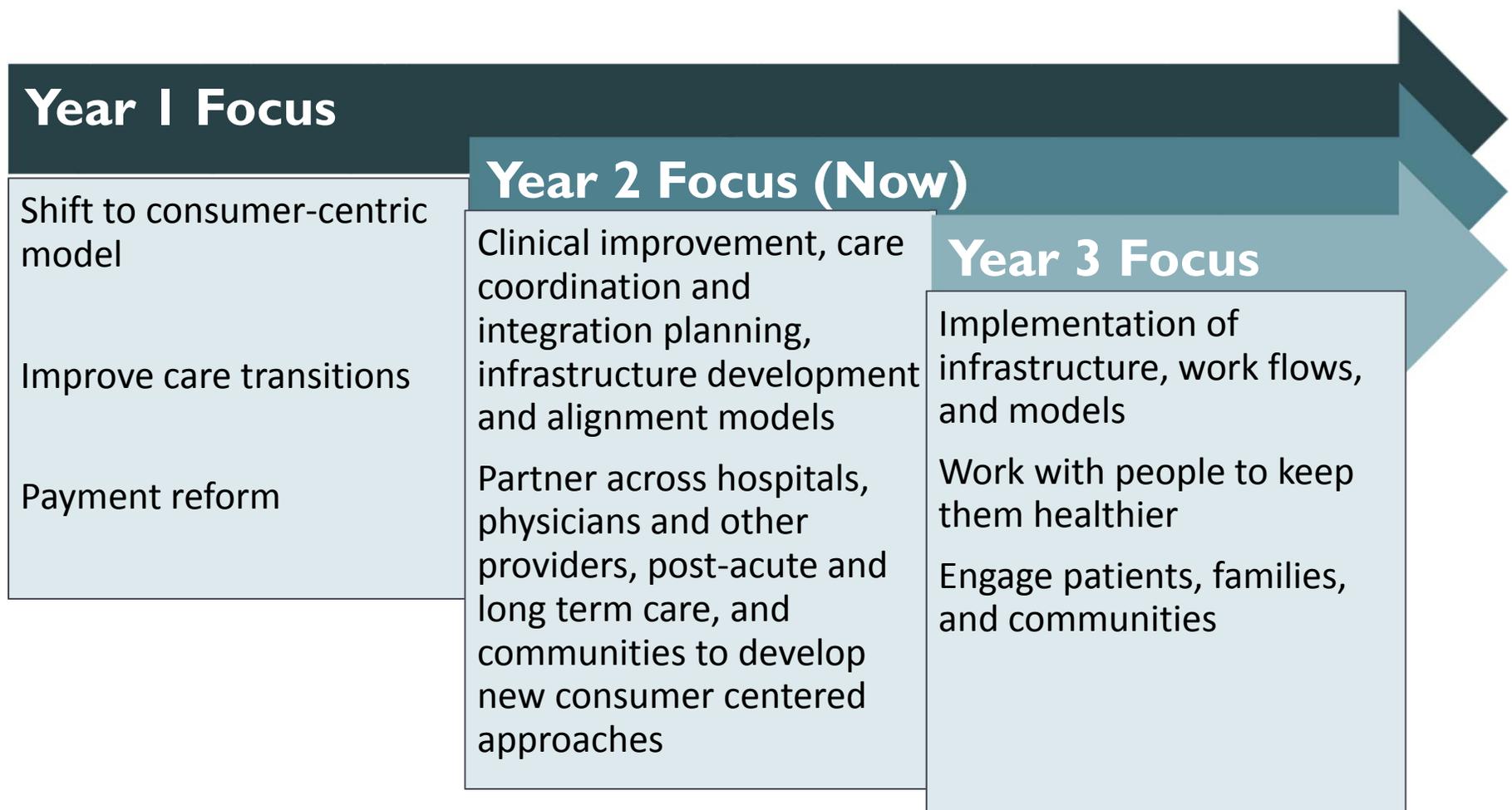
June 30, 2015

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# Regional Partnerships Reporting

# Regional Partnerships: Progress Requires Goals, and Goals Need Measures.

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# Regional Transformation Proposed Final Report Template

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## Regional Transformation Plan Template



### Goals, Strategies and Outcomes

Articulate the goals, strategies and outcomes that will be pursued and measured by the regional partnership.

Describe the target population that will be monitored and measured, including the number of people and geographical location.

Describe specific metrics that will be used to measure progress including patient satisfaction, quality, outcomes metrics, process metrics and cost metrics. Describe how the selected metrics draw from or relate to the State of Maryland's requirements under the new model.

Describe the regional partnership's current performance (target population) against the stated metrics.

# Performance Measurement

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Validated Measures

(Process, Cost, Quality, Patient Satisfaction  
Health)

Define Population

(Target Population, Region, Hospital level)

Adapt the measure to the plan

# Performance Measure Set

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## Core Set

- Uniform measures across all plans

## Plan Specific

- Validated measures based on plans
- New measures if needed

# Program Specific Measurement Potential Options

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- Maryland All Payer Model Contract Monitoring Measures
- GBR Infrastructure Reports
- HSCRC Total Cost Report (under development)
- CMS ACO Measure List
- Other validated quality measures
- Program specific unique measures

# HSCRC Total Cost of Care Report-Under Development

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## 1. Regulated:

- a. Hospital Inpatient:
  - i. Maryland Specialty Hospitals (Psych, Rehab, Children's Chronic)
  - ii. Maryland Acute Hospitals (Rehab, Oncology, Psych, Other)
- b. Hospital Outpatient:
  - i. Emergency Department
  - ii. Surgery
  - iii. Other Outpatient

## 2. Unregulated:

- a. Institutional:
  - i. SNF
  - ii. Long Term Care (LTC)
  - iii. Hospice
  - iv. Home Health
  - v. Other Institutional
- b. Professional:
  - i. ASC
  - ii. Urgent Care
  - iii. Primary Care
  - iv. Specialty
  - v. Therapies
  - vi. Other
- c. Other
  - i. Freestanding Lab
  - ii. Retail Pharmacy
  - iii. Freestanding Imaging

By  
Age,  
Zip Code,  
Payer Type

# ACO Measures

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- Set of measures that Medicare ACOs must report
- For purpose of demonstrating that care is being improved while savings are being realized
- Includes non-claims clinical data such as blood pressure readings
- Details can be accessed at:  
<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/R2015-Narrative-Specifications.pdf>
- Next slide shows a some measures that may be more applicable than others for this planning effort

# Some ACO Measures to Consider

Patient/Caregiver Exp	ACO #6	Shared Decision Making
Care coordination / Patient Safety	ACO #7	Health Status/Functional Status
	ACO #8	Risk Standardized, All Condition Readmissions
	ACO #9	ASC Admissions: COPD or Asthma in Older Adults
	ACO #10	ASC Admission: Heart Failure
	ACO #12	Medication Reconciliation
	ACO #13	Falls: Screening for Fall Risk
Preventive health	ACO #14	Influenza Immunization
	ACO #15	Pneumococcal Vaccination
	ACO #17	Tobacco Use Assessment and Cessation Intervention
	ACO #18	Depression Screening
At-Risk Population DM	ACO #27	Percent with diabetes whose HbA1c in poor control (>9 percent)
At-Risk Population IVD	ACO #30	Percent of beneficiaries with IVD who use Aspirin or other antithrombotic

# Example Difference Between ACO and PQI Measures: Uncontrolled Diabetes

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## ▶ ACO

- ▶ ACO # 27 = NQF 0059 (*NQF, National Quality Forum, is a place to find many more validated measures and links these to other sources*)
- ▶ Measure of poor control is percent of patients with an A1c > 9, so a clinical (non-claims) measure is needed
- ▶ Lens is physician panel of patients (or panels) but should be entire population as appropriate and possible

## ▶ PQI

- ▶ PQI # 14 = NQF 0638
- ▶ Measure of poor control is admissions for diabetes as a principle diagnosis (so claims data works and measure is an actual outcome of poor control)
- ▶ Lens is whole population in a geographic area

# Application of these Measures to Regional Partnerships

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- Selecting the Right Performance Measures
  - No need to reinvent the wheel or add new measures
  - Use Maryland measures, ACO measures or other NQF measures
  - Use evidence based or evidence-informed measures
- Some basic high level metrics are so fundamental to new All Payer Model and the goals of the Regional Partnerships, they should be included in all projects:
  - Recommended Core Outcome Measures
  - Recommended Core Process Measures
  - Recommended Core Savings Measures

# Recommended Core Outcome Measures for Regional Partnerships

Measure	Definition	Source	Population(s) expected
Total hospital cost per capita	Hospital charges per person	HSCRC Casemix Data	All population for covered zips, high utilization set, target population if different, each by race/ethnicity
Total hospital admits per capita	Admits per thousand person	HSCRC Casemix Data	
Total health care cost per person	Aggregate payments/person	HSCRC Total Cost Report	
ED visits per capita	Encounters per thousand	HSCRC Casemix Data	
Readmissions	All Cause 30-day Inpatient Readmits (see HSCRC specs)	Regional Readmission Reports (CRISP)	
Potentially avoidable utilization	Total PAU Charges/Total Charges	PAU Patient Level Reports	
Patient experience	TBD		
Composite quality measure	TBD		

# Recommended Core Process Measures for Regional Partnerships

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Measure	Definition	Source	Population(s) expected
Use of Encounter Notification Alerts	% of inpatient discharges that result in an Encounter Notification System alert going to a physician	CRISP	All population for covered zips, high utilization set, target population if different
Completion of health risk assessments	% High utilizers with <u>completed</u> Health Risk Assessments	Partnership	High utilization set, target population if different
Established longitudinal care plan	% of High Utilizers Patients with completed care	Partnership	High utilization set, target population if different
Shared Care Profile	% of patients with care plans with data shared through HIE in Care Profile	CRISP	High utilization set, target population if different
Portion of target pop. with contact from assigned care manager	% of High Utilizers Patients with contact with an assigned care manger	Partnership	High utilization set, target population if different

# Recommended Core Cost/Savings Measures for Regional Partnerships

- $ROI = G \text{ (variable savings)} \div D \text{ (annual intervention)}$
- ROI should be greater than 1 at steady state operations (and get there early)

Illustration	High Utilizers ≥ 3 IP Admits	High Cost Top 10%
A. Number of Patients	40,601	136,601
B. Number of Medicare and Dual Eligible	27,000	79,000
C. Annual Intervention Cost/Patient	\$3,500	\$3,500
D. Annual Intervention Cost (B X C)	\$95M	\$277M
E. Annual Charges (Baseline)	\$1.9B	\$3.8B
F. Annual Gross Savings (15% X E)	\$280M	\$570M
G. Variable Savings (F X 50%)	\$140M	\$285M
H. Annual Net Savings (G-D)	\$45M	\$8M

# Data Resources Available to Regional Partnerships

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- Regional Partnerships are expected to use a combination of data resources to monitor the performance of their programs
- Some data will need to be developed and produced by the Regional Partnership
- There are data resources available through DHMH, HSCRC and CRISP that can serve as a resource
  - An Inventory of data resources will be the subject of the July 9<sup>th</sup> Webinar
  - A Data Resources link is available on the Regional Partnership website that describes these resources

# Regional Partnerships Next Steps

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- Next webinars are:
  - July 9 – Data Resources (DHMH, HSCRC, CRISP and other)
  - July 23 – CRISP, activities list, tools to support transformation, e.g., care profiles and health risk assessments
- Report Inventory – in progress, to be posted on Basecamp

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# HSCRC Potential Consumer Engagement Measures

Prepared By:



NQF #	AHRQ #	Measure Title	Measure Description	Gap Area	Part of Cluster?	Program Alignment	Designated Care Setting	Designated Level of Analysis	Designated Data Sources	Stage II?	Stage III?
1919		Cultural Competency Implementation Measure	The Cultural Competence Implementation Measure is an organizational survey designed to assist healthcare organizations in identifying the degree to which they are providing culturally competent care and addressing the needs of diverse populations, as well as their adherence to 12 of the 45 NQF-endorsed® cultural competency practices prioritized for the survey. The target audience for this survey includes healthcare organizations across a range of health care settings, including hospitals, health plans, community clinics, and dialysis organizations.	Shared Decision-Making		MU2 Core: 80% all unique patients have demographics recorded (including language, gender, race, ethnicity...)	ASC; Ambulatory Care; Clinician Office/Clinic, Urgent Care, Emergency Medical Services/Ambulance; Home Health; Hospice; Hospital/Acute Care Facility, Specialty Hospitals	Facility; Health Plan; Integrated Delivery System	Healthcare Provider Survey		X
1641		Hospice and Palliative Care: Treatment Preferences	Percentage of patients with chart documentation of preferences for life sustaining treatments.	Shared Decision-Making/End of Life	Yes		Hospice, Hospital/Acute Care Facility	Clinician: Group, Facility	Electronic Clinical Data, EHR	X	
1898		Health literacy measure derived from the health literacy domain of the C-CAT	0-100 measure of health literacy related to patient-centered communication, derived from items on the staff and patient surveys of the Communication Climate Assessment Toolkit	Patient Nav/Self-Management	Yes		Ambulatory Care: Clinician Office/Clinic, Urgent Care, Hospital/Acute Care Facility	Facility	Healthcare Provider Survey		X
1892		Individual engagement measure derived from the individual engagement domain of the C-CAT	0-100 measure of individual engagement related to patient-centered communication, derived from items on the staff and patient surveys of the Communication Climate Assessment Toolkit	Patient Nav/Self-Management	Yes		Ambulatory Care: Clinician Office/Clinic, Urgent Care, Hospital/Acute Care Facility	Facility	Healthcare Provider Survey		X
1896		Language services measure derived from language services domain of the C-CAT	0-100 measure of language services related to patient-centered communication, derived from items on the staff and patient surveys of the Communication Climate Assessment Toolkit (C-CAT)	Patient Nav/Self-Management	Yes		Ambulatory Care: Clinician Office/Clinic, Urgent Care, Hospital/Acute Care Facility	Facility	Healthcare Provider Survey		X

# HSCRC CONSUMER ENGAGEMENT COMMUNICATION STRATEGY (PRELIMINARY)

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June 30, 2015

**Prepared by:**

Hillery Tumba

Communications Manager at Primary Care Coalition

CETF Member

# CETF Charge #1

- Provide a rationale for health literacy and consumer engagement
- Define audiences, identify messages, and propose education and communication strategies as appropriate
- Reflect the outcomes from the Communications and Community Outreach Task Force and the Care Coordination Workgroup

# Goals

- Engage, educate, and activate people in their own health care.
- Engage, educate, and activate consumers in health policy, planning, service delivery and evaluation at service and agency levels.
- Transformation of the health care delivery system to support consumer engagement.

# What Does Success Look Like?

- Target audiences understand how the health system should be used to achieve and maintain good health with
  - A positive experience
  - Good outcomes
  - Lower cost to them and to the system
- Improved health and cost reduction to the Maryland health care system.

# Objectives

1. Provide people with the information and resources needed to become health care aware consumers who are actively engaged in their own health care.
2. Empower people to contribute to decisions affecting their lives by providing with clear, culturally and linguistically appropriate, and actionable information and opportunities for effective interactions with health care professionals.
3. Educate people about the most appropriate settings for them to receive different types of health care.

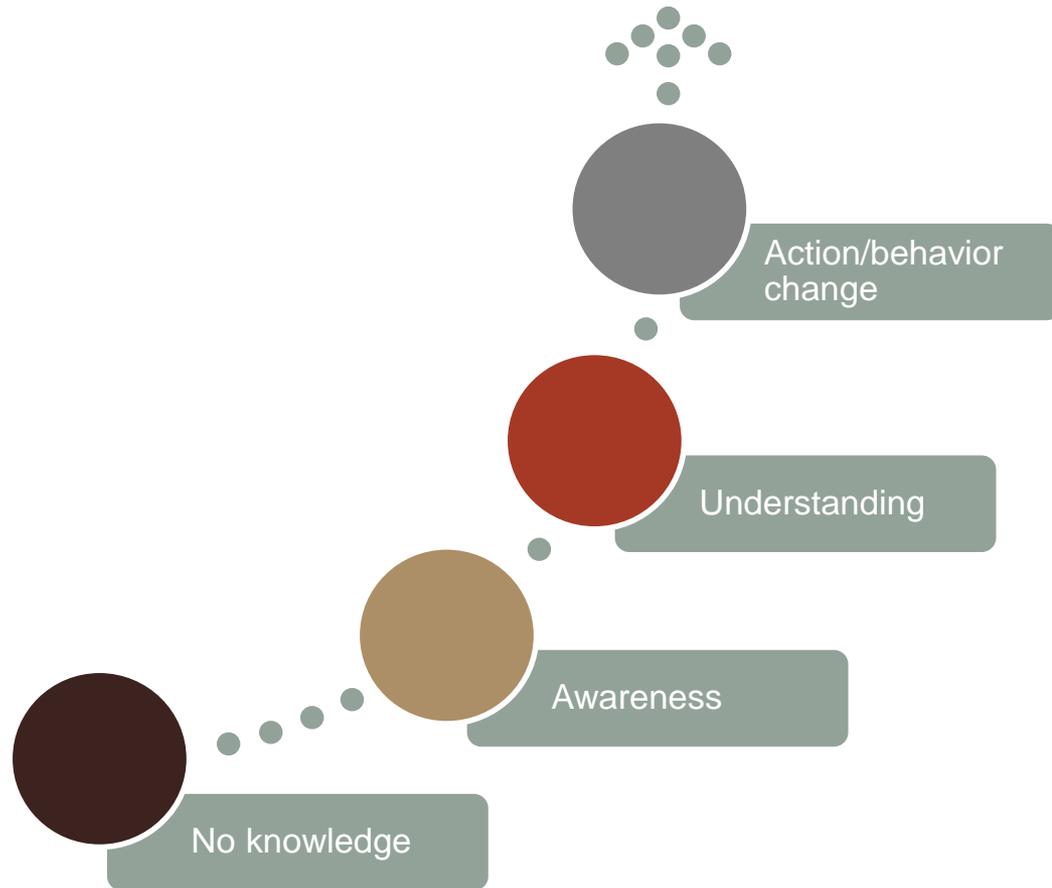
# Objectives (Continued)

4. Facilitate consumers' meaningful engagement in their own health care by educating and empowering people to employ care planning , self-management tools, and care coordination services if needed.
5. Create connections between government, hospitals, health care providers and individuals in the development of policies, procedures, and programs that will improve health outcomes, and patient satisfaction while lowering system costs.

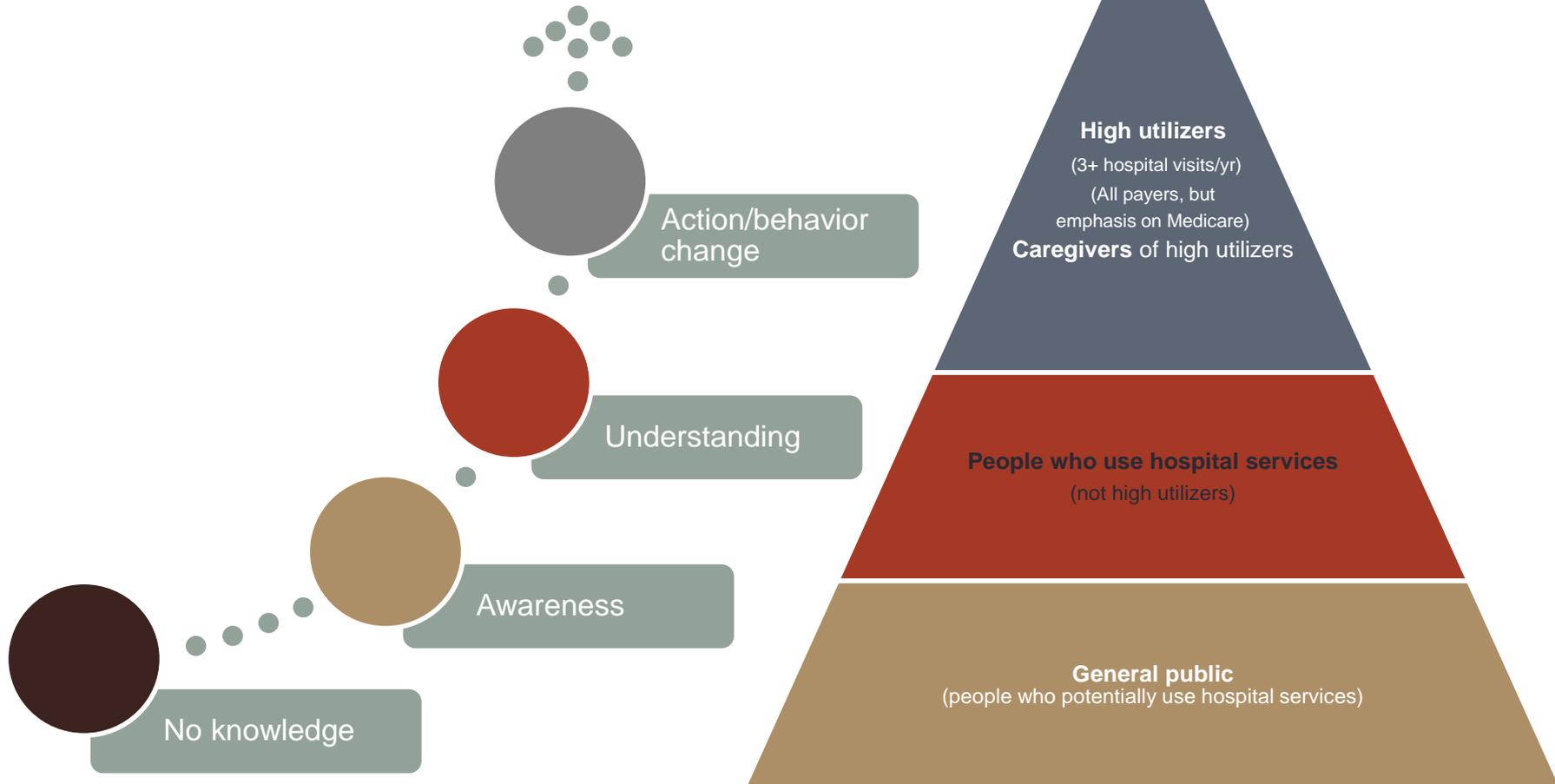
# Measures

- Knowledge and insight about a population or individual's level of engagement in health is critical
- Measures should be reliable, valid, and relevant to the audience(s)
- Potential domains to assess engagement comprehensively include:
  - Commitment
  - Ownership
  - Informed choice
  - Navigation
  - Confidence/trust
  - Health outcomes

# Audiences and Messages



# Audiences and Messages



# Audiences and Messages

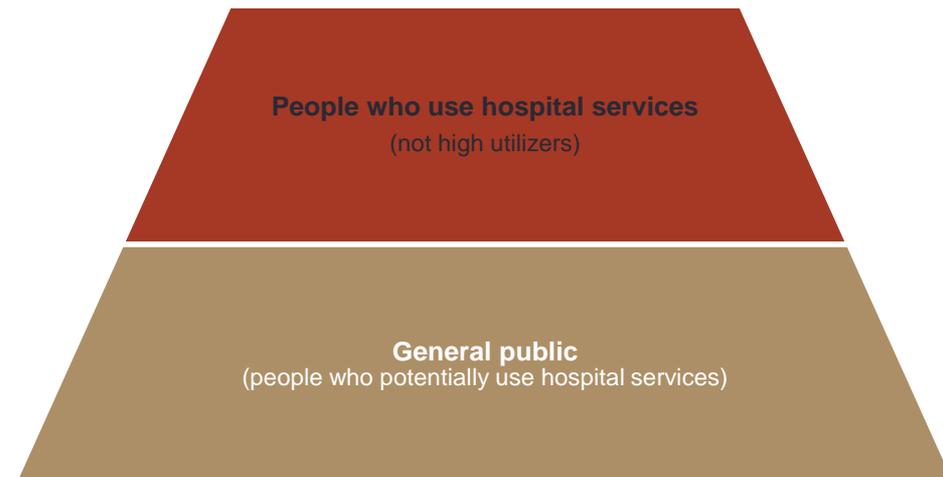
- Maryland is doing something unique and *you* are a part of it.
- Shop for health care quality. In Maryland, procedure cost should not influence your choice of hospital.
- The New All Payer Model will help you to get the right care, in the right place, at the right time.
- Teamwork among providers will make it easier for you to get care.
- You control who sees your health information.
- Know where to get your care (it costs you to get care in the wrong setting)
- Prevention is the most affordable care - see your doctor, eat healthy, live well.
- The money follows the patient – if your hospital performs well they will get more money

**General public**  
(people who potentially use hospital services)

# Audiences and Messages

## ***Same messages as general public plus***

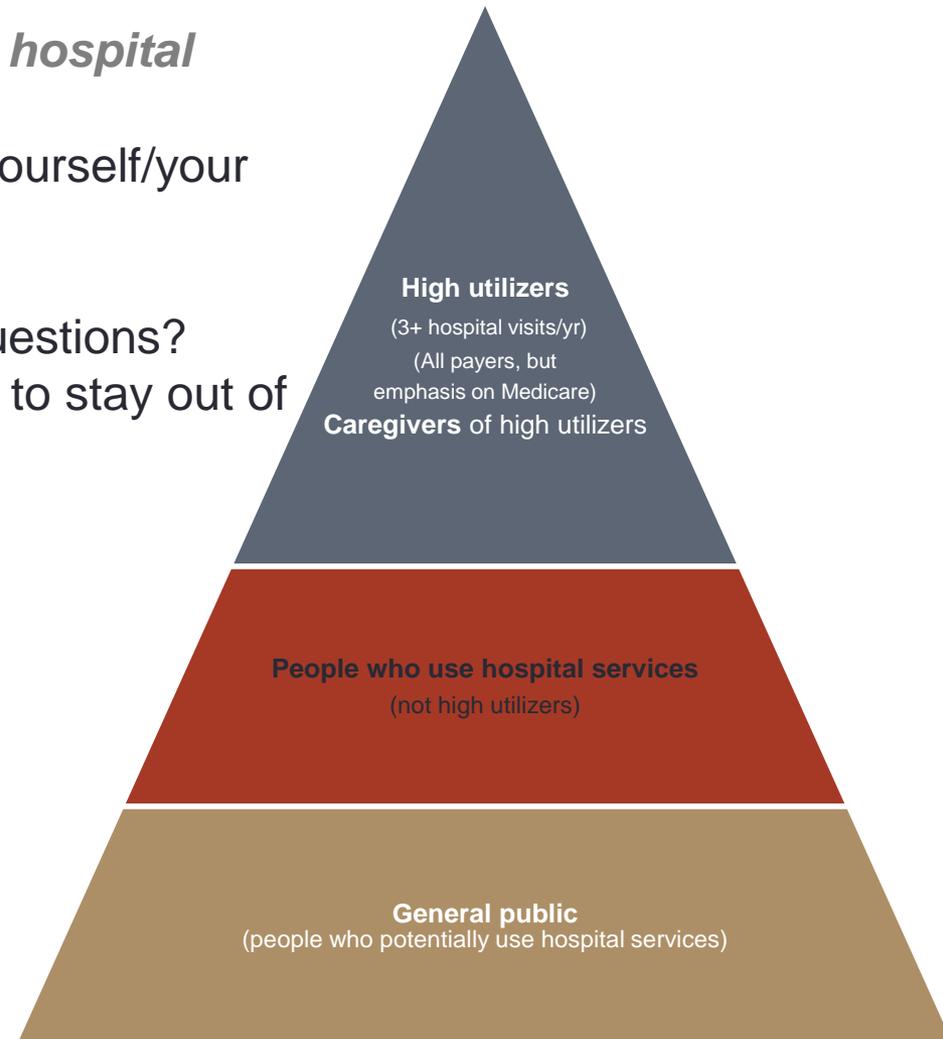
- Are you confident that you can manage your own health?
- Who is your primary care provider?
- Who should you call before you go to the hospital?
- Who should you call if you have a problem when you leave the hospital?
- What should you do when you leave the hospital?
- Do you have confidence in how your care is being managed?
- What are the primary causes for readmissions to hospitals and do you know how to prevent this/these?



# Audiences and Messages

*Same messages as general public and hospital users plus*

- Do you have a plan for taking care of yourself/your family?
- Do you understand the plan?
- Do you know who to ask if you have questions?
- Do you understand what you can do to stay out of hospital and in your home?



# Strategies and Tactics

- I. Consumer-centered policies informed by stakeholder involvement
- II. Hospitals incentivized to support individuals ability to access community based health care resources and manage their own care
- III. Health care aware consumers (patients, caregivers, etc.) provided with the information and resources they need to better manage their care.
- IV. Create a sense of ownership of the NAPM among consumers including high utilizers, people who use hospital services, and the general public.
- V. Ensure the cultural/linguistic appropriateness as well as accessibility and efficacy of materials provided by government, hospitals, providers, insurance carriers and others
- VI. Provide materials that appeal to diverse audiences and stakeholders

# Location Targeting

- Employ Singh Index to identify localized communities with high rates of hospital readmission.
- Collaborate with recipients of Regional Transformation Grants.
- Phase generalized engagement efforts (strategy IV) throughout the state starting in those areas with greatest numbers of high cost patients.

## Consumer Engagement Communication Strategy

### Goal(s):

- Engage, educate, and activate people who use (or are potential users of) hospital services in their own health care.
- Engage, educate, and activate people who use hospital services in health policy, planning, service delivery and evaluation at service and agency levels.
- Transformation of the health care delivery system to support consumer engagement.

**Comment [L1]:** see attached discussion points to address need to set as goal transforming the system.

**Comment [L2]:** See attached re. need to address the system vs. putting all of the emphasis on the consumer.

**Definition of Success:** Target audiences understand how the health system should be used to achieve and maintain good health with a positive experience, good outcomes and lower cost to them and the system, as evidenced by improved health and cost reduction to the Maryland health care system. .

**Alternate:** Target audiences have positive experiences and improved health outcomes which are aligned with a reductions in health care costs for individuals and the delivery system continuum..

### Objectives:

- Provide people who use (or are potential users of) hospital services with the information and resources needed to become health care aware consumers who are actively engaged in their own health care.
- Empower people who use (or are potential users of) hospital services to contribute to decisions affecting their lives by providing them with clear, culturally and linguistically appropriate, and actionable information and opportunities for effective interactions with health care professionals.
- Educate people who use (or are potential users of) hospital services about the most appropriate settings for them to receive different types of health care.
- Facilitate consumers' meaningful engagement in their own health care by educating and empowering people who use (or are potential users of) hospital services to employ care planning, self-management tools,, and care coordination services if needed.
- Create connections between government, hospitals, health care providers and individuals in the development of policies, procedures, and programs that will improve health outcomes, and patient satisfaction while lowering system costs.

**Comment [L3]:** added potential users of because it seems to me that care planning might include advance directives that should be done by full population

**Comment [L4]:** Is this strong enough ...see discussion question #1

### Measures:

Levels of consumer engagement in their health and health care vary greatly. In order to effectively design new programs and improve existing programs, knowledge and insight about a population or individual's level of engagement in health is critical. Payers, providers, regulators, and other organizations –as well as consumers themselves—can benefit from measures that are reliable, valid, and relevant to the audience(s) and, ideally, assess engagement comprehensively. Potential domains

Presented to CETF - 6.30.15

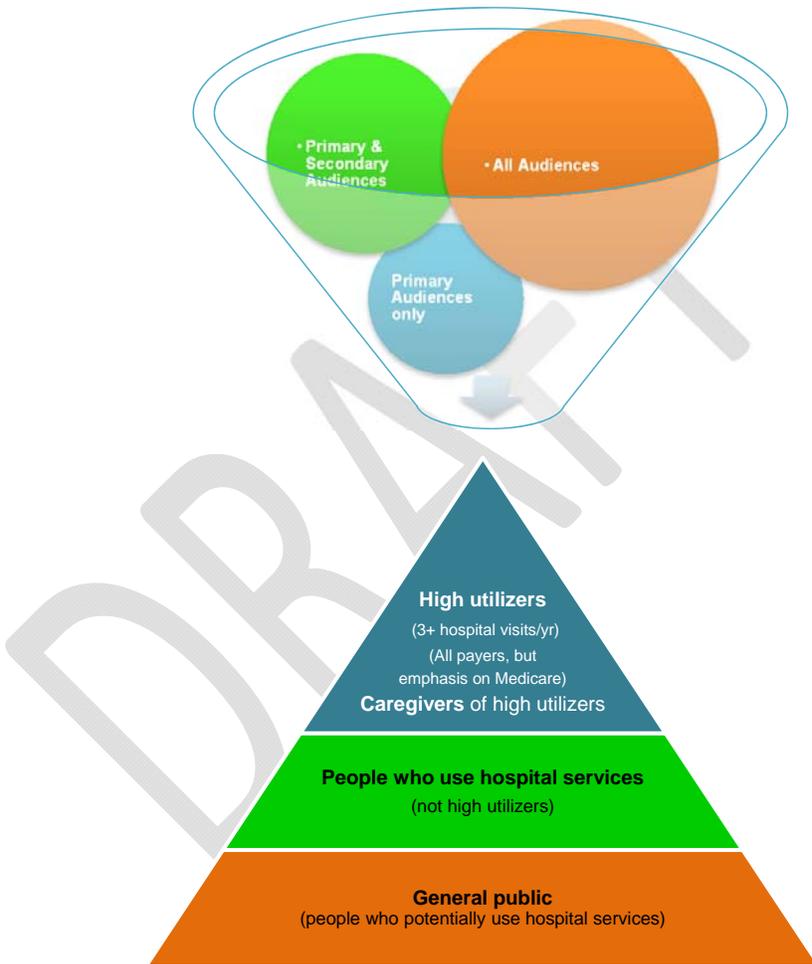
of health engagement may include commitment, ownership, informed choice, navigation, confidence/trust, and health outcomes.

- **[Note: Per Linda's suggestion we should have a section on measures. I can suggest lots of quantitative measures such as impressions, but think a focused discussion on the more meaningful outcomes focused measures is necessary. - HT]**

DRAFT

Presented to CETF - 6.30.15

**Audiences and Messages:** Segmentation of target audiences shows the priority of audience groups; however the messaging framework builds upon itself and funnels messages to audiences based on their priority. Primary audiences will be exposed to the general messages designed for all audiences *as well* as more specific messages focused on the behaviors we want to encourage specifically within our primary target audiences.



**1: Target audiences and messages.**

**Messaging Framework\*:**

<b>All</b>	<ul style="list-style-type: none"> <li>• Maryland is doing something unique and <i>you</i> are a part of it.</li> <li>• Shop for health care quality. In Maryland, procedure cost should not influence your choice of hospital.</li> <li>• The New All Payer Model will help you to get the right care, in the right place, at the right time.</li> <li>• Teamwork among providers will make it easier for you to get care.</li> <li>• Prevention is the most affordable care - see your doctor, eat healthy, live well.</li> <li>• You control who sees your health information.</li> <li>• Know where to get your care (it costs you to get care in the wrong setting)</li> <li>• Use “affordability” in language rather than “cost”</li> <li>• Your hospital - working to keep you healthy. The money follows the patient – if your hospital performs well they will get more money.</li> <li>• Are you confident that you can manage your own health?</li> </ul>
<b>Primary &amp; Secondary</b>	<ul style="list-style-type: none"> <li>• Are you confident that you can manage your own health?</li> <li>• Who is your primary care provider?</li> <li>• Who should you call <u>before</u> you go to the hospital?</li> <li>• Who should you call if you have a problem <u>when you leave</u> the hospital?</li> <li>• What should you do when you leave the hospital?</li> <li>• Do you have confidence in how your care is being managed?</li> <li>• What are the primary causes for readmissions to hospitals and do you know how to prevent this/these?.</li> </ul>
<b>Primary</b>	<ul style="list-style-type: none"> <li>• Do you have a care plan? Do you understand the elements of the care plan? Do you know who to ask questions of?</li> <li>• Do you understand what you can do to stay in good health?</li> </ul>
<b>Engaging Messengers</b>	<ul style="list-style-type: none"> <li>• Consumers/Patients who have culturally and linguistically appropriate information and tools targeted for their specific circumstances and which promote prevention will have better health outcomes with lower costs to the system.</li> <li>• Meet the patient where they are.</li> <li>• Dialogue and collaboration produce better outcomes...</li> <li>• "Health literate" consumers are more likely to incorporate healthy into their daily living</li> </ul>

**Comment [L5]:** This should probably be more nuanced -. Their treating providers share their information without their consent- allowed by HIPAA. They can opt-out of the HIE, but not granularly control at all.

**Comment [L6]:** don't know that this is alternative but along lines of what worked w/ focus group

**Comment [L7]:** Just trying this out here and in next group.

**Comment [L8]:** Maybe make this a little more consumer-friendly w/ Do you have a plan to take care of yourself or your loved one?  
Is this just when leaving hospital?

**Comment [L9]:** my attempt at the fisherman analogy

\* The messaging framework does not represent the final language, rather the core information or concept to be conveyed.

**Messengers and Distribution Channels:**

<b>Primary</b>	<ul style="list-style-type: none"> <li>• High utilizers</li> <li>• Caregivers</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Hospitals</b> <ul style="list-style-type: none"> <li>○ Medical staff</li> <li>○ Hospital volunteers and clergy</li> <li>○ Discharge planners</li> <li>○ Patient navigators</li> <li>○ Billing office</li> <li>○ Web-based resources</li> </ul> </li> <li>• <b>Payers</b> <ul style="list-style-type: none"> <li>○ Managed Care Organizations</li> <li>○ Insurance Carriers</li> </ul> </li> <li>• Community health workers</li> <li>• Community health clinics</li> <li>• Home health</li> <li>• Pharmacists</li> <li>• Primary care physicians</li> <li>• Caregiver support groups</li> <li>• Social workers/case managers</li> <li>• Long-term care facilities/providers</li> <li>• Behavioral health providers</li> <li>• Local Health Departments</li> <li>• DSS offices</li> </ul>
<b>Secondary</b>	<ul style="list-style-type: none"> <li>• People who use hospital services</li> <li>•</li> </ul>	<p>All of the above plus:</p> <ul style="list-style-type: none"> <li>• Advocacy and support groups for chronic conditions</li> <li>• ER waiting rooms (to reduce inappropriate use)</li> </ul>
<b>Tertiary</b>	<ul style="list-style-type: none"> <li>• General public</li> </ul>	<p>All of the above plus?</p> <ul style="list-style-type: none"> <li>• News media (traditional and online)</li> <li>• Community organizations</li> <li>• Primary care providers</li> <li>• Urgent care providers</li> <li>• Health fairs</li> <li>• MHBE/Connector Entities &amp; Partner Organizations</li> </ul>

**Comment [L10]:** aren't we talking about more than nurses?

**Comment [L11]:** or is this same as case managers

**Comment [L12]:** why aren't these under secondary & same w/ urgent care providers

**Comment [L13]:** Health fairs are sponsored by organizations and health departments. Suggest removing this here and tried to address in #III below.

Strategies and Tactics:

**I. Consumer-centered policies informed by stakeholder involvement**

- HSCRC - create opportunity for consumer representation on Commission
- HSCRC - Create a standing advisory committee (SAC) with broad representation, including consumers (see MHBE and MAC as examples)
- Educate consumer groups on how to effectively impact the design and implementation of the NAPM including how to reach the appointed consumer advocate on the HSCRC SAC.
- Educate consumer groups on how to effectively impact hospital policies and procedures
- Standardize hospitals' consumer feedback process for comments, complaints and commendations. and ensure that there is a meaningful response to complaints at the agency level.
- Develop and distribute information on how to provide consumer feedback for both state agencies and hospitals - in multiple formats (print and electronic) and that is culturally and linguistically appropriate for diverse populations
- Hospitals to provide multiple opportunities for consumers, representing the diversity of its community, to provide meaningful input on hospital governance.
- Develop and promote a Hospital 'Triple A' rating system based upon consumer engagement standards.

Comment [L14]: WE may want to change order of these

Comment [L15]: is it really the governance - i.e. system of management - or policies we are looking at?

Consider requirement that hospitals have PFACS and/or seats on relevant bodies

**II. Hospitals incentivized to support individuals ability to accessing community based health care resources and manage their own care**

- Require hospitals to provide transparent information on average procedure costs using the data made readily available by the Maryland Health Care Commission (www.marylandqmdc.org)
- Incorporate clear simple case management screening during discharge that coners social *and* health aspects necessary for a successful care transition. Ensure active listening and teach back methods are used during this screening.
- Encourage Medication Therapy Management for people at risk of becoming high utilizers.
- Encourage motivational interviewing for people at risk of becoming high utilizers.
- Encourage and reward Emergency Department based patient navigation that connects patients with appropriate community based resources (primary care, behavioral health care, social work case management, etc.).
- Promote the use of Community Benefit dollars to advance consumer engagement initiatives
- Encourage the use of Peer Support Specialist for behavioral health consumers

Comment [AE16]: Not sure if it fits there or elsewhere- you could also broaden in to say something like- encourage hospitals to engage with caregivers or patient advocates- such as peer support etc. Similar to the AARP request- caregivers need to be given info because often people leaving hospital aren't in a state to meet all their own health needs and fully understand their care plan.

**III. Health care aware consumers (patients, caregivers, etc.) provided with the information and resources they need to better manage their care.**

- Develop patient informed care planning resources to promote personal responsibility for care including advance directive assistance, POA for healthcare, etc.
- Develop clear public campaign with education materials in multiple formats to teach

consumers how to choose the right care, in the right place, at the right time.

- Provide materials in multiple formats that illustrates a care-transitions roadmap. This should include illustrations and helpful resources at each step.
- Create a searchable guide to community based resources (print and online) and allocate resources to keep this up to date.
- Provide consumers with a health care passport to complement electronic data transfer (Relying 100% on electronic health records and CRISP leaves out the most important person in the care team, the patient!)
- Offer consumers and caregivers electronic resources such as tele health, SMS follow up reminders, patient portals, etc.
- Work with CRISP et al, to develop clear communication materials about the HIE, including one consent form that can be used for any hospital or community provider.
- Recognizing that all residents could potentially use hospital services, develop materials to appeal to a broad base of Marylanders.

Comment [L17]: Needs to specify payer type accepted and wait times- or it is useless-

Comment [L18]: need to describe this

#### **IV. Create a sense of ownership of the NAPM among consumers including high utilizers, people who use hospital services, and the general public.**

- Create a NAPM-specific website for both the public and stakeholders (see #VI)
- Raise awareness of the New All Payer Model (NAPM) and involve the public in the count-down.
- Educate the general public about the NAPM and instill pride and excitement that Maryland is creating a unique model of delivery system transformation predicated on consumer involvement
- Develop a descriptive, compelling, and memorable brand for the NAPM Ensure that all consumer engagement materials are branded with core visual elements and messages
- Distribute frequent news releases and host press events to highlight NAPM successes , challenges. and opportunities for consumer engagement
- Modify display of state dashboard showing progress toward meeting NAPM goals so that it is meaningful to consumers (similar to a fundraising campaign). Promote this dashboard so that the public can easily find it (2 clicks or less).
- Issue frequent “report cards” illustrating progress toward meeting NAPM goals. Use this as a mechanism to celebrate successes and be transparent and forthcoming about challenges, possible solutions.and impact on consumers
- Develop talking points and engage people who command public attention as “champions” to talk about the NAPMs goals for improved quality of care and patient experience to their captive audiences and local communities (elected officials, community activists, local athletes and celebrities, business leaders, faith leaders, etc.)
- Mobilize grass-roots community organizers and partners to act as “ambassadors” for the NAPM in their home communities

## V. Ensure the cultural/linguistic appropriateness as well as accessibility and efficacy of materials provided by government, hospitals, providers, insurance carriers and others

### I. A note about plain language

*The taskforce recognizes that this report does not model plain language standards, as the target audience is members of the HSCRC who are accustomed to reviewing material with a high reading level.*

- 
- Involve consumer representatives in developing materials.
- Ensure basic health literacy and CLAS standards are followed . and that all materials are written at a 6<sup>th</sup> grade reading level.
- Ensure that all online materials are Section 508 compliant.
- Ensure that all information is available in at least one format that is appropriate for all ability types and literacy levels.
- Use surveys and/or focus groups to solicit consumer feedback on the design, format, and final language of materials prior to mass production.
- Provide information in formats that appeal to, and are accessible by, audiences across the spectrum of literacy and language needs.
- Build enough flexibility into consumer engagement materials to allow for localization of information and culturally appropriate translation of materials while being careful not to compromise the brand.

## VI. Provide materials that appeal to diverse audiences and stakeholders

- Develop standard materials as templates that can be customized with branding and sub messages specific to diverse stakeholders including hospitals, primary care practices, specialty care practices, advocacy and support groups for chronic conditions, etc.
- Use the NAPM website to act as portal from which stakeholders can download the templates for their use.
- To the extent possible, develop materials with a neutral appearance that complements the branding and style guides of as many hospitals as possible. (Be realistic about the extent to which this is possible, if branding styles are too disparate complement the look and feel of MHA materials.)
- Provide interactive “how to” materials that clearly illustrate various processes ranging from care transitions to submitting consumer feedback
- Deliver information in print, online, and mobile formats allowing each consumer to select the format that is most helpful to him/her.
- Create a single online resource containing consumer information relevant to the NAPM and link from that site to appropriate resources. Use simple web addresses and links so that web addresses are memorable and optimized for search engines. While existing sites may host this resource ensure that the front-end appears sleek and easy to navigate, avoid adding information to a crowded existing site.

**Comment [L19]:** Can't we say that the NAPM logo should be included on all relevant materials - would that address this?

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**Location Targeting:**

- Employ Singh Index of neighborhood disadvantage to identify localized communities with high rates of hospital readmission. Focus engagement strategies for high utilizers and care givers on these areas.
- Collaborate with recipients of Regional Transformation Grants and encourage them to engage consumers in developing their transformation plans.
- Phase more generalized engagement efforts (strategy IV) throughout the state starting in those areas with greatest numbers of high cost patients. (Efforts still need to be made throughout the state including in areas with lower cost patients. However, we can start with the low hanging fruit to begin to move the needle.)
  - Anne Arundel 3,601
  - Baltimore City 9,947
  - Baltimore County 7,742
  - Harford 1,875
  - Montgomery 3,697
  - Prince Georges 4,086

**Appendix A: Budget**

Many of the recommendations included in this document can be implemented at relatively little cost; however, the proposed strategies are mutually reinforcing and build upon one another over time. The exact budget for implementation will vary based on the strategies selected and the firm hired to develop and coordinate consumer engagement activities. The taskforce contacted three marketing and communications firms to obtain quotations for completing this work. The budget range proposed is based on the information provided by these firms.

**INSERT BUDGET RANGE. [Tiffany and Hillery to reach out to firms they know to obtain budget estimates.]**

**Appendix: Consumer and Community Engagement Principles**

- **Participation:** People and communities participate and are involved in decision-making about the health care system.
- **Person-centered:** Engagement strategies and processes are centered on people and communities.
- **Accessible and Inclusive:** The needs of people and communities, particularly those who may experience barriers to effective engagement, are considered when determining steps to enhance accessibility and inclusion.
- **Partnership:** People, including health care providers, community and health-related organizations work in partnership.
- **Diversity:** The engagement process values and supports the diversity of people and communities.
- **Mutual Respect and Value:** Engagement is undertaken with mutual respect and the valuing of other's experiences and contributions.
- **Support:** People and communities are provided with the support and opportunities they need to engage in a meaningful way with the health care system.

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- **Influence:** Consumer and community engagement influences health policy, planning and system reform, and feedback is provided about how the engagement has influenced outcomes.
- **Continuous Improvement:** The engagement of people and communities are reviewed on an on-going basis and evaluated to drive continuous improvement.

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## **Communication Climate Assessment Toolkit (C-CAT) Framework**

The C-CAT uses a series of coordinated measures in nine domains of communication. These nine domains were identified by an expert advisory panel and refined through the Ethical Force Program's consensus model. This framework will help organizations evaluate their communication policies and practices to ensure effective, patient-centered communication with people from diverse populations.

The nine domains of communication that the C-CAT evaluates are:

### **1. Leadership Commitment**

An organization should routinely examine its commitment, capacity and efforts to meet the communication needs of the populations it serves, including leadership involvement; mission, goals, and strategies; policies and programs; budget allocations; and workforce values

### **2. Information Collection**

An organization should use standardized qualitative and quantitative collection methods and uniform coding systems to gather valid and reliable information for understanding the demographics and communication needs of the populations it serves.

### **3. Community Engagement**

An organization should make demonstrable, proactive efforts to understand and reach out to the communities it serves, including establishing relationships with community groups and developing opportunities for community members to participate in shaping organizational policies.

### **4. Workforce Development**

An organization should ensure that the structure and capability of its workforce meets the communication needs of the populations it serves, including by employing and training a workforce that reflects and appreciates the diversity of these populations.

### **5. Individual Engagement**

An organization should help its workforce engage all individuals, including those from vulnerable populations, through quality interpersonal communication that effectively elicits health needs, beliefs and expectations; builds trust; and conveys information that is understandable and empowering.

### **6. Socio-Cultural Context**

An organization should create an environment that is respectful to populations with diverse backgrounds; this includes helping its workforce understand the socio-cultural factors that affect health beliefs and the ability to interact with the health care system.

### **7. Language Services**

An organization should determine what language assistance is required to communicate effectively with the populations it serves, make this assistance easily available and train its workforce to access and use language assistance resources.

## **8. Health Literacy**

An organization should consider the health literacy level of its current and potential populations and use this information to develop a strategy for the clear communication of medical information verbally, in writing and using other media.

## **9. Performance Evaluation**

An organization should regularly monitor its performance with regard to each of the prior content areas using structure, process, and outcome measures, and make appropriate adjustments on the basis of these evaluations.

For more information, please contact [CCAT@ama-assn.org](mailto:CCAT@ama-assn.org).

<http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program/patient-centered-communication/patient-centered-communication-framework.page?>

DRAFT: Outline of Consumer Engagement Task Force Report to the Commission  
6/29/15

1. Executive Summary
2. Background:
  - a. Overview of new All-Payer model and strong statement about linkage and importance to consumer engagement
  - b. Explanation of the purpose of this Work Group and our process
3. Broad vision
  - better care and population health, meeting the All-Payer near-term targets; how consumer engagement can contribute to achieving these goals.
  - The case for better consumer engagement--Overview of populations' prioritization
    - i. Rationale for focus (data and reason to focus efforts first on people with the greatest needs, then people that use hospital services, and then the public at large)
    - ii. Key determinants of need
  - Key Elements of Consumer Engagement
4. Existing infrastructure, gaps, opportunities to improve consumer engagement
5. Implementation strategies
  - a. Developing a communication strategy
  - b. Specifying key areas of focus
  - c. Identifying infrastructure needs
  - d. What are respective roles for different public and private sector organizations?
  - e. Determining the locus of new infrastructure (e.g. statewide, regional, local or hospital- specific)
  - f. Identifying infrastructure financing options
  - g. Specifying any legal and regulatory needs
6. Recommendations (Potential Areas of Recommendations)
7. Appendix of Important Resources