**Shady Grove Medical Center**

**Strategic Hospital Transformation Plan**

**December 7, 2015**

**Executive Summary**

Adventist HealthCare (AHC), including its two acute care hospitals, Shady Grove Medical Center (SGMC) and Washington Adventist Hospital (WAH), is the first and largest healthcare network based in Montgomery County and the largest provider of community benefits (FY2014). AHC provides a complete range of nationally recognized quality programs and compassionate care, ranging from surgery to rehab, home care and mental health, plus an array of wellness programs. The overall goal of AHC and its hospitals is consistent with that of the State of Maryland and the federal Affordable Care Act as well as the Institute for HealthCare Improvement’s Triple Aim of an effective, efficient and sustainable health care system for our community focused on efforts to improve health status and reduce health disparities. Specifically, AHC’s population health strategy is focused on achieving six overarching goals and as such has defined various initiatives targeted at meeting these goals. These goals include: (1) Improving Care Transitions by improving communication between providers, patients, caregivers, and community supports in order to provide appropriate, effective, efficient and safe care; (2) Developing and expanding infrastructure that facilitate greater physician alignment by optimizing the integration between hospital-based and community providers and building clinical integration and communication structures between community-based physicians; (3) Improving access to appropriate care for underserved populations by expanding primary care networks and partners, developing programs to foster patient engagement among underserved populations, and improving coordination of care between providers; (4) Reducing ED overutilization by identifying the underlying needs of high utilizers and facilitating patient linkages to primary care and specialty providers; (5) Improving the management of high risk populations including those with behavioral health issues by increasing touch points for targeted patients as well as outpatient and community-based services for underserved populations; and (6) Establishing a robust and enhanced community delivery network by developing a comprehensive, coordinated and integrated care continuum.

AHC and SGMC will continue to develop relationships and pursue initiatives that will support these goals and build an integrated delivery system built on population health management principles. We believe the supportive initiatives detailed below will allow AHC and SGMC to be successful in this transformation. Furthermore, our initiatives are aligned with those included in the SGMC FY2015 GBR infrastructure report, which describes investments in programs to ensure culturally-sensitive, quality care in various areas: prevention and wellness; organizational cultural and linguistic competence and health equity strategy to reduce disparities; enhanced access to primary care supports; community-based resources; partnerships to ensure coordinated care delivery; and primary care supports among others. Similarly, the SGMC community benefit report and Community Health Needs Assessment (CHNA) describe strategies to address population health needs (e.g., lung cancer screening), barriers to accessing healthcare, and ways to achieve better health through behavioral health interventions and prevention activities as well (e.g., diabetes self-management education and support for the uninsured). Finally, AHC and other Montgomery County hospitals participate in the NexusMontgomery Regional Partnership with the Primary Care Coalition of Montgomery County (PCC) to develop an infrastructure and multiple care management interventions to address preventable utilization by improving access for the uninsured, scaling up existing care transition services, and improving care coordination.

1. **Improving Care Transitions**

**Supporting Initiatives.** The improvement of care transitions to and from the acute care setting through effective communication among other providers, patients, caregivers and community support will lead to a reduction in hospital readmissions, improved patient outcomes, improved patient satisfaction, reduction in the total cost of care, and ultimately to the improvement in the overall health of the population.

There are certain socio-economic and clinical factors that lead to increased risk for avoidable utilization and contribute to the need for greater focus on the transition of care. The attached screening tool (Appendix A) was recently developed by AHC to identify patients that are at a high risk for readmission. Staffing investments will ensure that all high risk patients are assessed by case management to determine discharge needs/disposition and make appropriate arrangements through the coordination with other providers. Through this enhanced discharge process, every high risk patient will be discharged to an outpatient program that meets his or her needs. These programs may include SNF placement, acute rehab placement, home health, Carelink care coordination services, and SGMC Transitional Care Program. In addition to the risk stratification tool, a high risk discharge checklist (Appendix B) has been developed to ensure that all high risk patients have the basic needs addressed at discharge. This process tool will be built, electronically in the EMR, hardwiring the discharge process and allowing for better tracking of outcomes.

SGMC has developed a new “Transitional Care Program” (see Appendix C) focused on empowering the patient to manage their health successfully in the outpatient setting. This 90-day outpatient care coordination program offers an initial hospital visit at no cost to the patient.  The program requires sustainment of current full-time staff totaling 4 RN FTEs. The RN Transitional Care Manager follows the patient until discharge and addresses medication understanding and access, equipment needs, transportation, and follow-up with a PCP within 7 days of discharge. The hospital then provides the first home visit within 72 hours of discharge that focuses on medication reconciliation, discharge instructions review, a home safety check, preparation for follow up appointment with their primary care provider, and disease specific education and associated action plans. The home visit is followed by weekly phone calls and additional home visits provided throughout the program as needed. The RN or CHW will also attend the primary care provider appointment. Patients are provided with discharge instructions, disease specific education materials, medication cards filled out by the hospital, pill boxes and a notebook to record questions they would like to address during their post-acute provider visit. If patients have a diagnosis of Congestive Heart Failure (CHF) and/or diabetes, they will also receive telehealth services and will be monitored remotely every 24 hours by an RN.

The Behavioral Health Outpatient Wellness Clinic provides bridge appointments within seven days of discharge from inpatient services. The Needs Assessment team provides behavioral health evaluations and disposition services for the Washington Adventist emergency department. The Needs Assessment team works closely with the transitional care team in the emergency department to appropriately coordinate care in the community to avoid unnecessary readmissions.

Many of the patients discharged from SGMC to a SNF remain very high acuity which often presents transition of care challenges. Shady Grove has partnered with Sound Physicians, our current Hospitalist program partner, to embed providers at various local skilled nursing facilities.

SGMC is working to develop a Transitionalist Program to assist with the care of high risk patients being discharged to four of the local facilities in the hospital service area (those closest to SGMC).

Sound Physicians will imbed providers in Montgomery Village Healthcare Center, Collingswood Nursing Home, Potomac Valley Nursing and Wellness Center to transition patients from the hospital and assume care of the patient for the first 30 days at the facility. The Transitionalist will be notified by the Hospitalists of any patient without a PCP being discharged to any of these nursing homes, either by a phone call, through the nursing home liaison or through an order in the patient’s discharge summary. The Transitionalist has full access to the hospital’s EMR.

SGMC is currently partnering with local SNFs within its hospital service area to streamline the communication process when transitioning patients to and from the emergency room. This initiative is centered on improved care coordination, decreased readmissions and decreased admissions. This hospital plans to work with each facility to implement INTERACT and utilize the corresponding toolkit during the transfer process. The hospital will also identify a dedicated phone line for nurse to nurse communication/report as well as a dedicated phone line for provider to provider communication/report that will be used at every patient transfer. SGMC will provide shared EMR access between the hospital and the facilities in order to view pertinent patient information.

SGMC continues to invest in the development of an ED U-Turn program which is focused on decreasing unnecessary admissions and readmissions at SGMC by assessing patients for discharge needs, both medical and social, at the point of entry into the hospital. ED U-Turn Care Coordinators are imbedded in the ED to assess every patient and determine if there are any services or interventions that could be offered to discharge them directly from the ED and avoid an admission/readmission. The care coordinators also work very closely with the SNFs in SGMC’s hospital service area to determine appropriateness for admission and increased communication. This will expedite treatment and allow for appropriate and timely admissions to the hospital. Through the ED U-Turn Program at SGMC, intensive care coordination and multidisciplinary care planning for high utilizers is also provided.

SGMC also plans to partner with the Coordinating Center to provide light care coordination services for high risk, Medicare patients after discharge from a local skilled nursing facility who originated in the acute care setting at SGMC. The target population for this strategy includes those that are discharged from a skilled facility prior to 30 days. The Coordinating Center will provide light touch while the patient is in the facility, which will intensify upon discharge.

**Target Population.** Improving transitions of care will target the high-risk population in the acute care setting as determined by the risk stratification tool shown in Appendix A. Specific programs will target skilled nursing patients that originated in the acute care setting at SGMC and skilled nursing patients at four local facilities in the hospital service area. Additionally, behavioral health patients will receive community-based services and support in an outpatient setting.

**Specific Metrics**. The following metrics will be used to evaluate success and progress of the strategy. Specific definitions of select measures can be found in Appendix D.

* Reduction in Readmission Rate (including for behavioral health conditions)
* Reduction in Admissions from targeted SNFs
* % of Patients discharged with services
* % of Skilled Nursing Patients monitored by hospital staff

**Other Participants**. Outside partners include the local skilled nursing facilities detailed above, local home health agencies, including Adventist Home Health, Family Services Carelink, and The Coordinating Center. Behavioral health partners include Suburban Hospital, MedStar Montgomery Medical Center, Holy Cross Hospital, Montgomery County Department of Health and Human Services, Collaboration Council for Children, Youth and families, Montgomery County Fire and Rescue Services, Montgomery County Alcohol and Other Drug Abuse Advisory Council, Montgomery Correctional Facility, Primary Health Coalition, Family Services, Asian American Health initiative, Latino Health Steering Committee, African American Health Program, Interfaith Works, NAMI, and the Crisis Intervention Team for Montgomery County.

**Financial Sustainability**. The financial sustainability for these initiatives is partially supported by the initial infrastructure amounts received in rates in FY 2014 and 2015 and grant funding. This funding allows SGMC to fund start-up costs and additional resource requirements for some of these initiatives. Long term sustainability and the further expansion of these and other like programs will be funded by achieving the desired outcomes of these initiatives. A reduction in avoidable utilization will reduce some expenses to the hospital without initially causing a reduction in revenue which in turn will provide the hospital with the economic resources to sustain and grow programs that further reduce utilization and improve the health of the community.

1. **Developing Physician Alignment Infrastructure**

**Supporting Initiatives.**  Physician alignment is the effective coordination and collaboration between hospitals and physicians, and is a foundational goal to the provision of accessible, high quality, cost effective care for our community. AHC’s strategic focus for this goal is twofold: (1) Optimize the integration between hospital-based and community providers to improve access, patient engagement, clinical information systems integration, and care management transition collaboration; and (2) Build clinical integration and communication structures between community-based physicians to increase the effectiveness and efficiency of care. AHC is involved in several initiatives to advance this strategy of effective physician alignment: MidAtlantic Accountable Care Organization, One Health Quality Alliance, Ambulatory Care EMR Support program, and Population Health information infrastructure.

AHC sponsors the Mid-Atlantic Accountable Care Organization (ACO), which is comprised of 5 practices (~1,100 MDs) and 4 AHC hospitals, caring for nearly 14,000 Medicare patients. The ACO integrates patient-level data from hospital and ambulatory claims and clinical sources and utilizes those data to help drive point of care decision making, as well as stratify patients that benefit from intensive case management and care transition services. AHC has also formed a Clinically Integrated Network, One Health Quality Alliance (OHQA), engaging nearly 450 community and hospital based specialists in 43 community practices along with SGMC to coordinate patient interventions, manage quality and communication across the continuum of care and drive population health management. The providers in the OHQA have jointly come together to take on responsibility for improving quality and lowering the total cost of care delivered. AHC also sponsors the Ambulatory Care EMR support (ACES) program, which assists ambulatory physicians with the acquisition of an EMR and offers the following services: EHR Implementation Strategy & Planning, EHR Implementation, EHR – Optimization, Care Management System Implementation, Practice Dashboard Reports, and Lab/Radiology Interfaces. These services have been provided to over 55 ambulatory practices affecting over 500 community physicians and aligning them with AHC. Within the next 12 months, AHC plans to invest in a Population Health software platform that will support these organizations and provide the physician participants with actionable data critical to high-quality, coordinated patient care. This tool will leverage any data, any EHR, any vendor and any format to identify gaps in care for patient populations critical to the practice populations and quality improvement.

AHC has also set up a private Health Information Exchange (HIE) to create a longitudinal health record for the community providers to connect to and view data across the care continuum. This private HIE is registered with the Maryland Health Care Commission. AHC will expand its original scope to serve as a mechanism to connect ambulatory practices to the Maryland State Health Information Exchange (CRISP) as well. This will allow enhanced care coordination across the AHC healthcare system and improve quality care for patients beyond our current population. This would give an ambulatory practice the longitudinal patient record across all encounters at hospitals in Maryland, Delaware and Washington DC.

**Target Populations.** The specific target patient populations for this strategy involves patients who are transitioning between the hospital in-patient units and Emergency rooms and the community setting, as well as the patients under the care of the 450 providers in the network as well as the physician providers. The target physician populations for this strategy include hospitalists and hospital-based specialists, emergency room physicians, community primary care providers and community specialty care providers.

**Specific Metrics.** The following metrics will be used to evaluate success and progress of the strategy. Specific definitions of select measures can be found in Appendix D.

* Reduction in Hospital Admits per Capita
* Reduction in Health care costs/person
* Reduction in ED visits/person
* Reduction in Readmission Rate
* Reduction in PAU Rate for selected conditions
* Targeted Quality Metrics
* Increased Use of ENS
* Increased Number of Shared Care profiles
* % of Practices achieving Meaningful Use HIE goals
* Patient Satisfaction with care coordination
* Patient Satisfaction with physician/hospital communication

**Other Participants.** The physician alignment strategy involves relationship-building between hospital based and ambulatory providers, a coordinated IT infrastructure, enhanced documentation and dedicated care management handoffs between levels of care. The strategies are being advanced through the ACO, OHQA, and ACES, within a population health IT infrastructure. The ACO and OHQA physician/hospital participants meet regularly in structured board and quality and IT committee structures to develop standards and protocols to govern treatment and utilization of services, appropriate performance standards and goals, and appropriate utilization of providers and quality measures. The ACES providers utilize a common EMR platform to enhance data interoperability. AHC’s work on a population health infrastructure will create reporting structures to share the data and best practices among participating practices. Together, the organizations are creating a value-based care model and implementing collaborative approaches to manage population health in our area.

**Financial Sustainability.** The physician alignment strategy includes investments in physician connectivity, interoperability and enhanced communication infrastructure to support care coordination. These investments will drive improved quality of care and promote disease detection and prevention, enhanced primary care/specialty care/hospital and post-acute care collaboration, and, ultimately, increased health and wellness of the community. These investments will promote a virtuous cycle of connectivity among community and hospital providers and unlock resources that will drive overall financial sustainability of the strategy.

1. **Improving Access to Care**

**Supporting Initiatives.** Increasing access to care for underserved populations is a critical goal related to both SGMC’s mission and IHI’s Triple aim. SGMC’s strategic focus to achieving this goal includes: Primary care expansion, patient engagement especially targeting high-risk and underserved populations, alignment/integration among hospital/clinic/physician systems, and clinical systems information coordination through health information exchange (HIE). The overall SGMC population health strategic plan includes delivery of chronic disease care management to improve community health by establishing clinical integration across the AHC system and community partners, expanding medical home capabilities outside the hospital, leveraging links between IT platforms (e.g., HIE), and implementing health equity and wellness approaches to address community health needs, especially for the underserved. SGMC’s strategic delivery model includes various initiatives that reach all populations, but particularly those who are high utilizers (or at risk of becoming so) of hospital and emergency care, including disadvantaged populations (e.g., homeless, uninsured).

AHC’s Center for Health Equity and Wellness (the Center) is essential to AHC’s execution of population-based care by providing community-based health education and wellness classes, disease prevention and management programs, and health screenings (e.g., blood pressure, BMI, body composition, carbon monoxide) that are culturally/linguistically appropriate (e.g., bilingual health educators) and aligned with community health needs. AHC and the Center will leverage existing partnerships with Montgomery County Department of Health and Human Services (HHS), Primary Care Coalition of Montgomery County (PCC), and local safety net clinics resulting in several highly successful collaborations that will continue to help to ensure that underserved populations have access to and receive primary care services.For instance, SGMC will participate in the HHS Maternal Partnerships Program to provide obstetric and gynecologic services for uninsured women in Montgomery County. Also, SGMC will provide breast cancer screening and navigation for low-income women through partnerships with PCC, Women’s Cancer Control Program of Montgomery County, Maryland Cancer Crusade, and private foundations.

There are several community-based programs and initiatives in AHC’s plan to help people understand their health risks and self-manage diabetes including: healthy cooking and nutrition classes, evidence-based Diabetes Self-Management Program/Education, informal diabetes education to individuals in a group medical appointment, peer-led support groups to encourage healthy lifestyles, and community health education and screening. SGMC will continue to provide Diabetes Self-Management Education (DSME), accredited by the American Association of Diabetes Educators (AADE); and a free, community-based Stanford Model Diabetes Self-Management Program (DSMP) to people living with type-2 diabetes. SGMC will provide these programs to improve community health in populations that are likely to experience socioeconomic disadvantages and barriers to accessing health care. These programs align with community health needs identified in the SGMC Community Health Needs Assessment (CHNA).

To expand health information exchange, ACES will enhance the Adventist Health Information Exchange in 2016 to send safety-net EHR data from eight PCC partnering clinics to the state-wide HIE, CRISP, and allow data from CRISP to flow back into the patient’s individual health record.  This capability will provide a more comprehensive longitudinal view of the patient’s care across CRISP-connected entities statewide. Additionally, AHC plans to assess the current systems in place for coordination of care with homeless services providers, and explore ways to improve health information exchange (e.g., using a Homeless Management Information System or CRISP) to improve care coordination and track patient admissions. AHC will continue to serve as the hospital representative on Montgomery County’s Interagency Commission on Homelessness and collaborate with local hospitals, homeless shelters, and county behavioral health and correctional programs to work to improve transitional care for homeless individuals who are discharged from the hospital. Also, SGMC will continue tosupport and partner with Interfaith Works, a non-profit organization in Montgomery County that provides assistance to the county’s homeless population.

**Target Population.** The target population includes high-risk, complex individuals, such as the chronically ill, homeless, underserved and uninsured, low-income, racial/ethnic minorities, and seniors, transitioning between inpatient units/emergency departments and the community. Homelessness, in particular, amplifies the threat of various health conditions and introduces new risks, such as exposure to extreme temperatures. People who experience homelessness have multidimensional health problems and often report unmet health needs, even if they have a usual source of care.

**Specific Metrics.** The following metrics will be used to evaluate success and progress of the strategy. These measures will include stratification by demographic characteristics to identify potential disparities in access to care experienced by different racial, ethnic, and socioeconomic groups (e.g., lack of insurance, delays in receiving care).

* Hospital Admits per Capita (e.g., by race, ethnicity, and language preference)
* ED visits/person (e.g., by race, ethnicity, payer, and language preference)
* Readmission Rate (e.g., by race/ethnicity)
* PAU Rate for selected conditions (e.g., diabetes, heart failure, septicemia)
* Targeted Quality Metrics (e.g., flu immunization; outpatient core measures by race, ethnicity, and language preference)
* Patient Satisfaction with care coordination (e.g., HCAHPS data by race, ethnicity, and language preference)
* Patient Satisfaction with physician/hospital communication (e.g., HCAHPS data by race, ethnicity, and language preference)

**Other Partners.** This strategy includes partnerships among hospital-based and ambulatory providers, MidAtlantic ACO and One Health Quality Alliance, ACES, Center for Health Equity and Wellness (community-based health improvement), PCC, primary care safety net clinics, and HHS to improve access to care for underserved populations. AHC and SGMC partner with CCI, Mercy Health Clinic, and other clinics to provide free diagnostic services/lab work to their uninsured patients; and with Mobile Medical Care (MobileMed), which operates three mobile healthcare vehicles and provides primary and preventative healthcare to the uninsured, low income, working poor and homeless in Montgomery County.

**Financial Sustainability.** Some of the initiatives described above are subsidized through partial grants; however, because the objective of improved access to care is very much targeted at underserved populations with little or no financial means, there is often not a significant funding source for these types of activities. Financial efficiencies can be gained by eliminating the costs related to unnecessary utilization and improving access to and preventative services for these patients. This provides some offset for the expense incurred in providing these services and funding these initiatives. The remainder is a community benefit that SGMC and AHC are committed to, which is so important to AHC’s mission.

1. **Reducing Emergency Department (ED) Utilization**

**Supporting Initiatives.** SGMC is establishing initiatives to support the goal of reducing ED overutilization. Often overutilization is due either to the use of the ED for receiving care that would be more appropriately delivered in another care setting or frequent visits from patients with high risk factors that lead to unmanaged conditions. Top utilizers of the ED at SGMC are identified through reports from the EMR. A multidisciplinary team consisting of staff from population health, behavioral health, and ED nurses and providers meet every two weeks to review patients with the highest number of visits. The team then develops care plans that are entered into the EMR as a specialized note that remains with the patient across visits. This will be fully compatible with the care plan note and care profile currently being developed by CRISP. These comprehensive care plans and subsequent action items will be used to change overall utilization patterns for the highest utilizers and improve ED throughput.

SGMC will also submit plans to secure HSCRC grant funding to promote appropriate health care for the uninsured individuals who use the ED as a primary source of care. With this funding, the hospital plans to support the ED U-Turn Program and hire CHWs to provide intensive navigation to insurance enrollment assistance for uninsured clients; and identify primary and behavioral health providers, as well as social service providers. This will also include text message campaigns and personal calls to maintain patient engagement. CHWs will also be used to promote appropriate healthcare options by assigning the CHW to geographical locations with a high concentration of self-pay ED users. Year 2 of funding will focus on gain-sharing with select providers for performance measures around ED utilization and hospitalization of patient panels.

**Target Population.** These initiatives are targeted at high utilizers of ED services, including the uninsured, severely mentally ill, and patients who are not actively connected to a primary care provider.

**Other Partners.** Outside partners include the other acute care hospitals in Montgomery County (WAH, MedStar Montgomery General, Holy Cross Silver Spring, Holy Cross Germantown, and Suburban), local skilled nursing facilities, home health agencies, Primary Care Coalition, primary and specialty care providers, and Family Services Carelink.

**Specific Metrics.** The following metrics will be used to evaluate success and progress of the strategy. Specific definitions of select measures can be found in Appendix D.

* Reduction in ED Visits
* Reduction in ED revisits
* Increase in Insurance enrollment for ED high utilizers
* Increased number of patients connected with PCP and Specialty care provider.
* Increase inUse of care plan notes
* Increase in Care profile entered into CRISP

**Financial Sustainability.** The financial sustainability for these initiatives is partially supported by the initial infrastructure amounts received in rates in FY 2014 and 2015 and grant funding. This funding allows SGMC to fund start-up costs and additional resource requirements for some of these initiatives. Long term sustainability and the expansion of these and similar programs will be funded by achieving the desired outcomes of these initiatives. A reduction in avoidable utilization will reduce some expenses to the hospital without initially causing a reduction in revenue, which in turn will provide the hospital with the economic resources to sustain and grow programs that further reduce utilization and improve the health of the community.

1. **Improving the Management of High Risk Populations and Behavioral Health Populations**

**Supporting Initiatives.** The hospital has developed multiple initiatives to support the goal of improving care for high-risk chronic disease patients and behavioral health populations. Similar to many other initiatives, these strategies are expected to reduce hospital readmissions, reduce total cost of care, improve patient outcomes, and improve the overall health of the population. Two Outpatient Wellness Clinics are scheduled to open in 2016. These clinics will increase access to a full range of mental health and substance abuse services to adults, children and adolescents as well as their families. One of these clinics will provide primary care services along with psychiatric and substance abuse clinical services. The integrated clinic will also have telemedicine capability to further expand access to patients remotely.

In addition to supporting behavioral health programs, SGMC’s Telehealth Program is designed to support independent living at home for individuals with chronic medical conditions through remote monitoring and consistent education regarding symptoms and action plans. Patients with CHF and diabetes are identified while in the hospital and enrolled in the program. By providing the patient with the appropriate device, an RN is able to monitor the patient every 24 hours to identify and intervene when early symptoms present in order to avoid an unnecessary ED visit or hospitalization. This service enables the patient and care team to catch early signs of decompensation, empowers the patient in self-care and simplifies patient management. SGMC will expand the recently implemented program to increase the number of patients reached.

Through participation in Nexus Montgomery, SGMC plans to partner with Montgomery County senior housing developments to target all Medicare and dually eligible residents age 65 and older to receive care coordination activities in order to avoid unnecessary ED and hospital utilization. Through this collaborative, the hospital plans to train individuals within the housing facility on high-risk criteria in order to facilitate proper identification. The identified residents will then receive care coordination activities provided by The Coordinating Center for approximately 60 days. All patients discharged from the hospital who are residents will also be referred to The Coordinating Center for care coordination activities post-discharge.

SGMC has established and will continue to offer a CHF clinic that is open one day a week to follow CHF patients who are high risk for readmission. These patients are identified at SGMC and managed by a multidisciplinary team including a case manager, nurse educator, and Cardiologist. Prior to discharge, the patients are given the appointments to the CHF clinic and followed for at least 30 days. The nurse educator follows the patient in the clinic and provides additional education to the patient and family as needed. Also, these patients are provided with a weighing scale and a blood pressure monitor, if they do not have one or access to one. Transportation to the clinic is provided if this is an issue for the patient.

**Target Population.** The overarching goal of decreasing avoidable utilization and managing high risk populations is targeted at those who have high risk diagnoses, such as CHF and diabetes, and those living in senior living housing in Montgomery County. Behavioral health patients are a significant part of the pool of high-risk, high utilizers identified by hospitals. The behavioral health target population is defined as individuals who have an axis one mental health diagnosis and at least one of the following: (1) chronic homelessness as defined by HUD, (2) minimal or no supports, (3) more than one acute hospitalization and/or ED visits, and/or (4) more than one incarceration.

**Specific Metrics.** The following metrics will be used to evaluate success and progress of the strategy.

* Reduction in Readmission Rate
* Reduction in ED visits (including visits for behavioral health conditions)
* Reduction in suicide rate
* Reduction in substance abuse mortality
* Reduction in incarcerations
* Reduction in overall admissions
* Improved self-management

In addition to the specific measures that can be measured by the hospital, Healthy Montgomery and the BHTF use several behavioral health measures to focus Healthy Montgomery’s behavioral health work and monitor progress. The measures include emergency department visits for behavioral health conditions, suicide rates, adolescent/adult illicit drug use in the past month, and adults with any mental illness in past year.

**Other Partners.** Outside partners include the Montgomery County acute care hospitals, Healthy Montgomery Steering Committee and Behavioral Health Task Force, local senior housing facilities, primary and specialty care providers, and telehealth partners such as Trapollo, and Philips.

**Financial Sustainability**. The financial sustainability for these initiatives is partially supported by the initial infrastructure amounts received in rates in FY 2014 and 2015 and grant funding through the HSCRC Transformational Grant. This funding allows SGMC to fund start-up costs and additional resource requirements for some of these initiatives. Long term sustainability and the further expansion of these and other like programs will be funded by achieving the desired outcomes of these initiatives. A reduction in avoidable utilization will reduce some expenses to the hospital without initially causing a reduction in revenue which in turn will provide the hospital with the economic resources to sustain and grow programs that further reduce utilization and improve the health of the community.

1. **Developing and Enhancing a Community Delivery Network**

**Supporting Initiatives.** The success of care transformation is largely dependent upon the health system’s ability to create a comprehensive and aligned health care delivery network by collaborating with existing providers, health systems and services. This approach requires health systems to conduct thorough assessment of not only their own services, but other providers, service organizations and systems in their community. Adventist HealthCare has been focusing on four major programs that will support the goal of aligning resources in the community to deliver comprehensive care without duplicating infrastructures or services.

*Urgent Care Centers.* As the largest emergency care provider in Montgomery County with emergency centers at SGMC, WAH and Germantown Emergency Center, AHC recognizes the value of providing care for episodic and exacerbation of chronic condition events at lower acuity facilities as an alternative to hospital emergency room care. AHC opened its first urgent care center in Rockville, MD in the heart of our community near SGMC and is planning to open two more centers in 2016. AHC CentraCare – Germantown will be an ideal alternative to both AHC’s Germantown Emergency Center and Holy Cross Germantown’s Emergency Room. AHC CentraCare – Laurel will serve residents of Upper Montgomery, Prince George’s and Howard counties and provide a lower cost setting for quality episodic care for residents. In addition, AHC will seek partnership opportunities with retail health clinics in local supermarkets and drug stores to make sure that appropriate health care is offered at appropriate settings where safe escalation of care is built-in to higher acuity settings by creating clinical pathways in collaboration with these providers.

*Outpatient Imaging Centers*. Redundant and duplicative imaging work-ups due to lack of proper incentives to reduce them or share information between providers and health systems have long been cited as one of the main reasons for the high cost of health care. Many systems have tried to solve this issue by working closely with independent radiology service providers without much success since creating the alignment necessary to achieve such outcomes was almost impossible under the fee-for-service model. In an effort to properly align radiology providers to focus on the quality of their work as well as reduction of overall utilization of services, AHC has recently acquired the main radiology services providers and their outpatient imaging centers which will be accelerating integration of services between inpatient, outpatient and emergency care. New and integrated imaging services at AHC will offer coordinated patient care and seamless handoff between care events for our community of physicians and patients.

*Tele-health including psychiatric services*. Healthcare consumers have demonstrated an increasing appetite for virtual encounters with their providers in recent years. Virtual care encounters when applied appropriately can not only revolutionize how healthcare consumers receive care, but also how healthcare providers offer timely, cost effective, and quality care with more time to devote to their patients. AHC plans to create a robust tele-medicine service offering for the community utilizing our clinically integrated network of physicians for various specialties including primary care. Some of the initial efforts will be dedicated to expanding psychiatric services by connecting psychiatrists at AHC Behavioral Health & Wellness Services to a broader network of patient care locations within AHC through tele-medicine.

*Ambulatory Surgery Centers.* With an increasing number of procedures being safely offered at Ambulatory Surgery Centers, creating appropriate surgical care spectrum within AHC has become an important aspect in developing community network of providers. AHC has been working with its physician partners and local ambulatory surgery service providers to align resources to create a full spectrum of surgical services from the lowest acuity surgical procedures to complex cancer surgeries by creating clinical pathways for standardized care approaches, by planning new infrastructures that will serve our community’s surgical care needs yet not become a redundant and duplicative facility that competes unnecessarily, and by exploring different payment models through clinically integrated physician network.

**Target Population**. For these more global strategies, they are directed at the targeted service area, which includes the communities served by AHC.

**Specific Metrics.** The following metrics will be used to evaluate success and progress of the strategy. Specific definitions of select measures can be found in Appendix D.

* Reduction in Total health care costs per person
* Reduction in ED Visits per capita
* Reduction in Potentially avoidable utilization
* Reduction in Total hospital admits per capita

**Other Partners.** The following partners have been working collaboratively to build community delivery network: Physician partners providing emergency care at AHC’s acute care hospitals, primary care in AHC’s target service area, diagnostic services in AHC’s acute care hospitals, and surgical services to AHC’s target service area; MedStar Montgomery, Holy Cross Silver Spring, Holy Cross Germantown, and Suburban Hospital.

**Financial Sustainability.** The financial sustainability for these initiatives is primarily supported by AHC’s capital investment and operational income from ambulatory services such as outpatient imaging centers and urgent care centers. Long term sustainability and the further expansion of these and other like programs will be driven by the level of success in shifting of patient care activities to more appropriate settings by aligning reimbursement model to encourage such shifts.

**Appendices**

**Appendix A. Readmission Risk Score**

Exclude: Post-Partum, Nursery, Pediatrics, Outpatients, and Scheduled Procedures

1. Length of Stay 3-6 days 3
2. Length of Stay 7-13 5
3. Length of Stay 14+ 7
4. 30 Day Readmission 6
5. High Risk Diagnosis (PNE, CHF, Sepsis, AMI, CVA/TIA, DKA, PVD, Psych, Metastatic Tumor, ESRD) 6
6. Frequent ED Visits (2 or more per month) 5
7. Problem Medications (Anticoagulants, Insulin, Oral Hypoglycemics, Plavix/ASA dual therapy, Narcotics) 3
8. Poor Health Literacy (unable to teach back or understand basic health terms) 3
9. Self-Pay/Inadequate Financial Support 3
10. Poly-pharmacy (6 or more meds) 3
11. Frequent Admissions (2 or more within last 180 days) 2
12. Home Bound/Bed Bound 2
13. Chronic Cognitive Impairment 2
14. SNF Resident 2
15. Terminally Ill 2
16. Decubitus or Non Healing Wound 2
17. Needs Assistance with ADL’s or is dependent 1
18. Homeless/Shelter 1
19. Age 75 or greater and lives alone 1
20. Acute Confusion/Disorientation 1
21. Drug/ETOH Abuse 1
22. No support system/lack of family care 1
23. Hearing/Visual Impairment or Illiterate 1
24. Lack of transportation 1
25. Vent Dependent 1
26. Falls or Hx of falls in last 3 months 1

**Appendix B. Hospital Discharge Checklist**



**Appendix C. Transitional Care Program**



**Appendix D. Table of Select Metric Definitions**

|  |  |  |  |
| --- | --- | --- | --- |
| **Measure** | **Definition** | **Source** | **Population(s) expected** |
| Total health care cost per person | Aggregate payments/person | HSCRC Total Cost Report | All population for covered zips, high utilization set, target population if different, , each by race/ethnicity |
| ED visits per capita | Encounters per thousand | HSCRC Casemix Data | All population for covered zips, high utilization set, target population if different, , each by race/ethnicity |
| Potentially avoidable utilization | (see HSCRC specifications) | PAU Patient Level Reports | High utilization set, target population if different, each by race/ethnicity |
| Total hospital admits per capita | Admits per thousand | HSCRC Casemix Data | All population for covered zips, high utilization set, target population if different, each by race/ethnicity |
| Increased Number of Shared Care Profiles | Number of Practices within the One Health Quality Alliance receiving Shared Care Profiles on patients from CRISP | One Health Quality Alliance | Patient population covered by the One Health Quality Alliance’s 43 practices |
| % of Practices achieving Meaningful Use Stage 2 HIE metric | Number of Practices within the One Health Quality Alliance that successfully meet the CMS Stage 2 MU guideline under the Health Information Exchange measure | One Health Quality Alliance | This metric will cover the 450 providers in the One Health Quality Alliance, and measure the P2P communication between those providers |
| Patient Satisfaction with Care Coordination and Physician/Hospital Communication | Patient Satisfaction scores on an administered CAHPS survey under the domain areas of Care Coordination and Communication | One Health Quality Alliance results on the CAHPS surveys | Patient populations covered by the One Health Quality Alliance |
| Diabetes Testing Measure | **The percentage of members 18–75 years of age diagnosed with diabetes (type 1 and type 2) who had HbA1c testing in measurement year** | One Health Quality Alliance | Patient populations covered by the One Health Quality Alliance and MidAtlantic ACO |
| Diabetes Control Measure | * **The percentage of members 18–75 years of age with diabetes whose**   **most recent HbA1c level (during measurement year) is >9%** | One Health Quality Alliance | Patient populations covered by the One Health Quality Alliance and MidAtlantic ACO |
| Depression Screening Measure | * **Percentage of patients aged 18 years & older screened for clinical depression on using appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen** | One Health Quality Alliance | Patient populations covered by the One Health Quality Alliance and MidAtlantic ACO |
| Post-Partum Depression Screening Measure | * **The percentage of postpartum patients screened for clinical depression using depression screen within 3 months of delivery** | One Health Quality Alliance | Patient populations covered by the One Health Quality Alliance |
| Smoking Screening/Cessation Education Measure | * **Percentage of members 18 years of age and older who were current smokers or tobacco users & who were recommended cessation medications during the measurement year.** | One Health Quality Alliance | Patient populations covered by the One Health Quality Alliance and MidAtlantic ACO |
| Breast Cancer Screening Measure | * **Breast cancer screening: percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer any time on/between October 1-2 years prior to the measurement year and December 31 of the measurement year** | One Health Quality Alliance | Patient populations covered by the One Health Quality Alliance and MidAtlantic ACO |
| Pediatric BMI screening measure | * **Percentage of members 3–17 years of age who had an OP visit with a PCP or OB/GYN and who had evidence of the following during the measurement year.**   + **+BMI percentile documentation**   + **+ Counseling for nutrition**   + **+ Counseling for physical activity** | One Health Quality Alliance | Patient populations covered by the One Health Quality Alliance |
| Total hospital admits per capita | Admits per thousand | HSCRC Casemix Data | All population for covered zips, high utilization set, target population if different, each by race/ethnicity |