UNIVERSITY of MARYLAND
ST. JOSEPH MEDICAL CENTER

Strategic Hospital Transformation Plan – December 7th 2015

Executive Summary

As a proud member of the University of Maryland Medical System, the University of Maryland St. Joseph Medical Center (UM SJMC) provides the highest quality health care service for our community's medical needs. In close collaboration with its physicians, staff and community partners, UM SJMC provides a continuum of loving service and compassionate care for its patients and community members. As a Catholic hospital observing the *Ethical and Religious Directives,* UM SJMC is committed to:

- Making UM SJMC the preferred health partner for patients and providers
- Serving and advocating for those who are poor and marginalized
- Partnering with others to improve the quality of life in our community.

UM SJMC is located in a northern suburb of Baltimore County. The Primary and Secondary Service areas cover patients from a wide geographical area that spans from Owings Mills in the western side of Baltimore County to Essex and Dundalk in Eastern Baltimore County and reaches up into Southern Pennsylvania along the I-83 corridor. This area represents a broad range of populations in terms of economic, ethnic, racial and urban/rural considerations. It's important to note when considering the UM SJMC primary service area that there is a large pocket of unmet health needs in Hunt Valley in Northern Baltimore County. This largely Hispanic population is both underserved and underinsured and is an area from which many patients of our St. Clare Medical Outreach, a free clinic for those without health insurance, come from. UM SJMC has devoted considerable time and resources during the last 20 years in support of this population.

Community health outreach has been a mainstay of UM SJMC's philosophy of care and community commitment since its founding in 1864 by the Sisters of St. Francis of Philadelphia. In the mid-1990s, UM SJMC's St. Clare Medical Outreach began providing free primary care services to the underserved via a mobile van. The mobile van was retired in 2010, and since that time, a permanent home for the St. Clare Medical Outreach has been established. The bilingual staff provides more than 2,000 visits annually to culturally diverse patients needing primary care and health education.

UM SJMC's dedicated staff of certified community health specialists and one nurse have planned and held more than 200 health education events and free screenings in FY 15 serving almost 11,000 participants. Other programs coordinated by the community health team include free cancer screenings (breast, prostate, skin), weight and nutrition management and educational series, Living Well, designed to help patients living with chronic diseases such as congestive heart failure, COPD and diabetes. The team also recently launched a program called Stepping On to help reduce fall risks among the senior population.

Guided by the findings of the most recent Community Health Needs Assessment (CHNA), the community health team is able to respond and directly impact the health and educational needs of the community. Because access to health care rises to the top of the key health issues, the community health team has orchestrated a plan to move beyond the borders of the medical center campus and reach deeper into the community with events covering Baltimore County. This also included striking a partnership with the Y of Central Maryland to be the health provider of choice for the Towson location. The table below illustrates key health issues as prioritized from the most recent CHNA

Strategic Hospital Transformation Plan – December 7th 2015

Ranking of Key Health Issues from CHNA

Rank	Health Issue	% Respondents who selected this issue	% Respondents who selected this as most significant issue
1	Access to health care	72%	33%
2	Overweight/Obesity	56%	22%
3	Mental Health/Suicide	44%	22%
4	Diabetes	33%	6%
5	Substance Abuse/Alcohol Abuse	22%	6%
6	Heart Disease	17%	0%
7	Maternal/Infant Health	17%	6%
8	Aging/Chronic Disease Disability	17%	0%
9	Cancer	11%	6%
10	Tobacco	11%	0%

In addition to our longstanding relationship with the community, UM SJMC has taken an active interest in working toward reducing potentially avoidable utilization. A steering committee of key leadership, including the President and CEO of UM SJMC meets weekly to discuss utilization trends, assess progress with current initiatives and engage our providers in solution-oriented discussions with timely execution.

This document outlines many of the major strategies that have taken shape based on UM SJMC's assessment of its community's needs and active monitoring of avoidable utilization of hospital resources via readmissions, revisits, PQIs and PPC's.

UM SJMC realizes that hospitals can no longer maintain their myopic approach toward delivering healthcare and the need to engage our community partners in efforts as we work toward owning the patient experience across the care-continuum. With increasing access to health care, members of our community will need more affordable and efficient opportunities than those traditionally offered in a higher cost hospital setting. We must create these opportunities such that fewer patients require hospitalization and more patients engage in their own health care destiny. In accordance with this philosophy, UM SJMC has developed a Transformation Plan that establishes ten (10) specific strategies to support goals in the following care settings:

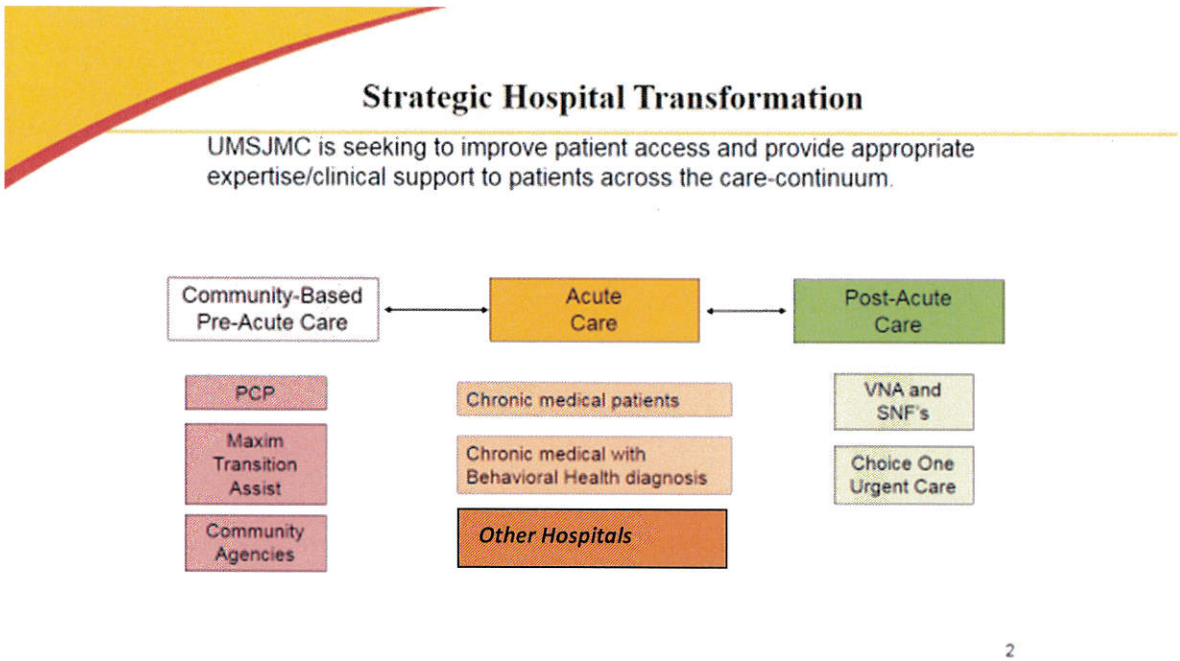
- Community Based Pre-Acute Care
- Acute Care
- Post-Acute Care

Each strategy addresses a specified transformational need, directs internal UM SJMC resources, and identifies collaborative community partners where appropriate.

Strategic Hospital Transformation Plan – December 7th 2015

1) Describe your overall goals:

University of Maryland St. Joseph Medical Center (UM SJMC) is seeking to better serve its' community in the most appropriate care-setting (pre-acute, acute-care, post-acute). Through strategic investments and partnerships with both hospital based and non-hospital based providers, UM SJMC is looking to enhance patient experience, improve quality of care and reduce unnecessary utilization of resources within the acute care setting.



Pre-Acute Care

Strong partnerships in this setting allow for UM SJMC to manage patients' in the community before they require the services of the Hospital.

Acute Care

High-risk patients that are discharged from UM SJMC stand to benefit with a more integrated network of hospital and non-hospital providers. UM SJMC has a strong foundation in both the pre-acute and post-acute care setting and is looking to build upon these to help manage patients in the most appropriate care setting.

Post-Acute Care

Closer collaboration and open communication with facilities regarding best patient practices will allow for improved patient care/patient satisfaction.

Strategic Hospital Transformation Plan – December 7th 2015

2) ***List the overall major strategies (3-10) that will be pursued by your hospital individually or in collaboration with partners (and answer questions 3-6 below for each of the major strategies listed here):***

Partnership Strategies	**Underway**	**Under-development**
1) Transition Assist Program	In home post discharge, 30 day follow up for high risk Med/Surg patients	In home post-discharge, 60-90 day follow up for high risk Behavioral Health patients, and high risk med/surg patients with behavioral health co-morbidities
2)Home-health Collaborative	Working closely with VNA to develop and implement best practice guidelines for care post-discharge for surgical patients, with particular focus on reducing readmissions	Expansion of partnership to work towards better serving patients with Behavioral health needs
3)SNF Collaborative	Working with top 6 sub-acute with a heavy focus on retrospective readmission review	Expansion of partnership to work towards better serving patients with Behavioral health needs at risk for acute care intervention
4)Urgent Care Center Investment	3 strategically placed urgent care centers that serve as an alternative to ED visit or after hours consult	Opening of 2 additional centers planned for CY 16
5)Discharge Medication program	Bedside delivery of medication in select patient units, pharmacy consults for patients at discharge and lastly a post d/c call follow up by pharmacy.	Expand bedside delivery of medication to every patient unit
Hospital Strategies	**Underway**	**Under-development**
6)Case Mgmt Care-plans	Care planning for ED high-utilizers	Expanding scope beyond ED to look at PAU population
7)Post Discharge Clinic	Recruitment in process of a care team (hospitalist, pharmacist, social worker and MA) to focus on High-Utilizers	Planning in process of a care team to focus on Behavioral Health High-Utilizers

8)Referral Coordinator	Coordinates appointments for patients without PCP for ED and inpatient admissions.	Expanding scope beyond PCPs to include appointments to cardiology, pulmonology, and endocrinology.
9)Palliative Care expansion	Currently we have a 0.8 FTE physician, 0.9 FTE NP for palliative care	Looking to expand to 1.5 FTE physician and 0.9 FTE NP
10)Outpatient Diabetes program	Most recently expanded the role of the outpatient diabetes educator to a full time position	Expansion of group classes to meet time considerations for patients

3) Describe the specific target population for each major strategy

Partnership Strategies	Target Population	Future Target Population
1)Transition Assist Program	High risk Med/Surg patients admitted to UM SJMC. (Using a risk stratification tool based on comorbidities and socioeconomic drivers)	High risk Medicare Behavioral Health patients w/underlying chronic conditions
2)Home-health Collaborative	Retrospective look at readmissions by DRG. Identifying trends to improve patient care post-discharge. Example: best practice guidelines developed for OHS and Ortho patients	Expansion of partnership to work towards better serving patients with Behavioral health needs
3)SNF Collaborative	Working with top 6 sub-acute care facilities with a heavy focus on retrospective readmission/high utilization review	Expansion of partnership to work towards better serving patients with Behavioral health needs
4)Urgent Care Center Investment	Low-acuity ED volume that can be seen in a more cost-effective setting. Pre-operative surgical testing. Per our CHNA, this serves our populations in Dundalk/Essex and Jacksonville.	Same

5)Discharge Medication program	Bedside delivery of medication in select patient units, pharmacy consults for patients at discharge and lastly a post d/c call follow up by pharmacy.	Expand bedside delivery of medication to every patient unit
Hospital Strategies	**Target Population**	**Future Target Population**
6)Case Mgmt Care-plans	3 or more admissions via ED within a 6 month period	Potentially avoidable utilization population specifically high utilizer Medicare PQI/RA population
7) Post Discharge Clinic	High-utilizer Medicare patient population with CHF, COPD, Septicemia, Pneumonia	High-utilizer Medicare patient population with behavioral health diagnosis/underlying chronic conditions
8)Referral Coordinator	Patients without a Primary Care physician in need of a post-discharge follow-up	Patients in need of a timely specialist appointment (will be discharged with appointment in hand)
9)Palliative Care expansion	Currently we have a 0.8 FTE physician, 0.9 FTE NP for palliative care	Looking to expand to 1.5 FTE physician and 0.9 FTE NP
10) Outpatient Diabetes program	Patients who are flagged as diabetics will receive inpatient consult and opportunity for follow-up appointment in clinic	Expanding the diabetes clinic as a community resource and referral destination for providers outside the hospital. Increase inpatient consults to diabetic admission and diabetes related admission (example: ICU, HF patients).

4) Describe the specific metrics that will be used to measure progress including patient Satisfaction; quality, outcomes, process and cost metrics for each major strategy

Type	Metric	Applicable Strategy
Regulated	Pre and post utilization of regulated services *(See table 1a)*	Applies to all strategies (1-10)

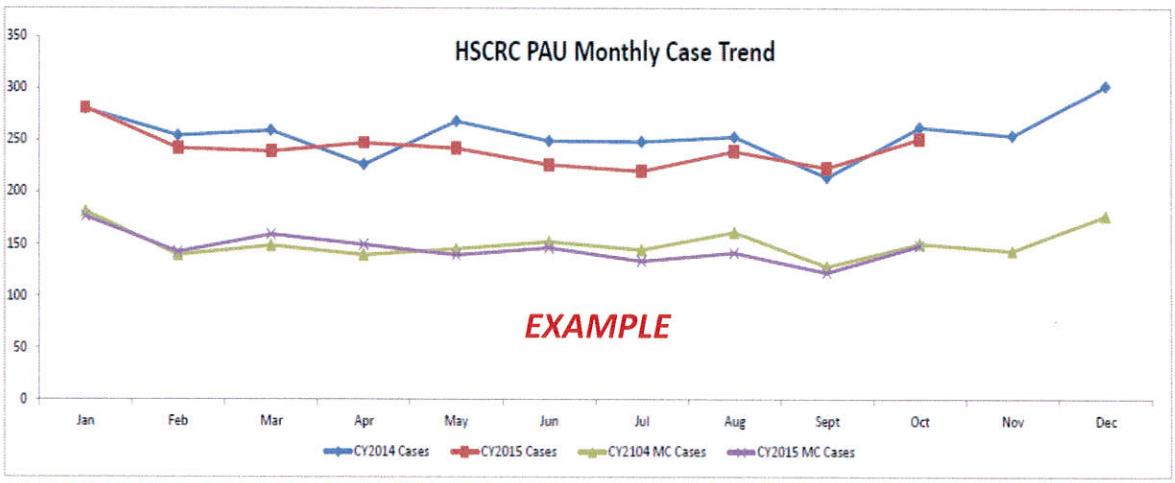
	Reduction in Potentially Avoidable Utilization (PAU) *(See table 1b)*	Applies to all strategies (1-10)
Other Regulated	Total hospital utilization (cost) per capita Total hospital admit per capita ED visits per capita Length of stay improvement Patient satisfaction scores	Applies to all strategies (1-10)
Unregulated	Growth in PCP patient panels Decrease in UM SJMC avoidable utilization for PCP panels Growth in Transitional care billing Growth in Chronic Care Management services PQI Quality metrics to be measured and improved upon once EMR is established (6/16) Patient Satisfaction with partners in pre-acute and post-acute care settings related to accessibility of timely appointments and quality of care	Applies to strategies (1,2,3,4,6,7 & 8)

Table 1a - Pre and Post Utilization of Regulated Services

METRIC	3 months BEFORE Care Plan Implemention	3 months AFTER Care Plan Implemention	% Change
# of ED Visits	561	243	***-56.7%***
# Admissions	112	45	***-59.8%***
# Observations	45	25	***-44.4%***
# of Morphine-like* Drugs Administered in ED	116	56	***-51.7%***

EXAMPLE

Table 1b - Reduction in Potentially Avoidable Utilization



5) ***List other participants and describe how partners are working with you on each specific major strategy***

Strategy	Non-Hospital Provider Partners
1)Transition Assist Program	Maxim – Industry partner that assesses admitted patients who qualify as high-risk based on psycho social criteria. Upon discharge patients are enrolled in Maxim's outpatient program where they are managed for 30 days post-discharge in the home, utilizing community health workers in conjunction with nursing and provider input
2/3) Home-Health/SNF Collaborative	Key representation from home-health care and local sub-acute care rehab facilities come-together once a month to do a retrospective review of readmissions. As a next step these members are being consulted to advise UM SJMC on how we can support their behavioral health patient populations' health needs.
4)Urgent Care Center Investment	Choice-One Urgent Care industry partner. Currently working with our Emergency Department and medical staff to serve as an alternative to the ED. The ultimate goal is to treat patients in the most appropriate care setting while decreasing unnecessary utilization of hospital resources.
5)Discharge medication program	Partnership with Walgreens to deliver medication at the patient bedside. The aim here is to allow for patients to leave with their medications in hand promoting better medication adherence and patient satisfaction
Strategy	**Hospital Provider Partners**
6)Case Mgmt Care-plans	Working with both employed and community based primary care providers to provide care planning resources (when needed) to their patients who are frequent flyers to our hospital. Utilization of CRISP database to understand patients' utilization of regulated services.
7)Post Discharge Clinic	Collaborating with Visiting Nurses Association, local sub-acute care facilities, Shepard Pratt and community agencies to serve as a resource for high utilizer chronic medical and behavioral health Medicare patients who do not have timely follow-up to appropriate clinical expertise. Utilization of CRISP database to understand patients' utilization of regulated services.

8)Referral Coordinator	Collaborating with our employed providers to improve timely access for patients discharge from UM SJMC in need of follow up with a primary care provider or specialist. Utilization of CRISP database to understand patients' utilization of regulated services.
9)Palliative Care expansion	Our palliative care team works collaboratively with our medical staff and appropriate patient population that would benefit from palliative care consult/follow-up
10)Outpatient Diabetes program	Working with our hospitalists and primary care practice to better identify patients in need of consultation and outpatient clinic visit.

6) ***Describe the overall financial sustainability plan for each major strategy***

Investment in population health initiatives are focused on the reduction of potentially avoidable utilization amongst the Medicare population as the highest users of services. Improved utilization will impact all patients regardless of payor, but Medicare patients being high utilizers will be impacted the greatest. With an average approved charge per case (ACPC) of approximately $12,000. The direct variable costs associated with each avoided readmission would reflect an average savings of approximately $4,000 per case. Savings per case will vary based on the case type and severity. This impact will most directly be seen in supply and drug costs which are assumed to be 100% variable. Additional savings will be realized, but to a lesser extent, in ancillary utilization and direct labor costs. In summary, the strategies listed below will help reduce overall hospital utilization and cover the costs of these programs. Our goal would be to continuously improve upon these initiatives and expand where there is further opportunity. Our efforts will be supported with tighter alignment with our community based partners.

Strategic Hospital Transformation Plan – December 7th 2015

Strategy	**Financial Sustainability** **Non-Hospital Provider Partners**
1)Transition Assist Program	Reduction in potentially avoidable utilization to UM St. Joseph and Maximizing State incentive programs i.e. Readmission Reduction Incentive Program, etc.
2/3)Home-Health/SNF Collaborative	Retrospective 'avoidable utilization' review has allowed for the development of best practice guidelines for care post-discharge within select service lines: Cardiac Surgery, Orthopaedics and Cardiology (Congestive Heart Failure). An improvement in Readmissions and unnecessary utilization across these services and beyond.
4)Urgent Care Center Investment	Reducing lower level acuity visits to the ED i.e. wound checks, suture removal, vaccinations, etc. Educating community providers about considering Urgent care vs. ED during off-hours
5)Discharge medication program	Improved Patient Satisfaction scores, increased patient compliance and lower unnecessary utilization
Strategy	**Financial Sustainability** **Hospital Provider Partners**
6)Case Mgmt Care-plans	Assessing pre- and post-utilization for frequent flyers (3 month pre-window vs. 3 month post-window). A decrease in avoidable utilization i.e. revisits to the ED, readmissions and PQI.
7)Post Discharge Clinic	Reduction in potentially avoidable utilization to UM St. Joseph and neighboring partner hospitals. Maximizing State incentive programs i.e. Readmission Reduction Incentive Program, etc. Increased patient satisfaction.
8)Referral Coordinator	Growth in PCP patient panels and increase in transitional care billing for primary care providers.
9)Palliative Care expansion	Length of stay/overall utilization reduction for patients receiving palliative care consults (risk adjusted for severity). Increased patient satisfaction.
10)Outpatient Diabetes program	Increased patient satisfaction, increase first time diagnosed inpatient to attend outpatient education.

Attachments

1. UM SJMC population health spending FY 2015 GBR
2. UMMS population health strategy summary

FY15 GBR Investments in Infrastructure Template

Hospital:	Univ of Maryland St. Joseph Medical Center
Date of Submission:	30-Sep-15
Health System Affiliation:	University of Maryland Medical System

Number of Investments Reported:	16
Total Investments ($):	Sum of cell C6 from investment tabs
	$ 3,087,849

Narrative Summary on GBR Investments in Population Health:	SJMC has embarked on a multifaceted approach to improve patient care, safety and satisfaction, with a focus on education and care management investments to ensure that patients receive the most effective and efficient care in the right setting at the right time.

1	Investment Number	1
2	Hospital Name	Univ of Maryland St. Joseph Medical Center
3	Investment Category (select from drop down box)	1. Patient centered investment
4	Investment Brief Description, including rationale and primary objective	Care Coordinator creates care reviews for patients identified as high priority that are used by providers for care planning decision making. Coordinator interfaces directly with frequest ED visitors to improve their health care management.
5	Target Patient Population	ED frequent visitors with potential for admissions and revisits
6	Total Expenses	$ 69,631
7	Total costs covered by restricted grant or donation?	$ -
8	Is investment in regulated, unregulated space, or both? (select from drop down box)	Regulated Space
9	Planning Start Date (Month/Year)	1-Aug
10	Hospital Start Date (Month/Year)	11/6/2014
11	Type of Staff	RN Case Manager
12	Total Annual FTEs	(Headcount 1) FY15 FTEs 0.67
13	External Partners	None
14	Links with existing state-wide or regional infrastructure	None
15	Outcome(s) or Proposed Outcome Measures	Reduction of PAU
16	Effectiveness of Investment in Achieving goals, including discussion of any barriers or lessons learned	Have seen increased awareness of ED providers regarding avoidable tests and treatments
17	Additional Comments	

1	Investment Number	2
2	Hospital Name	Univ of Maryland St. Joseph Medical Center
3	Investment Category (select from drop down box)	2. Provider/care team investment
4	Investment Brief Description, including rationale and primary objective	ED access evening case manager - reviews and provides guidance to care team regarding appropriate patient status (e.g. observation vs. inpatient) and alternatives to admission.
5	Target Patient Population	ED patients
6	Total Expenses	$ 135,259
7	Total costs covered by restricted grant or donation?	$ -
8	Is investment in regulated, unregulated space, or both? (select from drop down box)	Regulated Space
9	Planning Start Date (Month/Year)	7/1/2014
10	Hospital Start Date (Month/Year)	12/1/2015
11	Type of Staff	RN access case manager
12	Total Annual FTEs	FY15 FTEs = 1.4
13	External Partners	None
14	Links with existing state-wide or regional infrastructure	None
15	Outcome(s) or Proposed Outcome Measures	Reduction of PAU and improve ED discharge planning
16	Effectiveness of Investment in Achieving goals, including discussion of any barriers or lessons learned	Increase ED team knowledge of medical appropriateness of admission, observation and ED discharge
17	Additional Comments	

1	Investment Number	3
2	Hospital Name	Univ of Maryland St. Joseph Medical Center
3	Investment Category (select from drop down box)	1. Patient centered investment
4	Investment Brief Description, including rationale and primary objective	Care transitions program that identifies patients at high risk for readmission, in hospital and home assessment and care planning and provision of community health workers in home support
5	Target Patient Population	Patients at highest risk for readmission based on a predictive algorithm
6	Total Expenses	$ 235,728.00
7	Total costs covered by restricted grant or donation?	$ -
8	Is investment in regulated, unregulated space, or both? (select from drop down box)	Regulated Space
9	Planning Start Date (Month/Year)	30-Mar
10	Hospital Start Date (Month/Year)	1/26/2015
11	Type of Staff	Nurse practitioner, RNs, community health workers
12	Total Annual FTEs	Contracted service
13	External Partners	Maxim and Rightcare Solutions
14	Links with existing state-wide or regional infrastructure	None
15	Outcome(s) or Proposed Outcome Measures	Reduction in readmissions
16	Effectiveness of Investment in Achieving goals, including discussion of any barriers or lessons learned	TBD
17	Additional Comments	

1	Investment Number	4
2	Hospital Name	Univ of Maryland St. Joseph Medical Center
3	Investment Category (select from drop down box)	1. Patient centered investment
4	Investment Brief Description, including rationale and primary objective	Partnering with non-acute healthcare facilities to reduce unncessary hospital utilization
5	Target Patient Population	Non-emergent ED patients
6	Total Expenses	$ 449,690.00
7	Total costs covered by restricted grant or donation?	$ -
8	Is investment in regulated, unregulated space, or both? (select from drop down box)	Unregulated Space
9	Planning Start Date (Month/Year)	7/1/2014
10	Hospital Start Date (Month/Year)	5/14/2015
11	Type of Staff	Urgent care providers
12	Total Annual FTEs	Contracted
13	External Partners	Choice One
14	Links with existing state-wide or regional infrastructure	none
15	Outcome(s) or Proposed Outcome Measures	decreased urgent care visits in the emergency setting
16	Effectiveness of Investment in Achieving goals, including discussion of any barriers or lessons learned	TBD
17	Additional Comments	

1	Investment Number	5
2	Hospital Name	Univ of Maryland St. Joseph Medical Center
3	Investment Category (select from drop down box)	1. Patient centered investment
4	Investment Brief Description, including rationale and primary objective	Referral coordinator for patients without primary care physicians. Reminds patients of appointments, lab test and post-discharge care.
5	Target Patient Population	Patients who do not have a PCP or require immediate post-dicharge follow up
6	Total Expenses	$ 48,400.00
7	Total costs covered by restricted grant or donation?	$ -
8	Is investment in regulated, unregulated space, or both? (select from drop down box)	Regulated Space
9	Planning Start Date (Month/Year)	9/1/2014
10	Hospital Start Date (Month/Year)	10/1/2014
11	Type of Staff	Non-clinical
12	Total Annual FTEs	1
13	External Partners	None
14	Links with existing state-wide or regional infrastructure	None
15	Outcome(s) or Proposed Outcome Measures	Improved health care management in the community
16	Effectiveness of Investment in Achieving goals, including discussion of any barriers or lessons learned	60% show rate for all scheduled appointments
17	Additional Comments	

1	Investment Number	6
2	Hospital Name	Univ of Maryland St. Joseph Medical Center
3	Investment Category (select from drop down box)	2. Provider/care team investment
4	Investment Brief Description, including rationale and primary objective	Physician Liaisons provide coordination of care with community providers on PAU reduction initiatives
5	Target Patient Population	Community Provider patients
6	Total Expenses	$ 90,604.80
7	Total costs covered by restricted grant or donation?	$ -
8	Is investment in regulated, unregulated space, or both? (select from drop down box)	Both
9	Planning Start Date (Month/Year)	11/1/2014
10	Hospital Start Date (Month/Year)	11/1/2015
11	Type of Staff	Non-Clinical
12	Total Annual FTEs	1.5
13	External Partners	Community Providers
14	Links with existing state-wide or regional infrastructure	None
15	Outcome(s) or Proposed Outcome Measures	Improved health management of high risk patients
16	Effectiveness of Investment in Achieving goals, including discussion of any barriers or lessons learned	TBD
17	Additional Comments	

1	Investment Number	7
2	Hospital Name	Univ of Maryland St. Joseph Medical Center
3	Investment Category (select from drop down box)	1. Patient centered investment
4	Investment Brief Description, including rationale and primary objective	Provide evidence based self management for chronic disease patients
5	Target Patient Population	chronic disease patients
6	Total Expenses	$ 88,088.00
7	Total costs covered by restricted grant or donation?	$ 88,088.00
8	Is investment in regulated, unregulated space, or both? (select from drop down box)	Unregulated Space
9	Planning Start Date (Month/Year)	11/1/2014
10	Hospital Start Date (Month/Year)	1/1/2015
11	Type of Staff	Non-clinical educator
12	Total Annual FTEs	1
13	External Partners	None
14	Links with existing state-wide or regional infrastructure	None
15	Outcome(s) or Proposed Outcome Measures	Equip patients with self-management tools
16	Effectiveness of Investment in Achieving goals, including discussion of any barriers or lessons learned	TBD
17	Additional Comments	

1	Investment Number	8
2	Hospital Name	Univ of Maryland St. Joseph Medical Center
3	Investment Category (select from drop down box)	1. Patient centered investment
4	Investment Brief Description, including rationale and primary objective	Preferred provider for home care services to improve coordination of home care services with case management and care transitions
5	Target Patient Population	Patients discharged to home with skilled care needs
6	Total Expenses	$ 82,500.00
7	Total costs covered by restricted grant or donation?	$ -
8	Is investment in regulated, unregulated space, or both? (select from drop down box)	Unregulated Space
9	Planning Start Date (Month/Year)	3/1/2014
10	Hospital Start Date (Month/Year)	1/1/2015
11	Type of Staff	RNs
12	Total Annual FTEs	1 (contract)
13	External Partners	Visiting Nurses Association of Maryland
14	Links with existing state-wide or regional infrastructure	None
15	Outcome(s) or Proposed Outcome Measures	Improved home care management and reduction in readmissions
16	Effectiveness of Investment in Achieving goals, including discussion of any barriers or lessons learned	TBD
17	Additional Comments	

1	Investment Number	9
2	Hospital Name	Univ of Maryland St. Joseph Medical Center
3	Investment Category (select from drop down box)	1. Patient centered investment
4	Investment Brief Description, including rationale and primary objective	Expansion in palliative care
5	Target Patient Population	Patients discharged to home with skilled care needs
6	Total Expenses	$ 22,500.00
7	Total costs covered by restricted grant or donation?	$ -
8	Is investment in regulated, unregulated space, or both? (select from drop down box)	Unregulated Space
9	Planning Start Date (Month/Year)	7/1/2014
10	Hospital Start Date (Month/Year)	2/1/2015
11	Type of Staff	Nurse Practitioner
12	Total Annual FTEs	0.42
13	External Partners	
14	Links with existing state-wide or regional infrastructure	None
15	Outcome(s) or Proposed Outcome Measures	Improved patient satisfaction through better management of end of life conditions and reduce excessive use of critical care services
16	Effectiveness of Investment in Achieving goals, including discussion of any barriers or lessons learned	TBD
17	Additional Comments	

1	Investment Number	10
2	Hospital Name	Univ of Maryland St. Joseph Medical Center
3	Investment Category (select from drop down box)	1. Patient centered investment
4	Investment Brief Description, including rationale and primary objective	Wound Care Clinic expansion
5	Target Patient Population	Patients discharged to home with skilled care needs
6	Total Expenses	$ 344,658.00
7	Total costs covered by restricted grant or donation?	$ -
8	Is investment in regulated, unregulated space, or both? (select from drop down box)	Regulated Space
9	Planning Start Date (Month/Year)	12/1/2013
10	Hospital Start Date (Month/Year)	7/1/2014
11	Type of Staff	WOC RNs and Tech
12	Total Annual FTEs	3.00
13	External Partners	
14	Links with existing state-wide or regional infrastructure	None
15	Outcome(s) or Proposed Outcome Measures	The wound healing program provides wound care consultations and educational support to outpatients and their families regarding wound care management. These services have been shown to reduce ED visits and inpatient admissions.
16	Effectiveness of Investment in Achieving goals, including discussion of any barriers or lessons learned	TBD
17	Additional Comments	

1	Investment Number	11
2	Hospital Name	Univ of Maryland St. Joseph Medical Center
3	Investment Category (select from drop down box)	1. Patient centered investment
4	Investment Brief Description, including rationale and primary objective	Pharmacy Tech interviews every patient admitted through the ED to ensure proper data collection of home medication history to reduce the risk of in-house medication errors
5	Target Patient Population	Patients admitted throught the ED
6	Total Expenses	$ 69,559.88
7	Total costs covered by restricted grant or donation?	$ -
8	Is investment in regulated, unregulated space, or both? (select from drop down box)	Regulated Space
9	Planning Start Date (Month/Year)	
10	Hospital Start Date (Month/Year)	
11	Type of Staff	Pharmacy Tech
12	Total Annual FTEs	1.84
13	External Partners	None
14	Links with existing state-wide or regional infrastructure	None
15	Outcome(s) or Proposed Outcome Measures	Reduce in-house medication errors
16	Effectiveness of Investment in Achieving goals, including discussion of any barriers or lessons learned	TBD
17	Additional Comments	

1	Investment Number	12
2	Hospital Name	Univ of Maryland St. Joseph Medical Center
3	Investment Category (select from drop down box)	1. Patient centered investment
4	Investment Brief Description, including rationale and primary objective	Provide discharge medication instructions to inpatients with complex medication issues
5	Target Patient Population	Inpatients preparing for discharge
6	Total Expenses	$ 324,038.00
7	Total costs covered by restricted grant or donation?	$ -
8	Is investment in regulated, unregulated space, or both? (select from drop down box)	Regulated Space
9	Planning Start Date (Month/Year)	
10	Hospital Start Date (Month/Year)	
11	Type of Staff	Pharmacist
12	Total Annual FTEs	2.50
13	External Partners	None
14	Links with existing state-wide or regional infrastructure	None
15	Outcome(s) or Proposed Outcome Measures	Equip patients with self mangement tools. Studies have shown that pharmaceutical counseling can reduce the potential for readmission
16	Effectiveness of Investment in Achieving goals, including discussion of any barriers or lessons learned	TBD
17	Additional Comments	

1	Investment Number	13
2	Hospital Name	SJMC
3	Investment Category (select from drop down box)	2. Provider/care team investment
4	Investment Brief Description, including rationale and primary objective	Analysis of care best practices and understanding of cost of care tied to outcomes.
5	Target Patient Population	Sepsis, Joint Replacement, and Chest Pain
6	Total Expenses	$79,810
7	Total costs covered by restricted grant or donation?	no
8	Is investment in regulated, unregulated space, or both?	Regulated Space
9	Planning Start Date (Month/Year)	7/1/2014
10	Hospital Start Date (Month/Year)	7/1/2014
11	Type of Staff	MD/Quality Staff/Nurse/Finance
12	Total Annual FTEs	4.5
13	External Partners	
14	Links with existing state-wide or regional infrastructure	
15	Outcome(s) or Proposed Outcome Measures	Shorter LOS, less readmissions, and shift from Observation to shorter ED visits.
16	Effectiveness of Investment in Achieving goals, including discussion of any barriers or lessons learned	
17	Additional Comments	

1	Investment Number	14
2	Hospital Name	SJMC
3	Investment Category (select from drop down box)	1. Patient centered investment
4	Investment Brief Description, including rationale and primary objective	Contracting with Lumeris and Davita Healthcare partners to analyze and reduce all PAU volume.
5	Target Patient Population	PAU population
6	Total Expenses	$488,445
7	Total costs covered by restricted grant or donation?	no
8	Is investment in regulated, unregulated space, or both?	Both
9	Planning Start Date (Month/Year)	7/1/2014
10	Hospital Start Date (Month/Year)	7/1/2014
11	Type of Staff	MD\Nursing\Quality\Finance
12	Total Annual FTEs	
13	External Partners	Lumeris & Davita Healthcare Partners
14	Links with existing state-wide or regional infrastructure	none
15	Outcome(s) or Proposed Outcome Measures	Reduced PAUs
16	Effectiveness of Investment in Achieving goals, including discussion of any barriers or lessons learned	
17	Additional Comments	

1	Investment Number	15
2	Hospital Name	SJMC
3	Investment Category (select from drop down box)	2. Provider/care team investment
4	Investment Brief Description, including rationale and primary objective	Consolidation of lab and pharmacy services to provide faster turnaround and improve patient satisfaction & decrease length of stay. Also conduct ongoing blood utilization analysis to reduce utilization and improve patient outcomes.
5	Target Patient Population	Inpatients
6	Total Expenses	$87,526
7	Total costs covered by restricted grant or donation?	no
8	Is investment in regulated, unregulated space, or both?	Both
9	Planning Start Date (Month/Year)	7/1/2014
10	Hospital Start Date (Month/Year)	7/1/2014
11	Type of Staff	Lab/Pharmacy/MD
12	Total Annual FTEs	
13	External Partners	Price Waterhouse Cooper
14	Links with existing state-wide or regional infrastructure	
15	Outcome(s) or Proposed Outcome Measures	Reduced LOS and better patient outcomes for blood transfusion patients
16	Effectiveness of Investment in Achieving goals, including discussion of any barriers or lessons learned	
17	Additional Comments	

1	Investment Number	16
2	Hospital Name	SJMC
3	Investment Category (select from drop down box)	2. Provider/care team investment
4	Investment Brief Description, including rationale and primary objective	Capture and understand cost of care and tie to patient outcomes. Manage the continuum of care through better data on all aspects of the patient.
5	Target Patient Population	All regulated patients
6	Total Expenses	$471,410
7	Total costs covered by restricted grant or donation?	
8	Is investment in regulated, unregulated space, or both?	Regulated Space
9	Planning Start Date (Month/Year)	7/1/2014
10	Hospital Start Date (Month/Year)	7/1/2014
11	Type of Staff	MD/Finance
12	Total Annual FTEs	4+
13	External Partners	
14	Links with existing state-wide or regional infrastructure	
15	Outcome(s) or Proposed Outcome Measures	Lower cost of care and better patient satisfaction
16	Effectiveness of Investment in Achieving goals, including discussion of any barriers or lessons learned	
17	Additional Comments	

FY15 GBR Investments in Infrastructure Template

Hospital:	Univ of Maryland St. Joseph Medical Center
Date of Submission:	30-Sep-15
Health System Affiliation:	University of Maryland Medical System

Number of Investments Reported:	16
Total Investments ($):	Sum of cell C6 from investment tabs
	$ 3,087,849

Narrative Summary on GBR Investments in Population Health:	SJMC has embarked on a multifaceted approach to improve patient care, safety and satisfaction, with a focus on education and care management investments to ensure that patients receive the most effective and efficient care in the right setting at the right time.

UNIVERSITY of MARYLAND
MEDICAL SYSTEM

UMMS Population Health Strategy

The University of Maryland Medical System (UMMS) is committed to transforming the current health care delivery system to better manage populations of patients, particularly those patients with multiple chronic diseases. In order to achieve this goal, UMMS has embarked on a two-pronged strategy focusing on inpatient medical management, a key driver of success under Global Budget Revenue, and the development of an ambulatory care network that engages community physicians.

Consistent with UMMS' mission and larger strategic vision, the system seeks to create a population health management capability that will enable it to successfully perform under value-based contracting arrangements (i.e., better patient experience, improved outcomes, reduced cost growth, and enhanced provider satisfaction) with various commercial, Medicaid, and Medicare Advantage payers. This vision includes the following:

- Enabling a significant and growing portion of system revenues to come from sustainable and mutually beneficial risk contracts.
- Operationalizing a high-performing population health management function (i.e., a Population Health Services Organization) and care delivery model that is all-payer and all-patient capable.
- Establishing an attractive and scalable physician clinical integration vehicle that can be systematically deployed across regions.

In implementing these strategies, UMMS has engaged two operating partners with expertise in successfully developing and implementing these types of programs – Davita HealthCare Partners and Lumeris.

Inpatient Medical Management

UMMS has engaged Davita HealthCare Partners (DHCP) to improve the inpatient medical management capabilities at each of the hospitals in the system. The goals of the engagement with DHCP are to:

- Improve the quality of care
- Improve patient satisfaction
- Reduce unnecessary admissions
- Reduce readmissions
- Reduce length of stay

UMMS' engagement with DHCP focuses on specific areas:

- Designing, developing, and enhancing hospitalist programs

- Designing, developing, and enhancing transitions of care programs. This includes developing collaborative programs with post-acute providers including Skilled Nursing Facilities, Home Health Programs, Hospices, and other providers.
- Enhancing UMMS' existing care management and discharge planning programs
- Identifying alternative sites of care for patients to utilize as an alternative to the emergency room or inpatient stays

Ambulatory care network

UMMS has engaged Lumeris as an operating partner to accelerate the transition from volume- to value-based care and deliver improved clinical and financial outcomes. With a combination of clinical, operational, and information technology expertise, Lumeris is partnering with UMMS to set up a Population Health Services Organization (PHSO) as a shared service within the organization.

The PHSO will provide services to the UMMS Quality Care Network, a Clinically Integrated Network of providers that have a shared responsibility for the care of a defined population of patients and can contract as one entity with payers.

A PHSO employs a portfolio of people, programs and interventions including but not limited to:

- Care managers deployed toward high risk individuals
- Transitions of care programs
- Dedicated programs for high risk patients
- Pharmacy and therapeutics management programs
- Patient engagement technologies
- Practice transformation
- Provider education, coaching, support, and information

The PHSO and its staff are enabled by robust technology that is focused on:

- Consolidating disparate data sources into a single source of truth about a patient
- Supporting deep analytics related to segmentation, utilization, costing, and expectations
- Enabling care management work flows by various care managers and affiliated providers
- Supporting active and sustainable financial management of affiliated risk bearing entities