Doctors Community Hospital

Attachment A: Detailed Documentation of Strategic Transformation Plan

CY 2016

1		2		3	4-A	4-B	4-C	4-D	4-E	5	6-A	6-B	6-C
Overall Goals	**Initiative Number**	**Initiative Description**	**Care Delivery and Population Health Goals Supported:**	**Target Population**	**Patient Satisfaction Metrics**	**Quality Metrics**	**Outcome Metrics**	**Process Metrics**	**Cost Metrics**	**Other Participants**	**Financial Sustainability Plan - Expense**	**Financial Sustainability Plan - Revenue/Cost Savings**	**Financial Sustainability Plan - Calculated ROI**
Overall Major Strategy #1: Care Transition and Coordination Programs at DCH and with Other Hospitals													
I. Population Health - improving the health of the individual	**1**	**Totally Linking Care in Maryland (TLC-MD):** TLC-MD was formed in March 2015, bringing together the skills and resources of the southern counties of Maryland in an effort to collaborate and improve health care delivery to achieve the Centers for Medicare and Medicaid Service's (CMS) Triple Aim: providing better care for patients, improving population health outcomes, and lowering costs by improving our health systems. TLC-MD represents a commitment of all seven of the hospitals within Prince George's, Calvert, and St. Mary's counties to work together to achieve these aims.	1 through 8	1. Those identified as high-needs patients when they TLC-MD hospitals (High Needs Population); 2. Those who live in TLC-MD's service areas (the area for each hospital from which 85% of the hospitalized patients living in Maryland come) (HSA Population) 3. Those who live in Prince George's, Calvert, and St. Mary's counties (Counties Population). 4. High utilizers/readmitters that were admitted to DCH. 5. Breast cancer, oncology, bariatric, and patients without PCP's	HCAHPS	MHAC's	A through H	I through N	Under development by Regional Partnership.	1. TLC-MD members include: Ft. Washington Medical Center, Dimensions Health System, Calvert Medical Center,St. Mary's and MedStar Southern Maryland Hospital Center.	Under development by Regional Partnership.	Under development by Regional Partnership.	Under development by Regional Partnership.
I. Population Health - improving the health of the individual	**2**	**Transitional Care Program:** Expansion of Transitional Care program to a more robust program with additional staff within the hospital's Transitional Care department. In FY 2016, we added 3 Transitional Care Advocates and 1 Geriatric Social Worker. Additional reporting and consulting expenses were also added to this department to better identify the target population. The major strategy of this program is to identify patients that need transitional care services such as follow-up appointments with PCP's and specialists, medication reconciliation, and services from TLC-MD.	1 through 8						See tab 4-E for detail.		$ 751,500	$ 564,926	0.75
I. Population Health - improving the health of the individual	**3**	**Navigator Programs:** Expansion of Navigators for complex medical programs. It has been shown that patients in complex programs do better with assistance from a navigator. Navigators at DCH include: Breast Center Navigator Treatment Navigator in Women's Health Bariatric Navigator Oncology Navigator Patient Referral Liaison/Navigator. The major strategy of the Navigator program is to decrease the potentially preventable complications, readmissions, and revisits of patients in these programs. In addition, we believe a more robust navigator program will improve our patients' behavioral health, improve physician alignment/care coordination, and assist with other social determinants of health such as transportation, meals, etc.	1 through 8						See tab 4-E for detail.		$ 263,000	$ 376,617	1.43

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Overall Major Strategy #2: Patient Experience & Reduced Utilization													
II. Clinics/Physician Practices/Behavioral Health/Long Term/Post-acute- improving our service to our community	**4**	**CHF Clinic & Cardiac Rehab Clinic:** The Congestive Heart Failure Clinic is a comprehensive program that provides: - An experienced and board-certified heart failure cardiologist - A holistic care approach that includes the collaborative services of pharmacy, nutrition, physical therapy, cardiology, physician assistant, social work, home health and hospice care professionals – all accessible on Doctors Community Hospital's campus - Consultations for insured and uninsured patients who have physician referrals As a healthcare partner, the clinic's team collaborates with referring, primary care and cardiology physicians to keep them informed of their patients' progress. Also, after completing a four-session treatment program, a detailed report is sent electronically to referring physicians who will continue to care for their patients. The major strategy of the CHF clinic is to help patients with heart disease better understand and manage their condition and to reduce CHF readmissions to DCH. In addition to the CHF Clinic, DCH offers a Cardiac Rehab clinic. This is a secondary prevention program that provides a individualized treatment plan (ITP), which is updated monthly by the Medical Director and is communicated to the patient's referring physician or primary care physician.	1 through 4, and 6	1. CHF patients (based on diagnosis codes) 2. To be admitted into the DCH Pulmonary Rehab Program, the patient must meet the following criteria: - Have a diagnosis of moderate to severe COPD - Have a primary or secondary Pulmonary Diagnosis - Demonstrate potential for improvement - Demonstrate an ability to learn - Have a need for Respiratory and Rehabilitation Services - Have a capacity and willingness to participate in the program - Is medically stable 3. DCH Observation patients					See tab 4-E for detail.	1. TLC-MD: TLC-MD will refer patients to the CHF and Cardiac Rehab clinics.	$ 331,077	$ 303,629	0.92
II. Clinics/Physician Practices/Behavioral Health/Long Term/Post-acute- improving our service to our community	**5**	**Pulmonary Rehab Clinic:** DCH's Outpatient Pulmonary Rehabilitation Program provides a comprehensive outpatient program designed for the pulmonary compromised patient requiring Respiratory and Rehabilitation Services. This includes an environment of like patients with similar goals and clinical needs with equipment and services available on site to meet the immediate needs of the population. A patient-centered, outcome-focused approach is used by a board certified Pulmonologist and a licensed Respiratory Therapist with expertise in assessing the patient's clinical course and treatment plan until the patient is at optimal functional level and has completed the 18 week program. The patient will be discharged after completion of the 18 week/36 session program, or whenever they have met their rehabilitation goals. Each session consists of 5 patients to maximize individualized provider attention. Upon discharge, the patient is given recommendations on how to continue to optimize their functional capacity. The major goal of this program is to assist this population with care coordination and navigation of their illness.	1 through 4, 6		HCAHPS	MHAC's	A through C, and F through G	J through L, and N	PQI: 5 PQI 5 FYTD September 2015= 2.5% of discharges (245 discharges/year) Goal= reduce to 0.0% of discharges	2. Emergency Medical Associates, P.A., P.C. (EMA): Contracted physician group for our Emergency and Observation patients.	$ 105,278	$ 244,686	2.32
III. Per Capita Expenditure - decreasing the cost to patients at our hospital and in our community	**6**	**Observation ALOS:** Observation patients are often kept longer than necessary due to decreased physician and PA staffing at night. In order to correct this issue and decrease the average observation hours per visit to hospital target of 16 hours per visit, two PA's will be added at night. The primary goal is to decrease the average cost per Observation patient (and patient co-pays) at DCH.	4 and 6						Observation ALOS = 16 hours/visit		$ 208,000	$ 3,120,849	15.00

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Overall Major Strategy #3: Behavioral Health													
II. Clinics/Physician Practices/Behavioral Health/Long Term/Post-acute- improving our service to our community	**7**	**Sickle Cell Clinic:** As a result of the review of readmission patients, the hospital identified that Sickle Cell patients were being readmitted due to the lack of proper outpatient protocols. After discussions with the local physician practices and meetings with Johns Hopkins clinical representatives, the hospital decided to offer the Johns Hopkins protocols in our Infusion Clinic Center. The clinic is staffed with DCH healthcare professionals and a Medical Director. The major strategy is to change the behavior of this target population to reduce their dependence pain management medicine and reduce sickle cell readmissions (as defined by the HSCRC) while maintaining quality of care, reducing individual costs, and improving the community's health results. Following the expansion of the Clinic's focus into the Sickle Cell protocols, the local physicians expanded their hours and services, both of which helped to reduce unnecessary ER visits.	1 through 4, and 6	1. Sickle Cell patients (based on diagnosis code)	HCAHPS	N/A	D through G	J through L, and N	20% Reduction in Sickle Cell readmissions vs. the base year (FY 2013): FY 2013 = 101 readmissions Goal CY 2016 = 80 readmissions	1. Johns Hopkins Infectious Control staff	$ 79,772	$ 84,281	1.06
Overall Major Strategy #4: Physician Alignment													
II. Clinics/Physician Practices/Behavioral Health/Long Term/Post-acute- improving our service to our community	**8**	**Leland Ambulatory Care Center / La Clinica:** Doctors Community Hospital has a long term lease with Crescent Cities Charities, Inc., a non-profit Maryland corporation, to lease 7,600 square feet of space located on the first floor of Crescent Cities Center, 4409 East West Highway, Riverdale, MD (formerly known as Leland Hospital). Renovations include new patient exam rooms, physician and lab offices, lobby space and a conference room/health education area. DCH plans to partner with La Clinica del Pueblo, a non-profit, Federally Qualified Health Center (FQHC) clinic to offer primary and preventive health care services to uninsured and underserved residents, with a focus on Latino populations. La Clinica will provide services to include but not limited evaluation, education, immunizations, diagnostic and laboratory testing. Through the partnership with La Clinica, DCH will provide access to laboratory, radiology, specialty care, and hospital based services such as endoscopy, surgery, interventional radiology and cardiology services. The implementation of La Clinica will allow DCH to provide high quality, lower cost, more accessible health care services to more of its high risk residents to treat health issues that can be well managed out of a hospital inpatient setting. It is part of the primary care development network in Prince George's County.	4	1. PUMA 3 neighborhood - consisting of a predominantly low income, growing Latino population and elderly populations 2. PUMA 4 area consisting of a lower income, primarily African-American population 3. Medicare Care lives in our Primary and Secondary Service Areas: - 2015 = 11,000 beneficiaries - 2016 = 20,000 beneficiaries	HCAHPS	N/A	A through H	J through L, and N	See tab 4-E for detail.	1. MHA: DCH received a $380,000 grant from the MHA to help fund the renovations required to open the ambulatory care practice. 2. TLC-MD: TLC-MD plans to set up discharge clinics at physician offices where patients can speak with nurses, doctors, and pharmacists at no charge. 3. Sage Growth Partners: Sage is managing this initiative from a financial and operational perspective.	$ 5,790,559	$ 6,166,751	1.06
II. Clinics/Physician Practices/Behavioral Health/Long Term/Post-acute- improving our service to our community	**9**	**Community Health Care Center (Dr. Mohan/District Heights):** The Center will offer primary and preventive health care services to uninsured and underserved residents, with a focus on African-American populations. The Center will provide unregulated prenatal, gynecological, behavioral health and diabetes primary care services. The major strategy of this Center, located in a high need community for primary care services, will allow DCH to provide high quality, lower cost, more accessible health care services to more of its high risk patients to treat health issues that can be well managed out of a hospital inpatient setting. It is also part of the Prince George's Health Improvement Plan for primary care service expansion in high need areas.	4						See tab 4-E for detail.		$ 2,508,321	$ 2,945,785	1.17
III. Per Capita Expenditure - decreasing the cost to patients at our hospital and in our community	**10**	**ACO/CIN Expansion:** Develop Accountable Care Organization (ACO) and Clinically Integrated Network (CIN). The major strategy for joining an ACO is to build a Primary Care Physician network in our community that will reduce per capita cost to Medicare. The CIN will allow for gain sharing with the physicians once the business becomes profitable.	4						2014 Final Reconciliation PMPY Cost = $11,789 2015 3rd Quarter Trend = $11,435 Goal = $10,000		$ 1,535,916	$ 1,535,916	1.00

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Overall Major Strategy #5: Community Health													
I. Population Health - improving the health of the individual	**11**	**Mobile Clinic:** The "Community Health Connector" is a mobile van that travels to various locations in Prince George's County to help patients maintain or improve their health. The mobile clinic is staffed with DCH healthcare professionals. The clinic provides a wide range of services to people ages 16 and older, including: Blood pressure screenings, Electrocardiogram (EKG) testing, Flu and pneumonia vaccinations, Tetanus shots, and HIV screenings. The major strategy of the Mobile Clinic program is to decrease PAU volume at DCH by offering preventative services out in the community where it is more convenient to the patients, especially to those patients who are unable to commute to doctor appointments due to transportation issues.	1 through 4, and 8	1. PUMA 3 neighborhood - consisting of a predominantly low income, growing Latino population and elderly populations 2. PUMA 4 area consisting of a lower income, primarily African-American population 3. Medicare Care lives in our Primary and Secondary Service Areas: - 2015 = 11,000 beneficiaries - 2016 = 20,000 beneficiaries 4. Eligibility requirements for CPEST program include: - be Prince George's County residents - be age 50 or older - have a family history (mother, father, brother or sister) of colorectal cancer, if younger than age 50 meet low income threshold requirements - be uninsured or underinsured 5. Medically underserved women aged 40 to 64 years residing in Prince George's County who are of low income and are uninsured or underinsured (with a focus on African American women and women aged 50-64 years) 6. Diabetes diagnosis within PSA/SSA	HCAHPS	N/A	A through C, F and G	J through L, and N	See tab 4-E for detail.	1. Wal-Mart & Doctors Community Hospital Foundation (DCHF): DCHF obtained a $100,000 grant from Wal-Mart as seed funding for this initiative. DCHF continuously fundraises to support the on-going costs of the Mobile Clinic. 2. Prince George's Health Department referrals and State of Maryland grant funding 3. Currently, DCH works with several agencies/organizations, and one bi-lingual community navigator which provide education and navigation services on average to about 1500 women annually. These partnerships include: Community Navigation and Clinical Referrals Partners, Supporting our Sisters International (SOSI), Mary's Center, African Women's Cancer Awareness Association (AWCAA), Prince George's County Health Department, It's in the Genes, Prince George's County Alumnae Chapter of Delta Sigma Theta (PGCAC), and Reid Temple African Methodist Episcopal Church.	$ 150,000	$ 338,309	2.26
I. Population Health - improving the health of the individual	**12**	**Cancer Prevention, Education, Screening and Treatment (CPEST):** CPEST initiative is a Prince George's Health Department program for uninsured/underinsured, low-income residents. The goal of the CPEST program is to: - Increase awareness of the importance of colon and rectal (colorectal) cancer screening. - Provide education and outreach to the general public, medical providers and health educators. - Prevent and reduce overall colorectal cancer morbidity and mortality as well as health disparities among minorities in Prince George's County.	1 through 2, 5 through 6, and 8						Number of patients receiving free screening		$ 150,000	$ 150,000	1.00

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II. Clinics/Physician Practices/Behavioral Health/Long Term/Post-acute- improving our service to our community	**13**	**DCH Center for Comprehensive Breast Care and Women's Wellness:** The DCH Center for Comprehensive Breast Care and Women's Wellness has an extensive and deeply engaged network of organizations and agencies that provide clinical support, navigation services and/or referrals to the Breast Center for education and services. Most of these relationships, which primarily target diverse lower income, uninsured/underinsured populations, were developed over the course of three years for the Center's Prince George's County Continuum of Breast Care Program funded by the Susan G. Komen Foundation. The partnerships focus on two main areas 1) Community navigation/clinical referrals for services and 2) education and outreach. Overall Major Strategies: • Decrease the social, psychological and economic barriers through culturally relevant materials and effective outreach and education programs for patients and providers • Increase outreach and screening rates of medically underserved populations in Prince George's County including African-American, African immigrant and Latino women between the ages of 40-70. • Increase overall health literacy in targeted underserved populations at all ages that will facilitate proactive healthy behaviors that prevent the onset of disease, as well as facilitate effective disease management and self - advocacy.	1 through 2, and 8						Provide breast and cervical cancer screening and diagnostic services (as appropriate) to at least 350 eligible women annually. Provide patient navigation services to at least 50 women annually.		$ 510,042	$ 350,000	0.69
III. Per Capita Expenditure - decreasing the cost to patients at our hospital and in our community	**14**	**Diabetes Clinic:** Prince George's county has 13.5% of its population affected by diabetes, as compared to 8.3% in Maryland. Our strategy is to make medical visits at our Diabetes clinic more affordable for patients. In order to do this, DCH will move our Diabetes clinic to unregulated setting to lower the co-pays for our patients.	1 and 6						PQI: 3, 14 PQI 3 FYTD September 2015= 2.8% of discharges PQI 1 FYTD September 2015= 0.5% of discharges Goal= reduce to 0.0% of discharges		$ 1,499,035	$ 4,395,735	2.93
Overall Major Strategy #6: Nursing Home													
I. Population Health - improving the health of the individual	**15**	**Doctors Community Rehabilitation and Patient Care Center:** The Doctors Community Rehabilitation and Patient Care Center, formerly Magnolia Nursing Home, recently relocated to a brand new state-of-the-art building on DCH's campus. The improvements of the new facility include modernized patient rooms, an on-site rehabilitation center, and state-of-the-art equipment. DCH personnel (physicians, Transitional Care staff, and management) work closely with the staff of Doctors Community Rehabilitation and Patient Care Center. Medical staff from both the hospital and the nursing home conduct one-on-one meetings to ensure the proper care of the patients in the nursing home. Recently, DCH medical staff began on-site testing, x-rays, and lab work to prevent unnecessary admissions to the hospital. The major strategy is to reduce readmissions and unnecessary utilization. With the state-of-the-art facility, we are considering bundled services in orthopedics to reduce TCOC.	1 through 2, 5 through 8	1. DCH discharges to nursing homes	N/A	MHAC's	A through G	J through L	See tab 4-E for detail.	1. Genesis HealthCare, TLC-MD: Genesis is a regular participant at DCH's monthly Utilization Review (UR) meetings, which discuss readmissions from the nursing home among other utilization issues. 2. Genesis is also a member of TLC-MD and will implement changes to reduce readmissions at all of their nursing homes.	$ 83,500	$ 376,617	4.51
GRAND TOTAL											**$ 13,966,000**	**$ 20,954,100**	**1.50**