FREDERICK
REGIONAL HEALTH SYSTEM

Health Services Cost Review Commission

Requested

Frederick Memorial Hospital

Hospital Strategic Transformation Plan

December 7, 2015

Submitted to HSCRC.stp@Maryland.gov on: 12/07/2015

Contact Information:
Michelle Mahan
240-566-3355
mmahan@fmh.org

Frederick Memorial Hospital

Hospital Strategic Transformation Plan

Table of Contents

PAGE	TOPIC
Page 3	Executive Summary
Page 5	Description of Overall Goals
Page 6	Description of Major Strategies with Requested Components: ▪ Strategy # 1: Rapid Follow Up for Complex and Chronic Disease Patients ▪ Strategy # 2: Comprehensive Behavioral Health Continuum and Interventions ▪ Strategy # 3: Integration with Non-Hospital Based Providers and Community Resources ▪ Strategy # 4: Hospice and Palliative Care Utilization Improvement
Appendix A	Regional Partnership for Health System Transformation

Frederick Memorial Hospital
Hospital Strategic Transformation Plan
Executive Summary

There is tremendous change taking place in the healthcare industry and the Maryland model is being closely watched for the achievement of value through the efforts to improve patient and provider alignment, care coordination, patient outcomes, and collaboration with community healthcare resources.

Starting with a focus on achieving the Triple Aim goals of Better Health for the Community, Better Patient Care Experience and Lower or Controlled costs of care, Frederick Memorial Hospital has been focused on building capabilities to operate in a broader value based system. To date, significant investments have been made at Frederick Memorial Hospital (FMH) to enhance care management capabilities, implement sophisticated IT and Decision Support systems, develop a clinically integrated network in the Frederick market, and reduce operating costs while still maintaining financial stability.

It is from this base that FMH has continued to expand partnerships with other health systems for enhanced care and operating efficiencies, and currently has partnerships or alliances with seven Health Systems across Maryland.

Transforming the health care delivery system is a difficult task and requires reconfiguring the clinical delivery system and supporting infrastructure. In this new environment, the Global Budget Reimbursement (GBR) System has been crucial to allowing efficiencies to be implemented while not threatening the financial stability of the overall health system. Prior to the implementation of GBR, FMH began investing in quality and care management initiatives. Under GBR, funding has been provided for infrastructure and population health measures addressing some of the potential concern over sustainability. Investments to date have been focused on reducing overall hospital utilization and readmissions, potentially avoidable utilization, and improving the care continuum for patients with chronic disease.

To further the goal of improving care delivery and population health, FMH has included in the Frederick Regional Health System (FRHS) Strategic Plan these multi-year key objectives: (1) Integrating Value-Based Care; (2) Focus on Consumer Services and Access; (3) Provider Integration and Physician Leadership; (4) Operational Effectiveness and (5) Information Technology and Infrastructure. These FRHS Board approved objectives support the targeted eight focus areas asked to be addressed in the FMH Strategic Hospital Transformation Plan (STP).

While FMH has a myriad of focused groups working on population health transformation, this STP highlights the top four key areas identified through work with The Camden Group to develop an "Organization of Care" necessary to have an optimal centralized approach for integrating care management, and the effort in completing the Trivergent Regional Transformation Plan - Final Report submission working with Health Management Associates.

Attached as Appendix A is the submission copy of the Regional Partnership for Health System Transformation Final Report submitted on behalf of the three Trivergent hospitals and their community partners for your reference. This plan describes in detail the proposed delivery and financing model, the infrastructure and staffing/workforce that will support the model, the target outcomes for reducing utilization/costs and improving quality the health of the populations targeted, and effective strategies to continuously improve overall population health in the region.

The four key strategies and key interventions addressed in the Frederick Memorial Hospital's STP are:

(1) *Rapid Follow Up for Complex and Chronic Disease Patients*

- Enhance Chronic Disease Management: - post-discharge & ED transitions, medication management, care coordination, advancement of health literacy, education and patient engagement strategies
- Expand anti-coagulation clinic services
- Provide transportation services to those in need to/from appointments

(2) *Comprehensive Behavioral Health Continuum and Interventions*

- Identify patients at risk and link to appropriate services
- Provide intensive community based BH care management follow up for all discharged BHU patients

(3) *Integration with Non-Hospital Based Providers and Community Resources*

- Providing increased support through "high touch" Community Health Worker outreach
- Partnering with EMS on para-medicine programs
- Develop key community based partnerships to close gaps in care and remove barriers to appropriate community based services
- Launch community wide education around sites of care, access, ED use patterns and benefits of alternate sites of care
- Bridges Lay Health Educator program

- *Hospice and Palliative Care Utilization Improvement*

- Incorporate a Palliative Care RN as part of the Palliative care team to work on education of Palliative care vs. Hospice care for physicians and patients.
- Educate all physicians about the differences between palliative care and comfort care. Not all MDs are comfortable with the talk.
- Serve as a liaison between Case Management, the patient, physicians and Palliative and Comfort Care Service.
- Educate patients and families about the differences between palliative care and comfort care.
- Conduct community based educational events to ensure that all hospitalized patients are educated and given an opportunity to complete Advanced Directives

We appreciate the opportunity to submit this Strategic Transformation Plan to the HSCRC. If you have any questions or comments, please do not hesitate to call Michelle Mahan at 240.566.3355 or email at mmahan@fmh.org.

Describe Your Overall Goals:

The overall goals of the Frederick Memorial Hospital Strategic Transformation Plan are as follows:	Related Strategy Number
Reduce Potentially unnecessary utilization (PAUs)	#1,2,3
Improve access to care at the right setting and at the right time	#1,2,4
Increase outreach and education to improve community health, wellness and engagement	#1,2,3,4
Increase alignment among community providers to address gaps in social determinants of health	#1,2,3,4

Target Populations:

The goals target aging populations, frail elders, and patients with chronic medical conditions and serious mental illness. Also, the strategies place emphasis on primary care, prevention, and reduction of risk factors by reaching patients where they are, whether inside or outside of traditional health care settings.

Strategy # 1: Rapid Follow Up for Complex and Chronic Disease Patients

Objective: Establish a "Center/Site of Care" for chronic disease management and transitional medical home services

Background: Hospital patients deemed high utilizers of inpatient and emergency services have multiple chronic conditions as outlined in the Trivergent Regional Partnership for Health System Transformation Report. Nearly 80% of patients do not understand their prescription medication regime. These patients require more intensive support than primary care offices are equipped to provide within the timeframe allotted for office visits. FMH will establish a "Center" in which individuals with (1) chronic conditions or (2) without a medical home will receive affordable, comprehensive coordinated care. The Center will provide education, health care literacy support, dietary and pharmaceutical consultation, and connections to community based resources for patients and caregivers. The Center will act as the primary care support for unassigned patients during periods of transition and provide more intensive support for patients referred by their community PCP. The Center will provide an extension to PCP office outreach to help avoid emergency room utilization and subsequent hospital admissions related to noncompliance with the plan of care.

Key Interventions:

- Enhance Chronic Disease Management: - post-discharge & ED transitions, medication management, care coordination, advancement of health literacy, education and patient engagement strategies
- Expand anti-coagulation clinic services
- Provide transportation services to those in need to/from appointments

Target Population	Persons with chronic conditions and/or without a medical home for care
Measure of Success	
Metrics	Decreased readmissions
	Decreased PQI's
	Improve HCAHPS scores
	Time to follow up appointment after discharge
	Reduce "no show" appts. at provider offices or clinic or community partner appointments

Participants/Partners

The following organizations and individuals will be key partners and/or participants in our initiatives in various capacities. They may participate in planning and advisory groups, implementation of clinical interventions, education, or trainings. We will count on these partnerships to provide guidance and input as implementation begins in 2016.

- Primary Care Providers
- Group practices
- Home care/Hospice
- Health Department/AERS
- Skilled Nursing Facilities/ALFs
- Adult Day Care/Senior Centers
- Pharmacies
- Department of Aging
- EMS
- Department of Social Services
- Community behavioral health providers. i.e Way Station and Mental Health Association
- Private mental health and substance abuse treatment programs
- LHIC
- The Coordinating Center
- Halfway houses/shelters

Financial Sustainability

This strategy will require increased cost for training, incremental staffing, equipment, marketing, and interdepartmental coordination of approximately $1.7M annually. The anticipated decrease in ED & readmissions utilization will drive a decrease in variable costs in ED and inpatient settings, and the resulting GBR retained revenue will be available to reinvest in further expansion of the Center and related patient interventions. However, there is the potential once this program is established that the demand for the service will grow. In which case, the initial proforma estimates for volume may be understated. The HSCRC has provided financial support for population health infrastructure, however amounts provided in FY15 and FY16 do not fully cover the cost of the initiative. In order to balance the differential, between Infrastructure funds received and Population Health expenditure utilization improvement under GBR must occur.

Strategy # 2: Comprehensive Behavioral Health Continuum and Interventions

Objective: Integrate behavioral health (BH) into primary care and provide intensive community based care management to the BH population

Background: 70% of patients with multiple chronic illnesses are known to have concurrent unmet behavioral health and substance abuse needs. If unresolved, these add to the avoidable utilization of emergency and hospital services. Patients are unable to comply with medical regimes prescribed by their physician when faced with depression and other complex psychological disorders. Our goal is to reduce avoidable facility utilization by improving outpatient resources within the primary care setting (incl. ACO), develop key community based partnerships to close gaps in care and remove barriers to appropriate community based services.

Key interventions:

- Identify patients at risk and link to appropriate services
- Provide intensive community based BH care management follow up for all discharged BHU patients

Target Population	Adult patients in primary care with depression
	Adults participating in provided community health education
	Adults with a behavioral health and/or substance abuse diagnosis
Measure of Success	
Metrics	Decreased readmissions
	% of community providers participating in initiative (baseline at implementation)
	% of patients seen in participating PCP practices screened for depression using standardized tools.
	# low risk individuals screened by PHQ-9 referred for follow up
	# med risk individuals screened by PHQ-9 referred for follow up
	# high risk individuals screened by PHQ-09 referred for follow up
	% of high risk individuals with subsequent BH ED visit or BH admission within 30 days of referral

Participants/Partners

The following organizations and individuals will be key partners and/or participants in our initiatives in various capacities. They may participate in planning and advisory groups, implementation of clinical interventions, education, or trainings. We will count on these partnerships to provide guidance and input as implementation begins in 2016.

- Primary Care Providers
- Regional FQHCs
- Department of Aging
- Health Department/AERS
- Adult Day Care/Senior Centers
- Home health
- Pharmacies
- EMS / law enforcement
- Department of Social Services
- Behavioral health units
- Community behavioral health providers i.e. Way Station and Mental Health Association
- Private mental health and substance abuse treatment programs
- Halfway houses and homeless shelters
- LHIC
- The Coordinating Center

Financial Sustainability

This strategy will drive increased cost of training and incremental staffing of approximately $707K annually. The anticipated decrease in utilization will drive a decrease in variable costs in ED and inpatient settings. If there is resulting GBR retained revenue, it is likely to be reinvested in further expansion of behavioral health related patient interventions. Behavioral health continues to be a growing need in the community, thus it is likely additional infrastructure support will be needed to address the diverse issues.

Strategy # 3: Integration with Non-Hospital Based Providers and Community Resources

Objective: To develop resources and community partnerships to address care gaps and social determinants of health across diverse communities

Background: The health system conducted focus groups during our Community Health Needs Assessment. One of the outcomes of those sessions was learning that some communities needed health system support to come to their community/geography in order to build trust with elderly and minority members in those hot spot areas. A best practice learned from other communities nationally is the training and deployment of Community Health Workers, lay people, trained to reach out to their neighbors to provide educational support and linkage to other community based services.

Key interventions:

- Providing increased support through "high touch" Community Health Worker outreach
- Partnering with EMS on para-medicine programs
- Develop key community based partnerships to close gaps in care and remove barriers to appropriate community based services
- Launch community wide education around sites of care, access, ED use patterns and benefits of alternate sites of care
- Bridges Lay Health Educator program

Target Population	Individuals with 3 or more inpatient or ED visits in a 12 month period of time
	Patients with 6 or more ED visits in a 12 month period of time
Measure of Success	
Metrics	ED visits per capita
	Readmissions
	Potentially avoidable utilization
	Established longitudinal care plan
	Portion of target population with contact from assigned care manager

Participants/Partners

The following organizations and individuals will be key partners and/or participants in our initiatives in various capacities. They may participate in planning and advisory groups, implementation of clinical interventions, education, or trainings. We will count on these partnerships to provide guidance and input as implementation begins in 2016.

- Primary Care Providers
- Regional FQHCs
- Skilled Nursing Facilities
- Nursing Homes
- Adult day care /senior centers
- Home health/hospice
- Bridges Lay Health Educator
- Asian American Center
- Local health Department/AERS
- Department of Aging
- Department of Social Services
- Private mental health and substance abuse treatment programs
- Outpatient mental health clinics
- The Coordinating Center

Financial Sustainability

Services to reach the chronically ill in the community/home environment through high touch interventions will require investment in staffing resources. Investment in this resource will lead to decreased ED and hospital utilization which will drive down costs resulting in retained GBR revenue available to reinvest in other creative community partnerships, services and resources. There is a potential concern that demand for services that could exceed the capacity of program and funding sources. Management will monitor this closely.

Strategy # 4: Hospice and Palliative Care Utilization Improvement

Objective: To increase awareness and utilization of hospice and palliative care services at the appropriate time in order to maximize patient/family benefit.

Background: Utilization of hospice and palliative care services in the Frederick Community is roughly 50% of the Medicare fee for service average according to CMS statistics provided to our ACO. Frederick, as in many communities nationally has an opportunity to better educate citizens about the benefits of hospice and palliative care services. We are working to increase the number of citizens with Advanced Directives to ensure that patients' wishes regarding end of life care are prepared for and respected. With the shortage of fellowship trained hospice physicians nationally, we see a need to educate other care givers, provide additional mid-level provider support and educate providers and families about the benefits of palliative care to patients with multiple chronic conditions.

Key Interventions:

- Incorporate a Palliative Care RN as part of the Palliative care team to work on education of Palliative care vs. Hospice care for physicians and patients.
- Educate all physicians about the differences between palliative care and comfort care. Not all MDs are comfortable with the talk.
- Serve as a liaison between Case Management, the patient, physicians and Palliative and Comfort Care Service.
- Educate patients and families about the differences between palliative care and comfort care.
- Conduct community based educational events to ensure that all hospitalized patients are educated and given an opportunity to complete Advanced Directives

Target Population	Individuals with chronic conditions, end stage disease and diminished cognitive and ADL functions
Measure of Success	
Metrics	% of patients discharged with an Advance Directive
	Patient/Family Satisfaction/understanding
	Increased referral volumes
	Qualified patient evaluations
	Number of physicians referring to programs
	Referral response time

Participants/Partners

The following organizations and individuals will be key partners and/or participants in our initiatives in various capacities. They may participate in planning and advisory groups, implementation of clinical interventions, education, or trainings. We will count on these partnerships to provide guidance and input as implementation begins in 2016.

- Primary Care Providers
- ACOs
- Regional FQHCs
- Skilled Nursing Facilities/ALFs
- Adult day care/senior centers
- Health Department/AERS
- Home health
- Home Health Agencies
- Department of Aging
- Department of Social Services
- Coordinating Center
- EMS/emergency responders

Financial Sustainability

There is a significant opportunity to improve patient referrals to hospice and palliative services. Therefore, there is also related opportunity to decrease hospital utilization at the end of life. The reduced utilization will drive a decrease in costs and the resulting GBR retained revenue will be available to reinvest in community and population health infrastructure.

Describe Your Overall Goals:

The overall goals of the Frederick Memorial Hospital Strategic Transformation Plan are as follows:	Related Strategy Number
Reduce Potentially unnecessary utilization (PAUs)	#1,2,3
Improve access to care at the right setting and at the right time	#1,2,4
Increase outreach and education to improve community health, wellness and engagement	#1,2,3,4
Increase alignment among community providers to address gaps in social determinants of health	#1,2,3,4

Target Populations:

The goals target aging populations, frail elders, and patients with chronic medical conditions and serious mental illness. Also, the strategies place emphasis on primary care, prevention, and reduction of risk factors by reaching patients where they are, whether inside or outside of traditional health care settings.

Appendix A:

Regional Partnership for Health System Transformation

Regional Partnership for Health System Transformation

Regional Transformation Plan – Final Report

Due: December 7, 2015

Regional Partner: **Trivergent Health Alliance**

Maryland's Vision for Transformation: Transform Maryland's health care system to be highly reliable, highly efficient, and patient-centered. HSCRC and DHMH envision a health care system in which multi-disciplinary teams can work with high need/high-resource patients to manage chronic conditions in order to improve outcomes, lower costs, and enhance patient experience. Through aligned collaboration at the regional and state levels, the state and regional partnerships can work together to improve the health and well-being of the population.

Regional Partnerships: In order to accelerate effective implementation, Maryland needs to develop regional partnerships that can collaborate on analytics; target services based on patient and population needs, and plan and develop care coordination and population health improvement approaches. The Regional Partnerships for Health System Transformation are a critical part of the state's approach to foster this collaboration. As referenced in the RFP, the Regional Partnership plan will describe, in detail, the proposed delivery and financing model, the infrastructure and staffing/workforce that will support the model, the target outcomes for reducing utilization/costs and improving quality and the health of the populations targeted, and effective strategies to continuously improve overall population health in the region. In order to fulfill healthcare savings commitments by Maryland to CMS, the initial target populations have been identified as high utilizers such as Medicare patients with multiple chronic conditions and high resource use, frail elders with support requirements, and dual eligible' with high resource needs.

The Care Coordination Workgroup identified these populations as most likely to yield the biggest gains from the Regional Partnerships' efforts. The Workgroup also recommended the development of state-level integrated care coordination resources and in some areas recommended standardization and collaboration. The Care Coordination Workgroup's final report can be found at: http://www.hscrc.state.md.us/documents/md-maphs/wg-meet/cc/Care-Coordination-Work-Group-Final-Report-2015-05-06.pdf.

The Regional Partnership grants will culminate in the development of a regional transformation plan due in December 2015. Given the importance of regional collaboration to meet the goals of the new model, multi-year strategic plans for improving care coordination, chronic care, and provider alignment are required of all Maryland hospitals.

To achieve transformation on a regional and state-level, the following nine domains have been developed. These domains are meant to be a guide to the Regional Partnerships and other Maryland hospitals and serve as action steps during the planning process.

Nine Transformation Domains

1. Clearly articulate the goals, strategies, and outcomes that will be pursued and measured
2. Establish formal relationships through legal, policy, and governance structures to support delivery and financial objectives

3. Understand and leverage currently available data and analytic resources
4. Identify needs and contribute to the development of risk stratification levels, heath risk assessments, care profiles and care plans
5. Establish care coordination people, tools, processes, and technology
6. Align physicians and other community-based providers
7. Support the transformation with organizational effectiveness tools
8. Develop new care delivery models
9. Create a financial sustainability plan

As you utilize this template and develop your Regional Transformation Plan, please refer to the "Transformation Framework" as a reference guide.

Regional Transformation Plan Template

Goals, Strategies and Outcomes

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

The Trivergent Health Alliance, LLC ("Alliance") member health systems, consisting of Frederick Regional Health System, Inc. (FRHS), Meritus Medical Center, Inc. (MMC), and Western Maryland Health System Corporation (WMHS), came together to address the Regional Partnership for Care Transformation in March of 2015 with the common goal of transforming our local health care delivery system – to examine where we can leverage best practices, share lessons learned, and streamline resources in order to achieve better, more cost-effective outcomes. We are committed to meeting the state's All-Payer goals by implementing evidence-based, scalable and sustainable initiatives that improve the health and health care of the patients we serve as well as the population at large within our tri-county service area (Washington, Allegany and Frederick counties).

Our partnership was founded with the following overarching objectives:

- To initially focus our care delivery transformation by targeting opportunities where we can make an important difference in a relatively short period of time.
- To build a highly collaborative regional model, with customized local models of care, built on current 'best practices'.
- To design our interventions based on a deep understanding of health status and needs of region.
- To focus our clinical interventions on improved patient outcomes, economies of scale, financial savings and capabilities.
- To share resources to build a regional infrastructure that includes standard tools and systems, regional excellence in clinical staff training that focuses on patient-centered care, standard treatment protocols, efficacy and quality.
- To use data/analytics to make informed decisions and develop key metrics to monitor and evaluate success.
- To identity financial mechanisms and arrangements that will ensure sustainability of the model and incentivize providers to collaborate and participate in health care transformation.
- To identify needed initial and ongoing investments.
- To provide strong leadership that fosters a culture of innovation and change.

To identify the care models needed to address the health care priorities for our community, we used a data driven approach to identify the current health status and resource of use of most vulnerable as well as the entire population in our region, in order to determine what models would best address the greatest health care needs. By reviewing the Community Health Needs Assessment, Alliance hospital specific data, State and Regional data we determined that the Regional focus will be:

- Behavioral Health (BH): This includes all BH diagnosis, with the top 5 being Depression, Anxiety, Bipolar, Psychosis and Substance Abuse.
- High utilizers of inpatient services who may benefit from Complex Care Management. These patients have 3 or more Inpatient/Observation (OBS) discharges in a year with diagnoses of diabetes, cardiac disease including Congestive Heart Failure (CHF), and respiratory disease including Chronic Obstructive Pulmonary Disease (COPD) and anticoagulation patients.
- High Utilizers of Emergency Department (ED) Services: These patients have 6 or more ED visits in a year.

Through a collaborative planning process, we identified three major strategies as we prepare for regional care delivery transformation implementation. These strategies, along with the specific initiatives for that fall under each strategy, are listed below. We expect that our approach will most significantly impact our highest-need, highest-cost Medicare and dual eligible patients, who we believe will benefit from intense and targeted intervention; as a secondary but equally important focus, these initiatives will impact patients from all payers who meet our target population criteria. The improved processes and workflows we implement across the region will strengthen our health system as a whole and are expected to lower all-payer costs.

We define our initiatives are defined as either Model of Care (MOC) initiatives that will target current health system patients through interventions at the point of care; or as Population Health (PH) initiatives that take an upstream approach with the goal of community-wide prevention. We have numbered the initiatives in the table below, for ease of reference throughout this final report.

Strategy 1: Behavioral Health

Build a **multi-faceted Behavioral Health strategy** that focuses on outpatient case management, early detection and effective and timely support for at-risk patients. The strategy also includes at community-wide educational element aimed at reducing stigma and increasing understanding of behavioral health needs.

Goals, Strategies and Outcomes to be pursued:

The Alliance planning team identified Behavioral Health as primary focus for the region. Given the extent of the scope and need in the region, this strategy has three main initiatives, each with specific goals and expected outcomes:

1.1 Implement Behavioral Health (BH) Care Management (leveraging the best practice model currently in place at Western Maryland). The goals of this initiative are to:

a. Complete comprehensive psychosocial assessments of adult patients with a primary behavioral health diagnosis.
b. Link adult patients to behavioral health treatment and support services based on individualized needs.
c. Reduce Emergency Department (ED) re-visits within 30 days of discharge.
d. Reduce behavioral health readmissions within 30 days of discharge.

1.2 Integrate BH into primary care to identify patients at-risk and link them to appropriate resources. The goals of this initiative are to:

a. Establish a Regional Model of Integrated Behavioral Health Care open to all regional Primary Care Physician (PCP) practices.
b. Standardize an annual depression screening process to identify and treat at-risk adult patients. All adult patients will receive PHQ2 depression screening during their office visit in a 12-month period.
c. Improve coordination of behavioral health care using an evidence-based protocol to include specialty referrals, education, and linkage to community supports as indicated.
d. In conjunction with the Community Advisory Council (CAC) (see organizational chart) to create plans for connecting screened individuals at low risk to community based resources to help address social determinants impacting BH needs.
e. Identify a lead care manager for complex patients with co-occurring medical and behavioral health issues.

1.3 Reduce stigma and increase understanding of behavioral health needs through community health education, such as Mental Health First Aid (MHFA). The goals of this Population Health initiative are to:

a. In collaboration with the Community Advisory Council, identify target groups external to care delivery models for training and outreach, such as:
    - Law enforcement
    - Community Health Workers (CHW)/peer-lay outreach
    - Teachers
    - Senior providers such as senior centers, nursing homes, assisted living
    - Health care providers/medical care providers/FQHCs, hospice
    - Individuals impacted with/by behavioral health needs
b. Increase awareness through creation of appropriate materials for use with Community Advisory Council members/LHICs.
c. Improve appropriate access to needed behavioral health services.
d. Conduct 30 MHFA trainings a year, reaching over 500 people yearly.

Strategy 2: Complex Care Management (CCM)

Replicate and refine components of local best practices and standardize common metrics for a regional model of care for **High Utilizer (HU) populations with certain chronic disease conditions.**

Goals, Strategies and Outcomes to be pursued:

The Alliance Regional Partnership (Alliance, WMHS, MMC, FRHS) identified three overarching goals for this Model of Care strategy:

1. Regionalize processes and metrics for supporting patients in chronic disease management/education;
2. Reduce inpatient admissions and readmissions for patients served by this Model of Care; and
3. Establish common reporting template to track costs avoided for patients enrolled in CCM.

In order to achieve these goals, the Alliance Regional Partnership will invest in a common set of processes and strategies to engage High Utilizer (HU) patients in an intensive care management model that will:

1. Identify HU patients with chronic disease who meet criteria;

2. Engage them via referral and direct communications and outreach;
3. Enroll them in a Care Management Model that assesses needs and supports the HU patients through assignment of a Care Manager and creation of a care plan to ensure tracking, monitoring and follow-up;
4. Focus on supporting patient self-management and appropriate coordination with PCP/Specialty medical care;
5. Ensure discharge from the Complex Care Management (CCM) program when the patient is determined to have met care plan goals and can safely self-manage.

Strategy 3: Potentially Avoidable Emergency Department (ED) Visits
Work with ED providers and PCPs to reduce potentially avoidable ED visits.

Goals, Strategies and Outcomes to be pursued:
The goals and expected outcomes of this strategy are to reduce ED utilization by:
1. By improving communication between ED Physicians and PCPs for ED HU.
2. Improve handoffs between hospital-based and community providers.
3. Ensure timely access to community based care and interventions.
4. Increased patient engagement.

Strategy 4: Alliance Regional Partnership Regional Care Management Education Center (RCMETC)
Establish a Regional Care Management Education Center that will support the model of care and population health initiatives. This center is a necessary infrastructure requirement that will enable standardized staff onboarding and continuous staff education, focus on critical workforce competencies.

Goals, Strategies and Outcomes to be pursued:
The RCMETC will offer a standardized education program for the Care Management (CM) professionals and relevant support staff of the Alliance member Hospitals and partners.

The RCMETC will strive to achieve four goals:
1. Ensure that the Alliance Regional Partnership's Model of Care initiatives have a common framework for training CM staff on goals, processes, and outcomes tracking;
2. Provide a forum for understanding and closing local/regional CM gaps and communication;
3. Leverage a larger infrastructure to support the costs to acquire, develop and disseminate Care Management tools, curriculum and related technology;
4. Establish a process to coordinate and integrate the Regional Care Management process and goals with key community partners and which provide a means to help support our partners care management educational needs.

The RCMETC will be designed and developed as a service of the Alliance Regional Partnership hospitals, and will serve the growing number of staff who provide and/or support CM activities throughout the Alliance Regional Partnership network of providers who work with High Utilizer patients, both in direct care delivery and in provision of community supports.

The Goal for Year 1 is for the RCMETC to provide care management training to 500 individuals.

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

The table below lays out the target population, for our **baseline year (Year 1)** that will be monitored and measured and the number of people in the target population for each initiative. The HU population counts will fluctuate as unique patients meet, or no longer meet, the criteria outlined below for each strategies targeted population as per the inclusion/exclusion criteria described below. The geographic location for all initiatives is our tri-county service area of Frederick, Washington, and Allegany counties, and some also include patients from neighboring Garrett County.

Strategy 1: Behavioral Health
Build a **multi-faceted Behavioral Health (BH) strategy** that focuses on inpatient case management, early detection and effective and timely support for at-risk patients. The strategy also includes at community-wide educational element aimed at reducing stigma and increasing understanding of behavioral health needs.

1.1 Implement BH Care Management (leveraging the best practice model currently in place at WMHS).

- **Target population** –All persons discharged from the ED or from an inpatient hospital admission with a primary behavioral health diagnoses (including mental health or substance abuse diagnoses)
- **Number and geographic location** – For FY13-FY15, this totals 7,223 baseline unique patients, accounting for 9,298 total ED visits across our three counties (2,982 patients at FRHS; 1,851 patients at WMHS; and 2,390 patients at MMC).

1.2. Integrate BH into primary care to identify patients at risk and link them to appropriate resources.

- **Target population** – All adults treated in participating primary care practices, as well as adults who screen positive for depression.
- **Number and geographic location** –For this initiative, we will implement universal depression screening at primary care practices and ensure appropriate referrals and community linkages for patients based on their screening results. To estimate the potential impact of this initiative, we looked at the target population listed for Strategy 1.1 then drilled down to identify all of the of ED or Inpatient primary behavioral health diagnosis visits that were specific to mood disorders. Mood disorders are a diagnosis where if patients have the appropriate outpatient support and follow up, ED care and inpatient stays can often be avoided. We found that 5,855 unique patients with mood disorders account for 8,895 total ED and inpatient visits and total charges of $28,470,477 across all three hospitals. Data analysis of the target population for Strategies 1.1 and 1.2 by zip code revealed that utilization was concentrated in the zip codes associated with the major cities of the three counties.

1.3 Reduce stigma and increase understanding of behavioral health needs through community health education, such as Mental Health First Aid (MHFA).

- **Target population** - Adults participating in community health education and outreach.
- **Number and geographic location –** We expect to train 500 individuals, (which will include new hire and existing training to support strategy 1, 2 and 3 personnel as appropriate), on MHFA across all three counties.

Strategy 2: Complex Care Management (CCM)
Replicate and refine components of local best practices and standardize common metrics for a regional model of care for **High Utilizer (HU) populations with certain chronic disease conditions.**

Target population - To understand the specific characteristics of its HU population, the Alliance analyzed all patients at the three hospitals who met the following criteria for the period 7/1/14- 6/30/15:

- Patients with 3 or more inpatient discharges and/or observation stays of any length who have the following primary diagnoses: (Excludes discharges from OB, special care nursery and rehab. Also excludes expired patients.)
  - Endocrine, nutritional and metabolic disease and immunity disorders
  - Disease of the Circulatory System
  - Disease of the Respiratory System
  - Diseases Requiring Anti-Coagulation Therapy
- Includes discharges from BH units and palliative care

Patients who meet these criteria will be our target HU population for this initiative.

Number and geographic location - Using these criteria, we identified 1,153 HU patients among our three hospitals who accounted for 2,067 admissions, 565 readmissions, and charges amounting to $20,323,779 (not including ED charges), and readmission charges of $6,867,767. During further analysis, we discovered that when looking at all reasons for admission, not just the specific primary diagnoses above, we found that these 1,153 HU's actually account for 5,079 visits, 1,506 readmissions and $52,500,880 in total charges. All zip codes in primary and secondary areas for our hospitals were included. Due to the large geographical areas encompassed by zip codes in the region no trends were noticed except for a specific tract within the City of Cumberland MD. Additional analysis of this tract demonstrated that a significant percentage of high utilizers live in this area, but may not have one of the specific diseases above but contribute significantly to the readmission costs incurred at WMHS. In addition it was noted that there is limited access to primary care providers to serve these individuals. This anomaly will be addressed as part of this comprehensive regional grant.

Strategy 3: Decrease Emergency Department (ED) Potentially Avoidable Use (PAU))
Work with ED providers and PCPs to reduce potentially avoidable ED visits.

Target population - Baseline includes 3,171 unique patients derived from two target sub populations. These two sub-populations, described below, were determined to be a manageable group that the interventions are designed to support.

1. The first target sub population is patients with 6 or more ED visits in 12 months with no associated hospitalizations with the following primary diagnostic service (and associated ICD-9 code):
   - Disease of the nervous system (320-359)
   - Disease of the respiratory system (460-519)
   - Disease of the digestive system (520-579)

- Disease of the genitourinary system (580-629)
- Disease of the musculoskeletal system and connective tissue (710-739
- Symptoms, signs, and ill-defined conditions (780-799)
- Injury and poisoning (800-999)

Excludes: Obstetrics, Special Care Nursery patients, rehabilitation patients and death.

2. The second target sub population for Strategy 3 is comprised of 1,153 unique patients from the complex care management HU target population from Strategy 2. The complex care management inpatient/observation patients from Strategy 2 enter through the ED, therefore these strategies will be synergistic and lead to better overall coordination of care if they are included as a portion of the Strategy 3 target population. Additionally, the Strategy 2 high utilizers experience ED visits that do not result in a hospitalization and are captured for those patients with this strategy. We estimate (based on data from one hospital) that on average, the complex care management high utilizers from Strategy 2 had 2.3 ED visits annually that do not lead to a hospitalization; therefore we have included them in this strategy, in addition to Strategy 2 to reduce potentially avoidable ED visits.

Patients treated in the ED for Behavioral Health diagnosis that could potentially be avoided, with community based support, are captured in the Behavioral Health Strategies target population and interventions detailed above; reference BH Strategy 1. To avoid duplication of baseline data between the two Strategies relating to unique patients, number of visits and charges, that patient detail is captured only in Strategy 1's target population.

Number and geographic location-
Strategy 3's target population baseline includes 3,171 unique patients across our three counties (1.96% of the total ED unique patients) and account for 18,057 (9.55%) of all ED visits, and representing $10,485,129 (9.38%) in total ED charges.

- **The first sub target population is** 2,018 unique patients. These patients account for 14,961 ED visits that total $9,064,633 in ED charges.
- **The second sub target population** is 1,153 unique patients. These patients account for 2,306 ED visits that total an estimated $1,420,496 in ED charges.

Strategy 4: Regional Care Management Education Center (RCMETC)
Establish a regional Care Management Education Center that will support the model of care and population health initiatives. This center is a necessary infrastructure requirement that will enable standardized staff onboarding and continuous staff education, focus on critical workforce competencies.

Target population – Regional Care Partnership-Employed and affiliated health systems across the continuum of care that provide that provide Care Management services, including community partners, ambulatory, inpatient, emergency, behavioral health and specialty services.

Number and geographic location – We expect the target population to be about 500 staff from our three hospitals and partner

organizations.

- As of December 2015, the target population among the sponsor hospital employed staff is approximately 250 individuals, including: nurses, social workers/mental health professionals, community health workers and ancillary staff performing support functions.
- In addition, the RCMETC will provide education and training services to Care Management professional and ancillary staff from our partner organizations. We surveyed these organizations, and expect that this will include an additional 250 individuals who all work in the Washington, Allegany and Frederick counties, bringing the total to 500 individuals and ancillary personnel from partner organizations.

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

The specific metrics we will use for each initiative are outlined in the table below. Our overarching aim is to improve patient satisfaction, quality, outcomes, process and costs in ways that align with the State of Maryland's objectives. Metrics that draw from Maryland's All-Payer Model goals include: reductions in 30-day readmissions; cost savings that will reduce and/or help to slow per capita hospital cost growth (aligned with Maryland's goal of 3.58% growth); and selection of initiatives that will impact the highest need Medicare population (but will also touch other high-cost populations and the entire community).

Our metrics fall into the domains of Cost/Financial, Quality, and Patient Satisfaction. The Regional Partnership plans to track patient satisfaction measures for the three strategies within the following five industry standard CAHPS/HCAHPS areas:

- Getting the care they need
- Getting care quickly
- How well doctors communicate
- Care plan information and customer service/patient satisfaction
- How people rated their service and care

Patient satisfaction measures will be further refined during the implementation phase as we develop workflows and determine what is appropriate and feasible for each initiative. For example, we are considering replicating the WMHS Behavioral Health Care Management process to collect actionable patient satisfaction data through follow up phone calls for applicable strategies. Obtaining real-time patient satisfaction feedback will ideally be integrated as part of the care delivery interventions, allowing for continuous improvement. The following table outlines the remainder of our metrics.

Alliance Regional Partnership Care Transformation Metrics				
Initiative	Metric	Type of Measure: Quality, Pt Satisfaction, Financial	Outcome or Process Metric	√= Metric Aligns to State's Objectives
All	**Return on Investment (ROI), incorporating all strategies per year, and cumulative for 3 years. Then broken down per strategy/year.** A reduction in admissions and ED visits, including readmissions, will result in a quantifiable cost savings measure.	Cost/Financial	Outcome	√
1. Behavioral Heath Build a multi-faceted Behavioral Health strategy that focuses on inpatient case management, early detection and effective and timely support for at-risk patients. The strategy also includes a community-wide educational element aimed at reducing stigma and increasing understanding of behavioral health needs.				
1. 1 Implement BH Care Management (leveraging the best practice model currently in place at Western Maryland).	BH ED Visits raw number and per 1000 lives	Quality, Financial	Outcome	√
	BH Admission Rates (Based off total BH ED visits and per 1000 lives)	Quality, Financial	Outcome	√
	BH ED Revisits within 30 days (Raw count; total ED visits returned in 30 days/Total BH ED visits)	Quality, Financial	Outcome	√
	BH Readmission rates within 30 days (Raw count; total BH readmission returns/BH total admissions)	Quality, Financial, (indirect pt. sat.)	Outcome	√
1.2 Integrate BH into primary care to identify patients at risk and link them to appropriate resources.	Percentage of community providers participating in initiative.	Quality	Process	√
	Number of low, medium and high risk individuals screened by PHQ-9 referred for follow up	Quality	Process	√
	Percentage of patients seen in participating PCP practices in a given year that are screened for depression using standardized tools, PHQ-2 and PHQ-9.	Quality	Process	√

	Percentage of high risk individuals referred and had a subsequent BH ED visit or BH admission within 30 days.	Quality, Financial	Outcome	√
1.3. Reduce stigma and increase understanding of behavioral health needs through community health education, such as Mental Health First Aid (MHFA).	Number of Community Health Education/MHFA trainings conducted.	Quality	Process	√
	Number of individuals trained, targeting the follow groups: law enforcement, CHWs/Peer-lay outreach, teachers, senior provider (such as senior centers, nursing homes, assisted living), health care providers/medical care providers/FQHCs, hospice, individuals impacted with/by behavioral health needs.	Quality	Process	
	Rate of emergency department visits related to mental health disorders (per 100,000 populations). (State Health Improvement Process (SHIP) metric- Objective 34)	Quality, Financial	Outcome	√
Strategy 2: Complex Care Management (CCM)				
Replicate and refine components of local best practices and standardize common metrics for a regional model of care for High Utilizer (HU) populations to include those with certain chronic disease conditions (Endocrine, Nutritional and metabolic disease and immunity disorders, disease of the circulatory system, disease of the respiratory system, diseases requiring anti-coagulation therapy).	Reduction in admissions rates (raw count and per 1000 of population)	Quality, Financial	Outcome	√
	Reductions in readmissions rates (raw count and per 1000 of population)	Quality, Financial	Outcome	√
	Avoidance and reduction in cost of inpatient care for patients participating in program	Financial, Quality	Outcome	√
	CTM 3 - Care Transitions Measures- The following 3 industry standard HCAHP questions: 1. The hospital staff took my preferences, and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital. 2. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health. 3. When I left the hospital, I clearly understood the purpose for taking each of my medications.	Quality, Indirect Pt Sat.	Outcome	√
	Reduction in PQI's –Specifically the following PQI diagnosis as defined by the Agency for Healthcare Research and Quality, (AHRQ), that would not require hospitalization. PQI #1- Diabetes short-term complication admission rate PQI #3- Diabetes Long-Term Complications PQI #5- Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Oder Adults Admission Rate	Quality, Financial	Outcome	√

	PQI #7- Hypertension Admission Rate PQI #8- Heart Failure Admission Rate PQI #14- Uncontrolled Diabetes Admission Rate (raw count/PQI)			
Strategy 3: Decrease Emergency Department (ED) Potentially Avoidable Use (PAU)				
1. Improving care coordination between ED and community providers. 2. Providing increased support thru "high touch" CHW outreach 3. Par medicine program 4. Facilitate improved coordination of care post ED visit. 5. Tele-Monitoring; not only will help decrease PAU but will serve is an enabling initiative to support Strategy 2 above. 6. Friday Tuck-In Service; not only will help decrease PAU but will serve is an enabling initiative to support Strategy 2 above.	Total ED visits per capita and per 1000 population for region	Quality, Financial	Outcome	√
	Change in high utilizer ED visits – frequency and cost	Quality, Financial	Outcome	√
	Number of HU ED pts with subsequent ED visit in 72 hours and 90 days	Quality, Financial, Indirect Pt Sat	Outcome	√
	Identify the number of High utilizers per PCP	Quality	Outcome	
	Reduction in percent of total ED visits and charges that high utilizers represent	Quality, Financial	Outcome	√
	Reduction in Readmissions (all-cause 30 day) specific to HU population (Raw Count and ED Visits per 1000 of population)	Quality, Financial	Outcome	√
	Reduction in Potentially Avoidable Utilization (PAU): Internal reports available currently; Future CRISP report (Use diagnoses from HU data to determine PQIs that are most relevant)	Quality, Financial	Outcome	√
	Improve communication/texting to PCP for HU	Quality	Process	
	Percent of HUs who have follow up appt. with PCP or specialist within X days (possible for health system owned practices initially; will establish tracking method for independent practices	Quality, Indirect Pt Sat.	Process	√
	Percent of HUs engaged in intervention: complex care management, community health worker, tele monitoring	Quality, Indirect. Pt. Sat.	Process	√

Strategy 4: Regional Care Management Education Center (RCMETC)
Establish a Regional Care Management Education Center that will support the Models of Care and Population Health initiatives. This center is a necessary infrastructure requirement that will enable standardized staff onboarding and continuous staff education, focus on critical workforce competencies.

Since this is an infrastructure support initiative, specific metrics and curriculum requirements will be defined based on our Model of Care (MOC) strategy components and the needs of Care Managers. Metrics for our Model of Care strategies will be reported quarterly and curriculum development and refinement will occur on a semi-annual basis based on those outcomes. Specific metrics for this supportive strategy include:

- Number of Community Health Workers completing Mental Health First Aid training through Strategy 1.3
- Number of care management staff completing motivational interviewing training and engagement of patients with chronic disease
- Number of care coordination staff completing Health Coaching training
- Number of staff trained, by license/role (RN, SW, CHW, administrative, etc.)
- Number of staff trained, by practice setting (ED, Inpatient, Community based, etc.)
- Number of educational programs offered/year
- Distribution of attendees: Clinical Staff by job type, Community Partners, Physician Practices, etc. (This is future state goal, the Alliance will need to create infrastructure.)
- Pass rate for individual programs
- Number of yearly competencies completed
- Number of clinical opportunities for Masters level pre-licensed counselors (in house and community)
- Number of Schools of Social Work who partner for training and CEU opportunities

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

Each of our three Strategies and their associated target populations were selected based on extensive data analysis and assessment of Alliance resources and capabilities to determine what we can collectively accomplish that will have the greatest impact. A description of our current performance against the metrics for each strategy is summarized below. We provide baseline data wherever possible, however in some cases the baseline data will be collected in Year 1 of implementation.

Strategy 1: Behavioral Health
Build a **multi-faceted Behavioral Health strategy** that focuses on community case management, early detection and effective and timely support for at-risk patients. The strategy also includes at community-wide educational element aimed at reducing stigma and increasing understanding of behavioral health needs.

Strategy 1.1: Implement BH Care Management

Our current performance on key metrics for this strategy are in the tables below. In 2013, WMHS piloted BH CM, specifically targeting 30-day readmissions, and the program has seen a reduction in total readmissions within 30 days and the total readmission rate. ED revisits within 30 days will be added as a metric for FY16 and tracking with the intervention has begun. Based on WMHS's successful implementation of BH CM and the positive outcomes achieved to reduce ED visits and readmission rates (as shown in the highlighted values below), the regional plan is to replicate the core elements of the WMHS BH CM program at MMC and FRHS. We also intend to track and report BH ED visits and readmission rates per 1000 of the population.**BH ED Visits Baseline Data:**

Time Period	WMHS		FMHS		MMC	
	ED Visits	Readmission Rate	ED Visits	Readmission Rate	ED Visits	Readmission Rate
FY 13	2,697	16%	2,775	16%	3,065	Not available
FY 14	2,551	17%	3,130	20%	3,344	30%
FY 15	2,593	14%	3,172	19%	3,333	27%

30-Day Inpatient Admissions and Readmission Rate

Time Period	WMHS		FMHS		MMC	
	Inpt Visits	Readmission Rate	Inpt Visits	Readmission Rate	Inpt Visits	Readmission Rate
FY 13	1,207	19.7%	944	14%	1,031	7%
FY 14	1,107	12.92%	1,002	18%	1,049	6%
FY 15	1,126	11.35%	907	13%	1,082	11%

Source: Electronically collected by the hospitals' Behavioral Health directors.

Strategy 1.2. Integrate BH into primary care to identify patients at risk and link them to appropriate resources.

Our current performance on key BH metrics below indicate a need for early detection of BH conditions in primary care settings.

- **ED visits due to mood disorders:** Across the region, there are 5,855 unique patients with mood disorders who account for 8,895 total ED and inpatient visits. Baseline data demonstrate a high rate at which persons living in the community present in the EDs in crisis, diagnosed with a mood or substance abuse disorder. Intervention and mitigation starts with screening and supportive care management programs within the primary care offices and community settings.
- **For FY 13, 14, and 15 MMC's 30**-Day Inpatient Admission and Readmission Rate was the lowest in the region yet the ED readmission rate is the highest in the region. This is attributed to the practice pattern of the psychiatrists at MMC, and increase in

inpatient readmissions in the last fiscal year, the work team felt the most impactful intervention to benefit the region to reduce both ED revisits and 30-Day Inpatient Admissions and Readmission rate is through the use of BH Case Managers who can more readily work with the patient and implement care plans.

- **Number of low, medium and high risk individuals screened by PHQ-9 and referred for follow up:** While some primary care practices are screening for depression, the process, reporting and tracking is not consistent, but will be addressed during the implementation phase. Based on a review of 10 practices using the PHQ-2 or PHQ-9 depression screenings within the Frederick Integrated Health Network ACO (FIHN), with a total of 10,988 MSSP patients, we found that 24.72 % of patients were screened. Those that received a PHQ-9 screening were distributed by the following risk levels: low (mild) (57.9%), medium (moderate) (29%) and high (moderately severe and severe) (12.9%). During implementation, we will standardize the data collection of these results so that they can be captured and reported electronically for the regional partnership. We will uniformly risk stratify patients from their screening results as: normal (score of 1-4), mild depression risk (5-8), moderate risk (9-14), moderately severe risk (15-19), and severe risk for depression (20-27). The goal is to identify patients who are at mild to moderate risk so that referrals, care plans and linkages to needed resources so that treatment can be initiated in the outpatient settings preventing the need for costly BH-related ED and inpatient utilization. We will phase in this intervention, starting with implementation of universal screening with those practices already administering the PHQ-2 and PHQ-9; then deploy to the remainder of the hospital-employed primary care practices; then we will include all ACO-engaged primary care providers.

	# of Hospital Employed PCP Practices	# of Non-Employed PCP Practices in ACO	Total # of PCP Practices Currently Utilizing PHQ- 2 and PHQ- 9	% of Practices Currently using /Total Hospital Employed & ACO PCP Practices
WMHS	3	7	3	3/10 (30%) *
MMC	9	12	3	3 /21 (14%) *
FMHS	3	12	15	15/15 (100%) *

***Assessment tools are not currently used uniformly within each practice. The Regional Partnership's opportunity with this intervention is to standardize use PHQ-2 and PHQ-9 screenings for all adult patients on a predictable schedule to facilitate early detection, comprehensive care planning and facilitation of early engagement of a Masters Certified Behavioral Health Care Manager.**

1.3 Reduce stigma and increase understanding of behavioral health needs through community health education, such as Mental Health First Aid (MHFA)

The MHFA trainings that are at the heart of this initiative will be led by the Core Service Agency in Allegany County, the Washington County Mental Health Authority, Brook Lane, and the Frederick Mental Health Association. The number of trainings held in FY 15 and the number of individuals trained are shown below:

- Washington County: 6 community training events with 142 persons (3 law enforcement trainings, 55 city police officers and 8 sheriff's deputies)
- Allegany County: 16 trainings and 194 (121 core - of which 72 law enforcement, 69 youth, 4-TA)
- Frederick County: 17 trainings with 104 core, 2 police officers, 22 youth

This totals 440 individuals trained in FY2015. Our goal is to train 500 individuals on MHFA across all three counties in Year 1.

Strategy 2: Complex Care Management (CCM)
Replicate and refine components of local best practices and standardize common metrics for a regional model of care for **High Utilizer (HU) populations with certain chronic disease conditions.**

For Strategy 2, the Alliance's current performance against the stated metrics for the target population (primary diagnosis) is shown below:

Endocrine, nutritional and metabolic disease and immunity disorders	• Represents 210 visits • Represent 58 readmissions for a 27% readmission % with a charge of $520,000 • Represents $2,003,671 in total charges
Disease of the Circulatory System	• Represents 498 visits • Represents 158 readmissions for a 40% readmission % with a charge of $2,132,195 • Represents $5,310,154 in total charges
Disease of the Respiratory System	• Represents 905 visits • Represents 252 readmissions for a 27.8% readmission rate with a charge of $3,163,025 • Represents $9,163,188 in total charges
Diseases Requiring Anti-Coagulation Therapy	• Represents 454 visits • Represents 97 readmissions for 20% with a charge of $961,878 • Represents $3,846,767 in total charges

Current per capita charges for the ICD9 codes selected is $17,626.

Strategy 3: Potentially Avoidable Emergency Department (ED) Visits
Work with ED providers and PCPs to reduce potentially avoidable ED visits.

Strategy 3's target population encompasses 3,171 unique patients across our three counties, accounting for combined patient visits totaling 18,057, and representing $10,485,129 in total ED charges.

1. The first sub-population (high utilizers with 6 or more ED visits) is 2,018 unique patients. These patients account for 14,961 ED visits that total $9,064,633 in ED charges.

Strategy 3: Decreased ED PAU	
Metric	Current Performance:
ED Visits for primary diagnostic service:	Annually:
Disease of the nervous system (ICD-9 Codes: 320-359)	Represents 1,199 ED visits
Disease of the respiratory system (ICD-9 Codes: 460-519)	Represents 1,479 ED visits
Disease of the digestive system (ICD-9 Codes: 520 - 579)	Represents 1,102 ED visits
Disease of the genitourinary system (ICD-9 Codes: 580-629)	Represents 1,083 ED visits
Disease of the musculoskeletal system and connective tissue (ICD-9 Codes: 710-739	Represents 1,412 ED visits
Symptoms, signs, and ill-defined conditions (ICD-9 Codes: 780-799)	Represents 4,239 ED visits
Injury and poisoning (ICD-9 Codes: 800-999)	Represents 2,876 ED visits
Disease of the nervous system (ICD-9 Codes: 320-359)	Represents 1,199 ED visits

Per capita charges for the ICD9 codes selected are $4,510 and total ED charges are $9,064,633. Over half of these visits were coded as lower level emergency room acuity, therefore could have been treated in a lower level setting.

2. The second sub target population, a subset of the Complex Care Management patients from Strategy 2, equals 1,153 unique patients,

accounts for 2,306 ED visits that total $1,420,496 in ED charges. These ED visit charges were not included in calculation of strategy 2's Target Population's Annual Charges of $52,500,880. Further data analysis of Strategy 2's HU population found that, on average, those patients had 2.3 ED visits annually with no associated hospitalization. The total associated ED charges for this population equal $1,420,496.
Strategy 4: Regional Care Management Education Center (RCMETC) Establish a regional Care Management Education Center that will support the model of care and population health initiatives. This center is a necessary infrastructure requirement that will enable standardized staff onboarding and continuous staff education, focus on critical workforce competencies.
Because this is a support strategy that involves launching a new education center, there is no baseline data to report on this initiative.

Define the data collection and analytics capabilities that will be used to measure goals and outcomes.

Each of our hospitals will strengthen our data collection and analytics capabilities as part of the Alliance's efforts to streamline data and create consistent data definitions and collection methodologies to measure the results of our efforts. We will be pulling much of our outcomes measurement data from our hospital EHRs. The Alliance hospitals each have Meditech as their base EHR systems, but due to differences between their operating versions and hospital specific customizations over the years, designated data analysts/quality experts from each hospital are need to pull each strategies data requests to ensure accurate capturing and reporting all the needed information. The hospital specific data can then be aggregated in a standardized format so that it can be compiled and reported out regionally for the Alliance. Each hospital therefore has data personnel and capabilities supporting the work teams that are charged with designing and implementing our strategies.

To ensure that data requests are transparent and that standardized methods and criteria are being used to pull the data, weekly data meetings are held and facilitated by the project manager. This has allowed us to share the methodologies for pulling data, create customized reports, and ensuring that all three hospitals can regularly provide data that is able to be aggregated into a regional picture that will be used for evaluating our performance and continuous quality improvement.

Our data teams will also use the CRISP data to compare with self-collected data and track progress as we implement our strategies and initiatives. The baseline data collected over the past few months will allow us to measure our progress, and identify potential patients and conditions to target. Data teams at each of our hospitals will continue to communicate with each other to ensure consistent data collection and target opportunities for improvement. During implementation, these data teams will continue their routine meetings to facilitate collecting consistent and reliable data on an ongoing, timely basis and to update the performance metrics dashboard and the process metrics we have identified.

During the planning phase, the data teams have fulfilled data requests in additional to their already full workloads. To allow the strategies to continue to be data driven moving forward, 1.5 full time employee (FTE) will be budgeted for this work in the implementation grant. The 1.5 FTE would be divided equally among the three hospitals solely for data analysis. This would allow us to have dedicated, centralized data support and capacity to support the initiatives and complete robust analyses that includes cost, ambulatory data and measures, satisfaction measures at all points of the continuum, and qualitative and quantitative measures. Supporting our data teams and strengthening our collective data capacity as a Regional

Partnership, beyond what is currently in place at the individual hospitals, and will be foundational to our success.

List the major areas of focus for Year 1. (For the completion of this plan, if various areas of focus require different descriptions, please identify each area under the following sections of the plan.)

Our regional care delivery transformation strategies, particularly in Year 1, focus on lowering readmissions and connecting high utilizing patients to outpatient care and community resources outside of the hospital. Through the increased use of technology, the building of consistent and connected infrastructure and training, and enhanced communication between the hospitals and their community partners, the Partnership strives to lower the targeted patients' hospital and ED utilization and increase savings to reinvest in health improvement interventions. Engaging patients in new and innovative ways, such as using technology to monitor HU will drive savings while improving the health of our patients.

Specifically, the major area of focus for Year 1 is identifying High Utilizers and connecting them to care management to improve patient outcomes and lower costs. This will be achieved through:

- flagging the HU target populations to make them more apparent
- better inpatient discharge planning,
- ED discharges that include warm hand-offs to a care manager, and
- Pro-active connection to care management from the primary care practice teams.

Also included in this Year 1 priority are behavioral health patients that are often in the high utilizer categories, but their behavioral health needs are overlooked.

Beginning in Year 1 and beyond, our overarching focus with the initiatives described in this final report are to move toward Triple Aim goals of cost savings and improving care quality and outcomes, consistent with the State of Maryland's goals for reduction in readmissions and hospital-acquired conditions.

Formal Relationships and Governance

List the participants of the regional partnership such as hospitals, physicians, nursing homes, post-acute facilities, behavioral health providers, community-based organizations, etc. Specify names and titles where possible.

The Regional Partnership is comprised of formal relationships between the three sponsor health systems, including employed PCPs, which account for a substantial share of the providers in the region. We have also engaged and are seeking input and involvement from external (non-hospital affiliated) providers and community organizations in these endeavors. Recognizing that community and physician partners will change over time based on patient and strategy needs, the following core initial stakeholders and partners were identified that will be critical

to the success of our work. We conceptually grouped potential partners into two categories, **(1) Model of Care Partners** and **(2) Community/Population Health Partners.**

1. Model of Care Partners – These are organizations and individuals that will help advance our clinical initiatives as collaborators or integrators, usually with direct involvement in providing care to patients. These include Primary Care Providers, Behavioral Health care providers, specialists, home health agencies, behavioral health services, skilled nursing facilities (SNF), emergency service providers, etc. These partners play a primary role in addressing the health of high utilizers and patients with multiple chronic conditions, and may be incorporated into any incentive, gainsharing or financial models that are developed as part of the regional transformation plan.

We foresee a high level of physician engagement, particularly considering that hospital-employed and ACO Primary Care Physicians make up a large percentage of the PCPs in the region. (Frederick's ACO reports 80% of its county's PCPs are engaged with the ACO, Meritus reports 50%, and WMHS reports 40%.) Engagement of unaffiliated PCPs and specialists will be pursued once we **establish** the legal framework **that will allow us** integrate the initiatives with non-employed or, non-ACO providers and specialists. **Note that further detail on our Physician Alignment plans is below in the Physician Alignment section.**

The specific Model of Care Partners that will be critical to engage, by strategy, include:

- Strategies 1.1- BH Care Management and 1.2- Integration of BH in Primary Care:
  - Way Station, Archway, Core Service Agencies (CSA), Local Health Departments, Living Well, The Mental Health Center, Brook Lane Health Services, Villa Maria of Mountain Maryland, Committed to Change, Appalachian Behavioral Health, Hope Station, Wash. Co. Office of Consumer Advocacy, and private mental health and substance abuse treatment programs.
- Strategy 2- Complex Care Management of HU's with certain chronic diseases:
  - Identified patients, LHIC's, Health Departments, Meals on Wheels, Associated Charities, Mission of Mercy, Pharmacies, adult day care centers, and assisted livings.
- Strategy 3- ED PAU
  - Department of Aging, Heath Department/AERS, Department of Social Services (DSS), LHIC's, behavior health and substance abuse providers.

2. Community/Population Health Partners – These are organizations that work primarily to address the environmental and social determinants of health would participate by helping assess community impact, sharing in relevant community education and communication, and in initiatives that are designed to address community health and wellness activities, in order to prevent individuals from developing chronic conditions and becoming high utilizers.

During November, Model of Care partners and Community/Population Health partners were engaged in the work plans, timelines and financial constructs necessary to create detailed implementation roadmaps for 2016. We have also created a Community Advisory Council

(CAC) to advise us in our work, and to work in collaboration with the Local Health Improvement Coalitions. The CAC involves key Community/Population Health partners and stakeholders in our regional planning and implementation efforts. A charter for the CAC has been developed. The first meeting was held in November, and members will meet every other month or more frequently, if needed. CAC members were selected by the work team leads and approved by the Executive Committee. Community/population health partnerships and the CAC engagement will be fluid in order to accommodate to changing the needs of the patients within the communities we serve. The CAC's charter is included as **Appendix 1.**

Community Advisory Council Members:

Community Advisory Council Members			
Representation Needed:	FRHS	WMHS	MMC
(2) LHIC and Cores Service Agency (CSA) Representatives	Barbara A. Brookmyer, MD, MPH Frederick County Health Care Coalition Board of Directors Health Officer	Lesa Diehl, Director Allegany Co. Health Dept., MHSO, CSA	Rod MacRae, MA MHP, Director, Washington County Health Department
	Josh Pedersen Frederick County Health Care Coalition Board of Directors CEO, United Way of Frederick	Cathy Chapman, CRNP Chapman and Associates Health Care	Rick Rock, LCSW-C, Executive Director, Washington County Mental Health Authority, CSA
Law Enforcement	Designated Washington Co. Rep.to be the Regional Representative		Todd Kerns, Washington County Sheriff Representative
Area Agency For Aging	Designated Washington Co. Rep.to be the Regional Representative		Amy Olack Executive Director Commission on Aging
Consumer Advocacy Group or Consortium	Dr. Joseph Berman; Advocates for the Aged in Frederick County; (Back-up rep.: Cindy Powell)	Designated Frederick Co. Rep.to be the Regional Representative	
SNF	Designated Alleghany Co. Rep.to be the Regional Representative	Christopher P. Adams, MBA, LHNA, Devlin Manor Healthcare Center	Designated Alleghany Co. Rep.to be the Regional Representative
Hospice	Helen Kimble; Hospice of Frederick County	Candy Adams; Nurse Manager	Eric Klimes, CEO Hospice of Washington County
DSS	Richard Paulman, Ed. D. Director, Allegany County Department of Social Services	Designated Frederick Co. Rep.to be the Regional Representative	

Exec. Committee Representation	Eileen Jaskuta, MMC and Manny Casiano, FRHS
Membership from Alliance	Work Team Leads: Allen Twigg, Nancy Forlifer, Jo Wilson, Andrea Horton, Heather Kirby
Liaison between CAC, EC, and Work Teams	Work Team Leads: Allen Twigg, Nancy Forlifer, Jo Wilson, Andrea Horton, Heather Kirby
CAC Meeting Facilitator	Kristie Carbaugh, Regional Partnership Project Management Director
CAC Chair	To be determined within the next two CAC meetings; will need Executive Committee Approval

LHIC= Local Health Improvement Coalition; CSA= Core Service Agency Representative

Recognizing that not all community partners are represented on the CAC, the Regional Partnership invited all community partners to attend an Alliance Regional Care Transformation information and feedback session. Three sessions were held in November, attended by 37 community agency members representing 27 community partner agencies including skilled nursing and rehabilitation facilities, mental health authorities for all three counties, home health agencies, community health worker programs, Western Maryland Associated Health Education Center, Way Station, Inc., Garret County Lighthouse, charitable agencies and more. **Appendix 2** details the information session attendees by agency or organization.

Following these meetings, surveys were sent to all attendees requesting feedback regarding how they see their focus, interest and capabilities intersecting with the Alliance, so that we can engage in further discussions to organize partnerships. Feedback was aggregated then shared with the work team leads so that community partners could be incorporated into strategies for the implementation plan.

Summary

The following organizations and individuals were identified by the work teams as key partners and/or participants in our initiatives in various capacities. They may participate in planning and advisory groups, implementation of clinical interventions, education, or trainings. We will count on these partnerships to provide guidance and input as implementation begins in 2016.

Some of these partnerships have already been established for Year 1 of implementation, and other partnerships will be developed in Year 2 or 3 as the Alliance phases in our interventions (e.g., for our ED visit reduction initiative, we are starting with our hospital-employed and affiliated PCPs first and then engaging unaffiliated PCPs in the community).

Summary List of Current and Potential Alliance Partners

- Primary care providers
  - Hospital employed
  - Hospital affiliated (e.g., participate in ACO)
  - Unaffiliated
- The Mental Health Center
- Adult Evaluation and Review Services
- Brook Lane Health Services
- Villa Maria of Mountain Maryland

- Group practices
- Regional Health Care Networks of Community Providers/ACO's
  - WMHS- CIN (Clinically Integrated Network)
  - MMC- THP (Tristate Health Partners)- Meritus ACO
  - FRHS- FIHN (Frederick Integrated Healthcare Network)
- Regional FQHCs
  - Tristate Community Health Center
  - Hagerstown Family Healthcare (Formerly- Walnut Street Community Health Clinic)
  - Health Care for the Homeless Inc.
- Skilled nursing facilities
- Nursing homes
- Adult day care centers
- Assisted living facilities
- Senior centers
- Hospice
- Pharmacies
- MEP
- Home health agencies
- Way Station
- Archway
- Turning Point
- Core Service Agencies (CSAs) / Mental Health Authority
- Committed to Change
- Appalachian Behavioral Health
- Hope Station
- Washington County Office of Consumer Advocacy
- Behavioral health units of the three Alliance health systems
- Community behavioral health providers
- Private mental health and substance abuse treatment programs
- Outpatient mental health clinics
- LHICs
- Mental Health Association
- Helping Hands Training
- Meals on Wheels
- Associated Charities
- Mission of Mercy
- Coordinating Center
- Potomac Case Management
- Half way houses and homeless shelters
- EMS / emergency responders
- Police / law enforcement
- Local Health Departments
- Department of Aging
- Department of Social Services
- Living Well

Describe the governance structure or process through which decisions will be made for the regional partnership. List the participants of the structure/process.

The Trivergent Health Alliance (Alliance), LLC, was created in May 2014 to further the Triple Aim of CMS (lower cost, improve quality and improve the health of the populations served by the three hospitals). The Alliance is the sole member of the Trivergent Health Alliance MSO, LLC, which was created to further the cost saving portion of the triple aim. The Alliance Board of Directors is comprised of nine individuals: the Chairperson, Vice Chairperson, and CEO of each hospital (WMHS, MMC, FRHS); the MSO Board is comprised of 6 individuals including the CEO and CFO of each of the hospitals.

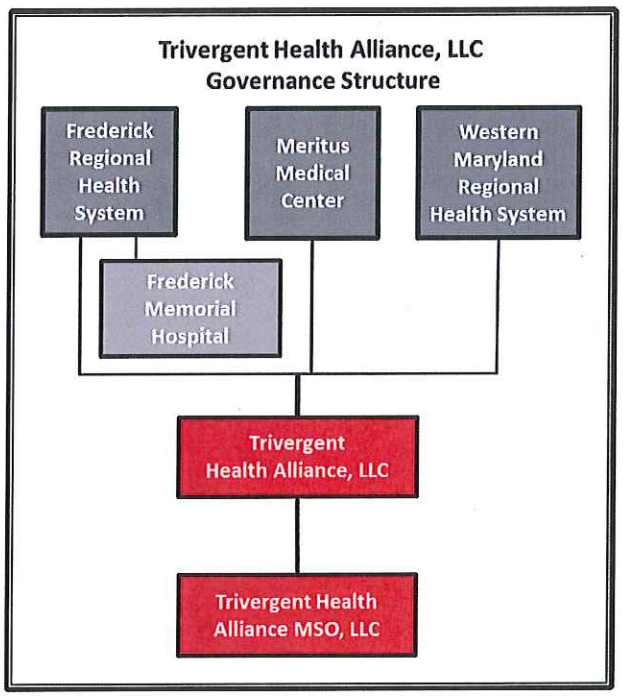
The Regional Partnership has developed a transparent and collaborative regional governance structure that includes representation from each

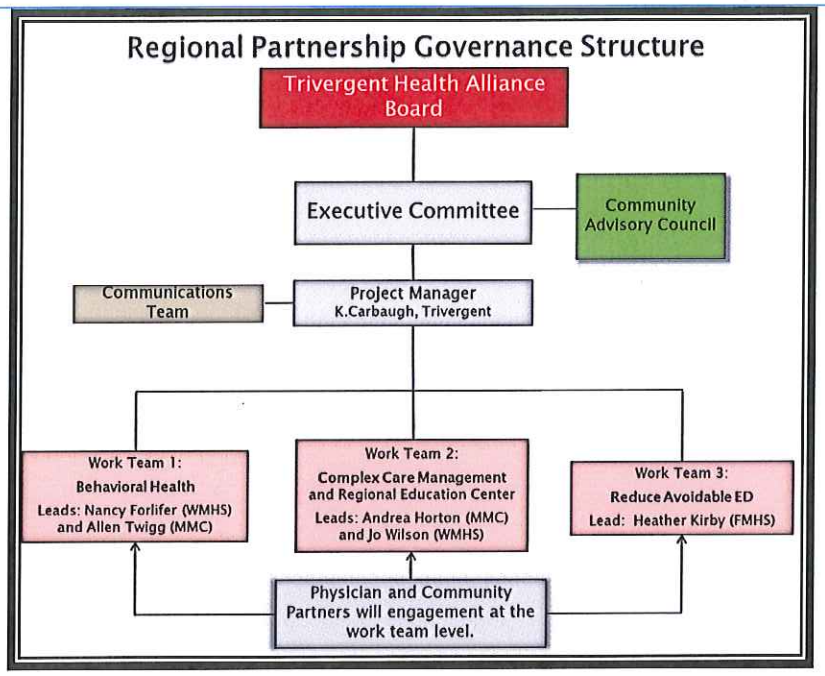
of our three health systems. The Executive Committee, reporting to the Alliance Board of Directors, meets biweekly and provides hands-on oversight of the multidisciplinary work teams. There are dedicated work teams to support each strategy that will remain in place during implementation. Each work team has representation from each hospital, has a designated Chief Financial Officer to provide financial advice, a data analyst, and designated team lead(s).

The Executive Committee is the decision-making body that includes senior leadership from FRHS, MMC and WMHS. The Executive Committee provides recommendations and updates to the Alliance Board of Directors. Decisions are made based on achieving consensus among representatives from all three Alliance hospitals. The Alliance Board of Directors meets quarterly or as needed to review and approve key items such as clinical initiatives, financial models and funds allocation, and staffing.

The Alliance receives substantial project management, infrastructure and implementation support from the Trivergent Health Alliance MSO, whose CEO serves on the Executive Committee and has hired a full-time Project Manager dedicated to Regional Partnership care delivery transformation initiatives.

Alliance Governance Structure:





Members of the Alliance Governing Bodies			
Alliance Governing Body	**Name**	**Title**	**Organization**
Alliance Board Chair	Ann-Herbert Rollins	FMH Board Chair	FRHS
Alliance Board & MSO Board	Tom Kleinhanzl	CEO	FRHS
Alliance Board	Jim Reinsch	FMH Board Vice-Chair	FRHS
Alliance Board & MSO Board	Joseph Ross	CEO	MMC
Alliance Board	James Stojak	MMC Board Chair	MMC
Alliance Board	Steven Hull	MMC Board Vice-Chair	MMC
Alliance Board & MSO Board	Barry Ronan	CEO	WMHC

Alliance Board	John Davis	WMHS Board Chair	WMHS
Alliance Board	Rolf Haarstad	WMHS Board Vice-Chair	WMHS
MSO Board	Michelle Mahan	CFO	FMHS
MSO Board	Tom Chan	CFO	MMC
MSO Board	Kim Repac	CFO	WMHC
Regional Partnership Care Transformation Executive Committee			
Executive Committee	Gerald Goldstein	Senior Vice President/CMO	WMHS
Executive Committee	Nancy Adams	SVP, Chief Operating Officer/CNE	WMHS
Executive Committee	Eileen Jaskuta	VP Quality	MMC
Executive Committee	Raquel Samson	Exec. Director THP/ACO	MMC
Executive Committee	Jennifer Teeter	AVP, Payer Contracts	FRHS
Executive Committee	Manny Casiano, MD	Chief Medical Officer	FRHS
Executive Committee	Raymond Grahe	Staff	THA

MMC = Meritus Medical Center; FRHS = Frederick Regional Health System; WMHS = Western Maryland Health System; THA = Trivergent Health Alliance

Identify the types of decisions that will be made by the Regional Partnership.

The Alliance Executive Committee – with leadership, guidance, and support from the Alliance Board of Directors – reviews, recommends, and approves the following before they can be implemented regionally. Decisions include but are not limited to:

- Care delivery transformation initiatives that should be prioritized and pursued regionally vs. at the individual hospital level.
- Regional provider, stakeholder and community partnership communication and engagement.
- Oversight and evaluation decisions related to delegated regional care strategies and implementation.
- Performance monitoring and improvement decisions related to regional partnership initiatives (i.e., ensuring that the partnership achieves the state's All Payer Model objectives).

The Executive Committee makes recommendations to Alliance Board regarding the following (but not limited to):

- Formal provider relationships and agreements, focused on regional care delivery and alignment.
- Regional financial strategy and implementation, including funds distribution and deployment of regional partnership resources
- Infrastructure needs, including recruiting and hiring staff at the regional partnership level.
- Identification of and recommendations for resolution of legal and compliance issues at the regional partnership level.

Describe the patient consent process for the purpose of sharing data among regional partnership members.

Efforts are underway to modify the existing patient consent forms to include the Alliance Regional Partnership. Once completed, this will allow for the patient to give consent to have their hospital specific data, as it applies to the Regional Partnership strategies and initiatives, to be utilized for such work. This will enable the Regional Partnership to be recognized as a legal entity in the consent process.

Describe the processes that will be used by the regional partnership improved care and the MOUs or other agreements that will be used to facilitate the legal and appropriate sharing of care plans, alerts and other data as described in the process.

Trivergent's legal counsel drafted a Business Associates Agreement (BAA) and Data Use Agreements (DUA); they have been shared with all three hospitals. Hospital legal counsels have been in the vetting process for over a month and the agreements are signed and in place; there is one BAA for each hospital.

Attach the list of HIPAA compliance rules that will be implemented by the regional partnership.

The compliance/privacy officers from each hospital have met with Trivergent leadership to ensure that the activities of the Regional Partnership will comply with all hospital HIPAA compliant policies and procedures. Individuals performing the activities of the Regional Partnership will be subject to same standards to ensure patient privacy. An example of the BAA between the Alliance and MMC is attached detailing the list of HIPPA compliant rules that all 4 organizations agree to adhere to can be referenced as **Appendix 4** (each BAA details the same HIPPA compliance rules).

Data and Analytics

Define the data collection and analytics capabilities that will be used to measure goals and outcomes, including specific metrics and measures.

Each of our hospitals will strengthen our data collection and analytics capabilities as part of the Alliance's efforts to streamline data and create consistent data definitions and collection methodologies to measure the results of our efforts. We will be pulling much of our outcomes measurement data from our hospital EHRs. Due to the differences between each EHR, we have designated data analysts/quality experts from each hospital to pull the needed data and ensure we are accurately capturing and reporting all the needed information. We then aggregate the data in a standardized format so that it can be compiled and reported out regionally for the Regional Partnership. Each hospital therefore has data personnel and capabilities supporting the work teams that are charged with designing and implementing the strategies.

Regional partnership specific process and outcome metrics will be pulled from multiple sources within each hospital's EHR. Metrics will be pulled on a defined schedule for reporting via the Regional Partnership Metric Dashboard and as deemed necessary to identify areas that are

working well or need problem solving to improve.

Our data teams will also use the CRISP data to compare with self-collected data and track progress as we implement our strategies and initiatives.

During the planning phase, the data teams during implementation have fulfilled Alliance data requests in additional to their already full workloads. To allow the strategies to continue to be data driven 1.5 full time employee (FTE) has been budgeted for this work in the implementation grant. The FTE would be divided equally among the three hospitals solely for data analysis. This would allow us to have dedicated, centralized data support and capacity to support the Alliance initiatives and complete robust analyses that includes cost, satisfaction measures at all points of the continuum, qualitative and quantitative measures. This data analytical resource will support the existing data infrastructure of the sponsors and strengthening our collective data capacity as a Regional Partnership, beyond what is currently in place at the individual hospitals, will be foundational to our success.

Risk Stratification, Health Risk Assessments, Care Profiles and Care Plans

Describe any plans for use of risk stratification, HRAs, care profiles, or care plans. Describe how these draw from or complement the standardized models being developed.

The Alliance will use risk assessments, risk stratification and/or care plans for each of our Model of Care strategies. Each strategy has a unique and targeted approach for how and when these tools are used, as outlined in the table below, yet the tools themselves will in most cases be standardized across the Regional Partnership. These tools will draw upon the up-to-date and comprehensive hospital data as inputs and will eventually build in CRISP models and capabilities. Specific use of risk stratification, HRAs, and care profiles or care plans for each strategy are noted below:

Strategy 1: Behavioral Health

Replicate the Behavioral Health Case Management Program currently in place at Western Maryland. WMHS will be the first to work on development or adoption of a risk stratification tool for this initiative, to determine the level of intensity needed for each patient's case management services. The goal will be to eventually expand the use of this tool to the other hospitals as a unified approach to risk assessment and stratification. This initiative targets any person with a mental health and/or substance abuse diagnosis seen in the ED to receive case management services. Currently, the intensity of case management services is based on the assessment of the ED Crisis Counselor or the Physician/CRNP from the inpatient Behavioral Health Unit. This is where an analytic risk stratification tool will provide greater clarity.

Integrate behavioral health into primary care to identify patients at risk and link them to appropriate resources. For assessments of this population, a standardized depression screening process will be put into place for all patients annually. The screening, if positive, will stratify patients using risk scores of High, Medium, or Low. These levels will drive the intensity of BH care management and co-management within the PCP practice. The BH provider will complete further assessments (including a psychosocial assessment), determine needs, and link the

patient to needed services. Accelerated access to psychiatrist evaluation will be available patients for high risk patients.

Strategy 2: Complex Care Management

Replicate best practice components and standardize common metrics for a model of care for High Utilizer populations with certain chronic disease conditions. This initiative uses risk assessment and stratification to identify High Utilizers (patients with 3+ IP or observation visits in a year, with specific diagnoses). These patients will receive care management services that will be documented and updated using a Patient-Centered Multidisciplinary Care Plan which includes the physical, psychosocial and social determinants of health.

Strategy 3: Potentially Avoidable ED Visits

ED providers and PCPs to reduce potentially avoidable ED visits. Risk stratification will be done based on patients' history of ED visits and ED billing data. Patient-centered care plans will be used (CREDO-like or an expanded, more comprehensive care plan that supports cross-continuum integration. Currently)

For risk stratification, include the types of patients, risk levels, data sources, accountabilities (who is accountable to do what?)

Types of patients: Patients who will be risk stratified vary by initiative and include: ED patients (including patients with mental health and/or substance abuse diagnosis seen in the ED), primary care patients, and all hospital patients (to capture High Utilizers).

Risk levels: Although the risk levels vary by intervention, the patients are typically stratified into:

- meets intervention criteria or not, and,
- High Medium or Low risk to determine referral and/or level of intensity of services.

Data sources: Data sources for risk stratification will include hospital billing and utilization data, EHR data, assessment results, diagnoses codes, and CRISP.

Accountabilities: The provider, crisis counselor, and/or care manager (depending on the intervention) are at the front lines of our initiatives. They are accountable for deploying risk assessment and stratification methods and tools to determine risk level, and ensuring referrals or warm-handoffs to the appropriate intervention. This is consistent with our Year 1 priorities focusing on care management processes and capabilities.

For HRAs, include the types of screenings, who is accountable for completing, and where information is recorded.

The types of screenings and accountabilities will vary by intervention, but for all three strategies, the unique medical record numbers (MRNs) for the HU target patients will be flagged, either automatically or manually (depending on EHR capabilities and speed of ability to implement), so that all care providers who work with the patient are aware of their risk level and can ensure appropriate interventions are implemented per the strategy initiatives.

Flagging patients in the EHR will be a challenge and require a significant amount of time during the first year of implementation, given the number of provider practices and the different EHRs in use.

Initially, we will flag the unique MRNs that we identified during the baseline data pull for the HU targeted populations, but there is EHR reporting infrastructure that needs built to be able to capture in a timely manner the new unique MRNs that fall into and out of the target population, to keep the EHR current. It is projected that this will require an IT build that will take 30 hours to complete, which will be done via an in-kind contribution from one of the hospitals. The goal is to use the logic built for one hospital and share it with the other two Alliance hospitals.

For Strategy 1, formal Health Risk Assessment screenings we will use are the PHQ-2 and PHQ-9 depression screening questionnaires. A standardized, evidence-based process for administering the screening tools will be implemented in each office workflow. Screening will be assimilated with minimal interruption to current workflows and patient throughput using the following standardized process:

- A PHQ-2 questionnaire will be handed to the patient by registration upon check in;
- Positive screens will be provided the PHQ-9 questionnaire for completion;
- Results will be entered into the EMR by a medical assistant or nurse;
- The score will be reviewed by the provider and shared with the patient.

For Strategies 2 and 3: Inpatient and ED High Utilizers will be assessed using each hospital's specific HRA and screening that is already incorporated into existing electronic documentation. The Alliance hospitals compared our existing tools and determined there is consistency in the core components of the HRAs currently in use. They do not require revision at this time, but will need to be taught and shared with new care team members. Providers and care managers are accountable for completing risk assessments and screenings. Information is recorded in patients' EHRs and care plans.

During the implementation phase, the Alliance hospitals will share and blend their individual, evidence-based HRAs currently in use to pursue a standardized regional HRA.

For care profiles and/or care plans, include the key elements that will be included, the systems through which they will be accessible, the people who will have access. Standardized care profiles are anticipated to be developed by the state-level integrated are coordination infrastructure.

CREDO care plans from MMC are being used by MMC and FRHS for the ED high utilizer strategy. WMHS is evaluating the capability of the CREDO care plans with their ERH as a standard regional ED HU care plans is desired. The Regional Partnership evaluated our existing hospital-specific complex care management care plans to assess the need to create new regional care plans and determined that, since the state is working on standardized care profiles and since there is already a high level of consistency among the hospitals' care plans, creating a new regional care plan would not be of immediate focus. Once the state-level standardized care profiles are made available through CRISP, the Regional Partnership will adapt what is currently in use to create alignment and consistency across the region and state. The key areas addressed by the current care plans include, but are not limited to:

- Patient Identifiers (so that the most up-to-date preferred methods of contact are available for reference).
- Assessment of the patient's existing support network
- Assessment of health needs and psychosocial needs
- A method to identify patient specific needs that are driving ED or Hospital utilization, which includes assessing and identifying barriers that may be prohibiting the patient from connecting with community based resources.
- Identification of the gaps that needs addressed
- Formulation of care plan with patient
- Inclusion of the patients identified support systems
- Documentation of the plan in EHR.

Care plans are accessible via the EHR.

Identify the training plan for any new tool identified in this section.

The Regional Care Management, Education and Training Center (RCMETC) is being developed with the explicit goal of providing training to the Regional Partnership on these and other tools and processes that advance the Alliance's care delivery transformation goals. The RCMETC will support consistent, standardized training on use of relevant risk stratification tools, care profiles and other pertinent, Alliance defined processes. We will deploy the most appropriate method to ensure that trainings are accessible, including trainings available in person, via webinar, and online via secure portal. Initial trainings as well as ongoing updates and refresher courses will be made available.

Care Coordination

Describe any new care coordination capabilities that will be deployed by the regional partnership.

The new care coordination capabilities and care management processes that we deploy as a regional partnership will, in many cases, be the foundation of our efforts. The most significant care coordination activities that bridge historic gaps and siloes will be in our ED use reduction initiative, our discharge transitions initiative, our complex high utilizer care management initiative, and our behavioral health/primary care initiative.

These initiatives involve deploying the following new care coordination capabilities as a Regional Partnership:

- Ongoing engagement of ED physicians and PCPs in real-time communication
- Secure text messaging to facilitate provider-to-provider communication
- Care Management will contact all High Utilizers weekly
- We are exploring implementing a paramedicine program (and were approached by MIEMSS (Maryland Institute for Emergency Medical Service Systems), as a potential community partner in this effort) to better reach high utilizers in Strategy 3 with care coordination. If the MIEMMSS program will not have an immediate impact on the HUs, the regional partnership will initiate our own paramedicine pilot program in Year 2

that targets HUs geographic hot spots.

- Deployment of a tele-monitoring program to detect the need for early intervention. Tele-monitoring will allow Care Managers assigned to the HU to reach out and coordinate connections with the appropriate outpatient resources and follow up to ensure follow through.
- Care teams and providers (including PCPs, nurses, BH providers and care managers) will communicate and share information with each other across settings in order to better coordinate care by flagging the high utilizer population for each strategy, so that all care team members who interact with the health record for these targeted patients are aware that they are a high utilizer. Care plans and notes will be visible within the health record. An approach to flagging HUs for community and physician partners that are not on our EHR system will be defined case by case, as needed. Flagging processes will be done in accordance with HIPPA requirements and in protection of the patient's right to privacy.
- Use of Community Health Workers to provide HU's a "high touch" aide to address their navigation needs, and linking patients to appropriate community resources and the Regional Care Management team.
- PCPs and BH providers will be co-located to facilitate warm-handoffs after PHQ-9 screenings and coordinated treatment of BH clients
- Care coordinators will go through standard trainings with the new Regional Training and Education Center. Health care professionals will be trained in Mental Health First Aid to ensure appropriate response and sensitivity in Mental Health crisis situations.
- Implementation of a Friday "Tuck-In" Service by which ED HU's are contacted by a Care Management Nurse to determine if there are any gaps in access to care, supplies, or deterioration in overall health so that the Care Manager can educate, coordinate and facilitate engagement of the appropriate outpatient care services and community agency involvement to effectively support the patient through community based services.

Identify the types of patients that will be eligible for care coordination and how they will be identified and by whom.

The following types of patients will be eligible for care coordination:

- Adults who come to the ED or are admitted as an inpatient with a mental health or substance abuse diagnosis
- High Utilizers with 3 or more inpatient or observation visits within 12 months
- Patients with 6 or more ED visits within 12 months
- Patients discharged at risk for readmission

These patients initially have been identified down to their unique medical record numbers (MRNs), using the HU target population inclusion criteria described above for each strategy. These patients will be flagged as HUs during the launch of the implementation phase. For maintaining up-to-date patient status and timely identification of HU's as they meet criteria, the Alliance hospitals are working on an in-kind data analytic resource investment to build reporting capabilities at the three hospitals to allow for timely provider notification regarding patients that newly meet, or no longer meet, the HU inclusion criteria for all three strategies. Once this reporting capability exists in one hospital, the reporting detail will be shared with the other two hospitals to facilitate their internal building of this capability. The aim is for the system to automatically flag the HU's medical record once HU criteria are met. If this is not possible, processes and workflows will be defined to assign responsibility for flagging patients in accordance with system capabilities.

Define accountability of each person in the care coordination process.

Accountability for care coordination lies with the entire care team, whose responsibilities are outlined below, by role and customized by strategy. The patient is the central factor within each strategy whose consent to engage with care coordination will be obtained. Once obtained, the patient will have a responsibility to be actively engaged in the care planning development process to create a plan that will meet their needs to achieve an improved state of health and wellness. Care team members in multiple settings will be accountable for activating and engaging patients in care coordination.

For strategies 1.1 and 1.2, Behavioral Health Care Managers will be accountable for completing the comprehensive psychosocial assessments of adults with primary behavioral health diagnosis, linking adult patients to behavioral health treatments and support services based on individual needs in order to facilitate and foster early outpatient interventions and effective management to reduce the need for crisis care at the ED or inpatient levels.

Registered nurse care managers, social work care managers, nurse practitioners, pharmacists, registered dieticians, CHW's, dieticians, receptionists, and medical assistants/registrars will address the needs of HU's targeted in Strategy 2 in various ways. These individuals are each key links in the care coordination process and will be accountable for fulfilling patients' needs in accordance with their respective roles, and for collectively achieving the outcome and process metrics defined. The goal is to ensure that the HU patients have a team of experts assisting with coordinating their care and engaging with comprehensive care plan development to equip the patient with what they need to achieve better health.

Describe staffing models, if applicable.

The staffing models are Strategy dependent although each Strategy analyzed best practices from each Hospital based on performance metrics (ROI, cost savings, patient outcomes) to determine the number and type of staff that were needed to achieve high performance and proper deployment. Best practices were used to determine staffing needs. The gaps identified were then used to determine the overall infrastructure need per Strategy and, per Hospital. The best practices were not designed to be exact replicas but to build upon the existing infrastructure present at each Hospital. Focus was placed on identifying the service and outcome to be replicated then the best utilization of resources to meet that service need. This process enabled each Hospital to determine their needs in order to achieve a Regional equivalent of services that is mostly standardized but does allow for the filling of specific Hospital specific patient population needs.

Strategy 1- Interventions 1.1 Replicate BH CM and 1.2 Integration of BH into Primary Care:
Each hospital determined their FTE need based on volumes data shared by Western Maryland Health System, then applied the data to their own projected volumes and demand to determine each hospital's specific FTE need.

Strategy 2- Complex Care Management of HU with certain diagnosis:
Each position requested per hospital was determined by the following logic:

- Identification of resources needed to close gaps that prevented a Regionally equivalent CM/care team services for HU's (registered dieticians, pharmacist, respiratory therapist, receptionist/registrar, medical assistant, care management social workers).
- Nurse practitioner to provide hands on patient care for complex chronic patients in conjunction with patient's primary care.
- Pharmacist to provide medication management, and management of outpatient anticoagulation patient needs.
- Denominators, for the following best practice staffing ratios used per hospital, were based on the respective hospital's unique HU patient volume within the total HU target population;
    - CHW Staffing 1:50 HU patients ratio
    - Registered Nurse Care Manager 1:125 HU patient ratio
    - Clinical Manager for each hospital given the new clinical resources to be hired per hospital

Strategy 3- Decrease ED PAU:

- Friday Tuck-in service needs were determined based RN CM patient ratio above.
- Community Health Worker (CHW) resource need was determined based on the same logic used for Strategy but adjusted to be based off the Strategy 3 HU target population per hospital.
- Paramedic need was based on sharing of best practice with local EMS providers currently conducting paramedicine pilot in Western Maryland.
- Improve of hand off/transition communication will be achieved through workflow and process changes, and utilizing existing staffing. Software needed to enhance timely HIPPA compliant communication was purchased as in-kind investment by the Alliance.

Strategy 4- Regional CM Education Center:

- Resources requested were based on Education expertise within MMC who have extensive experience with launching training programs. RCMEC staff will be a resource to the Care Management and Community Partners it will serve. A Care Management Education specialist will be needed to help create and maintain a curriculum that meets the needs of the health care team it is to serve: CHW, CM RN, CM SW, and Community Partners.
    - A Bachelor's Degree with a Health Educator focus and Mental Health background is needed to support and maintain the BH 1.3 Population Health intervention
    - A community partner liaison will focus heavily year 1 and 2 coordinating community engagement related to BH intervention 1.3- Population Health Strategy, year 3 this work load is anticipated to lighten and start in the later part of year 2 and continuing into year 3 this position will begin a new dynamic by coordinating community course offerings specific to CM.

Enabling Strategy:

- Project management is needed to manage facilitate and oversee the Regional Partnership work.
- Project management coordinator is needed to support the project manager.
- Staff accountant is required to support the three strategies for the Regional Partnership.
- The need for 3 Clinical Manager FTE's is detailed above under Strategy 2.
- The 1.5 data analytic FTE will allow for dedicated, centralized data support and capacity to support the Alliance initiatives and complete robust analyses including cost analytics.

The table below details the specific resources needed to support the three strategies initiatives by strategy, per hospital, per year 1, 2 and 3. Year 1 is the baseline, initiation of implementation. Recruiting, hiring, and training to occur year 1. Year 2 and 3 those same resource needs will need sustained as by this point all year 1 resource needs will be filled. Year 3 reflects full implementation, all staff will have been in place and had at least one year or more experience within their positions, new processes and workflows will be hardwired and efficiencies gained from having experienced personnel in these roles.

Year 1		Year 2		Year 3	
Strategy 1		**Strategy 1**		**Strategy 1**	
Proposed Staffing	FTE	Proposed Staffing	FTE	Proposed Staffing	FTE
Masters Level BH -Frederick	8.7	Masters Level BH -Frederick	8.7	Masters Level BH - Frederick	8.7
Masters Level BH -Meritus	7.6	Masters Level BH -Meritus	7.6	Masters Level BH -Meritus	7.6
Masters Level BH - WMHS	6.0	Masters Level BH -WMHS	6.0	Masters Level BH -WMHS	6.0
Strategy 2		**Strategy 2**		**Strategy 2**	
Proposed Staffing	FTE	Proposed Staffing	FTE	Proposed Staffing	FTE
FRHS		**FRHS**		**FRHS**	
RN - Manager/Clinician	1.0	RN - Manager/Clinician	1.0	RN - Manager/Clinician	1.0
NP	1.5	NP	1.5	NP	1.5
Registered Dietician	1.0	Registered Dietician	1.0	Registered Dietician	1.0
Respiratory Therapist	1.0	Respiratory Therapist	1.0	Respiratory Therapist	1.0
CHW	9.0	CHW	9.0	CHW	9.0
RN CM	2.0	RN CM	2.0	RN CM	2.0
Receptionist	1.0	Receptionist	1.0	Receptionist	1.0
SW	1.0	SW	1.0	SW	1.0
MMC	FTE	**MMC**	FTE	**MMC**	FTE
CHW	9.0	CHW	9.0	CHW	9.0
RN CM	1.0	RN CM	1.0	RN CM	1.0

Respiratory Therapist	1.0	Respiratory Therapist	1.0	Respiratory Therapist	1.0
Registered Dietician	2.0	Registered Dietician	2.0	Registered Dietician	2.0
SW	3.0	SW	3.0	SW	3.0
Pharmacist	2.2	Pharmacist	2.2	Pharmacist	2.2
WMHS		**WMHS**		**WMHS**	
NP	2.0	NP	2.0	NP	2.0
MA/Registrar	1.0	MA/Registrar	1.0	MA/Registrar	1.0
CHW	2.0	CHW	2.0	CHW	2.0
RN CM	2.0	RN CM	2.0	RN CM	2.0
Receptionist	0.0	Receptionist	0.0	Receptionist	0.0
Registered Dietician	1.0	Registered Dietician	1.0	Registered Dietician	1.0
Pharmacist	1.0	Pharmacist	1.0	Pharmacist	1.0
SW	1.0	SW	1.0	SW	1.0
Strategy 3 All Hospitals		**Strategy 3 All Hospitals**		**Strategy 3 All Hospitals**	
Proposed Staffing	FTE	Proposed Staffing	FTE	Proposed Staffing	FTE
CM for Tuck in Service working 7am to 7 PM on Fridays at each hospital	1.00	CM for Tuck in Service working 7am to 7 PM on Fridays at each hospital	1.00	CM for Tuck in Service working 7am to 7 PM on Fridays at each hospital	1.00
ED High Utilizers	FTE	ED High Utilizers	FTE	ED High Utilizers	FTE
CHW- Frederick	3.2	CHW- Frederick	3.2	CHW- Frederick	3.2
CHW- Meritus	3.2	CHW- Meritus	3.2	CHW- Meritus	3.2
CHW- WMHS	3.2	CHW- WMHS	3.2	CHW- WMHS	3.2
Paramedic Program	FTE	Paramedic Program	FTE	Paramedic Program	FTE
Paramedic	1.0	Paramedic	1.0	Paramedic	1.0
Regional Care Management Education Center	FTE	**Regional Care Management Education Center**	FTE	**Regional Care Management Education Center**	FTE
Care Management Education Specialist	1.0	Care Management Education Specialist	1.0	Care Management Education Specialist	1.0

Coordinator	1.0	Coordinator	1.0	Coordinator	1.0
Community Partner Liaison	1.0	Community Partner Liaison	1.0	Community Partner Liaison	1.0
BS HED w/MH	1.0	BS HED w/MH	1.0	BS HED w/MH	1.0
Enabling Strategies	FTE	**Enabling Strategies**	FTE	**Enabling Strategies**	FTE
Project Manager	1.0	Project Manager	1.0	Project Manager	1.0
Project Coordinator	1.0	Project Coordinator	1.0	Project Coordinator	1.0
Staff Accountant	1.0	Staff Accountant	1.0	Staff Accountant	1.0
Decision Support Analyst	1.5	Decision Support Analyst	1.5	Decision Support Analyst	1.5
Manager	3.0	Manager	3.0	Manager	3.0

Describe any patient engagement techniques that will be deployed.

Engaging patients and ensuring that they get the right care, at the right place, at the right time, is a critical component of all our efforts as a Regional Partnership. We plan to deploy the following patient engagement techniques through our initiatives:

- Meeting patients where they are, whether that's in the ED, in the hospital or in the community.
- Educating patients about the results of risk assessments and what it means for their health and health care needs.
- Linking patients to support programs and existing community resources, including self-management programs.
- Peer-to-peer education and awareness, such as identifying high functioning patients who can help with community health education regarding behavioral health
- Using health coaching, motivational interviewing, disease management training, and patient education.
- Ensuring discharge planning is patient centered and addresses risks and barriers to follow-up care
- Expanding use of home-based technology (e.g., tele monitoring).
- Developing and implementing focused, collaborative community health education.
- Deploying community health workers, complex care managers and community partners to address social determinants of health.

Physician Alignment

Describe the methods by which physician alignment will be created.

Physician alignment will be created and strengthened by building upon existing relationships with physicians, deploying new technologies and communication methods, and developing new curriculum and methods for physician educational efforts and outreach. Physician engagement methods that have begun or are planned are highlighted below:

- **Communication and inclusion as a first step.** On October 22, 2015 the Alliance kicked off the first of many physician forums. The first session, facilitated by a physician leader from FRHS, focused on updating physicians regarding the planning efforts and initiatives and obtaining feedback and input on their feasibility from a physician perspective. Eight providers (6 Physicians and 2 Nurse Practitioners) attended, representing all of the Hospitalist Groups, Emergency Room Providers Groups, and a few Primary Care Providers. The providers were supportive of the plans; they were engaged and verbalized that the goals of this work align to the patient needs they see. The greatest need noted from the first meeting was a means to engage additional Primary Care Providers. The Regional Partnership held a follow-up meeting, facilitated by a physician leader from FRHS, on November 18, 2015 targeting Primary Care Providers. Nine providers in total attended (6 primary care providers, 1 physician assistant, 1 nuclear medicine director, and 1 skilled nursing facility medical director). Again, the physicians embraced the initiatives and voiced that the target areas are where they see patient needs.

- **Ongoing training about health strategies and new approaches.** The regional education center will play a key role with this priority and will offer physician education on the support services that are available.

- **Build on current ACO structures and physician alignment methods.** We plan to build **on the current ACO structures in each county and align** physician **incentives and goals with the ACOs to the greatest extent possible.**

- **Provide the tools physicians need for better discharge planning and care transitions.** We will facilitate PCP alignment with discharge and care transition plans by ensuring that discharge information is faxed or emailed to the PCP; using Tiger Text secure messaging; ensuring that the provider has access to high-value hospitalization information; holding orientation programs at each hospital about discharge planning; making visits to physician offices to talk with and engage staff and providers; offering CME presentations by experts on the chronic conditions we are dealing with; and instituting a warm handoff phone call from the hospitalist to the PCP upon patient discharge.

- **Create value-based payment models to align incentives.** We are exploring incentive payment opportunities with the providers, such as, Center for Clinical Resources (CCR) fee and telemedicine visits.

Describe any new processes, procedures and accountabilities that will be used to connect community physicians, behavioral health and other providers in the regional partnership and the supporting tools, technologies and data that will assist provides in the activities associated with improved care, cost containment, quality and satisfaction.

The Alliance plans to establish a number of new processes, procedures and accountabilities to facilitate greater connectivity between providers and move us toward the Triple Aim of better care, better outcomes and lower cost. Our plans include:

- Capitalize on shared electronic coordination and standardized referral processes using a shared EMR. Data from the EMRs will be validated through CRISP.
- Integrate the depression screening tools PHQ2 and PHQ9 into primary care practices and share results with both the PCP and BH provider (where applicable).
- Establish new referral processes and procedures and explore the use of technology to improve efficiencies.
- Develop new work flows for discharge transitions and hand-offs that involve collaboration and communication of providers between settings.
- Collaborate with the Community Advisory Council (CAC) to enhance the referral system with community partners for services addressing social determinants of health.
- Explore the use of technology to improve efficiencies, including texting, telemedicine and tele-monitoring.
- Flag High Utilizer patients in the EMR and across the system so that they can be identified across the system of care. The hospitalist/attending will send a secure communication to the PCP and PCP/Ambulatory Care Manager with a notification that the patient is in the hospital and giving a brief description of the plan/request for follow up appointment. This triggers a specific process flow.
- Establish Friday "Tuck-In" service to pro-actively reach out to Strategy 3's ED HU's to assess for needs and coordinate the necessary appropriate outpatient community based support.

Describe any new value-based payment models that will be employed in the regional partnerships.

The Alliance will follow the leadership of the HSCRC in association with CMS for physician incentive programs that provide incentives to Primary Care physicians to better manage the total cost of care. The Alliance has experimented with a Pay for Performance model at one hospital that needs further refinement. The Alliance intends to explore leveraging the structure of the three regional ACOs to embed Counselors and Community health Workers in the Primary Care Practices in a manner to remain compliant with Stark regulations.

Throughout this process, the Alliance will establish value-based payment models to ensure the highest quality of care at a lower cost. Working with health plans and provider entities, the Alliance will create a multi-year, phased payment model that will generate significant cost savings and will align incentives for care givers, especially as we transition patients to their community providers to seek care for chronic and manageable issues. As the partnership encourages patients to seek treatment from primary care physicians, especially in the hospitals' ACO networks, financial incentives may be created for providers (to be determined by the Alliance) to create a care management plan and take the necessary steps to avoid patients' utilization of high cost, unnecessary services (e.g. emergency department). The initiatives align with the goal and incentives of each hospital sponsored ACO.

Organizational Effectiveness Tools

Attach the implementation plan for each major area of focus (with timelines and task accountabilities)

The draft implementation timelines detailing major areas of focus with task accountabilities is attached. Each strategy has a tab in the work book. The Project Manager is developing Gantt charts to include all major areas of focus utilizing her Lean training and background. The timelines and details concerning responsible party for tasks is actively being reconciled, finalized, and populated into Microsoft Project in preparation for inclusion as per the Implementation Planning RFP application requirements.

Describe the continuous improvement methods that will be used by the regional partnership.
The Regional Partnership Metric Dashboard will be tracked and evaluated on a routine basis for trends to identify what is meeting and achieving target and what areas to focus problem solving to drive continuous improvement and prioritize problem solving. The Executive Committee will review monthly, and the Alliance Board of Directors will review quarterly. Team Leads, work teams, departmental staff directly involved with the processes and workflow that are directly monitored by the RP Dashboard process and outcome metrics will be responsible for ensuring the needed data is collected, made transparent and trended to facilitate early detection of issues and what is working well. When metrics are not trending towards the target, barriers will be identified, prioritized and then problem solved by those resident experts closest to the problem. The Project Manager has extensive training in Lean process and has spent several years in the MMC Operations Improvement department. Lean will be the improvement philosophy and methodology utilized for the activities of the Regional Partnership for Care Transformation.

Attach a copy of the metrics dashboard that will be used to manage performance over time with an explanation of associated processes that will be used to monitor and improved performance.

The metrics dashboard, (inserted on page 42 and 43),on the next page, is designed to allow for a quick visual assessment of the Alliance's performance on outcomes and process metrics; as monthly values are populated on the dashboard, they will be color coded to indicate if the current performance is meeting, exceeding, or below the defined target.
During the implementation phase, the Regional Partnership will define standardized units of measurement and additional process metrics will be established as workflows and processes are further defined and refined. The dashboard metrics will align to the metrics stated in the previous section that asks for ***descriptions of the specific metrics to be used to measure progress*** that starts on **page: 10.**

Alliance Regional Partnership Care Transformation Metrics							Rolling 6 Month View						
Initiative	Metric	Standard Measurement Used (TBD)	Outcome or Process Metric	√= Metric Aligns to State's Objectives	Baseline Value	Goal/ Target Value	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Current Value=
All Strategies	ROI: Cummulative of all 3 Strategies		Outcome	√			Value	Value	Value	Value	Value	Value	Value
	ROI: Behavioral Health Strategy		Outcome	√			Value	Value	Value	Value	Value	Value	Value
	ROI: Complex Care Management		Outcome	√			Value	Value	Value	Value	Value	Value	Value
	ROI: Reduction of ED PAU (Potentially Avoidable Use)		Outcome	√			Value	Value	Value	Value	Value	Value	Value
	CTM 3 - Care Transitions Measures (3 questions required for Medicare ACOs	?Composite Score	Outcome	√			Value	Value	Value	Value	Value	Value	Value
1. Behavioral Heath Build a multi-faceted Behavioral Health strategy that focuses on inpatient case management, early detection and effective and timely support for at-risk patients. The strategy also includes a community-wide educational element aimed at reducing stigma and increasing understanding of behavioral health needs.													
1. 1 BH Care Management	BH ED Visits		Outcome	√									
	BH ED Visits		Outcome	√									
	BH Admission Rates		Outcome	√									
	BH ED Revisits within 30 days		Outcome	√									
	BH Readmission rates within 30 days		Outcome	√									
1.2 Integrate BH into Primary Care	Percentage of high risk individuals referred and had a subsequent BH ED visit or BH admission within 30 days.		Outcome	√									
	Percentage of community providers participating in initiative.		Process	√									
	Number of low, medium and high risk individuals screened by PHQ-9 referred for follow up		Process	√									
	Percentage of patients seen in participating PCP practices in a given year that are screened for depression using standardized tools, PHQ-2 and PHQ-9.		Process	√									
1.3. Reduce stigma and increase understanding of behavioral health needs through community health education.	Rate of emergency department visits related to mental health disorders (per 100,000 population). (State Health Improvement Process (SHIP) metric- Objective 34)		Outcome	√									
	Number of Community Health Education/MHFA trainings conducted.		Process	√									
	Number of individuals trained, targeting the follow groups: law enforcement, CHWs/Peer-lay outreach, teachers, senior provider (such as senior centers, nursing homes, assisted living), health care providers/medical care providers/FQHCs, hospice, individuals impacted with/by behavioral health needs.		Process										

Alliance Regional Partnership Care Transformation Metrics													Rolling 6 Month View
Initiative	Metric		Outcome or Process Metric	√= Metric Aligns to State's Objectives	Baseline Value	Goal/ Target Value	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Current Value=
Strategy 2: Complex Care Management (CCM)													
components of local best practices and standardize common metrics for a regional model of care for High Utilizer (HU)	Reduction in admissions		Outcome	√									
	Reductions in readmissions		Outcome	√									
	Avoidance and reduction in cost of inpatient care for patients participating in program		Outcome	√									
	Reduction in PQI		Outcome	√									
Strategy 3: Decrease Emergency Department (ED) Potentially Avoidable Use (PAU)													
1. Improving care coordination between ED and community providers. 2. Providing increased support thru "high touch" CHW outreach 3. Paramedicine program 4. Facilitate improved coordination of care post ED visit. 5. Tele-Monitoring; not only will help decrease PAU but will serve is an emabling initiative to support Strategy 2 above. 6. Friday Tuck-In Service; not only will help decrease PAU but will serve is an emabling initiative to support Strategy 2 above.	Total ED visits per capita, for region		Outcome	√									
	Change in high utilizer ED visits – frequency and cost		Outcome	√									
	Number of HU ED pts with subsequent ED visit in 72 hours and 90 days		Outcome	√									
	High utilizers per PCP		Outcome										
	Change in percent of total ED visits and charges high utilizers represent		Outcome	√									
	Readmissions (all-cause 30 day) specific to HU population		Outcome	√									
	Potentially avoidable utilization: Internal reports available currently; Future CRISP report (Use diagnoses from HU data to determine PQIs that are most relevant)		Outcome	√									
	Percent of HUs where communication/texting to PCP occurred as intended (possible if all use Tiger Text)		Process										
	Percent of HUs who have follow up appt with PCP or specialist within X days (possible for health system owned practices)		Process	√									
	Percent of HUs engaged in intervention: complex care management, community health worker, tele monitoring		Process	√									

Describe the work that will be done to affect a patient-centered culture.

All of our strategies are rooted in a patient-centered culture and are focused on adapting services to meet the needs of our target patient population. Engaging patients, providers, and caregivers through new education opportunities and care management strategies will create conversations and remove barriers to care. For example, through increased education about emergency department utilization versus other forms of care, the Alliance expects to establish new expectations and protocols for how patients seek care. Case Management services will develop individual plans to best suit

the needs of the patient and engage the patient to take control of their own care.

The Alliance will also engage consumer advocacy groups to build a sustainable patient-centered culture that focuses on shared decision-making among caregivers and the patient.

New Care Delivery Models

Describe any new delivery models that will be used to support the care coordination outcomes. (For instance, tele-visits, behavioral health integration or home monitoring.)

The regional care delivery transformation will include a number of new delivery models to support care coordination outcomes. For instance, connecting behavioral health providers and primary care physicians through warm handoffs will integrate these two disciplines and create a streamlined process for patients under this strategy. New telehealth technology will create easier access and more seamless transitions for patients moving between settings. Investing in new technology, including the use of WebEx and other teleconferencing portals, will allow alternative options for both educational and training opportunities.

The three hospitals engaged to purchase secure texting software which is HIPPA compliant to improve real-time communication between the emergency department and community PCPs.

Identify how the regional partnership will identify patients, new processes, new technology and sharing of information.

The three health systems will identify patients for various interventions as described above through risk assessment and stratification, and via flags and care plans embedded in EMRs that are easily accessible to all providers treating these patients, which in the case of High Utilizers is often many providers across different facilities.

New technologies include secure and HIPAA-compliant texting, tele-monitoring and telemedicine. Information will be shared between providers using technology as well as through phone calls (e.g., warm handoffs) and co-location on site (in the case of behavioral health and primary care integration). Information will be shared with patients not only directly from their providers but also via the new call center and through new coaching and education programs (e.g., disease management) that will be deployed.

High-level processes have been established for each of our initiatives, and detailed work flows will be developed and adopted as part of implementation.

Financial Sustainability Plan

Describe the financial sustainability plan for implementation of these models.

The financial sustainability of our initiatives is based in large part on cost reductions for High Utilizers, complex patients, and behavioral health patients through better care management and reductions in avoidable, ambulatory-sensitive utilization. The target populations we have identified are among the highest-cost, highest-need patients we see, and we believe there is vast opportunity for improving the processes and tools we use to treat them that will yield positive results, both in reduced medical costs and improved patient outcomes.

We expect to achieve a three-year, cumulative Medicare and Dual Eligible cost savings of $9,171,799.41 and an overall Return on Investment (ROI) of 2.61, using the ROI template from the implementation grant RFP (see table below). Savings will build from year one, we expect to remain sustainable via the ongoing hospital retention of the global budgets at each hospital.

Medicare and Dual Eligible Savings as Calculated Using the Implementation Planning Grant Application ROI Template:

	Year 1	Year 2	Year 3	3 Year Cumulative
A. Number of Patients	11,547	11,547	11,547	11,547
B. Number of Medicare and Dual Eligible	2,996	2,996	2,996	2996
C. Annual Intervention Cost/Patient	$ 581.40	$ 667.50	$ 650.18	$ 1,899.08
D. Annual Intervention Cost (B x C)	$ 1,741,888.96	$ 1,999,826.55	$ 1,947,934.28	$ 5,689,649.79
E. Annual Charges (Baseline)	$ 91,456,487.00	$ 91,456,487.00	$ 91,456,487.00	$ 274,369,461.00
F. Annual Gross Savings (Year 1- 10.84%, Year 2- 15%, Year 3- 17.8%)	$ 9,911,713.87	$ 13,705,426.08	$ 16,014,411.51	$ 39,631,551.46
G. Variable Savings (F x Year 1- 30%, Year 2- 40%, Year 3- 40%)	$ 2,973,514.16	$ 5,482,170.43	$ 6,405,764.60	$ 14,861,449.20
H. Annual Net Savings (Top: G/D) & (Bottom: G-D) for Years 1, 2 and 3; Last column- 3 Year Cumulative	1.71 $ 1,231,625.21	2.74 $ 3,482,343.88	3.29 $ 4,457,830.32	2.61 $ 9,171,799.41

Specifically, savings and income that will contribute to our sustainability include:

- Reductions in potentially avoidable ED visits and inpatient admissions, and decreased readmissions.
- Cost savings from avoided ED visits of high risk patients screened at PCP visits.
- Improved efficiencies from collaboration between the three hospitals (i.e., centralized infrastructure, tools and processes).
- Improved efficiencies from collaboration between providers (i.e., reducing unnecessary tests and services).
- Accounting for implementation ramp up: Year one costs have been pro-rated to account for the ramp of implementing the strategies; i.e. recruitment and training
- Goals for Targets Savings increase over the course of the 3 years.
    - Year one- Interventions will be in place apx. 9 mos. of the calendar year, may not reach all patients of each strategies due to not having a full year of new process and interventions in place.
    - Year 2- % Increases to account for the fact, strategies will be implemented at the point and all strategies will be able to reach all their targeted HU populations with the listed interventions.
    - Year 3- Accounts for efficiencies that are anticipated to be gained since we will have had 1.5 years to build the foundation and problem solve issues. Strategies will be operating well.
- Variable savings utilized: Year 1- 30%, Year 2- 40%, Year 3-40% based on the logic that the strategies for the targeted populations are placed in a diffuse pattern when the patients are admitted. Fixed costs impact will be minimal during the time periods as the HU's are not placed in one particular areas of the hospitals to warrant FTE reduction; only marginal soft savings will be yielded early on **for these smaller populations of high utilizers.**

The Strategies detailed above will improve outcomes and financial savings for the Medicare and Dual Eligible population in alignment with the State's quality and financial objectives but not be provided solely to the Medicare and Dual Eligible populations. The strategies above will undoubtedly have a quality and financial benefit to all payers who meet the target population criteria detailed above for each strategy. Therefore we included a second calculation matching the Medicare and Dual Eligible costs and savings calculation following the same logic listed above for **all payer saving and costs** which yields a 1.81 ROI over the three years after achieving 2.13 ROI in Year 3, which proves sustainability.

For both ROI calculations it was necessary to keep some values consistent to establish the impact achievable through the strategies:

- the number of patients (sum of the HU target population for all three strategies), however this number will vary year to year based on new patient's meeting the HU criteria, and managed patients, deaths, etc. will cause patients to no longer meet for inclusion;
- inflation was not factored in;
- the number of patient visits/encounters remained unchanged.

All HU Payer ROI Calculation

	Year 1	Year 2	Year 3	3 Year Cumulative
A. Number of Patients	11,547	11,547	11,547	11,547
B. Number of Medicare and Dual Eligible	2,996	2,996	2,996	2,996
C. Annual Intervention Cost/cumulative	$ 6,713,481	$ 7,707,609	$ 7,507,609	$ 21,928,700
D. Annual Intervention Cost/Patient/sum	$ 581	$ 667	$ 650	$ 1,899
E. Annual Intervention Cost (B x D) For Medicare and Dual Eligible Patients	$ 3,570,008	$ 4,121,523	$ 4,014,152	$ 11,705,684
F. Annual Charges (Baseline)	$ 91,456,487	$ 91,456,487	$ 91,456,487	$ 274,369,461
G. Annual Charge Savings % Target	11%	15%	18%	14%
H. Annual Gross Charge Savings (F x G)	$ 9,911,713	$ 13,705,426	$ 16,014,411	$ 39,631,554
I. ROI: Gross Charge Savings Per Intervention Cost Invested (H / C)	$ 1.48	$ 1.78	$ 2.13	$ 1.81
J. Variable Savings %	30%	40%	40%	37%
K. Variable Savings (H x J)	$ 2,973,514	$ 5,482,170	$ 6,405,764	$ 14,861,444
M. Annual Net Savings (K - E) for Years 1, 3 and 3; Last column- 3 year cumulative	$ (596,493)	$ 1,360,646	$ 2,391,612	$ 3,155,764

Describe the specific financial arrangements that will incent provider participation.

The Alliance is currently analyzing several financial arrangements to incent and engage providers. A significant portion of PCPs in our region are employed or affiliated with our hospitals and receive financial incentives for ACO and PCMH metrics, many of which are aligned with our initiatives. Therefore, a financial incentive to collaborate on these efforts in some cases already exists.

Beyond financial incentives, the processes we are instituting will make care more coordinated and efficient, and will support the work that providers are already doing (e.g., care transitions). As we heard during our provider forum, these initiatives are much desired in that they give providers the support and tools to help them better care for their patients. Tools and resources that will support providers include:

- Providing Mental Health worker
- Community Health Worker (CHW) to help identify social determinates of health needs
- Having CM to support their patients- to take the time to provide hand's on education, time to allow them to continue to see other pt.'s but ensure their patients are receiving what is needed to promote the patient's overall health and quality of life.
- Through alignment of workflow.
- Asking for their input when integrating these additional care providers to the outpatient health care delivery team regarding best ways to make the information transparent.
- Creating electronic triggers when able to allow for ease alerting these other are team members of their needed service.
- Creating visual flags so that HU are identified at the practice level.

There will be a continuous feedback loop that will allow the partnership to understand and address provider needs and enhance provider participation and engagement, with the goal of aligning financial payment models. The Regional Partnership will be flexible and would fully support and engage in a pay for performance incentive model if HSCRC were able to facilitate approval for such a model from CMS. Through alignment of workflow. Asking for their input when integrating these additional care providers to the outpatient health care delivery team regarding best ways to make the information transparent. Creating electronic triggers when able to allow for ease alerting these other are team members of their needed service. Creating visual flags so that HU are identified at the practice level.

Population Health Improvement Plan

Provide detailed description of strategies to improve the health of the entire region over the long term, beyond just the target populations of new care delivery models. Describe how this plan aligns with the state's vision, including how delivery model concepts will contribute and align with the improvement plan, as well as how it aligns with priorities and action plans of the Local Health Improvement Coalitions in the region.

It is well known that health care systems across any given community or region are generally fragmented. In analyzing the Alliance's Community Health Needs Assessments, there are opportunities for bridging and connecting those fragmented pieces. While an important first step in transforming care delivery will be to focus on the immediate and significant needs of high-cost Medicare beneficiaries, the Alliance recognizes that long-term sustainability of health improvements and the ability to advance population health will require complementary and equally important efforts in primary care, prevention and wellness.

The Alliance's population health strategy places particular focus on aging populations, frail elders and patients with chronic medical conditions and serious mental illness. Also, the strategy places emphasis on primary care, prevention, and reduction of risk factors, by reaching patients where they are, whether inside or outside of traditional health care settings. Specifically, the strategy incorporates and builds on the aims and objectives of existing LHIC health action plans, and leverages LHICs' experience and expertise summarized below:

The population health priorities for the LHIC's (in the counties associated with the Alliance hospitals). Items Hospitals have included as part of their **Community Benefits** are **bolded.**

Hospital	Associated LHIC
WMHS	Alleghany County- Alleghany County Health Planning Coalition (ACHPC): Access & Socioeconomics: • Access to Appropriate Care-**Community Health Workers, reduce transportation barriers, MHFA** • Early Childhood Development-Bridges to Opportunity-addressing poverty Healthy Lifestyle & Wellbeing • Increase healthy choices, including availability and affordability-**Family Fit, Change to Win, Coaching** • Violence Intervention Programs-**Forensic Nurse Examiner Program, outreach** Disease Management • Disease management targeting individuals with multiple conditions, in conjunction with primary care provider-**Center for Clinical Resources, support groups** • Increase availability of behavioral health services-**Comm. Case Mgmt.**
FRHS	Frederick County- Frederick County Health Care Coalition • **Dental Health Home** • **Healthy Workplace** • **Health Disparities Education and Awareness** • **Low income Elderly advocacy** • **Reduction of Deaths due to overdose and suicide**

MMC	Washington County- Washington County Health Improvement Coalition : Behavioral Health • Law enforcement crisis intervention training- • Mobile crisis social worker for community response - **Improve access to mental health treatment** • Behavioral Health Medical Home – **Use CRISP notifications to improve care coordination** • Suicide prevention • Mental Health First Aide Chronic Disease Management • Provide Living Well program to improvement management of chronic disease and diabetes - **Living Well diabetes education/support, Diabetes care specialists at discharge** • National Diabetes Prevention Program - **Training and education for diabetes prevention** • Hypertension screening "What's Your Number" campaign - **Community-wide blood pressure screening campaign** • Million Hearts: Reduction of hypertension by monitoring blood pressure - **Parish Nurse network providing 1:1 education, monitoring and lifestyle changes** • Smoking cessation • Reduce obesity - **5Kwalks, Body Mass Index (BMI) screening, nutrition counseling, CATCH** Coordination of Care • Clinical and Community Connections: Bidirectional sharing of info & community referral process – MOU with Way Station and ROI for all clients • Data system for submittal to CDC, SHIP

In addition to the efforts noted above, we believe that there are even more opportunities within our communities. The Alliance, through our Community Advisory Council (CAC), will focus on promotion of healthy lifestyles in addition to model of care strategies. The CAC will meet monthly to develop and oversee a population health strategy, review data, share progress, successes, and lessons learned from independent community programs. The table below illustrates our proposed "all-community" population health strategy, focusing on ongoing assessment and awareness.

Regional Committee: Community Advisory Council and Implementation Sub Teams				
Inputs/Ongoing assessment and awareness				
CHNA data	HRA stratifications with PCP offices	Mapping tool for 'hot spot' high utilizers (CRISP is developing for	County focus groups and town hall meetings	Consumer Advisory Councils

		state)		
Outputs / Strategic Initiatives				
Tobacco quit lines BH Crisis lines and mobile units	Obesity and physical wellness programs Diabetes support groups	Development of a cross-county health literacy program	Community-wide HIE platform with risk stratification of patients in counties/zip codes	Community Integrated Medical Homes (CIMH) Models

The goals of this comprehensive, patient-centered, population health approach are to reduce mortality, the burden of disease and health disparities, and to lower costs. It assures accountability for the overall cost of care provided to defined groups of people while improving and maintaining the health of the whole.

After many months of planning, the Alliance is ready to springboard into this model. The CAC has met during the planning phase and our regional process of ongoing awareness and assessment, as well as priority setting for key collaborative interventions pushing towards healthy lifestyles for our communities has begun.

Appendix 1: Community Advisory Council Charter

ALLIANCE REGIONAL CARE TRANSFORMATION
COMMUNITY ADVISORY COUNCIL
CHARTER
REVIEWED AND APPROVED BY ALLIANCE REGIONAL PARTNERSHIP
HEALTHY LIFESTYLES/COMMUNITY PARTNERS TASK FORCE

Charter: The Alliance Regional Partnership (RP) Community Advisory Council has been formed to discuss, respond to and advise the Alliance Regional Partnership on coordinated and targeted population health activities to improve the health status of the communities in the Alliance counties of Allegany, Frederick and Washington. It will be charged with reviewing common planning efforts, obtaining feedback from county based LHIC members and other partners, and advising the Alliance on implementation and resource needs.

Membership: Members are appointed by the Alliance Board of Directors and will comprise of at least 2 members from each county Local health Improvement Council and representatives of other key community partner organizations as relevant to the Alliance RP population health focus. Membership is for a 2 year term and terms will be staggered to facilitate continuity. CAC chair to be determined. Meetings are held bimonthly.

Roles of the Regional Partnership CAC:

- Focus on a regional view of population health activities;
- Disseminate information and innovation that could impact health outcomes in the RP;
- Review performance data of the RP related to the identified areas of focus;
- Ensure community engagement by bringing Regional Partnership information, ideas and actions back to their counties for discussion;
- Serve as the communication loop between the RP and the LHICs;
- Provide input to health systems for potential opportunities and practices to advance regional population health;
- Serve as a forum for education and training among CAC members to better understand how each impacts each other;
- Engage stakeholder not providing direct care services (e.g., libraries, schools, etc.);
- Provide input on creating patient-centered processes;
- Evaluate regional health data and ensure that target populations are appropriately selected;
- Identify and address social determinants of health;
- Advise on necessary and available resources to implement regional plans.

Appendix 1: Continued-

Guiding Principles:

- We support a highly collaborative regional model, with customized local models of care, built on best practices;
- We will assess and suggest interventions based on an understanding of the health status and needs of our region;
- We will support early opportunities for regional collaboration where we can make a difference in a relatively short period of time;
- We will provide feedback on needed initial and ongoing investments and resources;
- We will provide leadership and information to foster innovation and change to promote and improve the health of our communities.

Appendix 2: All Community Partner Information and Feedback Session Agency/Organization Representation

All Community Partner Info and Feedback Sessions

Agency/Organization representation who attended:

FRHS: 12 representatives; 10 agencies Golden Living, Frederick Mental Health Associates Home Call- Lutheran Health Care (2) Mission of Mercy Way Station	Parkview Medical Group (2) Potomac Case Management Services Frederick County Health Department Asian American Center of Frederick Roberts Home Medical
MMC: 11 representatives; 7 agencies Meritus Health Home Health Western Maryland Medical Center Tri-State Community Health Center Citizens Care and Rehab	Washington County Health Department (2) Brook Lane (2) United Way
WMHS: 14 representatives; 10 agencies/organizations Golden Living Center, Cumberland (3) Egle Nursing and Rehab WMHS- Frostburg Nursing and Rehabilitation Center- FNRC Associated Charities Alleghany County Health Department (ACHD) (2)	WMHS- Home Care WM AHEC- Area Health Education Center/MHA (2) Garrett County Lighthouse, Inc. WMHS- Home Care Community Health Worker Program Lions Center

Appendix 3: Business Associates Agreement detailing list of HIPPA compliance rules for the Regional Partnership

Confidentially Submitted By Trivergent Health Alliance, LLC

BUSINESS ASSOCIATE ADDENDUM

This HIPAA Business Associate Addendum (the "Addendum") is effective as of July 1, 2014 (the "Addendum Effective Date"), by and between **Meritus Medical Center** (the "Covered Entity"), and **Trivergent Health Alliance, LLC** (the "Business Associate"). This Addendum amends, supplements, and is made a part of that certain Collaboration and Data Sharing Agreement, by and between Business Associate and its members, including Covered Entity, as the same may be amended from time to time (the "Agreement"). This Addendum shall be applicable only in the event that Business Associate meets, with respect to Covered Entity, the definition of business associate set forth at 45 C.F.R. § 160.103.

RECITALS

A. Covered Entity is a "covered entity" as that term is defined at 45 C.F.R. § 160.103.

B. In connection with Business Associate providing services to Covered Entity pursuant to the Agreement, Business Associate may, on behalf of Covered Entity, create, receive, maintain, or transmit certain Protected Health Information ("PHI") as defined below.

C. Covered Entity and Business Associate intend to protect the privacy and provide for the security of PHI disclosed pursuant to the Agreement in compliance with the Health Insurance Portability and Accountability Act of 1996, Subtitle D of the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH"), and regulations and other guidance promulgated under both laws by the U.S. Department of Health and Human Services (collectively, "HIPAA"), as well as other applicable state and federal laws.

D. The purpose of this Addendum is to satisfy certain standards and requirements of HIPAA, including, but not limited to, 45 C.F.R. §§ 164.502(e), 164.504(e), 164.308(b), and 164.314(a).

In consideration of the mutual promises below and the exchange of information pursuant to this Addendum, the parties agree as follows:

1. DEFINITIONS.

a. "Breach" shall have the meaning given to the term "breach" at 45 C.F.R. § 164.402.

b. "Data Aggregation" shall have the meaning given to such term at 45 C.F.R. § 164.501.

c. "Designated Record Set" shall have the meaning given to such term under the Privacy Rule (as defined below), including, but not limited to, 45 C.F.R. § 164.501.

d. "ePHI" shall have the meaning given to the term "electronic protected health information" under the Security Rule (as defined below) at 45 C.F.R. § 160.103, as applied to the information created, received, maintained, or transmitted by Business Associate from or on behalf of Covered Entity.

e. "Individual" shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

f. "Minimum Necessary" shall have the meaning given to such term under 45 C.F.R. § 164.502(b) and Section 13405(b) of HITECH and any guidance promulgated thereunder.

g. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Part 160 and Part 164, Subparts A and E.

h. "Protected Health Information" or "PHI" shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. § 160.103, as applied to the information created, received, maintained, or transmitted by Business Associate from or on behalf of Covered Entity.

i. "Required by Law" shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. § 164.103.

j. "Secretary" shall mean the Secretary of the U.S. Department of Health and Human Services or his or her designee.

k. "Security Incident" shall have the meaning given to such term under the Security Rule, including, but not limited to, 45 C.F.R. § 164.304.

l. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. Part 160 and Part 164, Subparts A and C.

m. "Subcontractor" shall have the meaning as the term "subcontractor" at 45 C.F.R. § 160.103.

n. "Unsecured PHI" shall have the meaning given to the term "unsecured protected health information" at 45 C.F.R. § 164.402, as applied to the information created, received, maintained, or transmitted by Business Associate from or on behalf of Covered Entity.

All other terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in HIPAA. Any inconsistency in the definition of a capitalized term shall be resolved in favor of a meaning that permits compliance with HIPAA.

2. PERMITTED USES AND DISCLOSURES OF PHI.

Except as otherwise limited in this Addendum or the Agreement, Business Associate may do any or all of the following:

a. Use or Disclosure Under Agreement. Use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity to the extent specified in the Agreement, provided that such use or disclosure would not violate any applicable state law or the Privacy Rule if done by Covered Entity (except as permitted below in this Section 2).

b. Use for Administration. Use PHI, but only to the minimum extent necessary, for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.

c. Disclosure for Administration or as Legally Required. Disclose PHI, but only to the minimum extent necessary, for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, provided that (1) the disclosures are Required by Law, or (2) Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it shall remain confidential and shall be used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person (which purpose must be consistent with the limitations imposed upon Business Associate pursuant to this Addendum), and that the person agrees to promptly notify Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

d. Use for Reporting of Violations. Use PHI to report violations of law to appropriate federal and state authorities, consistent with 45 C.F.R. § 164.502(j).

e. Use for Data Aggregation Services. Use PHI to provide Data Aggregation Services relating to the health care operations of Covered Entity, as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B), but only if requested by Covered Entity in writing.

3. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE.

a. Limited by Agreement and Law. Business Associate shall not use or disclose PHI other than as permitted or required by this Addendum and the Agreement or as Required by Law.

b. Compliance with HIPAA. Business Associate shall be subject to, shall perform, and shall comply with all the applicable obligations and requirements imposed upon business associates (as that term is defined in 45 C.F.R. § 160.103) under HIPAA.

c. Appropriate Safeguards. Business Associate shall use appropriate safeguards and comply, where applicable, with the Security Rule with respect to ePHI, to prevent use or disclosure of PHI other than as provided for by the Agreement and this Addendum. Business Associate shall maintain a comprehensive written information privacy and security program that includes administrative, technical, and physical safeguards appropriate to the size and complexity of Business Associate's operations and the nature and scope of its activities.

d. Reporting of Improper Use or Disclosure, Breach of Unsecured PHI, or Security Incident.

1. Business Associate shall inform Covered Entity of any use or disclosure of PHI not provided for by the Agreement and this Addendum or of any Security Incident, including (without limitation) any potential Breaches of Unsecured PHI, without unreasonable delay and in any event not to exceed ten (10) days following Business Associate's discovery of such issues. (Potential Breaches shall be treated as discovered as set forth in 45 C.F.R. § 164.410(a)(2).)

2. If Business Associate must inform Covered Entity of a use, disclosure, or incident under Section 3(d)(1), Business Associate shall provide Covered Entity with the information set forth in 45 C.F.R. § 164.410(c) at the time of the initial notification or promptly thereafter as information becomes available. This can be accomplished by completing a report that is substantially similar to the format provided in Exhibit A or as otherwise agreed to by the parties. Business Associate also shall provide Covered Entity with any other information that Covered Entity may reasonably request.

3. Business Associate also shall cooperate with Covered Entity in investigating such issues and assist Covered Entity in determining whether such uses, disclosures, or Security Incidents constitute a Breach of Unsecured PHI.

4. If Covered Entity determines that a Breach of Unsecured PHI has occurred, Business Associate shall provide Covered Entity with any information reasonably necessary for Covered Entity to prepare appropriate and timely notifications of such Breach pursuant to 45 C.F.R. §§ 164.404, 164.406 and 164.408.

5. Business Associate shall report any uses or disclosures required under this Section 3(d) even if Business Associate deems the use or disclosure to be in good faith, unintentional, or inadvertent, or to have resulted in a low probability that the PHI has been compromised.

e. Subcontractors. If Business Associate discloses PHI to a Subcontractor or allows a Subcontractor to create, receive, maintain, or transmit PHI on its behalf, Business Associate must, in accordance with 45 C.F.R. §§ 164.502(e)(1)(ii) and 164.308(b)(2), obtain satisfactory assurances that the Subcontractor will appropriately safeguard the information. Specifically, Subcontractor must agree to the same restrictions, conditions, and requirements that apply to Business Associate with respect to such PHI under this Addendum, and

Business Associate must enter into a written arrangement with Subcontractor that complies with 45 C.F.R. §§ 164.504(e) and 164.314(a). If Business Associate becomes aware of a pattern of activity or practice of a Subcontractor that would constitute a material breach or violation of the written agreement between Business Associate and Subcontractor, Business Associate shall (1) take reasonable steps to cure such breach or end the violation, as applicable, or terminate such written agreement with such Subcontractor; and (2) promptly report such material breach or violation by the Subcontractor to Covered Entity in writing.

f. Access to PHI. To the extent that Business Associate maintains PHI in a Designated Record Set, Business Associate shall provide access to such PHI to Covered Entity in accordance with 45 C.F.R. § 164.524; provided, however, that such access shall be provided to Covered Entity within twenty-five (25) days of a written request from Covered Entity or in any shorter time period as required by applicable law. Covered Entity and Business Associate shall jointly determine what constitutes "PHI" or a "Designated Record Set," and such determination shall be final and conclusive. If Business Associate is unable to provide Covered Entity with access to such PHI within the required time frame, Business Associate shall timely request from Covered Entity, in writing, an extension, in accordance with 45 C.F.R. § 164.524.

g. Amendment of PHI. To the extent that Business Associate maintains PHI in a Designated Record Set, Business Associate shall make amendment(s) to such PHI in a Designated Record Set that Covered Entity directs or agrees to in accordance with 45 C.F.R. § 164.526; provided, however, that such amendments shall be provided to Covered Entity within forty-five (45) days of a written request from Covered Entity. Business Associate shall not charge any fee for fulfilling requests for amendments. Covered Entity and Business Associate shall jointly determine what constitutes PHI, and thus what information is subject to amendment pursuant to 45 C.F.R. § 164.526. The determination shall be final and conclusive. If Business Associate is unable to amend the PHI within the required time frame, Business Associate shall timely request from Covered Entity, in writing, an extension, in accordance with 45 C.F.R. § 164.526.

h. Documentation of Disclosures. Business Associate shall maintain a log that documents all disclosures of PHI and information related to such disclosures such that Covered Entity can respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528 and Section 13405(c) of HITECH and any regulations promulgated thereunder. At a minimum, the information to be documented in the log shall include: (1) the date of disclosure; (2) the name of the entity or person who received PHI and, if known, the address of the entity or person; (3) a brief description of the PHI disclosed; and (4) a brief statement of the purpose of the disclosure that reasonably informs the Individual of the basis for the disclosure, or a copy of the Individual's authorization, or a copy of the written request for disclosure. Business Associate shall provide the log to Covered Entity at least once annually.

i. Accounting of Disclosures. Upon request, Business Associate shall provide to Covered Entity an accounting of the disclosures of an Individual's PHI, collected in accordance with Section 3(h) of this Addendum. Such accounting shall be provided to Covered Entity within forty-five (45) days of a written request from Covered Entity in accordance with 45 C.F.R. § 164.528 and Section 13405(c) of HITECH and any regulations promulgated thereunder. If Business Associate is unable to provide Covered Entity with such an accounting within the required timeframe, Business Associate shall timely request from Covered Entity, in writing, an extension, in accordance with 45 C.F.R. § 164.528.

j. Right to Request Restrictions and Confidential Communications. To the extent that PHI and communications are within the control of Business Associate, Covered Entity shall direct all requests for restrictions and confidential communications in connection with the disclosure of PHI under 45 C.F.R. § 164.522 to Business Associate for evaluation. Business Associate shall respond directly to Covered Entity in a time and manner that will allow Covered Entity to comply with 45 C.F.R. § 164.522. Business Associate shall comply with any restriction to the use or disclosure of PHI that Covered Entity has agreed to or is required to abide by in accordance with 45 C.F.R. § 164.522.

k. Retention of PHI. All documentation that is required by this Addendum and HIPAA shall be retained by Business Associate for a period of six (6) years from the date of creation or when it was last in effect, whichever is later.

l. Other Obligations. To the extent that Business Associate, pursuant to this Addendum or the Agreement, is responsible for carrying out an obligation of Covered Entity under HIPAA, Business Associate shall comply with the requirements of HIPAA that apply to Covered Entity in the performance of such obligation.

m. Governmental Access to Records. Business Associate shall make its internal policies, practices, books and records relating to the use and disclosure of PHI that is received from, or created or received by Business Associate on behalf of, Covered Entity available to the Secretary and, at the request of Covered Entity, to Covered Entity, for purposes of determining Covered Entity's compliance with HIPAA. No attorney-client, accountant-client, or other legal privilege shall be deemed to have been waived by Covered Entity or Business Associate by virtue of Business Associate's compliance with this provision of the Addendum.

n. Mitigation. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate (or by any other person to whom Business Associate has disclosed PHI) in violation of the requirements of this Addendum. In addition, Business Associate shall cooperate with and implement any reasonable mitigation requests by Covered Entity relating to any actual or potential Breach or any attempted or successful Security Incident. Upon request, Business Associate shall provide Covered Entity with a written report of its mitigation efforts.

o. Minimum Necessary. Business Associate agrees that, to the extent practicable, it shall only request, use and disclose PHI in the form of a limited data set (as defined in 45 C.F.R. § 164.514(e)(2)), and that in all other cases it shall only request, use or disclose the Minimum Necessary amount of PHI necessary to accomplish the purpose of the request, use or disclosure.

p. Communication with Other Business Associates. In connection with the performance of its services, activities, and/or functions to or on behalf of Covered Entity, Business Associate may disclose information, including PHI, to other business associates of Covered Entity. Likewise, Business Associate may use and disclose information, including PHI, received from other business associates of Covered Entity, as if this information was received from, or originated with, Covered Entity. Business Associate shall document all such

disclosures of PHI in accordance with Section 3(h) of this Addendum if Covered Entity would be required to provide an accounting of such disclosures in accordance with HIPAA.

q. Compliance with EDI Standards. If applicable, Business Associate shall satisfy all applicable provisions of the HIPAA standards for electronic transactions and code sets, also known as the Electronic Data Interchange Standards (the "EDI Standards"), in accordance with 45 C.F.R. Part 162. If applicable, Business Associate further agrees that it shall ensure that any of its agents, including any subcontractors, that conduct standard transactions on its behalf, shall comply with the EDI Standards.

r. Prohibition on Sale of PHI and Marketing. Business Associate shall neither sell PHI nor use PHI in marketing.

s. De-identified Information. Business Associate may de-identify PHI and use it.

4. OBLIGATIONS OF COVERED ENTITY.

a. Notice of Privacy Practices. Covered Entity acknowledges that it is solely responsible for developing, updating and providing a notice of privacy practices, on behalf of itself, in accordance with 45 C.F.R. § 164.520. Covered Entity shall notify Business Associate of any limitations in its notice of privacy practices, to the extent that such limitations may affect Business Associate's use or disclosure of PHI.

b. Notification of Revocations. Covered Entity shall notify Business Associate of any changes in, or revocation of, authorization by an Individual to use or disclose PHI, to the extent that such changes or revocation may affect Business Associate's use or disclosure of PHI.

c. Notification of Restrictions. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to or is required to abide by in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

5. TERM AND TERMINATION.

a. Term. The term of this Addendum shall commence as of the Addendum Effective Date, shall be coterminous with the Agreement, and shall continue in full force and effect from year-to-year, but shall terminate as of the earliest occurrence of any of the following:

1. The Agreement is terminated;

2. This Addendum is terminated for cause as described in Section 5(b) of this Addendum;

3. The parties mutually agree to terminate this Addendum; or

4. This Addendum is terminated under applicable federal, state or local law.

b. Termination for Cause.

1. Upon Covered Entity's determination of a material breach by Business Associate of this Addendum, Covered Entity shall notify Business Associate of its knowledge of such breach and shall enter into discussions of how to cure the breach and take steps to prevent its recurrence. Business Associate shall have an opportunity to cure the breach, end the violation or institute changes within thirty (30) days.

2. Upon Business Associate's determination of a material breach by Covered Entity of this Addendum, Business Associate shall notify Covered Entity of its knowledge of such breach. Covered Entity shall have an opportunity to cure the breach or end the violation within thirty (30) days.

3. The Parties agree to use the dispute resolution provisions in the Agreement in connection with any dispute about a breach or the proposed cure.

c. Effect of Termination.

1. Upon termination of this Addendum for any reason, Business Associate shall return or destroy, at Covered Entity's election, all PHI received from, or created, received, maintained, or transmitted by Business Associate on behalf of, Covered Entity, that Business Associate still maintains in any form, as well as the documentation required by 45 C.F.R. § 164.530(j)(1) (all of which shall be collectively referred to as PHI for purposes of this Section 5(c)). Business Associate shall retain no copies of such PHI.

2. If the return or destruction of all PHI is not feasible, as determined by Covered Entity, Business Associate shall:

i. Retain only that PHI that is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities;

ii. Return to Covered Entity, or, at Covered Entity's election, destroy the remaining PHI that Business Associate still maintains in any form;

iii. Extend the protections of this Addendum to any retained PHI, continue to use appropriate safeguards, and comply with the Security Rule with respect to ePHI in order to prevent use or disclosure of the retained PHI other than as provided for in this Section 5(c)(2), for as long as Business Associate retains the PHI;

iv. Not use or disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set forth in Section 2(b) and Section 2(c) of this Addendum that applied prior to termination; and

v. Return to Covered Entity or, at Covered Entity's election, destroy, the PHI retained by Business Associate when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities.

3. These provisions shall apply to PHI that is in the possession of subcontractors or agents of Business Associate.

4. Business Associate shall certify to Covered Entity that it has destroyed or returned all such PHI requested to be destroyed or returned, as the case may be.

5. Any PHI that Business Associate destroys shall be destroyed in accordance with HIPAA.

6. MISCELLANEOUS.

a. Regulatory References. A reference in this Addendum to a section in HIPAA means the section as in effect or as amended, and for which Covered Entity's and Business Associate's compliance is required. A reference to HITECH shall only be applicable upon the occurrence of the relevant effective date of such reference.

b. Amendment; No Waiver. Upon the effective date of any federal statute amending or expanding HIPAA, any guidance or temporary, interim final or final regulations promulgated under HIPAA, or under any federal statute amending or expanding HIPAA (collectively, the "HIPAA Regulations") that are applicable to this Addendum or any amendments to the HIPAA Regulations, this Addendum shall be automatically amended, such that the obligations imposed on Covered Entity and Business Associate shall remain in compliance with such requirements, unless Covered Entity notifies Business Associate otherwise. The parties agree to take such action as is necessary to expressly reflect such automatic amendments in this Addendum from time to time. Except as provided otherwise in this Section 6(b), no waiver, change, modification, or amendment of any provision of this Addendum shall be made unless it is in writing and is signed by the parties hereto. The failure of either party at any time to insist upon strict performance of any condition, promise, agreement or understanding set forth herein shall not be construed as a waiver or relinquishment of the right to insist upon strict performance of the same condition, promise, agreement or understanding at a future time.

c. Survival. The respective rights and obligations of Business Associate under Section 3(k) (Retention of PHI) and Section 5(c) (Effect of Termination) of this Addendum shall survive the termination of the Agreement and this Addendum.

d. No Third-Party Beneficiaries. This Addendum is between the parties hereto. Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, upon any person other than Covered Entity, Business Associate and their respective successors, any rights, remedies, obligations or liabilities whatsoever.

e. Effect on Agreement. Except as specifically required to implement the purposes of this Addendum, or to the extent inconsistent with this Addendum, all other terms of the Agreement shall remain in force and effect.

f. Interpretation. Any ambiguity in this Addendum shall be resolved in favor of a meaning that permits Covered Entity and Business Associate to comply with HIPAA. The titles and headings set forth at the beginning of each section hereof are inserted for convenience of reference only and shall in no way be construed as a part of this Addendum or as a limitation on the scope of the particular provision to which it refers. In the event of an inconsistency between the provisions of this Addendum and the mandatory terms of HIPAA, as may be expressly amended from time-to-time by the Secretary, or as a result of interpretations by the Secretary, a court, or another regulatory agency with authority over the parties, the interpretation of the Secretary, such court, or regulatory agency shall prevail.

g. Invalid or Unenforceable Provision. The provisions of this Addendum shall be severable. The invalidity or unenforceability of any particular provision of this Addendum shall be construed, in all respects, as if such invalid or unenforceable provision had been omitted, and shall not affect the validity and enforceability of the other provisions hereof.

h. Nonassignability; Benefits and Burdens. Business Associate may not assign its rights, or delegate its duties or obligations, under this Addendum without the prior written consent of Covered Entity, which consent shall not be unreasonably withheld. This Addendum shall be binding upon, and shall inure to the benefit of, the parties hereto and their respective successors.

i. Governing Law. Except to the extent preempted by applicable federal law, this Addendum shall be construed, administered and governed under the laws of State of Maryland.

j. Entire Agreement. This Addendum, together with the Agreement, constitutes the entire agreement between Covered Entity and Business Associate with respect to the matters described herein. No promises, terms, conditions or obligations, other than those contained in this Addendum or the Agreement shall be valid or binding. Any prior agreements, statements, promises, negotiations, inducements, or representations, either oral or written, made by either party or agent of either party, that are not contained in this Addendum or the Agreement shall be of no force or effect.

k. Notices. All notices hereunder shall be in writing, and either delivered by hand, or sent by mail, or delivered in such other manner as the parties may agree upon, to the following:

Covered Entity:

Meritus Medical Center
11116 Medical Campus Road
Hagerstown, MD 21742
ATTN: Joseph Ross, President and Chief Executive Officer

Business Associate:

Trivergent Health Alliance, LLC
11116 Medical Campus Road
Hagerstown, MD 21742
ATTN: Chief Executive Officer

l. Counterparts. This Addendum may be executed in separate counterparts, none of which need contain the signatures of both parties, and each of which, when so executed, shall be deemed to be an original, and such counterparts shall together constitute and be one and the same instrument.

m. Independent Contractors. The parties to this Addendum are independent contractors. None of the provisions of this Addendum are intended to create, nor shall they be interpreted or construed to create, any relationship between Covered Entity and Business Associate other than that of independent contractors. Except as otherwise expressly set forth herein, neither party, nor any of its representatives, shall be deemed to be the agent, employee or representative of the other party.

n. Ownership of PHI. Business Associate, its agents, and its Subcontractors shall not be permitted to assert any ownership claims relating to the PHI created, received, maintained, or transmitted by Business Associate, its agents, or its Subcontractors, on behalf of Covered Entity.

[*Signatures appear on following page.*]

IN WITNESS WHEREOF, the parties hereto have duly executed this Addendum to be effective as of the Addendum Effective Date.

COVERED ENTITY:		**BUSINESS ASSOCIATE:**	
Meritus Medical Center		Trivergent Health Alliance, LLC	
By:	_____	By:	_____
Print Name:	_____	Print Name:	_____
Title:	_____	Title:	_____
Date:	_____	Date:	_____