Holy Cross Health

Strategic Transformation Plan

December 7, 2015

Executive Summary

Holy Cross Health is pleased to share the following Strategic Transformation Plan with the HSCRC and our colleagues throughout the state. Holy Cross Health is a health system serving Montgomery and Prince George's counties with 2 hospitals, 4 health centers for uninsured and Medicaid patients, 2 Ob/Gyn clinics for uninsured women, 2 primary care practices focused on care for seniors, and a myriad of community health services and activities. Since first opening our doors more than 50 years ago, Holy Cross Health has demonstrated commitment to meeting community needs time and again; always working toward ever-increasing responsiveness to the people we serve.

This plan supports the intentions of the Affordable Care Act and aligns closely with Maryland State Health Plan goals, including actions surrounding care integration, chronic disease support, primary care support, care management for highly complex and needy patients, integration of community resources and social determinants of health, and clinical consolidation and modernization to improve quality and efficiency. Under the Maryland waiver, hospitals are at financial risk for meeting their community's hospital needs. Each hospital thus bears tremendous responsibility for managing care to ensure appropriate hospital utilization as well as support of the health needs of those within our service area.

The Holy Cross Health Fiscal 2015 – 2018 Strategic Plan identifies three strategic principles that frame our response to the evolving environment and serve as the foundation of this Strategic Transformation Plan.

The three strategic principles are:

- Attract more people, serve everyone who needs us
- Manage quality, costs, and revenue effectively
- Improve and sustain individual and community health through innovation, alignment, and partnership

The first strategic principle aligns with our comprehensive acute and community strategies, including providing access and care management for uninsured populations and a deep focus on growing Holy Cross Germantown Hospital's ability to serve its community. The second strategic principle aligns with our operational and financial goals of improving efficiency. The third strategic principle aligns especially with our work in population health.

Holy Cross is firmly rooted in and committed to providing a path toward improving the health of our communities, enhancing patients' care, and reducing the rate of increase in per capita cost of care. Our plans are designed to effectively respond to the Affordable Care Act and Maryland's Medicare waiver, particularly in a growing and rapidly aging market. Both the Holy Cross Population Health Plan and

Community Benefit Plan guide the organization's activities that extend beyond the hospitals to improve health and better manage utilization through a range of partnerships.

This document includes five strategic elements: Primary Care Support, Hospital Based Programs, Care Transition Programs, Provider Supported Self-care, and Regional Partnerships. We have experienced varying levels of success to-date in each of these strategic areas, and we believe these elements taken together promote a comprehensive approach to population health management. Each of the five elements has many programmatic offerings and distinct measures of success. We are tying our measures of success to those developed by the State such that we may, as often as possible, share our successes and failures and learn from other best practices. We are currently funding these elements with revenue generated through our efficient operations, foundation support, and grant funding. It is our hope that some of these initiatives will be supported through the award of HSCRC Transformation Grant funding as we apply thorough our NexusMontgomery partnership.

Overall Goal

The overall goal of the Holy Cross Health Strategic Transformation Plan, which flows from our Strategic Plan and its three strategic principles, is to better engage individuals and others (providers, payers, and other organizations) to manage care within and beyond the hospital in order to improve health for communities and care for individuals while reducing cost. As such, it is our intent to meet the guidelines of Maryland's all-payer model through our own efforts and county-wide collaboration for care management.

We have no illusions about the challenges that lie ahead. We are attempting to generate new knowledge, establish new infrastructure, and modify years of practice while also living with significantly less revenue than has been available for 50 years. All of us, hospitals, physicians, patients, community members, and regulators have a lot to learn, but we are eager to confront the challenge and believe the plan that follows will move us essentially in the right direction.

The strategies in the following sections overlap and intertwine to create a web of supports for both preventive and on-going health care for the population in the Holy Cross Health service area. These strategies are a continuation of the work that Holy Cross Health has undertaken over the past decade.

In each case, there is special attention paid to at-risk populations, specifically seniors and the undocumented. Caring for the elderly population is key to the future success of effectively managing health care utilization. Seniors' use rate for hospital services is five times higher than those under age 65. And in Montgomery County, the number of those over age 65 will double in 20 years. Undocumented residents also significantly affect our community.

Despite the high cost of living, the Washington area close-in Maryland suburbs are a popular choice for undocumented residents. The area provides a stable economic climate with job opportunities, excellent public schools and comprehensive social services, a welcoming multi-cultural society, and communities with a critical mass of residents with similar geographic, cultural and linguistic backgrounds. The Migration Policy Institute estimates that there are 233,000 undocumented residents in Maryland with

36% (83,000) residing in Montgomery County, and 30% (69,000) residing in Prince George's County. Holy Cross Health's service area engulfs the majority of both counties.

The increased access to Medicaid under the Affordable Care Act has not had the same effect on undocumented residents as on citizens with similarly low income. The distribution of undocumented residents in Maryland results in a disproportionate financial impact on hospitals in Montgomery County and particularly on Holy Cross Health. This impact is evident in primary care, obstetrics, general hospitalization, dialysis and long term care services. Many of these are outside the regulated system and lack financial support.

While all of the strategies and tactics in this document represent the "right" thing to do for the populations we serve, few provide a self-sustaining source of income. To afford such programs, we will need to generate funds from our efficiency and attractiveness, as we have for over 15 years. However, to do all that is required going forward, we will need additional funding sources like the HSCRC Care Transformation Grant. All of these programs will be monitored using the following measures; quality, patient satisfaction, efficiency, and cost effectiveness.

Much of our plan will be accomplished through hospital based support services or strategic partnerships. These elements and relationships have been built into our hospitals, health centers, and community network including; case management, physician partnerships, palliative care, home health, faith community nursing, and community health liaisons. In addition, we plan to leverage the relationships we have fostered over many years with community partners. They include partners in three categories; payers, community organizations, and governmental agencies, including Montgomery County hospitals, the Primary Care Coalition of Montgomery County, Montgomery County Department of Health and Human Services, multiple Senior Living Communities, and payers such as Kaiser Permanente, CareFirst and Maryland Physicians Care.

Strategic Element 1: Primary Care Support

There are two major elements in the area of Primary Care Support. The first is provision of primary care to at-risk populations: uninsured, undocumented residents and seniors. They have been and continue to be the front lines of our plans to reduce hospital utilization.

Health Centers:

Holy Cross Health Centers in Aspen Hill, Germantown, Gaithersburg, and Silver Spring serve uninsured and Medicaid patients. They provide primary care services for adults and children, some specialty consults, and behavioral health services outside of the rate-regulated environment. Together, these health centers treated nearly 9,000 patients in FY 2015. Of the patients currently seen in our Health Centers, 84% are uninsured, 83% reside in Montgomery County, 65% are female and 55% are Latino, and over 50% are between the ages of 30-50. This population averages 3.6 visits per patient per year. These are visits that, in the absence of the health centers, would likely occur in a hospital emergency department.

Ob/Gyn and Senior Care:

Our Ob/Gyn clinics located at Holy Cross Hospital and Holy Cross Germantown Hospital provide primary maternity and gynecological care to over a thousand women every year. They produce extremely low rates of low birthweight babies and related NICU care. Holy Cross Health Partners in Kensington, a long-standing primary care practice primarily serves a geriatric population. This practice follows the CareFirst PCMH framework to tightly manage a population. In 2015 Holy Cross opened Holy Cross Health Partners at Asbury Methodist Village, a 1,500 resident senior living community. Our objective was to promote care continuity across multiple settings (primary care, hospital, home health, private duty, assisted living and skilled nursing facilities) that were integrated with residents' home environment in a supportive community. This community was particularly attractive because it offered an opportunity to better manage the significant amount of care utilized by our patients, 80% of whom are over age 80. Collectively, these 8 locations provide care for nearly 15,000 lives each year.

Moving forward, in addition to providing high quality primary care, we will also be monitoring utilization patterns for each panel of patients to identify frequent utilizers, prevalent chronic conditions and use of preventive services. This will allow for better management of chronic disease, timeliness of scheduled appointments, assurance of compliance, and comfort for both provider and patient that optimal health touchpoints are in place. We expect this to result in measures of patient satisfaction as measured by post-visit survey tools, increased adherence to care plans as measured by visit compliance, and reduction in preventable hospital encounters as measured by PAUs and readmission rates for the hospitals.

Over the next two years, we will evaluate expansion of the current Health Centers or the opening of a new location. Based on our current positive partnerships with Asbury Methodist Village we also plan to expand our practice to include specialty care as well as outpatient palliative care and geriatric assessment. Expanding palliative care and senior services throughout our rapidly aging region will allow us the ability to manage a panel of patients through informed decision making and appropriate care, enhance technology, and evolve communication vehicles so that we are better able to proactively meet senior health needs.

We will also evaluate partnerships with other senior living communities and skilled nursing facilities. We believe jointly managing seniors in the environment where they live allows us to respond to the many social determinants of health as well as the physical ailments. It also allows us to expand community based services such as Senior Fit classes and other community health programming in a targeted fashion to reach the maximum number of community members possible.

The second focus under the category of Primary Care Support is enhancing communication with primary care physicians, to improve care transitions following hospitalization. Improved communication enhances patient care and can help avoid unnecessary utilization. Our work in enhancing communication is in concert with our payer partners to support their approaches to effective utilization management. For example, the largest commercial insurer in our region, CareFirst, utilizes a Patient Centered Medical Home (PCMH) model for care management of its members. We have reached a

formal agreement with CareFirst to improve upon the model. Similarly, Kaiser Permanente is the state's largest and most established integrated health network. Based on a long-standing relationship, it uses Holy Cross for 74% of its admissions in our area and we work closely with Kaiser Permanente (KP) on care coordination and appropriate placement. Finally, Holy Cross became an owner of Maryland Physicians Care in order to help strengthen the care management of a large and growing Medicaid population of patients.

Holy Cross is currently partnering with Care First to improve communications and care coordination between our contracted hospitalists and PCMH primary care physicians. The hospitalists are calling each patient's primary care physician to discuss the care plan and preferences for specialty referrals. In the future, this will be enhanced through access to secure texting to allow for asynchronous communication. Holy Cross is partnering in similar ways with Kaiser Permanente. We have provided a network of information technology such that Kaiser Permanente physicians working at Holy Cross facilities can access both KP and Holy Cross records. We also have enabled sharing of critical information between records. We have established a secure network with KP such that their specialists can provide telehealth consults to hospital based patients in either one of our two hospitals.

On another front, Holy Cross provides information and education for physicians on how to enroll in CRISP and the benefit to patient and practice for sharing information within the State health information system. Moving forward, we will be working with CRISP to have contextual access within Cerner (our EMR) and to pilot CRISP and HSCRC tools that will enhance a hospital’s ability to manage a population. Also, as part of our NexusMontgomery application, we have plans to make care plans visible in CRISP to aid in communications and ultimately improve patient compliance.

As a 25% owner of Maryland Physicians Care, Holy Cross Health is seeking to build its presence in Montgomery County and simultaneously increase our role in providing high quality, effectively managed primary care for its members through our health centers. Over time, this will reduce the demand for ED services and improve health through routine and compliant care.

Strategic Element 2: Hospital Based Programs

Both Holy Cross Hospital and Holy Cross Germantown Hospital have state of the art facilities equipped with the latest technologies and all private rooms for safe and comfortable healing. The private rooms also make patient education, discharge planning, and other discussions related to patient choice much easier. The new facilities also promote more efficient utilization of beds. Both new facilities were created with the input of nursing and allied services such that patient flow and workforce efficiency is maximized. Going forward we will continue to study and utilize lean techniques to implement processes affecting workflow optimization.

Some examples of how we are improving the inpatient experience are the all important handoffs in making care more efficient. Regarding Length of Stay (LOS), we have implemented cohorting of hospitalist patients, separated observation patients from inpatients, and implemented multidisciplinary rounding. We have provided the hospitalists with geographic assignments within which to practice to improve scheduling and continuity of care. We also have provided dedicated units for Kaiser

Permanente patients to foster communication and workflow of their hospitalists and case managers. The intent of all of these efforts is to streamline operations and care planning for the most efficient and effective care. As we continue our LOS focus, specifically at Holy Cross Hospital, we will move forward with initiatives around multidisciplinary rounds such that case management, the hospitalists, the nursing team and the patient / family can make care plans, set goals and achieve a timely discharge with effective care transitions. We are piloting using technology to put predicted discharge dates on the patient list for proactive planning, holding twice daily discharge meetings where barriers to discharge are discussed and removed, and building of deeper relationships with post-acute facilities and home care providers to accept patients being discharged but needing extended care.

ED utilization continues to be high at both Holy Cross Hospital and Holy Cross Germantown Hospital. We have many programs with our health centers and partners to reduce ED utilization. With a growing and aging population and a high number of undocumented patients, ED utilization can be predicted to rise unless innovative programs and supports are available. One project that we are working on with partners throughout the county, including Kaiser Permanente, Montgomery County Fire and Rescue Services, Fast Track Urgent Care and the Holy Cross Health Centers is called the "Alternative Care Destination Pilot". Our intent, beginning in early 2016, is to pilot a program where priority 3 and 4 patients calling 911 for care will be triaged by EMS through telephonic and on-site triage processes such that the patient can be transitioned to the most appropriate site of care, be that the Holy Cross Hospital ED, a Holy Cross Health Center serving the uninsured, a Kaiser Permanente clinical decision unit (CDU), or an Urgent Care Center. This pilot will be focused on a small radius surrounding Holy Cross Hospital. After the 90-day pilot period, our hope is to expand the geographic area, partner organizations, and technology used. Ultimately, we would hope this could be something that all Montgomery County hospitals participate in and support through a greater web of partnerships and technological and staffing advancements.

Regarding quality and safety initiatives, our Holy Cross Health-wide programs to decrease hospital-acquired complications have resulted in improved MHAC scores. To achieve this success, we have performed competency training and implemented safety checks in many areas. One example is our implementation of competency training for central line insertion and transitioning to antibiotic impregnated intravenous central lines in order to reduce central line infections. We will continue implementation of best practices in other areas across all populations using those discussed in the Maryland and Trinity Health collaborative groups.

Holy Cross also plans continued investment in medication management and medication reconciliation. We are exploring creation of a team of "medication historians", trained individuals who would interact with our inpatient and observation populations to record and reconcile medications, getting the documentation right from the beginning. Success in this area would be measured by reduction in LOS as well as reduced readmissions. We are looking to use e-prescribe tools as well as expand the focus to include nursing education to ensure accurate medication history.

Another area of critical focus is Patient Satisfaction. Our QBR (quality based reimbursement) has half of the score focused on patient satisfaction. We recognize the growing importance of patient engagement

and patient satisfaction. Our current and planned efforts focus on hourly rounding, bedside hand-offs, and nursing and physician communications. We have engaged the Studer Group to support our patient engagement journey and are implementing their teaching principles at both of our hospitals.

Recognizing the unique needs of senior patients, we established the country's first Seniors Emergency Center to provide focused attention on treatment of seniors requiring emergency care. Similarly, our NICHE certification demonstrates our commitment to staff education, equipment and facility planning to enhance care for seniors. We are in the process of updating our seniors plan to ensure optimization of the care continuum focused on the unique needs of this growing demographic.

For undocumented patients especially, we have been particularly challenged to meet the long-term care needs for patients who do not have the means to pay for the services they need. In fact, anywhere between 14% and 31% of our dialysis patients are uninsured. While emergency Medicaid is available to them, it is a lengthy process that requires a significant level of cooperation from the patient resulting in a very long lead-time prior to authorization and reimbursement. We frequently pay for short-term rehabilitation services for uninsured patients who require skilled care following discharge. In addition, in FY 2015, Holy Cross Hospital spent $565,000 to secure a long-term care bed for undocumented patients who are too sick for home but not sick enough for hospital based care. We believe that a hospital paying for placement of undocumented individuals is untenable in the future environment. Part of our plan will be to work with the state and partner organizations to better provide a support network for these patients needing continued care, such as dialysis, or transitional care settings such as LTAC's or SNF's.

Finally, follow-up calls, home visits, and tactics identifying high-risk patients are employed to ensure good follow-up and readmission avoidance. More discussion follows below.

Strategic Element 3: Care Transition Programs

Care Transition programs begin in the inpatient setting. They involve linking the patient with the best program for their needs. We believe the care transition programs will result in lower rates of initial hospitalization and readmissions. Both are goals of the Maryland all-payer program. This is a continual and evolving process, both in the inpatient setting and in our focused transitional setting.

Currently, we have created 4 intervention pathways to manage populations at risk for readmission. The four programs are; post-discharge phone calls, transitional care program support, home health care, and skilled nursing facility placement. All adult patients get risk scores on admission based on point of entry (ED, OBS, IP) and use pattern. Case management conducts face-to-face interviews with those over age 70 and those with chronic disease to determine what post-discharge support they will need. Because of their high prevalence of chronic conditions and other needs, seniors are a critical focus of our care transitions program. Similarly, uninsured patients receive specific attention as well.

Post-discharge calls:

All medical-surgical patients who are discharged to home receive a series of three phone calls to ensure they understand their discharge instructions, have their medications, have received any ordered equipment or home health services, and have planned for or received follow up physician care. Any concerns identified during these calls are escalated to a nurse who can intervene to provide information or resolve a problem. Given the barriers that uninsured patients face we have dedicated staff specifically to providing follow up calls both to uninsured inpatients and emergency patients. With these calls we can be more involved in ensuring that whatever barriers may exist to accessing necessary medications, services or follow up care can be addressed. This can include making appointments and providing transportation vouchers.

Transitional Care:

The second intervention is the Transitional Care program which provides a home visit(s) and follow-up phone calls to patients who are not eligible for home health services but who are assessed as needing additional assistance to support a successful transition from hospital to home. For patients who are particularly complex due to co-occurring medical, behavioral and/or substance abuse issues we offer CareLink, an intensive care management program that involves multiple in-person and phone encounters to ensure a patient is stabilized following discharge.

Home-Health Care:

Appropriate referrals to home health care ensure that patients receive in-home skilled nursing or therapy services. We work closely with local home health agencies, particularly Holy Cross Home Care and Hospice, beginning prior to discharge, to ensure a smooth transition. We also maintain contact with these patients through the discharge phone calls during the first month following hospitalization.

SNF Placement:

Patients discharged to skilled nursing facilities have a particularly high readmission rate. Through a RFP process that focused on high-quality facilities, we identified 7 preferred providers in Montgomery County. We are working with these providers to reduce avoidable returns to the hospital. We are also focused on improving communication, both regarding individual patients and systemically, to ensure a smooth transition of care. Finally, recognizing the long journey of recovery that many of our patients face, we have begun arranging for home health services to follow skilled nursing placement even before the patient leaves the hospital. This enhances continuity and provides comfort to patients and families that they will have on-going support through transition across care settings.

Looking ahead, we intend to expand the scope of existing readmission prevention activities as part of the HSCRC-supported regional partnership grant. This will allow us to serve more of the patients who could benefit from these services. By working collaboratively with the other Montgomery County hospitals, we will be able to learn from each hospital's approach and adopt best practices to serve our community. We also intend to expand our palliative care programs. For many years we have offered a

robust palliative care program in Holy Cross Hospital. Through expansion at Holy Cross Germantown Hospital and growth at Holy Cross Hospital, we have increased palliative care services by 27% in the past year. We will continue to increase our palliative care service at both hospitals and intend to extend palliative care into the community by offering services at Holy Cross Health Partners at Asbury Methodist Village and potentially in other strategic partner clinical environments. We also intend to implement staff education regarding palliative care at all our facilities and at locations of strategic partners such as Sanctuary at Holy Cross and NMS Fairland skilled nursing facilities.

To evaluate the success of our inpatient and transitional care initiatives, we will be tracking metrics common to all Maryland hospitals including; HCAHPS scores for services, 30-day readmission rates, preventable readmissions, cost per readmission, and overall cost of care. We have collected baseline data on all of these elements and have set targets for each. For example looking at just our SNF readmission rates, we showed CY13 Jan-July SNF Readmission Rate = 20.7% (293/1414), and our experience in CY 15 Jan-July showed SNF Readmission Rate = 19.4% (300/1545). Our goal is to get SNF readmissions down to 18.7% in the next year. Similarly, we have observed 1.35 inpatient/observation contacts per unique Medicare patient in FY15. Approximately half of those additional contacts occurred during the first 30 days post discharge, the remainder during the rest of the year. Through our work, we anticipate an additional 26 case reduction on subsequent admissions. Our expanded care management program, for patients that don't qualify for homecare but are identified as at-risk will also target reduction in readmissions. Together, these initiatives account for the best opportunity to reduce observed to expected readmission rates and lower cost of care by eliminating the readmissions cost of approximately $15,000 per case.

Strategic Element 4: Provider supported self-care

This strategic initiative recognizes the critical role that individuals play in managing their own health and utilization. Rather than doing things to people or for people, we work with people in the hospital and in the community to improve capacity to effectively manage their own health. There are four significant components to this work: community outreach, community health programming, the Medical Adult Day Center and Caregiver Resource Center, and support for advance care planning.

Community Outreach

Holy Cross Health has community health workers who work in underserved communities to provide health information and referrals to our health centers as well as service such as employment support, notice of food banks or other services that can help individuals address social determinants of health. One full-time community health worker is focused particularly on the Georgia Avenue corridor between Silver Spring and Aspen Hill where we had identified a high number of repeat emergency visits in ZIP codes with a high score on the Community Need Index. In addition to provide direct outreach, Holy Cross Health has also developed a curriculum and provides training to increase the effectiveness of community health workers (working with us or other organizations). In addition to providing health information and referrals, our community health workers have supported insurance enrollment, providing information or referral to more than 10,000 people last year to help eligible individuals secure

more reliable access to care through insurance coverage. Going forward, we hope to also support education for newly insured residents on how to utilize their newfound insurance. We have previously worked with the Primary Care Coalition to jointly secure funding and will continue to look for other opportunities.

Community Health Programs

Holy Cross Health's community health programming engages individuals in managing their own health. For example, each week 1,200 individuals participate in Senior Fit exercise classes offered free of charge by Holy Cross Health at 23 sites around the region. In annual assessments, we see a high percentage of participants improving strength, flexibility as well as their sense of well-being. Other valuable self-care programs include Living Well: Chronic Disease Self-Management Program, Diabetes Prevention and Diabetes Self-Management, Pulmonary Maintenance, Falls Prevention, Memory Academy, Better Bones, Heart Failure Management, Kids Fit and Kids Shape. We also offer multiple other exercise and intellectual engagement programs offered at Senior Source, our center for active aging and at multiple community locations. Many of our evidence-based self-management programs adhere to strict curriculum requirements that can be difficult for participants. We intend to develop alternatives that may be more flexible and offer more opportunity for virtual participation in education, chat rooms and support groups. We will also be working to increase referrals to the program from our hospitals, health centers, and transitional care programs to complement the clinical services we provide.

Medical Adult Day Center / Caregiver Resources

Holy Cross Health's Medical Adult Day Center provides a safe, medically supervised, engaging setting for vulnerable adults, particularly those with dementia. It can be a valuable resource for families to help seniors remain in the community rather than becoming institutionalized. The Caregiver Resource Center, which is affiliated, with the Medical Adult Day Center provides information, referrals and numerous support groups to help people manage the responsibilities and challenges of caregiving. In 2014, the center's work in helping participants preserve function and cope with symptoms of dementia made it the first such center in all of Maryland to earn recognition for excellence in care by the Alzheimer's Foundation of America. We would like to continue to expand and support this center and evaluate the potential value in opening more, or collaborating with senior living communities to provide similar services for county residents not yet ready for or able to afford a senior living community.

Advanced Care Planning

In the coming year Holy Cross intends to expand its outreach to promote awareness and support community engagement regarding end of life care planning. Our goal is to provide culturally competent tools to support individuals' conversations with their families to identify their care priorities and their preferences. By working through our faith community nursing relationships, engaging residents of senior living communities, and through broad community promotion we hope to normalize such conversations and promote them as an empowering path toward self-care.

Strategic Element 5: Regional Partnership

Our final strategy focuses on the area of regional partnership. In May 2015 NexusMontgomery was awarded a $300,000 regional transformation planning grant with Holy Cross Hospital as the lead hospital. Our partners included Suburban Hospital, The Primary Care Coalition, two dozen market rate and subsidized senior living communities, the Montgomery County Department of Health and Human Services, Kaiser Permanente, Maryland Physicians Care, and several other community providers and agencies. During the planning process we have expanded our partnership to include all Montgomery County hospitals and we are now preparing to submit a Transformation Implementation Program proposal to fund the initiative we designed.

Our new, expanded NexusMontgomery Regional Partnership will submit two proposals. The first is to support care management interventions and infrastructure targeted toward high utilizers and those at risk of high and preventable utilization, particularly Medicare beneficiaries. This proposal has three components. The first component, as discussed earlier, is an expansion of existing care transition programs to reach more people in need. As part of this work the partnership will work with commercial and Medicaid MCO payers to better coordinate with their care management functions. The second component will focus on Medicare patients discharged to skilled nursing facilities and patients discharged to skilled home health care. The intervention will provide light monitoring while the patient is receiving SNF or home health care and more extensive care management upon discharge to support the transition from more intense clinical services. As part of this work the partnership will seek to better understand and address the root causes of readmission following SNF and/or home health care. The third component is the one that was proposed as part of the design grant. NexusMontgomery will work with Medicare and dual-eligible beneficiaries living in market rate and subsidized senior living communities in Montgomery County. The partnership will train referral sources embedded in the communities to identify seniors at high risk for an index admission and make a referral for care management to pre-emptively stabilize the resident and avoid hospital utilization. This proposal also will work with CRISP to create connectivity and data sharing to promote care management.

The second proposal that NexusMontgomery will submit is focused on special populations, specifically uninsured individuals and those who are severely mentally ill. For individuals who are uninsured and ineligible for coverage, particularly those who are using emergency departments as a primary source of care, we will try to redirect their care patterns. This will be done by expanding primary care capacity in safety net clinics, using community health workers to help with navigation, and implementing geographically targeted outreach and education. We also will target uninsured patients at hospital discharge to provide navigation and financial support for outpatient specialty care. For patients with severe mental illness we will expand the capacity of community-based teams who can help manage patients in community settings to avoid unnecessary hospital utilization. Though Montgomery County has the 2nd lowest rate of ED visits/100,000 population for Mental Health conditions in the state, the growth trend is troubling. Between 2010 and 2013, Mental Health visits in the ED increased by 38%, in a county with nearly 40% fewer ED treatment spaces per 100,000 than the state average. ED boarding of behavioral health patients is common and causes increased costs for the health system and higher risk for adverse outcomes. Similar concerns exist in the inpatient setting as well. The NexusMontgomery

regional partnership will work on care coordination and improved therapeutic and cost effective care to support this highly needy population. One goal is to build ACT teams. These teams will engage Medicaid enrollees in programs that offer support in areas such as; medication acquisition and management, episodic stabilization, support of clients in the ED, and providing transportation or other means to provide access to programs such as partial day support programs.

By creating NexusMontgomery, the Montgomery County hospitals have committed to exclusively working together to serve patients in our region. Collectively, the hospitals will develop shared functions to promote more efficient delivery of care coordination services and to provide the opportunity for shared evaluation and learning. Together, within NexusMontgomery, we will share infrastructure funds, staff resources, data – both transactional and evaluative, and coordinate jointly with providers, community based organizations and public health to develop common interventions and infrastructure in specific areas where collaboration brings greater return on investment than individual hospital efforts.

The value of building these new countywide services for care management is multifold. First, this type of arrangement allows us to form a coalition built on shared data and trusted relationships. Second, through a countywide framework, we are better able to provide care management at the location and level where they are needed most, and for longer periods where warranted. Third, through a countywide framework, we are able to scale the number of at-risk patients receiving care management services. Finally, through our regional partnership, we are better able to provide a breadth and depth of transitional care, primary care, and overall care management support for high need and complex patients.

Conclusion

Holy Cross Health's submission of this Transformation Plan is well aligned with its Strategic Plan. We feel confident that the initiatives currently underway will continue to be the appropriate focus as we move further into population health management. We are willing and prepared to accept the challenges to achieve a healthier, more informed, and more engaged population.

We will require funding from state and local bodies to continue this work and we will need to foster integration of the continuum of care, and in areas where we currently do not have control, we must build relationships and influence. To better understand the impact of our Transitional Care interventions we have begun monitoring the number of unique individuals we serve and the average number of touches (defined as inpatient, observation, or emergency visits) per unique individual. In this way we can monitor both our reach in serving more people who need hospital care as well as our effectiveness in reducing re-hospitalization within a year. This is but one of many measures that we will track to determine change in course, and ultimately success.

Moving forward, we will depend on our own process improvement efforts, our partnerships in care, and the support of the regulated payment system to successfully meet the challenges of the diverse, aging, and growing population in the region we serve.