HOWARD COUNTY GENERAL HOSPITAL

JOHNS HOPKINS MEDICINE

Hospital Strategic Transformation Plan

December 7, 2015

Howard County General Hospital

Hospital Strategic Transformation Plan – Executive Summary

The Maryland Waiver presents hospitals with a glide-path for change to realize health system transformation. Howard County General Hospital (HCGH) is committed to developing the Howard County Regional Partnership (HCRP) as the primary vehicle to coordinate efforts that improve the care delivery system and improve population health for our community.

Our hospital strategic transformation plan builds on infrastructure investments made to date and is linked to the HCRP's implementation plan. It includes the following four goals:

1) Improve care coordination to ensure seamless transitions between care settings and better manage patients' complex needs, focusing in particular on post-acute care coordination and processes to connect patients with multiple chronic conditions and significant social determinants to community-based resources and programs.

2) Develop data analytics infrastructure to support population health goals as outlined by the HCRP and provide real-time decision support for providers. Ultimately, we want to be able to proactively manage the health of the community instead of waiting for hospital utilization to intervene.

3) Involve primary care providers in the development and execution of a specific action plan to create an effective continuum that ensures access to care in the most appropriate setting. As HCRP focuses initially on a pathway for provider referrals to a community-based care coordination intervention for high-risk Medicare beneficiaries, the hospital will work with primary care practices to determine the top two to three projects that need to happen in calendar years 2016 and 2017 to achieve better provider alignment.

4) Improve access to urgent care mental health services. There are several gaps in the care continuum for behavioral health here in Howard County. This has been identified not only by our community health needs assessment but also by our Local Health Improvement Coalition as well as by a recent Howard County Behavioral Health Task Force. One such gap is a lack of access to urgent care mental health services. HCGH, with support from the Horizon Foundation, partnered with Way Station, Inc. to pilot a rapid access program. The pilot runs from September 1, 2015 through August 31, 2016. Although initially a short term investment, we will evaluate the program's effectiveness in order to determine what longer term investments are needed.

HOSPITAL STRATEGIC TRANSFORMATION PLAN

1. DESCRIBE YOUR OVERALL GOALS:

Howard County General Hospital (HCGH) has identified four overall goals as part of our strategic transformation plan.

1. **Care Coordination –** Improve care coordination to ensure seamless transitions between care settings and better manage patients' complex needs
2. **Population Health Analytics** – Develop data analytics infrastructure to support population health
3. **Provider Alignment** – Convene primary care providers to develop a specific action plan to create an effective continuum that ensures access to care in the most appropriate setting
4. **Behavioral Health** – Improve access to urgent care mental health services

2. LIST THE OVERALL MAJOR STRATEGIES (3-10) THAT WILL BE PURSUED BY YOUR HOSPITAL INDIVIDUALLY OR IN COLLABORATION WITH PARTNERS:

Care Coordination

Skilled nursing facilities (SNFs): HCGH has entered into a collaboration with Lorien Health Systems and Gilchrist Services[1] to better manage patients discharged from the hospital to Lorien's skilled nursing facilities. As part of the Howard County Regional Partnership (HCRP), this group has committed to standardizing the discharge process from HCGH to Lorien and will be developing and implementing care pathways for the top three causes of readmissions from Lorien properties (sepsis, congestive heart failure, and respiratory failure/pulmonary edema). In addition, one of our hospitalist physicians, who is also a geriatrician, will lead a monthly case review of patients (unplanned and planned transfers between acute and post-acute settings) to identify new areas for improvement, communication and collaboration. This is a model that has worked well for Lorien in other parts of the state and we are eager to implement it here in Howard County. Also, based on the early success of Lorien's telemedicine project in Harford County, we will explore the feasibility of using telemedicine to potentially avoidable utilization related to reduce emergency room visits, inpatient admissions and readmissions.

Acute Transitions: HCGH continues to utilize Lean methodology to build standard processes in order to ensure a smooth transition for admitted patients discharged to home. These processes are integrated into unit-based multidisciplinary rounds (e.g. daily discussion of plan of care with all members of the care team and early involvement of the patient and his/her family/caregivers).

[1] Gilchrist Services provides medical directorship and attending services for Lorien properties located in Howard County.

The work in this space will continue in calendar year 2016 and will expand to support HCRP's care coordination intervention (Community Care Team).

The hospital's Lean team is already working with staff in the Emergency Department (ED) to improve throughput times and other processes to reduce wait times and our "left without being seen" rates. In the upcoming year, the team will focus on designing and implementing a process for early identification of patients with significant social determinants and then provide seamless connections to community-based resources and services.

Population Health Analytics

With increased adoption of Electronic Health Records (EHRs) the opportunity for healthcare organizations to mine and report data as well as provide real-time decision support have become necessary tools to improve the health of populations. HCGH recognizes the need to improve the capability of understanding the characteristics of complex patient populations within our own organization and merge this data with external stakeholders (e.g. community based medical and social service providers). In partnership with CRISP, as well as internally, HCGH is investing in the ability to leverage "big data" into real-time decision support. By providing the care team with real-time identification of "high risk" patients and information on compliance with care pathways and protocols, decisions can be made in real-time to guide these patients to the most appropriate resources instead of retrospectively identifying them days, weeks, or months later. Expanding the availability of this information to external stakeholders supports the concept that we should be proactively managing patients instead of waiting until they come through the hospital's doors. This will require a combination of clinical, technical, and business perspectives to ensure that we are identifying the right information at the right time and getting it to the right people in the right way.

Provider Alignment

HCGH participates in the Howard County Advanced Primary Care Collaborative (APPC) – a convening started by the Howard County Health Department and the Horizon Foundation. APPC is comprised of nine practices and their patients represent more than one-third of the county's adult population. It is a learning collaborative that also offers technical assistance to groups working on practice transformation. HCRP is using the existing collaborative as the vehicle for provider alignment. Separately, HCGH operates two other groups involving primary care practices – the Primary Care Operations Council and the Physician Advisory Council. All three groups work on similar issues and member rosters overlap. During the first six months of calendar year 2016, the hospital will work with representatives from each of these three groups to create one committee, tied to HCRP's "Provider Alignment and Network Development" subcommittee, and develop a strategic plan to guide its work for fiscal year 2017. For example, priority projects identified separately by all three groups include the development of an urgent care strategy for the

county including patient education around appropriate ED use, engagement with specialty groups to begin to build informal networks and service level expectations, and a plan for patients without a usual source to care to be connected with medical homes.

Behavioral Health

There are several gaps in the care continuum for behavioral health here in Howard County. One such gap is a lack of access to urgent care mental health services. HCGH, with support from the Horizon Foundation, partnered with Way Station, Inc. to pilot a rapid access program. Launched in September 2015, the Howard County Rapid Access Program (RAP) is designed to provide access to urgent, outpatient, crisis stabilization services within 24-48 hours of referral for adults in need of immediate access to short term, psychiatric, problem-focused intervention, regardless of ability to pay. This service is intended to prevent further emotional distress/ decompensation which otherwise would result in accessing more acute levels of care. Services will be provided through Way Station's Outpatient Community Mental Health Clinic (OMHC) in Columbia, MD. Services provided during an average "episode of care" include: one psychiatric evaluation with a Nurse Practitioner, with 2 follow up medication management sessions, as well as an initial clinical evaluation with a therapist, with up to six therapy sessions. Way Station works to transition the patient, if needed, to a permanent community provider after the episode of care. Referrals are made from the hospital's ED and inpatient units. We are currently in the process of developing a method for Way Station to accept referrals from the county's mobile crisis team, operated by Grassroots Crisis Intervention Center.

3. DESCRIBE THE SPECIFIC TARGET POPULATION FOR EACH MAJOR STRATEGY:

Care Coordination

SNF: The target population are patients discharged from HCGH to any one of three Lorien SNF locations in Howard County.

Acute Transitions: While the work of the Lean team benefits all patients, the target population are patients at risk of readmission (either as inpatient or to the Emergency Department), in particular those who have significant social barriers to achieving their health goals (e.g. lack of usual source of care, no caregiver support, unstable housing, food insecurity, no usual source of transportation).

Population Health Analytics

Building this analytic capability will directly influence the work of hospital physicians and staff. The reporting function will support the work of the HCRP.

Provider Alignment
Our focus is on the nine practices who are members of the APPC as well as those who participate in one or both of the hospital-led primary care groups who are not part of APPC, including five solo practitioners and one pediatric practice. APPC members include the following groups: Columbia Medical Practice; Centennial Medical Group; Johns Hopkins Community Physicians; Chase Brexton Health Services; Evergreen; Maryland Primary Care Physicians; MedPeds; Personal Physician Care; Wellbeing Medical Care.

Behavioral Health
The target population for RAP are Howard County residents in need of access to urgent care mental health services that meet certain criteria regarding safe discharge, diagnosis treatable by medication and therapy in outpatient setting and the patient has been previously unsuccessful in obtaining access to a community provider. The program has the capacity to serve a total of 780 unique patients during the pilot year. It is payer agnostic.

4. DESCRIBE THE SPECIFIC METRICS THAT WILL BE USED TO MEASURE PROGRESS INCLUDING PATIENT SATISFACTION, QUALITY, OUTCOMES, PROCESS AND COST METRICS FOR EACH MAJOR STRATEGY:

Care Coordination
SNF: Readmissions and potentially avoidable utilization by patients from Lorien are two key metrics. As care pathways are developed and implemented in early 2016 for three leading causes of readmissions, specific metrics will be identified to assess the effectiveness of these tailored protocols. Given that the work of the collaborative between HCGH, Lorien and Gilchrist is tied to HCRP's plans for the post-acute care setting, we will have one set of metrics to measure progress in this setting, including the care coordination between HCGH and SNF.

Acute Transitions: Similar to the above comments regarding the HCGH-Lorien-Gilchrist collaborative, we will utilize the patient satisfaction, quality, outcomes, process and cost metrics developed by the HCRP. This set includes HSCRC required elements.

Population Health Analytics
This strategy is focused on developing the capability to turn data into information to be used to provide real-time decision support as well as support the reporting functions to monitor performance of the HCRP. Progress depends on the functionality being developed and actual use of information.

Provider Alignment

Based on the strategy related to provider alignment as outlined in response to Question 2, we are rather process focused. Progress will be measured by our ability to harmonize the three separate groups into one committee linked to the HCRP and develop and approve a strategic plan with specific tactics to deploy by the start of fiscal year 2017.

Behavioral Health

In addition to tracking 30 day readmissions for patients referred to RAP, the following metrics are used to measure progress made with the pilot program.

Diagnostic Presentation

- Diagnosis upon RAP referral
- Diagnosis upon RAP discharge or termination

Continuity of Care / Transition

- # of RAP clients transitioned back to previous provider at termination
- # of RAP clients transitioned to new provider at termination
- # of RAP clients terminated with no follow up provider
- # of RAP clients enrolled with Way Station at termination

Access to Care Challenges

- Average # of providers client actually contacted for service prior to enrolling in RAP
- # of providers contacted for service as part of RAP transition planning
- By insurer / payer: Average wait (days / weeks) for prescriber appointment as part of the RAP transition process

Payer Mix

- # of RAP clients by payer (Medicare, Medicaid, commercial, self-pay, uninsured)
- # of RAP uninsured clients enrolled who obtained insurance during the episode of care

Clinical Parameters

- Avg. # of prescriber appointments per RAP client (month, quarter, year)
- Avg. # of therapist appointments per RAP client (month, quarter, year)
- Total # of sessions completed per client

Program Parameters

- Total # of unique individuals served

- Total # of cancellations and "No Shows" during week, month, quarter, year
- Average # days from hospital discharge/referral to first appointment
- # of RAP clients who left prior to completion of episode of care
- # of RAP clients terminated prior to 9th visit by reason code

Retrospective hospital charges of referred individuals are assessed on an ongoing basis to determine the potentially avoided costs resulting from the program. In the short term, these are calculated strictly from HCGH data, however, we have talked to CRISP about utilizing a version of their PATH report to look at cost data across all hospitals for RAP patients. We anticipate conducting pre-/post-intervention comparison on an individual basis as well as a year-over-year comparison using HCGH data.

5. LIST OTHER PARTICIPANTS AND DESCRIBE HOW OTHER PARTNERS ARE WORKING WITH YOU ON EACH SPECIFIC MAJOR STRATEGY:

Care Coordination

SNF: HCGH is partnering with Lorien Health Systems and Gilchrist on this work. Executive leadership from Lorien and Gilchrist has been identified as members of the steering committee that will oversee the work of the HCRP. We established a committee of our Board of Trustees to act as the HCRP. The committee will have several subcommittees, including one focused partnership performance and will include key staff from Lorien and Gilchrist. In addition, a smaller operations group led by our hospitalist geriatrician and a member of our Lean team have already come together to start work on improvements to the discharge process and care pathway development.

Acute Transitions: In addition to internal staff representing nursing, case management, social work, and physicians, key community partners include the Johns Hopkins Home Care Group; the Community Care Team (currently operated by Healthy Howard, Inc.); Howard County Health Department (HCHD); Howard County Department of Citizen Services and its Office on Aging; and members of the Local Health Improvement Coalition (LHIC). HCHD has secured funding for and will soon release an RFP to build a community resource platform. This platform will not only serve as the central repository for all community-based resources and programs and help coordinate referrals but will also provide a mechanism to coordinate follow up and track referrals. Such a platform will support our efforts to provide seamless connections to community-based resources and services.

Population Health Analytics
Building in-house capacity requires the involvement of several internal stakeholders. As other members of the Johns Hopkins Health System have expertise in the area, including Johns Hopkins Bayview, Johns Hopkins Hospital and Johns Hopkins Health Care, we will seek their input and guidance as well. Given that infrastructure will allow for reporting functions to monitor performance of the HCRP, we will work closely with members of the regional partnership.

Provider Alignment
The hospital will work with primary care providers, HCHD, Horizon Foundation and internal staff to establish one primary care committee to replace the three existing groups and define the strategic plan for fiscal year 2017.

Behavioral Health
RAP is one part of a larger community-based effort to address behavioral health that has brought together the hospital, Howard County Government, Howard County Mental Health Authority, HCHD, Horizon Foundation, LHIC and Grassroots Crisis Intervention Center. Our service provider partner is Way Station's Outpatient Community Mental Health Clinic (OMHC). The Horizon Foundation is providing grant support for this pilot as well as funding the program evaluation.

6. DESCRIBE THE OVERALL FINANCIAL SUSTAINABILITY PLAN FOR EACH MAJOR STRATEGY:

Care Coordination
SNF: HCGH will utilize infrastructure funds to support the protected time of the hospitalist to lead this collaboration. As additional needs are identified (e.g. costs to Lorien to build out lab testing or other features tied to care pathways developed, telemedicine equipment), we will work with our partners to develop a funding strategy.

Acute Transitions: HCGH has invested in the development of a Continuous Improvement and Innovation team that includes Lean facilitators/project managers. Staff are deployed to lead a variety of process improvement efforts throughout the hospital and the care coordination strategies outlined in this plan have been incorporated into the team's project plan for the remainder of fiscal year 2016 and will be factored into the development of its budget and project plan for fiscal year 2017.

A principal goal of enhanced care coordination is the reduction of readmissions and other potentially avoidable utilization. Commensurate with a reduction in avoidable utilization and good expense management, the Global Budget Revenue (GBR) should provide a source of sustainable funding for care coordination initiatives. An existing acute transitions initiative – multi-disciplinary

rounds – has seen a reduction in patient length of stay that favorably impacts the variable cost of care (e.g. pharmaceutical, medical supply, staffing costs). The reduction in variable costs under the GBR model will lead to increased margins that could be used to invest in similar programs.

Population Health Analytics
Improved availability of actionable information will result in driving down costs for Medicare high utilizers as well as for other at-risk patient populations. Reductions in both avoidable utilization and the variable cost to care for patients under the GBR model promote margin expansion. Margin expansion provides sustainable funds for continued investment in population health initiatives.

Provider Alignment
Funding for the existing APPC ends in June 2016. With the start of fiscal year 2017, the hospital will utilize infrastructure funds to provide financial and operational support for the combined group.

Behavioral Health
HCGH and the Horizon Foundation have provided funding for the RAP pilot initiative. The results of the program evaluation determine whether funding will continue and we will discuss financial sustainability with our community partners.