

Meritus Medical Center Strategic Transformation Plan

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.

Meritus Medical Center's Vision for Transformation: Meritus Medical Center in collaboration with Meritus Health exists to improve the health status of our region by providing comprehensive services to patients and families. This mission emphasizes three core activities:

- Providing patient and family centered care
 - Bringing the patient and family perspectives into the planning, delivery and evaluation of care to improve quality and safety
- Improving the health status of our region
 - Responding to national healthcare reform and total patient revenue economic structures that incentivize value, by expanding the focus to include improving the health status of our region
- Functioning as a regional health system
 - Meeting the healthcare needs of the communities beyond the Meritus Health's traditional service area of Washington County

Our vision states that we will relentlessly pursue excellence in quality, service, and performance. This vision embodies the imperative expressed by our community that emphasized becoming an organization that continually strives for excellence.

Our culture is driven by the values of respect, integrity, service, and excellence delivered to patients and families through teamwork. It is through these values that Meritus Health will fulfill our mission and achieve our vision.

Meritus has established a strategic plan to achieve its vision by focusing on improvements in the areas of quality, service, performance, and culture:

Quality

- Successfully manage the quality of care, the cost of care, and the volume (utilization) of care in response to the national healthcare delivery and reimbursement trends.

Service

- Provide an exceptional patient experience by utilizing patient and family centered care principles across the organization.

Performance

- Improve financial performance in response to changes in healthcare reimbursement and to ensure we have the resources to pursue the fulfillment of our mission and vision.
- Develop information technology capabilities to support the achievement of the organizational vision and strategies.

Culture

- Empower employees and providers to put patients and families at the center of everything we do while attracting, retaining, developing, and rewarding our workforce.
- Strengthen physician and provider alignment with Meritus Health by developing an innovative, high-performing medical staff.

Meritus developed its mission, vision, and current strategic in 2012 in response to the changes in healthcare delivery in Maryland and nationally. The new strategy heightened the organization's focus on providing high quality, cost effective care, and improving the overall health of our community. The proposed Regional Transformation Plan with Trivergent Health Alliance is an extension of Meritus' strategy for success in the evolving healthcare environment and will play a significant part in achieving our vision for improving population health.

Overall Major Strategies

Strategy 1: Behavioral Health

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 at community-wide educational element aimed at reducing stigma and increasing understanding of behavioral health needs.

Goals, Strategies and Outcomes to be pursued:

The Meritus team along with the Alliance Regional Partnership 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 two Model of Care initiatives and an enabling strategy, each with specific goals and expected outcomes:

1.1 Implement Behavioral Health (BH) Community Care Management (leveraging the best practice model currently in place at Western Maryland Health System).

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 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. Work with the Community Advisory Council (CAC) 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 initiative are to:

- a. With consultation of the Community Advisory Council, identify target groups apart from health care delivery models for training, education 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 / Federally Qualified Health Centers (FQHCs), hospice
 - Individuals impacted with/by behavioral health needs
- b. Increase awareness through creation of appropriate educational and support materials for use with Community Advisory Council members and Washington County Local Health Improvement Coalition (WCLHIC).
- c. Improve understanding and appropriate access to behavioral health services and supports.
- d. Conduct Mental Health First Aid (MHFA) trainings annually in coordination with the Alliance.

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:

Meritus Health along with the Alliance regional partnership 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 Regional Partnership will invest in a common set of processes and strategies to engage High Utilizer (HU) patients in our region 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. Meritus is a best practice site for the embedded outpatient care management team in the primary care setting.
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 docs and PCPs for ED High Utilizers (HUs).
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: 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:

Meritus Health as a member of the Alliance RCMETC will offer a standardized education program for the Care Management professionals and relevant support staff of the Alliance Hospitals and partners.

The RCMETC will strive to achieve four goals:

1. Ensure that the Regional Partnership's model of care initiatives have a common framework for training Care management staff on goals, processes, and outcomes tracking;
2. Provide a forum for understanding and closing local/regional Care Management 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 involve the regional care management process and goals with key community partners and provide a means to help support their care management education 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 Care Management activities throughout the Regional Partnership network of providers who work with High Utilizer patients, both in direct care delivery and in provision of community supports.

Target Populations

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

- **Target population** –All persons discharged from the Emergency Department or Inpatient behavioral health unit with a primary behavioral health diagnosis (including mental health or substance abuse diagnosis).
- **Number and geographic location** – For FY15 Meritus cared for 2,390 unique patients with a primary behavioral health diagnosis, accounting for 3,333 total visits seen in the Emergency Department (ED). When 1,048 inpatient hospitalizations are included, total charges for all primary behavioral health discharges equal \$9,259,212.

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 nine Meritus ACO 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 and Inpatient primary behavioral health diagnosis visits that were specifically for mood disorders. Mood disorders are a diagnosis where if patients have the appropriate outpatient support and follow up, ED visits and inpatient hospitalization can often be avoided. We found that 1,992 unique patients with mood disorders accounted for 2,755 total ED visits. When 837 inpatient hospitalizations are included, total charges for all mood disorders equal \$6,964,489.

Data analysis of the target population for Strategies 1.1 and 1.2 by zip code revealed that utilization was concentrated in the primary service area with Washington County zip accounting for > 80% of Meritus discharges.

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 on MHFA across all three counties. The expectation is that the Meritus population will be approximately 165 persons.

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, Meritus analyzed all patients 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 for FY15, we identified 432 HU patients who accounted for 1,953 total visits, 789 of which were for a targeted diagnosis. During further analysis, we discovered that when looking at all reasons for admission, not just the specific primary diagnoses above, we found that these same these 432 HU’s actually account for 1,703 readmissions and \$15,848,761 in total charges. Data analysis of the target population by zip code revealed that utilization was concentrated in the primary service area with Washington County zip accounting for > 80% of Meritus discharges.

Strategy 3: Decrease Emergency Department (ED) Potentially Avoidable Use (PAU)

Work with ED providers and PCPs to reduce potentially avoidable ED visits.

Target population – The target population includes 689 unique patients derived from two target sub populations. These two sub-populations, described below, were determined to be a manageable group that the interventions should be 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; conversion to ICD-10 in progress):

- 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 432 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 may experience ED visits that do not result in a hospitalization and this captures those patients. We estimate 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; this high ED utilization is why we will include them in this strategy to reduce potentially avoidable ED visits.

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 – Meritus staff that provide Care Management services across the continuum of care, including ambulatory, inpatient, emergency, behavioral health and specialty services.

Number and geographic location

- As of December 2015, the target population among Meritus employed staff is approximately 80 individuals, and includes 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 80 individuals who all work in Washington County.

Metrics that will be used to measure progress for each major strategy

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	√
	CTM 3 - Care Transitions Measures (3 questions required for Medicare ACOs)	Quality, Indirect Pt Sat.	Outcome	√
1. Behavioral Health 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 Admission Rates	Quality, Financial	Outcome	√
	BH ED Revisits within 30 days	Quality, Financial	Outcome	√
	BH Readmission rates within 30 days	Quality, Financial	Outcome	√
	Percentage of ACO providers participating in initiative.	Quality Financial, (indirect pt. sat.	Outcome	√
1.2 Integrate BH into primary care to identify patients at risk and link them to appropriate resources.	Number of low, medium and high risk individuals screened by PHQ-9 referred for follow up	Quality	Process	√
	Percentage of patients seen in participating ACO 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	Process	√
	Number of Community Health Education/MHFA trainings conducted.	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 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	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-	Reductions in readmissions	Quality, Financial	Outcome	√
	Avoidance and reduction in cost of inpatient care for patients participating in program	Quality, Financial	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 Older Adults Admission Rate PQI #7- Hypertension Admission Rate PQI #8- Heart Failure Admission Rate PQI #14- Uncontrolled Diabetes Admission Rate	Financial, Quality	Outcome	√

coagulation therapy).				
	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 Older Adults Admission Rate PQI #7- Hypertension Admission Rate PQI #8- Heart Failure Admission Rate PQI #14- Uncontrolled Diabetes Admission Rate	Quality, Financial	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. 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.	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	Outcome	√
	High utilizers per PCP	Quality, Financial, Indirect Pt Sat	Outcome	√
	Change in percent of total ED visits and charges high utilizers represent	Quality	Outcome	
	Readmissions (all-cause 30 day) specific to HU population	Quality, Financial	Outcome	√
	Potentially avoidable utilization: Internal reports available currently; Future CRISP report (Use diagnoses from HU data to determine PQIs that are most relevant)	Quality, Financial	Outcome	√
	Percent of HUs where communication/texting to PCP occurred as intended (possible if all use Tiger Text)	Quality, Financial	Outcome	√
	Percent of HUs who have follow up appt. with PCP or specialist within X days (possible for health system owned practices)	Quality	Process	
	Percent of HUs engaged in intervention: complex care management, community health worker, tele monitoring	Quality, Indirect Pt Sat.	Process	√

	Quality, Indirect. Pt. Sat.	Process	√
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.			
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:			
<ul style="list-style-type: none"> • 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.) • Total number of educational programs offered • Pass rate for individual programs 			

Partners for Each Specific Strategy

<p>Strategy 1: Behavioral Health Build a multi-faceted Behavioral Health strategy that focuses on outpatient case management, early detection and effective and timely intervention for at-risk patients. The strategy also includes at community-wide educational element aimed at reducing stigma and increasing understanding of behavioral health needs.</p>
<p>Regional Healthcare Alliance - Collaboration, infrastructure and reporting Behavioral Health Providers – Patient-centered care, education, transitions, collaboration</p> <ul style="list-style-type: none"> ○ Behavioral Health Services ○ Brook Lane Health Services ○ The Mental Health Center ○ Potomac Case Management ○ QCI ○ Washington County Health Department ○ WayStation <p>Hagerstown Family Healthcare and Tristate Community Clinic (Regional FQHCs) – Local law enforcement – Safety, support, transitions Meritus ACO – Quality, cost-effective care, coordination</p>

Primary care providers - Patient-centered care, coordination, quality, collaboration

- Meritus employed
- Meritus affiliated (e.g., participate in ACO)
- Unaffiliated

Washington County Mental Health Authority – Quality, infrastructure, reporting
Washington County Office of Consumer Advocacy – Advocacy, support, coordination of resources
Washington County Local Health Improvement Coalition (LHIC) – Collaboration, resource allocation, implementation
CRISP – Notifications to enhance communication

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.**

Regional Healthcare Alliance - Collaboration, infrastructure and reporting
Primary care providers - Patient-centered care, coordination, quality, collaboration

- Meritus employed
- Meritus affiliated (e.g., participate in ACO)

Meritus ACO - Quality, cost-effective care, coordination
Hagerstown Family Healthcare and Tristate Community Clinic (Regional FQHCs) - Care coordination, quality, collaboration
Washington County Local Health Improvement Coalition (LHIC) – Collaboration, resource allocation, implementation
Commission on Aging – Advocacy, education, resources, support
Washington County Office of Consumer Advocacy – Advocacy, support, coordination of resources
Skilled nursing facilities / Assisted living facilities- Care coordination, transitions, collaboration, supportive care
Senior centers – Support, education, socialization
Hospice - Care coordination, transitions, collaboration, outpatient palliative care
Pharmacies - Care coordination, quality, collaboration
Potomac Case Management – Linkage, support, rehabilitation
Faith Communities – Support, education, collaboration

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

Regional Healthcare Alliance - Collaboration, infrastructure and reporting
Primary care providers - Patient-centered care, coordination, quality, collaboration

- Meritus employed
- Meritus affiliated (e.g., participate in ACO)
- Unaffiliated

Meritus ACO - Quality, cost-effective care, coordination
Hagerstown Family Healthcare and Tristate Community Clinic (Regional FQHCs) - Care coordination, quality, collaboration
Washington County Local Health Improvement Coalition (LHIC) – Collaboration, resource allocation, implementation

<p>Commission on Aging – Advocacy, education, support</p> <p>Washington County Office of Consumer Advocacy – Advocacy, support, coordination of resources</p> <p>Skilled nursing facilities / Assisted living facilities - Care coordination, transitions, collaboration, supportive care</p> <p>Senior centers – Support, education, socialization</p> <p>Hospice - Care coordination, transitions, collaboration</p> <p>Pharmacies - Care coordination, quality, collaboration</p> <p>Faith Communities – Support, education, collaboration</p>
<p>Strategy 4: Regional Care Management Education Center (RCMETC)</p> <p>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.</p>
<p>Regional Healthcare Alliance Collaboration, infrastructure and reporting</p> <p>Washington County Local Health Improvement Coalition - Collaboration, resource allocation, needs assessment</p> <p>Other community care providers</p>

Financial Sustainability

This plan is a work in progress specific to Meritus. In conjunction with the Regional Partnership for Healthcare transformation, below is the plan for financial sustainability.

Describe the financial sustainability plan for implementation of these models. Section is a WIP:

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 \$ \$2,058,398.65 and an overall Return on Investment (ROI) of 2.31 as per the ROI template for the Meritus Health implementation grant (see table inserted below) . As savings taper beyond year one, we expect to remain sustainable via the ongoing hospital rate increase and leveraging all possible reimbursement for services (e.g., billing care management fees, billing for telemedicine, billing/reimbursement available from integration of BH professionals in the PCP office). These reimbursement mechanisms have been identified and are being further explored to determine feasibility.

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

	Year 1	Year 2	Year 3	All Years Combined
A. Number of Patients	3,511	3,511	3,511	10,533

B. Number of Medicare and Dual Eligible	701	701	701	2,103
C. Annual Intervention Cost/Patient	664.17	767.49	748.50	2,180.16
D. Annual Intervention Cost (B x C)	465,585.80	538,009.28	524,698.73	1,528,293.81
E. Annual Charges (Baseline)	21,907,479.00	21,907,479.00	21,907,479.00	65,722,437.00
F. Annual Gross Savings (14.44% x E)	2,374,770.72	3,286,121.85	3,899,531.26	9,560,423.84
G. Variable Savings (F x 37.50%)	712,431.22	1,314,448.74	1,559,812.50	3,586,692.46
H. Annual Net Savings (1)(G/D) & (2)(G-D)	1.53	2.44	2.97	2.35
	246,845.42	776,439.46	1,035,113.77	2,058,398.65

This section is WIP:

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 visit.
- Improved efficiencies from collaboration between the three hospitals (i.e., centralized infrastructure, tools and processes).
- Improved efficiencies from collaboration between providers (i.e., reduce 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 gain 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 targeted populations are placed in a diffuse pattern when inpatient. Fixed costs will not be impacted within the first 2 years as the HU's do are not placed in one particular areas of the hospitals to warrant FTE reduction, yet soft savings will be yielded early on.

ROI Calculation for All Target Population Payers:

WIP: Need to insert detail to explain this view:

- Calculations are based on Net Annual Charges, not total Annual Charges and why
- Comprehensive view details:
 - Total intervention cost for patients and payers within the 3 strategies HU target populations
 - Variable Savings Used

ROI is inclusive of all HU patients

Years 1 - 3 Data Combined All 3 Work Teams Combined	
A. Number of Patients	3,511
B. Number of Medicare and Dual Eligible	701
C. Annual Intervention Cost	\$ 7,654,550.00
D. Annual Intervention Cost/Patient	\$ 2,180.16
E. Annual Intervention Cost (B x D) For Medicare and Dual Eligible Patients	\$ 3,740,309.90
F. Annual Charges (Baseline)	\$ 65,722,437.00
G. Annual Charge Savings Target	14%
H. Annual Gross Charge Savings (F x G)	\$ 9,560,423.84
I. ROI Gross Charge Savings Per Intervention Cost Invested (H/C)	\$1.25
J. Variable Savings %	38%
L. Variable Savings (H x J)	\$ 3,586,692.46
O. Annual Net Savings (L - E)	\$ (153,617.44)

Describe the specific financial arrangements that will incent provider participation.

Meritus and the Alliance are currently analyzing several financial arrangements to incent and engage providers. A significant portion of PCPs in Washington County are employed or affiliated with Meritus Medical and/or the Meritus ACO 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). Creating electronic triggers when able to allow for ease alerting these other are team members of their needed service. As we heard during our provider forum, these initiatives are much desired in that they give providers the support and tools to help provide better care to their patients. Providing social workers and CHW will also help to identify social determinates of health and individualized patient needs. Having CM support their patients, taking the time to provide hands on intervention and taking the time necessary to ensure that their patients are receiving what is needed will result in improved overall health and quality of life.

Ongoing collaboration with providers will create a continuous feedback loop that will allow our partnerships better understand and address provider needs and enhance provider participation and engagement, with the goal to align financial payment models in the future. Through the alignment of workflows, ongoing support and asking for provider input when integrating these additional care providers to the outpatient health care team will help make communication transparent.