Peninsula Regional Medical Center
Population Health Strategic Transformation Plan

Executive Summary

Please find attached Peninsula Regional Medical Center's (PRMC's) Strategic Transformation Plan. Since the implementation of the Global Budget Revenue (GBR) agreements in January of 2014, infrastructure monies that have been distributed by the Health Services Cost Review Commission (HSCRC) have been utilized to develop population health activities that are based upon community needs. PRMC's overarching goals have been to provide care within the community and region that improves the overall quality of life of the residents of its' primary service area. This is in line with the mission of the organization: "To improve the health of the communities we serve." In addition, PRMC has been focused on reducing health disparities, working with community organizations that impact the population on a daily basis, and increasing access to care outside of the acute care setting. PRMC's 2015 Community Health Benefits report detailed the need to provide enhanced services around diabetes, obesity, chronic diseases and mental health. As such PRMC has put into place the following programs:

1. **Health Education**: Focused on diabetes and chronic conditions such as congestive heart failure and chronic kidney disease.
2. **Chronic Disease Management**: Heartline, a data collection source, and health coaches who utilize the information to assist patients in better managing chronic disease.
3. **Care Management**: Intervention strategies under the care management program include the utilization of community health workers, PRMC physicians creating and utilizing care plans for patients with multiple chronic diseases, the expansion of a *Transitions of Care* team who follow patients for 30 days post discharge and assist patients with chronic disease education and management techniques, providing support to meet and address social needs, and completing a medication reconciliation to prevent medication errors.
4. **Behavioral Health:** Expansion of services to address the need for mental health and substance abuse care.

Each of these important initiatives will be defined further in the attached strategic plan format as well as operationally enhanced through additional resources as part of the HSCRC's Care Coordination grant process.

As PRMC seeks to further their population health efforts it has been determined that there is a great need to focus intervention strategies in the community utilizing Care Managers located in primary care offices. These Care Managers will assist Primary Care Physicians in caring for patients with multiple chronic conditions and which in turn drive multiple admissions/emergency room visits. Care Managers will complete the continuity in care for patients who are managed by a *Transitions of Care* nurse 30 days post discharge.

Further, the need to access care for those patients who do not have a Primary Care Physician will be addressed by assisting patients within a *Bridge Clinic* for post discharge follow-up visits. The Bridge

Clinic will be staffed by primary care physicians who will see patients who cannot see their own primary care physician within 3-5 days of discharge, or patients who do not have a primary care physician. In addition, PRMC will be providing a Mobile Van to address rural disparities in accessing health care within PRMC's region. The Mobile Van will be deployed to communities with high ED utilization and readmissions as well as isolated and disparate communities where access to primary care and /or transportation is problematic.

Finally, in collaboration with multiple partners such as Atlantic General Hospital and McCready Hospital, emergency response teams on Smith Island, as well as multiple Skilled Nursing Facilities (SNFs) and Rehabilitation providers, PRMC seeks to prevent avoidable admissions by addressing behavioral/chronic health needs through working partnerships with these providers that will facilitate regular communications regarding high utilizers as well as the application of telemedicine and enhanced coordination with the Maryland Institute for Emergency Services Systems (MIEMSS) field programs.

PRMC seeks to enhance and expand these population health intervention strategies by obtaining additional funding through the HSCRC Care Coordination grant process. Through this effort, PRMC has targeted a patient population to create core competencies and immediate success. Utilizing resources such as CRISP to monitor population health efforts and the productivity of Care Management, PRMC looks to scale these population health efforts further in the future. Once the programs are fully established, additional patient populations will be included into the programs across the broader PRMC service area. Reinvestments will be made back into the programs to increases resources and enhance care management technologies.

PRMC believes that the sum of these population health intervention strategies will have the direct result of decreasing readmissions, reducing unnecessary admissions, and ultimately decreasing the total cost of care in the Lower Eastern Shore region. We also believe these strategies, while improving the quality of care and health status of all patients in the region, will have the most significant impact on the Medicare population. These anticipated reductions in Medicare costs and improvement in patient outcomes will directly support the goals of CMS's three part aim and the new demonstration model in Maryland.

PRMC will work diligently to monitor and manage its key care coordination intervention plans and population health performance metrics utilizing internal data, shared information with other providers and community partners as well as utilizing the resources of the CRISP health information exchange.

Required Executive Summary and Hospital Strategic Transformation Plan Format
Due: December 7, 2015

The ***Executive Summary*** (1-2 pages) should be a high level description of your hospital's strategic transformation plan to support Maryland's goals (as described on page 1) and can be submitted as an attachment in Word format.

Hospital Strategic Transformation Plan
1. Describe your overall goals:
• Peninsula Regional Health System's mission is to: Improve the Health of the Communities we Serve. • Improve the population health status and overall quality of life. • Reduce the health disparities among the population by identifying segments that are most at risk for various diseases and injuries. Plans for targeting these individuals may then be developed as evidenced in Peninsula Regional's participation in many of the local community health organizations. • Increase accessibility to preventative – health and wellness - services for our communities.

2. List the overall major strategies (3-10) that will be pursued by your hospital individually or in collaboration with partners (and answer questions 3-6 below for each of the major strategies listed here):
Currently: Past 12 Months a) Provide diabetes awareness, education and management to lower shore community i) Continue to create general public awareness around the high prevalence of diabetes in this region, including travel to community events where at-risk populations are present for screenings and education ii) Partnered with MAC and local providers, including PHDs and Atlantic General Hospital and Community Foundation, and others to present, "Diabetes Self-Management" classes for identified high risk community members with diabetes. This is a program of patient engagement program that has the patient set attainable goals and moves them stepwise to better self care/knowledge. b) Reduce the proportion of children and adolescents who are considered obese i) Reduce the number of residents in Wicomico, Worcester and Somerset Counties who are considered overweight by developing an educational module (including handouts) to be used whenever the Wagner Wellness Van participates in local community events. Develop healthy plate and games for children, take Healthy Plate game to community events and encourage participation ii) Partnered with National Children's and the YMCA to staff a childhood obesity screening and activity program c) Chronic Disease Management i) Heartline: providing remote data collection and data management services in connection with the treatment of medical conditions such as congestive heart failure ii) Health Coaches who focus on chronic conditions such as heart failure and chronic kidney disease and patients who are at risk for readmission iii) In partnership with the University of Maryland, to provide access for Delmarva residents who are in kidney failure and who could benefit from a transplant

iv) Develop community wide pathways and patient education tools for COPD, CHF, and Diabetes.

v) Develop teams including physicians, case managers, and specific practitioners with expertise in each of these conditions, including insurance case managers and health department representatives.

vi) Utilize these tools and educational materials in our "Million Hearts" grant for CHG and Hypertension in partnership with MAC, Transitions, cardiology practices, and the FQHC and in partnerships with the PHDs.

d) Care Management

i) Utilization of Community Health workers

ii) Peninsula Regional Medical Center: primary care providers developing care plans that are patient centric and are targeted to patients with chronic conditions

iii) Creation of Transitions of Care Nurses: nurses who follow patients for 30 days, patients who are screened as high risk

iv) Medication reconciliation process upon admission and prior to discharge

v) Social workers who assist the care team in assessing the social needs of the patients

vi) Partial Hospitalization Program: secondary to a community assessment for gaps in services for the region focusing on Behavioral Health

vii) To provide behavioral health services for patients either in the community or prior to discharge who need extra care prior to discharge to home

viii) Partnered with Adventist Health to recruit 2 child and Adolescent psychiatrists

Future: (Grant and Strategic Intent)

e) Provide a bridge clinic to patients who do not have a primary care physician or need to see a primary care physician

i) To increase access to care to an aging population

ii) Patients who are a high risk for readmission and need to see a physician within 48-72 hours of discharge and whose own PCP cannot accommodate will be referred and an appointment will be established prior to discharge by Transitions RNs. Patients without PCPs who require post discharge follow up will be referred for a 2-5 day appointment.

f) Mobile Van

i) A medical van that was originally outfitted for wellness checks will now be used to make "rounds" on patients in their communities

ii) The van is targeting communities with high ED utilization and readmissions as well as isolated and disparate communities where access to primary care and/or transportation is problematic

iii) The van will assist patients in managing their chronic conditions but live remotely from providers

iv) PRMC is collaborating with Atlantic General Hospital and McCready Health to assist with their high utilizers in remote and disparate communities

g) In Collaboration with Atlantic General Hospital and McCready Health

i) Provide Care Management and communication between PRMC's, AGH's and McCready's emergency rooms

ii) To assist patients in accessing the appropriate chronic care management and mental health professionals to reduce ED utilization

iii) Utilizing CRISP to establish a "community plan of care" for patients who utilize all three institutions

h) Community Case Management and Transitions of Care

i) Provide case managers in employed primary care practices and in affiliated primary care practices to manage Medicare high utilizers who are attributed to these practices

ii) Additional high risk for readmission patients not attributed to these primary care practices will be managed for up to 90 days

iii) The Care Manager will assist the primary care physician in actively managing the patients chronic conditions to prevent avoidable utilization of PRMC's acute care setting

iv) Care managers will work with Primary Care Practitioners, patients and their families to make palliative care and hospice referrals for outpatient symptom control and counseling as well as in-home services.

v) Patients and their health partners (family, friends) are taught to assist patients in management of their health

i) In collaboration with 7 SNF's/Rehab: (listed in section 5 below)

i) Work with 7 nursing homes who have agreed to work on pathways to telecommunicate with hospitalist at PRMC to discuss high risk patient who may need care within the nursing home versus care in the acute care setting

j) Smith Island/Crisfield Clinic: Telemedicine

i) Working with EMT's who will assess patients within the home setting and work with hospitalist at PRMC via telemedicine for patients who need care but may or may not need to be admitted to PRMC

k) Health, Wellness and Chronic Disease Management Competencies.

i) Engage PRHS's self-insured covered lives in health and wellness programs

ii) Engage PRHS's self-insured covered lives with chronic disease controlled through case management or other disease management programs.

iii) Formulate a health and wellness program for the community.

l) Develop clinical integration including physician alignment and new partnerships

i) Stand up an Accountable Care Organization

ii) Develop a path to connect community physicians with the new EMR

m) Cultivate an environment that encourages inquiry and innovation contributing to solutions, improvements and generalizable knowledge that positively impacts our community.

i) Develop research based protocols.

3. Describe the specific target population for each major strategy
Current: a) Provide diabetes awareness, education and management to the community i) All residents of PRMC service area ii) Children and teens with diabetes iii) Children and teens with undiagnosed diabetes iv) All residents of PRMC service area b) Reduce the proportion of children and adolescents who are considered obese i) All residents in Wicomico, Worcester and Somerset Counties ii) Children (and families of those children) enrolled in PRMC Day Care iii) All residents in PRMC service area iv) Under- and uninsured community members c-d) For services listed above in c and d v) All residents in Wicomico, Worcester and Somerset Counties vi) All residents in the PRMC service area vii) Residents with chronic conditions and mental health conditions
Future: (Grant and Strategic Intent) e-j) Analysis has determined the target patient population for the items (e-j) above are Medicare Patients with 2 or more bedded care encounters in a year and with chronic condition diagnosis and mental health diagnosis i. Total Medicare high utilizers: 1,330 ii. Medicare high utilizers by zip codes within the PRMC region which includes Delaware as well as Wicomico, Worcester and Somerset Counties k) Health, Wellness and Chronic Disease Management Competencies i. PRHS covers nearly 4,000 employees and dependents on their health plan ii. The community is the Primary and Secondary Service Areas with approximately 462,000 people. l) Develop clinical integration including physician alignment and new partnerships. i. Independent and employed providers within the Primary and Secondary Service Areas. m) Cultivate an environment that encourages inquiry and innovation contributing to solutions, improvements and generalizable knowledge that positively impacts our community. i. Independent and employed providers within the Primary and Secondary Service Areas.

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:**

Current:

a) Provision of diabetes awareness, education and management to the community will be measured *globally* by monitoring SHIP measure #27 (reducing diabetes complications as measured by reduction in diabetes-related emergency department visits)

   i) General public awareness
      (1) Track number of public fairs/events where assessments were performed and number of lives "touched"
      (2) Track number of self-assessment questionnaires completed
      (3) Track number of diabetes support group meetings
      (4) Track hits to diabetes website

   ii) Diabetes support group for teens and kids
      (1) Track number of attendees to support group
      (2) Track number of physician referrals

   iii) "Educating the educators"
      (1) Track number of educators trained
      (2) Track number of groups presented to

   iv) Support and work with Tri-County Diabetes Alliance
      (1) Track number of participants in all collaborative meetings

b) Reduce the proportion of children and adolescents who are considered obese – this set of initiatives will be measured *globally* my monitoring SHIP measure #31 (reducing the proportion of children and adolescents who are considered obese)

   i) Reduce the number of residents in Wicomico, Worcester and Somerset Counties who are considered overweight
      (1) Track number of venues in which information was distributed

   ii) Implement Healthy Day Care Program for PRMC Day Care
      (1) Track the number of venues in which information was distributed
      (2) Track consults/communication with and education of parents

   iii) Restaurant challenge
      (1) Track number of participating restaurants
      (2) Track number of community participants
      (3) Track number of restaurants that use the recipe after the event

iv) Health Fest Expo

(1) Track number of attendees

(2) Track number of screened participants

(3) Track number of critical values

v) Develop Healthy US Pediatric Weight Management Program to provide screening and education for under- and uninsured community members about the importance of physical activity. Hold several 12-week programs to educate children and families on healthy lifestyle

(1) Track number of enrolled participants

(2) Track weight loss

(3) Track program attendance

c) For programs listed as c and d

i) Reduction of PAU's

ii) Reduction of ED utilization

iii) Reduction of Medication errors prior to discharge to home

d) Community Case Management/Transitions of Care

i) Reduce readmission rate for managed patients by 10%

Future: (Grant and Strategic Intent)

Over-arching Goals (e-j):

Reduction of PAU's

Reduction of avoidable utilization of the emergency room

Reduce readmissions to acute care setting

Programmatic Specific Goals:

e&h) Increase the number of eligible patients who agree to participate in case management

Increase the number of high risk for readmission clients have a follow-up appointment scheduled for the first 3 days post discharge

Increase the number of patients agreeing to case management have a Plan of Care developed in CRISP/visible to the care team

f) Mobile Van

1) Increasing access to Primary Care providers by referring to participating practices

2) Patient engagement and satisfaction by utilizing a questionnaire to discover any gaps in care within specific communities/locations as a baseline; repeat at the end of one year to determine level of satisfaction with services and further needs of community

3) Reduce overall ED utilization for at risk population areas with high ED usage

g) Collaboration with AGH: ED Case Management

1) Reduce ED utilization by managed clients

2) Increase the number of patients referred to Primary Care of Behavioral Health providers as indicated by diagnosis

3) Increase the number of high utilizers screened for behavioral health or addiction diagnosis
4) Increase the number of clients agreeing to case management have a Plan of Care in CRISP for the team to utilize

i) SNF
1) Reduce readmission to hospital from SNF/Rehab participants

j) Smith Island Telemedicine
1) Improving patient engagement from a baseline assessment that will be complete upon commencement of the program and reassessed 12 months after the program begins
2) Respond to 100% of requested telemedicine assessments for emergent situations within 20 minutes
3) Respond to request for telemedicine "office visit" with scheduled visit within 48 hours

k) Health, Wellness and Chronic Disease Management Competencies.
1) Track the number of self-insured covered lives participating in health and wellness programs.
2) Track the number of self-insured covered lives enrolled in chronic disease management programs.
3) Track the number of programs offered to the community .

l) Develop clinical integration including physician alignment and new partnerships.
1) Approval from CMS to standup an ACO
2) Satisfy all 1st year requirements
3) Implement continuum of care management tools for four chronic disease states.

m) Cultivate an environment that encourages inquiry and innovation contributing to solutions, improvements and generalizable knowledge that positively impacts our community.
1) Track number of research based protocols developed.

5. **List other participants and describe how other partners are working with you on each specific major strategy:**

Current:

a) Provision of diabetes awareness, education and management to the community will be measured globally by monitoring SHIP measure #27 (reducing diabetes complications as measured by reduction in diabetes-related emergency department visits)

   i) General public awareness
      (1) PRMC Diabetes Education Program
      (2) Tri-County Health Departments
      (3) Tri-County Diabetes Alliance

   ii) Diabetes support group for teens and kids
      (1) PRMC Diabetes Education Program

   iii) "Educating the educators"
      (1) PRMC Diabetes Education Program
      (2) Wicomico County Board of Education
      (3) Wicomico County School Nurses

   iv) Support and work with Tri-County Diabetes Alliance
      (1) Tri-County Health Departments
      (2) UMES McCready
      (3) Atlantic General
      (4) TLC Salisbury
      (5) Urban Ministries

b) Reduce the proportion of children and adolescents who are considered obese – this set of initiatives will be measures *globally* by monitoring SHIP measure #31 (reducing the proportion of children and adolescents who are considered obese)

   i) Reduce the number of residents in Wicomico, Worcester and Somerset Counties who are considered overweight
      (1) PRMC Health and Wellness Committee
      (2) PRMC Education Department

   ii) Implement Health Day Care Program for PRMC Day Care
      (1) PRMC Health and Wellness Committee
      (2) PRMC Day Care

iii) Restaurant challenge

(1) PRMC

(2) Tri-County Diabetes Alliance

iv) Health Fest Expo

(1) PRMC

(2) James M. Bennett High School

v) Develop Healthy US Pediatric Weight Management Program to provide screening and education for under- and uninsured community members about the importance of physical activity. Hold several 12-week programs to education children and families on healthy lifestyle

(1) PRMC

(2) CNMC

(3) YMCA Delmarva

(4) We Can

(5) PRMC Foundation

c) Chronic Disease Management partnered with the following providers/resources

i) University of Maryland to provide chronic kidney disease management

ii) MAC to provide chronic disease certification programs/coordination of community health workers for home visits

iii) PRHC to provide home visits, chronic disease self-management coaching, and community health workers for transitions of care

iv) Partnered with several local churches and homeless shelters to provide referrals to providers

d) Care management

i) Partnered with Adventist Health to provide behavioral health services in the emergency department and the ambulatory clinic

Future: (Grant and Strategic Intent)

e) Partnering with Lower Shore Health Clinic and Go-Getters to provide access to behavioral health services

f) Partnering with AGH and McCready Health to provide access to care to disparate communities

g) Partnering with AGH and McCready Health to provide ED care management for high utilizers in collaboration with Emergency Service Associates.

h) Transitions of Care

i) Partnering with the following 7 SNF's/Rehab/ Nursing Homes

   i) Salisbury Genesis
   ii) Aurora Nursing Home
   iii) Berlin Nursing Home
   iv) White Oak SNF
   v) Harrison House
   vi) Hartley Hall
   vii) Deers Head Center

j) Partnering with EMT services and the Crisfield clinic to provide care management and telemedicine services to the high utilizers of Smith Island

k) Health, Wellness and Chronic Disease Management Competencies.
   a. Internal to Employees and Dependents
   b. Through the development of a "playbook", PRHS will share findings and best practices with area businesses.

l) PRMC Clinically integrated network; Develop clinical integration including physician alignment and new partnerships.
   a. Independent and employed providers within the Primary and Secondary Service Areas

m) Cultivate an environment that encourages inquiry and innovation contributing to solutions, improvements and generalizable knowledge that positively impacts our community.
   a. Johns Hopkins Clinical Research Network
   b. Independent and employed providers within the Primary and Secondary Service Areas

6. **Describe the overall financial sustainability for major strategy:**
Current: a) Provision of diabetes awareness, education and management to the community will continue to be funded by PRMC. b) Reduce the proportion of children and adolescents who are considered obese – this set of initiatives will continue to be funded by PRMC. c) Chronic Disease Management; continued to be funded by PRMC d) Care Management; continued to be funded by PRMC
Future: (Grant and Strategic Intent) e-j) For all programs outlined under "e-j" the funding source will be as follows: i) Majority of funding for the programs "e-j" will be provided by the HSCRC grant upon receipt. Sustainable through a permanent rate adjustment for which those monies will be spent on population health activities ii) Through reduction of PAU's iii) Through the collection of fees such as TOC and CCM fees k) Health, Wellness and Chronic Disease Management Competencies i) Internally funded by PRMC l) Develop clinical integration including physician alignment and new partnerships i) Funded by MMSP/ACO achievements m) Cultivate an environment that encourages inquiry and innovation contributing to solutions, improvements and generalizable knowledge that positively impacts our community i) Partially funded by the Richard A. Henson Foundation and PRMC