

Executive Summary

Shore Region Health Strategic Transformation Plan:
University of Maryland Medical Center at Easton
University of Maryland Medical Center at Dorchester
University of Maryland Medical Center at Chestertown

As University of Maryland Shore Regional Health expands the regional health care network, we have explored and renewed our mission, vision and values to reflect a changing health care environment and our communities' needs. University of Maryland Shore Regional Health's Strategic Transformation Plan (STP) is consistent with the University of Maryland Medical System's (UMMS) larger strategic vision to create a population health management capability that will enable successful performance under value-based contracting arrangements. (*See* UMMS Population Health Strategy, Appendix 1). Additionally, the STP supports the efforts currently underway in Maryland, to strengthen primary care and coordinate hospital care with community care; map and track preventable disease and health costs; develop public-private coalitions for improved health outcomes; and establish Regional Partnerships.

A critical component of the plan is the collaboration between our hospitals and local public health agencies in the development of community health improvement strategies. Through external collaborations, Shore Regional Health (SRH) is working toward collectively solving the complex health and social problems that result in health inequities as evidenced in our Community Benefit Report and Community Health Needs Assessment. Shore Regional Health is increasingly aligning its community health and outreach planning with SHIP and LHIC plans. Leadership from SRH, University of Maryland Medical System, public health, and the communities are building on promising local strategies, including the Health Enterprise Zone model, and applying emerging tools and technologies to improve the delivery of health care.

All strategies support the goals to: (1) Build capacity; (2) Address health disparities and promote health equity; and (3) Reduce avoidable hospital utilization. The strategies focus on practical issues and the development of processes that are required for long-term successful collaboration with diverse stakeholders. Metrics have been developed for the activities described in the STP that are aligned with the State's All Payer Model. We are building appropriate discrete data capture tools to demonstrate cause/effect between various community programs and lower utilization of hospital resources. The financial sustainability of the STP is the expected savings driven by reduced admissions, readmissions, and potentially avoidable utilization. This is of particular importance in our rural service area, where broad dispersal of resources across numerous small-scale programs often results in limited results or sustainability.

University of Maryland Shore Regional Health's STP provides the framework for improved care coordination to improve care delivery for our community. Development of initiatives with key community partners is ongoing and the plan will continue to be updated to reflect progress and changes.

Hospital Strategic Transformation Plan

1. Describe your overall goals:

- Continue the transformation of our 3 hospitals: University of Maryland Medical Center at Easton; University of Maryland Medical Center at Dorchester; University of Maryland Medical Center at Chestertown into a regional health system, providing consistent, high-quality healthcare for the 5 counties of the Mid-Shore
- Transform our delivery models from a focus on inpatient care to a focus on building healthy communities through enhancing our outpatient services, our coordination with existing community health providers, and when needed, our direct coordination and management of the chronic care of our most complex patients.
- Reduce 30-day readmission rate by 10-12%, See Appendix 2

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):

1. **Organize and coordinate existing community services** including Shore Regional Health owned and private home health agencies, visiting nurse programs, community outreach programs, municipal and foundation grant-based patient support programs
2. Work with **skilled nursing facilities** to monitor and **reduce re-hospitalization** and enhance communication when hospital transfer is necessary
3. Develop a robust hospital operated, **discharge, chronic disease management and data coordination clinic**
4. Operationalize a hospital based **Bridge Clinic** to better manage patients being discharged from the inpatient **behavioral health** unit at UMSMC at Dorchester. The program supports the goal of reducing readmissions to the inpatient unit and emergency department due to long waits for psychiatric care from community.

Strategy 1. Coordination of Care with Post-acute Providers

3. Describe the specific target population for each major strategy:

The focus of our Care Transitions efforts involves supporting the improvement of quality, the reduction of expense and enhancement of the patient experience associated with improved organizational communication and collaboration with community based organizations/stakeholders. These efforts are currently and primarily focused on reducing readmissions to the hospitals.

The population of patients addressed is viewed across multiple variables. Two primary variables include Dx and Payer status.

Admit Dx/Primary:

Pulmonary	37%
Cardiac	23%
Gen Med/Other	19%
Kidney	7%
GI	6%
Uro	6%

Dx on Readmission/Primary:

Pulmonary	37%
Cardiac	22%
Gen Med/Other	20%
GI	8%
Kidney	7%
Uro	5%

Payer Mix

Medicare	65%
MA (all vendors)	10%
Commercial/Other	25%

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:

- Metrics: - Care coordination dashboard- Monthly report by compliance assistant which includes admission, discharge, Observation, Average LOS, skilled nursing, acute rehab, ALF, Home Health, Psych Hospital, Hospice referrals.
- See Table 1 for measures we are using to ascertain trends and impact of all of our readmission avoidance strategies.

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

1) Continuum of Care Committee

- Quarterly regional interagency committee originally developed by/chaired by UMSRH Care Coordination. Currently overseen by UMSRH Care Transitions.
- Serves as a quarterly forum for UMSRH to update or seek collaboration on health system changes or initiatives. Likewise serves as a means for other organizations to accomplish the same. Serves to be very effective enhancing communication; catalyzing coordination of efforts and prompting ideas/opportunities for shared success in effective and efficient care of persons served in the community

- Participants include representatives from UMSRH, Compass Regional Hospice, Coastal Hospice and Palliative Care, Talbot Hospice, SNF- Signature Health- Mallard Bay, Consulate Health Care- Envoy, Integrace- Bayleigh Chase, Genesis, Autumn Lake, Caroline Center, Heartfields of Easton, Maryland Access Point, Mid-Shore Mental Health, QA County Dept of Health, Talbot County Dept of Health, Talbot & Caroline Dept of Aging, Home Ports, Home Instead, Comfort Keepers, Amedysis Home Health, Home Call Home Health
- 2) Hospice and Palliative Care Committee
- Quarterly regional committee developed and overseen by UMSRH Care Transitions program
 - Serves as a reliable means to meet and discuss updates, changes, opportunities or issues that may arise regarding the hospice services and the provision of palliative care
 - Participants include representatives from UMSRH departments (Care Transitions; Palliative Care; Shore Home Care; Care Coordination; Shore Wellness Partners) and representatives from our three area hospice organizations
 - Talbot Hospice (Talbot County)
 - Compass Regional Hospice (Kent; Queen Anne's and Caroline Counties)
 - Coastal Hospice and Palliative Care (Dorchester County)
- 3) Ad Hoc – Ongoing UMSRH Care Transitions Program / Agency Networking
- Ongoing 1:1 contacts and on site meetings to further engagement and collaboration; seek opportunities for interactions between leadership both organizational and medical/physician.
 - Care Coordination department and Care Transitions also work at times with AERS- County level- Adult evaluation/Review service- to help assess the population's needs for services; DSS- Dept. social services- assist pts with application for MA, which in turn helps with placement and long term care; Maryland Access Point- assists pts with Insurance needs, and ROI- assists pts with financial component of patient care.

6. Describe the overall financial sustainability plan for each major strategy:

The strategy is critical to achieving sufficient alignment of priorities and resources to produce and build upon improved outcomes. It is expected that participants in this program will have fewer ED visits, fewer admissions/observation cases and fewer hospital days. Avoiding hospitalization will also have an impact on patient charges to insurers. Future funding may come through the development of a Medicare Shared Savings.

Monitoring of success of the program is ongoing using the metrics described in Question 4

Strategy 2. Work with Skilled Nursing facilities to Monitor and Reduce Re-hospitalization

3. Describe the specific target population for each major strategy:

Population at risk for readmission from Skilled Nursing facility

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:

- Metrics: Measure 7 and 30-day readmission rate per Skilled Nursing facility.
Denominator- # of pts sent on index admission, numerator- # of pts readmitted.
- Metrics: - Care coordination dashboard- Monthly report by compliance assistant which includes admission, discharge, Observation, Average LOS, skilled nursing, acute rehab, ALF, Home Health, Psych Hospital, Hospice referrals.
- Metrics: Modified LACE scores- Done on Care Coordination admission assessment using base LACE assessment and adding Psycho-social, financial and co-morbidities as they describe our unique population of patients and their needs.
- Metrics: LACE Scores tracked post discharge using the High Risk daily huddle, to ensure that high risk 6 and above have a discharge plan that includes home visits of SNF placements (with pt.'s agreement and preference).
- See Table 1 for measures we are using to ascertain trends and impact of all of our readmission avoidance strategies.

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

Skilled Nursing Facility Consortium

- Monthly regional committee developed and overseen by UMSRH Care Transitions program
- Serves as a reliable means to meet and discuss updates, changes, opportunities or issues that may arise regarding the transitions in care; readmissions; other PAUs; required information exchanges e.g. MOLST, risk assessments; collaboratives on care management and avoiding hospital admissions e.g. Emergency Dept physicians and SNF physicians in event of SNF patient sent to UMSRH EDs
- Participants include representatives from UMSRH departments (Care Transitions; Care Coordination; Shore Home Care; Palliative Care; Shore Wellness Partners) and representatives from our area skilled nursing facilities
 - Integrate/ Bayleigh Chase (Talbot County)
 - Genesis/ The Pines (Talbot County)
 - Signature Health care / Mallard Bay (Dorchester County)
 - Genesis / Chesapeake Woods (Dorchester County)
 - Caroline Nursing and Rehabilitation Center (Caroline County)
 - Envoy of Denton (Caroline County)
 - Genesis / Corsica Hills (Queen Anne's County)
 - UM Shore Nursing and Rehabilitation Center (Kent County)
 - Autumn Lake Healthcare at Chestertown (Kent County)

6. Describe the overall financial sustainability plan for each major strategy:

Establishing the Skilled Nursing Facility Consortium is financially sustainable and is a necessary investment in the infrastructure that will support UMSRH Care Transitions/ Care Coordination, and area SNF's to discuss facility specific readmissions/return to the hospital. Financial incentives are contingent on:

- Review and Analysis i.e. reason and avoidable/non avoidable.
- Process improvement opportunities discussed as well as any possible immediate actions explored and implemented
- Serves as reliable medium to seek improvements in communication, care and preparation before discharge from the hospital
- Ongoing education on improvements, changes and trends that may influence performance and may be better addressed through collaborative follow-up action

It is expected this program will result in a reduction of patient transfers to the hospital, fewer ED visits, fewer admissions/observation cases, and fewer hospital days. Avoiding hospitalization will also have an impact on patient charges to insurers. Future funding may come through the development of a Medicare Shared Savings.

Monitoring of success of the program is ongoing using the metrics described in Question 4.

Strategy 3. Discharge, Chronic Disease Management and Data Coordination

3. Describe the specific target population for each major strategy:

- High utilizing patients who are not connected to ongoing primary care
- Chronically ill patients with typical, long standing combinations of diabetes, CHF, COPD, and/or kidney disease who are prescribed between 5 and 15 medications
- Rural patients with long travel times to care providers and who often do not have access to information technology resources
- Patients with sub-acute mental illness, social isolation, and/or limited family support who need assistance in making healthcare decisions that provide the best care in the best venue.

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:

We will be monitoring utilization rates and readmission rates in ER usage amongst patients receiving services from these various organizations. Thus, by building appropriate discrete data capture tools we will be able to know if there is an association between various community programs and lower utilization of hospital resources. This data is being captured in Midas through custom-designed forms specifically looking at what services the patients are using. This data will be reported from the discharge clinic to the utilization management committee and up through the performance management committee ultimately to senior leadership of the Board of Directors

- Data monitored monthly through measures using included patients as a measure of direct impact.
- Monitor readmission reports and PAU reporting as a measure of indirect impact
- Reported to UM committee, Performance improvement and to senior leadership
- Expect 6 to 12-month time to see significant system--wide impact
- Limited impact on the most expensive 10% will fall off denominator list through attrition
- This program will mitigate utilization of second and third deciles of highest utilizing patients (10-30% on the top 100 list)
- Included patients will be their own controls, will need to monitor screening and capture if impact on overall system measures is less than anticipated
- See Table 1 for measures we are using to ascertain trends and impact of all of our readmission avoidance strategies.

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

All of our strategies are part of a spectrum of discharge, follow-up, and readmission management. We are working with a variety of community and hospital partners including:

- Community physicians
- Shore Home Health
- Shore Wellness Partners
- Genesis Healthcare (and less formally with other SNFs in our community)
- Queen Anne County Department of Emergency Services – Mobile Integrated Community Health (MICH)
- Sante group – Eastern Shore Mobile Crisis

6. Describe the overall financial sustainability plan for each major strategy:

The chronic disease management program is expected to help patients maintain their health and avoid future hospital utilization. It is expected that participants in this program will have fewer ED visits, fewer admissions/observation cases and fewer hospital days. Avoiding hospitalization will also have an impact on patient charges to insurers. Future funding may come through the development of a Medicare Shared Savings.

Monitoring of success of the program is ongoing using the metrics described in Question 4.

Strategy 4. Shore Behavioral Health Services Bridge Clinic

3. Describe the specific target population for each major strategy:

The Bridge Clinic of Shore Behavioral Health (BH) will provide support services to patients who are being discharged from inpatient behavioral care at Shore Medical Center at Dorchester to the community.

BH is the leading product line of readmissions at SMC-D accounting for 19% of readmissions.

Nearly 29% of the FYTD readmissions to other hospitals that originate from SMC-D are from DRGs that would be considered BH or Substance Abuse (SA).

Admission Criteria includes:

A Shore Regional Health client who was recently discharged from behavioral health inpatient unit without timely access (within 10 days) to a provider of psychiatric care

- A behavioral health diagnosis,
- 18 years of age or older,
- A resident of Caroline, Dorchester, Kent, Queen Anne’s, or Talbot Counties

The number of clients served depends on the complexity and needs of the client.

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: See Table 1 for measures we are using to ascertain trends and impact of all of our readmission avoidance strategies.

The Bridge Clinic will seek to reduce readmissions to the behavioral health inpatient unit and return visits to the ED by 50%. Currently, there is on average a 6% readmission rate to behavioral health unit, or 3 patients per month. The rate of discharged behavioral health patients returning to the ED within 30 Days is 25%, or 13 patients per month and would be reduced to 12.5% or 6.5 patients per month in year one of the program.

See Table 1 for measures we are using to ascertain trends and impact of all of our readmission avoidance strategies.

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

Partner with community based providers to ensure appropriate continuity of care for patients. Community Partners:

- Marshy Hope
- Corsica River
- Community Behavioral Health
- For All Seasons

6. Describe the overall financial sustainability plan for each major strategy:

The program seeks sustainability through billing of therapy services and physician consultation dollars as well as an expected saving from a reduction in ED visits, and admissions. Establishing the Bridge Clinic when coupled with the Intensive Outpatient Program will provide a viable option to emergency department and inpatient psychiatric care. Financial incentives contingent on providing services through the Bridge Clinic are:

- Decreased avoidable readmissions by establishing goals of care, collaborating with outpatient services and community partners to increase timely referrals.
- Decreased ED visit and hospital admission costs.

Monitoring of success of the program is ongoing using the metrics described in Question 4.

Table 1:
Measures used to ascertain trends and the impact of all of readmission avoidance strategies.

	Measure	Numerator	Denominator	Source
1	Screening of Inpatients – identify initial target population			
2	% of inpatients with High or Mod risk by LACE per month	high or mod risk inpatients	all inpatients in the month	Case Mgmt Reports
3	<i>% of observation status patients with high or mod risk by LACE per month</i>	<i>high or mod risk obs patients</i>	<i>all obs patients in the month</i>	<i>Case Mgmt Reports</i>
4	<i>For patients screening +, hx of prior LACE scores</i>	<i>Trending or calculation?</i>		<i>DC clinic after action</i>
5	Success at initial follow up evaluation and plan for + screened patients			
6	<i>% of patients screening positive who were MOD or HIGH with phone contact</i>	<i>Pts referred for discharge clinic with only phone contact</i>	<i>Pts referred for discharge clinic</i>	<i>DC clinic after action</i>
7	<i>% of patients screening positive who were MOD or HIGH scheduled for an appointment</i>	<i>Pts referred for discharge clinic with in-person visit</i>	<i>Pts referred for discharge clinic</i>	<i>DC clinic after action</i>
8	% of patients who screen positive who complete initial appointment in person within 3-7 days of discharge	Pts referred for discharge clinic with in-person visit date of contact < 8 days from DC date	Pts referred for discharge clinic	DC clinic after action
9	<i>% of patients who screen positive who complete initial appointment over phone in 3-7 days of discharge</i>	<i>Pts referred for discharge clinic with phone contact date of contact < 8 days from DC date</i>	<i>Pts referred for discharge clinic</i>	<i>DC clinic after action</i>
10	% of patients refuse or no-show and why	Pts referred for discharge clinic who no show, refuse, or no contact	Pts referred for discharge clinic	DC clinic after action
	Clinical Outcomes from follow up visit			
11	% of patients receiving intervention from:			
12	Pharmacy	# receiving this service	Pts referred for discharge clinic	Will need check boxes on dc clinic after action
13	NP/Medical director	# receiving this service	Pts referred for discharge clinic	Will need check boxes on dc clinic after action
14	Social work	# receiving this service	Pts referred for discharge clinic	Will need check boxes on dc clinic after action
15	Further referral to SWP or HH or other community program	# receiving this service	Pts referred for discharge clinic	Will need check boxes on dc clinic after action

16	Communication and/or follow up with PCP	# receiving this service	Pts referred for discharge clinic	Will need check boxes on dc clinic after action
17	<i>Referral for new PCP</i>	<i># receiving this service</i>	Pts referred for discharge clinic	<i>Will need check boxes on dc clinic after action</i>
18	<i>30-day readmission rates and causes</i>	<i>Patients with FU clinic referral admitted back in <31 days</i>	Pts referred for discharge clinic	<i>CDCC event note</i>
19	<i>ER visit rates and causes</i>	<i>Patients with FU clinic referral to ER <31 days</i>	Pts referred for discharge clinic	<i>CDCC event note</i>
	<i>CDCC monitoring</i>			
20	<i>% patients that stay on CDCC monitoring</i>	<i>Pts kept for CDCC clinic</i>	Pts referred for discharge clinic	<i>CDCC Enrollment note</i>
21	<i>% of patients with chronic disease types</i>	<i>Categories of disease types</i>	Pts kept for CDCC clinic	<i>CDCC intake note</i>
22	CHF			
23	COPD			
24	DM			
25	Other social risk factors			
26	Number of contacts per patient	Contacts in system	Pts in CDCC clinic	CDCC event note
27	<i>ER visits 6 mos. prior to enrollment</i>	<i>ER visit in 6 mos. prior to CDCC enrollment</i>	<i>Pts in CDCC clinic</i>	<i>CDCC Admit note and CDCC event note</i>
28	<i>ER visits since enrollment – 6 mos. rolling</i>	<i>ER Visits</i>	<i>Pts in CDCC clinic</i>	<i>CDCC event note</i>
29	<i>Admits in 6 mos. prior to enrollment</i>	<i>Admits prior to enrollment</i>	<i>Pts in CDCC clinic</i>	<i>CDCC Admit note and CDCC event note</i>
30	<i>Admits since enrollment – 6 mos. rolling</i>	<i>Admits</i>	<i>Pts in CDCC clinic</i>	<i>CDCC event note</i>



UMMS Population Health Strategy

The University of Maryland Medical System (UMMS) is committed to transforming the current health care delivery system to better manage populations of patients, particularly those patients with multiple chronic diseases. In order to achieve this goal, UMMS has embarked on a two-pronged strategy focusing on inpatient medical management, a key driver of success under Global Budget Revenue, and the development of an ambulatory care network that engages community physicians.

Consistent with UMMS' mission and larger strategic vision, the system seeks to create a population health management capability that will enable it to successfully perform under value-based contracting arrangements (i.e., better patient experience, improved outcomes, reduced cost growth, and enhanced provider satisfaction) with various commercial, Medicaid, and Medicare Advantage payers. This vision includes the following:

- Enabling a significant and growing portion of system revenues to come from sustainable and mutually beneficial risk contracts.
- Operationalizing a high-performing population health management function (i.e., a Population Health Services Organization) and care delivery model that is all-payer and all-patient capable.
- Establishing an attractive and scalable physician clinical integration vehicle that can be systematically deployed across regions.

In implementing these strategies, UMMS has engaged two operating partners with expertise in successfully developing and implementing these types of programs – Davita HealthCare Partners and Lumeris.

Inpatient Medical Management

UMMS has engaged Davita HealthCare Partners (DHCP) to improve the inpatient medical management capabilities at each of the hospitals in the system. The goals of the engagement with DHCP are to:

- Improve the quality of care
- Improve patient satisfaction
- Reduce unnecessary admissions
- Reduce readmissions
- Reduce length of stay

UMMS' engagement with DHCP focuses on specific areas:

- Designing, developing, and enhancing hospitalist programs



- Designing, developing, and enhancing transitions of care programs. This includes developing collaborative programs with post-acute providers including Skilled Nursing Facilities, Home Health Programs, Hospices, and other providers.
- Enhancing UMMS' existing care management and discharge planning programs
- Identifying alternative sites of care for patients to utilize as an alternative to the emergency room or inpatient stays

Ambulatory care network

UMMS has engaged Lumeris as an operating partner to accelerate the transition from volume- to value-based care and deliver improved clinical and financial outcomes. With a combination of clinical, operational, and information technology expertise, Lumeris is partnering with UMMS to set up a Population Health Services Organization (PHSO) as a shared service within the organization.

The PHSO will provide services to the UMMS Quality Care Network, a Clinically Integrated Network of providers that have a shared responsibility for the care of a defined population of patients and can contract as one entity with payers.

A PHSO employs a portfolio of people, programs and interventions including but not limited to:

- Care managers deployed toward high risk individuals
- Transitions of care programs
- Dedicated programs for high risk patients
- Pharmacy and therapeutics management programs
- Patient engagement technologies
- Practice transformation
- Provider education, coaching, support, and information

The PHSO and its staff are enabled by robust technology that is focused on:

- Consolidating disparate data sources into a single source of truth about a patient
- Supporting deep analytics related to segmentation, utilization, costing, and expectations
- Enabling care management work flows by various care managers and affiliated providers
- Supporting active and sustainable financial management of affiliated risk bearing entities

Readmission Avoidance Activities



Blue = Planning Stages
Green = Implemented and/or monitoring
Orange = Active, working on improvements

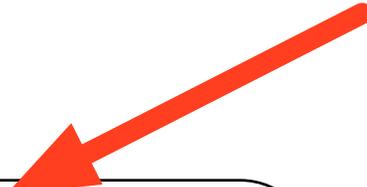
- Protocols
- SNF Relationships
- M.O.D

- Lace Screening
- High Risk Huddle

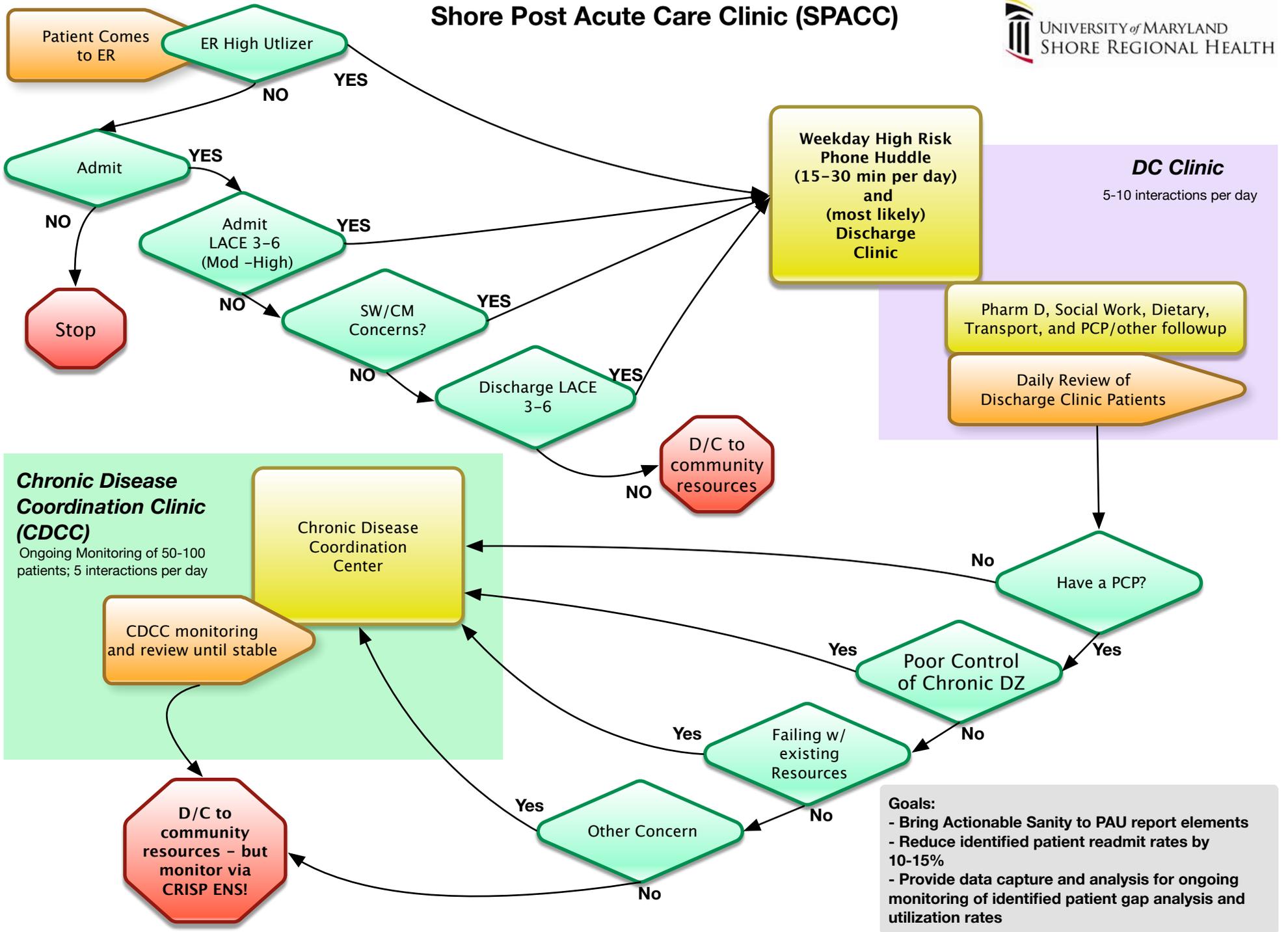
- D/C Documentation Tab
- Case Mgmt Rounds
- U.M./Throughput/
Discharge Committees

- SPACC
- Home Health & Rehab
- Shore Wellness Partners

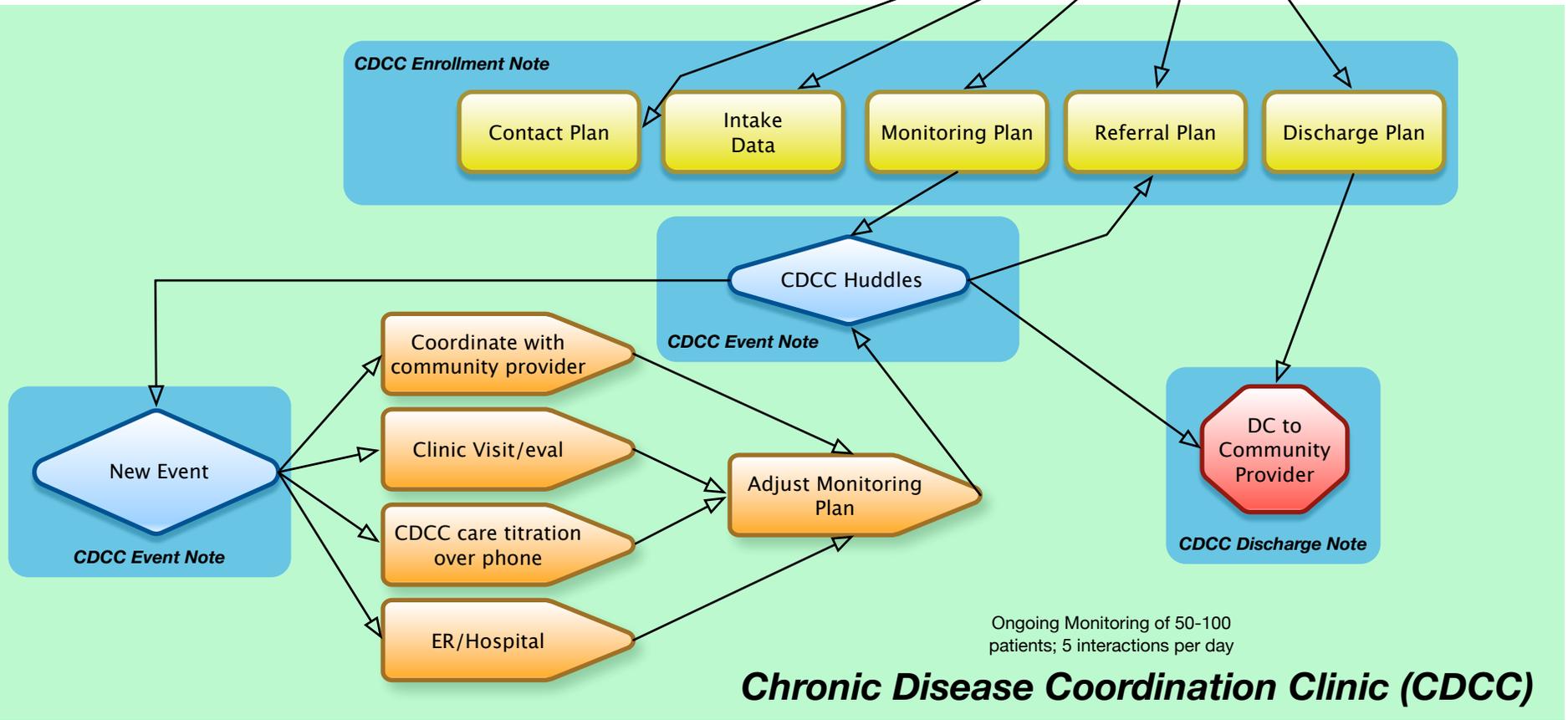
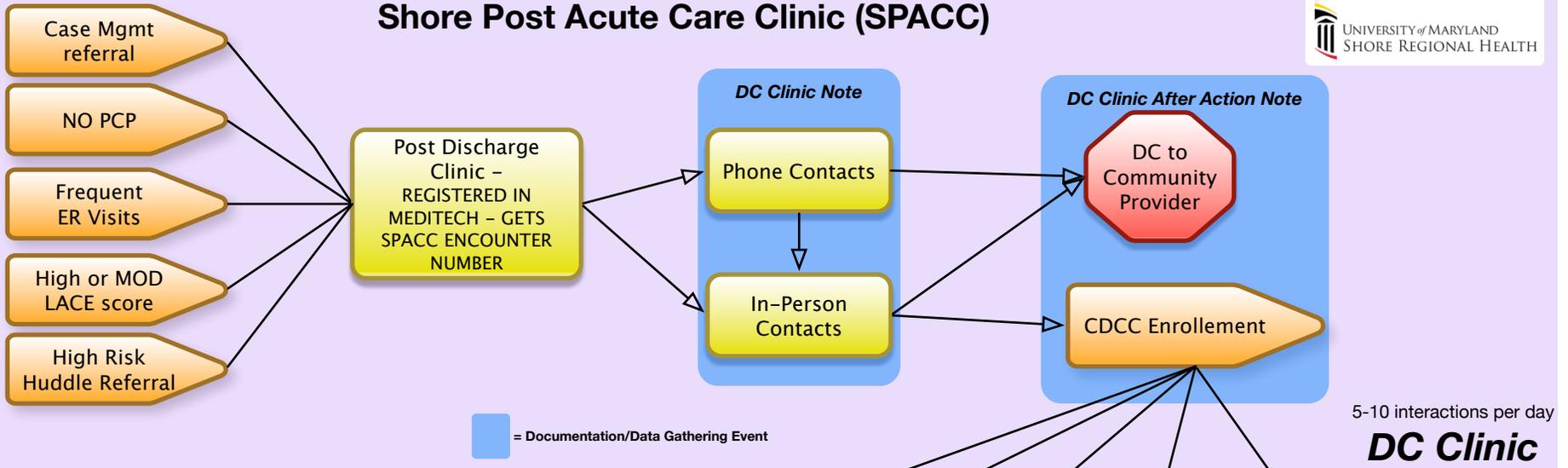
One piece of larger puzzle



Shore Post Acute Care Clinic (SPACC)



Shore Post Acute Care Clinic (SPACC)



Chronic Disease Coordination Clinic (CDCC) Monitoring and Event Detail

