Levindale Hebrew Geriatric Center and Hospital Strategic Transformation Plan

Year 1, CY2016

EXECUTIVE SUMMARY

Levindale Hebrew Geriatric Center and Hospital, as part of the LifeBridge Health system, embraces the core values of the Institute for Healthcare Improvement's Triple Aim: improving the patient experience, improving outcomes, and reducing potentially avoidable utilization.

LifeBridge Health's population health strategy is predicated on the provision and coordination of a full spectrum of health and wellness services across all care settings and throughout the care continuum, while integrating health care, public health activities, and addressing the social and environmental determinants of health. We are dedicated to improving the health of our communities while reducing our cost of care delivery by ensuring that patients are provided the right level of services based on acuity; improving access to preventive care, including primary and chronic care management; and enhancing community programs and social services connections in our community.

Our strategic transformation plan encompasses the following strategies: 1) Optimizing care coordination for high utilizers through a system-wide care coordination hub; 2) Providing intensive care coordination for complex patients at highest risk for readmission; 3) Strengthening primary care access and delivery; 4) Strengthening behavioral health care access and delivery; 5) Improving Chronic Disease Management; 6) Implementing Population Health Information System Solutions; 7) Advancing Clinical Integration; and 8) Ensuring Community Outreach, Education, and Programming.

We will be building upon our current efforts to address readmissions, high utilizers, access to primary care and chronic health care, and segmenting our population to provide targeted care models and goals. We will be focused on ensuring information exchange, analytics and patient-facing technology, and controlling the continuum of care through clinically integrated networks using team-based care models. Our model will include care navigators and social workers in addition to multi-disciplinary teams of clinicians, ensuring the maximum level of care using the lowest-cost provider. We are increasing our efforts around chronic disease management and increased access to primary care through partnerships with Federally-Qualified Health Centers and community clinics and we continue to enhance internal infrastructure and community connections to expand our palliative care program and support behavioral health. These efforts include leveraging telemedicine in order to expand access and provide needed behavioral health resources.

But we will not only address the health care needs of our communities. We have developed an extensive set of community initiatives that help our patients access care and services that support positive outcomes, and we are continually working to integrate community programs and partners to provide the most comprehensive and cost-effective set of resources for our neighborhoods. We will bolster our efforts around provision of care to our patients in our facilities and in their own homes through our expanded community health worker model.

All of our population health strategies focus on managing to better outcomes, improving access to primary care and subspecialty disease management, providing social services support, facilitating transition of patients to a primary care medical home, and engaging patients in understanding and accessing their health information in support of improved self-management.

In every program and initiative we are committed to developing measurable goals, measures of success, and re-evaluating outcomes, as they impact the three elements of the Triple Aim, in order to improve and track our success through measurable, pre-determined metrics.
Each of our strategies seeks to fill gaps identified in the current portfolio of services available to our neighborhoods; not duplicate available services provided by valued community partners.

In order to achieve savings goals, return on investment, and sustainability, LBH is committed to moving care from the expensive acute care setting into the community where primary care physicians (PCP's) can provide care that is appropriate for the patient. In doing so LBH will reduce PAU's and the impact will produce savings. Over time and as the subsequent populations are rolled into our initiatives and programs, further savings will be realized. We also expect that by putting services into the community, such as RN care managers and community health workers (CHW's), by placing social workers into primary care practices, and by moving towards PCMH accreditation, primary care physicians will have the additional time needed to ensure consistent care pathways and utilization of the chronic care management code. These additional activities, in concert with guaranteeing staff are functioning at the top of their license, further support financial sustainability.

At the core of population health is patient-centered care. But this means more than providing integrated medical care, behavioral health solutions, and social supports. Patient-centered-care requires us to identify barriers to good health and develop personalized solutions to break down those barriers. Our strategic transformation plan identifies these healthcare disparities in order to design programs that create positive change in people's lives and in the health of 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):*

Grant Specific Strategies:

In this first year and with the award of the Transformation Grant Northwest Hospital is focused on the following interventions:

1) **Optimizing care coordination for high utilizers through a system-wide care coordination hub:** Creating an integrated 24/7 call center staffed by nurses and care coordinators. Care Navigators will work with discharged patients to obtain appropriate follow up appointments, medications, and resources to manage their health. In addition, care navigators will proactively reach out to high utilizers, in order to address needs that could prevent an emergency room visit or inpatient stay. Expansion of staff to address these needs includes clinical pharmacists and nurse practitioners who will make rounds/home visits on frail patients who cannot leave their home environment for a primary care physician visit, connecting them with palliative support as needed. Integrating the ambulatory care coordination hub with inpatient and ED-based care management, and other care transition programs, is essential in order to ensure a seamless patient experience.
2) **Providing intensive care coordination for complex patients at highest risk for readmission**: Fully-implementing the LifeBridge Health Preferred Skilled Nursing Facilities (SNF) Network to reduce SNF's admissions and readmissions to LBH facilities and utilizing Post-Acute Physician Partners to assist Skilled Nursing Facilities in the care of high risk readmissions.
3) **Strengthening primary care access and delivery**: Embedding care coordinator resources in primary care practices. Care teams comprised of social workers, nurses, care navigators, community health workers, practice managers, and medical assistants will care for medically complex patients. These teams will be based in large practices with high volumes of complex patients, while smaller practices will share a team and resources allocated between the smaller practices in carefully coordinated fashion.
4) **Strengthening behavioral health care access and delivery**: Increasing the workforce of behavioral care clinicians and staff to provide direct care in the primary care setting and using screening tools to identify and refer patients to appropriate mental health specialty programs, including the use of depression screening tools in primary care practices with associated referral processes.

Other Strategies:

5) **Improving Chronic Disease Management:** Patients with chronic diseases such as CHF, COPD and Diabetes utilize a proportionally higher degree of health care resources, have higher potentially avoidable readmissions and form the highest risk groups for inferior, long -term outcomes. Development of chronic disease management strategies combines the approach for seamless transitions of care for acute episodes for these patients as well as development and implementation of evidence based pathways fostering self - management and wellness. Northwest Hospital is building a physical and strategic process

for management of chronic disease with integrated primary care and behavioral health. LifeBridge Health has implemented a CHF clinic at Sinai Hospital. The program will manage patients discharged from the ED and the inpatient units with acute episodes of severe CHF. Patients will be identified by a high risk algorithm and referred for CHF management by an NP/Cardiologist team for post-acute services as outpatients until they are stable. Communication will be real time with primary care providers and family as patients are transitioned back to the PCP upon improvement with a detailed plan of care. Similar programs are under development for COPD and Diabetes. For Diabetes, and in collaboration with the Lifebridgehealth Physician Network (LBPN), our partnered provider network, we are initiating a process to bring all of the PCP's towards a National Committee for Quality Assurance (NCQA) Diabetes Recognition Program. Population Health is working closely with the Quality subcommittee of LBPN to accomplish this goal in 2016. Additionally, we are currently designing and preparing to construct a multidisciplinary primary care and chronic disease management program with integrated behavioral health and wrap-around support services, enabling better patient access and economies of scale.

6) **Implementing Population Health Information System Solutions:** Through our Cerner Healthe Intent population health management platform including HealtheRecord and HealtheRegistries we will now have the capability to: a) Aggregate, normalize, and standardize data across multiple disparate sources, enabling advanced decision support, predictive algorithms, population identification, risk stratification, and advanced analytics; b) Track risk-based payer contract measure requirements and provide an overall view of how the organization is performing across various outcome measures including drill-down capabilities on a patient, practice, or population; c) Effectively identify, score and predict risks of individuals or populations, to allow targeted interventions and campaigns; d) Advance the transformation of the outpatient care management model for patient care and care coordination including Patient-Centered Medical Home (PCMH). The call center component of our grant application is integrated into our overall clinical call strategy which currently provides a) Capability to link primary care physicians in the community with hospitalists and others caring for the patient providing a warm handoff for patients and b) a patient call center to assist patients with high risk chronic conditions and help them navigate from the inpatient setting to home and other post-acute settings. The patient call center connects to the patient before leaving the acute care setting, assists in making appointments for follow up, identifies and helps resolve barriers for transportation, pharmacy needs, durable medical equipment deliveries and does follow up phone calls to confirm adherence to prescribed interventions and resolves questions/concerns. We are also piloting several patient-facing technology solutions that provide in-home monitoring for our high-risk patients. These tools will enable us to continue to maximize our systems to mine EHR, claims, and other data sources for high-risk and rising risk patients, resulting in improved care coordination, focused interventions, decreased readmissions, decreased PAU's for chronic diseases, increased provider to provider communication, and increased patient engagement.

7) **Advancing Clinical Integration**: Levindale, as part of LifeBridge Health, is working toward full clinical integration which requires a higher degree of collaboration, cooperation and mutual interdependence among all LifeBridge Health caregivers as well as other

independent and community providers. To foster this environment we have recently reorganized, creating a Vice President of Clinical Transformation who oversees population health, case management, and ambulatory and physician practice outcomes across the system. In addition, we have created a new system-wide Clinical Transformation Leadership Council to bring together physicians, clinicians, population health, quality, strategy and finance to optimize communication and participation. This infrastructure is integrated with the existing Population Health Steering Committee and sub-committee addressing Health Equity, a Readmissions Council, and our LifeBridge Physician Network (LBPN) which is a voluntary, physician-governed association of all care providers in, any way credentialed, in the LifeBridge Health system with the goals of creating better patient-centered, integrated care. Population Health and LBPN have many overlaps in committee membership and leadership to enhance integration of the Population Health Strategy in alignment with LBPN and network clinical practice.

8) **Ensuring continued and expanded community outreach, education, and programming:** As part of our overall population health strategy we will be expanding and integrating our existing community outreach programs and partnering with other entities to provide new services for our community.

Our outreach programs in the **M. Peter Moser Community Initiatives** Department are designed to attend to not only the health but also the social well-being of the people in our surrounding neighborhoods. The Diabetes Medical Home Extender program focuses on helping people with poorly controlled diabetes who live in the communities surrounding the hospital. Clients, who are identified during their inpatient stay, are then provided nursing and community health worker services in their homes post-hospitalization to connect with support services and receive education. **HIV Support Services** provides counseling, information & referrals to HIV+ men, women, children and youth receiving care at Sinai Hospital. Referrals of newly identified HIV+ individuals or patients who have been lost to care come from providers in the hospital's infectious disease specialty clinic or the OB/GYN service. Staff provide psychosocial assessment, supportive counseling, services coordination and home visiting. Our **Community Improvement Department** will provide expanded health education and screenings in addition to administering the **Changing Hearts Program**. This program is designed to help individuals understand their identified risk(s) for heart disease, demonstrate how to minimize/modify those risk factors, and provide education on how to maintain a healthy lifestyle to prevent heart disease. The **Changing Hearts Program** includes: heart health risk assessment, screenings, body composition analysis, health education counseling with a registered nurse, educational materials, follow-up calls and/or home visits with a CHW focusing on an individualized plan developed with participant, lifestyle classes to help maintain a long-term change, and web-based links to resources to improve cardiac health. Sinai Hospital and **Comprehensive Housing Assistance Inc.** (CHAI) have been awarded a grant from Civic Works to be a service site for the **Housing Upgrades to Benefit Seniors (HUBS)** initiative to serve older residents in the communities of northwest Baltimore City, a valuable program to many of Levindale's patients as well.

Finally, we are embarking on a new partnership and piloting the **Maryland Faith Community Health Network (MFCHN)** with **Maryland Health Care For All** and numerous faith communities. MFCHN is

designed to promote health, maximize enrollment in health care coverage and support Maryland's health care system transformation under the waiver. Through our efforts, we aim to serve hundreds of residents in the LifeBridge Health communities through their congregations and health care providers. Timely evaluation of our efforts will contribute to the professional knowledge base regarding potential impact of faith/health partnerships on promoting access to timely, primary care. This model is characterized by deep faith leader engagement and agreements between individual congregations and hospitals that commit to working with appointed congregation-based liaisons to support congregant network members and their caregiver(s) before, during and after a hospital stay. This project has garnered the attention of the **American Hospital Association's Health Research and Educational Trust and the Robert Wood Johnson Foundation through their Culture of Health Learning Collaborative**. LifeBridge Health has been identified as an industry leader that is taking an innovative approach to collaboration. LifeBridge Health will be participate in site visits and collaborative webinars to foster learning, networking and sharing of expertise and resources among other industry leaders participating in the collaborative. These learnings will inform case studies we will embed in a Roadmap Guide that provides resources for community partnerships. The Roadmap Guide will be a publicly available tool to help hospitals and community partners learn how to develop and implement effective partnerships.

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

Grant Specific:

1) Optimizing care coordination for high utilizers through a system-wide care coordination hub; 2) Providing intensive care coordination for complex patients at highest risk for readmission; 3) Strengthening primary care access and delivery; 4) Strengthening behavioral health care access and delivery:

Through data analysis 2,690 patients were identified as high utilizers who had 3 or more bedded encounters and 2 or more chronic conditions for all payers. The highest number of patients who were over-utilizers and high cost were Medicare patients. In the first year, LifeBridge Health plans to focus on the 1,256 Medicare high-utilizing patients, followed by 521 dual-eligible patients in CY 17 and 537 Medicaid patients in CY 2018. LifeBridge Health aims to directly impact at least 1,300 patients through the targeted interventions each year to ensure positive ROI for the related expenditures.

Other Populations:

5) **Improving Chronic Disease Management:** High risk patients with acute episodes of chronic disease. Additionally, hospital and community providers will refer patients with chronic disease for ongoing management.
6) **Implementing Population Health Information System Solutions:** All patients in our health care system and in our community.
7) **Advancing Clinical Integration:** All patients in our health care system and in our community
8) **Ensuring Community Outreach, Education, and Programming:**
   Patients who live in the primary service area and are diagnosed with diabetes, victims of domestic violence, adults with identified heart health risk factors who live in hospital's Community Benefit Service Area, all patients requiring health education resources, faith leaders and their congregants in the community seeking to provide enhanced care and education.

*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**:*

LifeBridge Health measures for population health will address improved and increased patient access to primary care, increased patient engagement and understanding of care, decreased inpatient utilization, decreased ED utilization, increased education on right level of care and specific disease management metrics, increased connections to community resources, and ultimately improved health indicators for specific diseases focusing on congestive heart failure, diabetes, COPD, asthma, and behavioral health, culminating in improved mortality rates for our community. We will use the following standardized Core Outcome Measures as proposed by the HSCRC to assess overall progress of each of the programs and will track Process Measures tailored to the identified population and specific program characteristics.

Core Outcome Measures:

- Total hospital cost per capita
- Total hospital admits per capita
- Total health care cost per person
- ED visits per capita
- Readmissions
- Potentially avoidable utilization
- Patient experience

Core Process Measures

- Completion of risk scoring upon admission
- Completion of Health Risk Assessment
- Contact from an assigned care manager or navigator
- Established longitudinal care plan
- Shared care profile
- Patient engagement survey for self-report to show if patient is more consistently able to understand disease/care for self after program intervention
- Patient connection to outpatient palliative care Nurse Practitioner
- Successful telephonic contacts with patients
- Within 48 hours of discharge, patients receiving follow up call for medication history, medication understanding, and medication access
- Patients with an identified primary care provider
- Patients proactively connected to a PCP with no prior acute hospitalization
- Patients connected to a PCP after an acute episode with an appointment scheduled
- Patients screened for depression in any setting
- Behavioral Health (BH) patients identified in acute setting and referred to a BH specialist/program
- BH patients proactively connected to a BH specialist or program with no prior acute hospitalization
- Subset of patients discharged to a skilled nursing facility (SNF) within the SNF Preferred Provider Network for whom an evidence-based handoff tool was used

Grant Specific Measures:

1) Optimizing care coordination for high utilizers through a system-wide care coordination

hub

- Use of Encounter Notification Alerts from CRISP
- Establish a longitudinal care plan
    - Use of the Shared Care Profile: CRISP
    - Portion of target population with contract from assigned CM

2) Provide intensive care coordination for complex patients at highest risk for readmission

- Portion of target population with contact from assigned Care Manager (CM) in PCP setting

3) Strengthen primary care access and delivery

- # of Patients successfully connected with PCP
- # of Patients connected with PCP within 3-5 post discharge from acute facility
- # of Patients receiving medication reconciliation 48 hours post discharge

4) Strengthen behavioral health care access and delivery

- # of Behavioral health patients connected to a BH specialty program
- # of Patients who have been screened for depression and notification of the CM or PCP with results of the screen.

Other Measures:

5) Improving Chronic Disease Management:

Improved patient satisfaction. Improved outcomes measured by disease specific indices (CHF-increase EF%, better weight management, exercise tolerance, COPD-Improved Peak flow, better exercise tolerance-, Diabetes- Reduction in HgbA1C, fewer hypoglycemic episodes, reduced BMI, eye and foot exams). Reduction of utilization of high acuity resources-- reduced readmissions in 30-90 days, reduction of ER or acute care visits, engagement with Subspecialists and PCP.

6) Implementing Population Health Information Systems Solutions

Cerner Healthe Intent will provide the information technology tool that enables a robust population health management program which is EMR-agnostic, will integrate with CRISP and other state-level solutions and will provide: 1) clinical decision support at the point of care supporting evidence-based best practices, 2) attribution and risk stratification for focused populations, 3) patient engagement, 4) analytics, reporting, and performance tracking including scorecards that track provider, provider group, hospital, and system population health interventions and measures, and 5) actionable registries for improved clinical outcomes (Diabetes, CHF and Adult Wellness registries, as well as IVD/CAD, Asthma, Hypertension, COPD, Atrial Fibrillation, Depression, Maternity Health, Pediatric Wellness, Senior Wellness).

7) Advancing Clinical Integration:

Using key quality metrics to improve the care for patients to increase efficiency of services provided while decreasing overall costs to the health system. One intended outcome is increased patient engagement through knowledge assessments pre/post testing, and biometric changes assessed through group sessions for Diabetes specific programming. The vehicle of group sessions has proven to show better patient accountability and reliability in improving disease management. Other measures to be tracked include: increased provider engagement and access to patient-centered approach care coordination, increased patient

access through in-network referrals, increased appointment availability, increased patient satisfaction, as well as increased patient record visibility across the state of Maryland leading to better care coordination and communication among providers.

8) Ensuring Community Outreach, Education, and Programming:

- Reduction in inpatient admissions (Diabetes Medical Home Extender (DMHE) program showed a 68% reduction for the 100 active clients involved in the program after 90 days of program participation).
- Improved self-management behaviors
- Improved support services awareness
- Reduction in hospitalizations
- Reduction in ED visits
- Reduction in Hospital readmissions
- Improved patient experience

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

Grant Specific Partners:

Access Carroll: Founded in 2005, Access Carroll (AC), Inc. is a joint venture between Carroll Hospital, the Carroll County Health Department and the Partnership for a Healthier Carroll County, Inc. An NCQA-recognized PCMH, Access Carroll provides free medical and dental care to uninsured, low-income Carroll County residents who meet certain eligibility requirements, 80% of whom have three or more chronic diseases. Through its affiliation with Carroll Hospital, services provided include laboratory testing, imaging studies and patient education and a high quality alternative to overuse of the ED. Over 1,200 patients were referred to Access Carroll by various Carroll providers in FY15, of which 855 became new patients.

The Partnership for a Healthier Carroll County: Recognizing the growing importance of helping people better manage their health and stay well, together with the Carroll County Health Department, Carroll Hospital created the Partnership for a Healthier Carroll County in 1999. The Partnership identifies population health needs in the county and develops unique approaches to meet those needs by collaborating with a network of local agencies.

Community Health Partnership of Baltimore: LBH (through Sinai Hospital) has partnered with Johns Hopkins in its proposal for a regional collaborative of six Baltimore City hospitals to address the challenge of shared patients. LBH has committed to share programs, experiences, and data through this collaborative with the goal of developing a regional approach to an all-payer all-population care coordination strategy. The members of the collaborative have agreed to identify strategies to appropriately care for and manage shared patients. Outcomes will include a shared dashboard, and shared care planning templates housed in CRISP. In addition, this partnership has created alignment strategies around shared high-utilizer patients, risk assessments and care plans, and analytics. LBH will work to ensure care coordination and efficiencies for each of its hospitals for all shared patients, regardless of geographic location.

Chase Brexton Healthcare: local FQHC and receiving agency for referrals for primary care. Chase Brexton has already engaged LBH in the process of linking High Utilizer patients in the inpatient and ER acute care settings at Northwest Hospital without a designated PCP to a PCP within Chase Brexton. Chase Brexton has agreed to initiate plans to integrate Chronic Disease Management and

Behavioral Health for the patients in their system that are utilizers of LBH acute care settings with the processes outlined in this application.
Home Care Maryland: Home care agency in the portfolio of LifeBridge Health partnerships
Baltimore City Health Department: Agreeing not to duplicate efforts, LifeBridge Health intends to work in collaboration with the Baltimore City Health Department to support systems and behavioral health resources, and acknowledge that LBH will work to fill gaps in care.
Other Partners:
Maryland Health Care for All : partnering through the Maryland Faith Community Network to provide post-discharge social support to LBH patients through faith network.
American Hospital Association's Health Research and Educational Trust and the Robert Wood Johnson Foundation through their Culture of Health Learning Collaborative will highlight LifeBridge Health's work in innovative community partnerships.

*6. Describe the overall financial sustainability plan **for each major strategy:***
For the Grant Specific Plan:
Levindale Hebrew Geriatric Center and Hospital is committed to moving care from the expensive acute care setting into the community where primary care physicians can provide care that is appropriate for the patient. In doing so LBH will reduce PAU's and the impact will produce savings for the Medicare payer. Over time and as the subsequent populations are rolled into the program this will produce further savings to Medicaid and eventually to all payers. Through the grant funding as a permanent GBR adjustment the right sizing of the population and the activities around the high utilizing population we expect an ROI greater than 1, and as such we plan to reinvest those dollars into expanding the population health activities to the next level of high utilizers. We also expect that by putting services into the community, such as RN care managers and community health workers (CHW's), by placing social workers into primary care practices, and by moving towards PCMH accreditation, primary care physicians will have the additional time needed to ensure consistent care pathways and utilization of the chronic care management code for Medicare Patients. These additional activities, in concert with guaranteeing staff are functioning at the top of their license, further support financial sustainability.
Other Strategies Plan:
Levindale Hebrew Geriatric Center and Hospital is committed to moving care from the expensive acute care setting into the community where primary care physicians can provide care that is appropriate for the patient. In doing so LBH will reduce PAU's and the impact will produce savings. Over time and as the subsequent populations are rolled into our initiatives and programs further savings will be realized. We also expect that by putting services into the community, such as RN care managers and community health workers (CHW's), by placing social workers into primary care practices, and by moving towards PCMH accreditation, primary care physicians will have the additional time needed to ensure consistent care pathways and utilization of the chronic care management code. These additional activities, in concert with guaranteeing staff are functioning at the top of their license, further support financial sustainability.