University of Maryland Charles Regional Medical Center
Strategic Hospital Transformation Plan

Overall Goal and Executive Summary

Consistent with Maryland's new Medicare waiver, the overall goal of the University of Maryland Charles Regional Medical Center's (UM CRMC) Strategic Hospital Transformation Plan is to achieve the "Triple Aim" in Charles County. The "Triple Aim" has been defined by the Institute for Healthcare Improvement (IHI) as follows:

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.

IHI's innovation team has developed a concept design and described an initial set of components of a system that would fulfill the Triple Aim, including:

- Focus on individuals and families
- Redesign of primary care services and structures
- Population health management
- Cost control platform
- System integration and execution

Accomplishing the Triple Aim will require a major paradigm shift as we move from silos of care to population health. This shift in health care delivery will involve caring for patients in a more holistic manner while being sensitive to cultural diversity, disparities in care, and the growing population of vulnerable seniors.

To improve population health, Charles County needs more primary care, more specialty care, more patient education and support related to managing health, more prevention, and more care coordination. It will take a proactive approach with community partners to design programs to help individuals with preventable complications avoid unnecessary hospitalization. With this population health approach, the goals of reducing readmissions and preventing potentially avoidable utilization can be attainable. The targets to keep clearly in focus are assuring patients get the right care, in the right setting, at the right time and at the least appropriate cost.

Overall metrics of success include:

- Reductions in total hospital costs per capita
- Reductions in total hospital admissions per capita
- Reductions in Emergency Department visits per capita
- Reductions in all cause 30-day readmissions
- Reductions in potentially avoidable utilization
- Improvements in composite quality measure
- Improvements in HCAHPS scores

Integration With Community Resources

Strategy # 1: **Further integrate community resources and advance the existing collaboration with the Partnership for a Healthier Charles County, the county's local health coalition, in order to jointly address identified health needs and more effectively implement the Charles County Health Improvement Plan.**
Target Population: The target population of the Partnership for a Healthier Charles County includes all of the residents of Charles County. Based upon the latest health needs assessment, the Partnership's Health Improvement Plan is focusing on three critical areas: • Chronic Diseases Prevention and Management • Access To Care • Behavioral Health (Mental Health and Substance Abuse)
Metrics: Metrics being used be the Partnership to measure success in Charles County include: • Increase the percentages of adults who are at a healthy weight from 27.9% to 28.5% by 2017. • Decrease the percentage of residents 13-18 who are obese from 12.3% to 11.3%. • Reduce diabetes emergency department visits from 208.7 per 100,000 to the Maryland rate of 205.0 per 100,000. • Reduce hypertension emergency department visits from 308.1 per 100,000 to 305.0 per 100,000. • Decrease the colon and rectal cancer mortality rate from 19.4 per 100,000 to 18.0 per 100,000. • Increase the number physicians by 7 providers. • Reduce the preventable hospital stay rate from 71 per 1,000 Medicare enrollees to 69 per 1,000 enrollees. • Reduce mental health emergency visits from 3,045.8 per 100,000 to 3015 per 100,000. • Reduce addictions-related emergency department visits from 1200.4 per 100,000 to 1188 per 100,000.
Partners: The Executive and Steering Committees of the Partnership include UM CRMC, the Charles County Department of Health, the Charles County Public Schools and the College of Southern Maryland. The Partnership was formed in 1994 and has been guiding population health initiatives in the County since that time. Membership in the Partnership is made up of more than 30 non-profit and county health providing organizations and community support groups.
Financial Sustainability: The Partnership for a Healthier Charles County is a financially sustainable organization. Annual support from UM CRMC for FY 2016 is estimated at $60,000.

Strategy # 2: **Expand collaborative and innovative efforts across the care continuum with our community partners in the Transition Care Coalition.** The Transition Case Managers recognized a need for better care coordination to help reduce readmissions and avoidable utilization and formed a Care Transition Coalition in March 2013. The mission behind this coalition is to foster a smooth transition in care from the hospital back to the community to ultimately increase quality of care while decreasing hospital readmissions, avoidable emergency department utilization and other episodic care. The goal of care coordination is to make sure our community's needs are understood, that a process is in place to develop action plans, and that there is good communication between healthcare teams across the continuum of healthcare services.
Target Population: The target populations for the Transition Care Coalition are high risk patients with chronic diseases, including diabetes, COPD, CHF, pneumonia, sepsis and renal failure.
Metrics: Measures of success will include improvements in Prevention Quality Indicators (PQI) and reductions in all cause 30-day readmissions and emergency department visits and revisits.
Partners: The Transition Care Coalition is sponsored by UM CRMC and currently consists of 106 active members representing over 40 community partner agencies. These include both health and social services agencies serving Charles County and adjacent jurisdictions.
Financial Sustainability: Costs of the Transition Care Coalition are approximately $5,000 annually for collateral materials and refreshments.

Strategy # 3: **Establish a new Population Health Department to coordinate population health initiatives, improve data analysis and implement this Strategic Hospital Transformation Plan.** One of UM CRMC's key strategic initiatives for meeting the Triple Aim in Charles County is to create a new Population Health Department. The new department will guide ongoing collaborative efforts with our partners, engage in further planning and policy development, and broadly focus on health promotion, disease prevention and chronic disease management. Building this new Population Health Department will involve creating a new manager position of 1.0 FTE who will spearhead the implementation of this Strategic Hospital Transition Plan. Midas is a clinical information database system that has been implemented across the University of Maryland Medical System and CRISP is the statewide health information exchange. The ability to make better use of the extensive information contained in Midas and CRISP has been identified as a critical need by both the Case Management and Performance Improvement departments in order to monitor and measure the impact of various quality and population health initiatives. To that end, UM CRMC intends to recruit an experienced Systems Analyst to join its new Population Health Department.

Target Population: Given its broad mandate to help improve population health, the target population for the new Population Health Department is the entire population in Charles County.
Metrics: All of the metrics identified in this Strategic Hospital Transformation Plan will be under the purview of the new Population Health Department.
Partners: The new Manager of Population Health will coordinate efforts with all of UM CRMC's partners. The new Systems Analyst will also work with our partners at Midas and CRISP.
Financial Sustainability: The estimated incremental cost of the new Population Health Department is approximately $200,000 annually, in addition to existing staffing costs of $225,000 annually.

Chronic Disease Supports

Strategy # 4: **Continue to offer chronic disease support programs.**

UM CRMC has implemented several chronic disease support programs including the Better Breathers Club and the Healthier Hearts Club. The target populations for these two programs include patients with Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF).

Distribution of needed medical equipment began with a partnership with CCS Medical. As a result of this partnership, glucometers are distributed to all patients with diabetes needing a monitoring device. Through a grant from CareFirst to the CRMC Foundation, scales are also being distributed to the financially compromised CHF patients. A goal for 2016 is to add Blood Pressure monitoring devices to the list of distributed items for patients with hypertension. Assuring that patients with chronic disease have the necessary equipment for self-monitoring empowers this population to manage their health and better collaborate with the medical team for care.

In partnership with the Charles County Department of Health, the Transition Case Managers are utilizing Self-Management Plan Referrals to connect patients with chronic diseases of hypertension, obesity, and/or diabetes with resources in the community, appropriate education, and follow-up calls for the Health Department at 3, 6, and 9 months. This new initiative started in October, 2015.

In January 2016, Charles County is beginning 6 week courses on Chronic Disease Self-Management. The location of the first set of classes will be at UM CRMC and then efforts are planned to extend to other locations to be more embedded in our community, including faith based organizations.

Target Population: Patients with chronic diseases are the target population for these initiatives.
Metrics: Reductions in readmissions and emergency visits for patients enrolled in the programs.

Partners: Initial staff training for the Better Breathers Club was provided by the American Lung Association. The Healthier Hearts Club also partners with The Heart Center of Southern Maryland, a local cardiology group, As noted above, UM CRMC partners with the Health Department on the Self-Management Plan Referral program and Charles County on community education. It also partnered with CCS Medical.
Financial Sustainability: The projected cost of these initiatives is $35,000 to $50,000 annually.

Strategy # 5: **Develop an inpatient wound prevention and treatment program.** UM CRMC has recently expanded its highly successful outpatient wound healing program to the inpatient setting in partnership with its vendor Healogics. Given its award winning outpatient program, UM CRMC is serving as a "Beta Site" for the development of Healogics' new inpatient program. The new inpatient program is designed to train and support our staff and providers in the care and management of wounds and other skin related conditions; as well as prevent the development of hospital acquired wounds.
Target Population: Healogics, the national leader in outpatient wound care services, is developing a new evidenced-based, comprehensive practice model to deliver consistent, high quality results to hospitalized patients at risk or requiring treatment of a wound.
Metrics: Metrics for success of the inpatient wound program include reductions in hospital associated wounds and reductions in lengths of stay for patients with wounds.
Partners: As discussed above, our partner for this strategy is Healogics. Staff of the Center for Wound Healing is also initiating collaborative efforts to improve wound care at a local nursing home (Sagepoint) as a pilot project that may be expanded to the remaining nursing home partners..
Financial Sustainability: The annual cost of the inpatient wound initiative is approximately $135,000.

Strategy # 6: **Develop a Diabetes Self-Management program.** Diabetes is rampant in Charles County, but the necessary resources to care for patients are in short supply. According to the latest community health needs assessment, the prevalence of Diabetes has risen from 8.1% in 2012 to 12.4% in 2015. Diabetes is also a major issue for the African-American population in Charles County. To help address the issue, UM CRMC plans to develop a comprehensive, American Diabetes Association (ADA) or American Association of Diabetes Educators (AADE) recognized disease management program to reduce the risks and complications of people with diabetes.
Target Population: The Diabetes Self-Management program will serve diabetic patients referred from UM CRMC, as well as from community physicians.
Metrics: Metrics will include reductions in admissions, readmissions and emergency department visits for diabetic complications.
Partners: UM CRMC is developing its new Diabetes Self-Management program in collaboration with the Partnership for a Healthier Charles County's Chronic Disease Prevention and Management

team.

Financial Sustainability: The cost of starting this new program is estimated to be $100,000. The program should become financially self-sustaining since ADA/AADE recognized Diabetes Self-Management Training programs qualify for payment by Medicare and other insurance programs.

Strategy # 7: **Develop a Palliative Care program at UM CRMC.**

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten nor postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help families cope during the patients illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counseling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Target Population: Patients with chronic disease needing symptom management.

Metrics: Measures for success of the palliative care program include reductions in 30-day all cause readmissions, reductions in Emergency Department revisits, and improvements in HCAHP scores.

Partners: UM CRMC is evaluating how best to partner with existing Palliative Care programs within UMMS, our hospitalist group (MDICS) and Hospice of Charles County.

Financial Sustainability: UM CRMC is actively recruiting for Palliative Care providers: Physician, Nurse Practitioners or Physician Assistants to start up a palliative care program. Start-up costs are estimated at $200,000.

Long Term and Post-Acute Care Integration And Coordination

Strategy # 8: **Continue to coordinate with and support the initiatives to reduce unnecessary utilization launched by UM CRMC's hospitalist group (MDICS) and emergency physician group (EMA).**

In coordination with UM CRMC, the hospitalist group (MDICS) and the emergency physician group (EMA) have developed a strategic alliance to improve patient care and reduce readmissions and potentially avoidable utilization. This strategic alliance includes a nursing home component

since MDICS also provides physician staffing at all four nursing homes in Charles County. In addition, these efforts are being supported by the Transition Case Managers who meet monthly with representatives of the four (4) nursing homes in Charles County.

MDICS cares for the vast majority of inpatients and observation patients at UM CRMC. They conduct post-discharge telephone calls to all of their patients. Those patients requiring additional clinical support are referred to the Transition Case Managers for follow-up.

A possible new initiative involves discussions with EMA to support their interest in providing Charles County's homebound population with primary care at their assisted living facility or in their home. EMA recently purchased Capitol Coordinated Care and is branching into other counties in Maryland to provide needed MD, NP/PA in-home healthcare services.

Target Populations: Target populations include nursing home patients, assisted living residents, and the home-bound patients.

Metrics: Measures of success will include improvements in Prevention Quality Indicators (PQI) and reductions in all cause 30 readmissions and emergency department revisits.

Partners: Partners include MDICS (hospitalist group) and EMA (emergency provider group), as well as local nursing homes and assisted living facilities.

***Financial Sustainability*:** These initiatives by MDICS and EMA should be financially sustainable through professional fee billings.

Strategy # 9: **Develop a Transition Care Clinic for post-discharge patients to improve care transitions back to their community providers, as well as reduce readmissions and potentially avoidable utilization.**

Many post-discharge patients at high risk for readmission are unable to schedule appropriate follow-up care in a timely manner due to the pronounced shortage of primary and specialty physicians in Charles County. The Transition Care Clinic will provide needed follow-up care for up to 30-days until the patient can be transitioned back to community providers.

Target Populations: The target population of the new Transition Care Clinic will be patients identified by the Transition Case Managers as being at high risk of readmission. To accomplish such identification, the Transition Case Managers use an internally developed re-hospitalization risk assessment tool. The Transition Case Managers are currently trialing the LACE tool for possible use.

Metrics: The specific metrics used in measuring the success of the Post-Acute Discharge Clinic will include the number of patients being identified and referred, the time it takes them to receive care, as well as reductions in 30-day all cause readmissions.

Partners: In coordination with the other hospitals in the UMMS system, UM CRMC is planning to start a new Transition Care Clinic. (Additional information about UMMS approach to population health is presented under Exhibit I). Other partners working on this initiative include our hospitalist group (MDICS) and our emergency physician group (EMA).

Financial Sustainability: The estimated start-up cost of the new Post-Acute Discharge clinic is $200,000. Over time, financial support for the Transition Care Clinic should decline due to professional fee billings.

Physical and Behavioral Health Integration and Coordination

Strategy # 10: Continue to work collaboratively with Calvert Memorial Hospital and the Partnership for a Healthier Charles County to address the behavioral health needs of Charles County.

Since UM CRMC does not have an inpatient behavioral health service, it contracts with Calvert Memorial Hospital for psychiatric social workers to provide coverage in the Emergency Department and consultation on the inpatient units. Furthermore, it is a priority objective of the Partnership for a Healthier Charles County and its Behavioral Health team to reduce mental health and substance abuse emergency department visits.

To augment the work of an existing Emergency Department Case Manager, UM CRMC is adding a new Social Worker to the staff in the Emergency Department. This new position is presently being recruited as a high priority. The new position will allow for expansion of efforts with the high-utilizer population whose need for care is often influenced by social determinants and/or behavioral health disorders.

The heroin epidemic has hit Charles County hard. Through the Partnership for a Healthier Charles County's Behavioral Health Team, a total of 31 law enforcement officers from the Charles County Sherriff's Office and the La Plata Police Department were trained in Naloxone distribution on June 25 and 26, 2015. An additional 25 officers were trained on July 16, 2015.

The Partnership's Behavioral Health Team will also train staff at UM CRMC's Emergency Department in SBIRT (Screening, Brief Interventions and Referral to Treatment) for patients with substance use problems. The team also plans to offer a CME program for community physicians on SBIRT.

Target Population: The target population for these initiatives is patients with behavioral health disorders.

Metrics: Measures of success will include reductions in mental health and addictions-related Emergency Department visits.

Partners: As discussed above, UM CRMC's partners include Calvert Memorial Hospital and the Partnership for a Healthier Charles County. In addition, UM CRMC partners with local EMS and

law enforcement in addressing behavioral health issues.
Financial Sustainability: The annual cost of the behavioral health coverage agreement with Calvert Memorial Hospital is approximately $270,000. While this coverage expense is a cost of doing business, it is still a significant amount. The expansion in the Emergency Department of one Social Worker FTE is estimated to cost $85,000.

Primary Care and Specialty Support

Strategy # 11: **Develop a new primary care group serving Charles County in collaboration with UM Community Medical Group.** The lack of primary care physicians in Charles County is a major obstacle to improving the population's health. In large part, the shortage of physicians is fostered and exacerbated by a physician fee schedule differential of 10% to 15% between the three Southern Maryland counties and surrounding jurisdictions. The development of a new primary care group in collaboration with the University of Maryland Community Medical Group is a major initiative will take multiple years to fully complete.
Target Population: The target population will be patients with inadequate access to a primary care physician in Charles County.
Metrics: Success will be measured by the number of primary care physicians recruited, as well as reductions in unnecessary hospital utilization.
Partners: UM CRMC is collaborating with the University of Maryland Community Medical Group, to develop a new primary care practice in Charles County. .
Financial Sustainability: UM CRMC, in collaboration with the University of Maryland Community Medical Group, is undertaking the business planning necessary to start a new primary care practice to begin addressing the shortage of primary care physicians. Capital costs and start-up/ongoing operating losses are yet to be finalized, but will be substantial.

Strategy # 12: **Leverage the relationship with the University of Maryland Medical School to bring faculty specialists to Charles County.** The lack of specialty providers in Charles County is also a significant issue. UM CRMC is currently working to bring faculty specialists from the University of Maryland Medical Center to Charles County, including Vascular Surgeons to provided vascular specialty support to patients at the Wound Healing Center and Pediatric Cardiologists to support the newborn nursery, as well as colo-rectal surgeons, thoracic surgeons, and the kidney transplant surgeons. Additional specialists needed in the community include psychiatrists, endocrinologists, pulmonologists, neurologists, and infectious disease physicians. To accommodate these specialists, and future expansion of specialty

services, UM CRMC will need to secure appropriated office space in Charles County. The Charles Regional Foundation owns a vacant office with 1800 square feet that will be renovated and equipped for them, followed by the execution of fair market value time-share leases.
Target Populations: The target populations include patients requiring specialty care.
Metrics: Success will be measured by the number of faculty specialists recruited to Charles County.
Partners: UM CRMC's partners in this initiative are faculty from the University of Maryland School of Medicine.
Financial Sustainability: The estimated capital cost of renovating and equipping office space to improve the availability of specialty physicians in Charles County is $250,000. This is only an initial investment toward a larger, long term effort.

Case Management And Other Supports For High Needs and Complex Patients

Strategy # 13: Continue to develop case management and other supports to improve population health coordination and better manage patients with complex conditions. Under its new Global Budget Revenue (GBR) agreement, UM CRMC added staff to create a Transition Case Management Program, which is currently staffed with 1.5 FTEs of RN Case Managers experienced in caring for complex hospital patients and assessing their post-acute care needs. This additional staffing allows for comprehensive care coordination, as well as effective community-based education and follow-up care for patients with chronic illness. To further expand this effort, it is expected that additional staff will be recruited over the next 6-12 months, the skills-mix of whom is currently under evaluation. The Transition Case Managers, ED Case Manager, and their department Manager are members of the Health Connections Tri-County Care Coordination Coalition. This coalition aligns effort of Calvert, Charles and St. Mary's counties in population health and readmission reduction. Quarterly meetings are held to discuss best practices for the similar populations served in each of these counties. One such initiative is the Neighborhood Wellness Advocates program that has shown itself to be an important component of population health intervention with social determinants of health. This model is under consideration for expanding into Charles County through a partnership with the Health Department under a Mobile Integrated Healthcare structure, and with Case Management being an integral referral source for appropriate high-risk patients for these services.
Target Populations: Staff of the Transitional Case Management Program focus their efforts on patients with complex chronic conditions who are at high risk for readmission.
Metrics: Measure of success for the program include reductions in readmissions to achieve HSCRC targets.
Partners: As noted previously, the Transition Case Managers started and work closely with the Transition Care Coalition which includes 106 active members representing over 40 community

partner agencies.
Financial Sustainability: The cost of the Transitional Case Management staff which has been added to date is approximately $200,000 annually.

Episode Improvements, Including Quality and Efficiency Improvements

Strategy # 14: **Continue to develop and implement evidence-based best practices to improve the quality and efficiency of episodic care.** Another aspect of the strategic alliance between MDICS and EMA has been the implementation of evidence based best practices at UM CRMC. These evidence best practice initiatives have included: • A sepsis initiative that was awarded the Maryland Patient Safety Center's Minogue Award in 2014. This sepsis protocol is currently being expanded state-wide. • A low risk chest pain pathway to redirect such patients from the ED / inpatient care to a local cardiology practice with the appropriate follow-up appointments secured prior to discharge. • A new protocol for managing patients with deep vein thrombosis (DVT) on an outpatient basis. As part of system-wide Clinical Performance Councils, UM CRMC participates in physician led works groups focusing on Emergency Medicine, Maternal/Child Health, Sepsis, and Joint Replacement Surgery.
Target Populations: Target populations include patients with sepsis, chest pain and deep vein thrombosis (DVT). In addition, target populations involve patients needing Emergency care, Obstetrics, and Joint Replacement Surgery.
Metrics: Metrics for success will include improved patient care and reduced utilization and costs.
Partners: UM CRMC's partners include MDICS, EMA, the medical staff and UMMS in implementing evidenced-based clinical best practices.
Financial Sustainability: These initiatives to implement evidence-based best practices are financially sustainable since they are under the auspices of MDICS, EMA and UMMS.

Clinical Consolidation And Modernization To Improve Quality and Efficiency

Strategy # 15: Reduce lower acuity Emergency Department visits by opening a new Urgent Care Center immediately adjacent to UM CRMC.

Given the shortage of primary and specialty physicians in Charles County, UM CRMC's Emergency Department treats too many patients who could be seen in a lower acuity setting. To help address this issue, UM CRMC opened a new Urgent Care Center (UCC) immediately adjacent to the Hospital's campus on September 14, 2015.

Patient volumes have been steadily ramping up. During the eighth week of operation the new UCC treated an average of 35 patients per day. For October 2015, Emergency Department utilization decreased by 400 visits from October 2014, while the UCC treated 845 patients in October. This is the first time in many years that UM CRMC's ED has not experienced growth.

Target Populations: Target populations include patients with minor illnesses and injuries.

Metrics: Metrics for success of the new Urgent Care Center include patient volumes, profitability, and reductions in lower acuity patients treated in the Emergency Department.

Partners: The new UCC has been developed in collaboration with the emergency physician group (EMA) which is staffing it.

Financial Sustainability: The capital costs associated with this project were $385,000. Start-up operating losses projected for the first 12 months of operations are projected to be $600,000. Over time, the new Urgent CC should become financially sustainable through professional fee billings.

Improving The Patient Experience

Strategy # 16: Continue to improve the Patient Experience at UM CRMC as measured by HCAHPS.

Like many hospitals in Maryland, UM CRMC has not performed well on HCAHPS. According to CMS, "public reporting of the survey results is designed to create incentives for hospitals to improve quality of care." That is, HCAHPS do not simply measure patient satisfaction, but is actually a substantive measure of patient care quality and efficiency.

Target Populations: While the target population is inpatients, outpatients, and emergency patients at UM CRMC, improvement of their experience will also require targeting additional staff training.

Metrics: Metrics for success include increasing the percentage of patients rating their experience as a 9 or 10 on HCAHPS surveys.

Partners: To improve the patient experience, UM CRMC and UMMS are partnering with Press Ganey.

Financial Sustainability: Training costs for the phases is estimated as $50,000. Such training costs will need to be sustained over time.

Exhibit 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