Appendix A:
Executive Summary and Hospital Strategic Transformation Plan Format
Union Hospital of Cecil County
12/7/15

Executive Summary

The state's readmission rate remains high, but there has been significant improvement in hospital acquired conditions and other quality measures. Driven by these results, both CMS and the HSCRC will accelerate the movement towards population health delivery and associated payment models. The traditional drivers of merger, access to capital and competitive pressure, are being replaced by the need for scale to create an integrated provider network and the clinical, administrative and information technology (IT) platform needed for population health.

Union Hospital is currently building its population health infrastructure to support its community and those communities that could benefit from a regional approach to health care delivery. Union Hospital's 2016 Strategic Plan is organized around three mutually supportive competencies that support improvement in patient outcomes, enhance seamless clinical communication, and support patients in their own environment. These competencies are:

- Clinical Integration
- Operational Effectiveness
- Population Health

The implementation of Union's clinical integration and population health tactics become more complex in this regionally enhanced health care delivery environment. Union must determine the proper balance between internally developed competencies and those that could be provided by one (or more) system/payor partners through participation in their network. Union Hospital's operational effectiveness will be critical to success in fixed budget or at risk reimbursement models. The ability to optimize the use of Union Hospital's physical, human and financial resources is a strategic priority. It will be achieved through continuous process improvement, partnership/merger to achieve scale and, most importantly, through enhancements in clinical quality.

Union Hospital Strategic Transformation Plan

1. Describe your overall goals:
   - **A. Clinical Integration.** The achievement of clinical integration requires changes in organizational structure, governance, and most importantly provider culture to achieve care that is safe, timely, effective, efficient, and patient and family focused.
   - **B. Operational Effectiveness.** This is the capacity of Union Hospital to achieve its mission through the optimum use of physical and human resources. During the term of this plan, the reimbursement environment will move from a global budget system to a model based on total cost of care. Investments in population health resources and information technology will be substantial. Expectations for quality, evidence-based care delivery will increase and at-risk payment models will proliferate. Union Hospital needs "high reliability" quality improvement processes, a more structured approach to resource allocation, accurate real time performance data, and a supportive organizational culture.
   - **C. Population Health.** Population Health is an approach to health care delivery that focuses on the improvement of the health of a population. A population can be defined geographically (Cecil County) or as the sum of multiple subsets (patients with diabetes, at the end of life, or with behavioral health disorders). Population health is based on disease prevention and early intervention.

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):

   A. Clinical Integration

   Strategy 1. Development of a portfolio of quality and financial alignment strategies with physicians to enhance clinical outcomes, improve patient satisfaction, and reduce cost of care.

   B. Operational Effectiveness

   Strategy 1. Using a Lean approach and organization accountability improvement structures, address major processes critical to organizational success.

   Strategy 2. Establish an enhanced process to review clinical products, contracts, equipment, and technology for their efficacy, safety, and impact on organizational resources.

   Strategy 3. Create a benchmark "Culture of Patient Safety" where the patient and family experience is enhanced at Union Hospital through an organization-wide, long term leadership and staff commitment. Success will be measured using objective data and "Culture of Patient Safety" survey results.

   C. Population Health

   Strategy 1. Develop or acquire the infrastructure needed to identify, prioritize and monitor targeted populations

   Strategy 2. Develop an ambulatory care management system in collaboration with other providers

   Strategy 3. Develop/adopt a risk stratification tool to help measure effectiveness of interventions for targeted populations

   Strategy 4. Develop community wellness and health literacy programs

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

A. Clinical Integration

Union Hospital, in collaboration with University of Maryland Medical System (UMMS), will partner with its community providers in establishing a Clinically Integrated Network (CIN). This is defined as a network of physicians, and other provider organizations, that have shared responsibility for the care of a defined population of patients and can contract as one entity with third party payors in risk-based ventures. The CIN will include both employed and independent providers who will develop unified approaches to care delivery, on a local and regional level, utilizing expanded care management programs and IT platforms.

B. Operational Effectiveness

For Strategies 1 and 3, Union Hospital will work with patients who need care, but do not need to be admitted to the hospital; patients and family in order to help improve communication and involvement in the discharge plan; and primary care physicians, hospital and practice staff, and other staff as needed in order to provide a personal handoff describing the plan from the provider/staff that cared for the patient. Identification using criteria and the expeditious treatment of the patient populations will decrease potentially avoidable utilization (PAU). For Strategy 2, Union hospital will work with hospital leadership and vendors.

C. Population Health

For Strategies 1-3, Union Hospital will work with high-utilizer, Medicare patients, as well as other high-utilizer patient populations. Union Hospital will work in partnership with Upper Chesapeake Health through the HSCRC Regional Transformation Grant partnership to develop CRISP capabilities, which will allow partners to identify and track high-utilizer, Medicare patients. Other grant interventions, like the use of community care teams including the deployment of community health workers and the use of emergency medical services for transport and field triage, will assist partners (hospitals, health departments, community services, etc.) in targeting community resources toward the high-utilizer, Medicare patients to provide assistance throughout the continuum of care.

For Strategy 4, Union Hospital will work with the general public and its own employee base in order to assist them in learning how to stay healthy. To facilitate a concerted wellness effort, Union Hospital will work with community programming.

4. Describe the specific metrics that will be used to measure progress **for each major strategy**:

A. Clinical Integration

Union Hospital will hold physicians accountable for improvement of clinical outcomes, reducing the cost of care, and improving patient satisfaction. Metrics have not yet been developed for this strategy; however, those that are chosen will provide insight into utilization of outpatient and ambulatory care services so that physicians can be held accountable for appropriate care coordination.

Some examples of metrics for improving clinical outcomes and reducing the cost of care could be measuring the:

a) Number of ancillary tests performed
b) Use of Encounter Notification System (ENS)
c) Number of unique Cecil County residents accessing ambulatory services
d) Analysis of impact on local community health data studied through the Community Health Needs Assessment annual update

An example of a metric for improving patient satisfaction could be the:

a) Analysis of improvements in the NRC Picker (National Research Corporation) patient satisfaction scores for outpatient/ambulatory care

B. Operational Effectiveness

For Strategy 1, Union Hospital will measure components necessary to address overutilization of the emergency department (ED), a key factor in determining accountability and which is critical to organizational success. Therefore the hospital will measure:

a) Number of unique Cecil County residents accessing ambulatory services;
b) Number of ED visits per capita;
c) Number of readmissions; and
d) PAU.

Given that there are disease burdens or illnesses that account for high rates of readmissions, Union Hospital will analyze the above components and compare them to local community health data, drawing linkages to determine what, if any, impact there is on the county's community health profile over time.

Union Hospital will measure how processes cultivate a "Culture of Safety" for patients. Strategy 2 discusses enhancing the review of clinical products, contracts, equipment and technology for their impact on safety and organizational resources; while Strategy 3 looks at impact on staff and leadership commitment to patient safety, including the patient and family experience. Both strategies reflect the importance of patient comfort and satisfaction, which can be measured by analyzing the patient experience. A tool to enhance the patient safety will include measuring the use and efficacy of the shared care profile among health care providers and community service supports. Looking at the bigger picture, Union Hospital will measure patient safety against total health care cost per person, number of ED visits per capita, PAU (specific to MHACs), and the use of ENS.

C. Population Health

Union Hospital will measure impact of the development of infrastructure needed to identify, prioritize, and monitor targeted patient populations (Strategy 1), to include the development of an ambulatory care management system in collaboration with other providers (Strategy 2). Macro-level analysis for both strategies will allow Union Hospital to measure impact according to the number of ED visits per capita and the number of readmissions. Union Hospital will also measure fluctuations in the number of unique Cecil County residents accessing ambulatory services, since the hospital will be assessing how built infrastructure affects utilization, especially when broken-out by disease burden or illness (diagnosis on admission/readmission) and access points within and external to the hospital system (ED, urgent care, etc.). Looking at overall impact on the community the hospital will analyze local community health data to determine if impact has occurred on health outcomes and the reduction of overutilization of the ED and number of readmissions. These macro-level metrics can also be tied back into the analysis of PAU.

Micro-level analysis will be conducted through measurement of:

a) The appropriate usage of the ENS (applicable to both strategies);
b) The portion of the target population with contact from an assigned care manager (Strategy 2); and
c) Effectiveness of shared care profiles shared between organizations (Strategy 2).

The micro-level metrics support provider accountability as it relates to effective care coordination. Assumption: Enhanced built infrastructure will improve the patient experience (measuring patient satisfaction could be applied to both strategies).

Creating a standardized approach for risk stratification of patients (Strategy 3) will allow Union Hospital to assess its real impact on patient health – answering the question: are people moving from higher risk to lower risk because of interventions tailored to fit their needs or targeted toward certain health aspects of their population? Metrics that will assist the hospital in answering this question are:

a) Analyzing impact on total hospital admits per capita, number of ED visits per capita, and number of readmissions;
b) PAU;
c) Impact of established longitudinal care plans and shared care profiles between applicable organizations; and
d) Portion of target population with contact from an assigned care manager (analyzing impact of care transitions).

For Strategy 4, Union Hospital will measure the effectiveness of community wellness and health literacy programs. On a macro-level, and to ascertain the impact of built infrastructure on access to wellness initiatives, Union Hospital will measure the number of unique Cecil County residents that access ambulatory services as an important determinant of efficacy of programming.

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

A. Clinical Integration

Union Hospital currently has an affiliation with UMMS where UMMS is providing a level of strategic oversight in several areas of hospital operations and patient care. Union Hospital utilizes this support to enhance clinical integration and to support its employed physician practices and the community physician practices in order to enhance clinical outcomes, improve patient satisfaction, and reduce the cost of care (Strategy 1).

B. Operational Effectiveness

Several partners assist Union Hospital in enhancing operational effectiveness. UMMS and DaVita HealthCare Partners are integral to operational effectiveness, especially for Strategy 1 (using organizational accountability to facilitate organizational success) and Strategy 3 (creating a benchmark "Culture of Patient Safety"). Strategy 1 also utilizes the relationships with Union Hospital's medical staff, made up of employed and contracted physicians (like the Montgomery Emergency Physicians that staff Union Hospital's ED and urgent care centers), as well as those community physicians with privileges. A supported medical staff is integral to organizational success, and with a cohesive medical staff, the hospital can provide more effective, qualitative, and efficient health care. Much like clinical integration, operational effectiveness, more specifically organizational accountability and success, hinges on relationships facilitated outside the hospital. An example is the relationship with the local skilled nursing facilities (SNFs), where Union Hospital works diligently to enhance and improve care transitions and identify gaps in care, PAU (including readmissions), and appropriate facility-to-community connectedness.

Through Strategy 2 (establishing an enhanced process to review clinical products, contracts, equipment and technology for their efficacy and safety), Union Hospital benefits from several data-supported partnerships that: enhance operational effectiveness through management of information security (Free State); enable telehealth monitoring (AT&T and Vivify), tracking, monitoring, and interpreting big data (CRISP); manage effective and efficient claims denials and appeals (UR Solutions); and access actionable data, best practices and cost reduction strategies through an alliance of nationwide hospitals (Premier Inc.). Strategy 3 (creating a benchmark "Culture of Patient Safety") is also supported through the Premier Inc. partnership.

C. Population Health

Union Hospital will work with several partners for Strategy 1 (develop an infrastructure needed to identify, prioritize, and monitor targeted populations), Strategy 2 (develop an ambulatory care management system in collaboration with other providers), Strategy 3 (develop/adopt a risk stratification tool to help measure effectiveness of interventions for targeted populations), and Strategy 4 (develop community wellness and health literacy programs). A common partner for all four strategies will be the Cecil County Health Department which provides support on all levels of care coordination and patient supports, including building services in the community in collaboration with Union

Hospital. The health department is also an integral partner in the conduction of the Community Health Needs Assessment and Community Health Improvement Plan, especially in its role as main support for the Cecil County Local Health Improvement Coalition.

For Strategy 1, Union Hospital will also utilize the relationships from CRISP and Premier Inc.

For Strategy 2, Union Hospital will utilize DaVita HealthCare Partners. DaVita provides consultative support to achieve better coordination of care and improved patient outcomes through care management, the reduction of hospital readmissions, and care transitions. These aspects are all integral to the development of an ambulatory care management system. This is an important partnership because the focused care coordination environment that is created connects the hospital's internal care practices with its external partners in care coordination. Some examples of these external partners include:

a) *The Interagency Council*. Made up of care support teams/staff from the Cecil County Health Department, the Department of Community Services, including the Adult Disability Resource Center and Elkton Senior Center, the Department of Social Services, SNFs, and a variety of other local non-profits, agencies, and medical facilities. The Interagency Council meets to discuss intensive/complex community care patents/clients, connecting them with appropriate resources according to care plans.
b) *SNFs – Calvert Manor, Transitions, and Laurelwood.* Union Hospital works with the SNFs to enhance and improve care transitions between organizations.
c) *City Pharmacy.* This locally owned pharmacy partners with the hospital for patient medication support programs, like the Community Assisted Medication Program (CAMP) for patients with financial need and the Bedside Medication Delivery Program where patients receive medications before they are discharged (to enhance transitions from the hospital to the community).

For Strategy 2, Union Hospital will utilize its contractual partners:

a) *Montgomery Emergency Physicians (MEP).* Union Hospital contracts with MEP to facilitate care in two of its urgent care centers as part of its ambulatory care profile.
b) *UMMS Thoracic Surgery Group.* Union Hospital contracts with this group to provide thoracic surgery access in Cecil County.

For Strategy 2, Union Hospital will utilize AT&T and Vivify for telehealth monitoring interventions. AT&T provides the blue tooth-enabled equipment and the cellular connection needed to facilitate telehealth monitoring for high-utilizer patients with COPD, CHF, Diabetes, and Hypertension. Vivify is the secure cloud-based application that connects to Union Hospital's outpatient and inpatient EMRs to facilitate the tether between the patient and the provider for effective care management.

Finally, for Strategy 2, Union Hospital will utilize the partners described above, but also the relationships that are currently being cultivated through the HSCRC's Regional Transformation Grant partnership between Union Hospital and UMMS' Upper

Chesapeake Health. The grant supports interventions to regionally reduce readmissions and improve care management in the community for high-utilizer, Medicare patients that access both Union Hospital and Upper Chesapeake Health. This grant is integral to the success of Strategies 1-4. Grant partners include:

a) Harford County and Cecil County Health Departments
b) Department of Aging in Harford County
c) Department of Community Services in Cecil County
d) Hart-to-Heart Transportation
e) Harford County Emergency Medical Services
f) Lorien Health (Harford County SNF)
g) Beacon/West Cecil Health Center (FQHC)
h) Amedysis (home health)
i) Representatives from the Regional Behavioral Health Collaborative, LLC (Union Hospital/UMMS-Upper Chesapeake)
j) Local Health Improvement Coalitions (Healthy Harford and Cecil County's Coalition)
k) CRISP
l) Med Chi
m) Health Management Associates

For Strategy 3, Union Hospital will utilize internal partners to develop/adopt the risk stratification tool, including DaVita HealthCare Services. Internal departments that will be consulted include: case management, nursing, pharmacy, the ED, and the multi-specialty practices. Once the tool is implemented, the hospital will work with external partners, like community agencies, the health department, departments of social and community services, emergency medical services (and others) to see that its implementation is effective.

For Strategy 4, Union Hospital will utilize support from: 1) the hospital Employee Wellness Program, which facilitates internal wellness initiatives through its partner Lifework Solutions (personal employee wellness tracking with wellness coach support); and 2) the Community Benefits program, which facilitates external community health programs in partnership with a variety of community partners, through program development and shared programming support. Shared programming support refers to Union Hospital making referrals to community health programs or working together with community organizations to facilitate access to care, care coordination efforts, health education, and other assistance, especially among the most vulnerable and underserved in the community.

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

The financial sustainability plan is supported primarily by the TPR incentive built permanently into rates to support the investments listed in the table below. This emphasizes Union Hospital's ability to use the TPR funds for investments integral to the success of the Triple AIM and not strictly for the operational needs of the organization. The investments in the table below show that Union Hospital's operations are shifting in focus from solely inpatient care to patient care that is managed across the care continuum, including more consistent integration and coordination of community supports.

Investments that Union Hospital will use to fund supports for the strategies of clinical integration (CI), operational effectiveness (OE), and population health (PH) are categorized according to the following (in the table below):

1. Patient centered investments;
2. Provider/care team investments; and
3. Health information technology to support patient and/or provider investments.

The table below links the investment categories and their annual costs to the applicable Union Hospital Strategic Transformation Plan strategies:

Investment Category	Investment	Annual Cost	Strategy
1	Discharge Follow-up Phone call	$62,104	PH – Strategy 1-3
1	Behavioral health counselor in Union Primary Care practices	$50,000	PH – Strategy 1, 2
1	Home Visit Program	$238,909	PH – Strategy 1-3
1	Pulmonary Rehab	$96,137	PH – Strategy 1-3
1	Employee wellness	$166,830	PH – Strategy 3-4
1	Bariatric program	$202,157	PH – Strategy 1-3
1	Palliative care program	$187,548	PH – Strategy 1-3
1	Centralized scheduling	$237,559	OE – Strategy 1-4
1	Thoracic clinic	$50,000	PH – Strategy 1-3
1	Low dose lung CT Coordinator (0.25 FTE)	$25,000	PH – Strategy 1, 2
1	Cardiology clinic	$50,000	PH – Strategy 1-3
1	Behavioral health collaboration (0.5 FTE & 2, 0.25 FTE)	$52,657.18	PH – Strategy 1-3
2	Case managers in the ED	$212,701	OE – Strategy 1; PH – Strategy 3
2	Surgical PA	$117,482	OE – Strategy 1
2	Clinical integration with medical staff	$100,000	CI – Strategy 1; OE –Strategy 1-4; PH – Strategy 2, 3
2	Medical staff development	$10,376,016	OE –Strategy 1-4; PH – Strategy 3
3	DHIN	$260,000	CI – Strategy 1; OE – Strategy 3; PH – Strategy 1, 2

3	CRISP	$65,000	CI – Strategy 1; OE – Strategy 3; PH – Strategy 1, 2
3	HIS – 2 FTE support	$160,000	OE – Strategy 1, 2; PH – Strategy 1
3	Redundant Fiber – Windstream	$36,000	OE – Strategy 1, 2; PH – Strategy 1
3	Telehealth pilot with AT&T	$3,987	PH – Strategy 1-3

The total amount to be invested for financial sustainability for Fiscal Year 2016 will be $12,750,087.18.