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Garrett Regional Medical Center

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HSCRC Hospital Strategic Transformation Plan Submission

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**Executive Summary**

In alignment with the State of Maryland’s goals to transform the approach to chronic disease management through cogent, community-wide care coordination, Garrett Regional Medical Center (GRMC) will implement programmatic initiatives to improve chronic care management and improve the overall health of the population served by the facility. GRMC will be investing in collaborative relationships with providers, community agencies, and other health care related services to deliver a model of improved care coordination to the community. As the State of Maryland moves forward with health system reforms that lower cost and improve access to care, GRMC will focus on building collaborative efforts to care for those patients with chronic health conditions in the community. GRMC has been serving the region since 1950 as the sole community acute-care hospital in the area and is a resilent partner, engaged in care coordination improvement, reducing in-patient utilization, and reducing readmissions. Through adoption of the CMS triple aims, GRMC will work with the State of Maryland to strengthen healthcare access and transition to meet the new paradigm of healthcare delivery for the residents of the region. GRMC will call its endeavor *The Well Patient Program* to reinforce patient engagement toward wellness and remove negative connotations for people that have a greater need for active social workers in their care processes.

GRMC’s Mission is to promote the health of the regional community and provide safe, high-quality care and health services for patients. The hospital’s vision is outlined below:

Garrett Regional Medical Center

* Will be viewed as the healthcare provider of choice in the region and be recognized for excellence in delivering safe patient care, exceeding the expectations of those we serve
* Will be recognized as a collaborative community leader, partner and resource,

striving to proactively respond to the health and wellness needs of the region.

GRMC collaborates with the Garrett County Health Department (GCHD) in the development of the Community Health Needs Assessment and incorporates that information into the Hospital’s strategic planning process. The Hospital’s Board of Governors’ Strategic Planning Committee obtains multi-agency input and includes the GCHD members on the committee. The GRMC Board of Governors includes six seats out of fifteen from county elected officials and a seventh seat is held by the President of the Town Council for the town of Oakland, Maryland. The remaining Board members are community constituents.

GRMC also regularly meets and collaborates in community-wide Performance Improvement initiatives with organizations including the Western Maryland Accountable Care Organization (ACO), the GCHD, Garrett County Community Action Committee, Western Maryland Area Health Education Center (WMAHEC), Garrett County Health Planning Council, the American Cancer Society, the Federally Qualified Health Center (FQHC) and West Virginia University. GRMC continually interacts to collect and provide feedback about methods for development of initiatives and improvement of current endeavors.

The last community-wide health needs assessment was conducted in 2012, and one is currently in process. The results of this assessment demonstrated that many residents in the hospital service area suffer from chronic disease conditions that can be managed through chronic care coordination including cancer, heart disease, lung disease, mental health conditions, and diabetes. GRMC will focus efforts on these chronic disease conditions to help patients receive care in the most appropriate, effective and efficient setting.

GRMC will be implementing several initiatives in the short and long term to strengthen the community primary care base and coordinate care to improve patient outcomes. These initiatives include the implementation of the hospital based *Well Patient Program* with a nurse navigator, telemedicine services, information technology purchases to share information among providers, and outreach services to community agencies for care coordination, collaboration and outcomes tracking. GRMC has already started some of the groundwork for these initiatives including meeting with various stakeholders in the community to organize the structure of this collaboration and researching of best practices toward care coordination.

These initiatives align with the State of Maryland’s plan for healthcare transformation. The All-Payer Model supports the basis of chronic disease management and care. GRMC will align with the State of Maryland’s goal to improve care coordination and disease management across all settings.

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| **Hospital Strategic Transformation Plan** |
| 1. Describe your overall goals:   Goal 1: To improve care coordination for chronic disease conditions in the region over the next twelve months as measured by referrals to the *Well Patient Program* and decreased readmissions to the facility.  Goal 2: To decrease the Potentially Avoidable Utilization rate at GRMC from our current rate of 10.7%.  Goal 3: To develop a program to manage patients in the appropriate care setting for their health care needs as evidenced in decreased hospital inpatient utilization for chronic diseases. |
| 1. List the overall major strategies (3-10) that will be pursued by your hospital individually or in collaboration with partners (and answer question 3-6 below for each of the major strategies listed here):   Strategy 1: Implementation of the *Well Patient Program* at GRMC to ensure patients receive care in the appropriate care setting and to foster patient engagement in a proactive manner.  Strategy 2: Implementation of a nurse navigator program for coordination of chronic care services and complex needs for residents in the hospital service area.  Strategy 3: Implementation of telemedicine services for neurology services and behavioral health services to create access to care and coordinate outpatient care for this group of patients.  Strategy 4: Implementation of an information technology platform to assist with care plan development and collaboration with local primary care providers and community agencies.  Strategy 5: Implementation of a daily multidisciplinary care plan meeting with all disciplines to coordinate inpatient care and the utilization of a social worker to coordinate post discharge care that facilitates patient engagement and supports patients to return to healthy activities of normal daily living. |
| 1. Describe the specific target population for each major strategy:   Strategy 1: Target population will be identified as the high utilizers of hospital based services.  Strategy 2: Target population will be those patients living with chronic diseases or complex care needs.  Strategy 3: Target population will be those patients in the hospital service area who present with acute neurological conditions or behavioral health needs that may not have access to specialty care locally but can receive services via telemedicine.  Strategy 4: Target population is all inpatients admitted to the facility to help coordinate their care in the post-hospital setting.  Strategy 5: Target population is all inpatients admitted to the facility to coordinate their care post-discharge to the appropriate community agencies or long term care facilities. |
| 1. Describe the specific metrics that will be used to measure progress including patient satisfaction, quality, outcomes, process and cost metrics for each major strategy:   Strategy 1: Metrics include ED visits per 6 months, Potentially Avoidable Utilization (PAU) Rate, Readmission Rate, and percentage of high utilizer patients enrolled in the *Well Patient Program,* internal data tracking and PAU charges.  Strategy 2: Metrics include Potentially Avoidable Utilization Rate, Readmission Rate, ED visits per 6 months, PAU charges, and Total Health Care Cost per beneficiary.  Strategy 3: Metrics include number of telemedicine consults, Shared Care Profile with percentage of patients that have shared care plans with a telemedicine provider, patient satisfaction level with telemedicine consult.  Strategy 4: Metrics include number of primary care providers that are interfaced into care plan program, Encounter Notification Alerts  Strategy 5: Metrics include number of referrals to community agencies for care coordination, Readmission rates, and PAU rate. |
| 1. List other participants and describe how other partners are working with you on each specific major strategy:   Strategy 1: The Patient Care Management department at GRMC will lead the *Well Patient Program.* Community participants in the *Well Patient Program* will include the Garrett County Health Department for Home Health Services, Behavioral Health and Adult Psychiatric Evaluation Services. Garrett County Community Action will be involved for transportation assistance, energy assistance, and housing needs. Hospice will be a participant for palliative care needs of patients in the program. Garrett County Lighthouse will be a participant for outpatient psychiatric rehabilitation needs and emergency housing.  Strategy 2: Community participants for the nurse navigator program include the local primary care providers including Mt Laurel Medical Center, the Garrett County Federally Qualified Health Center. The navigator will work closely with the primary care base in coordinating follow-up care. The nurse navigator will also partner with the Garrett County Health Department for home health needs and behavioral health services. The four local nursing homes will be partnering with the nurse navigator to ensure the needs of those patients can be met at the nursing home or to ensure the patient is treated in the most appropriate care setting.  Strategy 3: Participants in the telemedicine strategy include our affiliate institution, West Virginia University Health System (WVU)now known as WVU Medicine. WVU will provide the specialty physicians that will participate in the telemedicine consults for neurology and behavioral health services.  Strategy 4: Participants for the Information Technology platform will be multiple patient care departments at GRMC along with the primary care providers who will have access to the care plans.  Strategy 5: Participants in the multidisciplinary care plan meeting will include various disciplines at GRMC such as Patient Care Management (social workers); Patient Education; Nursing; Primary Care Physicians; Cardiac and Pulmonary Rehabilitation; Diabetes Education; Flagship Physical Therapy; Pharmacy and a Dietician. The social worker will partner with various community agencies including Garrett County Health Department for post-discharge needs; Mountain Laurel Medical Center (FQHC) and other PCP’s for follow-up care; the local nursing homes for transition of care; Garrett County Community Action for transportation and home needs; and the Garrett County Lighthouse for psychiatric needs in the post-acute care setting. |
| 1. Describe the overall financial sustainability plan for each major strategy:   Strategy 1: The financial stability for this initiative will come from the cost savings realized from decreased utilization of potentially avoidable services for care that can be provided in a more appropriate setting with better management of high-risk patients. This will result in less PAU charges for the hospital so that scarce hospital resources can be utilized more efficiently.  Strategy 2: The nurse navigator role will sustain itself through success of the *Well Patient Program,* which will have a focus of decreasing acute care services. This group of patients will require ongoing support from the navigator. While the nurse navigator’s services are not billable, the resulting reduction in readmissions and overutilization of emergency services over the long term will provide a positive return on investment (ROI) for the position.  Strategy 3: Telemedicine services will be absorbed within the hospital budget as the originating service fees are negligible. The benefit, however, is that patients will receive a quicker diagnosis to help place them in a more appropriate care setting locally, if possible, or transfer them to the higher level of care faster.  Strategy 4: The implementation of the IT platform will assist in identifying patients as being enrolled in the *Well Patient* Program, and will assist in care plan development. These IT upgrades will be a significant investment for GRMC through initial implementation and ongoing annual maintenance fees. The ROI will be realized through decreased readmissions and PAU rates. The sustainability of the IT fees will be built into the annual budget for the hospital.  Strategy 5: The multidisciplinary care plan meetings will be incorporated into the daily routine of the hospital. The social worker sustainability will be recognized through savings from reduced readmissions and utilization of services. |

**Appendices**









