Calvert Health System
Calvert Memorial Hospital
An Executive Summary

Health care has often been described by many experts as among the most complex industries in the world. Now frequently compared to other highly complex industries such as aviation, nuclear energy and strategic defense, health care shares many of the challenges to perform with high reliability and optimally under many situations. Today, our federal government is taking unprecedented steps to reform health care. Healthcare organizations are challenged to think out of the box by re-engineering processes which allow us to trim costs while improving quality and safety outcomes for our patients and community.

Patient safety is more than a goal at Calvert Health System (CHS) - it is our number one priority. CHS acknowledges the risk of harm to our patients as we carry out our work and we embrace the challenge of the Triple Aim as we work to provide health care to our population, improve quality in our healthcare services and lower the costs of the healthcare we provide. To be strategic, thoughtful and effective in achieving these aims, we have outlined a multiyear plan that is reflective of the *Transformations Framework* and positions CHS to have a positive impact on not only our local community but on the goals established by the State of Maryland as reflected in the Maryland State Health Improvement Plan (MD SHIP).

The challenge ahead has not changed; we must perform at the highest levels possible with less financial resources than in past years. Across the nation, quality, patient safety and patient perception scores are incrementally improving. Facing these challenges requires our hospital's traditional role as a member of the community to change. We must engage patients and extend our reach in the community. We must develop and fully utilize partnerships and community resources that make our work more effective while enabling us to also contribute our resources in service to others. In our Strategic Transformation Plan we outline many existing programs, along with programs in the planning and development phases, that address our need to cultivate better community partnerships and unique care delivery models that we believe will address the complex care patients require while reducing overall healthcare utilization and costs. CHS will continue to implement successful programs that identify early patient health needs and navigate individuals into appropriate lifestyle change and wellness programs.

CHS has used its most recent community health needs assessment to formulate goals and objectives which are directed at defined populations and locations of greatest needs within our county. One of our greatest challenges is access to care for patients in the community due to limited public transportation and the rural landscape of our county. As with many areas in Maryland, we face a significant provider shortage - our latest physician development study indicates a need for 20 additional Primary Care Providers in Calvert County, however this is a challenge which may far exceed our realistic capabilities.

The traditional definition of population health encompasses a broad range of factors that may change health outcomes—everything from the physical environment to social structure to resource allocation. As a result, hospitals may find it difficult to identify which population health factors they can directly impact with their limited resources. Calvert Memorial Hospital leads the Calvert County Community Health Improvement Roundtable which is comprised of local community health agencies, the Calvert Health Department, Calvert Hospice, Office on Aging,

long term care providers, county government and others. The Roundtable has identified three priority areas in Calvert County:

- Access to Healthcare (indicators: Adolescent Routine Checkup (Medicaid), Primary & Non Primary Care Provider Rates, Dentist Rates, Adults Routine Checkup Adults unable to Afford to See a Doctor)
- Cancer (indicators: Age-adjusted death rates due to cancer [breast, prostate, colorectal cervical], Cancer Medicare Population)
- Substance Abuse (indicators: Adults who binge drink, death rate due to Drug Use, adults who smoke.

Fiscal year 2012 was the first year that CHS concentrated our efforts on population health initiatives. Data analysis guided us to focus on population health and areas of immediate priority, which included improving quality and patient safety, increasing care coordination and expanding preventive services/wellness outreach programs. Many of these initiatives continued into FY 2016, while new initiatives are continually added as our strategies evolve and efforts are evaluated. Our most recent successful initiatives include an expanded, more robust multidisciplinary Transitional Care Program, a post-acute discharge clinic, a collaborative involving all post-acute community providers, a mobile medical and dental clinic, and our robust church health ministry program. We continue to assess the effectiveness and efficiency of our work through careful evaluation of utilization data, readmission rates, mortality rates and patient feedback.

Hospital Strategic Transformation Plan

Remaining innovative and patient centered in the Health Care Reform environment has created unique opportunities for hospitals to embrace new models of care. There has been a nationwide redirection of health care efforts away from traditional hospital care and towards population health management. Resources are being mobilized to help people get healthy and stay healthy, while assisting those with chronic diseases to improve their healthcare self-management.

Calvert Memorial Hospital (CMH) is a founding member of Totally Linking Care in Maryland, Inc. (TLC-MD), a collaborative partnership between eight hospitals in Calvert, St. Mary's and Prince George's Counties. Created as a learning organization utilizing the HSCRC Transformations Framework, TLC-MD is anchored by Doctors Community Hospital, Ft. Washington Medical Center, Laurel Regional Hospital, Prince George's Hospital Center, Bowie Medical Center, MedStar Southern Maryland Hospital, Calvert Memorial Hospital and MedStar St. Mary's Hospital.

Formerly known as the Southern Maryland Regional Coalition, TLC-MD was formed in March 2015, bringing together the skills and resources of the southern counties of Maryland in an effort to collaborate and improve health care delivery to achieve the Centers for Medicare and Medicaid Service's (CMS) Triple Aim: providing better care for patients, improving population health outcomes, and lowering costs by improving our health systems. Table 1 provides an overview of CMH's strategic objectives and their alignment with the objectives of TLC-MD:

Table 1: Alignment of CMH and TLC-MD Strategic Goals

Strategy–Calvert Memorial Hospital	**Alignment with TLC-MD**
Establish comprehensive behavioral health services including substance abuse utilizing community partner	TLC-MD is committed to addressing the behavioral health needs of patients – CMH will leverage opportunities for sharing providers and services and will utilize best practices from TLC-MD partners when creating treatment models
Implement a collaborative approach for IT governance to coordinate IT systems to fit the needs of internal clients and to foster evidence based practice	TLC-MD is committed to creating an IT infrastructure which foster collaboration among partners and facilitates efficiency in outcomes reporting and informed decision making
Invest in community partnerships to increase visibility and actively engage in prevention and health and wellness initiatives	TLC-MD is committed to the creation and utilization of community partnership, including health ministries, to provide quality service to all patients and maximize available resources

Overall goals:

Align CMH strategic goals with the IHI Triple Aim Project, linking initiatives to improve the patient's experience of care, improve the health of populations, and reduce the per capita costs of health care by:

- Improving the patient centered experience by ensuring patient's receive the right care in the right setting, as evidenced by the reduction of all cause admissions / readmissions, observation stays, emergency department visits and health care spend per capita
- Improving synergy (connectivity, consistency, efficiency, and effectiveness) of patient centered chronic disease specific care planning, education and medication management provided by our community health care partners, with a focus on long term / post-acute care and high needs / complex patients
- Improving communication flow and "breaking down the silos" between our community health care partners, as evidenced by the development and implementation of post-acute pathways and protocols
- Improving access to care, especially for underserved populations in Calvert County, and utilizing local resources efficiently and effectively to serve the needs of patients
- Serving those who, due to gaps in resource access for somatic, behavioral health and/or substance abuse care needs, are:
  - unable to access appropriate care within 5 days post-discharge
  - afford essential medications and medication-related supplies
  - secure transportation to health care appointments
  - manage their multiple medications
  - access post-acute care resources

  in the hopes of avoiding high-cost hospital visits/stays
- Developing and facilitating access to community focused initiatives which address preventive care opportunities and activity of daily living improvement.

Overall major strategies:

- Calvert CARES Program: In January 2015, the Calvert CARES (Collaborative Activation of Resources and Empowerment Services) Program was developed as a targeted initiative guided by the:
  - IHI Triple AIM framework
  - Maryland HSCRC incentive program
  - 2014 Community Health Assessment
  - Maryland State Health Improvement Plan (SHIP)
  - Affordable Care Act
  - Maryland Waiver

The philosophy behind Calvert CARES is quite simple:

- knock down barriers and build bridges to care
- listen actively / often to our patients
- know what agencies and organizations exist in our community and create a forum for them to flourish
- promote patient engagement to empower them towards a healthier lifestyle and improved health care management.

- Transitions to Home (T2H): Health management coaching and resource access guidance through phone calls and home visits provided by nurses, initiated in 2012 and expanded in FY 2014 to include a social worker and a pharmacist.
- Partners in Accountable Care Collaboration and Transitions (PACCT): Coalition of local agencies and health care providers, initiated Fall 2013, focused on optimizing patient outcomes through improved care coordination, collaboration and communication.
- Patient Portal: Patient secure internet access to their hospital medical record and services, such as reviewing lab results, scheduling appointments and paying hospital bills, which was initiated July 2014.
- Medication Assistance Program (MAP) / Transportation Assistance Program (TAP): Initiated in FY 2015, these programs provide needs-based assistance to help patients pay for essential medications, medical supplies or transportation to medical appointments when financial resources and assistive programs don't meet the identified gap.
- Discharge Care Clinic (DCC): Beginning April 2015, provided care management coaching, health status assessment, goals building, intervention planning, medication therapy management, psycho-social support and resource access, in a relaxed clinic setting. Program is structured to allow patients extended time with the care team (nurse, physician, pharmacist and social worker) to facilitate information processing and dialogue between the patient and the care provider.
- Project Phoenix: Our newest program, begun August 2015, provides mental health and substance abuse care management coaching and resource access guidance, via phone calls and in person coaching sessions provided by a social work case manager, through a Community Health Resources Commission grant awarded to the Calvert County Health Department.

► Prevention Population Health Program: Developed as a targeted initiative guided by the:

- IHI Triple AIM framework
- 2014 Community Health Assessment
- Maryland State Health Improvement Plan (SHIP)
- Affordable Care Act

▪ Diabetes Self-Management Program: Comprehensive educational program led by a team of Certified Diabetes Educators (Registered Nurse and Registered Dietitian) and certified by the American Diabetes Association. Provides individual assessments and personalized meal plans, sets health goals and provides follow-up contact to successfully manage diabetes on a group and individual basis. Provides continuity of care through collaboration with the referring physicians.

▪ Health Ministry Team Network: Begun in 2006 as a synergistic relationship with the faith community to provide training while serving as a resource center for the development of health ministry teams. Teams provide health promotion and disease prevention ministry that is based on the care of the whole person. We currently have over 25 active churches.

▪ Calvert Community Dental Care: Begun in 2009 to provide high quality, basic restorative and preventive dental care and education focused on improving the overall oral health of our community. Our collaborating partners include Calvert County Public Schools, Calvert County Health Department and Health Ministry Team Network.

▪ KeepWell @ Work: A comprehensive health management program which focuses on health promotion through health risk factor identification with the goal of preventing the onset of disease. Services provided include coaching to encourage health lifestyle behaviors as well disease management to optimize wellness potential. Targeted programs are designed and developed to meet the identified needs of the community.

► Acute Care Case Management Program: Expanded program team to include weekend (1.2 FTE) and Emergency Department (1.5 FTE) coverage plus added a weekday Case Manager to decrease average daily caseload with goal of spending more direct contact time with patients to facilitate an efficient and effective CMH stay and transition plan.

► Palliative Care Program: New program developed and implemented with added roles of Medical Director and Coordinator with symptom management provided via a contract for palliative care credentialed Nurse Practitioner.

Specific target population for each major strategy:

► Calvert CARES Program targets four areas of identified patient need / care gaps:

- Chronic heart failure, diabetes, pneumonia and other chronic/co-morbid diseases
- Lacked a primary care provider
- Could not afford medications
- Had limited or no access to transportation for medical appointments

- Transitions to Home (T2H): Focus on population with somatic care and psycho-social needs. CMH patients, regardless of age or payer, who meet one or more of the following criteria:
  - Readmitted in last 30 days
  - > 2 ED visits w/in 30 days
  - Hospital LOS > 5 days
  - > 2 inpatient admissions / observation stays in past 12 months
  - Requires intensive case management
  - Un/Under insured
  - Transferred to higher level of care then returned to community
  - Unable to schedule provider visit w/in 5 days post discharge
  - Newly diagnosed or poorly managed chronic health condition
  - Complex poly-pharmacy
  - Adherence barriers
- Partners in Accountable Care Collaboration and Transitions (PACCT): Patients eligible for or receiving post-acute community services, inclusive of but not limited to county / state, skilled nursing, assisted living, home health care, home care, medical equipment, pharmacy, hospice, palliative care, etc. programs / resources.
- Patient Portal: Meaningful Use attestation to awareness and enrollment for all CMH inpatient admissions and observation stays, while also facilitating awareness and enrollment for any patients presenting to the Emergency Department or other outpatient services.
- Medication Assistance Program (MAP) / Transportation Assistance Program (TAP): CMH patients who meet Transitions to Home criteria and demonstrate a reasonable inability to pay for a portion or all of their medications or medically-related transportation needs. Screening tool completed by Social Work to determine patient need.
- Discharge Care Clinic (DCC): Same target population / criteria as Transitions to Home.
- Project Phoenix: Focus on behavioral health and substance abuse population. Same criteria as Transitions to Home.

► Prevention Population Health Program targets broad community residents to:

- Reduce cancer, heart disease and diabetes
- Provide access to health services
- Provide awareness of screening and healthy lifestyle education
- Remove transportation barrier by collaborating with community partners

- Diabetes Self-Management Program: All diagnosed Type 1 and Type 2 diabetes patients. Must have referral from physician.
- Health Ministry Team Network: Congregational members and defined populations within the geographical location of each faith based organization.
- Calvert Community Dental Care: Medicaid adults and children, as well as residents of Southern Maryland who meet income eligibility.

- KeepWell @ Work: Services available to entire community, with emphasis placed on worksites, to help establish a culture of wellness at worksites and improve the overall health of the workforce in Southern Maryland.

► Acute Care Case Management Program targets any patient with an emergency department visit, observation stay or inpatient admission.

► Palliative Care Program targets patients scoring between 4 and 7 on the Palliative Care Screening Tool, although any patient may be referred for a palliative care consult. Patients scoring between 7 and 10 may be referred for Hospice, dependent upon patient / family preference.

Specific metrics for each major strategy:

► Calvert CARES Program: See Attachment 1 for logic model

- Transitions to Home (T2H):
  - < 9% of patients admitted inpatient will be readmitted to any hospital within 30 days of their initial discharge (readmission)
  - 4% reduction in Emergency Department visits
  - 75th percentile for HCAHPS Transition of Care
- Partners in Accountable Care Collaboration and Transitions (PACCT):
  - 10% reduction in readmissions (hand-off communication issues)
    - Curaspan Discharge Central and Ride Central implementation – completed
  - 10% reduction in Medicare readmissions
  - 10% reduction in readmissions from a skilled nursing / rehab facility
    - INTERACT implementation facilitation – target July 1, 2016
  - 10% reduction in readmissions of patients discharged to home with home health care
- Patient Portal:
  - 50% of patients registered for inpatient admission or outpatient observations stay will be made aware of the portal
  - 5% of patients registered for inpatient admission or outpatient observation stay will be enrolled in / access the portal
- Medication Assistance Program (MAP) / Transportation Assistance Program (TAP):
  - 10% reduction in readmission due to medication plan non-adherence (MAP) - use TLC-MD Readmission RCA tool for this data
  - 10% reduction in readmission due to medication plan non-adherence (MAP) - use TLC-MD Readmission RCA tool for this data
- Discharge Care Clinic (DCC):
  Reduce patient risk of readmission due to care / resource access gaps (metrics same as for Transitions to Home)
  - > 90% of DCC patients needing a primary care provider will be connected with one
  - > 90% of DCC patients state they know when, how and why to take medications

- > 90% of DCC patients state that they feel better prepared to follow their health plan
- > 90% of DCC patients state that they know what they need to do between the clinic visit and their next Dr.'s appointment

- Project Phoenix:

  Metrics same as for Transitions to Home, with focus on behavioral health patients

▶ Prevention Population Health Program:

- Diabetes Self-Management Program:
  - 80% disease knowledge improvement
  - 10% reduction in patient ED utilization due to diabetes (SHIP)
- Health Ministry Team Network (HMTN):
  - 10% increase in churches joining HMTN
  - 10% increase in encounters
- Calvert Community Dental Care:
  - 10% increase in the number of Medicaid children receiving preventive dental exams (SHIP)
  - 10% reduction in ED dental visits due to lack of dental providers (MC/MA) (SHIP)
  - 1% reduction in death rate due to oral cancer by provide Oral Cancer Screening (SHIP)
- Keepwell @ Work:
  - 5% reduction in death rates due to heart disease (SHIP)
  - 10% reduction in death rate due to cancer (SHIP)
  - 5% reduction in obesity rates for adults and adolescents (SHIP)
  - 90% of participants are navigated to appropriate level of care with out of range screenings
  - 80% participant compliance with annual reassessment to monitor progress and reduction of risk factors

▶ Acute Care Case Management Program:

- < 9% of patients admitted inpatient will be readmitted to any hospital within 30 days of their initial discharge (readmission)
- 4% reduction in Emergency Department visits
- 75th percentile for HCAHPS Discharge Information
- 75th percentile for HCAHPS Transition of Care
- Reduce hospital utilization through improved technology use, care coordination and hand-off communication through Curaspan Discharge Central and Ride Central implementation – completed
- 10% reduction in Medicare readmissions
- 10% reduction in readmissions from a skilled nursing / rehab facility
- 10% reduction in readmissions of patients discharged to home with home health care

▶ Palliative Care Program:

- 15% reduction in readmission rate for patients identified as palliative care

As a partner organization within TLC-MD, CMH will contribute to the overall goals of this new coalition. The core process measures and core outcome measures by which our TLC-MD work will be evaluated is detailed below in Tables 2 and 3.

Table 2. Core Outcome Measures – from the RFP & TLC-MD Proposal

Measure	Definition	Goals	Source	Population	Baseline Data
Total Hospital charges per capita	Hospital charges per person (monthly)	Growth <3.58% from CY 2013 in 2015; meeting state goals in ensuing years	HSCRC case-mix data	HSA and Counties Populations	$4,220/person/year
Total Hospital Admissions per capita	Admissions & Observation patients >24hr per 1000/month	< national average N/1000/month for Medicare within two yrs.	HSCRC Case-mix data	HSA and Counties Populations	22.02 admissions /1000 Medicare FFS beneficiaries'/month
ED visits per capita	ED visits per thousand/month	2% per year decrease	HSCRC Case-mix data	HSA and Counties Populations	25.33 ED visits /1000 Medicare FFS beneficiaries'/month
Readmissions	All-cause readmissions within 30 days, both as N/1000/month and as N/discharges	< national average N/1000/mo for Medicare within two years	CRISP	HSA and Counties Populations	3.26 readmissions /1000 Medicare FFS beneficiaries'/month
Potentially avoidable utilization	As per HSCRC specifications	Reduction of 15% per year for two years	PAU Patient Level Reports – HSCRC and CRISP	HSA and Counties Populations	$9,599,027
Patient experience	% rating 9 or 10 overall (would prefer care transitions elements)	Close half of the gap between current average and national average each year	HCAHPS, reported to each hospital	Weighted average of hospitals	Will be developed during grant period

Table 3: Core Process Measures– from the RFP & TLC-MD Proposal

Measure	Definition	Goal	Source	Population	Baseline Data
Use of encounter notification alerts	% of inpatient discharges that result in an encounter notification system alert going to a physician	50% of inpatient discharges of high needs patients meet criterion within a year, then closing half of the remaining each year thereafter; goal metrics for all discharges the same, but lagged by a year	CRISP	Discharges of High-Needs Population; then all hospital discharges	0
Completion of health risk assessments	% of high utilizers with completed HRAs (in hospital record or linked care coordination record)	50% within a year, then closing half of the gap remaining each year thereafter	Aggregation of reports from coalition hospitals, merged with reports from care coordination contractors	High-Needs Population	0

Table 3, cont: Core Process Measures– from the RFP & TLC-MD Proposal

Measure	Definition	Goal	Source	Population	Baseline Data
Established longitudinal care plan	% of high utilizers with completed care plan	50% within a year, then closing half of the remaining gap each year thereafter	Reports from care coordination contractor and sampling of hospital records on high utilizers	High-Needs Population	0
Shared Care Profile	% of high-utilizers with care profiles shared through CRISP	25% in the first year available, 50% in the second, and closing half of the gap each year thereafter	CRISP (when available)	High Needs Population	0
Portion of target population with contact with an assigned care manager	% of high utilizers with contact with an assigned care manager	80% of persons consenting to care management, refusal rate <25%	Aggregation of reports from the hospitals and eQHealth	High-Needs Population	(11 of first 164 opted out) 93.2% of high utilizers had contact with CM

Other strategy participants and their collaboration on each specific major strategy:

► Calvert CARES Program: Joined the Virginia Health Quality Center (VHQC) QIO Care Transitions Project: Connecting Care, with the goal of a 20% reduction in hospital readmissions by 2019.

- Transitions to Home (T2H):
  - Calvert Physician Associates (CPA) and Calvert Internal Medicine Group (CIMG) provide improved access to care for patients needing a provider or needing to see their current CPA / CIMG provider expeditiously
  - Chesapeake Potomac Home Health Agency (CPHHA) provides skilled home health for eligible patients who are identified as needing / wanting services post-discharge to home
  - County and State support services (ex.: DSS, APS, Department on Aging)
- Partners in Accountable Care Collaboration and Transitions (PACCT): See Attachment 2 for member list and Attachment 3 for charter. PACCT members who are potential referral sources for patient discharge / transition planning have implemented or facilitated staff access to Curaspan's Discharge Central product. A core group of skilled nursing facilities have agreed to form a team to develop an INTERACT implementation plan.
- Patient Portal: PACCT membership has referred post-discharge patients to the Patient Portal Liaison for facilitated enrollment. Skilled nursing facilities who will be a part of the INTERACT implementation team have committed to holding a portal enrollment fair at their facilities to assist their residents in accessing the portal.
- Medication Assistance Program (MAP) / Transportation Assistance Program (TAP):
  - Walgreens Pharmacy has partnered with CMH in accepting MAP vouchers from patients and invoicing the program (CMH) after medication has been dispensed to the patient
  - Checkered Taxi has partnered with CMH in accepting TAP vouchers from patients and invoicing the program (CMH) after transportation has been provided

- Discharge Care Clinic (DCC): Same as Transitions to Home, with addition of Physician Inpatient Care Specialists (MDICS). The DCC physician is a contracted member of the MDICS staff, which facilitates the bridge between acute and post-acute care for these high risk patients.
- Project Phoenix: Calvert County Health Department (CCHD) is the lead agency, in partnership with CMH, in providing this service through a Maryland Health Care Resources Commission grant. CCHD employs and supervises the project Case Manager and provides data collection, aggregation, analysis and reporting support.

► Prevention Population Health Program:

- Diabetes Self-Management Program: Calvert County Health Department (Diabetes management pilot), Southern Maryland physician patient referral, Calvert County Government worksite wellness education
- Health Ministry Team Network: Referring partners and program participants for respective populations: Calvert County Health Department (smoking cessation and colorectal cancer), Department of Social Services (WIC, local resources), Hospice (palliative care, living will), SMILE (food pantry, thrift), Calvert Substance Abuse, CAASA, Farming For Hunger (food distribution) and Lyons Club Calvert Community Dental Care (screenings)
- Calvert Community Dental Care: Referring partners and program participants for respective populations:: Calvert County Health Department (adult access, specialty care and sealants), Southern Maryland Community Network (special needs population) , The Judy Center, Calvert County Public Schools, Head Start (school linked dental care for children and adolescents), Health Ministry Team Network (dental and oral cancer screenings and education and awareness)
- KeepWell @ Work: Provide onsite wellness programs for employees: The Arc of Southern Maryland, Hospice, Calvert County Public Schools, Charles County Public Schools, Calvert County Government, Southern Maryland Community Network, DM Group, Chesapeake Spa & Resort, Gentle Dentistry.
  Provide health risk assessment for community: Health Ministry Team Network.
  Provide collaborative service and programs: World Gym and Calvert Physical Therapy.

► Acute Care Case Management Program: Case Management Team collaborates with MDICS staff, Transitions to Home Team and various PACCT / community agencies. Through the use of Curapsan's Ride Central, case managers coordinate patient medical transportation needs with AAA ambulance company.

► Palliative Care Program: Calvert Hospice, Palliative Medicine of Southern Maryland (PMSM) and MDICS are partners in this program. Through contractual relationships the Medical Director is provided by MDICS and the Palliative Care Nurse Practitioner is provided by PMSM.

Overall financial sustainability plan for each major strategy:

Having hired a grant writer, CMH is now positioned to seek out and acquire grant funds to sustain many of our innovative programs. Each of our initiatives is a potential future grant opportunity, but we are acutely aware of the limitations of grant support sustainability. As a part

of our annual budget planning process we evaluate each initiative for ROI, outcomes attained, grant opportunities and potential incentive money. Sustainability of these initiatives will also be significantly impacted by the HSCRC's future plans for the TPR rate setting model: volume based (potential to be penalized for meeting decreased utilization targets) vs. incentive based (rewarded for improving outcomes / decreasing avoidable utilization). Our ability to reinvest in the health of our community is directly related to our ability to produce sufficient revenue to maintain acute and outpatient services. Meeting our targeted operating margins allows us to use "profit" as a community investment.

► Calvert CARES Program:

- Transitions to Home (T2H): Budgeted by CMH and sustained through meeting outcomes targets which are linked to financial incentive rewards.
- Partners in Accountable Care Collaboration and Transitions (PACCT): Partner agencies contribute their time as a community benefit and budget accordingly for new programs / IT needs. CMH provides leadership to this group as a part of their community benefit.
- Patient Portal: Patient Portal Liaison position (0.5 FTE) supported through Meaningful Use dollars allocated via CMH budget. Goal is to facilitate patient self-enrollment process during hospital visit while continuing to support post-discharge self-enrollment.
- Medication Assistance Program (MAP) / Transportation Assistance Program (TAP): Budgeted by CMH with future expansion possible through the TLC-MD grant budget.
- Discharge Care Clinic (DCC): All services currently provided free of charge. FTE's supplies, equipment and office space budgeted by CMH with future expansion possible through the TLC-MD grant budget.
- Project Phoenix: Social Work Case Manager position (1.0 FTE) supported by Maryland Health Care Resources Commission 3 year grant (FY16 – FY18) awarded to Calvert County Health Department (CCHD), in partnership with CMH. If this project yields targeted outcomes, CMH will work with CCHD to identify future grant opportunities and will provide budgeted financial support as needed.

► Prevention Population Health Program:

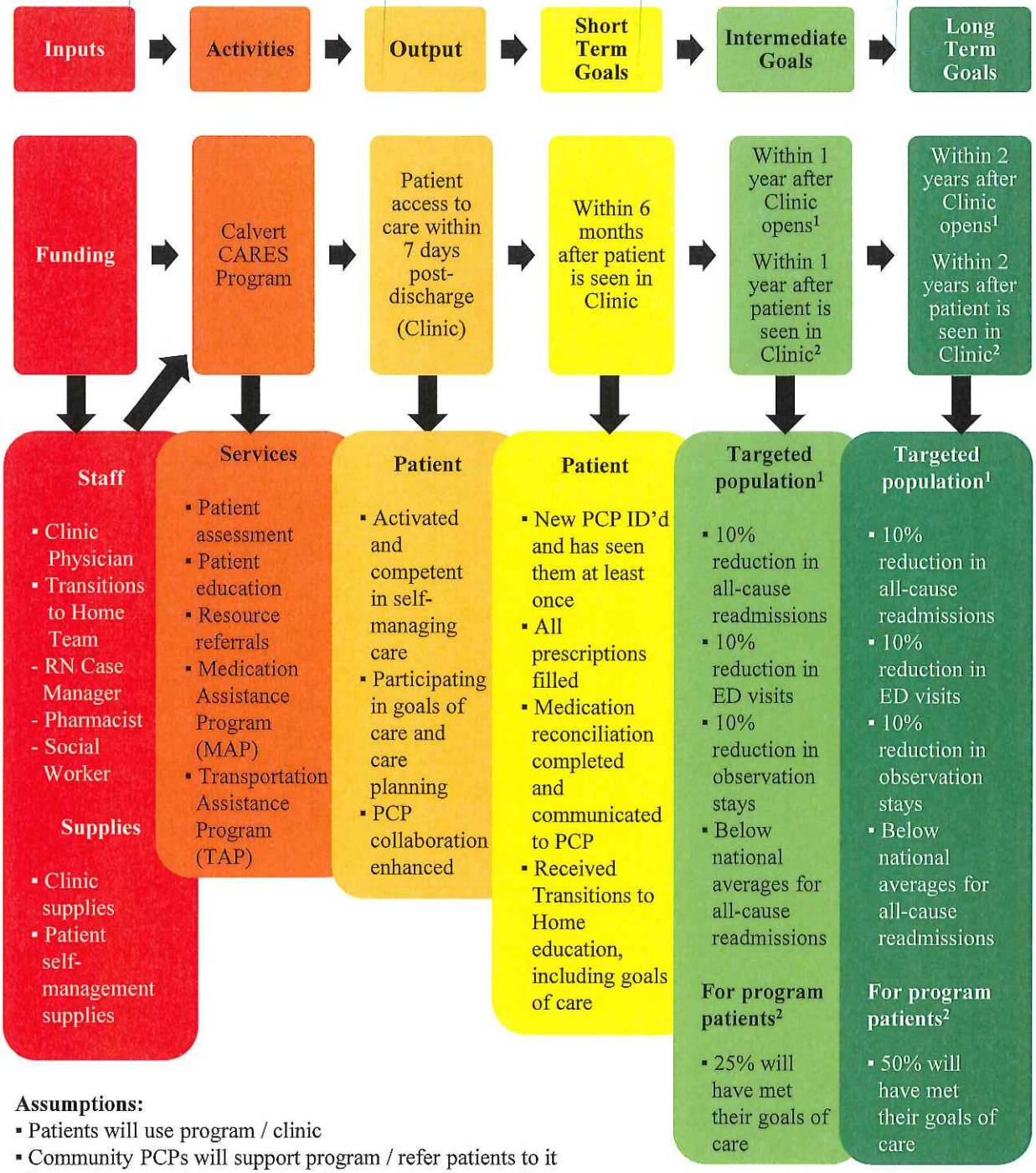
- Diabetes Self-Management Program: Reimbursement from insurance coverage and charity care of eligible patients
- Health Ministry Team Network: Services provided through hospital KeepWell department no offsetting revenue.
- Calvert Community Dental Care: Reimbursement through Medicaid dental plan, sliding fee scale fees and grant funding through Office of Oral Health and Calvert County Health Department.
- KeepWell @ Work: Nominal fees charges to business to off-set costs as well as grant funding through United Way as part of Calvert Can Eat Right Move More Breathe Free initiative.

► Acute Care Case Management Program: Budgeted by CMH and sustained through meeting outcomes targets which are linked to financial incentive rewards.

► Palliative Care Program: Budgeted by CMH and sustained through meeting outcomes targets which are linked to financial incentive rewards.

Attachment 1

Calvert CARES Program Logic Model



Assumptions:

- Patients will use program / clinic
- Community PCPs will support program / refer patients to it
- Patient / community perception about access to care will improve

Contextual Factors:

- Increasing hospital-based health care utilization is due to access to care challenges of under insured, uninsured
- Calvert County has a greater than average growth in the population over age 65
- Calvert Memorial Hospital is experiencing an increase in patient acuity, intensiveness and complexity

Partners in Accountable Care Collaboration and Transitions (PACCT) Membership 2015

Attachment 2

Organization	Last name	First name
A Homemade Plan	Stott	Tyler
Asbury Home Care	Wooge	Linda
Asbury Solomons	Ayme'	Maria
Asbury Solomons Services Liaison	Mattingly	Heather
Asbury Solomons/Asbury Home Care	Daye	Tammy
Calvert County Adult Day Care	Lake	Ruth
Calvert County Health Dept.	McDonald	Doris
Calvert County Health Dept.	Keller	Erika
Calvert County Health Dept.	Bauman	Sam
Calvert County Nursing Center	Brooksbank	Renee
Calvert County Nursing Center	Simpkins	Robyn
Calvert County Office on Aging	Caudle	Lisa
Calvert Hospice/So. MD Palliative Care	Fleming	Jean
Calvert Hospice/So. MD Palliative Care	Rawlings	Kara
Calvert Internal Medicine Group	Logan	Kendra
Calvert Internal Medicine Group	Zahringer	Stacy
Calvert Physician Associates	Bennett	Diane
Charlotte Hall	Jones	Adrianne
Charlotte Hall	Lewis	Carole
Charlotte Hall	Steffey	Leslie
Charlotte Hall	Murphy	Lisa
Charlotte Hall	Grzyb	Pam
Chesapeake Potomac Home Health	Litz	Sherri
Chesapeake Shores Nursing and Rehab	Friedman	Kelly
Chesapeake Shores Nursing and Rehab	Bowie	Lisa
Circle of Care/Sagepoint	Stedman	Lee Ann
CMH Grant Coordinator	Carnes	Melissa
CMH Hospitalist	Choi	Chang
CMH Hospitalist; Physician for Discharge Clinic	Annulis	Thomas
CMH Integrated Care Management	James	Kelli
CMH Integrated Care Management	Rice	Teri
CMH Integrated Care Management/Transitions	Seawell	Holly
CMH Integrated Care Mgmt. Director	Twigg	Karen
CMH Integrated Care Mgmt./Transitions	Western	Sara
CMH Palliative Care and Social Work	Sacks	David
CMH TCU	Chavis	Michelle
CMH TCU	Pruitt	Sharon
CMH TCU	Wheaton	Mathew
CMH VP of Clinical Services	Couchman	Diane
CMH VP of Quality and Risk Mgmt.	Dohony	Susan
CMH Wellness/Keep Well Dept.	Fowler	Margaret
Lincare	Jahed	Kim
Newbridge Spine Center and Pain Clinic	Cummings	Michelle
Options	Bellis	Michael
Partners in Care	Williams	Pam
Restore Healthcare	Mouldern	Nina
Right at Home	Hartman	Heather
Solomons Nursing Center	Swift	Jamie
The Charleston Senior Community	Ashby	Kelly
VHQC	Thomas	Carla
VHQC	Arthur	Kelly
Walgreens Infusion	Gundlach	Debbie
Walgreens	Hanlon	Kevin

PACCT Charter

Partners in Accountable Care Collaboration and Transitions

Committee Purpose	PACCT's purpose is to facilitate and promote collaboration between our community health care partners, with the goal of eliminating care fragmentation, while fostering an environment of collegiality, networking and resource sharing focused on enhancing our efficiency and effectiveness in optimizing patient outcomes.

Meetings:	The Steering Committee will meet a minimum of quarterly, with a required attendance (by member or proxy) at 75% of the scheduled meetings for all committee meetings. Sub-committees and task forces may be formed on an ad hoc basis, with the same attendance requirements.

Members:	Committee membership shall be representative of the community health care resources in the Calvert Memorial Hospital catchment area. Members should designate a proxy to attend in their place if they are unable to attend a meeting.

Goals / Key Result Areas:	1) Improve the patient centered experience by ensuring patient's receive the right care in the right setting, as evidenced by the reduction of all cause readmissions to Calvert Memorial Hospital (see dashboard for targets). 2) Improve synergy (consistency, efficiency, and effectiveness) of patient centered disease specific care planning, education and medication management provided by our community health care partners. 3) Improve communication flow and "breakdown the silos" between our community health care partners, as evidenced by the development and implementation of post-acute pathways and protocols.

Strategies:	1) Improve patient engagement: motivational interviewing & synchornization of education 2) Improve networking between community partners 3) Enhance information / strategy sharing 4) Take Transitions to Home and Patient Portal Programs "on the road" to community partners 5) Optimize engagement with / use of community resources 6) Optimize use of technology 7) Explore incentivization methods (what's in it for me?) 8) Brand our collaborative and publicize what we are doing / why / outcomes 9) Leverage our collective to increase our access to resources and capabilties and explore ways to share risks and benefits ($)

Key Result Measures:	1) Reduction in all cause readmission rate to < 9% 2) Reduction in nurisng home readmission rate to < 12% 3) Reduction in Medicaid readmission rate to < 12% 4) Reduction in Medicare patient readmission rate to <12%

Revised 3/19/15