# Doctors Community Hospital Strategic Transformation Plan

## Executive Summary

Doctors Community Hospital ("DCH") is actively working to achieve the Triple Aim of healthcare and the goals of Maryland's All‐Payer Model Agreement between the State of Maryland and the Center for Medicare & Medicaid Innovation (CMMI). Our population chronic disease strategies aim at keeping patients in our community healthy at home, reducing hospital costs, and improving our quality of care in the hospital. Our overall care coordination goal is to improve our results in patient‐centered and population‐focused performance standards while moving forward towards reducing the total cost of care (TCOC) for our patients. To achieve these goals of reduced utilization and improved chronic care, our initiatives range from the regulated settings of our hospital and the medical office building to the unregulated settings of our physician offices out in our community. Under the flexibility of Global Budget Revenue (GBR) funding, FY 2014 was the first year that DCH focused on population health initiatives. Many of these initiatives continued into FY 2015 and FY 2016, while new initiatives are continually added to our strategies. We do anticipate in the years to come that some initiatives are tested, changed, or even ended if the results are not forthcoming.

DCH’s CY 2016 Strategic Transformation Plan is based on three major care coordination improved delivery and population health goals:

1. Population Health
2. Clinics/Physician Practices/Behavioral Health/Long Term/Post-Acute
3. Per Capita Expenditure

The *Population Health initiatives* focus on improving the health of the patients who are receiving care at our hospital. These initiatives include an expanded, more robust Transitional Care Program, increased patient care navigators, collaboration with the Doctors Community Rehabilitation and Patient Care Center (our jointly-owned nursing home located on the hospital’s campus), the “Community Health Connector” mobile clinic, and our participation in Prince George’s County’s CPEST program. Our goal with these initiatives is to improve the health of our patients by offering medical support and education to our high-risk patients who are suffering from complicated or chronic illnesses.

The *Clinics/Physician Practices/Behavioral Health/Long Term/ Post-Acute* improvements focus on improving our services in the community through an expanded presence of clinics and physician practices. These clinics/practices include both hospital based, regulated clinics, and unregulated primary care physician practices. The regulated clinics were implemented in order to improve the care coordination of the patients in our communities. The unregulated clinic, the DCH Center for Comprehensive Breast Care and Women’s Wellness, offers many free services to its patients in order to better serve the underserved or uninsured population. The primary care practices that we plan to open in CY 2016 will offer the much needed primary and preventative care services that our community is currently lacking.

Finally, the *Per Capita Expenditure* initiatives focus on decreasing the cost to patients at our hospital and in our community. These initiatives vary in type and include decreasing the cost of care in both the regulated and unregulated settings. In the regulated setting, we hope to reduce the average observation length of stay to an average of 16 hours per visit by adding additional physician assistants at night. In addition, in order to reduce the cost of our Diabetes patients, we plan to move our medical visits from our regulated Diabetes clinic to an unregulated setting. This will reduce the co-pays for these patients and make access to care more affordable. In the unregulated setting, such as physician, nursing home, and home health services, our goal is to reduce the TCOC. First, in FY 2015 we partnered with the existing Prince George’s Accountable Care organization (ACO) to further build a network of primary care physicians to reduce the per capita cost to Medicare. Beginning in FY 2016, we will expand the ACO into other insurance carriers and build a clinically integrated network (CIN) to reduce TCOC with assistance from nursing homes, home health services, and other ambulatory providers.

More detail of DCH’s CY 2016 Strategic Transformation Plan is included in the following pages and attachments. These include:

1. Hospital Strategic Transformation Plan (in HSCRC word format)
2. Attachment A: Detailed documentation of our Strategic Transformation Plan
3. Attachment B: Detailed documentation of cost metrics (4-E)
4. Attachment C: Detailed documentation of financial sustainability (6 A-C)
5. Attachment D: HSCRC Outcomes and Process Measures

Questions can be addressed to:

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| Hospital Strategic Transformation Plan (HSCRC Format) |
| 1. **Describe your overall goals:**

As we continue our efforts in improving the overall health of our population, we keep in mind three major goals:1. Population Health - improving the health of the individual
2. Clinics/Physician Practices/Behavioral Health/Long Term/Post-acute- improving our service to our community
3. Per Capita Expenditure - decreasing the cost to patients at our hospital and in our community.

We believe that focusing on these three goals will help us achieve the Triple Aim of healthcare by keeping patients health at home, partnering with more physicians in the community, and by offering lower cost settings to those patients that do require hospitalization. The strategies that we have in place are both in the regulated and unregulated settings to prepare our health system for the next phase of the Maryland Medicare Waiver. |
| 1. **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):**

Overall Major Strategy #1: Care Transition and Coordination Programs at DCH and with Other Hospitals Initiatives:* 1. Totally Linking Care in Maryland LLC
	2. Transitional Care Program
	3. Navigation Program

Overall Major Strategy #2: Patient Experience & Reduced UtilizationInitiatives:* 1. CHF Clinic & Cardiac Rehab Clinic
	2. Pulmonary Rehab Clinic
	3. Observation ALOS

Overall Major Strategy #3: Behavioral HealthInitiatives:* 1. Sickle Cell Clinic

Overall Major Strategy #4: Physician AlignmentInitiatives:* 1. Leland Ambulatory Care Center / La Clinica
	2. Community Health Care Center in District Heights
	3. ACO/CIN Expansion

Overall Major Strategy #5: Community HealthInitiatives:* 1. Mobile Clinic
	2. Cancer Prevention, Education, Screening and Treatment (CPEST)
	3. DCH Center for Comprehensive Breast Care and Women's Wellness
	4. Diabetes Clinic

Overall Major Strategy #6: Nursing HomeInitiatives:* 1. Doctors Community Rehabilitation and Patient Care Center
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| 1. **Describe the specific target population for each major strategy:**

Overall Major Strategy #1: Care Transition and Coordination Programs at DCH and with Other Hospitals1. Those identified as high-needs patients when they TLC-MD hospitals (High Needs Population); 2. Those who live in TLC-MD's service areas (the area for each hospital from which 85% of the hospitalized patients living in Maryland come) (HSA Population)3. Those who live in Prince George's, Calvert, and St. Mary's counties (Counties Population). 4. High utilizers/readmitters that were admitted to DCH.5. Breast cancer, oncology, bariatric, and patients without PCP'sOverall Major Strategy #2: Patient Experience & Reduced Utilization1. CHF patients (based on diagnosis codes) 2. To be admitted into the DCH Pulmonary Rehab Program, the patient must meet the following criteria: - Have a diagnosis of moderate to severe COPD - Have a primary or secondary Pulmonary Diagnosis - Demonstrate potential for improvement - Demonstrate an ability to learn  - Have a need for Respiratory and Rehabilitation Services - Have a capacity and willingness to participate in the program - Is medically stable 3. DCH Observation patientsOverall Major Strategy #3: Behavioral Health1. Sickle Cell patients (based on diagnosis code)Overall Major Strategy #4: Physician Alignment1. PUMA 3 neighborhood - consisting of a predominantly low income, growing Latino population and elderly populations 2. PUMA 4 area consisting of a lower income, primarily African-American population 3. Medicare Care lives in our Primary and Secondary Service Areas: - 2015 = 11,000 beneficiaries - 2016 = 20,000 beneficiariesOverall Major Strategy #5: Community Health1. PUMA 3 neighborhood - consisting of a predominantly low income, growing Latino population and elderly populations 2. PUMA 4 area consisting of a lower income, primarily African-American population 3. Medicare Care lives in our Primary and Secondary Service Areas: - 2015 = 11,000 beneficiaries - 2016 = 20,000 beneficiaries 4. Eligibility requirements for CPEST program include: - be Prince George’s County residents - be age 50 or older - have a family history (mother, father, brother or sister) of colorectal cancer, if younger than age 50 meet low income threshold requirements - be uninsured or underinsured 5. Medically underserved women aged 40 to 64 years residing in Prince George's County who are of low income and are uninsured or underinsured (with a focus on African American women and women aged 50-64 years) 6. Diabetes diagnosis within PSA/SSA Overall Major Strategy #6: Nursing Home1. DCH discharges to nursing homes |
| 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:**

Overall Major Strategy #1: Care Transition and Coordination Programs at DCH and with Other Hospitals

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| Patient Satisfaction | HCAHPS improvement |
| Quality: | MHAC improvement |
| Outcomes: | HSCRC list: A through H |
| Process: | HSCRC list: I through N |
| Cost metrics: | See Attachment A & B for details |

Overall Major Strategy #2: Patient Experience & Reduced Utilization

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| Patient Satisfaction | HCAHPS improvement |
| Quality: | MHAC improvement |
| Outcomes: | HSCRC list: A through C, and F through G |
| Process: | HSCRC list: J through L, and N |
| Cost metrics: | See Attachment A & B for details |

Overall Major Strategy #3: Behavioral Health

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| Patient Satisfaction | HCAHPS improvement |
| Quality: | N/A |
| Outcomes: | HSCRC list: D through G |
| Process: | HSCRC list: J through L, and N |
| Cost metrics: | See Attachment A & B for details |

Overall Major Strategy #4: Physician Alignment

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| Patient Satisfaction | HCAHPS improvement |
| Quality: | N/A |
| Outcomes: | HSCRC list: A through H |
| Process: | HSCRC list: J through L, and N |
| Cost metrics: | See Attachment A & B for details |

Overall Major Strategy #5: Community Health

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| Patient Satisfaction | HCAHPS improvement |
| Quality: | N/A |
| Outcomes: | HSCRC list: A through C, F and G |
| Process: | HSCRC list: J through L, and N |
| Cost metrics: | See Attachment A & B for details |

Overall Major Strategy #6: Nursing Home

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| --- | --- |
| Patient Satisfaction | N/A |
| Quality: | MHAC |
| Outcomes: | HSCRC list: A through G |
| Process: | HSCRC list: J through L |
| Cost metrics: | See Attachment A & B for details |

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| 1. **List other participants and describe how other partners are working with you on each specific major strategy:**

Overall Major Strategy #1: Care Transition and Coordination Programs at DCH and with Other Hospitals1. TLC-MD: TLC-MD will refer patients to the CHF and Cardiac Rehab clinics. 2. Emergency Medical Associates, P.A., P.C. (EMA): Contracted physician group for our Emergency and Observation patients works with our UR committee.Overall Major Strategy #2: Patient Experience & Reduced Utilization1. TLC-MD members include: Ft. Washington Medical Center, Dimensions Health System, Calvert Medical Center, St. Mary’s and MedStar Southern Maryland Hospital Center will have a care coordination/transition program for high-utilizers. 2. TLC-MD: use TLC-MD's software to document care plans and care coordination activity. 3. TLC-MD: DCH performs Root Cause Analysis (RCA) and contacts TLC-MD to visit the bedside and enroll the patient into the TLC care coordination and care transition programs.Overall Major Strategy #3: Behavioral Health1. Johns Hopkins Infectious Control staff work with our staff to improve processes to reduce dependence and increase patient health outcomes.Overall Major Strategy #4: Physician Alignment1. MHA: DCH received a $380,000 grant from the MHA to help fund the renovations required to open the ambulatory care practice. 2. TLC-MD: TLC-MD plans to set up discharge clinics at physician offices where patients can speak with nurses, doctors, and pharmacists at no charge. 3. Sage Growth Partners: Sage is managing this initiative from a financial and operational perspective.Overall Major Strategy #5: Community Health1. Wal-Mart & Doctors Community Hospital Foundation (DCHF): DCHF obtained a $100,000 grant from Wal-Mart as seed funding for this initiative. DCHF continuously fundraises to support the on-going costs of the Mobile Clinic. 2. Prince George's Health Department referrals and State of Maryland grant funding 3. Currently, DCH works with several agencies/organizations and one bi-lingual community navigator which provide education and navigation services on average to about 1500 women annually. These partnerships include: Community Navigation and Clinical Referrals Partners, Supporting our Sisters International (SOSI), Mary's Center, African Women's Cancer Awareness Association (AWCAA), Prince George's County Health Department, It's in the Genes, Prince George’s County Alumnae Chapter of Delta Sigma Theta (PGCAC), and Reid Temple African Methodist Episcopal Church.Overall Major Strategy #6: Nursing Home1. Genesis HealthCare, TLC-MD: Genesis is a regular participant at DCH's monthly Utilization Review (UR) meetings, which discuss readmissions from the nursing home among other utilization issues.2. Genesis is also a member of TLC-MD and will implement changes to reduce readmissions at all of their nursing homes. |
| 1. **Describe the overall financial sustainability plan for each major strategy:**

Below is listed the detail for each Major Strategy, and the Grand total of 1.5 ROI. We are a learning organization and will try these efforts to effect change but will continually revise our plans to meet the Triple Aim.Overall Major Strategy #1: Care Transition and Coordination Programs at DCH and with Other Hospitals.Overall Major Strategy #2: Patient Experience & Reduced Utilization. Overall Major Strategy #3: Behavioral Health.Overall Major Strategy #4: Physician Alignment.Overall Major Strategy #5: Community Health.Overall Major Strategy #6: Nursing Home. **Grand Total:** |