**Appendix A**

**Required Executive Summary and Hospital Strategic Transformation Plan Format Due: December 7, 2015**

The ***Executive Summary*** (1-2 pages) should be a high level description of your hospital’s strategic transformation plan to support Maryland’s goals (as described on page 1) and can be submitted as an attachment in Word format.

| **Greater Baltimore Medical Center Hospital Strategic Transformation Plan** |
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| 1. Describe your overall goals: |
| * The quantitative data used to inform GBMC’s most recent community health assessment identified four key areas of opportunity:   1. Access to Health Care   2. Chronic Health Issues (heart disease, cancer, asthma/respiratory disease, stroke)   3. Risk Factors for Chronic Health Issues (Overweight/Obesity, Tobacco/Alcohol Use)   4. Maternal & Infant Health * The qualitative information collected identified four opportunity areas:  1. Access to Health Care 2. Chronic Health Issues (Diabetes, Heart Disease, Cancer) 3. Overweight/Obesity 4. Mental Health  * The over-arching vision that guides our transformation: “to every patient, every time, we will provide the care we would want for our own loved ones”   The initiatives described in this document are designed to:   * Promote access to health care to two underserved populations (low-income seniors and children receiving residential mental health treatment) * Provide chronic care management along with mental health management for high utilizing patients * To leverage the patient centered medical home within the ACO model |

| **Greater Baltimore Medical Center Hospital Strategic Transformation Plan** |
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| 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): |
| * 1. As identified by both the Key Informant and Secondary data profile portion of the community health needs assessment, access to care is one of the most significant barriers to satisfying the health needs of the community and a common obstacle to achieving good health.      1. Finding access to the appropriate care can prove to be a difficulty, particularly for low income seniors. GBMC has dedicated a full time geriatric nurse practitioner to service the healthcare needs of low income seniors within its community benefit service area. This nurse practitioner’s sole responsibility is to provide education and primary care services (physical history, medication management assistance, blood pressure screenings and seasonal vaccinations) at Towson area low-income senior living facilities. This was a service that had at one-time been provided by Baltimore County, but has been discontinued. The primary objective of the initiative is to coordinate care and provide guidance to finding and receiving the appropriate healthcare resources for the targeted low income senior population. In addition, direct care is provided to patients on a temporary basis until they have located and established a primary care provider.      2. There are many at risk adolescents that, for a variety of reasons, do not have the necessary access to health care. To address the need of improved access to healthcare services in the community, GBMC has focused its effort on improving access to care to children and adolescents receiving residential mental health treatment at the Villa Maria and St. Vincent’s Centers in Timonium (approximately 170 residents between the ages of 5 and 14). Owing to a variety of complex socio-economic issues, this highly at-risk population tends to have a variety of associated medical conditions. GBMC has provided a Pediatrician to the centers in order to provide primary care assessments and treatment, review medical reports, coordinate specialized care and dietary needs as necessary and provide preventive care.   2. Sexual abuse is an unfortunate reality across the state and country. This is a necessary service for the victims of sexual abuse in GBMC’s community.      1. The GBMC program provides medical/forensic examinations for victims of sexual assault and rape in Baltimore County. GBMC is the only hospital in Baltimore County to provide these services to victims 13 and above. The program provides compassionate care to these victims and forensic examinations provide invaluable evidence to law enforcement and the Baltimore County State's Attorney's office for prosecution. In addition to providing early forensic examinations to assist with law enforcement, the goal is also to connect victims with any resources they may need such as continued medical care or psychological counseling. |

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| 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): |
| * 1. Care Management      1. Increased the number of care coordinators to assist care managers with arranging appointments for high risk patients as well as patients with no PCP prior to discharge      2. Created a post-acute network to enhance the collaboration and communication between GBMC and the SNF providers: the post-acute providers were required to report agreed-upon quality, fill rate, and satisfaction data to GBMC      3. Home health network: Partnered with preferred home care providers: Johns Hopkins Home Care Group, Bayada, Coram, and Apria Home Care Group      4. Dedicated ED Care Management Team: in an initiative to reduce readmissions, two (2) RN care managers and one (1) social worker was added to the ED in an effort to re-route appropriate patients to the outpatient care setting      5. Transitions of Care: Process to reduce readmissions and avoidable utilization through collaboration with the primary care team. Within 48 hours of hospital discharge an RN Care Manager contacts the patient to review discharge instructions including medications; completes a chronic condition care plan; and connecting patients to community resources      6. Meds to Beds: Delivered patient medication to bedside prior to discharge, partnered with Walgreens      7. Invested in an advanced primary care model that is based on the PCMH in place of a fee-for- service primary care system. The model increased access to care to 7 days a week and 12 hours of coverage; opened 30% of slots for patient care, this allowed the PCMH to handle emergencies and reduce visits to the ED |

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| 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): |
| **GRANT: Future**   * 1. Improving GBMC’s Patient Centered Medical Homes by adding behavioral health specialist to primary care providers      1. Providing psychiatric consultation services      2. Use of a mental health screening tool      3. Licensed mental health professional will be embedded as members of the primary care team in a number of GBMC’s medical homes      4. Evidence based guidelines will be utilized in the primary care sites to guide evaluation, treatment approaches and referral protocols to direct the “stepped” care approach for referral to a psychiatrist for therapy      5. Telemedicine will be utilized within the primary care offices to assure real-time referral to a psychiatrist for patients who have urgent needs   2. Behavioral Health network: Identifying patients while in the acute care setting and providing psychiatric services on an outpatient basis, as resources are needed in the medical home the psychiatrist can be referred to. Partners to assist in the mental health network are: Mosaic, Sheppard Pratt and Kolmac      1. Psychiatric consultation in the hospital: As patients are identified through the screening tool the network will provide psychiatrists to respond to referrals for in-house evaluations and care plan development      2. Post discharge mental health support: The network will provide transition mental health services to patients who would benefit from short-term behavioral health services immediately after discharge from the hospital or after an ER episode; this will assure that patients are connected to mental health resources more immediately after an episode of care, consistent with GBMC’s focus on effective care transitions      3. Telehealth services   3. Support Our Elders: Palliative Care for Complex Chronic Patients: In partnership with Gilchrist, a Nurse Practitioner follows patients into their homes to provide care      1. A patient is identified as needing services within the home if they fall within the criteria for palliative care. The palliative care coordinator will coordinate services for that patient      2. A palliative care nurse practitioner will visit the patient within the patient’s home      3. Assisting the patient and their family in management of the patients chronic disease symptoms      4. Assisting the patient in the reduction of depression and anxiety through providing care in the home      5. The Nurse Practitioner will aid the family in navigating treatment options and goals of the patient |

| **Greater Baltimore Medical Center Hospital Strategic Transformation Plan** |
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| 1. Describe the specific target population **for each major strategy** |
| * 1. Improving access to medical care for specific populations      1. Individuals residing in one of the following Towson-area low income senior living facilities: Aigburth Vale, Tabco Towers, Virginia Towers, Trinity House, Parkview at Towson, Village Crossroads, Gallagher Services, Village Crossroads, and Lamplight Inn.      2. Children and adolescents receiving residential mental health services at Villa Maria and St. Vincent’s Centers   2. Sexual assault examination and referral program      1. Sexual assault victims   3. Care Management      1. Patients with chronic conditions, high risk for readmissions and utilization, frail and elderly   **GRANT: Future**   * 1. For population health activities identified for the grant; the targeted patient population identified via zip codes in the GBMC service area total 1, 054 Medicare patients who are identified as high utilizers   2. Criteria to identify the high utilizers population were: three (3) or more bedded encounters within the last 12 months, patients were classified as medically complex with two (2) or more chronic conditions with or without mental health diagnosis |

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| 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**: |
| * 1. Improving access to medical care for specific populations      1. Nurse practitioner services to individuals residing in Towson-area low income senior living facilities         1. The number of visits made to patients         2. The number of at risk seniors who receive flu vaccinations         3. The number of admissions to the hospital for members in the GBMC accountable care organization      2. Physician services to residents at Villa Maria and St. Vincent’s Centers         1. Reduction of doctor and/or emergency department visits as a result of better specialized care   2. Sexual assault examination and referral program      1. The number of victims who receive forensic exams      2. The number of patients who go on to receive counseling services      3. The number of people reached through community outreach and lectures   3. With the implementation of Care Management and the components of the Care Management listed above we have the following results:      1. Since 2012, the number of hospital discharges per thousand has decreased by 28.21% since 2012      2. Emergency department visits per thousand in this same population decreased by 11.7%      3. There has been a 7.8% decrease in 30-day all cause readmissions      4. Readmission rate of GBMC hospital for all patients and payers in 2012 was 6.63% with a steady decline to the current level of 5.59%, which represents a decrease of about 30 patients per month      5. GBMC currently has the lowest severity adjusted readmission rate in the state. In addition to improved utilization, total annual expenditures for the GBHA MSSP population have decreased by 9.75% since 2012 |

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| 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**: |
| **GRANT: Future**   * 1. Aside from the core baseline measures that have been identified in Table 1 of the grant application, such as: Total cost of care per capita, reduction of PAU’s, reduction of readmissions and reduction of emergency department utilization; programmatic metrics have been identified      1. Number of patients with a primary care physician      2. Number of high utilizers enrolled into the care management program      3. Number of high utilizers who need psychiatric services      4. Number of high utilizers who are enrolled with the psychiatric services      5. Number of high utilizers with a care plan |

| **Greater Baltimore Medical Center Hospital Strategic Transformation Plan** |
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| 1. List other participants and describe how other partners are working with you on **each specific major strategy:** |
| * 1. Improving access to medical care for specific populations      1. Nurse practitioner services to individuals residing in Towson-area low income senior living facilities         1. Catholic Charities            1. Partnered on a grant to improve Aging in Place         2. St Ambrose Housing         3. Inspirit Counseling Services            1. Partnered in a grant to provide in home counseling services         4. Towson University community health nursing students         5. Towson University occupational therapy students         6. Stevenson University community health nursing students         7. Notre Dame of Maryland pharmacy students      2. Physician services to residents at Villa Maria and St. Vincent’s Centers         1. Catholic Charities (Villa Maria and St. Vincent’s Centers)   2. Sexual assault examination and referral program      1. Baltimore County Police Department      2. State’s Attorney’s Office   3. Care Management Program      1. Baltimore County Health Department – Community resource, will provide home visits for high risk members of the community, provide community health education programs      2. Care Progress – Health technology company that provide medication reviews and medication reconciliation      3. Evergreen Health – Provide telemedicine services across primary care settings      4. Health Care for All Coalition – Health Care advocacy group      5. Keswick Multi-Care Center – Post acute network for home health and skilled nursing      6. Kolmac – Provide services in substance abuse      7. Mosaic community services – Outpatient mental health and substance abuse services      8. Sheppard Pratt Health System – Psychiatrists provided to GBMC |

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| 1. List other participants and describe how other partners are working with you on **each specific major strategy:** |
| **GRANT: Future**   * 1. Improving GBMC’s Patient Centered Medical Homes by adding behavioral health specialist to primary care providers      1. Sheppard Pratt Health System – Providing more psychiatrists to the PCMH to care for patients who are a part of the targeted patient population      2. Mosaic community services – Expansion of mental health services to the targeted patient population      3. Keswick Multi – The expansion of the home health and skilled nursing facilities as preferred resources to the PCMH      4. Evergreen Health – Expansion of the telemedicine program to include more behavioral health services      5. Care Progress – The process to conduct medication reviews and medication reconciliation will be focused on the targeted patient population   2. Behavioral Health Network      1. Kolmac – Is a preferred provider in substance abuse services      2. Health Care for All Coalition – The continuation of current program but outreach to the targeted patient population identified within the grant      3. Baltimore County Health Department – The continuation of current program but now focused on the targeted patient population identified within the grant   3. Support Our Elders      1. Gilchrist – In collaboration with GBMC identify patients who require palliative and support      2. MedStar Health – Collaborating with GBMC on patients who require palliative support but may live in another zip code |

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| **Greater Baltimore Medical Center Hospital Strategic Transformation Plan** |
| 1. Describe the overall financial sustainability plan **for each major strategy:** |
| * 1. Improving access to medical care for specific populations      1. Nurse practitioner services to individuals residing in Towson-area low income senior living facilities         1. Approximately: $207,005         2. Physician services to residents at Villa Maria and St. Vincent’s Centers: $192,436   2. Sexual assault examination and referral program: $304,272 |
| **GRANT: Future**   * 1. The approximate grant request is $1,395M: this is to provide FTE’s such as a high utilizer Care Managers, Care coordinator, clinical pharmacist, psychiatric nurse, palliative care coordinator and palliative care nurse practitioner   2. As new contracting models take shape, and as GBMC’s program proves its value – in terms of medical cost savings, patient satisfaction, employee productivity, and reduction of long-term risk factors – GBMC expects that the program will be self-sustaining through contracting models designed around PCMHs, mental health carve-outs, and/or value-based contracts specific to mental health services. ACO funding of the PCMHs: * The expectation is that the Greater Baltimore ACO will continue to fund the PCMHs, and that a single funding stream to the ACOs will include support for both the medical and behavioral health services care coordination. Savings from the ACO will also support performance-based activity for behavioral health service providers in the ACO. * GBMC expects to work with its partner, Evergreen Health, to develop the “value proposition” to payors, accompanied by hard data to demonstrate the costs of under treatment and the savings of a collaborative care model where more care is shifted to the community-based setting. This is expected to lead to mental health contracts that may take any number of forms: * Contracts with employers * Mental health carve-outs with commercial payors * Value-Based Insurance Design (VBID) – GBMC is identified as a high value provider and copayments would be eliminated. This model would be designed to remove financial barriers and encourage patients themselves to seek high value behavioral health care providers. (Note: GBMC is in the preliminary stages of discussing a partnership with Evergreen Health to develop such a product). * Medicaid program – As ACOs are established for Medicaid and dual eligibles, GBMC expects that there will be the opportunity for performance incentives based on state defined quality measure, models that are already in place in other states. GBMC would expect a mental health carve-out PMPM to manage patients identified for an integrated care plan. |