HSCRC Regional Partnership Transformation Grant

FY 2020 Report

The Health Services Cost Review Commission (HSCRC) is reviewing the following for FY 2020: this Report, the Budget Report, and the Budget Narrative. Whereas the Budget Report distinguishes between each hospital, this Summary Report should describe all hospitals, if more than one, that are in the Regional Partnership.

Regional Partnership Information

Regional Partnership (RP) Name	Community Health Partnership of Baltimore
RP Hospital(s)	1. Johns Hopkins Hospital 2. Johns Hopkins Bayview Medical Center 3. LifeBridge Sinai Hospital 4. Mercy Medical Center
RP POC	Lindsay Hebert, MSPH, Interim Director, CHPB Johns Hopkins HealthCare, LLC Lhebert3@jhmi.edu
RP Interventions in FY 2020	1. Community Care Team 2. Home-Based Primary Care/JHOME 3. Behavioral Health Bridge Team 4. Homeless Convalescent Care 5. Neighborhood Navigators 6. Patient Engagement Program/Provider Training 7. Helping Up Mission's Next Step Program
Total Budget in FY 2020 *This should equate to total FY 2020 award*	FY 2020 Award: $4,182,255.18
Total FTEs in FY 2020	Employed: 50.1 FTE
	Contracted: 29 FTE 18 part-time stipend employees
Program Partners in FY 2020 *Please list any community-based organizations or provider groups, contractors, and/or public partners*	1. Sisters Together and Reaching, Inc. 2. The Men & Families Center 3. Health Care for the Homeless 4. Johns Hopkins Medicine 5. Helping Up Mission

Overall Summary of Regional Partnership Activities in FY 2020

(Free Response: 1-3 Paragraphs):

The Community Health Partnership of Baltimore (CHPB) has served Medicare fee-for-service (FFS) patients across Baltimore City, coordinating care for residents with complex medical, behavioral, and/or social challenges. CHPB has focused on identifying and addressing social determinants of health so patients can focus on leading healthy lives. Our care team-based approach, collaboration with primary care providers, and innovative use of health behavioral specialists and community health workers has helped Baltimore residents become more engaged in their healthcare.

In FY2020, CHPB focused strategically on increasing enrollment in our Community Care Team (CCT) and Behavioral Health Bridge Team (Bridge) interventions by following up with patients who had recently visited the emergency room with a low acuity need. Our teams were able to connect with patients 1-3 days after their visit, offering support with their healthcare follow-up and more often, connections to social services in Baltimore. This strategy proved successful in helping us augment enrollment and also in engaging patients with local resources, non-profits, and healthcare providers.

Conservative estimates for each initiative's return on investment (ROI) are provided in this report. We are proud to present ROIs greater than 1.0 for 3 of 4 initiatives. In keeping with the HSCRC's prescribed methodology, and estimating that only 50% of the cost reductions are attributable to these interventions, we calculate ROIs ranging from 0.74-3.5.

CHPB partner hospitals are appreciative to have had this opportunity to collaborate and look forward to continuing discussions around strengthening relationships with each other and with community-based organizations. We look forward to serving the community in new and innovative ways in the future.

Intervention Program

Please copy/paste this section for each Intervention/Program that your Partnership maintains, if more than one.

Intervention or Program Name	Community Care Team (CCT)
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	All
Brief description of the Intervention *2-3 sentences*	The CCTs expand upon existing services of primary care providers to meet the needs of and coordinate care for a high-risk, Medicare population. Each team consists of a minimum of one Nurse/Social Worker Care Manager, two Community Health Workers, and one Health Behavior Specialist. The teams assess social influencers of health, medical, and behavioral health needs of

	patients. The teams meet a patient's needs by connecting the patient to primary care, resources to abate social barriers, and other medical and behavioral health resources.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	Sisters Together and Reaching, Inc. Johns Hopkins Medicine
Patients Served *Please estimate using the Population category that best applies to the Intervention, from the CY 2018 RP Analytic Files. HSCRC acknowledges that the High Utilizer/Rising Risk or Payer designations may over-state the population, or may not entirely represent this intervention's targeted population.* *Feel free to **also** include your partnership's denominator.*	# of Patients Served as of June 30, 2020: 444 patients were enrolled and receiving CCT services during the year, regardless of enrollment date
	Denominator of Eligible Patients: From RP Analytic Files: Out of a population of 74,445 individuals with Medicare FFS in our Partnership area in 2020, 501 patients were deemed eligible for outreach CCT services.
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	Due to the COVID-19 pandemic, utilization patterns and enrollment processes were disrupted, making accurate measurement of outcomes pre and post difficult. Therefore, we chose to evaluate the results of individuals enrolled only through February 2020, before the pandemic closed down hospitals and health systems. The pre post results presented here represent individuals enrolled from July 2019 through February 2020. Pre/post intervention reports are only available for individuals enrolled in the CCT who have a common MRN, panel analysis on the 412 individuals who had a Hopkins MRN (the most common MRN among the population) showed significant post CCT enrollment reductions in both hospital utilization and charges that appear to persist or even improve over time. In this summary, we choose to focus on a 6 month pre/post period, since our intervention is intended to create both short- and longer- term results, and 6 months in a pre- period is more representative of the patient's prior utilization than one or three months, which may only show an acute episode and not persistent high utilization.

Considering the 412 individuals who had 6 or more months of post data, we found that the number of patients with 1 or more visits dropped by 4%, the rate of visits per 10 members dropped by 13.4 visits (13.5% decrease), the average charges per member dropped by $13,672 (27.2% decrease in charges per member), and the average charge per visit was reduced by $925 (19.8% decrease). Please refer to the Pre Post Summary Analysis for more information on the reductions in visits and charges after enrollment in the CCT at 1, 3, 6, and 12 months.

When examining total hospital charges and visits pre post, we find that at 6 months, the total hospital charges in the post period are reduced by $4,390,052 (30.2% reduction) after enrollment in the CCT as compared to total charges across the 6 months prior to CCT enrollment. Further, the number of hospital visits dropped by 174 visits (33.4% decrease) in the 6 months after enrollment in the CCT as compared to the 6 month pre period.

Each hospital serving as a partner in CHPB saw a significant reduction in hospital charges pre/post for individuals enrolled in the CCT at 6 months. For more information on these numbers, as well as for the visual month by month trends in pre/post visits and charges, please refer to the CCT 6 month Panel Analysis as well as the 6 month relative trend analyses for hospital visits and charges.

Please see Appendix A for the CCT's 6 Month Pre/Post Analysis Report from CRISP.

Intervention-Specific Outcome or Process Measures
(optional)
These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership maintains and uses to analyze performance. Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.

Process Measures	Number
Total number of patients deemed eligible for CCT outreach, after screening process	501
Total number of patients enrolled and receiving CCT services during the year, regardless of enrollment date	444
Total number of patients enrolled in CCT on June 30, 2020	0
Number of cases closed because all patient goals were met	92
Number of cases closed because patient was transferred to other care management program (i.e.: working with care managers at hospital or primary care clinic)	44
Number of cases refusing CCT services after patient was referred	236

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<tr><td></td><td>
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<tr><td>Number of patients who were deceased after patient referred</td><td>8</td></tr>
<tr><td>Number of cases not meeting program criteria after patient was referred</td><td>28</td></tr>
<tr><td>Number of cases unable to locate after patient was referred</td><td>93</td></tr>
<tr><td>Average age for enrolled patient</td><td>52.5 years old</td></tr>
<tr><td>Average number of chronic conditions for enrolled patients (from CRISP High Utilizer data)</td><td>4</td></tr>
<tr><td>Average number of successful CHW contacts per patient per month</td><td>Approx. 2.8</td></tr>
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<tr><td>Successes of the Intervention in FY 2020
Free Response, up to 1 Paragraph</td><td>Successes of the CCT intervention include the fact that hospitals were able to establish strong working relationships with partners at Sisters Together and Reaching, (STAR), the organization that hires, trains, and manages community health workers (CHWs). STAR CHWs worked directly with Case Managers (CMs) and Health Behavior Specialists (HBSs). The teams huddled weekly to discuss specific cases and learn from each other. On a monthly basis, all of the teams came together for Care Conference, where outside presenters offered information about resources in the city. These improvements in staff collaboration and partnership were the greatest success. Over the years of this initiative, team members established strong working relationships with each other and with local organizations and non-profits to which they often referred patients.</td></tr>
<tr><td>Additional Free Response (Optional)</td><td>Using data from the Summary Report in CRISP through February (to ensure COVID period data did not skew the results), we saw a savings of $13,672 in the 6 month pre/post cohort. Given the smaller number of individuals for whom we had a common MRN and at least 6 months of data since enrollment (N=412), we extrapolate a 6 month ROI using the following methods.

Using a conservative approach that attributes only 50% of the savings directly to the CCT and attributes the rest to factors other than the CCT (regression to mean, other programs, life factors, etc.), we calculate an ROI for the 444 individuals enrolled in the program by multiplying the average savings per person in the 6 month cohort in CRISP times the number of individuals enrolled (444). Next, we subtract the total savings calculated in the last step from the cost of the CCT per year, then divide that number by the 6 month cost of the program to calculate an estimated ROI. The estimated ROI on the 444 individuals enrolled is 1.56, and would be 4.11 if</td></tr>
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we did not discount by 50% to be conservative. We apply this same methodology in other sections as well.

ROI (based on 6-month pre/post savings)	
Average reduction in per member charges at 6 months from Pre/Post Reports in CRISP	$13,672.00
Per member reduction in charges discounted by 50%	$6,836.50
Members enrolled in CCT	444
Total cost of CCT program (for 6 months)*	$1,186,498
Total member savings at 6 months	$3,035,406
6 Month ROI	1.56

*Figure based on FY19 expenditures, as FY20 budget was significantly reduced and some services were provided in-kind in FY20.

Intervention or Program Name	Emergency Department Initiative (EDI)
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	JHH JHBMC
Brief description of the Intervention *2-3 sentences*	The Emergency Department Initiative (EDI) is a strategic referral program for patients who have recently visited an emergency department with a low acuity need (levels 4 and 5). The day after their ED visit, a clinical screener determines if they might be eligible to receive CHPB services. CHWs outreach the patients by phone, within 48 hours of their ED visit, for follow-up and engage them in a discussion about their plan of care. In some cases, CHWs are able to help the patient navigate the challenges they are facing. In other instances, CHWs refer patients to other initiatives within CHPB or to local community resources.
Participating Program Partners *Please list the relevant community-based*	Sisters Together and Reaching, Inc. Johns Hopkins Medicine (various departments)

organizations or provider groups, contractors, and/or public partners	
Patients Served *Please estimate using the Population category that best applies to the Intervention, from the CY 2018 RP Analytic Files. HSCRC acknowledges that the High Utilizer/Rising Risk or Payer designations may over-state the population, or may not entirely represent this intervention's targeted population.* *Feel free to **also** include your partnership's denominator.*	# of Patients Served as of June 30, 2020: 954 Denominator of Eligible Patients: 2,241
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	Due to the COVID-19 pandemic, utilization patterns and enrollment processes were disrupted, making accurate measurement of outcomes pre and post difficult. Therefore, we chose to evaluate the results of individuals enrolled only through February 2020, before the pandemic closed down hospitals and health systems. The pre post results presented here represent individuals enrolled in the ED Initiative from July 2019 through February 2020. Pre/Post Reports are only available for individuals enrolled in the EDI who have a common MRN, panel analysis on the 356 individuals who had a Hopkins MRN (the most common MRN among the population) showed significant post enrollment reductions in both hospital utilization and charges that appear to persist or even improve over time. The goal of the EDI Initiative is to reduce ED utilization and costs using a short term intervention. Therefore, we use pre/post intervention reports showing 3 months pre and post intervention ED utilization and costs. Considering the 277 individuals who had 3 or more months of post data, we found that the number of patients with 1 or more visits dropped by 65.6%, the rate of visits per 10 members dropped by 13.0 visits (60% decrease), the average charges per member increased by $637 per member who did have another ED visit. The average charge per visit also increased by $67 (5.7% increase). Given the large decrease in the number and rate of visits, and the increase in charges per member and per visit, we believe it is likely that those who did show up in the ED again after enrollment were less likely to

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<td>have an unnecessary visit. Please refer to the Pre Post Summary Analysis for more information on the reductions in visits and charges after enrollment in the EDI at 1 and 3 months.

When examining total ED charges and visits pre post, we find that at 3 months, the total ED charges in the post period are reduced by $399,081 (57.9% reduction) after enrollment in the EDI as compared to ED charges across the 3 months prior to EDI enrollment. Further, the number of ED visits dropped by 351 visits (60.2% decrease) in the 3 months after enrollment in the EDI as compared to the 3 month pre period.
For more information on these numbers, as well as for the visual month by month trends in pre/post visits and charges, please refer to the EDI 3 month Panel Analysis as well as the 1 month relative trend analyses for ED visits and charges.

Please see Appendix A for the EDI Pre/Post Analysis Report from CRISP.</td>
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<td>Intervention-Specific Outcome or Process Measures
(optional)
These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership maintains and uses to analyze performance. Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.</td>
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<table>
<tr><th>Process Measures</th><th>Number</th></tr>
<tr><td>Total number of patients referred from JHH and JHBMC</td><td>36,018</td></tr>
<tr><td>Total number of patients ever eligible for outreach – STAR CHWs</td><td>2,241</td></tr>
<tr><td>Total number of cases with successful contacts – STAR CHWs</td><td>1726</td></tr>
<tr><td>Total number of cases with unsuccessful contacts – STAR CHWs</td><td>515</td></tr>
<tr><td>Total number of cases successfully contacted but never enrolled – STAR CHWs</td><td>772</td></tr>
<tr><td>Total number of cases ever enrolled – STAR CHWs</td><td>954</td></tr>
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<td>Successes of the Intervention in FY 2020
Free Response, up to 1 Paragraph</td>
<td>• The intervention leads prioritized identifying and hiring competent, resourceful staff that were respected in the communities. This led to increased engagement and trust with patients.
• Over the course of this work, STAR created partnerships with over 100 external organizations to help mitigate social determinants of health that impact these populations. These partnerships assisted the CHWs in being able to help the patients and their families stabilize their housing, transportation, food, utilities, and even helped to address issues of medication and treatment adherence.</td>
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EDI teams were able to connect and partner with primary care providers and specialists at partner hospitals. Most notably, they made great connections for patients struggling with substance use disorders.
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<tr><td>Additional Free Response (Optional)</td><td>
Using data from the Summary Report in CRISP through February (to ensure COVID period data did not skew the results), we saw a savings of $399,081 in the 3 month pre/post cohort. Given the smaller number of individuals for whom we had a common MRN and at least 3 months of data since enrollment (N=277), we extrapolate a 3 month ROI using the following methods.
Using a conservative approach that attributes only 50% of the savings directly to the EDI and attributes the rest to factors other than the EDI (regression to mean, other programs, life factors, etc.), we calculate an ROI for the 954 individuals enrolled in the program by dividing the difference in total ED charges pre/post (399,081) by the number of individuals in the panel (277). Then, we divide this number by two to calculate a 50% savings attribution, then multiplying the average savings per person in the 3 month cohort in CRISP times the number of individuals enrolled (954). Next, we subtract the total savings calculated in the last step from the cost of the EDI for 3 months to calculate an estimated ROI. The estimated ROI on the 954 individuals enrolled is 1.32, and would be 3.63 if we did not discount by 50% to be conservative.
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<tr><th colspan="2">ROI (based on 3-month pre/post savings)</th></tr>
<tr><td>Average reduction in per member charges at 3 months from Pre/Post Reports in CRISP</td><td>$1440.72</td></tr>
<tr><td>Per member reduction in charges discounted by 50%</td><td>$720.36</td></tr>
<tr><td>Members enrolled in ED program</td><td>954</td></tr>
<tr><td>Total cost of ED program (for 3 months)*</td><td>$296,624.50</td></tr>
<tr><td>Total member savings at 3 months</td><td>$687,223.44</td></tr>
<tr><td>3 Month ROI</td><td>1.32</td></tr>
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*Figure based on FY19 expenditures, as FY20 budget was significantly reduced and some services were provided in-kind in FY20.
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Intervention or Program Name	Home-Based Primary Care/JHOME
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	Johns Hopkins Bayview Medical Center Johns Hopkins Hospital LifeBridge Sinai Hospital
Brief description of the Intervention *2-3 sentences*	Home-Based Primary Care (JHOME) is a community-based program that provides home-based medical care, care management, caregiver support, counseling, and acute inpatient continuity to high-need, high cost, home-bound individuals on a longitudinal basis. The multi-disciplinary team consists of a Program Director, Geriatrician, Certified Registered Nurse Practitioner, Social Worker, Registered Nurse, Practice Manager, Patient Service Coordinator, and a Licensed Practical Nurse.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	Johns Hopkins Medicine Department of Geriatrics
Patients Served *Please estimate using the Population category that best applies to the Intervention, from the CY 2018 RP Analytic Files. HSCRC acknowledges that the High Utilizer/Rising Risk or Payer designations may over-state the population, or may not entirely represent this intervention's targeted population.* *Feel free to **also** include your partnership's denominator.*	# of Patients Served as of June 30, 2020: 333 Note: Due to unexpected need to re-budget funds in early 2020, this program did not enroll any new patients after May 2020.
	Denominator of Eligible Patients: From RP Analytics Files: Out of a population of 74,445 individuals with Medicare FFS in the RP area, only those who are homebound are eligible for this intervention. As this number is not readily available, we instead will use total referrals as the denominator of eligible patients. There were a total of 433 total referrals to this intervention in FY20. The JHOME team continued to manage patients who were enrolled in FY19, in addition to newly referred patients.

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<td>Pre-Post Analysis for Intervention
(optional)
If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.</td>
<td>Due to the COVID-19 pandemic, utilization patterns and enrollment processes were disrupted, making accurate measurement of outcomes pre and post difficult. Therefore, we chose to evaluate the results of individuals enrolled only through February 2020, before the pandemic closed down hospitals and health systems. The pre post results presented here represent individuals enrolled in the JHOME Initiative from July 2019 through February 2020.

Pre/Post Reports are only available for individuals enrolled in JHOME who have a common MRN. Panel analysis on the 248 individuals who had a Hopkins MRN (the most common MRN among the population) showed significant post enrollment reductions in both hospital utilization and charges.

Considering the 193 individuals who had 6 or more months of post data, we found that the number of patients with 1 or more visits dropped by 28%, the rate of visits per 10 members dropped by 16 visits (46% decrease), and the average charges per member decreased by $11,530 per member. The average charge per visit also decreased by $2,017. Please refer to the Pre Post Summary Analysis for more information on the reductions in visits and charges after enrollment in JHOME at 6 months.

When examining total ED charges and visits pre post, we find that at 6 months, the total ED charges in the post period are reduced by $2,597,606 (64% reduction) after enrollment in JHOME as compared to ED charges across the 6 months prior to JHOME enrollment. Further, the number of ED visits dropped by 309 visits (46% decrease) in the 6 months after enrollment in JHOME as compared to the 6 month pre period.

For more information on these numbers, as well as for the visual month by month trends in pre/post visits and charges, please refer to the JHOME 6 month Panel Analysis as well as the 6 month relative trend analyses for ED visits and charges.

Please see Appendix A for the EDI Pre/Post Analysis Report from CRISP.</td>
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<td>Intervention-Specific Outcome or Process Measures
(optional)
These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership maintains and uses to analyze performance.</td>
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<table>
<tr><th>JHOME Process Measure</th><th>Number or Percent</th></tr>
<tr><td>Total Number of Patients Newly Referred</td><td>433</td></tr>
<tr><td>Total Number of Patients Newly Enrolled</td><td>333</td></tr>
<tr><td>Total Number of Home Visits</td><td>4363</td></tr>
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<tr><td>Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.</td><td>
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<tr><td>Total Urgent Visits</td><td>193</td></tr>
<tr><td>Percent of Patients with Completed Annual Wellness Visits</td><td>62%</td></tr>
<tr><td>Total Inpatient Encounters</td><td>468</td></tr>
<tr><td>Total Number of ED Visits</td><td>383</td></tr>
<tr><td>Percent of Deaths at Home and in Hospice</td><td>61%</td></tr>
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<tr><td>Successes of the Intervention in FY 2020
Free Response, up to 1 Paragraph</td><td>
Program transitions for sustainability and scalability post-award, including:

Moving the program organizationally within Johns Hopkins while building a multidisciplinary, multi-agency team that works efficiently together in serving over 300 homebound older adults in Baltimore and Howard County.
Implementing a contract with Medicare Advantage to help the program become financially sustainable.
Establishing partnership with Howard County General Hospital's Community Care Team to expand the JHOME service into the Howard County area.

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<tr><td>Additional Free Response (Optional)</td><td>
<table>
<tr><th colspan="2">ROI (based on 6-month pre/post savings)</th></tr>
<tr><td>Average reduction in per member charges at 6 months from Pre/Post Reports in CRISP</td><td>$11,530</td></tr>
<tr><td>Per member reduction in charges discounted by 50%</td><td>$5,765</td></tr>
<tr><td>Members enrolled in JHOME</td><td>333</td></tr>
<tr><td>Total cost of JHOME program (for 6 months)*</td><td>$427,294</td></tr>
<tr><td>Total member savings at 6 months</td><td>$1,919,745</td></tr>
<tr><td>6 month ROI</td><td>3.49</td></tr>
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*Figure based on FY19 expenditures, as FY20 budget was significantly reduced and some services were provided in-kind in FY20.
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Intervention or Program Name	Behavioral Health Bridge Team

RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	All
Brief description of the Intervention *2-3 sentences*	The Bridge Team is a multi-disciplinary team that works with patients exhibiting complex psychiatric needs, substance use disorder (SUD), and other complex care management needs associated with behavioral health. The primary goal of the Bridge Team is to facilitate a successful transition to a medical home and engage patients in behavioral health services. The team consists of a part-time Psychiatrist, a Health Behavior Specialist Team Lead, a Health Behavior Specialist, and two behavioral health Community Health Workers.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	Johns Hopkins Medicine
Patients Served *Please estimate using the Population category that best applies to the Intervention, from the CY 2018 RP Analytic Files. HSCRC acknowledges that the High Utilizer/Rising Risk or Payer designations may over-state the population, or may not entirely represent this intervention's targeted population.* *Feel free to **also** include your partnership's denominator.*	# of Patients Served as of June 30, 2020: 38 enrolled and open in the intervention; many more with successful contacts with the team
	Denominator of Eligible Patients: Total from RP Analytics Files: Out of a population of 74,445 individuals with Medicare FFS in the RP area, only those who meet psychiatric criteria are eligible for this intervention. As this number is not readily available, we instead will use total referrals as the denominator of eligible patients. There were a total of 690 patients referred to this program.
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or*	Due to the COVID-19 pandemic, utilization patterns and enrollment processes were disrupted, making accurate measurement of outcomes pre and post difficult. Therefore, we chose to evaluate the results of individuals enrolled only through February 2020, before the pandemic closed down hospitals and health systems. The pre post results presented here represent

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<td>other file format of the Intervention's Pre-Post Analysis.</td>
<td>individuals enrolled in the Bridge Team Initiative from July 2019 through February 2020.

Pre/Post Reports are only available for individuals enrolled in Bridge who have a common MRN. Panel analysis on the 21 individuals who had a Hopkins MRN (the most common MRN among the population) showed post enrollment reductions in charges while the number of total visits did not change much.

The Bridge Team patient panel contains 21 patients for the time period July 2019 through February 2020. In this summary, we use the CRISP pre/post data for the 13 patients with data for analysis 6 months before and after enrollment. Patients were not included in CRISP's reporting if they were enrolled less than 2 months, and/or their MRN was not able to be located in CRISP's system.

The patients enrolled in the Bridge intervention had $644,738 in total charges prior to enrollment and $608,681 after enrollment, showing a reduction of $36,057 over 6 months and an average decrease of $3,005 per patient. The number of total visits for this cohort prior to enrollment in the Bridge team was 133, and decreased to 132 after 6 months of enrollment in the intervention. On average, the total charges per visit decreased by $236 per patient after 6 months.

Please see Appendix A for the Bridge Team's 6 Month Pre/Post Analysis Report from CRISP.</td>
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<tr>
<td>Intervention-Specific Outcome or Process Measures
(optional)
These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership maintains and uses to analyze performance. Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.</td>
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<tr><th>Process Measure 2020</th><th>Number</th></tr>
<tr><td>Total number of patients referred – standard referral</td><td>54</td></tr>
<tr><td>Total number of patients enrolled – standard referral</td><td>18</td></tr>
<tr><td>Total number of patients referred – ED referral</td><td>690</td></tr>
<tr><td>Total number of cases with successful contacts – ED referral</td><td>172</td></tr>
<tr><td>Total number of patients enrolled – ED referral</td><td>20</td></tr>
<tr><td>Total number of outreach interactions with HBS (not unique patients)</td><td>299</td></tr>
<tr><td>Total number of outreach attempts with HBS</td><td>1287</td></tr>
<tr><td>Total number of outreach interactions with CHW (not unique patients)</td><td>722</td></tr>
<tr><td>Total number of outreach attempts with CHW</td><td>1074</td></tr>
<tr><td>Average length of treatment (days)</td><td>130</td></tr>
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Successes of the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	• The CCT HBS combined with the Bridge team and participated in rounds and consultation with the team's members (including psychiatrist). • The team successfully implemented telemedicine to address COVID-19 safety concerns. This included regular check ins with patients, review of Safety Plans to include COVID-19 issues, and continued treatment sessions. • The Bridge Team successfully discharged 89% of enrolled patients, having achieved care goals, including connection to outpatient behavioral health programs (an increase of 5% from the previous year). • Bridge team developed and implemented 2- and 4-week follow up with patients discharged from team to determine if they were still connected to treatment. 100% of those patients discharged with goals met were still connected to treatment at both the 2 and 4 week periods. • 70% of the patients referred through the EDI initiative successfully completed all or part of their agreed upon goals (all of which included goals to connect to long-term medical and/ or behavioral health services). • The teams fostered collaborative relationships with recovery centers, counseling centers, and providers at clinics to assist with medication-assisted therapy.
Additional Free Response (Optional)	See ROI table below.

ROI (based on 6-month pre/post savings)	
Average reduction in per member charges at 6 months from Pre/Post Reports in CRISP	$3005
Per member reduction in charges discounted by 50%	$1502.50
Members enrolled in Bridge	38
Total cost of Bridge program (for 6 months)*	$223,405
Total member savings at 6 months	$57,095
6 Month ROI	0.74

*Figure based on FY19 expenditures, as FY20 budget was significantly reduced and some services were provided in-kind in FY20.

Intervention or Program Name	Convalescent Care
RP Hospitals Participating in Intervention	All

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<tr><td>Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.</td><td></td></tr>
<tr><td>Brief description of the Intervention
2-3 sentences</td><td>Convalescent Care provides people experiencing homelessness who are discharged from a hospital partner a place to stay, rest, and recuperate from an acute illness or surgery. On the Convalescent Care unit, patients receive 12-hour-a-day nursing services (medication education, care coordination, and wound care) and social work services (to link patients to housing resources, income, mental health, and addiction services).</td></tr>
<tr><td>Participating Program Partners
Please list the relevant community-based organizations or provider groups, contractors, and/or public partners</td><td>Health Care for the Homeless</td></tr>
<tr><td rowspan="2">Patients Served
Please estimate using the Population category that best applies to the Intervention, from the CY 2018 RP Analytic Files. HSCRC acknowledges that the High Utilizer/Rising Risk or Payer designations may over-state the population, or may not entirely represent this intervention's targeted population.
Feel free to also include your partnership's denominator.</td><td># of Patients Served as of June 30, 2020:
80</td></tr>
<tr><td>Denominator of Eligible Patients:

Total from RP Analytic Files: Out of a population of 74,445 individuals with Medicare FFS in the RP area, only those who are homeless and being discharged from the hospital are eligible for this intervention. The total referrals of individuals leaving the hospital in need of convalescent care were estimated to be approximately 400.</td></tr>
<tr><td>Pre-Post Analysis for Intervention
(optional)
If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.</td><td>Unable to report pre-post analysis for FY20. Due to transitions in leadership and inability to access patient-specific MRNs, CRISP panels were not available.</td></tr>
</table>

Intervention-Specific Outcome or Process Measures (optional)

These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership maintains and uses to analyze performance. Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.

Convalescent Care Process Measure	Number
Total Number of Patients Referred	341
Total Number of Accepted Referrals	106
Total Number of Patients Presenting for Care	80
Average Number/percent of Beds Filled Monthly (out of 12)	11
Average Length of Stay per Month (days)	57
Number of Patients Who Saw a Primary Care Physician within 7 days of discharge from Convalescent Care	5
Number/Percent of Patients with Follow Up to Behavioral Health within 14 days of discharge from Convalescent Care	3
Number of Patients sent to ED from Health Care for the Homeless	27
Number of patients readmitted to Hospital from Health Care for the Homeless	20
Number of Patients Successfully Discharged from Unit	37

Successes of the Intervention in FY 2020

Free Response, up to 1 Paragraph

- CCP was able to recruit and hire for all vacant positions. This included stabilization of medical providers at CCP that had otherwise seen a lot of turnover. Continuity of care was better orchestrated, and clients were receiving more comprehensive care as a result.
- The flexibility/adaptability of the team has been a great success. Even with change in setting in the pandemic, they continued to provide support in the form of medical care, mental health therapy, and case management.
- Success Story: CCP admitted an 80 year old man after he completed a year of sobriety in transitional housing. He came to CCP with a diagnosis of lung cancer, was connected to chemotherapy and then immunotherapy, and then transitioned to an assisted living facility where he has remained. He has also stayed connected to medical care and mental health therapy.
- Success Story: A man was admitted to CCP for connection to outpatient wound care for large venous stasis ulcers to both his legs. He not only connected to a wound care clinic where he continues to get weekly compression therapy, but started regularly attending appointments at his anticoagulation clinic for warfarin monitoring. Additionally, he started on suboxone, and has been using money every month to pay off his housing balance while he stays at the shelter.

Additional Free Response (Optional)	Unable to report intervention-specific ROI for FY20. Due to transitions in leadership and inability to access patient-specific MRNs, CRISP panels were not available.

Intervention or Program Name	Neighborhood Navigators
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	Johns Hopkins Hospital Johns Hopkins Bayview Medical Center
Brief description of the Intervention *2-3 sentences*	The Men and Families Center (MFC) in East Baltimore hires and trains Neighborhood Navigators and Case Coordinators. Neighborhood Navigators (NNs) are present in/around the 21205 zip code, serving people they encounter regardless of whether or not the individual's address is in 21205. The majority of their clients reside in the 21202, 21205, 21206, 21213, 21217, 21218, 21223, and 21224 zip codes. NNs engage them in discussions about available healthcare and social service resources that might help meet their needs. Case Coordinators (CCs), located at MFC, are available to provide more direct assistance to clients (i.e.: helping them enroll in health insurance, helping them to find employment, etc.).
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	The Men & Families Center
Patients Served *Please estimate using the Population category that best applies to the Intervention, from the CY 2018 RP Analytic Files.* *HSCRC acknowledges that the High Utilizer/Rising Risk or Payer designations may*	# of Patients Served as of June 30, 2020: 2349
	Denominator of Eligible Patients: According to the American Community Survey, as of 2018, there were estimated 14,580 individuals residing in the 21205 area where the Neighborhood Navigators were deployed. The eligible population could be much larger, given the NN serve any individuals in need of assistance who

<table>
<tr><td>over-state the population, or may not entirely represent this intervention's targeted population.
Feel free to also include your partnership's denominator.</td><td>they encounter in 21205, regardless of address of residence.</td></tr>
<tr><td>Pre-Post Analysis for Intervention
(optional)
If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.</td><td>N/A</td></tr>
<tr><td>Intervention-Specific Outcome or Process Measures
(optional)
These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership maintains and uses to analyze performance. Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.</td><td>

<table>
<tr><th colspan="2">HSCRC FY19 NN MFC Summary 7/1/19 - 6/30/20</th></tr>
<tr><th>Neighborhood Navigator Process Measure</th><th>Number</th></tr>
<tr><td>Total number of clients served</td><td>2349</td></tr>
<tr><td>Median newly assessed per month</td><td>221</td></tr>
<tr><th>Identified Needs</th><th>7/1/2019 - 6/30/2019</th></tr>
<tr><td>Employment and Training</td><td>1283</td></tr>
<tr><td>Housing Services</td><td>1032</td></tr>
<tr><td>Insurance Support</td><td>788</td></tr>
<tr><td>Utility Bills</td><td>426</td></tr>
<tr><td>Re-entry Services</td><td>410</td></tr>
<tr><td>Dental Care</td><td>335</td></tr>
<tr><td>Emergency Assistance</td><td>299</td></tr>
<tr><td>ID Services</td><td>254</td></tr>
<tr><td>Vision Care</td><td>186</td></tr>
<tr><td>Transportation</td><td>125</td></tr>
</table>

The following table reports on the work of the Case Coordinators at MFC during FY20.

<table>
<tr><th>Services identified by Case Coordinators</th><th>7/1/19 - 6/30/20</th></tr>
<tr><td>Total # of CC Encounter Forms entered</td><td>112</td></tr>
<tr><td>Total # of clients (unique) serviced by CC who were referred by NN</td><td>93</td></tr>
<tr><td>Total # of Case Coordinators</td><td>2</td></tr>
</table>

</td></tr>
</table>

Successes of the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	• During FY20, NNs made 4,859 total encounter contacts and 2,349 of these were unique clients. • M&FC secured additional funding from JHH for FY21.
Additional Free Response (Optional)	NA

Intervention or Program Name	Patient Engagement Program
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	All (until March 2020, when the program was stopped early due to changes in budget)
Brief description of the Intervention *2-3 sentences*	The Patient Engagement Program (PEP) is a comprehensive, in-person, skills-based training program that teaches nurses, physicians, social workers, and other providers how to change their team's culture, engage their patients as partners in health care, and communicate in a way that motivates patients to engage in healthier behaviors.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	Johns Hopkins Medicine

<table>
<tr><td rowspan="2">Patients Served
Please estimate using the Population category that best applies to the Intervention, from the CY 2018 RP Analytic Files.
HSCRC acknowledges that the High Utilizer/Rising Risk or Payer designations may over-state the population, or may not entirely represent this intervention's targeted population.
Feel free to also include your partnership's denominator.</td><td># of Patients Served as of June 30, 2020:

This intervention does not directly serve patients, but rather CHPB and hospital partner staff.

CHPB Interventions' Staff: 3
CHPB Hospital Partners' Staff: 43
The Johns Hopkins Hospital: 35
Johns Hopkins Bayview Medical Center: 1
LifeBridge Sinai Hospital: 7
Mercy Medical Center: 0</td></tr>
<tr><td>Denominator of Eligible Patients: N/A</td></tr>
<tr><td>Pre-Post Analysis for Intervention
(optional)
If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.</td><td>N/A</td></tr>
<tr><td>Intervention-Specific Outcome or Process Measures
(optional)
These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership maintains and uses to analyze performance.
Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.</td><td>Not reported</td></tr>
</table>

Successes of the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	• Launched and refined an e-learning curriculum that improves sustainability of PEP and decreases the time spent doing live training from 8 hours to 4 hours • Among CHPB intervention staff and hospital partners who were trained, trainees and hospital leaders reported consistent improvement in confidence in communication skills • Planning for tailoring training for those working with disease-specific populations, based on city- and state-wide efforts to address chronic conditions
Additional Free Response (Optional)	None

Intervention or Program Name	Helping Up Mission's Spiritual Recovery Program
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	Johns Hopkins Bayview Medical Center
Brief description of the Intervention *2-3 sentences*	Helping Up Mission provides hope to people experiencing homelessness, poverty, or addiction by addressing their physical, psychological, social, and spiritual needs. The goal of this initiative is to provide safe, stable shelter to homeless men and women who are waiting to be admitted into a treatment program. This initiative is specific to patients who are being discharged from Johns Hopkins Bayview Medical Center.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	Helping Up Mission
Patients Served *Please estimate using the Population category that best applies to the Intervention, from the*	# of Patients Served as of June 30, 2020: 150
	Denominator of Eligible Patients:

CY 2018 RP Analytic Files. HSCRC acknowledges that the High Utilizer/Rising Risk or Payer designations may over-state the population, or may not entirely represent this intervention's targeted population. Feel free to ***also*** *include your partnership's denominator.*	Total from RP Analytic Files: Out of a population of 74,445 individuals with Medicare FFS in the RP area, only those who have a substance use disorder diagnosis and were being discharged from JHBMC were eligible for this intervention. The total number of eligible patients was 1736.
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	N/A
Intervention-Specific Outcome or Process Measures (optional) *These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership maintains and uses to analyze performance. Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.*	(see table below)

Measure	Number
Total Enrollees - Men	96
Total Enrollees - Women	54
Total Enrollees - All	150
Average Length of Stay in Next Step Program – Men	6.5 days
Average Length of Stay in Next Step Program – Women	6.1 days
Referrals to HUM Spiritual Recovery Program	14
Referrals to other SUD Treatment Program	98
Discharges - Total	150
Discharges – Personal Choice	37
Discharges - Medical	1
Discharges – Under Influence of Drugs	1
Discharges – In Good Standing	120
Discharges – HUM Spiritual Recovery Program	14

Successes of the Intervention in FY 2020	• Throughout the program, HUM's Next Step program has demonstrated an approximately 70% placement rate into treatment.

Free Response, up to 1 Paragraph	• During this period to-date, nearly 10% of Next Step clients entered HUM's long-term recovery programs and we have seen over 22% placed in the JHH 911 Broadway Center for Addictions Program through our partnership. • In terms of a client success testimonial, a female patient was referred to HUM's Next Step program at Chase St and was placed in treatment at Marian House, where she was able to get legal issues resolved, secure a Driver's license and is now employed at Johns Hopkins Hospital as a Nutrition Assistant.
Additional Free Response (Optional)	NA

Core Measures

Please fill in this information with the latest available data from the in the CRS Portal Tools for Regional Partnerships. For each measure, specific data sources are suggested for your use– the Executive Dashboard for Regional Partnerships, or the CY 2018 RP Analytic File (please specify which source you are using for each of the outcome measures).

Utilization Measures

Measure in RFP *(Table 1, Appendix A of the RFP)*	**Measure for FY 2020 Reporting**	**Outcomes(s)**
Total Hospital Cost per capita	**Partnership IP Charges per capita** Executive Dashboard: 'Regional Partnership per Capita Utilization' – Hospital Charges per Capita, reported as average 12 months of CY 2018 -or- Analytic File: 'Charges' over 'Population' (Column E / Column C)	Using Medicare FFS population in the RP Analytic file, Charges over Population = $9169.57 hospital charges per capita
Total Hospital Discharges per capita	**Total Discharges per 1,000** Executive Dashboard: 'Regional Partnership per Capita Utilization' –	Using Medicare FFS population in the RP Analytic file, Hospital Discharges per 1000/population of Medicare FFS = 0.263

	Hospital Discharges per 1,000, reported as average 12 months of FY 2020 -or- Analytic File: 'IPObs24Visits' over 'Population' (Column G / Column C)	
ED Visits per capita	**Ambulatory ED Visits per 1,000** Executive Dashboard: 'Regional Partnership per Capita Utilization' – Ambulatory ED Visits per 1,000, reported as average 12 months of FY 2020 -or- Analytic File 'ED Visits' over 'Population' (Column H / Column C)	Using Medicare FFS population in the RP Analytic file, Hospital Discharges per 1000/population of Medicare FFS = 0.303

Quality Indicator Measures

Measure in RFP *(Table 1 in Appendix A of the RFP)*	**Measure for FY 2020 Reporting**	**Outcomes(s)**
Readmissions	**Unadjusted Readmission rate by Hospital** (please be sure to filter to include all hospitals in your RP) Executive Dashboard: '[Partnership] Quality Indicators' – Unadjusted Readmission Rate by Hospital, reported as average 11 months of FY 2020 -or- Analytic File: 'IP Readmit' over 'EligibleforReadmit' (Column J / Column I)	Using Medicare FFS population in the RP Analytic file, IP Readmissions/Number eligible for readmissions = 0.158* This number is reported for 11 months.

PAU	**Potentially Avoidable Utilization** Executive Dashboard: '[Partnership] Quality Indicators' – Potentially Avoidable Utilization, reported as **sum** of 12 months of FY 2020 -or- Analytic File: 'TotalPAUCharges' (Column K)	Using Medicare FFS population in the RP Analytic file PAU charges = $108,746,159.30.

CRISP Key Indicators (Optional)

These process measures tracked by the CRISP Key Indicators are new, and HSCRC anticipates that these data will become more meaningful in future years.

Measure in RFP *(Table 1 in Appendix A of the RFP)*	**Measure for FY 2020 Reporting**	**Outcomes(s)**
Portion of Target Population with Contact from Assigned Care Manager	**Potentially Avoidable Utilization** Executive Dashboard: 'High Needs Patients – CRISP Key Indicators' – % of patients with Case Manager (CM) recorded at CRISP, reported as average monthly % for most recent six months of data *May also include Rising Needs Patients, if applicable in Partnership.*	Not reported

Self-Reported Process Measures

Please describe any partnership-level process measures that your RP may be tracking but are not currently captured under the Executive Dashboard. Some examples are shared care plans, health risk assessments, patients with care manager who are not recorded in CRISP, etc. By-intervention process measures should be included in 'Intervention Program' section and don't need to be included here.

Return on Investment – (Optional)

Annual Cost per Patient as calculated by:

Total Patients Served (all interventions) / Total FY 2020 Expenditures (from FY 2020 budget report)

4,348 patients served/ $3,296,830 in expenditures

The formula above provides the per patient cost of the program. For more information on the ROIs for specific interventions, including cost-savings for patients served, please see the “Additional Information” sections in the program summaries above.

Impact of COVID-19 on Interventions – (Optional)

Please include information on the impact of COVID-19 on your interventions, if any. Freeform Narrative response, 1-3 paragraphs.

Beginning in March 2020, our interventions saw decreased referrals and enrollment across the board. In some cases, patients transitioned to working with CHWs, care managers, and HBSs telephonically. Patients who would have otherwise been discharged after brief stays at HealthCare for the Homeless' CCP were not able to find secure housing. Team members reported increased social needs, especially regarding food insecurity, housing assistance, and unemployment benefits.

Intervention Continuation Summary

Please include a brief summary of the successful interventions that have been supported by this grant program that will be continuing after the conclusion of the grant. Freeform Narrative Response, 1-3 paragraphs.

The interventions within CHPB were monitored and evaluated on an ongoing basis, and hospital leaders and stakeholders were provided reports on a monthly basis. The four hospitals ultimately decided to continue partnering with HealthCare for the Homeless, to offer the Comprehensive Care Practice program after the conclusion of the grant. In addition, Johns Hopkins Hospital decided to continue scaled-back versions of the Community Care Team intervention with Sisters Together and Reaching (STAR) and the Neighborhood Navigator (NN) intervention with Men and Families Center (MFC).

While other interventions may not be sustained in the immediate near-term, the working relationships fostered during this partnership have been tremendously helpful to the four hospital partners and community-based organizations. We anticipate continuing many of these discussions in the future, especially as we seek to re-bid for future regional partnership awards.

Opportunities to Improve – (Optional)

If there is any additional information you wish to share to help the HSCRC enhance future grant programs, please include the information here. Freeform Narrative Response, 1-3 paragraphs.

NA

Conclusion

Please include any additional information you wish to share here. As a reminder, Commissioners are interested in tying RP annual activities to the activities initially proposed in the RFP. Free Response, 1-3 Paragraphs.

CHPB leadership has been grateful for the opportunity to carry out this work over the past four years. While our operational plan was updated slightly each year, we offered the same set of interventions

outlined in the original proposal. We continually examined and refined interventions to maximize efficiency and benefit to the patients and providers we brought together. We are proud of the impact we have made and will continue to make in East Baltimore.

Our partner hospitals and CBOs are appreciative for the recent opportunity to re-bid for new behavioral health- and diabetes-specific awards beginning in FY21. We look forward to continued partnership with the HSCRC to address population health issues across the state of Maryland.

Appendix A

CRISP Pre/Post Reports

Pre/Post Analysis - Summary

The analysis is based on admissions before and after the enrollment date.

Program Name
CHPB CCT Enrollment July 19-Feb 20 (210009)

Chronic Conditions
All Patients

N/A

N/A

Most Recent Payer
All

Visit Type
All

Chronic Condition Operator
◉ AND
◯ OR

Total Number of Members on Panel that could contribute to analysis

	1 Month	3 Months	6 Months	12 Months
Total Number of Patients in Panel that could contribute to analysis	399	356	300	142

Percent of Members on the Panel with 1 or more Visits

Time Period	Total Number of Patients with a visit - Pre	Total Number of Patients with a visit - Post	Total Number of Patients with a visit - Pre %	Total Number of Patients with a visit - Post %	Change in Number of Patients
1 Month	315	257	78.9%	64.4%	-14.5%
3 Months	335	295	94.1%	82.9%	-11.2%
6 Months	289	277	96.3%	92.3%	-4.0%
12 Months	137	139	96.5%	97.9%	1.4%

Rate of Visits per 10 Members

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Rate of Visits per 10 patients - Pre	Rate of Visits per 10 patients - Post	Visits Rate change
1 Month	789	676	19.8	16.9	-2.8
3 Months	2,035	1,689	57.2	47.4	-9.7
6 Months	3,109	2,705	103.6	90.2	-13.5
12 Months	2,794	2,491	196.8	175.4	-21.3

Average Charge per Member

Time Period	Total Number of Patients with at least 1 visit pre or post	Total charges - Pre	Total charges - Post	Average Charge per patient - Pre	Average Charge per patient - Post	Total Charges per Patients change
1 Month	347	$6,227,746	$2,280,767	$19,771	$8,875	($10,896)
3 Months	347	$11,320,959	$6,226,389	$33,794	$21,106	($12,688)
6 Months	295	$14,518,693	$10,128,641	$50,238	$36,565	($13,672)
12 Months	139	$10,295,738	$9,361,484	$75,151	$67,349	($7,803)

Average Charge per Visit

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Total charges - Pre	Total charges - Post	Average Charge per visit - Pre	Average Charge per visit - Post	Total Charges per Visit change
1 Month	789	676	$6,227,746	$2,280,767	$7,893	$3,374	($4,519)
3 Months	2,035	1,689	$11,320,959	$6,226,389	$5,563	$3,686	($1,877)
6 Months	3,109	2,705	$14,518,693	$10,128,641	$4,670	$3,744	($925)
12 Months	2,794	2,491	$10,295,738	$9,361,484	$3,685	$3,758	$73

Casemix Data Through:
03/31/2020

ENS Panels Last Updated:
05/28/2020

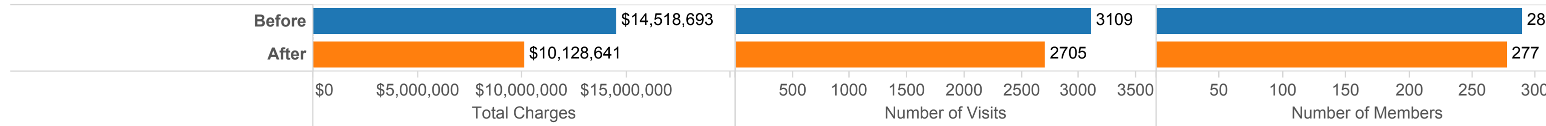
- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
  - Panel information provided to CRISP by ENS
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
- Individual patients identified using CRISP EID
- CRISP suppressed cells with counts of 10 and under
- Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis
- Months of Analysis is not based on calendar days or 30 days but calculated by getting the same date, months in advance. eg. 1 Month before Feb 28th is Jan 28th and 1 Month before June 15th is May 15th and so on.
- Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.

Pre/Post Analysis

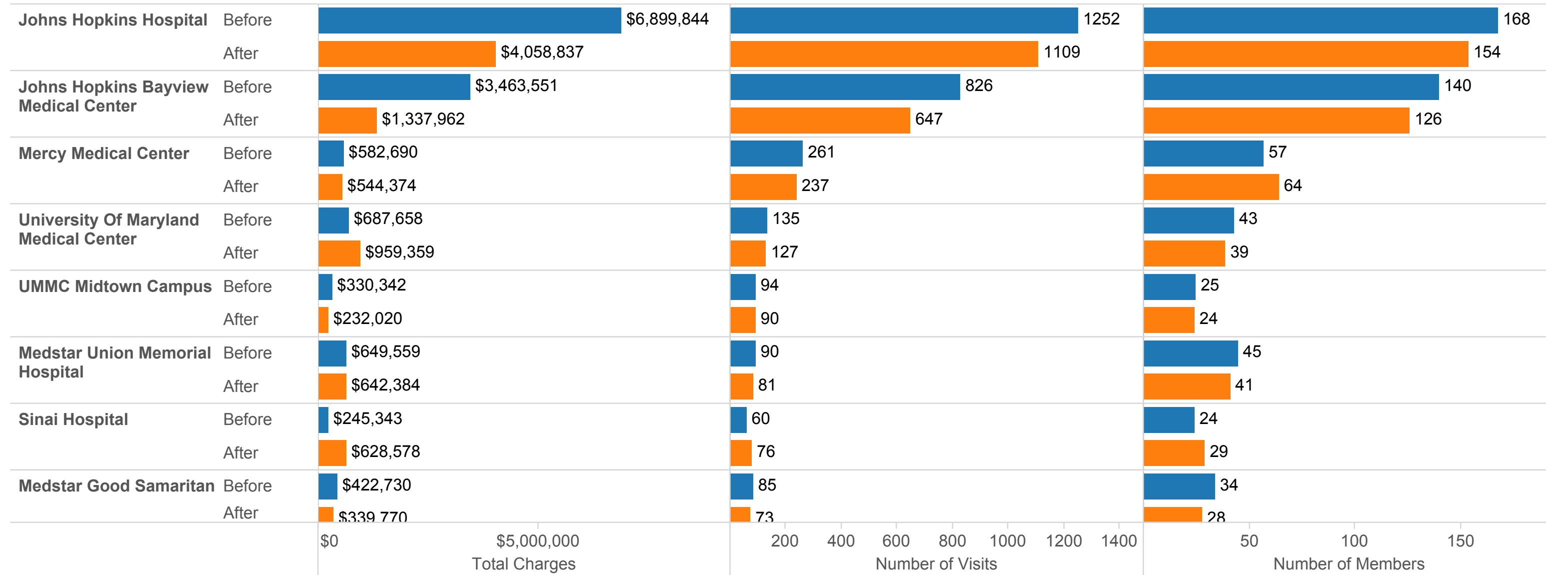
Analysis of 6 Months of Visits Before and After the Enrollment Date

The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they do not have data for the entire period before and after the analysis. Number of Members with data for the analysis shows, the number of members that are included in the report for a given selection.

All Hospitals



Hospital Details



Total Number of Members in the Panel

412

Number of Members with Data for Analysis

300

Number of Members with Visits during Analysis Period

295

Before or After Enrollment
Before | After

Most Recent Payer
All

Time Period
6 Months

Visit Type
All

Sorting Option
Total Visits - After Enrollment

Hospital Name
All

Program Name
CHPB CCT Enrollment July 19-Feb 20 (..

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
- AND (selected)
- OR

Casemix Data Through:
03/31/2020
ENS Panels Last Updated:
05/28/2020

- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
  - Panel information provided to CRISP by ENS
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
- Individual patients identified using CRISP EID
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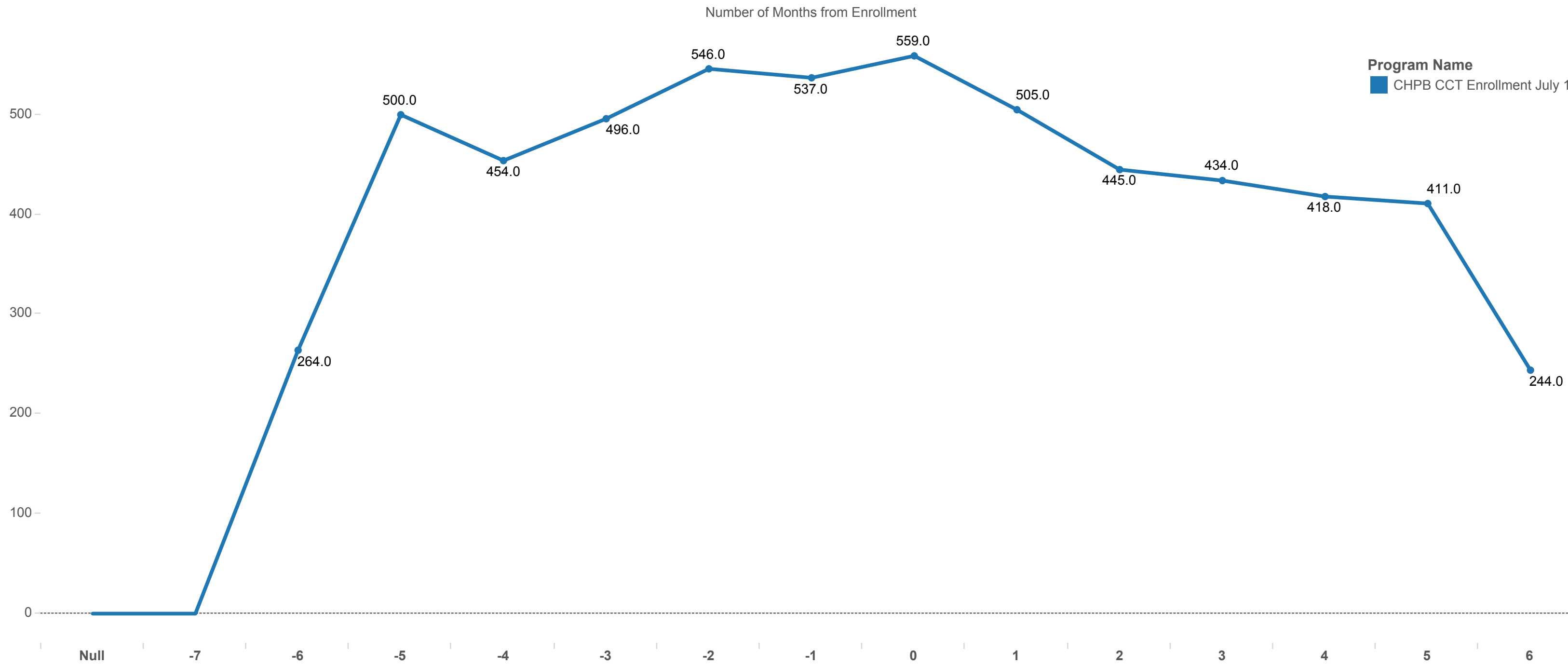
Pre/Post Analysis

Analysis of 6 Months of Visits Before and After the Enrollment Date

The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they do not have data for the entire period before and after the analysis. Number of Members with data for the analysis shows, the number of members that are included in the report for a given selection.

Relative Trend



Most Recent Payer
All

Time Period
6 Months

Trend Metric
Visits

Visit Type
All

Hospital Name
All

Program Name
CHPB CCT Enrollment July 19-Feb ..

Chronic Conditions

All Patients

N/A

N/A

Chrionic Condition Operator
(●) AND
( ) OR

Casemix Data Through:
03/31/2020
ENS Panels Last Updated:
05/28/2020

- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
  - Panel information provided to CRISP by ENS
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
- Individual patients identified using CRISP EID
- CRISP suppressed cells with counts of 10 and under
- Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis
- Months of Analysis is not based on calendar days or 30 days but calculated by getting the same date, months in advance. eg. 1 Month before Feb 28th is Jan 28th and 1 Month before June 15th is May 15th and so on.
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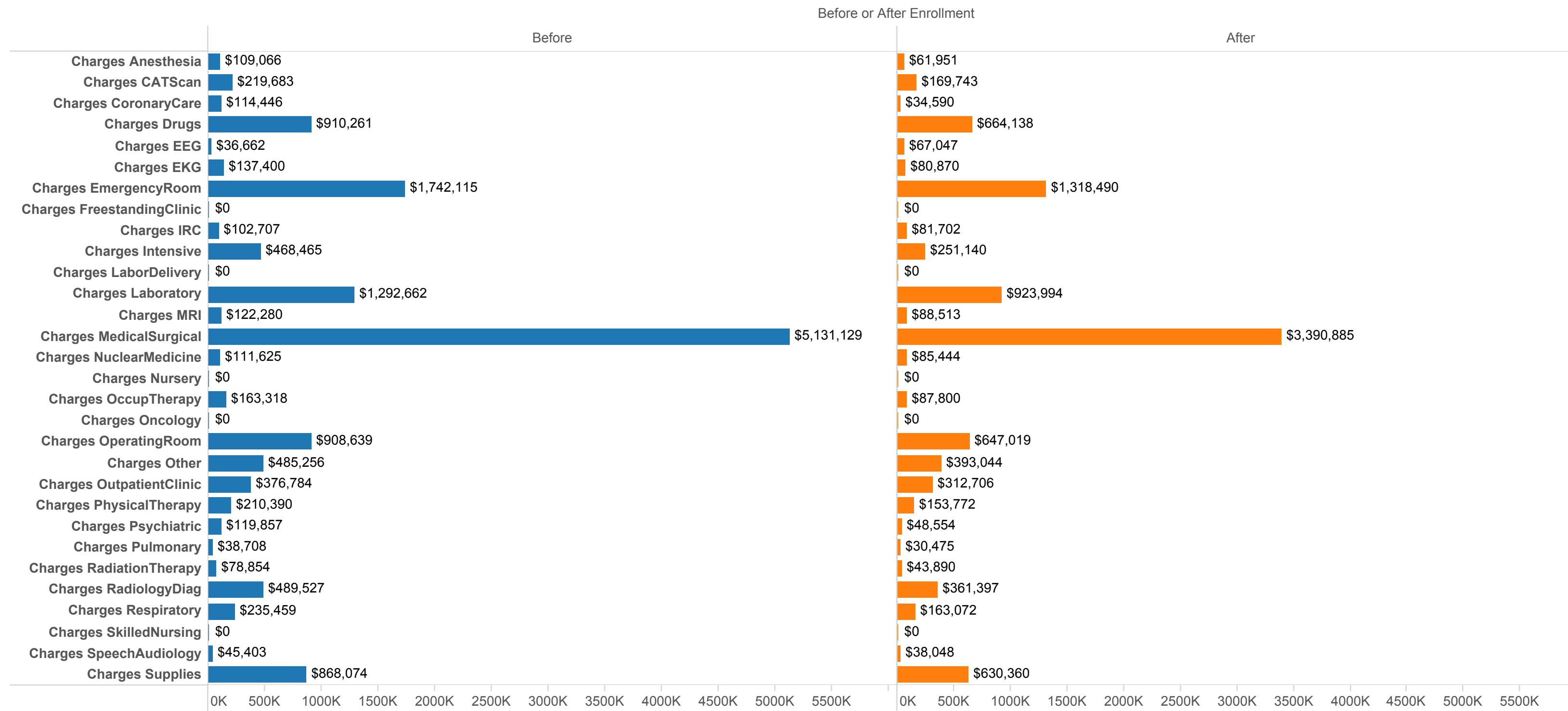
Pre/Post Analysis

Analysis of 6 Months of Visits Before and After the Enrollment Date

The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they do not have data for the entire period before and after the analysis. Number of Members with data for the analysis shows, the number of members that are included in the report for a given selection.

Breakdown of Charges Sheet



Most Recent Payer
All

Visit Type
All

Hospital Name
All

Time Period
6 Months

Program Name
CHPB CCT Enrollment July 19-Feb ..

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
- (•) AND
- ( ) OR

Casemix Data Through: 03/31/2020

ENS Panels Last Updated: 05/28/2020

- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
  - Panel information provided to CRISP by ENS
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
- Individual patients identified using CRISP EID
- CRISP suppressed cells with counts of 10 and under
- Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis
- Months of Analysis is not based on calendar days or 30 days but calculated by getting the same date, months in advance. eg. 1 Month before Feb 28th is Jan 28th and 1 Month before June 15th is May 15th and so on.
- Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.

Pre/Post Analysis - Summary

The analysis is based on admissions before and after the enrollment date.

Program Name
CHPB EDI Initiative July -June 2020 (210009)

Chronic Conditions
All Patients

N/A

N/A

Most Recent Payer
All

Visit Type
ED

Chronic Condition Operator
◉ AND
○ OR

Total Number of Members on Panel that could contribute to analysis

	1 Month	3 Months	6 Months	12 Months
Total Number of Patients in Panel that could contribute to analysis	356	270	242	<11

Percent of Members on the Panel with 1 or more Visits

Time Period	Total Number of Patients with a visit - Pre	Total Number of Patients with a visit - Post	Total Number of Patients with a visit - Pre %	Total Number of Patients with a visit - Post %	Change in Number of Patients
1 Month	342	66	96.1%	18.5%	-77.5%
3 Months	267	90	98.9%	33.3%	-65.6%
6 Months	240	117	99.2%	48.3%	-50.8%
12 Months	<11	<11			

Rate of Visits per 10 Members

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Rate of Visits per 10 patients - Pre	Rate of Visits per 10 patients - Post	Visits Rate change
1 Month	500	124	14.0	3.5	-10.6
3 Months	583	232	21.6	8.6	-13.0
6 Months	733	409	30.3	16.9	-13.4
12 Months	<11	<11			

Average Charge per Member

Time Period	Total Number of Patients with at least 1 visit pre or post	Total charges - Pre	Total charges - Post	Average Charge per patient - Pre	Average Charge per patient - Post	Total Charges per Patients change
1 Month	356	$584,506	$147,892	$1,709	$2,241	$532
3 Months	270	$688,530	$289,449	$2,579	$3,216	$637
6 Months	242	$899,721	$525,763	$3,749	$4,494	$745

Average Charge per Visit

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Total charges - Pre	Total charges - Post	Average Charge per visit - Pre	Average Charge per visit - Post	Total Charges per Visit change
1 Month	500	124	$584,506	$147,892	$1,169	$1,193	$24
3 Months	583	232	$688,530	$289,449	$1,181	$1,248	$67
6 Months	733	409	$899,721	$525,763	$1,227	$1,285	$58

Casemix Data Through:
03/31/2020
ENS Panels Last Updated:
05/28/2020

- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
  - Panel information provided to CRISP by ENS
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
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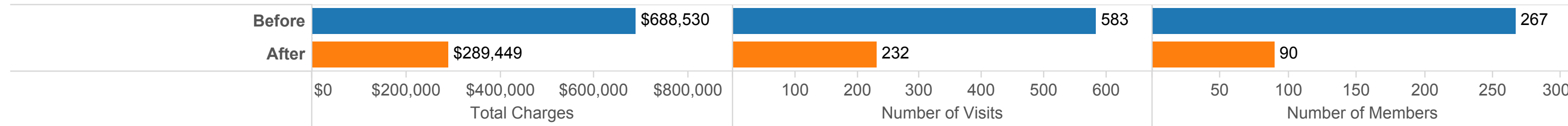
- Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.

Pre/Post Analysis

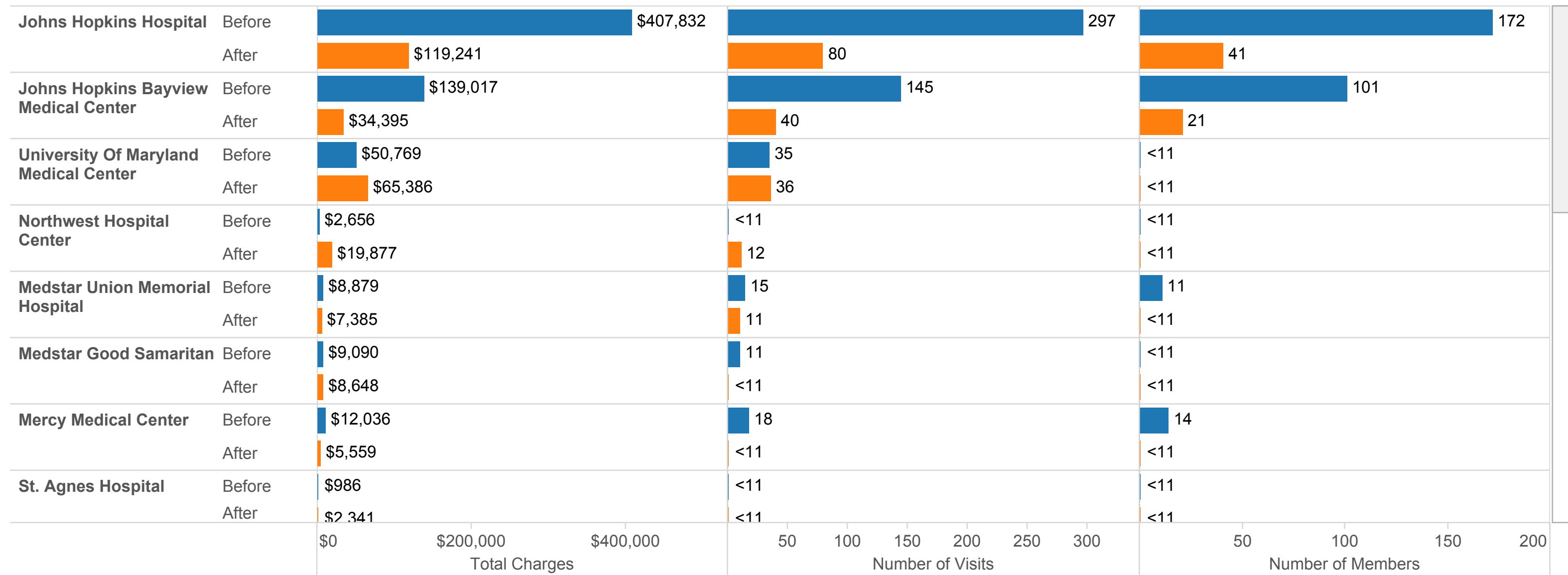
Analysis of 3 Months of Visits Before and After the Enrollment Date

The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they do not have data for the entire period before and after the analysis. Number of Members with data for the analysis shows, the number of members that are included in the report for a given selection.

All Hospitals



Hospital Details



Total Number of Members in the Panel

817

Number of Members with Data for Analysis

277

Number of Members with Visits during Analysis Period

270

Before or After Enrollment
Before | After

Most Recent Payer
All

Time Period
3 Months

Visit Type
ED

Sorting Option
Total Visits - After Enrollment

Hospital Name
All

Program Name
CHPB EDI Initiative July -June 2020 (2..

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
- (selected) AND
- OR

Casemix Data Through: 03/31/2020

ENS Panels Last Updated: 05/28/2020

- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
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Pre/Post Analysis

Analysis of 3 Months of Visits Before and After the Enrollment Date

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Most Recent Payer
All

Time Period
3 Months

Trend Metric
Visits

Visit Type
ED

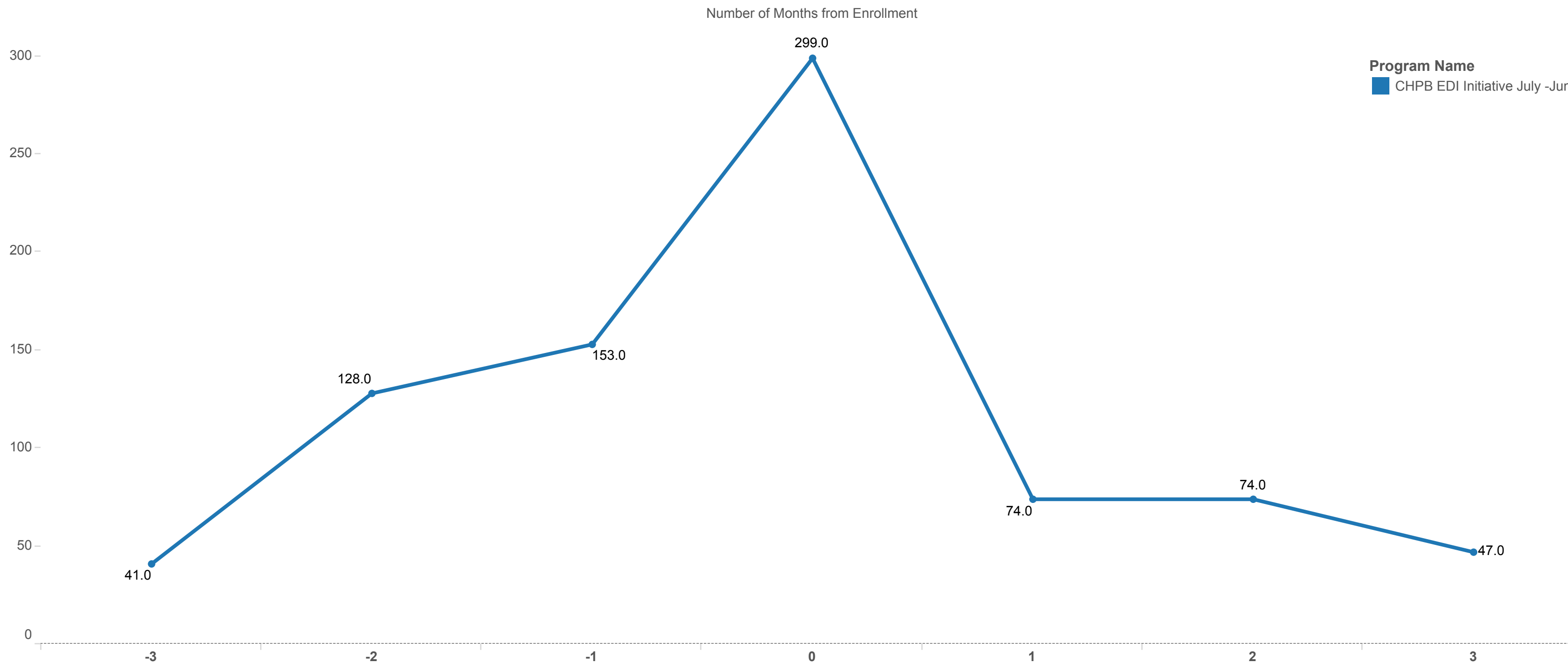
Hospital Name
All

Program Name
CHPB EDI Initiative July -June 2020 ..

Chronic Conditions
All Patients
N/A
N/A

Chrionic Condition Operator
- (●) AND
- ( ) OR

Relative Trend



Casemix Data Through:
03/31/2020
ENS Panels Last Updated:
05/28/2020

- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
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Pre/Post Analysis

Analysis of 3 Months of Visits Before and After the Enrollment Date

The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they do not have data for the entire period before and after the analysis. Number of Members with data for the analysis shows, the number of members that are included in the report for a given selection.

Most Recent Payer
All

Visit Type
ED

Hospital Name
All

Time Period
3 Months

Program Name
CHPB EDI Initiative July -June 2020 ..

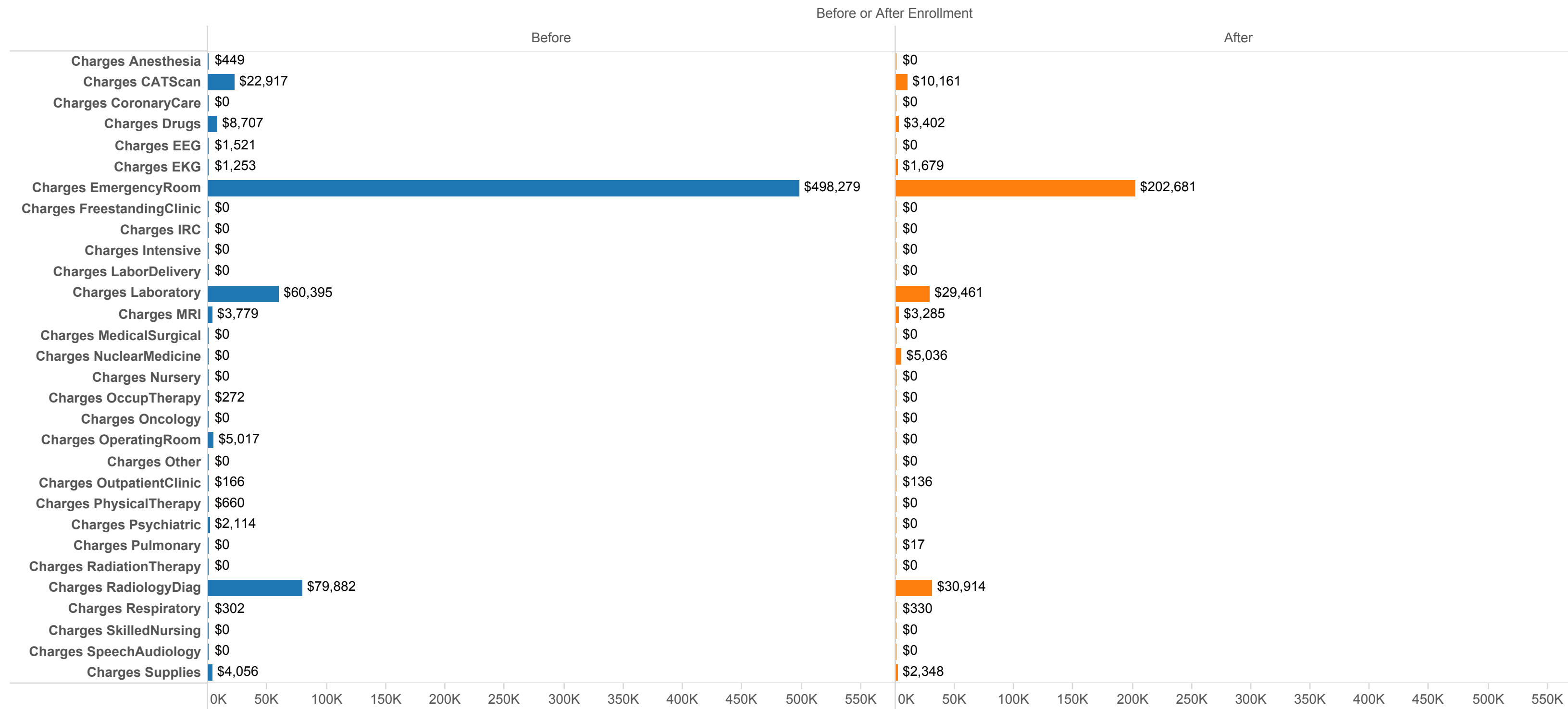
Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
◉ AND
○ OR

Breakdown of Charges Sheet



Casemix Data Through:
03/31/2020

ENS Panels Last Updated:
05/28/2020

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- Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.

Pre/Post Analysis - Summary

The analysis is based on admissions before and after the enrollment date.

Program Name
CHPB Bridge Team FY20 (210009)

Chronic Conditions
All Patients

N/A

N/A

Most Recent Payer
Medicare FFS

Visit Type
All

Chronic Condition Operator
◉ AND
○ OR

Total Number of Members on Panel that could contribute to analysis

	1 Month	3 Months	6 Months	12 Months
Total Number of Patients in Panel that could contribute to analysis	20	20	14	<11

Percent of Members on the Panel with 1 or more Visits

Time Period	Total Number of Patients with a visit - Pre	Total Number of Patients with a visit - Post	Total Number of Patients with a visit - Pre %	Total Number of Patients with a visit - Post %	Change in Number of Patients
1 Month	15	11	75.0%	55.0%	-20.0%
3 Months	18	16	90.0%	80.0%	-10.0%
6 Months	12	12	85.7%	85.7%	0.0%
12 Months	<11	<11			

Rate of Visits per 10 Members

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Rate of Visits per 10 patients - Pre	Rate of Visits per 10 patients - Post	Visits Rate change
1 Month	31	15	15.5	7.5	-8.0
3 Months	69	80	34.5	40.0	5.5
6 Months	133	132	95.0	94.3	-0.7
12 Months	<11	<11			

Average Charge per Member

Time Period	Total Number of Patients with at least 1 visit pre or post	Total charges - Pre	Total charges - Post	Average Charge per patient - Pre	Average Charge per patient - Post	Total Charges per Patients change
1 Month	17	$344,326	$46,088	$22,955	$4,190	($18,765)
3 Months	19	$641,912	$357,861	$35,662	$22,366	($13,295)
6 Months	13	$644,738	$608,681	$53,728	$50,723	($3,005)

Average Charge per Visit

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Total charges - Pre	Total charges - Post	Average Charge per visit - Pre	Average Charge per visit - Post	Total Charges per Visit change
1 Month	31	15	$344,326	$46,088	$11,107	$3,073	($8,035)
3 Months	69	80	$641,912	$357,861	$9,303	$4,473	($4,830)
6 Months	133	132	$644,738	$608,681	$4,848	$4,611	($236)

Casemix Data Through: 06/30/2020

ENS Panels Last Updated: 08/20/2020

- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
  - Panel information provided to CRISP by ENS
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
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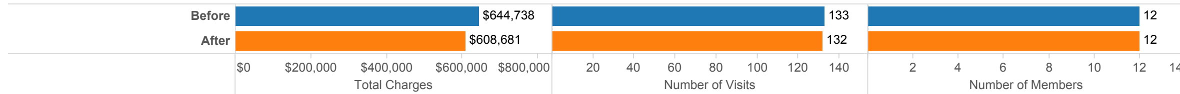
Pre/Post Analysis

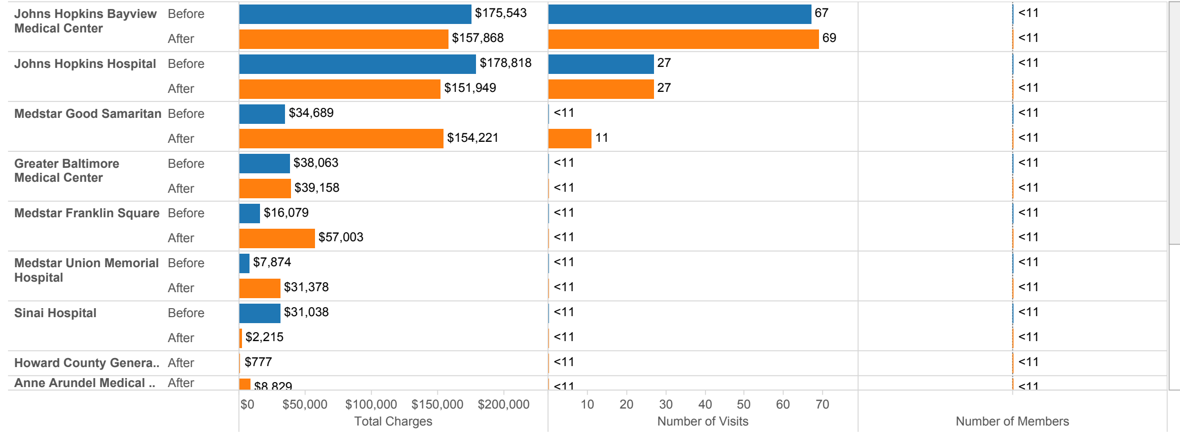
Analysis of 6 Months of Visits Before and After the Enrollment Date

The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they do not have data for the entire period before and after the analysis. Number of Members with data for the analysis shows, the number of members that are included in the report for a given selection.

All Hospitals



Hospital Details



Total Number of Members in the Panel

21

Number of Members with Data for Analysis

15

Number of Members with Visits during Analysis Period

13

Before or After Enrollment
Before
After

Most Recent Payer
Medicare FFS

Time Period
6 Months

Visit Type
All

Sorting Option
Total Visits - After Enrollment

Hospital Name
All

Program Name
CHPB Bridge Team FY20 (210009)

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
- (●) AND
- ( ) OR

Casemix Data Through:
06/30/2020
ENS Panels Last Updated:
08/20/2020

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Most Recent Payer
Medicare FFS

Time Period
6 Months

Trend Metric
Visits

Visit Type
All

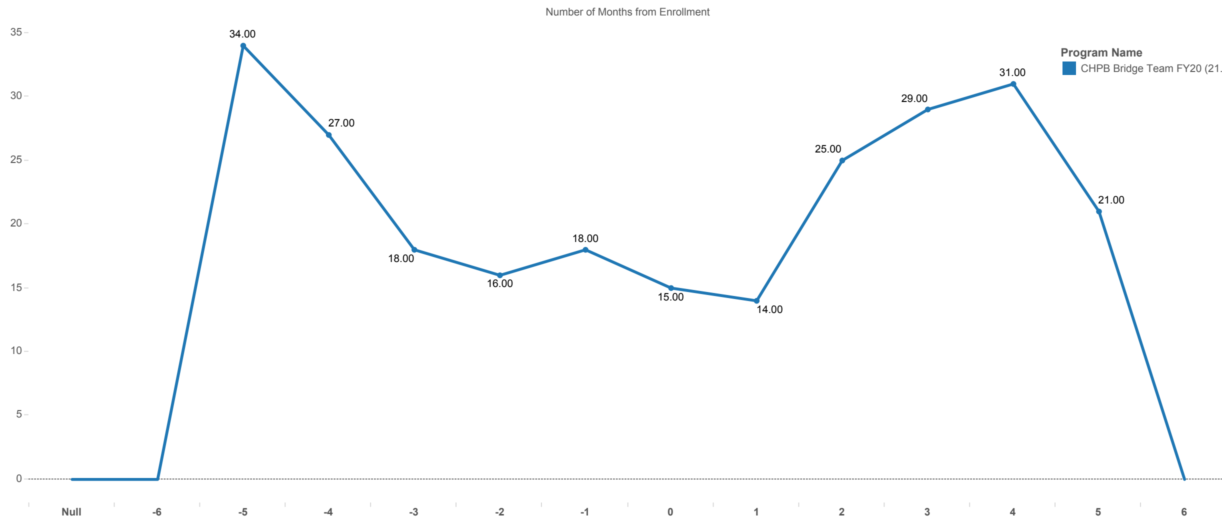
Hospital Name
All

Program Name
CHPB Bridge Team FY20 (210009)

Chronic Conditions
All Patients
N/A
N/A

Chrionic Condition Operator
AND
OR

Relative Trend



Casemix Data Through:
06/30/2020
ENS Panels Last Updated:
08/20/2020

- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
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Pre/Post Analysis

Analysis of 6 Months of Visits Before and After the Enrollment Date

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Most Recent Payer
Medicare FFS

Visit Type
All

Hospital Name
All

Time Period
6 Months

Program Name
CHPB Bridge Team FY20 (210009)

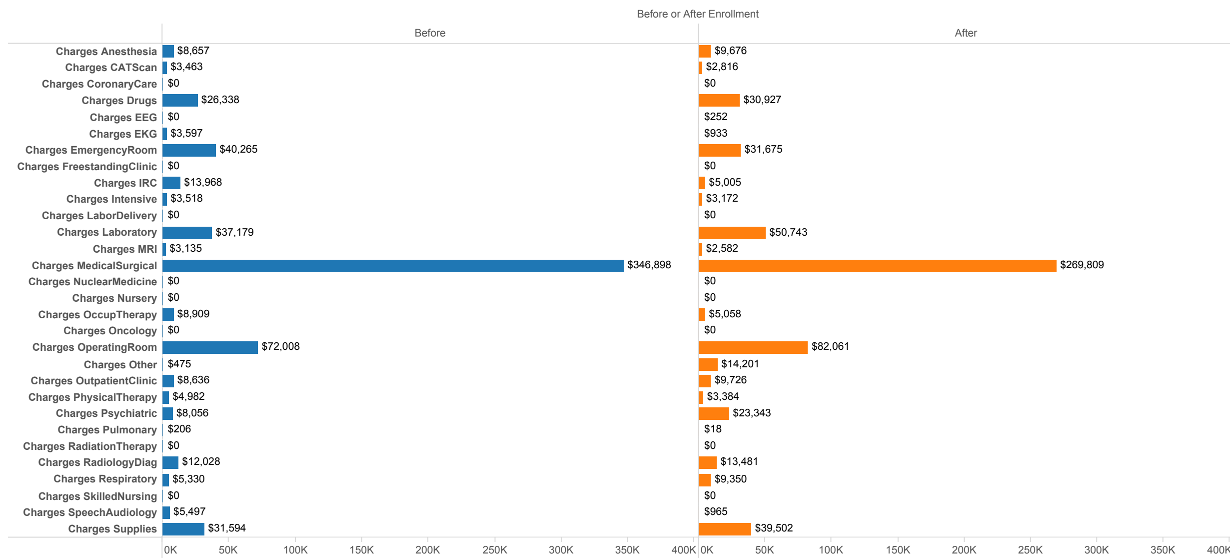
Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
◉ AND
○ OR

Breakdown of Charges Sheet



Casemix Data Through:
06/30/2020
ENS Panels Last Updated:
08/20/2020

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Pre/Post Analysis - Summary

The analysis is based on admissions before and after the enrollment date.

Program Name
JHOME Full Panel (210029)

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(●) AND
( ) OR

Most Recent Payer
Medicare FFS

Visit Type
All

Total Number of Members on Panel that could contribute to analysis

	1 Month	3 Months	6 Months	12 Months
Total Number of Patients in Panel that could contribute to analysis	248	223	193	155

Percent of Members on the Panel with 1 or more Visits

Time Period	Total Number of Patients with a visit - Pre	Total Number of Patients with a visit - Post	Total Number of Patients with a visit - Pre %	Total Number of Patients with a visit - Post %	Change in Number of Patients
1 Month	119	49	48.0%	19.8%	-28.2%
3 Months	164	91	73.5%	40.8%	-32.7%
6 Months	162	108	83.9%	56.0%	-28.0%
12 Months	142	115	91.6%	74.2%	-17.4%

Rate of Visits per 10 Members

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Rate of Visits per 10 patients - Pre	Rate of Visits per 10 patients - Post	Visits Rate change
1 Month	192	69	7.7	2.8	-5.0
3 Months	439	209	19.7	9.4	-10.3
6 Months	672	363	34.8	18.8	-16.0
12 Months	1,052	503	67.9	32.5	-35.4

Average Charge per Member

Time Period	Total Number of Patients with at least 1 visit pre or post	Total charges - Pre	Total charges - Post	Average Charge per patient - Pre	Average Charge per patient - Post	Total Charges per Patients change
1 Month	136	$1,236,742	$259,133	$10,393	$5,288	($5,104)
3 Months	179	$3,312,421	$826,364	$20,198	$9,081	($11,117)
6 Months	175	$4,057,143	$1,459,537	$25,044	$13,514	($11,530)
12 Months	150	$4,825,278	$2,866,870	$33,981	$24,929	($9,052)

Average Charge per Visit

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Total charges - Pre	Total charges - Post	Average Charge per visit - Pre	Average Charge per visit - Post	Total Charges per Visit change
1 Month	192	69	$1,236,742	$259,133	$6,441	$3,756	($2,686)
3 Months	439	209	$3,312,421	$826,364	$7,545	$3,954	($3,591)
6 Months	672	363	$4,057,143	$1,459,537	$6,037	$4,021	($2,017)
12 Months	1,052	503	$4,825,278	$2,866,870	$4,587	$5,700	$1,113

Casemix Data Through:
03/31/2020

ENS Panels Last Updated:
05/21/2020

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Pre/Post Analysis

Analysis of 6 Months of Visits Before and After the Enrollment Date

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Total Number of Members in the Panel

430

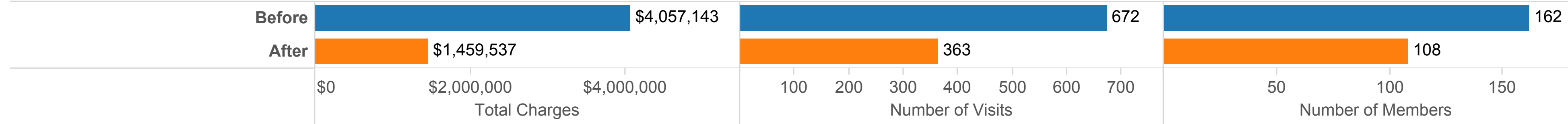
Number of Members with Data for Analysis

282

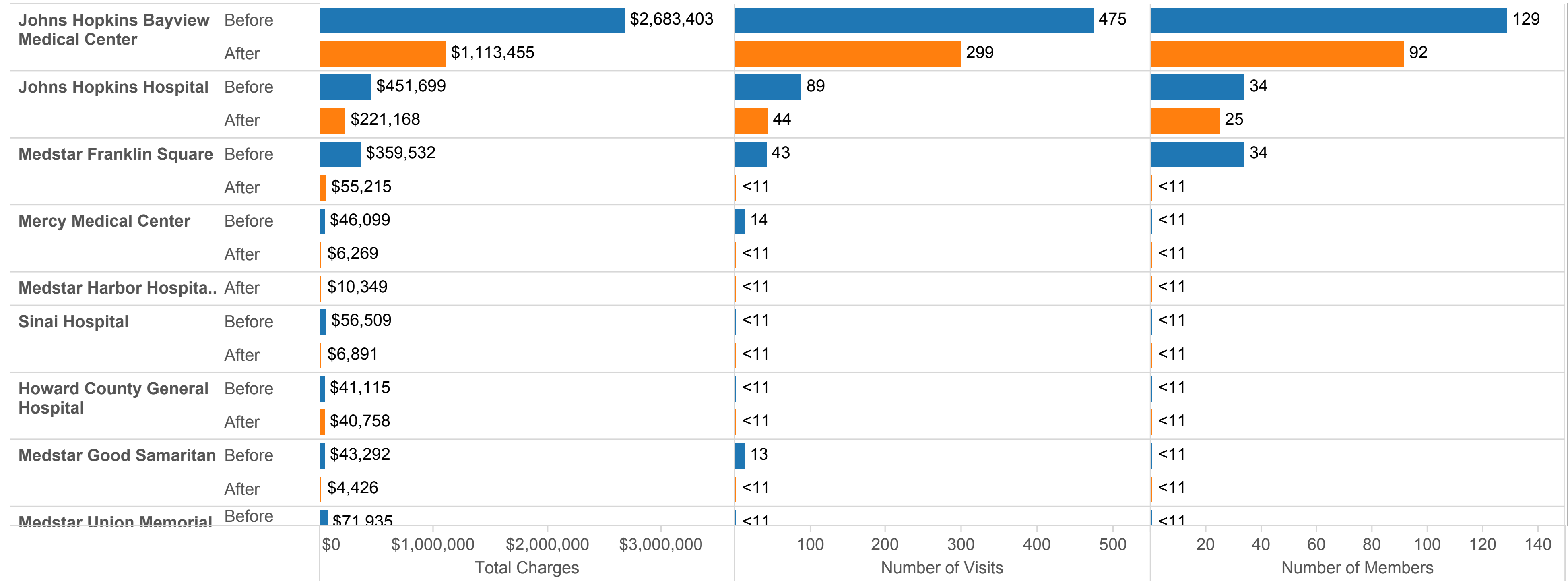
Number of Members with Visits during Analysis Period

175

All Hospitals



Hospital Details



Before or After Enrollment
Before After

Most Recent Payer
Medicare FFS

Time Period
6 Months

Visit Type
All

Sorting Option
Total Visits - After Enrollment

Hospital Name
All

Program Name
JHOME Full Panel (210029)

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

Casemix Data Through:
03/31/2020
ENS Panels Last Updated:
05/21/2020

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Pre/Post Analysis

Analysis of 6 Months of Visits Before and After the Enrollment Date

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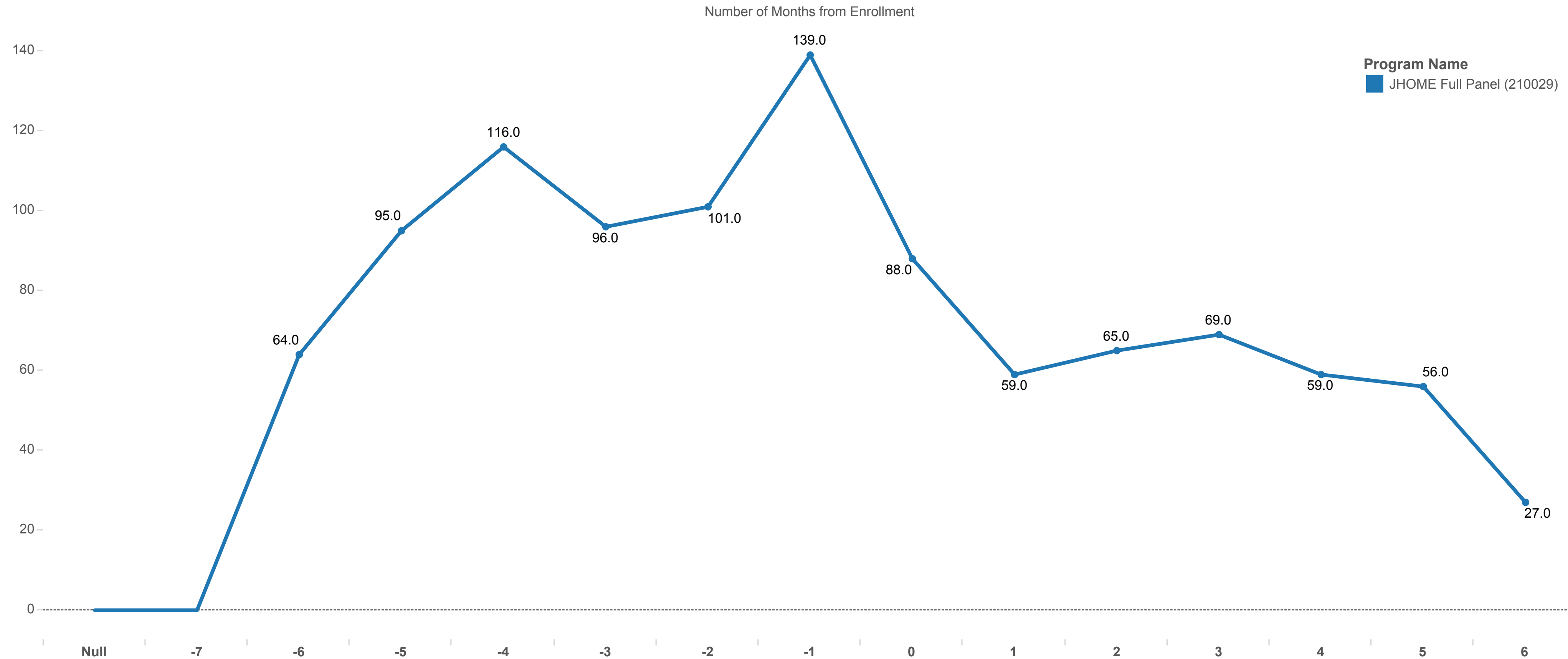
Relative Trend



Most Recent Payer
Medicare FFS

Time Period
6 Months

Trend Metric
Visits

Visit Type
All

Hospital Name
All

Program Name
JHOME Full Panel (210029)

Chronic Conditions
All Patients

N/A

N/A

Chrionic Condition Operator
- (•) AND
- ( ) OR

Casemix Data Through:
03/31/2020

ENS Panels Last Updated:
05/21/2020

- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
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Pre/Post Analysis

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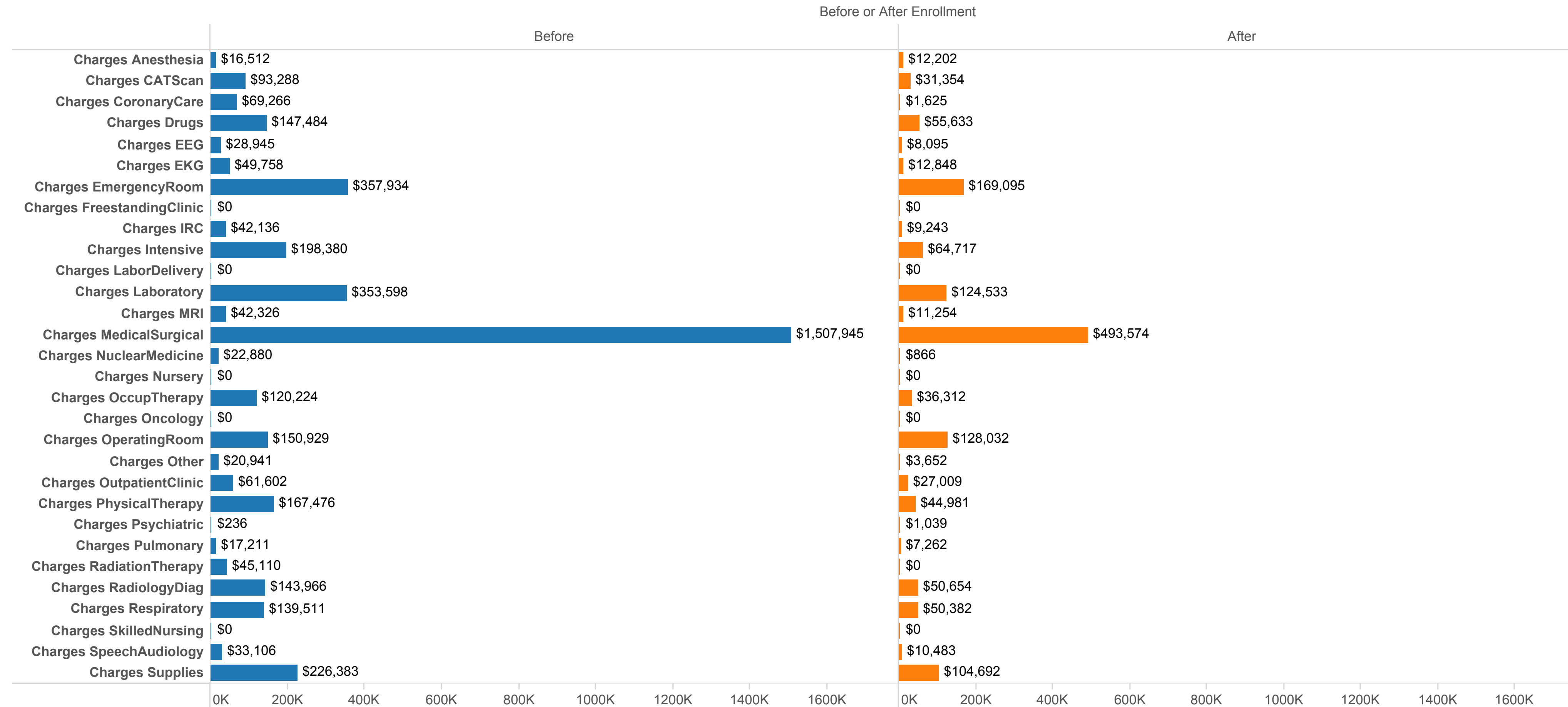
Breakdown of Charges Sheet



Most Recent Payer
Medicare FFS

Visit Type
All

Hospital Name
All

Time Period
6 Months

Program Name
JHOME Full Panel (210029)

Chronic Conditions

All Patients

N/A

N/A

Chronic Condition Operator

- (•) AND
- ( ) OR

Casemix Data Through:

03/31/2020

ENS Panels Last Updated:

05/21/2020

- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
  - Panel information provided to CRISP by ENS
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
- Individual patients identified using CRISP EID
- CRISP suppressed cells with counts of 10 and under
- Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis
- Months of Analysis is not based on calendar days or 30 days but calculated by getting the same date, months in advance. eg. 1 Month before Feb 28th is Jan 28th and 1 Month before June 15th is May 15th and so on.
- Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.