HSCRC Transformation Grant

FY 2020 Report

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

Regional Partnership Information

Regional Partnership (RP) Name	Greater Baltimore Medical Center
RP Hospital(s)	Greater Baltimore Medical Center
RP Point of Contact	Sarah Fogler, Senior Director of Population Health
RP Interventions in FY 2020	Expansion and Management of Chronic Conditions Through Improved Integration of Mental Health Services, Palliative Care Services, and Care Coordination
Total Budget in FY 2020 *This should equate to total FY 2017 award*	FY 2020 Award: $1,269,079
Total FTEs in FY 2020	Employed: 17
	Contracted: 11
Program Partners in FY 2020 *Please list any community-based organizations or provider groups, contractors, and/or public partners*	• Sheppard Pratt Health System • Catholic Charities • MedStar • Notre Dame School of Pharmacy • Lorien at Home • Diamond Lab Services • SNAP • Moveable Feast

Overall Summary of Regional Partnership Activities in FY 2020

(Freeform Narrative Response: 1-3 Paragraphs):

The Behavioral Health Enhanced Patient-Centered Medical Home (BHE-PCMH) – This initiative builds upon the patient-centered medical home model operating in GBMC's primary care practices by

embedding mental health professionals in the practices. In partnership with Sheppard Pratt, mental health professionals are embedded in the GBMC primary care practices, which provides for ready access to behavioral health consultants and psychiatric consultation services. The initiative also integrates behavioral health resources into the inpatient setting by providing psychiatric consultation and post-discharge mental health and community linkage support.

Expansion of Palliative Care and Elder Medical Care (formerly Support Our Elders) – This initiative is continuing to be supported by a strong partnership between Gilchrist and Medstar, where patients with advanced and complex chronic disease are provided with clinical and social support in their homes to include addressing food insecurities and other social determinants of health. This service is offered in numerous outpatient settings to include independent living or a facility based environment. This program has also expanded to provide clinical staff for palliative efforts from 2 nursing homes to 5 nursing homes within the service area. In addition, during the COVID 19 pandemic, the palliative efforts were concentrated and sought after for a COVID 19 positive facility to assist to both patients and staff as they continue to navigate the effects of the pandemic in a facility setting.

Expansion of Care Coordination and Care Management Services – This initiative supports both inpatient and ambulatory care management services. The inpatient care management focus is on high-utilizer patients and preventing unnecessary inpatient admissions. Specifically, Social Determinants of Health and High Risk for Readmissions assessments are completed on patients, and PCP appointments are arranged for the high-risk population prior to discharge to ensure a smooth transition back to the community. The Ambulatory Care Management focus is on preventative health care and care management and coordination for patients with chronic diseases served in GBMC primary care practices. Transition of Care and Social Determinants of Health assessments are performed, as well as medication reconciliation, chronic and acute disease management, and patient education. Efforts have emphasized helping patients achieve and maintain better health with tactics in place to reduce avoidable hospital utilization, eliminate gaps in care for routine screenings, and improve quality outcomes for patients with chronic conditions.

Intervention Program

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

Intervention or Program Name	Expansion and Management of Chronic Conditions Through Improved Integration of Behavioral Health Services
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	Greater Baltimore Medical Center
Brief description of the Intervention *2-3 sentences*	Mental health professionals are embedded in GBMC primary care practices to provide screening, short-term intervention, and ongoing counseling/behavioral management. Specialty outpatient psychiatric services and consultation services are provided at GBMC's medical homes (primary care offices) and

	psychiatrists also provide evaluations on inpatient and ER patients and provide post-discharge mental health support (time-limited services). As needed, patients are referred to community based programs and services for longer-term support.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	Sheppard Pratt Health System
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: From July 2019 – June 2020, GBMC provided behavioral health services to 3,368 unique patients. Denominator of Eligible Patients: 48,388 unique patients received a PHQ9, Gad 7, or AUDIT C screening in FY 2020 – industry standard screenings for depression, anxiety, and substance use, respectively.
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	Appendix 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.*	
Successes of the Intervention in FY 2020 *Freeform Narrative Response, up to 1 Paragraph*	- Practice sites newly eligible for behavioral health services in FY 2019 (including aligned Maryland Primary Care Program practices, Complex Care, and Pediatrics) continued to engage in the program, with

	Pediatrics in particular completing nearly 200 patient visits; - Despite a pandemic-correlated dip in visits, there was a steady volume of behavioral health and psychiatry referrals and visits throughout the year; - A formal Screening, Brief Intervention, and Referral to Treatment (SBIRT) protocol was introduced for substance use across all primary care sites; - Reduced inpatient, ED, and observation stay cost and utilization demonstrated; - Increased awareness and adoption of the program among primary care and specialty providers, patients, and the community.
Additional Freeform Narrative Response (Optional)	The long term financial sustainability of this program continues to be a challenge. Fee for service revenue in the behavioral health counseling realm is not sufficient to pay for highly skilled Licensed Clinical Social Workers as co-located therapists. As the grant sunset was confirmed in Fall 2019, GBMC began transitioning to the Collaborative Care Model to support behavioral health needs of GBMC patients in a more financially viable fashion.

Intervention or Program Name	Expansion and Management of Chronic Conditions Through Palliative Services and Elder Medical Care
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	Greater Baltimore Medical Center
Brief description of the Intervention *2-3 sentences*	GBMC's Gilchrist Services, in partnership with MedStar's Total Elder Care (TEC) program, has expanded the program Elder Medical Care (formerly Support Our Elders) by 26% over the prior fiscal year. Medicare patients who are unable to make frequent visits to their primary care physician are currently supported at home by a rounding interdisciplinary team including physicians, nurse practitioners, social workers, and administrative coordinators who can care for complex chronic conditions within the patient's home. Gilchrist Services has also increased the palliative care program in partnership with area nursing homes from 2 nursing homes to 5 nursing homes over the prior fiscal year. Palliative services are provided by a

	nurse practitioner to better manage symptoms and discuss patient care plans. The need for palliative services in nursing homes became exponentially significant during the COVID 19 pandemic which Gilchrist Services responded to by providing Nurse Practitioners in 100% COVID 19 + area nursing homes.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	● Catholic Charities ● MedStar ● Notre Dame School of Pharmacy ● Lorien at Home ● Diamond Lab Services ● SNAP
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: 654 patients
	Denominator of Eligible Patients: Estimated 14,500 Medicare beneficiaries
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	Appendix B
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.*	
Successes of the Intervention in FY 2020	The Elder Medical Care Home Services program continued to experience growth with an overall rate of 26% in our average daily census during FY 2020. The program also continued to

Freeform Narrative Response, up to 1 Paragraph	expand in focusing on Social Determinants of Health and specifically food insecurities. In partnership with Produce in A SNAP, food was delivered by the Elder Medical Care Home Services staff on a weekly basis to patients assessed to be in need. Ongoing ancillary services continued to support the primary care providers by providing lab services, Community Service Coordinators and interventions by pharmacists on a case by case basis enabling increased clinical interventions in the home setting.
Additional Freeform Narrative Response (Optional)	

Intervention or Program Name	Expansion and Management of Chronic Conditions Through Care Coordination
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	Greater Baltimore Medical Center
Brief description of the Intervention *2-3 sentences*	GBMC has been working to expand its hospital-based care management function to focus on high-utilizer patients and preventing unnecessary inpatient admissions through the implementation of a Complex Care Clinic and a “Great Saves” program. The Complex Care Clinic provides more intense care management support for high-utilizers, while the Great Saves Program serves to divert patients to outpatient services, as clinically appropriate. Additionally, care management/coordination support is fully integrated in all 10 of the GBMC employed primary care practices, as well as a care team supporting affiliated Maryland Primary Care Program practices. The care management/coordination staff in each primary care practice works to proactively meet the health and social needs of high-risk patients to avoid unnecessary emergency department use, inpatient hospital admissions, and/or avoidable readmissions.
Participating Program Partners *Please list the relevant community-based 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 2017 RP Analytic Files.*	# of Patients Served as of June 30, 2020: 5,121 (as defined by the average number of high-risk target patients being managed by the care management team)

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.*	Denominator of Eligible Patients: Estimated 14,500 Medicare beneficiaries
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	Appendix C (for early results associated with the Complex Care Clinic) Appendix D (for Great Saves data)
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 include: • New care planning EMR module launched to capture care planning productivity on high-risk patients defined as having a high risk score, uncontrolled diabetes and/or hypertension, and/or having a severe behavioral health diagnosis; nearly 35% of high-risk patients care planned and followed by care management team. • Nearly 2,000 transition of care calls were made by the care management team, which include medication reconciliation, follow-up appointment scheduling, etc. • More than 10,000 Social Determinants of Health assessments completed with Care Coordinators in practices arranging for community resources in areas of need.
Successes of the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	Successes in FY 2020 include: improved quality of care as evidenced by steady improvement in key clinical quality measures; improvement in the promotion of health and wellness as evidenced by demonstrated reductions in gaps in care; development of a targeted care management approach on high-risk and clinically complex patients; the launch of a Complex Care Clinic to focus on high-intensity, and in many cases. high-utilizing patients; and EMR development enabling cross-continuum care planning and communication on high-utilizers and high-risk patients.
Additional Free Response (Optional)	

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 2019 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 2019 -or- Analytic File: 'Charges' over 'Population' (Column E / Column C)	Regional Partnership per Capita Utilization' – Hospital Charges per Capita CY19: $363 hospital charges per capita FY20: $348 hospital charges per capita Data Used from: Executive Dashboard for Regional Partnerships for FY20 (July 2019 – June 2020) and also run for CY19 (Jan 2019 - Dec 2019)
Total Hospital Discharges per capita	**Total Discharges per 1,000** Executive Dashboard: 'Regional Partnership per Capita Utilization' – Hospital Discharges per 1,000, reported as average 12 months of FY 2020 -or- Analytic File: 'IPObs24Visits' over 'Population' (Column G / Column C)	Regional Partnership per Capita Utilization' – Hospital Discharges per 1,000, reported as average 12 months of FY 2020 9 hospital discharges per 1000 Data Used from: Executive Dashboard for Regional Partnerships for FY20 (July 2019 – June 2020)
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)	Regional Partnership per Capita Utilization' – Ambulatory ED Visits per 1,000, reported as average 12 months of FY 2020 25 outpatient ED visits per 1000

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' – <u>Unadjusted Readmission Rate by Hospital</u>, reported as average 12 months of FY 2020 -or- Analytic File: 'IP Readmit' over 'EligibleforReadmit' (Column J / Column I)	[Partnership] Quality Indicators' – <u>Unadjusted Readmission Rate by Hospital</u>, reported as average 12 months of FY 2020 10.0% unadjusted readmission rate Data Used from: Executive Dashboard for Regional Partnerships for FY20 (July 2019 – June 2020)
PAU	**Potentially Avoidable Utilization** Executive Dashboard: '[Partnership] Quality Indicators' – <u>Potentially Avoidable Utilization</u>, reported as **sum** of 12 months of FY 2020 -or- Analytic File: 'TotalPAUCharges' (Column K)	'[Partnership] Quality Indicators' – <u>Potentially Avoidable Utilization</u>, reported as **sum** of 12 months of FY 2020 $21,043,416 potentially avoidable utilization Data Used from: Executive Dashboard for Regional Partnerships for FY20 (July 2019 – June 2020)

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	**Measure for FY 2020 Reporting**	**Outcomes(s)**

(Table 1 in Appendix A of the RFP)		
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.*	Jan 2020 – 18.5% Feb 2020 – 18.3% Mar 2020 – 19.9% Apr 2020 – 14.8% May 2020 – 19.3% Jun 2020 – 20.9% July 2020 – 19.2% Data Used from: Executive Dashboard for Regional Partnerships

Self-Reported Process Measures

Please describe any partnership-level 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.

Please refer to Appendix E.

Return on Investment – (Optional)

Annual Cost per Patient as calculated by:

Please refer to Appendices.

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

Please refer to Appendices.

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.

GBMC data supports that COVID had a brief disruptive impact on standard work implemented as part of this grant opportunity. For example, in-office social determinant of health assessments declined from February through May as a result of patients not visiting the office. Visit volume, and the corresponding in-person care management and care coordination work, began to recover in May as telemedicine grew. This is also true of the behavioral health services offered to primary care patients—however, the pandemic corresponded with a change in the behavioral health model, so there was likely a confounding impact on the behavioral health visits. In terms of the services provided by Elder Medical Care and Palliative Care, there was an increase in services as partnerships we strengthened with facilities in greater need of palliative care to support COVID patients.

Overall, the impact of COVID on the grant funded initiatives resulted in new workflows that capitalized on telemedicine flexibilities and demonstrated the agility of the health care system to continue to serve patients in need.

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.

GBMC anticipates continuing all current initiatives and is actively exploring new grant and funding opportunities to support the important work summarized in this narrative report. Specifically, GBMC and Sheppard Pratt are exploring a new behavioral health model that may not only produce robust clinical outcomes, but may also prove more financially sustainable. The Elder Medical Care and Complex Care Programs, as well as care management staff, will continue to be supported as the system explores new funding streams—for example, the Maryland Primary Care Program care management fees intended to support care management efforts.

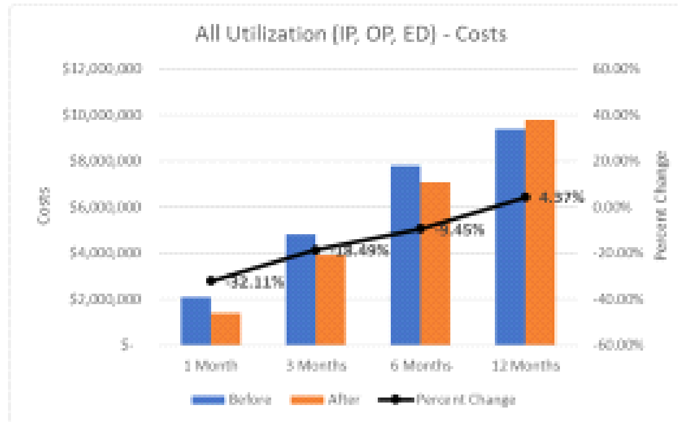
Opportunities to Improve – (Optional)

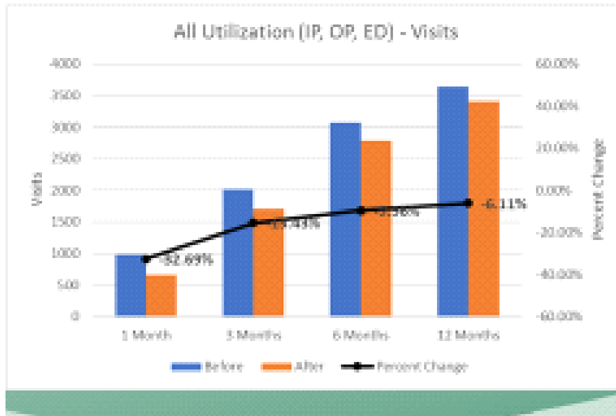
If there is any additional information you wish to share to help the HSCRC enhance future grant programs, please include the information here. Freeform Narrative Response, 1-3 paragraphs.

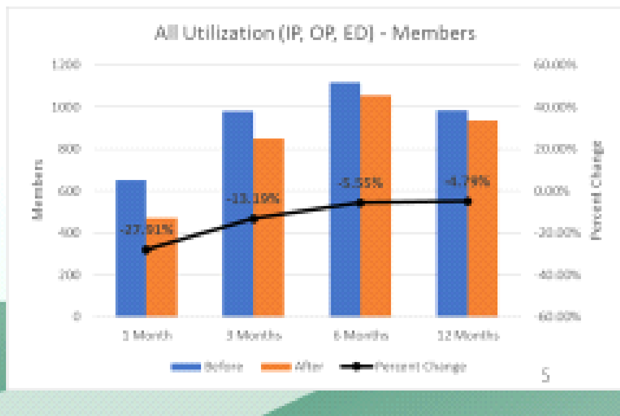
GBMC intends to capitalize the newly available HSCRC grant opportunities—as part of a regional application for the GBRICS opportunity and an independent application for the DPP opportunity. As the HSCRC and health systems launch the Care Transformation Initiative, it would ideal to formulate grant opportunities based on the successful CTIs.

Appendix A. Pre-/Post-Analysis on Expansion and Management of Chronic Conditions Through Improved Integration of Behavioral Health Services

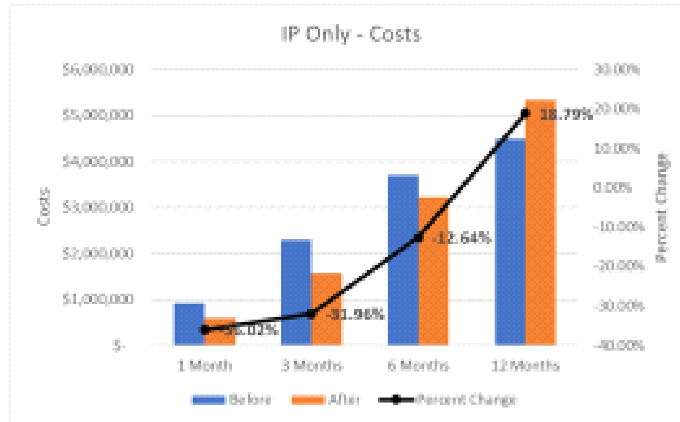
Hospital Utilization – All Services (IP, OP, ED) – Summary

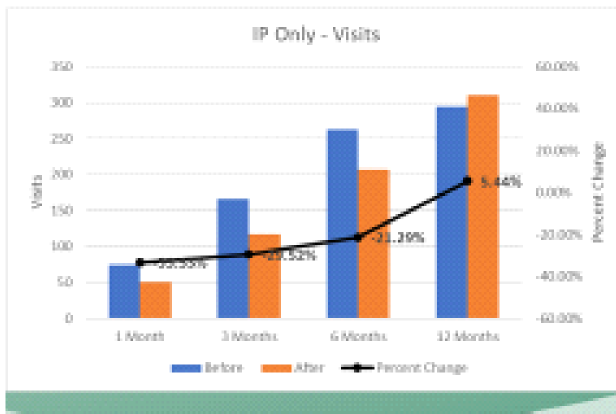


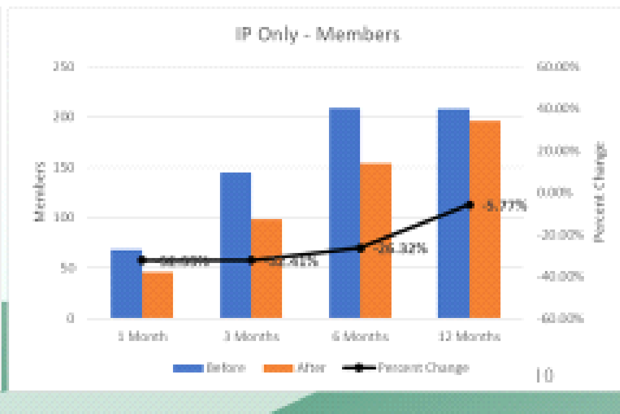




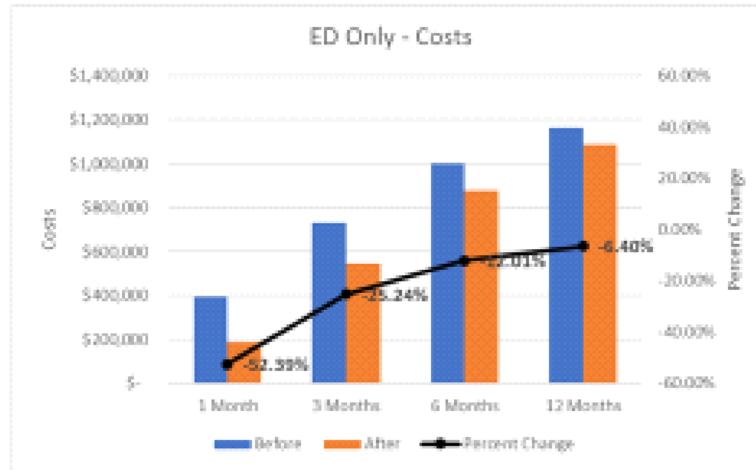
Hospital Utilization – Inpatient Only – Summary

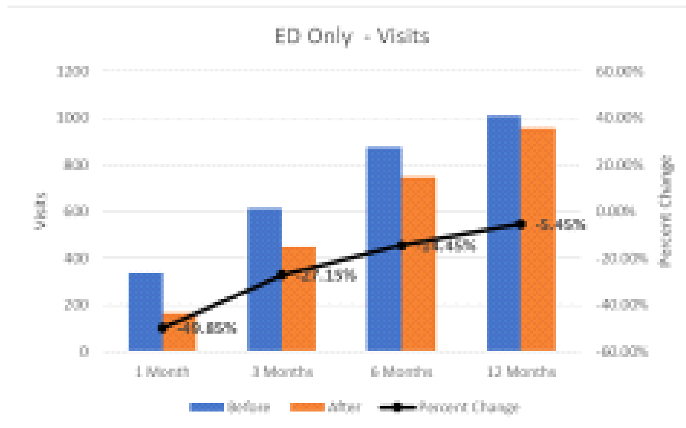


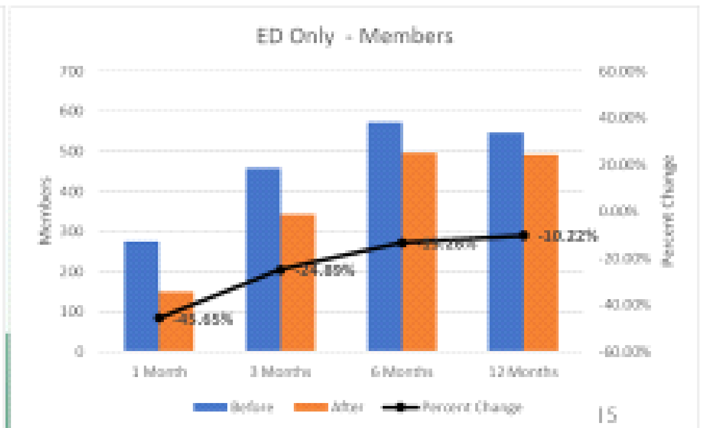




Hospital Utilization – ED Only – Summary







Appendix B. Pre/Post Analysis on Expansion and Management of Chronic Conditions Through Palliative Services and Elder Medical Care

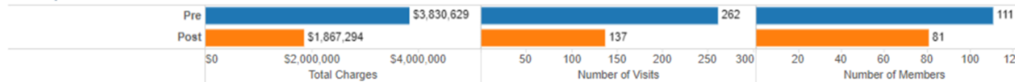
Inpatient – 12 Months

Pre/Post Analysis

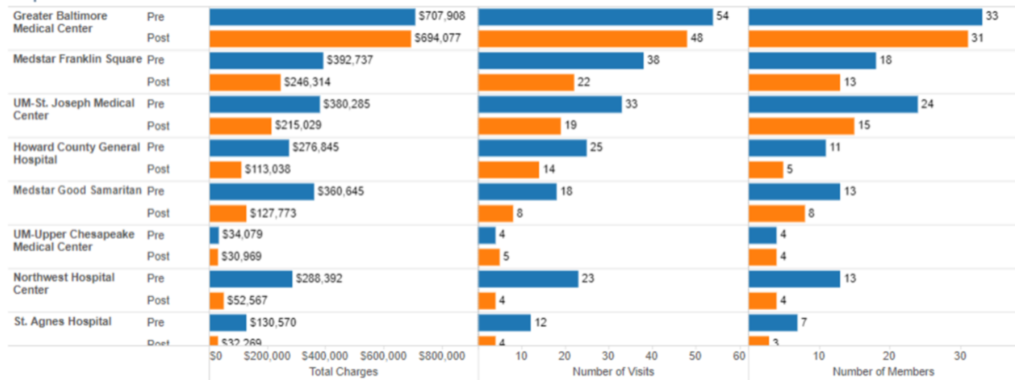
Analysis of 12 Months of Visits Before and After the Enrollment Date

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

231

Number of Members with Data for Analysis

229

Number of Members with Visits during Analysis Period

135

Before or After Enrollment
Pre
Post

Most Recent Payer Group
(All)

Time Period
12 Months

Visit Type
(Multiple values)

Sorting Option
Total Visits - After Enrollment

Hospital Name
(All)

Program Name
EMC at Home_2.17.2020 12 month (2100...

Chronic Conditions
All Patients

N/A

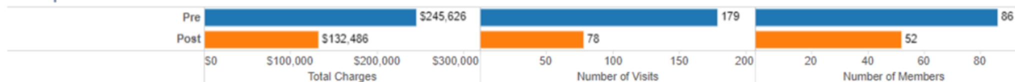
Emergency Department – 12 Months

Pre/Post Analysis

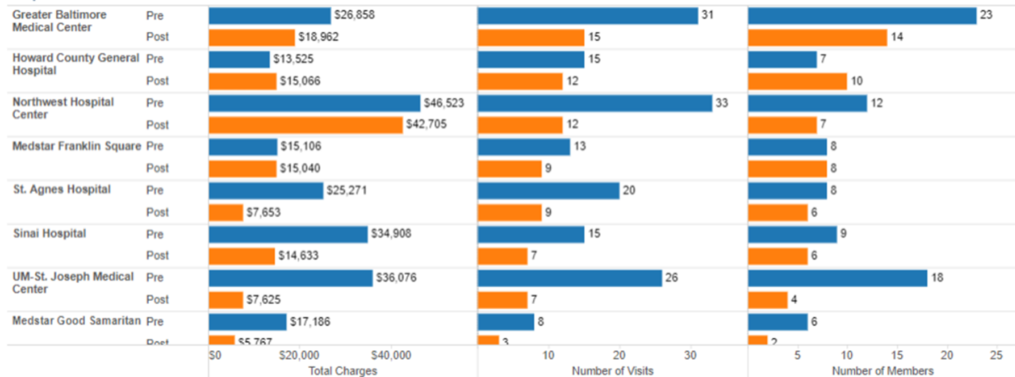
Analysis of 12 Months of Visits Before and After the Enrollment Date

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

231

Number of Members with Data for Analysis

229

Number of Members with Visits during Analysis Period

106

Before or After Enrollment
Pre
Post

Most Recent Payer Group
(All)

Time Period
12 Months

Visit Type
ED

Sorting Option
Total Visits - After Enrollment

Hospital Name
(All)

Program Name
EMC at Home_2.17.2020 12 month (2100...

Chronic Conditions
All Patients

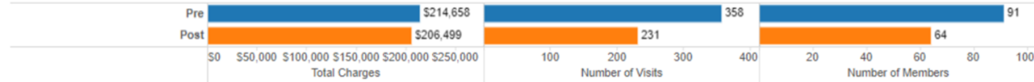
N/A

Outpatient – 12 Months

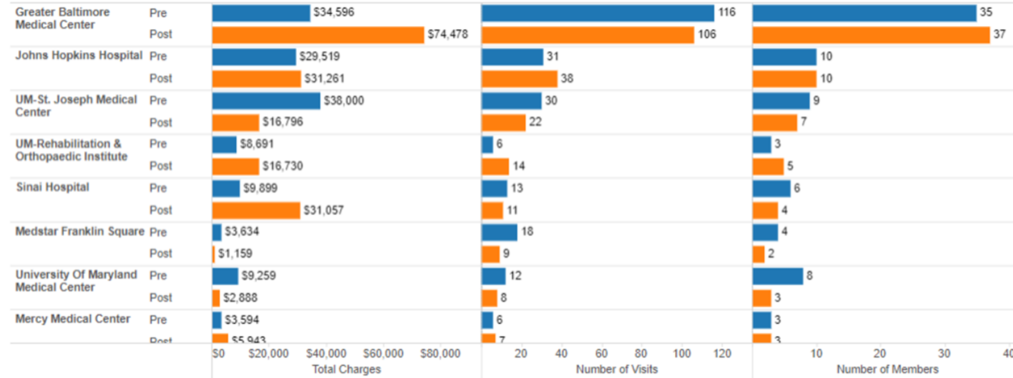
Pre/Post Analysis   Analysis of 12 Months of Visits Before and After the Enrollment Date

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

231

Number of Members with Data for Analysis

229

Number of Members with Visits during Analysis Period

117

Before or After Enrollment: Pre / Post

Most Recent Payer Group: (All)

Time Period: 12 Months

Visit Type: OP

Sorting Option: Total Visits - After Enrollment

Hospital Name: (All)

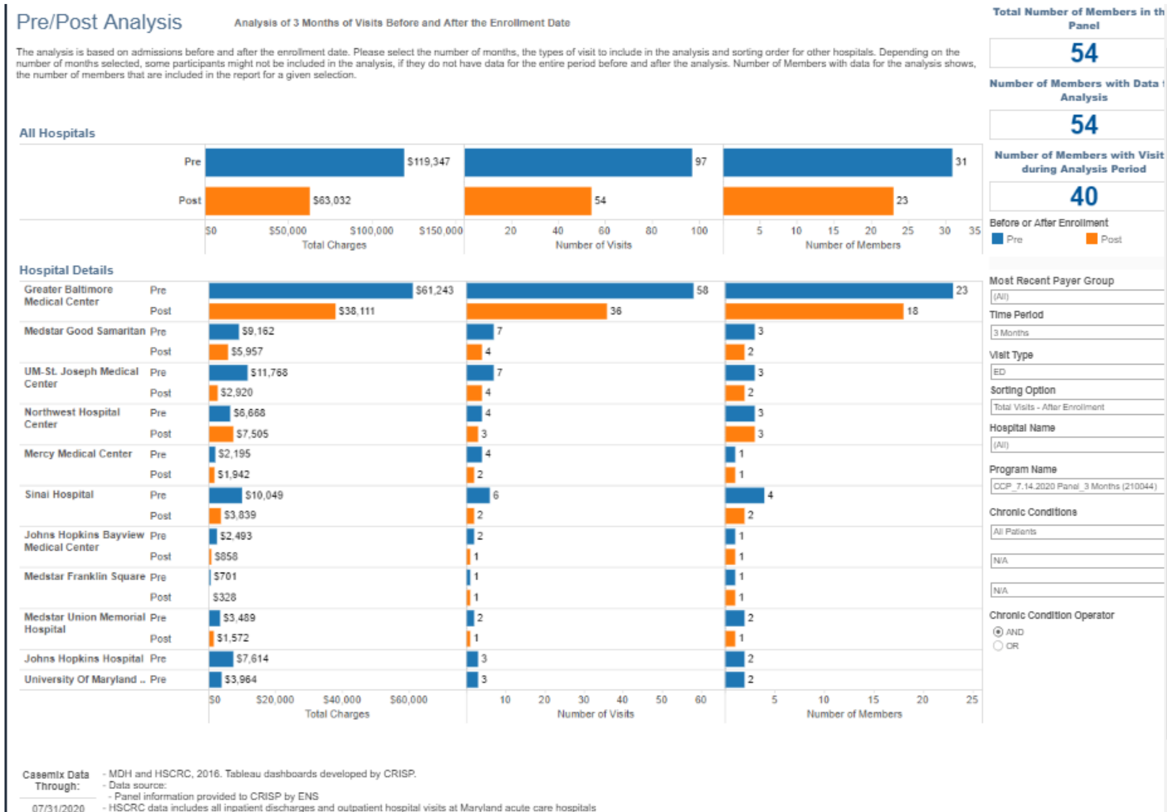
Program Name: EMC at Home_2.17.2020 12 month (2100...

Chronic Conditions: All Patients

N/A

Appendix C. Pre/Post Analysis on Expansion and Management of Chronic Conditions Through Care Coordination, Complex Care Clinic

ED Visit Type – Complex Care Clinic Pre Post 3 Months



IP/Obs Visit Type – Complex Care Clinic Pre Post 3 Months

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.

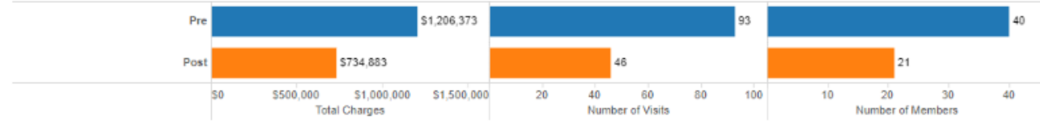
Total Number of Members in th Panel: 54

Number of Members with Data f Analysis: 54

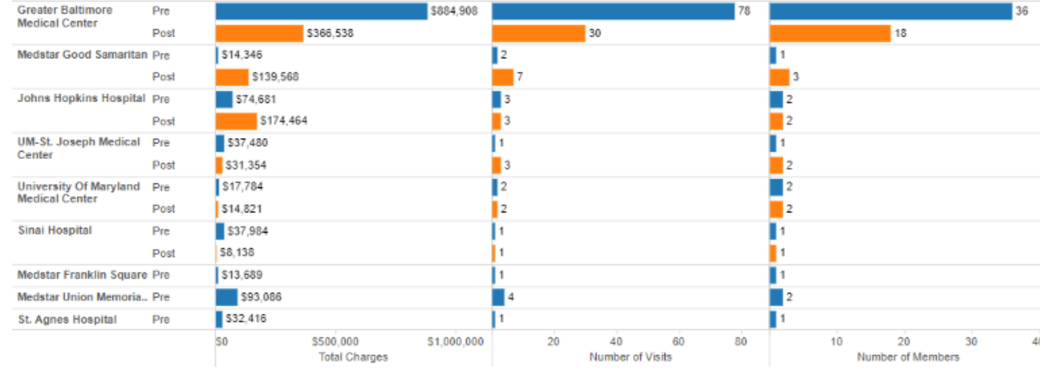
Number of Members with Visit during Analysis Period: 40

Before or After Enrollment: Pre, Post

All Hospitals



Hospital Details



Most Recent Payer Group: (All)

Time Period: 3 Months

Visit Type: (Multiple values)
- (All)
- ED
- ✓ IP
- ✓ OBS > 23
- OP

Cancel | Apply

Program Name: CCP_7.14.2020 Panel_3 Months (210044)

Chronic Conditions: All Patients

N/A

N/A

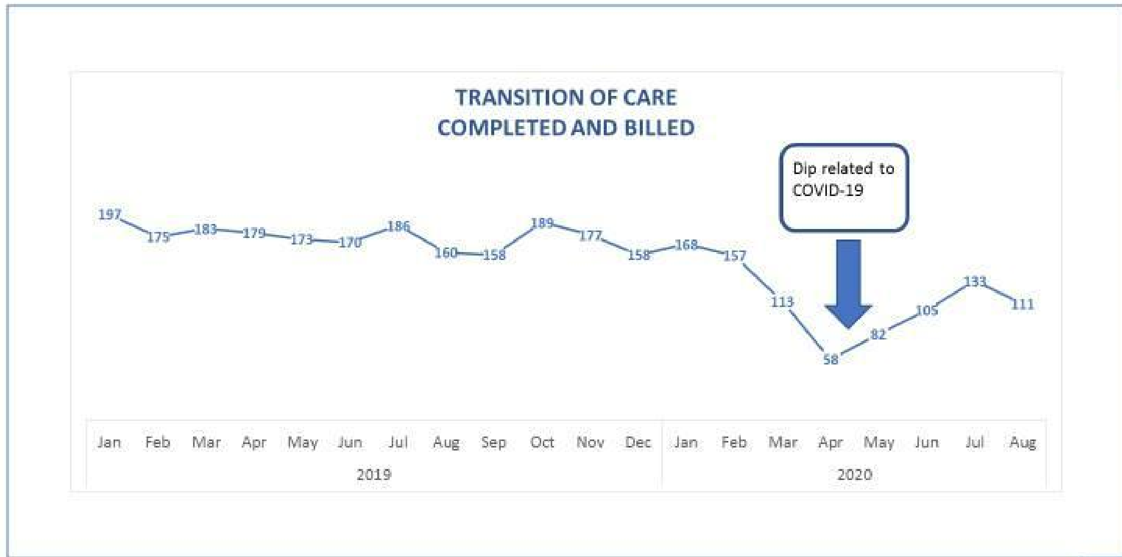
Chronic Condition Operator
- ◉ AND
- ○ OR

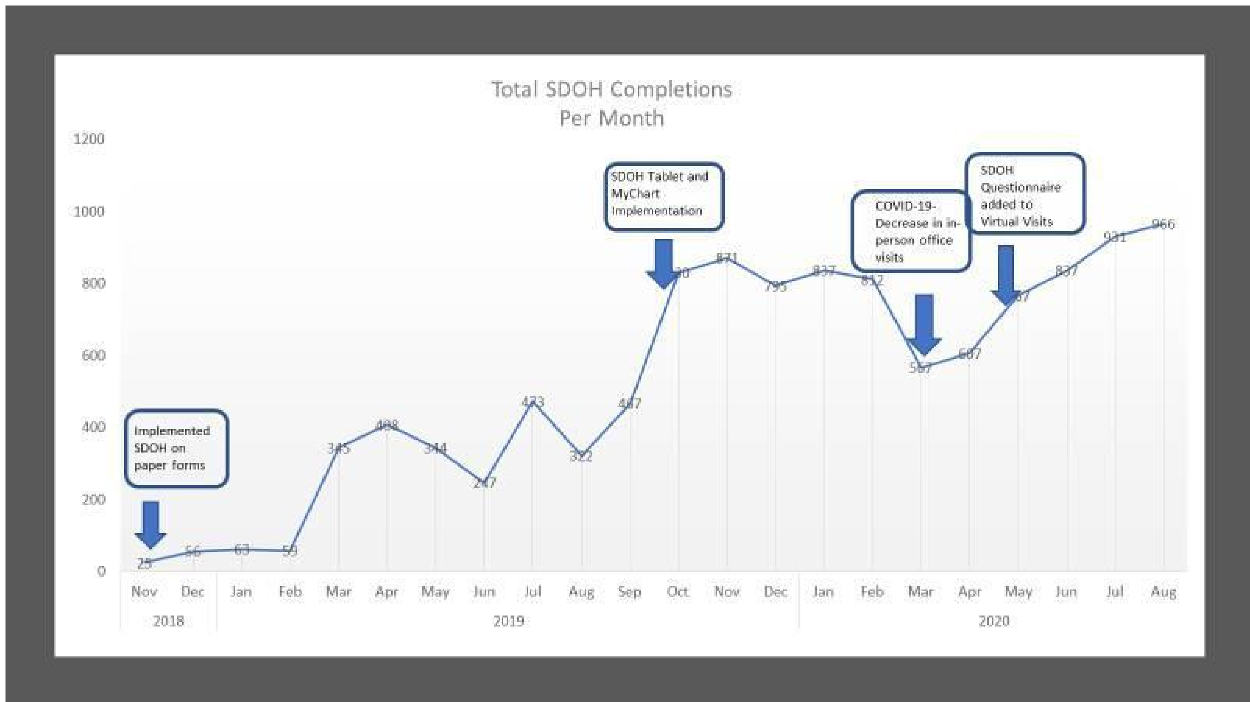
Appendix D. Expansion and Management of Chronic Conditions Through Care Coordination, Great Saves Data

Month	Great Saves
Feb-20	18
Mar-20	8
Apr-20	8
May-20	6
Jun-20	21
Jul-20	15
Aug-20	23

*Note: A change in staff interrupted the collection of Great Saves data for the full fiscal year.

Appendix E. Self-Reported Process Measures Specific to Care Management: Transitions of Care, Social Determinants of Health Assessments, and High-Risk Patient Care Planning





Care Planning Performance