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	Howard Health Partnership (HHP)
RP Hospital(s)	Howard County General Hospital (HCGH)
RP Point of Contact	Tracy Novak, Director of Population Health; phone 410-720-8762; email tnovak2@jhmi.edu
RP Interventions in FY 2020	1. Community Care Team (CCT) 2. Johns Hopkins Home Based Medicine (JHOME) 3. Remote Patient Monitoring (RPM) 4. Behavioral Health Rapid Access Program (RAP) 5. Journey to Better Health (J2BH) 6. Behavioral Health Navigators 7. Advance Care Planning 8. Educational Resources/Classes
Total Budget in FY 2020	FY 2020 Award: **$566,602**
Total FTEs in FY 2020	Employed: **17.4**
	Contracted: **1**
Program Partners in FY 2020 *Please list any community-based organizations or provider groups, contractors, and/or public partners*	Berkeley Research Group, LLC; CRISP; Cardiovascular Specialists of Central Maryland; Centennial Medical Group; Columbia Medical Practice; Ellicott City Healthcare; 26 faith-based organizations; Foreign-Born Information and Referral Network (FIRN); Gilchrist Services; Horizon Foundation; Howard County Health Department; Howard County Local Health Improvement Coalition (LHIC); Howard County Office on Aging and Independence; Johns Hopkins Community Physicians; Johns Hopkins Home Care Group; Johns Hopkins Medicine; Johns Hopkins Home Based Medicine (JHOME); Johns Hopkins University; Lorien Health Systems; Maryland Primary Care Physicians; NeighborRide; Dr. Scott Maurer's practice; Way Station Inc.

Overall Summary of Regional Partnership Activities in FY 2020

(Freeform Narrative Response: 1-3 Paragraphs):

The Howard Health Partnership (HHP) had a very successful year and engaged over 4,700 patients across its interventions and classes, recognizing some people may have participated in more than one. Since the launch of HHP in July 2016, more than 18,000 people have been touched by a HHP intervention.

Members of the HHP governance structure remain very engaged. We launched a new HHP Assisted Living Facility (ALF) Collaborate in FY20 to improve patient health outcomes for HCGH patients transferred to partnering ALFs and develop strategies to strengthen care coordination between ALFs, SNFs, and the hospital. This group has representation from 11 different ALFs across Howard County. Due to COVID-19, most of our interventions shifted to telehealth and remote access, however we are proud that we could quickly pivot to meet the needs of our target population.

We continued to leverage and promote HHP's infrastructure for other Total Cost of Care initiatives. For the Maryland Primary Care Program, we dedicated Community Care Team (CCT) staff to several practices for care management services to attributed beneficiaries as well as providing other HHP wrap-around interventions/services. We also worked collaboratively with the Health Department and Howard County Department of Fire and Rescue Services to develop a funding proposal for a multi-tiered intervention that would, in part, utilize CCT to reduce EMS high utilizers for consideration by the Howard County government.

Intervention Program 1: Community Care Team (CCT)

Intervention or Program Name	Community Care Team (CCT), which includes an embedded Community Health Worker in the hospital
RP Hospitals Participating in Intervention	Howard County General Hospital
Brief description of the Intervention *2-3 sentences*	The Howard County Community Care Team (CCT) serves adult Howard County residents who have Medicare or are dually eligible with Medicaid who have had two or more encounters (inpatient, emergency or observation) at HCGH within the past year. Patients and their caregivers receive program benefits for 30-90 days by a multi-disciplinary team that provides home-based care coordination services. Community health workers (CHW), nurses and a social worker deliver services including health education, disease-specific management, medication reconciliation, connection to and coordination with health care providers, and extensive social support and advocacy with linkages to appropriate community resources. A CHW is embedded in the hospital to visit patients' bedsides in order to enroll them in the program.

Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	CRISP; Centennial Medical Group; Columbia Medical Practice; FIRN; Gilchrist Services; Howard County Health Department; Howard County - Local Health Improvement Coalition (LHIC); Johns Hopkins Community Physicians (Howard County locations); Johns Hopkins Home Care Group; Johns Hopkins Medicine; Johns Hopkins Home Based Medicine (JHOME); Maryland Primary Care Physicians; Dr. Scott Maurer's practice.
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: **512** Enrolled, **991** Referred Denominator of Eligible Patients: **39,112** - Medicare FFS Alternative Denominator: **3,332** - Number of eligible patients who meet the RP criteria of 1) Howard County Resident, 2) Medicare or Dual-Eligible, 3)2 or more HCGH encounters (ED/IP/Obs stay) in FY20
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	Pre-post analyses is included as an attachment on page 17.
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.*	1. Acceptance Rate: **52%** 2. Graduation Satisfaction Rate: **100%** 3. 30 Day All-Cause readmission rate: **13.2%** *Note: Readmission data are preliminary and partial year due to CRISP data run-out.*
Successes of the Intervention in FY 2020 *Freeform Narrative Response, up to 1 Paragraph*	Under the Maryland Primary Care Program, CCT dedicated care management staff to 3 primary care practices in Howard County. In Spring 2020, Care Management Program Manager Rachael Holton Parran was appointed by Governor Larry Hogan to the Maryland State Community Health Worker Committee. The CHW Committee was created to advise the Maryland Department of Health on matters relating to the certification and training of community health workers. CCT submitted an application to the Maryland Department of

	Health to become a certified CHW training site; the application was accepted on 9/23/20.
Additional Freeform Narrative Response (Optional)	To enhance the efficacy and efficiency of the CCT program, care management staff used supportive tools including CRISP, CAREAPP (a resource database and bidirectional referral system) and HALO Communications (a secure text messaging service offered by CRISP).

Intervention Program 2: Johns Hopkins Home Based Medicine (JHOME)

Intervention or Program Name	Johns Hopkins Home Based Medicine (JHOME)
RP Hospitals Participating in Intervention	Howard County General Hospital
Brief description of the Intervention *2-3 sentences*	Johns Hopkins Home-Based Medicine (JHOME) is an in-home primary care program for adults age 65 or older who are unable to leave their homes due to medical conditions or physical limitations. Participants benefit from our team of experienced geriatricians, nurse practitioners, registered nurses, social workers and community health workers. Our highly skilled team works with patients to develop care plans that meet their individual needs. To participate in the program, patients must live in certain areas of Baltimore City, Baltimore County or Howard County.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	Johns Hopkins Home Care Group
Patients Served	# of Patients Served as of June 30, 2020: **39**
	Denominator of Eligible Patients: **39,112** -Medicare FFS
Pre-Post Analysis for Intervention (optional)	N/A
Intervention-Specific Outcome or Process Measures (optional)	N/A

Successes of the Intervention in FY 2020 *Freeform Narrative Response, up to 1 Paragraph*	JHOME expanded to Howard County to provide home-based primary care services to vulnerable seniors. Through a concerted marketing effort, JHOME received referrals from a variety of groups, including CCT, the HCGH inpatient team, JHCP providers, and other outside organizations.
Additional Freeform Narrative Response (Optional)	N/A

Intervention Program 3: Remote Patient Monitoring (RPM)

Intervention or Program Name	Remote Patient Monitoring (RPM)
RP Hospitals Participating in Intervention	Howard County General Hospital
Brief description of the Intervention *2-3 sentences*	Home-based program for patients with heart failure, COPD or diabetes with daily monitoring by RN of biometric & symptom data. This allows for immediate feedback to the patient and care team as needed, and provides an opportunity for disease education. The nurse monitors data and interacts with the patient and care team.
Participating Program Partners	Johns Hopkins Home Care Group
Patients Served	# of Patients Served as of June 30, 2020: **194**
	Denominator of Eligible Patients: **39,112** - Medicare FFS Alternative denominator: **492** patients - number of HCGH Medicare/Dually eligible for Medicaid patients with an inpatient stay for CHF or COPD in FY20
Pre-Post Analysis for Intervention (optional)	N/A
Intervention-Specific Outcome or Process Measures (optional)	30 Day All-Cause Readmission rate: **8%** *Note: Readmission data are preliminary and partial year due to CRISP data run-out.*
Successes of the Intervention in FY 2020 *Freeform Narrative Response, up to 1 Paragraph*	Ongoing collaboration with CCT, inpatient teams at HCGH and the Patient Access Line (PAL) nurses helped to encourage RPM referrals throughout the year. In addition, CCT's collaboration with 3 primary care practices in Howard County through the Maryland Primary Care Program, assisted in increasing the number of community referrals to RPM. Pulse

	Ox technology provided through RPM was especially useful to patients discharged from HCGH with COVID-19.
Additional Freeform Narrative Response (Optional)	N/A

Intervention Program 4: Behavioral Health Rapid Access Program (RAP)

Intervention or Program Name	Behavioral Health Rapid Access Program (RAP)
RP Hospitals Participating in Intervention	Howard County General Hospital
Brief description of the Intervention *2-3 sentences*	RAP provides access to urgent, outpatient, crisis stabilization services within two business days of referral for adults (18 years and older) who present in the ED, on the inpatient psychiatric unit or on a medical unit and are in need of immediate access to varying levels of psychiatric treatment. The service links patients to the level and type of care needed to prevent further emotional distress and decompensation that would otherwise result in accessing more acute levels of care. Services are provided through Way Station, a subsidiary of Sheppard Pratt at the Columbia, Maryland site. Patients are able to receive up to 9 treatment sessions that include prescriber and therapy, regardless of their ability to pay. Way Station assists patients who need a higher level of outpatient care or treatment beyond the 9 sessions provided through RAP.
Participating Program Partners	Way Station, Inc.; Grassroots Crisis Intervention Center
Patients Served	# of Patients Served as of June 30, 2020: **194**
	Denominator of Eligible Patients: **384,210** - All Payer Alternative denominator: **2,555 -** number of HCGH ED Patients receiving behavioral health treatment in the ED.
Pre-Post Analysis for Intervention (optional)	N/A
Intervention-Specific Outcome or Process Measures (optional)	30 Day All-Cause Readmission rate: **8%** *Note: Readmission data are preliminary and partial year due to CRISP data run-out.*

Successes of the Intervention in FY 2020 *Freeform Narrative Response, up to 1 Paragraph*	Through collaboration and effective communication between the hospital and Way Station, the needs of the patients are met in a timely and efficient manner. Linkages to psychiatric care for patients discharged from the hospital are made through the use of a cloud-based scheduling system which allows appointments to be scheduled 24 hours a day by hospital staff with Way Station, improving transitions for patients from the hospital to care in the community within 48hrs.
Additional Freeform Narrative Response (Optional)	RAP is funded by HCGH.

Intervention Program 5: Journey to Better Health (J2BH)

Intervention or Program Name	Journey to Better Health (J2BH)
RP Hospitals Participating in Intervention	Howard County General Hospital
Brief description of the Intervention *2-3 sentences*	J2BH works with Howard County faith-based organizations to support the health of their members. J2BH offers chronic disease prevention and management strategies to their members tailored to their needs. Program strategies include: ● **Chronic Disease Screenings and Education:** Conduct screenings for hypertension, obesity and pre-diabetes and classes on chronic disease self-management within the congregations. Class offerings include Living Well with Chronic Disease, Living Healthy with Hypertension, Living Well with Diabetes, Cancer Self-Management, and Mental Health First Aid Training. ● **Volunteer Support for significant health events**: Offer access to the Member Care Support Network (MCSN) which aims to pair members with trained volunteer Community Companions.
Participating Program Partners	Abiding Savior Lutheran Church; Atholton Seventh Day Adventist Church; Bethany Church; Bethany United Methodist; Bridgeway Community Church; Celebration Church; Christ Episcopal Church; Christ Memorial Presbyterian Church; Church of the Resurrection; Columbia Community Church; Ellicott City Assembly of God Church; First Baptist Church of Guilford; First Evangelical Lutheran Church; Glen Mar United Methodist Church; Hope Bible Church; Iglesias De Dios Pentecostal; Locust United

	Methodist Church; Muslim Family Center; New Hope Adventist Church; North American Division Seventh-day Adventist Church; Oneness Ministries; Saint James United Methodist Church; St John Baptist Church; St. John the Evangelist Roman Catholic Church; Unitarian Universalist Congregation of Columbia; Unity Baptist Church.
Patients Served	# of Patients Served as of June 30, 2020: **1,513**
	Denominator of Eligible Patients: **384,210** - All Payer
Pre-Post Analysis for Intervention (optional)	None – Due to the nature of this program, not all participants are hospital patients. We therefore cannot perform a Pre/Post Analysis with CRISP data.
Intervention-Specific Outcome or Process Measures (optional)	1. Number of people screened: **402** 2. Total Wellness Classes Offered: **17** 3. New Member Care Support Network volunteers trained: **37** 4. Total number of congregations: **26**
Successes of the Intervention in FY 2020 *Freeform Narrative Response, up to 1 Paragraph*	Since FY17 the J2BH program has screened 2,373 community members, with emphasis on teaching self-management skills. Since inception they have grown from 11 to 26 participating congregations, all while growing their volunteer Member Care Support Network. J2BH has expanded class offering to include Chronic Disease Self-Management Program (CDSMP), Diabetes Self-Management Program (DSMP), Cancer Self-Management, Chronic Pain Self-Management as well as Tomando de su Salud, which is CDSMP taught in Spanish. At the end of FY20, J2BH transitioned to virtual offerings to meet COVID 19 needs for vulnerable populations and increased volunteer support for phone-based pairing with members needing non-clinical support during COVID 19 pandemic. J2BH also supported the Howard County Health Department with the We Care initiative by training new 9 CARE ambassadors in member connection, resource referrals and the Patient Engagement Program (PEP).
Additional Freeform Narrative Response (Optional)	N/A

Intervention Program 6: Behavioral Health Navigators (BHN)

Intervention or Program Name	Behavioral Health Navigators (BHN)

RP Hospitals Participating in Intervention	Howard County General Hospital
Brief description of the Intervention *2-3 sentences*	As pediatric and adult patients with behavioral health issues (diagnosed mental illness and/or substance use disorder) enter the hospital's ED, BHNs assist by providing information and making connections to community resources with the goal of successfully engaging them in treatment. This includes referrals and linkages to mental health treatment, substance use treatment, support groups and housing programs. BHN services consist of a screening that identifies non-medical needs, completing referrals, assistance with scheduling post discharge mental health or drug treatment appointments, and follow up phone calls within 48 hours of discharge from the ED to ensure linkages have successfully occurred.
Participating Program Partners	Howard County Government
Patients Served	# of Patients Served as of June 30, 2020: **468**
	Denominator of Eligible Patients: **384,210 - All Payer** Alternative denominator: **2,555 -** number of HCGH ED Patients receiving behavioral health treatment in the ED.
Pre-Post Analysis for Intervention (optional)	N/A
Intervention-Specific Outcome or Process Measures (optional)	N/A
Successes of the Intervention in FY 2020	The BHNs support the Emergency Department (ED) psychiatric service by assisting with placing patients in crisis beds and supporting efforts with bed placement to inpatient psychiatric facilities. This support results in a better patient experience and improved patient throughput in the HCGH ED. The BHNs assist with and provide support to a new SBIRT (Screening Brief Intervention and Referral to Treatment) initiative in the ED which identifies patients with substance use disorders. By supporting the Peer Recovery Coaches during evening and weekend hours, the BHNs screen patients with a substance use disorder and assist with connecting them to the peers and appropriate treatment and recovery resources.

Additional Freeform Narrative Response (Optional)	Funding is provided by the Howard County Government.

Intervention Program 7: Advance Care Planning (ACP)

Intervention or Program Name	Advance Care Planning (ACP)
RP Hospitals Participating in Intervention	Howard County General Hospital
Brief description of the Intervention *2-3 sentences*	An Advance Care Planning Coordinator meets bedside with patients to educate them about Advance Directives (AD) and ensure their end-of-life wishes are appropriately documented in the EMR. The coordinator targets patients who are 65+ years old who either 1) don't have an AD, 2) have an AD, but don't have it on file in the hospital's EMR (Epic). She works with them to either create/update their Advance Directive or assists in uploading it to Epic.
Participating Program Partners	None
Patients Served	# of Patients Served as of June 30, 2020: **1,984**
	Denominator of Eligible Patients: **39,112**- Medicare FFS Alternative denominator: **6,165** number of HCGH inpatients who are 65+ years receiving treatment in FY19
Pre-Post Analysis for Intervention (optional)	N/A
Intervention-Specific Outcome or Process Measures (optional)	**37** Community members who ACP coordinator assisted with Advance Directive. **37** Community members who participated in ACP office hours.
Successes of the Intervention in FY 2020 *Freeform Narrative Response, up to 1 Paragraph*	The ACP Coordinator continues to increase the number of ADs being completed and collected by patients in the past fiscal year. Her bedside conversations with patients and their families has helped to educate them on what an AD is and the importance of completing one; increasing the number of ADs completed by both patients and family members. She developed folders that are individualized for each patient based on the information that is needed to have the conversation and complete an AD. The Coordinator role has also increased awareness among hospital staff and with

	community members. The ACP Coordinator provided presentations to groups in the community and is available on a one to one basis to community members through monthly office hours or scheduled appointments.
Additional Freeform Narrative Response (Optional)	In an effort to increase the awareness and knowledge of hospital employees the ACP Coordinator participated in the hospital's annual benefits fair, providing information to staff and encouraging them to complete an AD by making the tools to do so readily available.

Intervention Program 8: HHP Educational Resources and Classes

Intervention or Program Name	HHP Educational Resources and Classes 1. Patient Engagement Program (PEP) 2. Powerful Tools for Caregivers (PTC) 3. Living Well (Chronic Disease Self-Management Programs) 4. Mental Health First Aid (MHFA)
RP Hospitals Participating in Intervention	Howard County General Hospital
Brief description of the Intervention *2-3 sentences*	The HHP offers classes to providers, patients and caregivers to support engaging patients in their health care. The Johns Hopkins Medicine Patient Engagement Program (PEP) is a comprehensive, web-based and in-person, skills-based program that teaches health care 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. Powerful Tools for Caregivers (PTC) is an evidence-based class for family caregivers that offers tools and strategies to better handle the unique challenges caregivers face. Living Well courses teach patients with chronic disease about their disease and coaches them on healthy behaviors. Mental Health First Aid (MHFA) is an 8-hour education program that introduces participants to risk factors and warning signs of mental illnesses, builds understanding of their impact, and overviews common supports.
Participating Program Partners	Johns Hopkins Medicine, Howard County Office on Aging and Independence, Howard County Local Health Improvement Coalition, FIRN

Patients Served	# of Patients Served as of June 30, 2020: Powerful Tools for Caregivers class attendees: **46** Living Well class attendees: **80** Mental Health First Aid class attendees: **92**
	Denominator of Eligible Patients: **384,210** - All Payer
Pre-Post Analysis for Intervention (optional)	None – Due to the nature of this program, not all participants are hospital patients. We therefore cannot perform a Pre/Post Analysis with CRISP data.
Intervention-Specific Outcome or Process Measures (optional)	<u>Patient Engagement Program (PEP):</u> PEP training participation for CCT and J2BH staff: **100%** <u>Powerful Tools for Caregivers (PTC):</u> Participant Satisfaction: **78%** Capacity: **96%** <u>Living Well:</u> Participant Satisfaction: **100%** Capacity: **45%** <u>Mental Health First Aid:</u> Capacity: **42%**
Successes of the Intervention in FY 2020	**Patient Engagement Program (PEP):** HHP staff have embraced the PEP's training and maintenance. All staff were trained in FY20. Two CCT staff members continue to serve as PEP champions and lead monthly skills maintenance exercises. Columbia Medical Practice and some hospital inpatient staff (social workers and case managers) are trained and participate in the maintenance program. In FY20, we continue to use the e-learning curriculum with self-paced training so that in-person learning time is reduced from 8 hours to 4. **Powerful Tools for Caregivers (PTC):** Continued to make a difference in caregiver's lives, especially in terms of their self-confidence with decision making and the realization they do not need to face it alone. Caregivers come to the class to gain knowledge about how to manage their journey more easily through communication, and to use tools to relieve the many stresses they encounter. **Living Well:** Offered a diversity of classes including Chronic Disease, Diabetes, Cancer, and Chronic Pain. All classes

	except Cancer and Pain Management were offered in both English and Spanish. **Mental Health First Aid:** HHP also offers Youth Mental Health First Aid, and two HHP staff members are trained to offer the course. Participant evaluations noted classes as informative, helpful, and beneficial in educating Howard County residents and reducing stigma around Mental Health.
Additional Freeform Narrative Response (Optional)	N/A

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)	**$2,331** *Source file: RP_AnalyticFile_01JUL19_30JUN20_Monthly_20200804a*
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)	**84.86** *Source file: RP_AnalyticFile_01JUL19_30JUN20_Monthly_20200804a*

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)	**181.40** *Source file: RP_AnalyticFile_01JUL19_30JUN20_Monthly_20200804a*

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 12 months of FY 2020 -or- Analytic File: 'IP Readmit' over 'EligibleforReadmit' (Column J / Column I)	**10.6%** *Source file: RP_AnalyticFile_01JUL19_30JUN20_Monthly_20200804a*
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)	**$70,087,867** *Source file: RP_AnalyticFile_01JUL19_30JUN20_Monthly_20200804a*

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.*	None

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.

Number of HHP Governance Meetings in FY20: 11 Meetings

Number of Hours of HHP Governance Meetings in FY20: 17 hours

Leveraging Other Networks: HHP Leadership participates on a CAREAPP Network hosted by the Howard County Health Department to monitor and expand use of CAREAPP, a web-based risk assessment screening tool and community resources database with a bi-directional referral tracking system. The CAREAPP Network includes 34 community partner organizations including community service agencies, government organizations, educational institutions, and healthcare centers in Howard County, working in partnership with the Howard County Health Department to optimize care coordination for Howard County residents.

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)

Based on an external analysis of the Community Care Team (CCT), enrolled patients rate of growth in the post enrollment period was lower than not enrolled for beneficiaries that died or had ESRD; trends were consistent for those patients that did not die. TCOC savings equals $1,842 per beneficiary per year post enrollment. Through care coordination efforts, enrolled patients had a positive impact on the readmission reduction payment policy: enrolled patients avoided 8 readmissions post enrollment, a favorable impact of $91,500. Observed to expected ratio pre-enrollment 1.3790 to post enrollment 1.1369. There was an increase in palliative care documentation in the post-enrollment period for enrolled beneficiaries which can favorably impact expected and score for the Mortality domain of QBR.

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.

In mid-March, the Community Care Team (CCT) transitioned to telephonic and video visits with patients to ensure continuity of care. CCT staff received training for telehealth, including MyChart (Epic's patient portal) and other approved platforms to communicate. Knowing that clients would likely need more support during the pandemic, staff conducted more frequent outreach to provide COVID-19 education and ensure social supports such as food, prescriptions and caregivers. Staff developed and shared critical resources for patients, including lists of grocery stores and pharmacies that delivered to homes.

Journey to Better Health transitioned to virtual offerings to meet COVID-19 needs for vulnerable populations, as well as increased volunteer support for phone-based pairing with members needing non-clinical support during COVID 19 pandemic.

Pulse Ox technology provided through Remote Patient Monitoring (RPM) was especially useful to patients discharged from HCGH with COVID-19.

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 grant. Freeform Narrative, 1-3 paragraphs.

The following interventions were successful and will continue after the conclusion of the grant with other grant or hospital funding. Please see above for program description and successes:

1. Community Care Team (CCT)
2. Johns Hopkins Home Based Medicine (JHOME)
3. Remote Patient Monitoring (RPM)
4. Behavioral Health Rapid Access Program (RAP)
5. Journey to Better Health (J2BH)
6. Behavioral Health Navigators
7. Advance Care Planning
8. Educational Resources/Classes: Patient Engagement Program (PEP); Powerful Tools for Caregivers (PTC); Living Well (Chronic Disease Self-Management Programs); Mental Health First Aid (MHFA)

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.

N/A

Pre/Post Analysis - Summary

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

Program Name
CCT_Patient_List_FY20Q4 (210048)

Chronic Conditions
All Patients

Most Recent Payer
All

Visit Type
All

N/A

N/A

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	440	345	233	16

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	250	125	56.8%	28.4%	-28.4%
3 Months	268	163	77.7%	47.2%	-30.4%
6 Months	204	154	87.6%	66.1%	-21.5%
12 Months	16	11	100.0%	68.8%	-31.3%

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	406	203	9.2	4.6	-4.6
3 Months	693	412	20.1	11.9	-8.1
6 Months	764	508	32.8	21.8	-11.0
12 Months	49	39	30.6	24.4	-6.3

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	280	$3,836,997	$1,120,820	$15,348	$8,967	($6,381)
3 Months	283	$5,169,754	$2,642,546	$19,290	$16,212	($3,078)
6 Months	218	$5,699,203	$3,650,401	$27,937	$23,704	($4,233)
12 Months	16	$258,633	$141,740	$16,165	$12,885	($3,279)

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	406	203	$3,836,997	$1,120,820	$9,451	$5,521	($3,929)
3 Months	693	412	$5,169,754	$2,642,546	$7,460	$6,414	($1,046)
6 Months	764	508	$5,699,203	$3,650,401	$7,460	$7,186	($274)
12 Months	49	39	$258,633	$141,740	$5,278	$3,634	($1,644)

Casemix Data Through:
07/31/2020

ENS Panels Last Updated:
09/10/2020

- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
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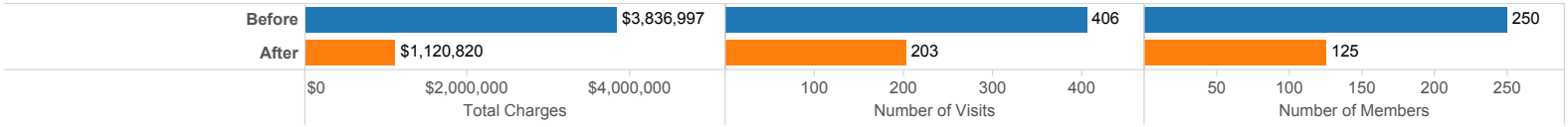
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
- Individual patients identified using CRISP EID
- CRISP suppressed cells with counts of 10 and under
- Depending on the number of months selected, some participants might not be included in 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

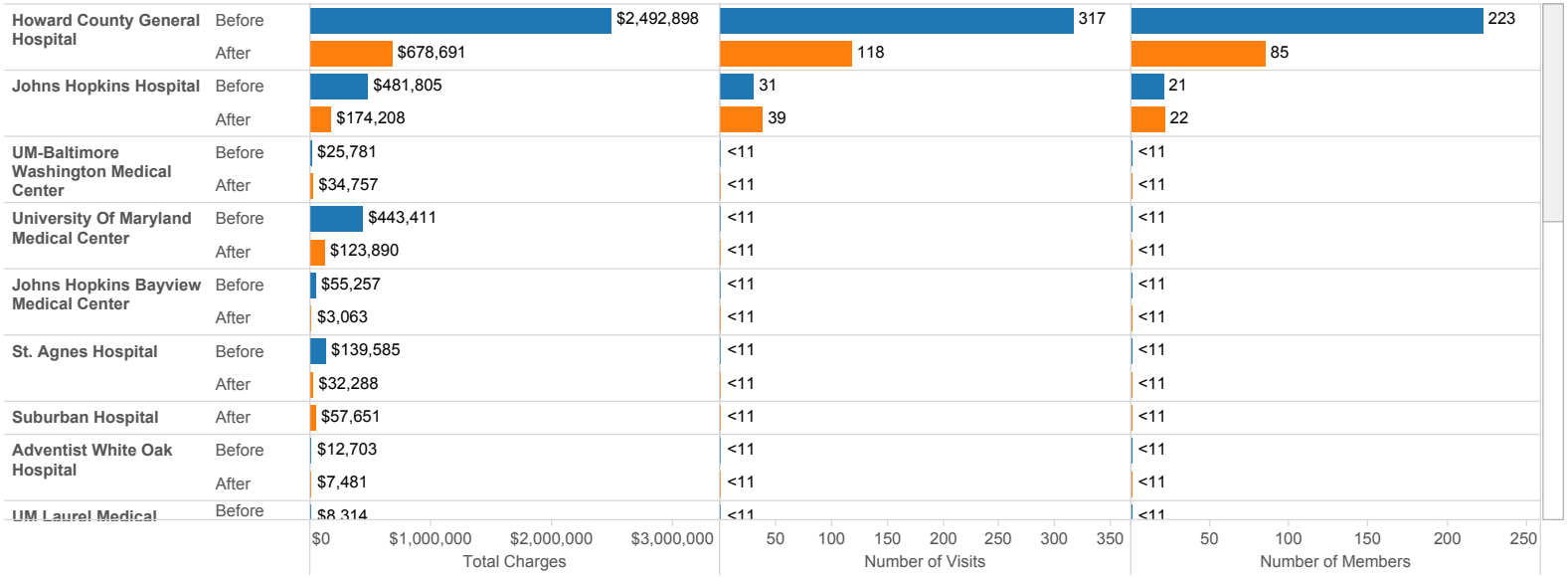
Analysis of 1 Month of Visits Before and After the Enrollment Date

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



Casemix Data Through:

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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.

Total Number of Members in the Panel

440

Number of Members with Data for Analysis

440

Number of Members with Visits during Analysis Period

280

Before or After Enrollment

Before After

Most Recent Payer

All

Time Period

1 Month

Visit Type

All

Sorting Option

Total Visits - After Enrollment

Hospital Name

All

Program Name

CCT_Patient_List_FY20Q4 (210048)

Chronic Conditions

All Patients

N/A

N/A

Chronic Condition Operator

(•) AND

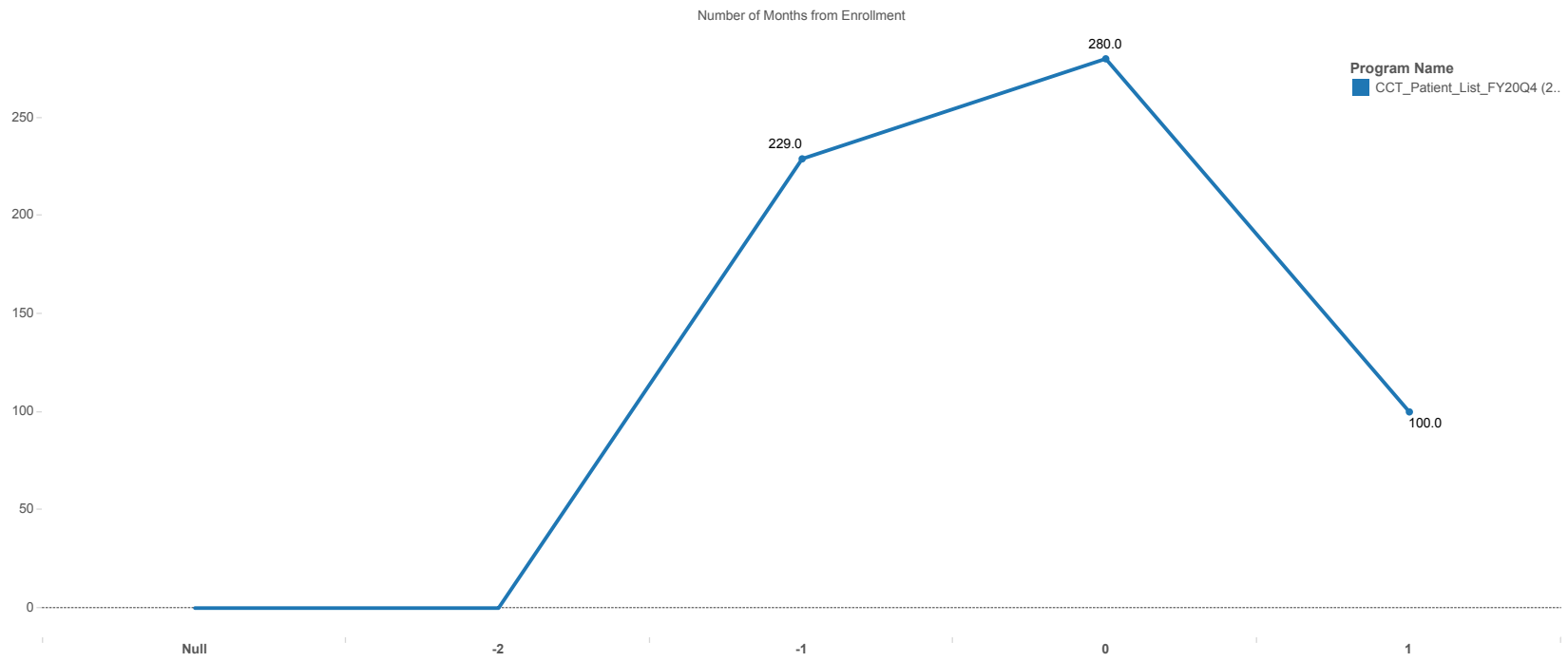
( ) OR

Pre/Post Analysis

Analysis of 1 Month 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
1 Month

Trend Metric
Visits

Visit Type
All

Hospital Name
All

Program Name
CCT_Patient_List_FY20Q4 (210048)

Chronic Conditions

All Patients

N/A

N/A

Chrionic Condition Operator

(•) AND
( ) OR

Casemix Data Through:
07/31/2020
ENS Panels Last Updated:
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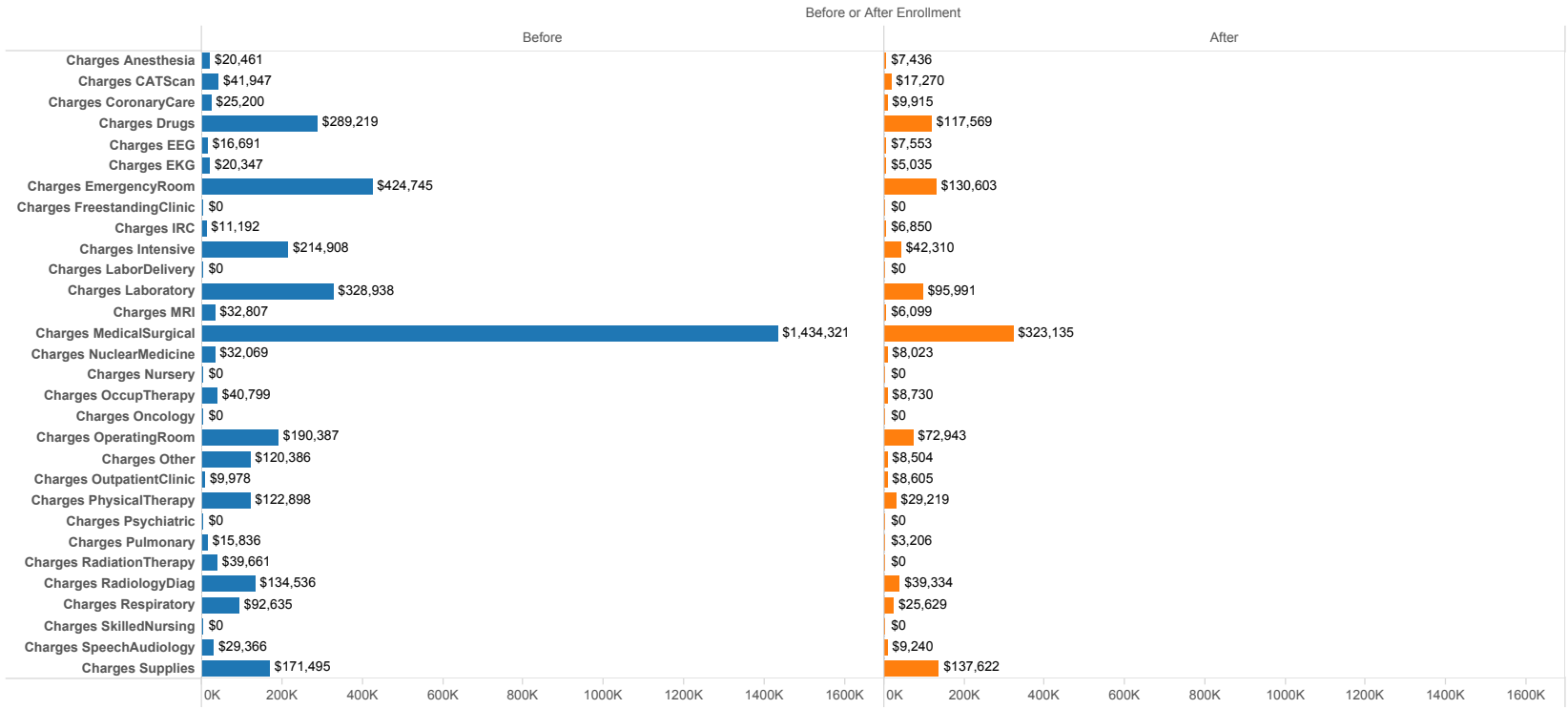
Pre/Post Analysis

Analysis of 1 Month 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
1 Month

Program Name
CCT_Patient_List_FY20Q4 (210048)

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

Casemix Data Through:
07/31/2020

ENS Panels Last Updated:
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