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

<table>
<tr><td>Regional Partnership (RP) Name</td><td>LifeBridge Health System</td></tr>
<tr><td>RP Hospital(s)</td><td>• Sinai Hospital of Baltimore
• Northwest Hospital
• Carroll Hospital</td></tr>
<tr><td>RP Point of Contact</td><td>Sharon McClernan, RM, BSN, MBA, MHA
Vice President for Clinical Integration
smcclernan@lifebridgehealth.org</td></tr>
<tr><td>RP Interventions in FY 2020</td><td>• Community Care Coordination – Sinai Hospital of Baltimore and Northwest Hospital
• Emergency Department Navigation – Sinai Hospital of Baltimore and Northwest Hospital
• Behavioral Health Navigation – Carroll Hospital
• Coordination of Care in Elderly population – Carroll Hospital
• Outpatient Palliative Care – Carroll Hospital</td></tr>
<tr><td>Total Budget in FY 2020
This should equate to total FY 2017 award</td><td>FY 2020 Award: Details in Appendix A.
<table><tr><th>Hospital Site</th><th>FY2020 Amount</th></tr><tr><td>Sinai</td><td>$494,821</td></tr><tr><td>Northwest</td><td>$278,254</td></tr><tr><td>Carroll</td><td>$172,203</td></tr><tr><td>TOTAL Budget</td><td>$945,278</td></tr></table></td></tr>
<tr><td rowspan="2">Total FTEs in FY 2020</td><td>Employed FTEs: 19.5</td></tr>
<tr><td>Contracted: None</td></tr>
</table>

Program Partners in FY 2020 *Please list any community-based organizations or provider groups, contractors, and/or public partners*	1. The Coordinating Center 2. Absolute Care 3. DeVita 4. Season's Hospice 5. Pulse 6. Future Care 7. Home Care Maryland 8. Access Carroll 9. Community Health Partnership of Baltimore (CHPB) 10. Carroll Lutheran Village

Overall Summary of Regional Partnership Activities in FY 2020

(Freeform Narrative Response: 1-3 Paragraphs):

This year's strategy has been to transition partnership care coordination services to the developed and expanding LBH system-wide care management programs while maintaining those community relationships strengthened through the partnership.

Sinai and Northwest's Community Care Coordination team worked with partners to facilitate handoffs of shared patients. The program added staff to support systemwide needs at the hospital and community practice levels. We have leveraged the use of CRISP and Socially Determined data to inform program development and targeted interventions. ED Navigation continues to support the high demand for onsite real-time care coordination and follow-up for those frequenting the ED.

At Carroll Hospital, the behavioral health navigator has been an integral part of the team to focus on meeting the needs of the high-risk patients in the community. The partnership with a senior care community to provide care coordination services onsite has provided an extra layer of support and resources to that high-risk population thus improving overall health and quality of life. Outpatient palliative care support provides early intervention for symptom management for patients with chronic illness which improves overall health outcomes and quality of life as well as documenting and respecting the patient's individual goals of care.

Intervention Programs

Intervention or Program Name	Community Care Coordination
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	• Sinai Hospital of Baltimore (Core Program Sponsor) • Northwest Hospital
Brief description of the Intervention *2-3 sentences*	Community Care Coordination is an ambulatory community-based care management program serving high, moderate/ rising at-risk patients accessing health care services through LifeBridge Health System hospitals or partnering facilities. The program provides individualized interventions; meeting each patient where they are in their health care journey. The Community Care Coordination team focuses on improving the medical, behavioral and social health of identified patients. The multi-disciplinary team of Registered Nurses (RNs), Social Workers (SWs), and Community Health Workers (CHWs) engage patients at various points of service across the health care continuum and throughout the community. Interventions and services are delivered via face to face and telephonic encounters. The team works collaboratively with other care team members and community agencies to address drivers for the over and under-utilization of health care services.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	Program Partners through the CHPB: 1. Sisters Together and Reaching, Inc. (Community Care Team) 2. Health Care for the Homeless 3. Behavioral Health Bridge Team 4. Patient Engagement Program Training (JHM) 5. Helping Up Mission 6. Other Community Partners (Table 1. Program Community 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*	# of Patients Served as of June 30, 2020: **1,453**
	Denominator of Eligible Patients: Unknown

<table>
<tr><td>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></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></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>Intervention Touchpoint</th><th>Count</th></tr>
<tr><td>In-person Visits</td><td></td></tr>
<tr><td>Home Visit</td><td>438</td></tr>
<tr><td>Provider</td><td>369</td></tr>
<tr><td>Bedside (Inpatient)</td><td>75</td></tr>
<tr><td>Other (Community)</td><td>207</td></tr>
<tr><td>Phone Calls</td><td></td></tr>
<tr><td>Successful Phone call</td><td>7,484</td></tr>
<tr><td>Unsuccessful</td><td>1,884</td></tr>
<tr><td>Messages left</td><td>2,289</td></tr>
<tr><td>Email</td><td>365</td></tr>
<tr><td>Text</td><td>188</td></tr>
<tr><td>Mailings</td><td>429</td></tr>
<tr><td>Fax</td><td>83</td></tr>
<tr><td>Total number of touchpoints</td><td>13,811</td></tr>
</table>
</td></tr>
<tr><td>Successes of the Intervention in FY 2020
Freeform Narrative Response, up to 1 Paragraph</td><td>Community Care Coordination
Increased program capacity by adding four RNs and two CHWs during FY20.
Integrated into community practices; developing supportive relationships and increasing referrals and patient engagement.
Transitioned to Cerner's HealtheCare care management platform which supports care coordination workflows and provides data points for analytics</td></tr>
<tr><td>Additional Freeform Narrative Response (Optional)</td><td></td></tr>
</table>

Intervention or Program Name	Emergency Department Navigation
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	• Sinai Hospital of Baltimore (Core Program Sponsor) • Northwest Hospital
Brief description of the Intervention *2-3 sentences*	The ED Navigation team is staffed with Community Health Workers (CHWs) who provide services to patients that are frequent ED utilizers and/ or likely 30-day readmissions. Primary interventions include: • Assessing and mitigating barriers to care • Linking patients to a PCP, Psychiatrist or Specialist • Connecting patients to community resources. Patients are followed for 30 days from ER discharge and can be transitioned to the Community Care Coordination program for ongoing care management needs.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	See Table 1. Program Community 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: **1,891** Denominator of Eligible Patients: Unknown
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	

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.

Intervention Touchpoint	Count
In-person Visits	
Home Visit	*2*
Provider	*4*
ED	*587*
Bedside (Inpatient)	*526*
Phone Calls	
Successful Phone call	*1,047*
Unsuccessful	*197*
Messages left	*433*
Email	*24*
Text	*2*
Mailings	*24*
Fax	*11*
Total number of touchpoints	**2,857**

Successes of the Intervention in FY 2020
Freeform Narrative Response, up to 1 Paragraph

- ED Navigation successfully managed an increase in the number of substance abuse and psychiatric patient referrals since March 2020. These referrals have been rerouted given furloughs of SBIRT and Psychiatric ER Teams.
- Working with Substance Abuse treatment facilities like Amatus, Baltimore Station, and Helping up Mission has enabled substance abuse patients to be successfully referred and linked to treatment.
- Utilizing more homeless shelters such as Falls Way, KIPP and Health Care for the Homeless. Bryson Health Care Services, and Mosaic Behavioral Health Center has enabled psychiatric patient population to be referred and transitioned for services and not overload ER beds.
- Post ER follow up by the CHWs has contributed to the hospital's success with lower 30-day readmission rate.

Additional Freeform Narrative Response (Optional)

<table>
<tr><td>Intervention or Program Name</td><td>Behavioral Health Navigation - Carroll</td></tr>
<tr><td>RP Hospitals Participating in Intervention
Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.</td><td>Carroll Hospital</td></tr>
<tr><td>Brief description of the Intervention
2-3 sentences</td><td>The Behavioral Health Navigators are a part time RN and a part time social worker to equal one full FTE. Both positions provide Care Coordination Services for high risk patients who have behavioral health and substance use issues.

Referrals come through an automated documentation system, from the inpatient and outpatient BH units, physicians as well as identified of high-risk patients.</td></tr>
<tr><td>Participating Program Partners
Please list the relevant community-based organizations or provider groups, contractors, and/or public partners</td><td>• Access Carroll
• Carroll County Health Department</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:

<table><tr><th>Behavioral Health</th><th>Total Number</th></tr><tr><td>Patients served</td><td>458</td></tr><tr><td>Encounters with patients</td><td>1,993</td></tr><tr><td>Hours spent</td><td>305.3</td></tr></table></td></tr>
<tr><td>Denominator of Eligible Patients: Unknown</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>Utilization Data for Behavioral Health Navigation patients that fall under INP Psych and Psych 30-day Readmit programs:

Inpatient psych utilization reduction = 43 %
Psych 30-day Readmission Reduction= 68%</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</td><td>Utilization before and after intervention by Navigator
Success stories are tracked and shared on a regular basis.</td></tr>
</table>

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*	The Behavioral Health Navigators have successfully worked with patients to refer to treatment and provide resources. In addition, they network with community agencies and internal partners to coordinate care in the most appropriate and cost-effective setting to promote positive patient outcomes.
Additional Freeform Narrative Response (Optional)	

Intervention or Program Name	Coordination of Care in the Elderly Population
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	Carroll Hospital
Brief description of the Intervention *2-3 sentences*	Through a partnership between Carroll Lutheran Village (CLV) and Carroll Hospital, a Care Coordinator was hired by CLV to provide care coordination services to independent living residents of CLV. Referrals and made from the residents themselves, from physicians, from the hospital and from identification of high-risk patients.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	• Carroll Hospital • Carroll Lutheran Village
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*	# of Patients Served as of June 30, 2020:

Care Coordination in Elderly Population	**Total Number**
Patients served	602
Encounters with patients	1,336
Hours spent	371.5

population, or may not entirely represent this intervention's targeted population. *Feel free to **also** include your partnership's denominator.*	Denominator of Eligible Patients: 491 residents currently living in Independent Living at Carroll Lutheran Village
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 care coordination intervention outcomes data: Reduction in Emergency Department utilization: 31% Reduction in hospital inpatient admissions 30%
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.*	Utilization before and after intervention by Navigator Success stories are tracked and shared on a regular basis
Successes of the Intervention in FY 2020 *Freeform Narrative Response, up to 1 Paragraph*	The Care Coordinator has become the person that residents seek out when they need resources. She has been able to proactively identify and reach out to patients as well as educate on health needs and community resources. CLV has recognized the impact of the addition of this care coordinator in their continuum of care community and is fully vested to support this position beyond the grant period.
Additional Freeform Narrative Response (Optional)	

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

Intervention or Program Name	Outpatient Palliative Care Program (OPPC)
RP Hospitals Participating in Intervention	Carroll

<table>
<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>The OPPC Care Nurse works with individuals who are diagnosed with chronic illness. She collaborates with physicians, NPs and other providers to coordinate symptom management and provides resources and support to patients and families in the outpatient setting.</td></tr>
<tr><td>Participating Program Partners
Please list the relevant community-based organizations or provider groups, contractors, and/or public partners</td><td>• Carroll Hospital
• Carroll Hospice
• Skilled Nursing Facilities
• Home Care Agencies
• Physicians</td></tr>
<tr><td>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>Number of Patients Served as of June 30, 2020:

<table><tr><th>Outpatient Palliative Care Program</th><th>Total Number</th></tr><tr><td>Encounters with Patients</td><td>6,305</td></tr><tr><td>Patients referred to Hospice</td><td>133</td></tr><tr><td>Advanced Directives</td><td></td></tr><tr><td>Conversations with Patients</td><td>83</td></tr><tr><td>Advanced Directive completed</td><td>13</td></tr><tr><td>Patients referred to community services</td><td>286</td></tr></table>
Denominator of Eligible Patients: Unknown</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>Pre/post OPPC intervention outcomes data:

Reduction in Emergency Dept visits= 1.5%
Reduction in inpatient hospital admission = 45%
Reduction in hospital observation unit usage = 37%</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.</td><td>• Volume of unique patients and encounters
• Pre and post intervention hospital utilization
• Number of advanced directives completed
• Number of referrals to hospice</td></tr>
</table>

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*	The transition of the OPPC program to align with hospice as well as a full time NP to see patients for symptom management in the home. This re-alignment maximizes use of resources and creates efficiency.
Additional Freeform Narrative 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

<table>
<tr><th>Measure in RFP
(Table 1, Appendix A of the RFP)</th><th>Measure for FY 2020 Reporting</th><th>Outcomes(s)</th></tr>
<tr><td>Total Hospital Cost per capita</td><td>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)</td><td>Year to Date Per Capital Utilization through June 2020

LifeBridge RP Combined: $135; 15.3% unfavorable variance

<table><tr><td>Sinai</td><td>$81; 21.5% unfavorable variance</td></tr><tr><td>Northwest</td><td>$29; 5.5% unfavorable variance</td></tr><tr><td>Carroll</td><td>$25; 8.9% unfavorable variance</td></tr></table>
Source: Executive Dashboard:
‘Regional Partnership per Capita Utilization’ –
Hospital Charges per Capita</td></tr>
<tr><td>Total Hospital Discharges per capita</td><td>Total Discharges per 1,000

Executive Dashboard:</td><td>Year to Date Per Capital Utilization through June 2020</td></tr>
</table>

<table>
<tr>
<td></td>
<td>'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)</td>
<td>LifeBridge RP Combined: 3; -9.4% favorable variance

<table><tr><td>Sinai</td><td>2; 9.2% unfavorable variance</td></tr><tr><td>Northwest</td><td>1; -18% favorable variance</td></tr><tr><td>Carroll</td><td>1; -25.5% favorable variance</td></tr></table>
Source: Executive Dashboard:
'Regional Partnership per Capita Utilization' –
Hospital Discharges per 1,000</td>
</tr>
<tr>
<td>ED Visits per capita</td>
<td>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)</td>
<td>Year to Date Per Capital Utilization through June 2020

LifeBridge RP Combined: 13; -25.6% favorable variance

<table><tr><td>Sinai</td><td>5; -20.9% favorable variance</td></tr><tr><td>Northwest</td><td>4; -30% favorable variance</td></tr><tr><td>Carroll</td><td>4; -26.8% favorable variance</td></tr></table>
Source: Executive Dashboard:
'Regional Partnership per Capita Utilization' –
Ambulatory ED Visits per 1,000</td>
</tr>
</table>

Quality Indicator Measures

<table>
<tr>
<td>Measure in RFP
(Table 1 in Appendix A of the RFP)</td>
<td>Measure for FY 2020 Reporting</td>
<td>Outcomes(s)</td>
</tr>
<tr>
<td>Readmissions</td>
<td>Unadjusted Readmission rate by Hospital (please be sure to filter to include all hospitals in your RP)

Executive Dashboard:
'[Partnership] Quality Indicators' –</td>
<td>June 2020 rate, with variance compared to June 2019

LifeBridge RP Combined: 8.7%; -28.3 favorable variance

<table><tr><td>Sinai</td><td>8.1%; -31.2% favorable variance</td></tr></table></td>
</tr>
</table>

	Unadjusted Readmission Rate by Hospital, reported as average 12 months of FY 2020 -or- Analytic File: 'IP Readmit' over 'EligibleforReadmit' (Column J / Column I)	<table><tr><td>Northwest</td><td>9.7%; -6.1% favorable variance</td></tr><tr><td>Carroll</td><td>8.3%; -41.5% favorable variance</td></tr></table> Source: Executive Dashboard: '[Partnership] Quality Indicators' – Unadjusted Readmission Rate by Hospital
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)	LifeBridge RP Combined: $9,889,706; 4.8% unfavorable variance <table><tr><td>Sinai</td><td>$5,682,811; 44.7% unfavorable variance</td></tr><tr><td>Northwest</td><td>$2,256,858; -32.4% favorable variance</td></tr><tr><td>Carroll</td><td>$1,950,037; -10.3% favorable variance</td></tr></table> Source: Executive Dashboard: '[Partnership] Quality Indicators' – Potentially Avoidable Utilization

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.*	LifeBridge RP Combined: 15.35% (Jan-Jun 2020 average)

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.

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)

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 the final two quarters of FY20, LifeBridge Health's Care Coordination teams have seen an increase in referrals across multiple interventions. We know that COVID-19 is a contributing factor. Already existing medical, financial, and psycho-social challenges have been magnified and exposed with the COVID-19 pandemic. Our hospitals have been forced to furlough staff in inpatient and outpatient settings; increasing demands for managing patients in the community. Ambulatory Care Coordination teams have collaborated with PCPs and specialist to schedule and facilitate telehealth visits. Staff partnered with the Maryland Food Bank to participate in food drops and food deliver to homes.

During this time of COVID-19, Community Health Workers in the ER have had to adjust to social distancing protocols, wear personal protective equipment at all times, utilize alternative methods to complete patient assessments and have changed their work schedule and hours to support other auxiliary teams and ensure more patients are being seen.

Our Population Health/ Care Coordination team leveraged CRISP and Socially Determined neighborhood level data to identify our most vulnerable populations. With this information, we embarked on a six-week mobile clinic pilot to provide care and COVID-19 testing to our patients and community residents whom lacked access to testing sites and/ or were simply just too afraid to venture out to the hospital or their PCPs. The pilot ended after successfully providing care and testing to more than 300 patients. We've recently obtained approval and funding to continue to build on the mobile clinic's lessons learned and look forward the opportunity to meet and serve in our communities where we are needed most.

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 Transformation Grant has help to support and propel the development and expansion of our interventions. Through the partnerships, we continue to collaborate to coordinate care and share best practices. Program funding, collaborative efforts and community relationships building and strengthening have all contributed to our programs' successes. We look to continue all supported programs while seeking ongoing opportunities to improve the health and wellness of our communities.

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.

APPENDIX A: LifeBridge Health 2020 HSCRC Transformation Implementation Budget and Expenditures

As demonstrated in the attached budgetary documents LifeBridge Health (LBH) has designed a comprehensive Transformation Implementation Program budget for year four of the award, per HSCRC requirements. The following accounts for the outlined budget projections for this past fiscal year and highlights in-kind investments made in the program by LBH.

The budget documents present a combined request from all three acute-care hospitals in the LifeBridge Health network:

BUDGET:

Hospital Site	FY2020 Amount
Sinai	$494,821
Northwest	$278,254
Carroll	$172,203
TOTAL Budget	**$945,278**

Cost per intervention:
Our overall programmatic goal is to optimize care coordination services for high utilizers through a system-wide approach which integrates:

1. A community care coordination model of RN's and Social Workers. (In fiscal year 2019, we added a Manager, 1 RN, 1 SW, and two community health workers to this staffing matrix to support continued program growth.) This team will continue to work with high utilizers identified by the hospital as well as by primary care and specialty clinics within the LifeBridge network.
2. Addition of Care Navigators in our ED to enhance coordination of care for patients in our Emergency department.
3. An expansion of our already integrated, professionally staffed, 24/7 call center.
4. Enhanced data reporting and analytic capabilities through the addition of analytic resources.

The total cost for this intervention is **$1,342,959**

Cost per category: The costs for each of the key categories identified in the Healthcare Transformation Implementation Plan Request for Proposals (RFP) are as follows (for all interventions combined):

- **Workforce**: **$1,142,959**

  The staffing plan was designed based on our funding parameters and staffing model. We initially utilized the Berkeley Research Group (BRG) to provide a staffing matrix framework to support the program build, based on evidence-based practices and BRG's expertise on the Maryland All-Payer system. As the program has continued to mature and evolve, we continue to evaluate appropriate staffing ratios based upon patient acuity and psycho-social complexity.

- **Information Technology (IT): $59,136.** The majority of these costs are related to standard technology components for all personnel. These costs are detailed in the budget document in HSCRC's format and include such items as computers, printers, call center licenses, and cell phones/data plans.

- **Other implementation activities**: **$139,678.** Other costs primarily include Patient transportation and pharmacy support to patients, and staff travel, training and supplies.

- **Indirect costs: $86,517**. LBH is using a 10% facilities & administration (F&A) rate for this grant, even though the calculated F&A rate for each hospital is over 20% per IRS Form 990. LBH appreciates that funding available for the Transformation Implementation Program is extremely limited given the scale of work necessary to meet the goals of the All-Payer Model. This funding for overhead is the same rate that LBH accepts for NIH Cooperative Group Clinical Oncology trials that strive to provide an extremely significant public benefit with relatively limited funds.

  LBH's F&A rate is aligned with CFR 2 Part 200.420 regarding costs that are "incurred for common or joint objectives and therefore cannot be identified readily and specifically with a particular sponsored project, an instructional activity, or any other institutional activity." These include depreciation and interest cost associated with the institution's physical plant; operating and maintenance costs such as utility/facility costs (rent, heat, electricity, etc.); security costs; custodial costs; and common administrative functions such as payroll and purchasing.

- **In-Kind:** LifeBridge contributed **$397,681** additional towards the total program budget of **$945,278** for this fiscal year. This represents more than **42%** of the total award for Fiscal year 2020. Overall management of this program necessitates significant analytic-based support in conjunction with operation and fiscal management. LifeBridge Health continues to support the full initial award amount for Care Management for our vulnerable Medicare population. Consequently, the level of in-kind investment on behalf of LBH is instrumental in ensuring operational effectiveness and programmatic success.

Table 1. Program Community Partners

Homeless Shelters & Services
Baltimore County Westside Men's Shelter
Eastern Family Resource Center
Falls Way
Health Care for the Homeless
KIPP
Our Daily Bread Employment Center
Weinberg Housing and Resource Center-Code Blue Shelter
Food
Baltimore City Social Services
Baltimore County Social Services
Community Assistance Network
Maryland Food Bank
Langston Hughes Community Resource Center
Calvary Baptist Church
Transforming Life Outreach Ministry
Transportation
MTA Mobility
Uber
Legal/ Hispanic Services
Esperanza Center
Maryland Legal Aid
Primary Care
Chase Brexton
Jai Medical Center
Sinai Community Care Clinic
Dental Services
Keypoint Health Services
Kool Smiles
University of MD Dental School
Psychiatry
BH Health Services Inc.
Bryson Health Care Services
Mosaic
JHBMC Acute Psychiatry Unit
JHBMC Chemical Dependency Unit (CDU)
JHH Intensive Treatment Unit (ITU)

JHH Motivational Behaviors Unit (MBU) Sinai Outpatient Psychiatry
New Horizon Health Services Inc.
North Carroll Counselling Center
Recovery Network
S and S Counseling Services
Starting Point
Walter P Carter Center Baltimore County
Westside Men's Shelter
Substance Abuse Treatment
A.F. Whitsitt Center
Alliance Incorporated
Amatus
American Addictions Center
Avery Road (under Mountain Manor)
Baltimore Station
Christopher Place
Chrysalis House
Delphi Behavioral Health Group
Father Martin's Ashley/Ashley Addiction
Gaudenzia- Park Heights
Helping Up Mission (HUM)*
Hilltop Recovery Center
Hope House- Crownsville
Hope House- Laurel
Hudson Health
Massie Unit
MCVET (MD Center for Veteran Education Training)
Mountain Manor- Baltimore
Mountain Manor- Emmitsburg
Pathways (through AAMC)
Powell Recovery Center
Recovery Network
Right Turn of Maryland
Serenity Acres
Shoemaker (under Mountain Manor)
South Baltimore Station*
The Salvation Army Adult Rehabilitation Center
Tuerk House
Warwick Manor Behavioral Health
Bridge House

Bright Hope House
Build Fellowship, Inc.
Caton House
Chip House
Damascus House
Four States, Christian Mission, Inc.
Fresh Start Recovery House
Friendship House
Hamilton House
I Say No 2, Inc.
Mann House
Nazareth House
Olson House
Prodigal Son House
Seton Hill Station Treatment Center
Wells House Inc.
Valley House
Building Veterans
Recovery Houses
Bright Hope House
Daysprings
Gale House
Homecoming Project Inc.
My Sister's Center for Women
Marian House
Martha's Place
Beginning Effective Recovery Together (BERT)
Mattie B. Uzzle Center
The W House
A Step Forward, Inc.
Beginning Effective Recovery Together (BERT)
Bridge House
Evolve Life Centers
I Can, We Can
Our New House, Inc.
Our New House, Inc.
Port Recovery
Project PLASE
Wakefield House