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	Totally Linking Care, MD (TLC-MD)
RP Hospital(s)	Doctors Community Hospital, UM Capital Region Health (Laurel and Prince George's Hospital Centers), MedStar Southern Maryland Hospital, MedStar St. Mary's Hospital, and Ft. Washington Hospital
RP Point of Contact	David Chernov, Executive Director, david.chernov@tlc-md.org
RP Interventions in FY 2020	1) Care Coordination (RN based) 2) Community Health Workers 3) Medication Therapy Management (UM School of Pharm) 4) Faith-based Community Engagement (Maryland Citizens' Health Initiative Education Fund)
Total Budget in FY 2020 *This should equate to total FY 2017 award*	FY 2020 Award: $1,200,000
Total FTEs in FY 2020	Employed: 0
	Contracted: 10 (for Executive Director, Analytics, Policy Manual, Trainer, Grant writer, RNs, CHWs, and RX Medical partners and staff at Member Hospitals)
Program Partners in FY 2020 *Please list any community-based organizations or provider groups, contractors, and/or public partners*	1. eQHealth (software and services) 2. Prince George's Healthcare Alliance (CHWs) 3. Univ of MD School of Pharmacy (Medication Therapy Mgmt.)

	4. Maryland Citizens' Health Initiative Education Fund (Faith-based)

Overall Summary of Regional Partnership Activities in FY 2020

(Freeform Narrative Response: 1-3 Paragraphs):

In FY 2020 TLC-MD continued to focus on high utilizers (2+ chronic conditions) admitted to partnership hospitals in Prince George's and St. Mary's Counties. Enrollment (and eligibility) in the TLC-MD program was initiated by hospital-based care/case managers via TLC-MD's population health software platform. Patients were then automatically assigned (via the software platform) an RN care manager to determine post-discharge support requirements. Care Managers then determined the TLC-MD program most applicable (often all programs were assigned) and facilitated the upload of necessary clinical documentation to allow communication between all members of the care team (often from different providers) via a secure messaging system embedded in the TLC-MD population health platform. This platform also provided the ability to create "patient panels" for submission to CRISP for both ENS messaging (admission/discharge alerts) and creation of the Pre/Post Report for outcomes analysis (please see Attachment A).

TLC-MD used the outcomes analysis provide by CRISP to determine success factors for Potentially Avoidable Utilization (PAU), Prevention Quality Indicators (PQI), and Readmissions. As reported in Attachment A, TLC-MD achieved significant savings for not only Member hospitals, but for the healthcare system across the state, as reported by the significant reduction in Total Cost of Care (TCOC).

Data analysis revealed a significant trend in lower hospital utilization and hospital charges as result of care coordination. The most compelling findings were among patients designated with a PAU and PQI showing a 67% relative reduction in hospital admission charges, a 68% relative reduction in hospital admissions, and a 69% relative reduction in the number of patients seen. These findings underscore the importance of coordinated outpatient care. Many patients with chronic conditions lack health insurance and access to primary care, resulting in repeat hospitalizations. Enrolling patients in TLC-MD's Coordinated Care program can reduce the burden on local health care systems and improve the health and wellbeing of communities served in Southern Maryland.

Intervention Program

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

<table>
<tr><td>Intervention or Program Name #1</td><td>Care Coordination to include RNs for patients with 2+ Chronic Conditions</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>All</td></tr>
<tr><td>Brief description of the Intervention
2-3 sentences</td><td>All patients meeting criterial are assigned a care coordinator (RN) to be the “quarterback” for all interactions with the patient. This includes coordinating/adding additional programs (outlined here) as well as implementing the discharge plan and helping to schedule follow-up appointments with PCP/specialists.</td></tr>
<tr><td>Participating Program Partners
Please list the relevant community-based organizations or provider groups, contractors, and/or public partners</td><td>1. Hospital Staff: Case Managers, RNs
2. EQHealth: software, RN services</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: 523</td></tr>
<tr><td>Denominator of Eligible Patients:

Denominator of Eligible Patients:
CRISP Analytical File CY 2018:

<table>
<tr><th>POP Category</th><th>Year</th><th>Population</th><th>Patients</th><th>Regional Partnership</th></tr>
<tr><td>2+ Chronic Conditions and Medicare FFS</td><td>2018</td><td>121,142</td><td>18,672</td><td>Totally Linking Care Southern MD</td></tr>
</table>
</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>Please see Attachment “A”</td></tr>
</table>

Intervention-Specific Outcome or Process Measures (optional) *These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership maintains and uses to analyze performance.* *Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.*	
Successes of the Intervention in FY 2020 *Freeform Narrative Response, up to 1 Paragraph*	Based on aggregate data on the number of patients, hospital admissions, and hospital charges including both potentially avoidable and unavoidable visits: Prior to enrolling in TLC-MD's Care Coordination program: ◉ 763 patients ◉ 2445 hospital admissions Total Relative Charges Before Care Coordination: $20,833,355 After enrolling in TLC-MD's Care Coordination program: ◉ 523 patients ◉ 1691 hospital admissions Total Relative Charges After Care Coordination: $10,822,305 Care Coordination relative impact: ◉ 48% reduction in hospital admission charges ◉ 31% reduction in hospital admissions ◉ 31% reduction in the number of patients Total Relative Cost Reduction: $10,011,050
Additional Freeform Narrative Response (Optional)	

Intervention or Program Name #2	Community Health Workers (CHW)
RP Hospitals Participating in Intervention	All

<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>This program connects the patient with a formally trained community health worker from their community who understands their challenges, lives in their neighborhood and can relate to their needs/issues and barriers. CHWs work very closely with the assigned care manager (RN) and conduct SDOH assessments, create individualized patient care plans, initiate interventions, health literacy education and resource connections to address clients' social barriers, report findings to the care team to reduce hospital readmissions, ED visits and address care gaps.</td></tr>
<tr><td>Participating Program Partners

Please list the relevant community-based organizations or provider groups, contractors, and/or public partners</td><td>Prince George's Healthcare Alliance (PGCHCA) and member hospitals. Hospitals have the option of using their own CHWs or can contract with TLC-MD's provider (PGHCA).</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># of Patients Served as of June 30, 2020: 310

Denominator of Eligible Patients: same as Care Coordination Program

<table>
<tr><th>POP Category</th><th>Year</th><th>Population</th><th>Patients</th><th>Regional Partnership</th></tr>
<tr><td>2+ Chronic Conditions and Medicare FFS</td><td>2018</td><td>121,142</td><td>18,672</td><td>Totally Linking Care Southern MD</td></tr>
</table>
</td></tr>
<tr><td></td><td></td></tr>
</table>

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.*	
Successes of the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	Data associated with patients assigned to this program were not partitioned from overall analysis. Thus, overall success is reported in Intervention #1 above (virtually all patients were assigned a CHW). Interestingly, hospitals found the opportunity to use third party vendors for CHW support were as "satisfied" with outcomes as were hospitals that used in-house resources for CHWs.
Additional Free Response (Optional)	Community health workers (CHWs) connect underserved individuals to health and social services, helping to reduce health care costs associated with medical, behavioral, and social determinants of health. By helping TLC-MD patients address unmet social needs through personalized support and CHW interventions for patients referred to a CHW, the pre-post data demonstrated a significant reduction in hospital visits and significant reduction in hospital costs. Patient-centered, CHW interventions coupled with nurse care coordination that addresses unmet social needs of patients are a cost-effective method.
Intervention or Program Name #3	Medication Therapy Management (MTM, P3)

RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	All
Brief description of the Intervention *2-3 sentences*	In partnership with the University of Maryland School of Pharmacy (P3 program), provides Medication Therapy Management (MTM) services to patients transitioning hospital to home. Patients referred into the program included those on multiple medications, struggling with cost of medications, non-adherent to medications, newly diagnosed with Diabetes, and frequent acute care utilizers for Ambulatory Care Sensitive Conditions (ACSC) such as Congestive Heart Failure, Asthma, Hypertension and Chronic Obstructive Pulmonary Disease. MTM services included; - Reconciliation of discharge medications with medications in the home after discharge - Assessment of patient health status for stability or improvement, scheduling of post discharge follow up appointments or lab monitoring as indicated in hospital discharge summary, - Patient education regarding medication changes during hospitalization - Closing communication gaps with patient's community-based providers and community pharmacy - Care coordination with Community Health Workers upon identification of Social Determinant of Health barriers to optimal patient outcome
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	University of Maryland School of Pharmacy (P3 program)
Patients Served *Please estimate using the Population category that best applies to the Intervention, from the CY 2018 RP Analytic Files.*	# of Patients Served as of June 30, 2020: 6
	Denominator of Eligible Patients:

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: same as Care Coordination Program **POP Category**: 2+ Chronic Conditions and Medicare FFS **Year**: 2018 **Population**: 121,142 **Patients**: 18,672 **Regional Partnership**: Totally Linking Care Southern MD
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.*	• Development of various process maps/workflows for P3 MTM services based on hospital's use of internal or external care team/resources • Operationalized P3 MTM coordination and communication with other care team members in a patient centered manner • Began program pilot to test various workflows and models in 2 hospitals out of 6 hospitals • Both hospitals were able to successfully refer patients into the P3 MTM program via the TLC-MD population health software platform • Total of 6 patients referred to P3 MTM program • Of the 6 patients referred, 2 were served by P3 MTM program, 3 patients were unable to reach after 3 attempts, while 1 patient was discharged to hospice
Successes of the Intervention in FY 2020	Mixed, due to the advent of COVID just as this program was maturing and uniform referral processes across all member hospitals were in place. TLC-MD was in the process of creating

Free Response, up to 1 Paragraph	panels for CRISP analysis to compare patients assigned to this program vs. not enrolled to determine outcomes analysis, but due to the fact that all in-home visits were terminated in March, 2020 completion of this project was suspended.
Additional Free Response (Optional)	This program is in partnership with the University of Maryland School of Pharmacy and provides both telephonic and telehealth patient consults in the patient's home. In addition, TLC-MD is experimented with using community health workers to facilitate telehealth in patient's homes, solving for the lack of computer expertise of many of TLC-MD's patients' homes. Again, TLC-MD's mature infrastructure can now study the effects of combining interventions (medication therapy management and CHWs) via a trusted third party to help maximize and optimize patient outcomes and may be addressed in future grant awards.

Intervention or Program Name #4	Faith-based Community Engagement
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	Pilot with Doctors Community Hospital, Ft. Washington, MedStar Southern Maryland, MedStar St. Mary's, and University of Maryland Capital Region Health
Brief description of the Intervention *2-3 sentences*	Upon enrollment in TLC-MD via a TLC-MD member hospital, patients have the opportunity to share their preferred faith-based congregation to be notified of their admission/re-admission to any MD hospital. TLC-MD works with CRISP to create ENS messages that are routed to a trained hospital liaison who then contacts a trained congregation leader who initiates their specific process/team to visit their congregant in a MD hospital. Hospitals also leveraged relationships with congregations to offer diabetes prevention programming in the community.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	Maryland Citizens' Health Initiative Education Fund, Inc.
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, 2019: Pilot stage – not applicable at this time.
	Denominator of Eligible Patients: Some hospitals intend to offer this program to all patients, other hospitals intend to use this program for high utilizers in the eQHealth system only. The denominator will vary from hospital to hospital.

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.*	The Maryland Faith Health Network (MFHN) model is designed to improve communication among the people caring for a person at their hospital and the people caring for the person within their faith community. Professional literature on faith and health partnerships indicates that this model can reduce potentially avoidable utilization and strengthen relationships between hospitals and community leaders, thereby building regional cross-sector capacity for collaboration to promote population health. To date, the MFHN has met with all hospitals in TLC-MD to discuss the model and consider the opportunities and challenges associated with implementation. All hospitals created interdisciplinary teams to implement this model and/or adapt existing systems to achieve similar patient experience. Doctors Community Hospital, Fort Washington and University of Maryland Capital Region all developed model workflows for implementation.
Successes of the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	TLC-MD partners have expressed great interest in working with congregations.
Additional Free Response (Optional)	This intervention is based on a very successful model deployed by LifeBridge Health and TLC-MD's selected partner for this program. TLC-MD has learned that we need to "meet the patient where they are…" to increase the chance of patient engagement. If patient engagement cannot be accomplished while the patient is in the hospital (which is often the case, hence our "problem"), TLC-MD has another chance via the patient's trusted advisors (faith-based support members). This initiative also leverages CRISP's ENS service to notify specifically trained faith-based congregation leads (via the hospital ENS contact) of their member's recent hospital admission/discharge. TLC-MD categorized this initiative as an extension of the CHW intervention and is exploring further expansion into other areas that TLC-MD patients have "trusted" advisors.

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)	CY 2019 Analytic File: 'Charges' over 'Population' (Column E / Column C): $5,381.24
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)	Analytic File: 'IPObs24Visits' over 'Population' (Column G / Column C); 21%
ED Visits per capita	**Ambulatory ED Visits per 1,000** Executive Dashboard: 'Regional Partnership per Capita Utilization' –	Analytic File 'ED Visits' over 'Population' (Column H / Column C) 32%

	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)	

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)	Analytic File: 'IP Readmit' over 'EligibleforReadmit' (Column J / Column I): 13% for TLC-MD
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)	Analytic File: 'TotalPAUCharges' (Column K): $107,316,340.35

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.*	23%

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 do not 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.

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 importance of *RN based care management* as determined by the outcomes analysis provided in this report has demonstrated to all Member hospitals the importance of continuing this intervention. In addition, the use of CHWs to provide home-based support has also been demonstrated to be of tremendous value to all Member hospitals. Several TLC-MD members have chosen to continue using third parties to provide this service even after funding was eliminated as of June 30, 2020. More time was required for analysis for medication therapy management, but important lessons learned (lack of telehealth capability due to patient's technical issues at home) will be addressed post-COVID. Early analysis indicated that home visits for this intervention may be of much more value than telehealth.

Faith-based support provided the most intriguing opportunity for patient engagement (post-discharge) especially when combined with hospital visits immediately prior to discharge. One of the barriers to success for the overall project was patient desire to engage providers in their homes. Trust issues appeared to be best addressed by members from patient's religious congregations and will be addressed in future HSCRC RP funding.

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.

By far, the most important improvement would be to insure clear determination of "success factors." Internal ROI calculations are difficult, as various stakeholders often had concerns over methodology. The use of CRISP as the "single source of truth" would be very beneficial moving forward.

Funding variability from year to year is also of concern in regard to multi-year contractual terms for third party providers. Early communication from HSCRC per changes in funding (for the next FY) would be of great benefit for planning and setting of expectations for services for Member hospitals and patients.

Finally, intermittent discussion with HSCRC during the FY would be of great benefit to ensure RP progress is proceeding as intended, and to of course have the opportunity to make changes due to unforeseen consequences of factors beyond the control of the RP. This is of utmost importance if funding changes will be made in the following FY of the 5-year award.

Attachment A

TLC-MD Care Coordination Hospital Admission Impact Executive Summary

Hospitals: Doctors Community Medical Center, MedStar St. Mary's Hospital, MedStar Southern Maryland Hospital Center, UM-Prince Georges Hospital Center, Adventist Healthcare Fort Washington Medical Center, and UM-Laurel Medical Center

Date Range: July 1, 2019 to June 30, 2020

Totally Linking Care in Maryland (TLC-MD) and the State of Maryland are working in collaboration to improve health outcomes and hospital utilization among patients across Southern Maryland. Eligible patients receive community-based support with a licensed RN to assist with treatment plans that include medication adherence, nutrition and lifestyle guidance, and follow-up care with primary care physicians. This coordinated care approach bridges the gap from hospital care to home care. The vision of this program is to reduce hospital utilization among patients that experience high hospital utilization for preventable conditions.

The Maryland Health Services Cost Review Commission manages a Potentially Avoidable Utilizations (PAU) savings policy. Under this policy, a PAU is identified as

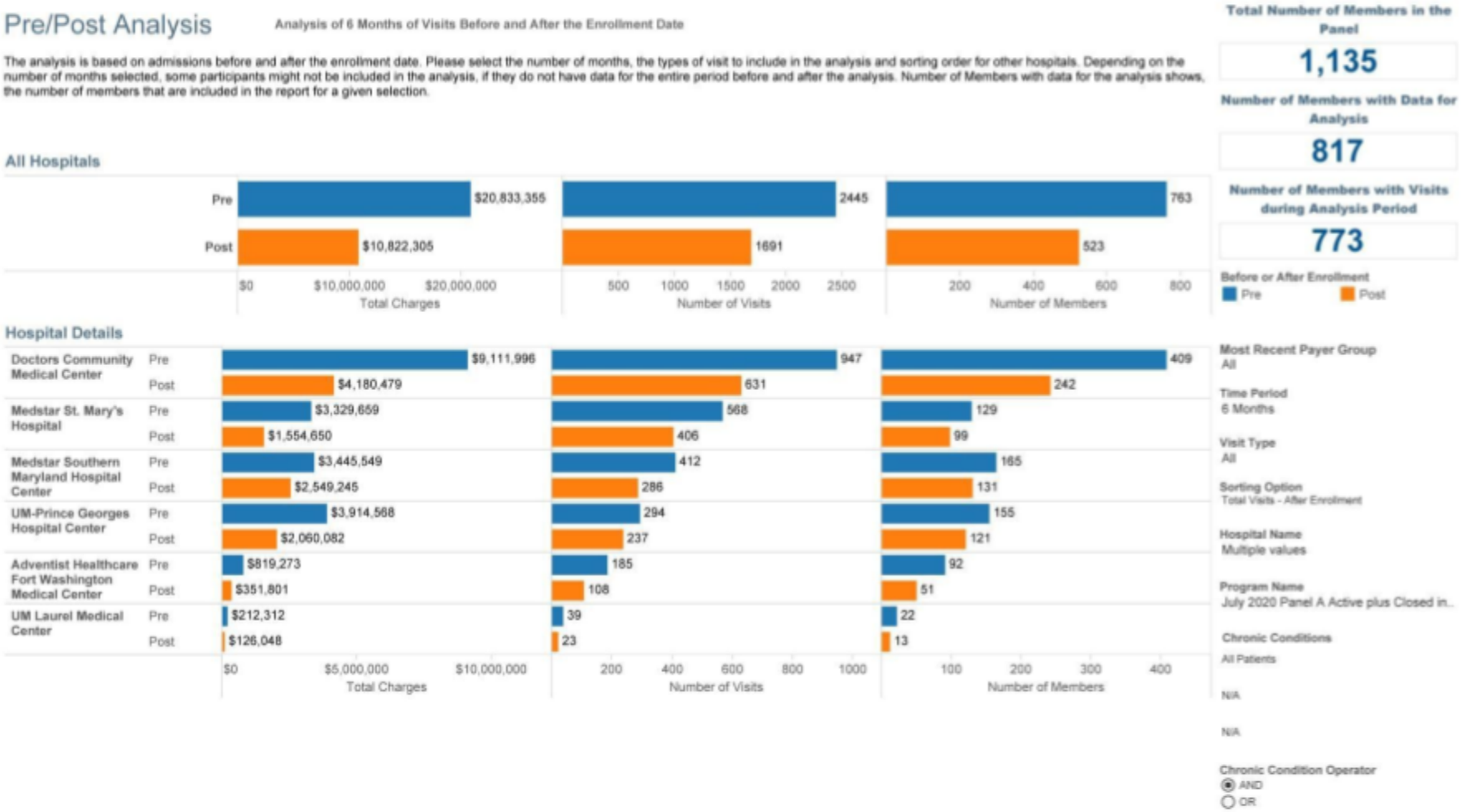
readmissions and hospital admissions for ambulatory-care sensitive conditions that can be prevented with appropriate outpatient care. The specific conditions are further measured by the Agency for Health Care Research and Quality's Prevention Quality Indicators (PQIs) and include diseases such as diabetes, hypertension, and asthma. (*See Definitions section for full list*).

The data provided in this report uses CRISP data panels to compare hospital admissions, readmissions, number of patients, and hospital charges from pre to post enrollment into TLC-MD. Data analysis revealed a significant trend in lower hospital utilization and hospital charges as result of care coordination. The most compelling findings were among patients designated with a PAU and PQI showing a 67% relative reduction in hospital admission charges, a 68% relative reduction in hospital admissions, and a 69% relative reduction in the number of patients seen.

These findings underscore the importance of coordinated outpatient care. Many patients with chronic conditions lack health insurance and access to primary care, resulting in repeat hospitalizations. Enrolling patients in TLC-MD's Coordinated Care program can reduce the burden on local health care systems and improve the health and wellbeing of communities served in Southern Maryland.

Pre and Post Aggregate Analysis by Hospital

This analysis provides an overview of total hospital charges, total number of patients, and total admissions in TLC-**MD**'s care coordination program. This panel of 1,135 patients includes a combination of active cases under TLC-**MD**'s Care Coordination and cases that have closed in the last 12 months. Of these patients, 817 had availab le data in CRISP. Of these 817 cases, 773 patients had pre and post visit data.



*Dashboard generated in CRISP

Pre and Post Breakdown of Hospital Charges

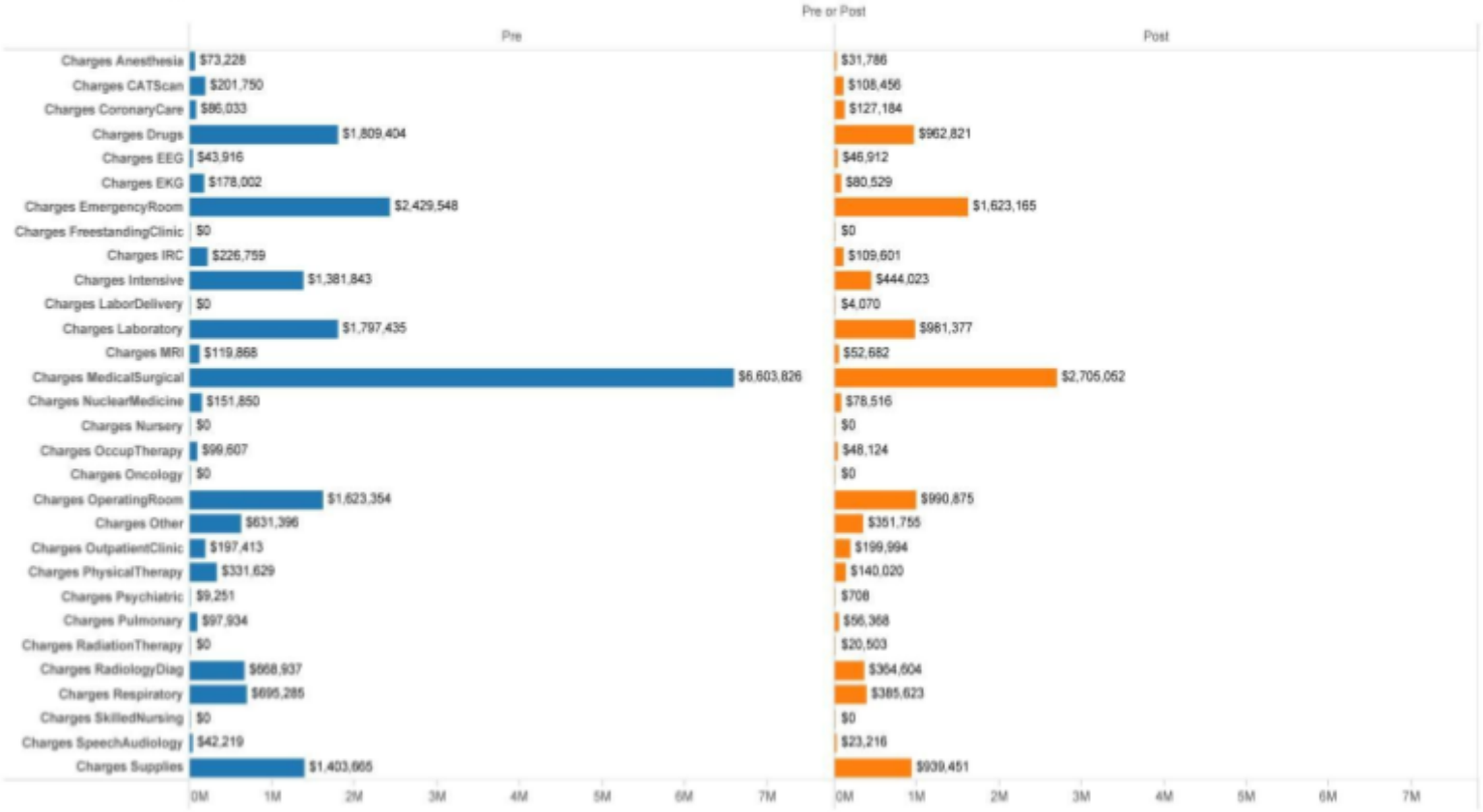
This analysis shows a breakdown of hospital charges from pre to post enrollment into TLC-MD.

Pre/Post Analysis

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

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

Breakdown of Charges Sheet



Most Recent Payer Group
All

Visit Type
All

Hospital Name
Multiple values

Time Period
6 Months

Program Name
July 2020 Panel A Active plus Close..

Chronic Conditions
All Patients

N/A

N/A

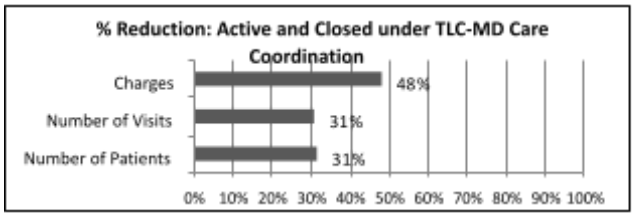
Chronic Condition Operator
(•) AND
( ) OR

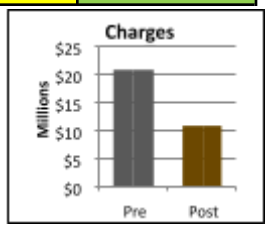
*Dashboard generated in CRISP

TLC-MD Care Coordination Hospital Admission Impact

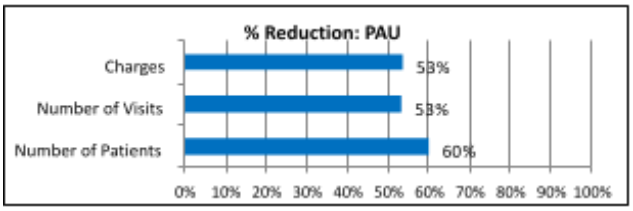
This table illustrates the impact of TLC-MD by Potentially Avoidable Utilization (PAU), Prevention Quality Indicators (PQI), and Readmissions.

	PRE	POST	DELTA	PERCENT REDUCTION
SECTION A: AGGREGATE DATA				
Active and Closed Last 12 Months under TLC-MD Care Coordination				
Charges	$20,833,355	$10,822,305	$10,011,050	48%
Number of Visits	2445	1691	754	31%
Number of Patients	763	523	240	31%

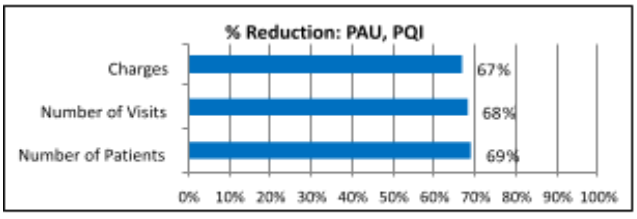




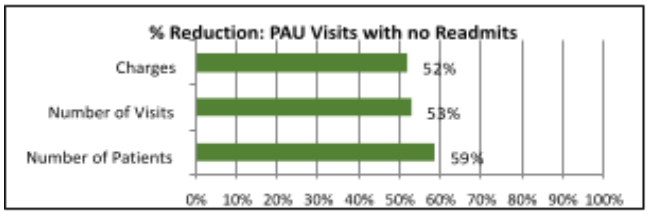
PAU	Inpt + Obs >23, PAU = 'Yes'			
Charges	$13,123,363	$6,103,649	$7,019,714	53%
Number of Visits	1012	474	538	53%
Number of Patients	636	255	381	60%

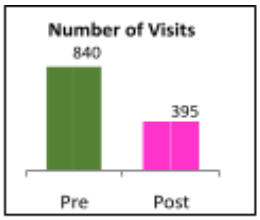


PAU, PQI	Inpt + Obs >23, PAU = 'Yes' and PQI = 'Yes'			
Charges	$7,343,151	$2,433,535	$4,909,616	67%
Number of Visits	607	193	414	68%
Number of Patients	480	148	332	69%

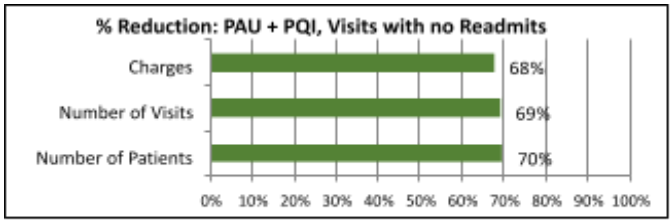


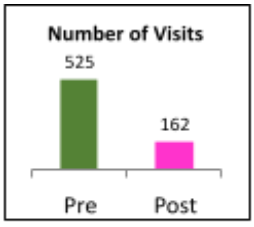
SECTION B: ADMISSIONS ONLY DATA				
PAU Visits with no Readmits	Inpt and obs >23hr, PAU= 'Yes'			
Charges	$10,126,738	$4,863,925	$5,262,813	52%
Number of Visits	840	395	445	53%
Number of Patients	607	250	357	59%





	PRE	POST	DELTA	PERCENT REDUCTION
PAU + PQI, Visits with no Readmits	Inpt and obs >23hr, PAU = 'Yes' and PQI = 'Yes'			
Charges	$6,097,952	$1,974,649	$4,123,303	68%
Number of Visits	525	162	363	69%
Number of Patients	434	132	302	70%

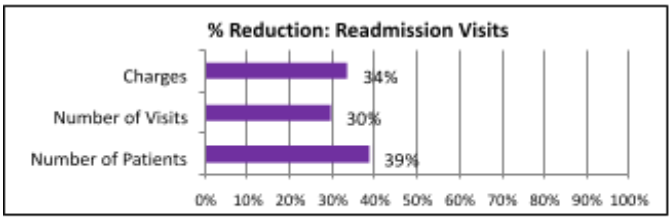




SECTION C: READMISIONS ONLY DATA

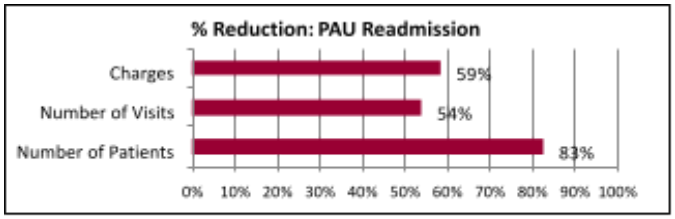
Readmission Visit Readmit, Input + OBS > 23

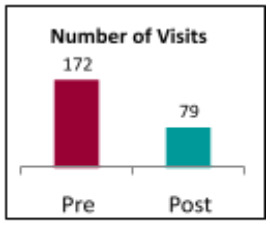
Charges	$4,072,053	$2,700,691	$1,371,362	34%
Number of Visits	242	170	72	30%
Number of Patients	181	111	70	39%



PAU Readmission PAU Only

Charges	$2,996,624	$1,239,723	$1,756,901	59%
Number of Visits	172	79	93	54%
Number of Patients	29	5	24	83%

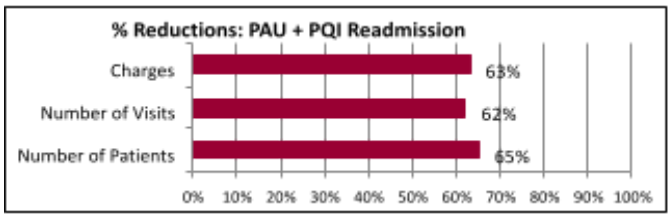


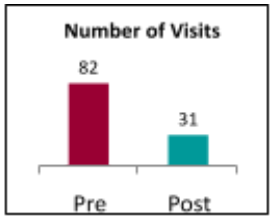


PAU + PQI Readmission PAU + PQI

Charges	$1,245,199	$458,886	$786,313	63%

Number of Visits	82	31	51	62%
Number of Patients	46	16	30	65%





Explanation of Data: TLC-MD Care Coordination Hospital Admission Impact (Pre and Post)

Patient Panel: Combination of active cases under TLC-MD's Care Coordination and cases that have closed in the last 12 months.

SECTION A: Aggregate Data

This section includes aggregate data on the number of patients, hospital admissions, and hospital charges. Data include both potentially avoidable and unavoidable visits.

Prior to enrolling in TLC-MD's Care Coordination program:

- **763** patients
- **2445** hospital admissions

Total Relative Charges Before Care Coordination: **$20,833,355**

After enrolling in TLC-MD's Care Coordination program:

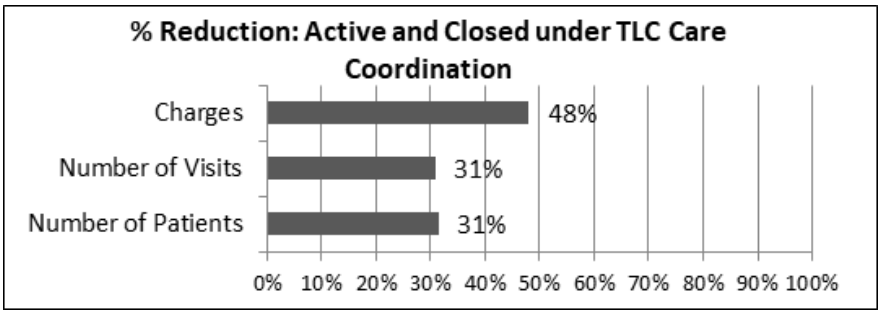
- **523** patients
- **1691** hospital admissions

Total Relative Charges After Care Coordination: **$10,822,305**

Care Coordination relative impact:

- **48%** reduction in hospital admission charges
- **31%** reduction in hospital admissions
- **31%** reduction in the number of patients

Total Relative Cost Reduction: **$10,011,050**



Potentially Avoidable Admissions (PAU)

(Filters: IP and Obs>30; PAU=Yes)

This is a subset of the aggregate data described above. PAU admissions includes all hospital admissions and readmissions among patients identified as potentially avoidable.

Prior to enrolling in TLC-MD's Care Coordination program:

- **636** patients with a PAU
- **1012** hospital admissions

Total Relative Charges Before Care Coordination: **$13,123,363**

After enrolling in TLC-MD's Care Coordination program:

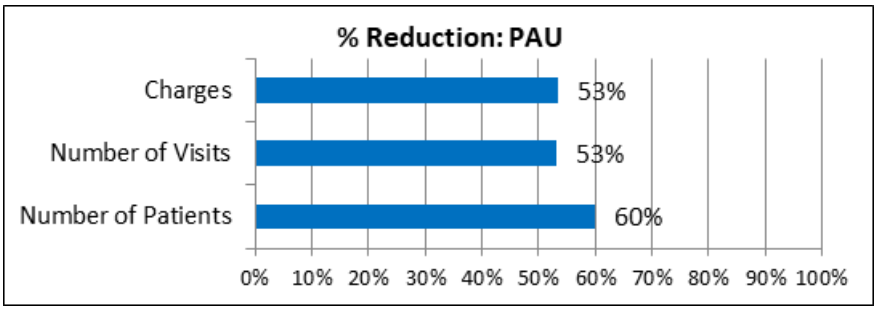
- **255** patients with a PAU
- **474** hospital admissions

Total Relative Charges After Care Coordination: **$6,103,649**

Care Coordination relative impact among patients with a PAU:

- **53%** reduction in hospital admission charges
- **53%** reduction in hospital admissions
- **60%** reduction in the number of patients

Total Relative Cost Reduction: **$7,019,714**



Potentially Avoidable (PAU) Admissions with a Prevention Quality Indicator (PQI)

(Filters: IP and Obs>30; PAU=Yes; PQI=Yes)

PAU and PQI admissions, includes all hospital admissions and readmissions with patients identified with a Potentially Avoidable Utilization (PAU) and Prevention Quality Indicator (PQI).

Prior to enrolling in TLC-MD's Care Coordination program:

- **480** patients with a PAU and PQI
- **607** hospital admissions

Total Relative Charges Before Care Coordination: **$7,343,151**

After enrolling in TLC-MD's Care Coordination program:

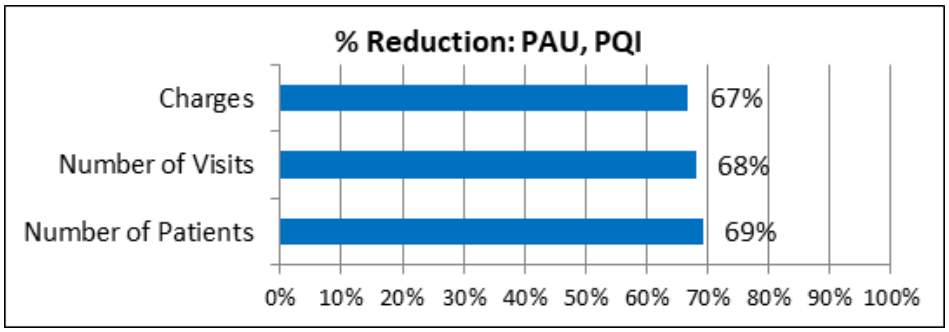
- **148** patients with a PAU and PQI
- **193** hospital admissions

Total Relative Charges After Care Coordination: **$2,433,535**

Care Coordination relative impact among patients with a PAU and PQI:

- **67%** reduction in hospital admission charges
- **68%** reduction in hospital admissions
- **69%** reduction in the number of patients

Total Relative Cost Reduction: **$4,909,616**



SECTION B: Admissions Only Data

Potentially Avoidable Admissions (PAU) ONLY with No Readmits

(Filters: IP and Obs>30; PAU= Yes; Readmission=No)

PAU Admissions ONLY, includes patients identified with a Potentially Avoidable Utilization that only had hospital admissions. No readmission visits were included.

Prior to enrolling in TLC-MD's Care Coordination program:

- **607** patients with a PAU
- **840** hospital admissions

Total Relative Charges Before Care Coordination: **$10,126,738**

After enrolling in TLC-MD's Care Coordination program:

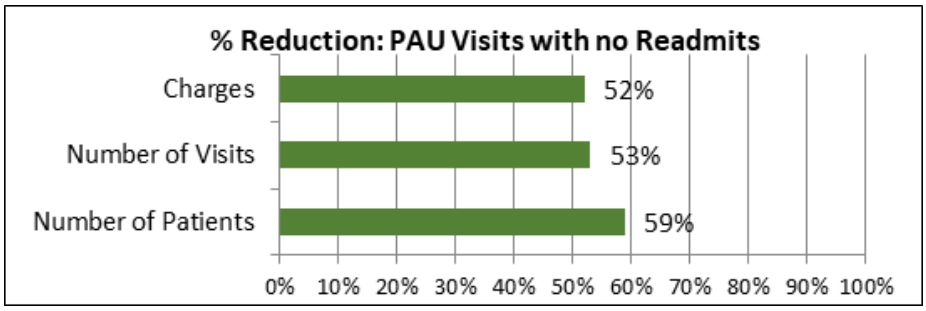
- **250** patients with a PAU
- **395** hospital admissions

Total Relative Charges After Care Coordination: **$4,863,925**

Care Coordination relative impact among patients with a PAU:

- **52%** reduction in hospital admission charges
- **53%** reduction in hospital admissions
- **59%** reduction in the number of patients

Total Relative Cost Reduction: **$5,262,813**



Potentially Avoidable (PAU) Admissions with a Prevention Quality Indicator (PQI) ONLY with No Readmits

(Filters: IP and Obs>30; PAU=Yes; PQI= Yes; Readmission=No)

PAU and PQI Admissions ONLY, includes patients identified with a Potentially Avoidable Utilization and Prevention Quality Indicator that only had hospital admissions. No readmission visits were included.

Prior to enrolling in TLC-MD's Care Coordination program:

- **434** patients with a PAU and PQI
- **525** hospital admissions

Total Relative Charges Before Care Coordination: **$6,097,952**

After enrolling in TLC-MD's Care Coordination program:

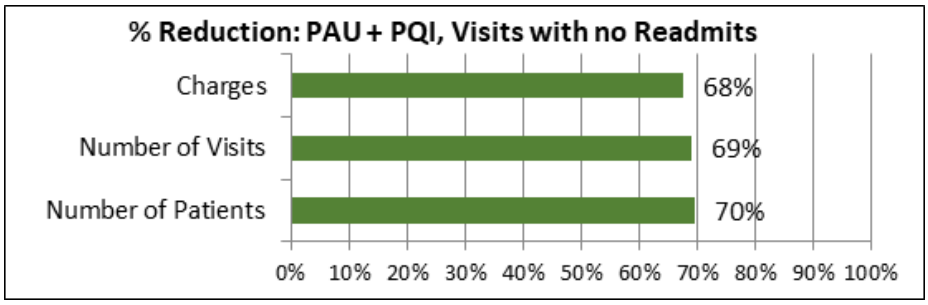
- **132** patients with a PAU and PQI
- **162** hospital admissions

Total Relative Charges After Care Coordination: **$1,974,649**

Care Coordination relative impact among patients with a PAU and PQI:

- **68%** reduction in hospital admission charges
- **69%** reduction in hospital admissions
- **70%** reduction in the number of patients

Total Relative Cost Reduction: **$4,123,303**



SECTION C: Readmissions Only Data

Readmissions ONLY

(Note: Some readmission data entries are missing in CRISP)

Readmissions ONLY, includes the total number of hospital admissions within 30 days of a prior hospital admission.

Prior to enrolling in TLC-MD's Care Coordination program:

- **181** patients
- **242** hospital readmissions

Total Relative Charges Before Care Coordination: **$4,072,053**

After enrolling in TLC-MD's Care Coordination program:

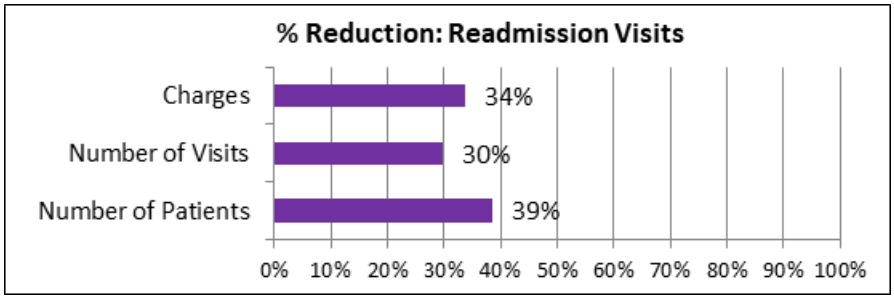
- **111** patients
- **170** hospital readmissions

Total Relative Charges After Care Coordination: **$2,700,691**

Care Coordination relative impact among all readmissions:

- **34%** reduction in hospital readmission charges
- **30%** reduction in hospital readmissions
- **39%** reduction in the number of patients

Total Relative Cost Reduction: **$1,371,362**



Potentially Avoidable Readmissions ONLY

(Calculation: PAU Admissions MINUS PAU Admissions ONLY)

PAU Readmissions ONLY calculation, indicates the number of hospital admissions within 30 days of a prior hospitalization, among patients identified with a Potentially Avoidable Utilization.

Prior to enrolling in TLC-MD's Care Coordination program:

- **29** patients with a PAU
- **172** hospital readmissions

Total Relative Charges Before Care Coordination: **$2,996,624**

After enrolling in TLC-MD's Care Coordination program:

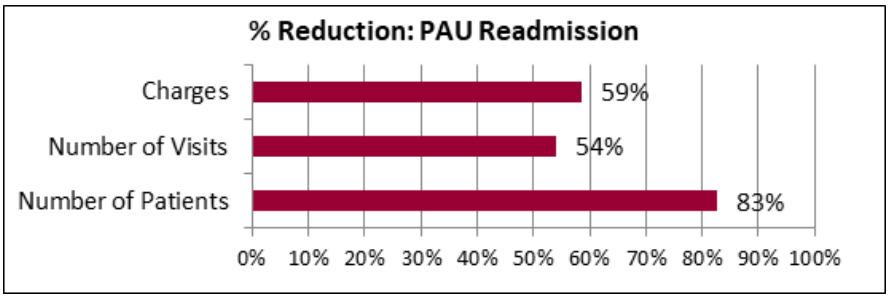
- **5** patients with a PAU
- **79** hospital readmissions

Total Relative Charges After Care Coordination: **$1,239,723**

Care Coordination relative impact among all readmissions:

- **59%** reduction in hospital readmission charges
- **54%** reduction in hospital readmissions
- **83%** reduction in the number of patients

Total Relative Cost Reduction: **$1,756,901**



Potentially Avoidable Readmission with Prevention Quality Indicators

(Calculation: PAU and PQI Admissions MINUS PAU and PQI Admissions ONLY)

PAU and PQI Readmissions calculation, indicates the number of hospital admissions within 30 days of a prior hospitalization among patients identified with a Potentially Avoidable Utilization and Prevention Quality Indicator.

Prior to enrolling in TLC-MD's Care Coordination program:

- **46** patients with a PAU and PQI
- **82** hospital readmissions

Total Relative Charges Before Care Coordination: **$1,245,199**

After enrolling in TLC-MD's Care Coordination program:

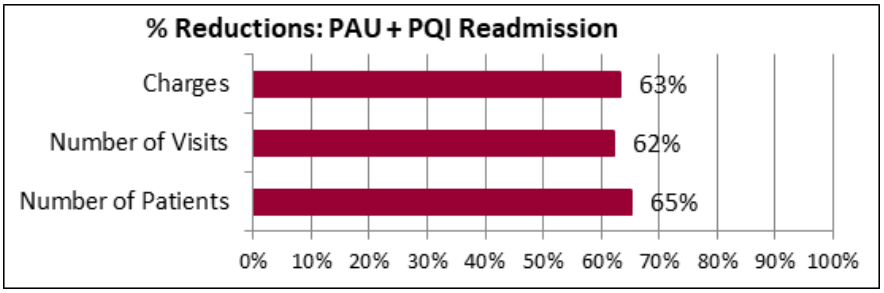
- **16** patients with a PAU and PQI
- **31** hospital readmissions

Total Relative Charges After Care Coordination: **$458,886**

Care Coordination relative impact among all readmissions:

- **63%** reduction in hospital readmission charges
- **62%** reduction in hospital readmissions
- **65%** reduction in the number of patients

Total Relative Cost Reduction: **$786,313**



TLC-MD Care Coordination Hospital Admission Impact Doctors Community Medical Center Executive Summary

Date Range: July 1, 2019 to June 30, 2020

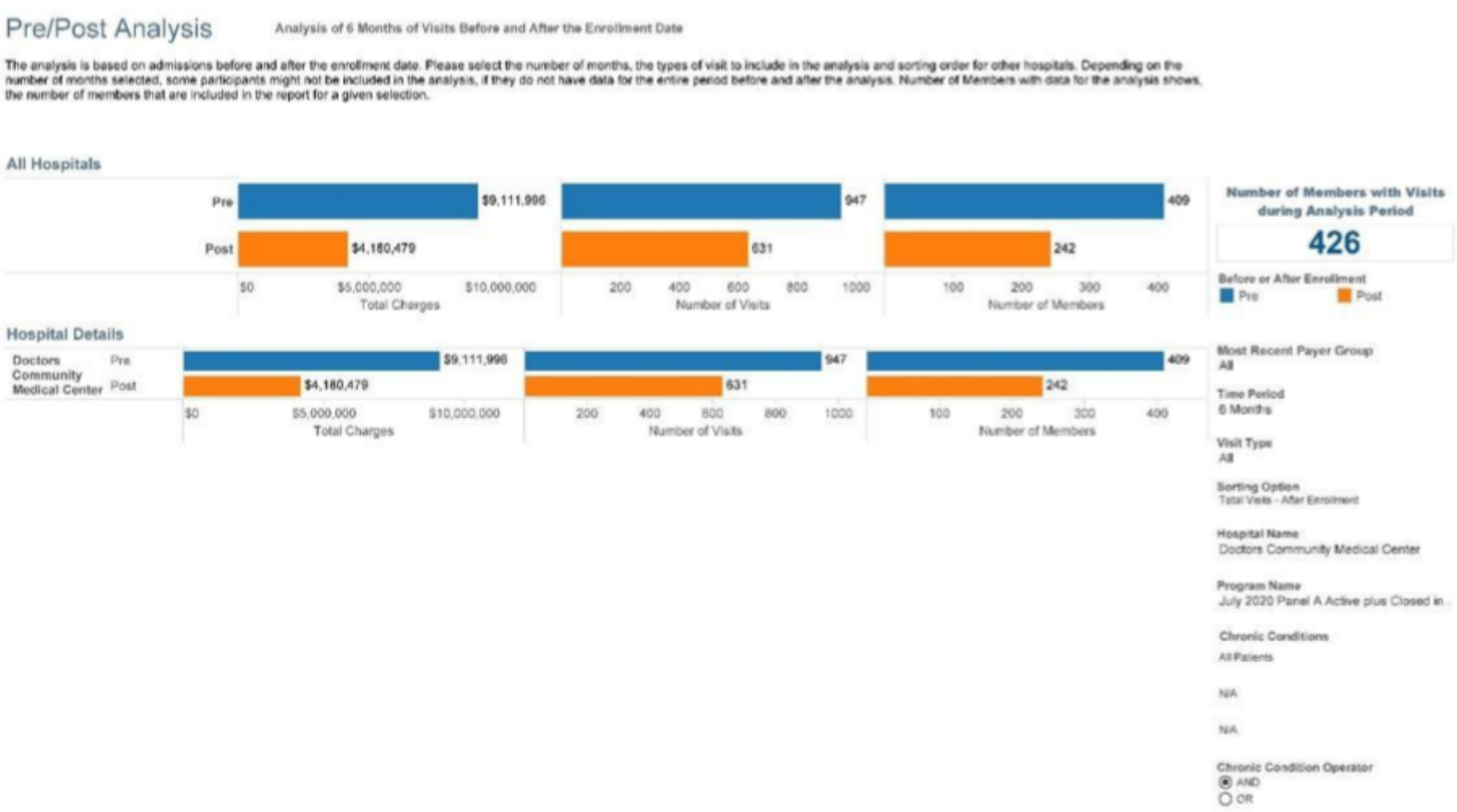
The data provided in this report uses CRISP data panels to compare hospital admissions, readmissions, number of patients, and hospital charges from pre to post enrollment into TLC-MD. Data analysis revealed a significant trend in lower hospital utilization and hospital charges as result of care coordination. The most compelling findings were among patients designated with a PAU and PQI showing a 66% relative reduction in hospital admission charges, a 67% relative reduction in hospital admissions, and a 68% relative reduction in the number of patients seen.

These findings underscore the importance of coordinated outpatient care. Many patients with chronic conditions lack health insurance and access to primary care, resulting in repeat

hospitalizations. Enrolling patients in TLC-MD's Coordinated Care program can reduce the burden on local health care systems and improve the health and wellbeing of communities served in Southern Maryland.

Pre and Post Aggregate Analysis by Hospital

For Doctors Community Medical Center, 426 patients had pre and post visit data for the enrollment period.



*Dashboard generated in CRISP

Pre and Post Breakdown of Hospital Charges

This analysis shows a breakdown of hospital charges from pre to post enrollment into TLC-MD.

Pre/Post Analysis

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

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

Most Recent Payer Group: All

Visit Type: All

Hospital Name: Doctors Community Medical Center

Time Period: 6 Months

Program Name: July 2020 Panel A Active plus Close..

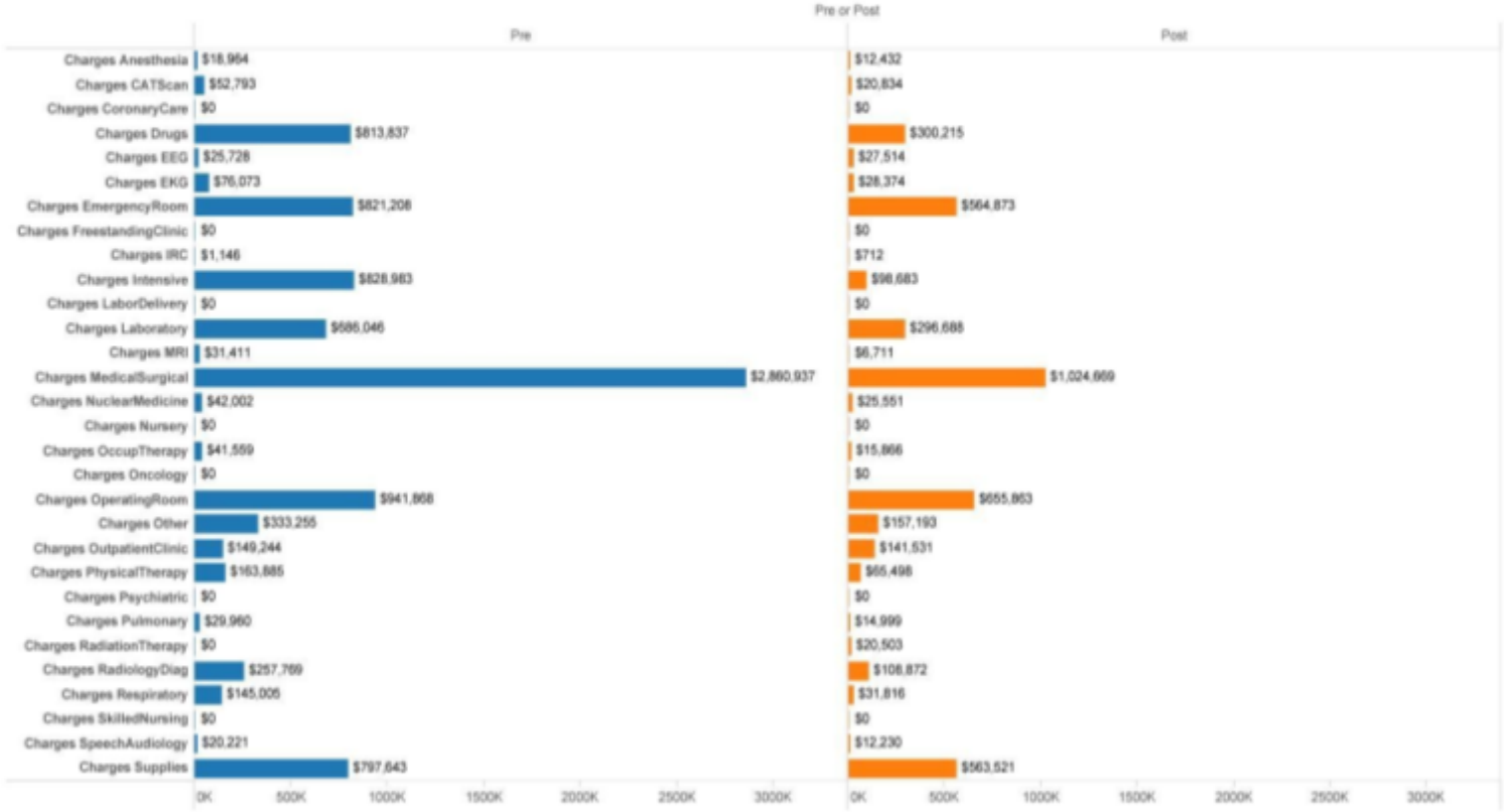
Chronic Conditions: All Patients

N/A

N/A

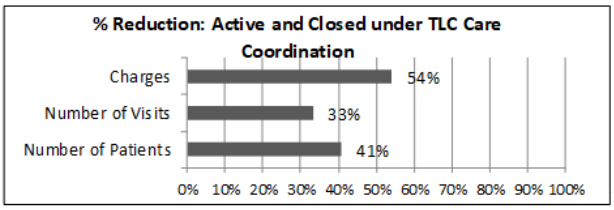
Chronic Condition Operator: (•) AND ( ) OR

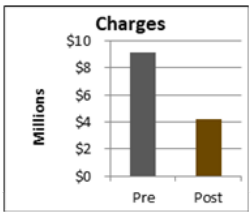
Breakdown of Charges Sheet



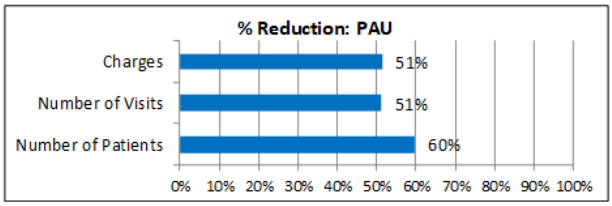
*Dashboard generated in CRISP

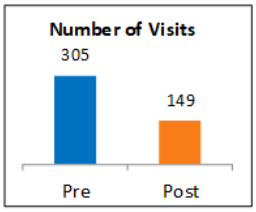
	PRE	POST	DELTA	PERCENT REDUCTION
SECTION A: AGGREGATE DATA				
Active and Closed Last 12 Months under TLC-MD Care Coordination				
Charges	$9,111,996	$4,180,479	$4,931,517	54%
Number of Visits	947	631	316	33%
Number of Patients	409	242	167	41%



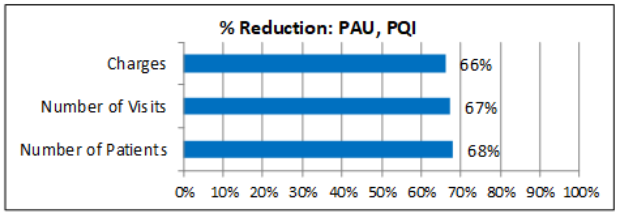


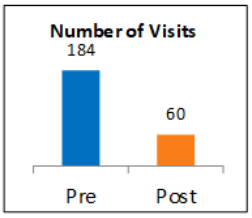
PAU	Inpt + Obs >23, PAU = 'Yes'			
Charges	$3,788,744	$1,842,495	$1,946,248	51%
Number of Visits	305	149	156	51%
Number of Patients	223	90	133	60%





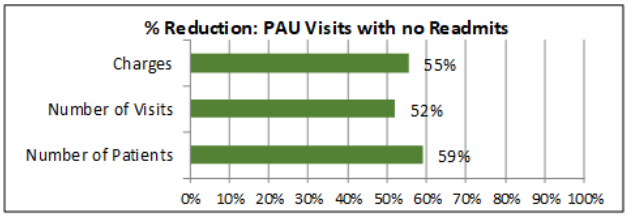
PAU, PQI	Inpt + Obs >23, PAU = 'Yes' and PQI = 'Yes'			
Charges	$2,132,100	$721,066	$1,411,034	66%
Number of Visits	184	60	124	67%
Number of Patients	163	52	111	68%

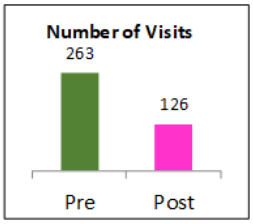




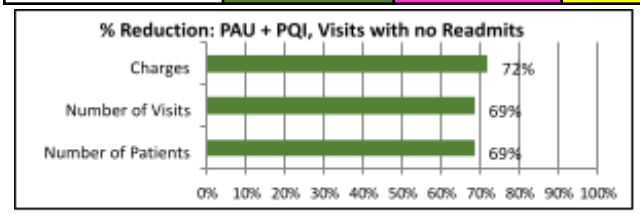
SECTION B: ADMISSIONS ONLY DATA

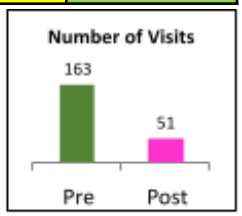
PAU Visits with no Readmits	Inpt and obs >23hr, PAU='Yes'			
Charges	$3,070,102	$1,366,245	$1,703,857	55%
Number of Visits	263	126	137	52%
Number of Patients	212	87	125	59%





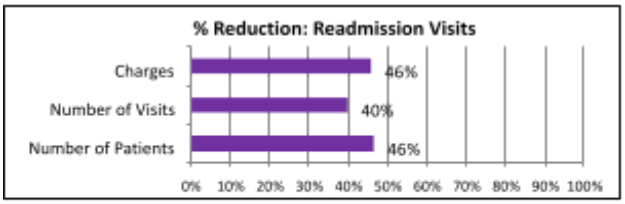
	PRE	POST	DELTA	PERCENT REDUCTION
PAU + PQI, Visits with no Readmits	Inpt and obs >23hr, PAU = 'Yes' and PQI = 'Yes'			
Charges	$1,910,359	$533,822	$1,376,536	72%
Number of Visits	163	51	112	69%
Number of Patients	147	46	101	69%



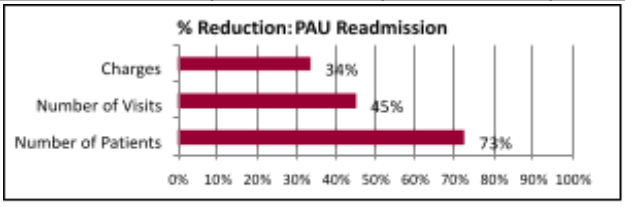


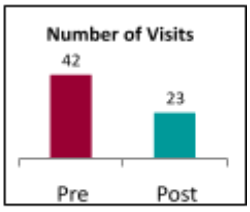
SECTION C: READMISSIONS ONLY DATA

Readmission Visit	Readmit, Input + OBS > 23			
Charges	$1,254,125	$680,574	$573,550	46%
Number of Visits	73	44	29	40%
Number of Patients	56	30	26	46%

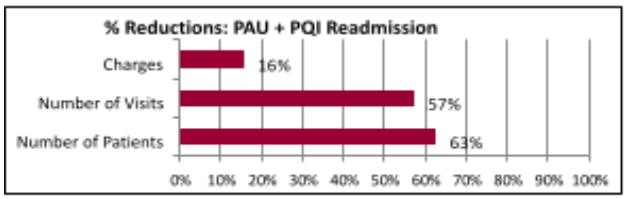


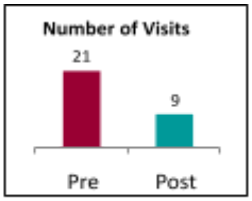
PAU Readmission	PAU Only			
Charges	$718,642	$476,250	$242,392	34%
Number of Visits	42	23	19	45%
Number of Patients	11	3	8	73%





PAU + PQI Readmission	PAU + PQI			
Charges	$221,742	$187,243	$34,498	16%
Number of Visits	21	9	12	57%
Number of Patients	16	6	10	63%





Doctors Community Medical Center Explanation of Data: TLC-MD Care Coordination Hospital Admission Impact (Pre and Post)

Patient Panel: **Combination of active cases under TLC-MD's Care Coordination and cases that have closed in the last 12 months.**

SECTION A: Aggregate Data

This section includes aggregate data of number of patients, hospital admissions, and hospital charges. Data include both potentially avoidable and unavoidable visits.

Prior to enrolling in TLC-MD's Care Coordination program:

- **409** patients
- **947** hospital admissions

Total Relative Charges Before Care Coordination: **$9,111,996**

After enrolling in TLC-MD's Care Coordination program:

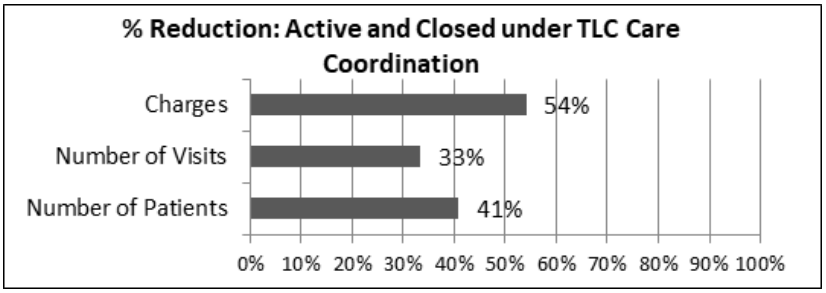
- **242** patients
- **631** hospital admissions

Total Relative Charges After Care Coordination: **$4,180,479**

Care Coordination relative impact:

- **54%** reduction in hospital admission charges
- **33%** reduction in hospital admissions
- **41%** reduction in the number of patients

Total Relative Cost Reduction: **$4,931,517**



Potentially Avoidable Admissions (PAU)

(Filters: IP and Obs>30; PAU=Yes)

This section provides a subset of the aggregate data described above.
PAU admissions includes all hospital admissions and readmissions among patients identified as potentially avoidable.

Prior to enrolling in TLC-MD's Care Coordination program:

- **223** patients with a PAU
- **305** hospital admissions

Total Relative Charges Before Care Coordination: **$3,788,744**

After enrolling in TLC-MD's Care Coordination program:

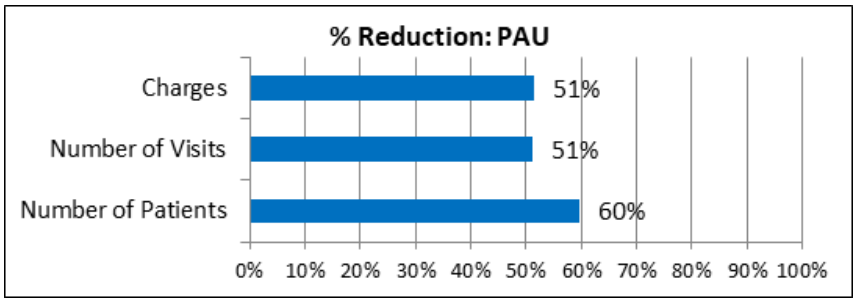
- **90** patients with a PAU
- **149** hospital admissions

Total Relative Charges After Care Coordination: **$1,842,495**

Care Coordination relative impact among patients with a PAU:

- **51%** reduction in hospital admission charges
- **51%** reduction in hospital admissions
- **60%** reduction in the number of patients

Total Relative Cost Reduction: **$1,946,248**



Potentially Avoidable (PAU) Admissions with a Prevention Quality Indicator (PQI)

(Filters: IP and Obs>30; PAU=Yes; PQI=Yes)

PAU and PQI admissions, includes all hospital admissions and readmissions with patients identified with a Potentially Avoidable Utilization (PAU) and Prevention Quality Indicator (PQI).

Prior to enrolling in TLC-MD's Care Coordination program:

- **163** patients with a PAU and PQI
- **184** hospital admissions

Total Relative Charges Before Care Coordination: **$2,132,100**

After enrolling in TLC-MD's Care Coordination program:

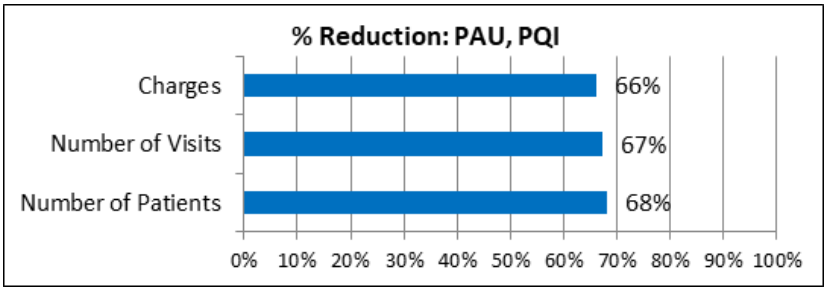
- **52** patients with a PAU and PQI
- **60** hospital admissions

Total Relative Charges After Care Coordination: **$721,066**

Care Coordination relative impact among patients with a PAU and PQI:

- **66%** reduction in hospital admission charges
- **67%** reduction in hospital admissions
- **68%** reduction in the number of patients

Total Relative Cost Reduction: **$1,411,034**



SECTION B: Admissions Only Data

Potentially Avoidable Admissions (PAU) ONLY with No Readmits

(Filters: IP and Obs>30; PAU= Yes; Readmission=No)

PAU Admissions ONLY, includes patients identified with a Potentially Avoidable Utilization that only had hospital admissions. No readmission visits were included.

Prior to enrolling in TLC-MD's Care Coordination program:
- **212** patients with a PAU
- **263** hospital admissions

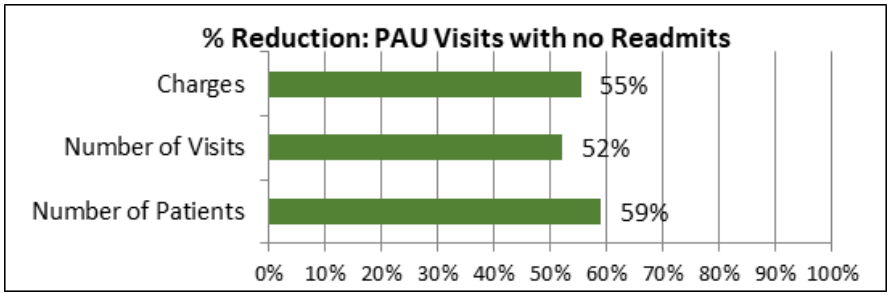
Total Relative Charges Before Care Coordination: **$3,070,102**

After enrolling in TLC-MD's Care Coordination program:
- **87** patients with a PAU
- **126** hospital admissions

Total Relative Charges After Care Coordination: **$1,366,245**

Care Coordination relative impact among patients with a PAU:
- **55%** reduction in hospital admission charges
- **52%** reduction in hospital admissions
- **59%** reduction in the number of patients

Total Relative Cost Reduction: **$1,703,857**



Potentially Avoidable (PAU) Admissions with a Prevention Quality Indicator (PQI) ONLY with No Readmits

(Filters: IP and Obs>30; PAU=Yes; PQI= Yes; Readmission=No)

PAU and PQI Admissions ONLY, includes patients identified with a Potentially Avoidable Utilization and Prevention Quality Indicator that only had hospital admissions. No readmission visits were included.

Prior to enrolling in TLC-MD's Care Coordination program:

- **147** patients with a PAU and PQI
- **163** hospital admissions

Total Relative Charges Before Care Coordination: **$1,910,359**

After enrolling in TLC-MD's Care Coordination program:

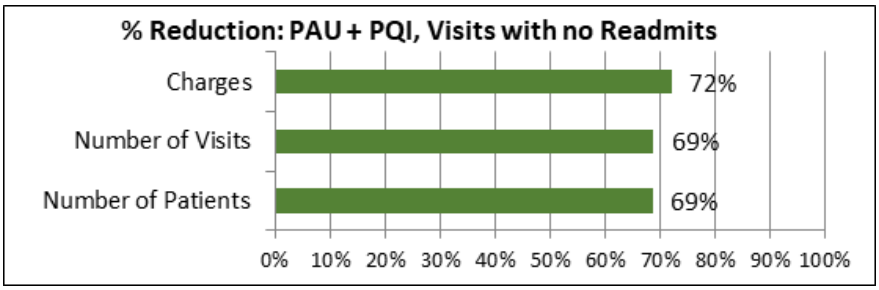
- **46** patients with a PAU and PQI
- **51** hospital admissions

Total Relative Charges After Care Coordination: **$533,822**

Care Coordination relative impact among patients with a PAU and PQI:

- **72%** reduction in hospital admission charges
- **69%** reduction in hospital admissions
- **69%** reduction in the number of patients

Total Relative Cost Reduction: **$1,376,536**



SECTION C: Readmissions Only Data

Readmissions ONLY

(Note: Some readmission data entries are missing in CRISP)

Readmissions ONLY, includes the total number of hospital admissions within 30 days of a prior hospital admission.

Prior to enrolling in TLC-MD's Care Coordination program:

- **56** patients
- **73** hospital readmissions

Total Relative Charges Before Care Coordination: **$1,254,125**

After enrolling in TLC-MD's Care Coordination program:

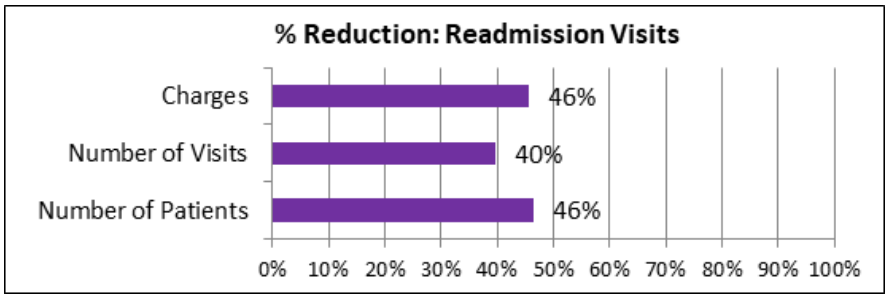
- **30** patients
- **44** hospital readmissions

Total Relative Charges After Care Coordination: **$680,574**

Care Coordination relative impact among all readmissions:

- **46%** reduction in hospital readmission charges
- **40%** reduction in hospital readmissions
- **46%** reduction in the number of patients

Total Relative Cost Reduction: **$573,550**



Potentially Avoidable Readmissions ONLY

(Calculation: PAU Admissions MINUS PAU Admissions ONLY)

PAU Readmissions ONLY calculation, indicates the number of hospital admissions within 30 days of a prior hospitalization, among patients identified with a Potentially Avoidable Utilization.

Prior to enrolling in TLC-MD's Care Coordination program:

- **11** patients with a PAU
- **42** hospital readmissions

Total Relative Charges Before Care Coordination: **$718,642**

After enrolling in TLC-MD's Care Coordination program:

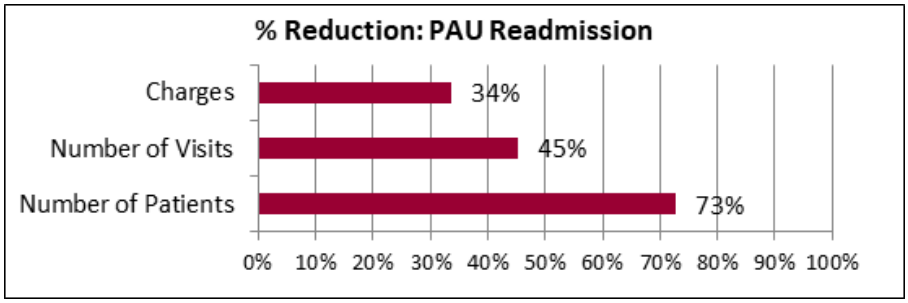
- **3** patients with a PAU
- **23** hospital readmissions

Total Relative Charges After Care Coordination: **$476,250**

Care Coordination relative impact among all readmissions:

- **34%** reduction in hospital readmission charges
- **45%** reduction in hospital readmissions
- **73%** reduction in the number of patients

Total Relative Cost Reduction: **$242,392**



Potentially Avoidable Readmission with Prevention Quality Indicators

(Calculation: PAU and PQI Admissions MINUS PAU and PQI Admissions ONLY)

PAU and PQI Readmissions calculation indicates the number of hospital admissions within 30 days of a prior hospitalization among patients identified with a Potentially Avoidable Utilization and Prevention Quality Indicator.

Prior to enrolling in TLC-MD's Care Coordination program:

- **16** patients with a PAU and PQI
- **21** hospital readmissions

Total Relative Charges Before Care Coordination: **$221,742**

After enrolling in TLC-MD's Care Coordination program:

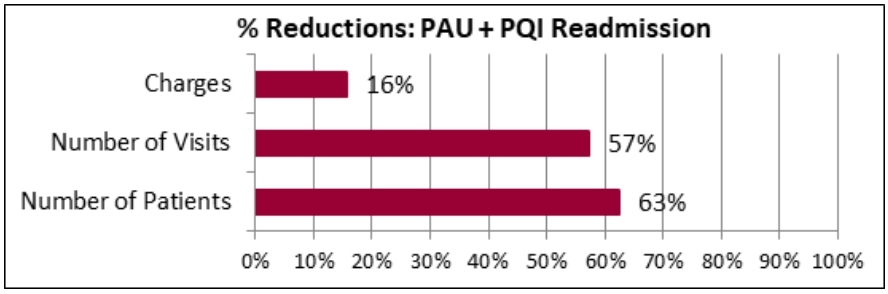
- **6** patients with a PAU and PQI
- **9** hospital readmissions

Total Relative Charges After Care Coordination: **$187,243**

Care Coordination relative impact among all readmissions:

- **16%** reduction in hospital readmission charges
- **57%** reduction in hospital readmissions
- **63%** reduction in the number of patients

Total Relative Cost Reduction: **$34,498**



MedStar St. Mary's Hospital

TLC-MD Care Coordination Hospital Admission Impact MedStar St. Mary's Hospital Executive Summary

Date Range: July 1, 2019 to June 30, 2020

The data provided in this report uses CRISP data panels to compare hospital admissions, readmissions, number of patients, and hospital charges from pre to post enrollment into TLC-MD.

Data analysis revealed a significant trend in lower hospital utilization and hospital charges as result of care coordination. The most compelling findings were among patients designated with a PAU and PQI showing a 70% relative reduction in hospital admission charges, a 70% relative reduction in hospital admissions, and a 74% relative reduction in the number of patients seen.

These findings underscore the importance of coordinated outpatient care. Many patients with chronic conditions lack health insurance and access to primary care, resulting in repeat hospitalizations. Enrolling patients in TLC-MD Coordinated Care program can reduce the burden on local health care systems and improve the health and wellbeing of communities served in Southern Maryland.

Pre and Post Aggregate Analysis by Hospital

For MedStar St. Mary's Hospital, 131 patients had pre and post visit data for the enrollment perio d.

Pre/Post Analysis

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

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

*Dashboard generated in CRISP

Pre and Post Breakdown of Hospital Charges

This analysis shows a breakdown of hospital charges from pre to post enrollment into TLC-MD.

Pre/Post Analysis

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

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

Most Recent Payer Group
All

Visit Type
All

Hospital Name
Medstar St. Mary's Hospital

Time Period
6 Months

Program Name
July 2020 Panel A Active plus Close..

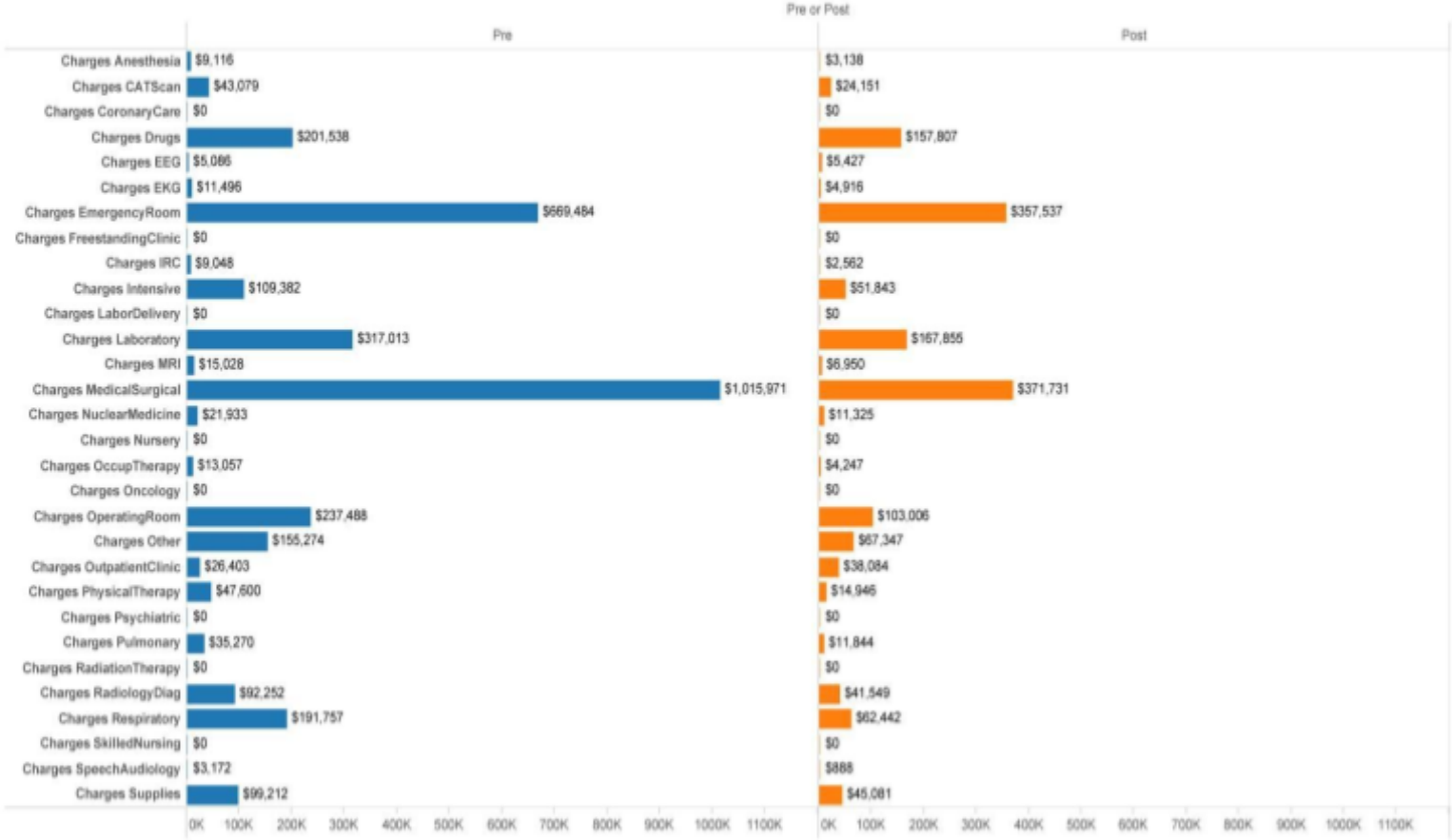
Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

Breakdown of Charges Sheet



*Dashboard generated in CRISP

MedStar St. Mary's Hospital TLC-MD Care Coordination Hospital Admission Impact

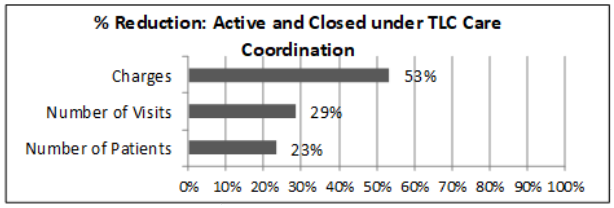
This table illustrates the impact of TLC-MD by Potentially Avoidable Utilization (PAU), Prevention Quality Indicators (PQI), and Readmissions.

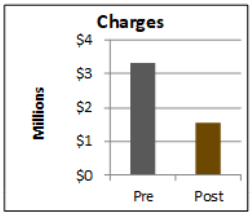
	PRE	POST	DELTA	PERCENT REDUCTION

SECTION A: AGGREGATE DATA

Active and Closed Last 12 Months under TLC-MD Care Coordination

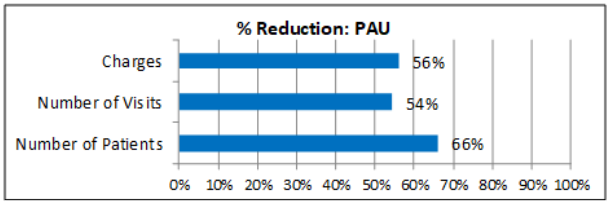
Charges	$3,329,659	$1,554,650	$1,775,009	53%
Number of Visits	568	406	162	29%
Number of Patients	129	99	30	23%

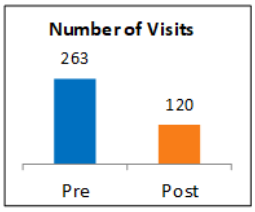




PAU Inpt + Obs >23, PAU = 'Yes'

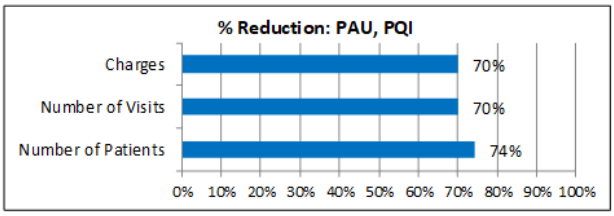
Charges	$3,112,436	$1,365,919	$1,746,516	56%
Number of Visits	263	120	143	54%
Number of Patients	171	58	113	66%

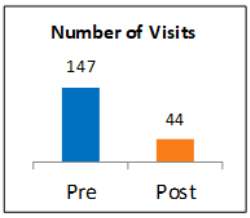




PAU, PQI Inpt + Obs >23, PAU = 'Yes' and PQI = 'Yes'

Charges	$1,705,108	$511,679	$1,193,429	70%
Number of Visits	147	44	103	70%
Number of Patients	117	30	87	74%

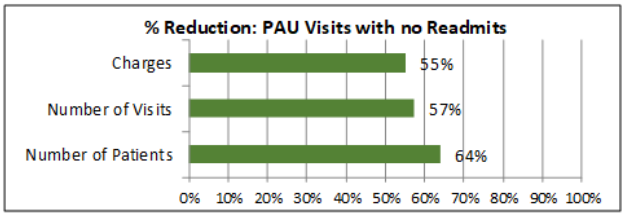


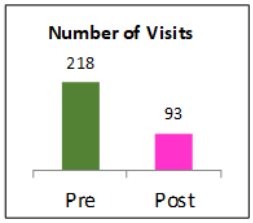


SECTION B: ADMISSIONS ONLY DATA

PAU Visits with no Readmits Inpt and obs >23hr, PAU= 'Yes'

Charges	$2,344,463	$1,052,088	$1,292,374	55%
Number of Visits	218	93	125	57%
Number of Patients	161	58	103	64%

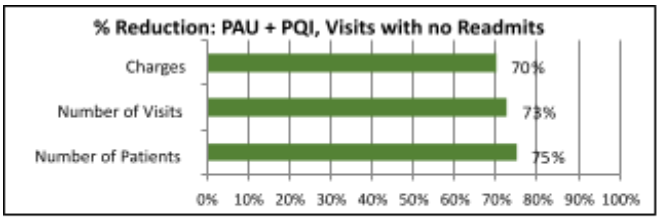


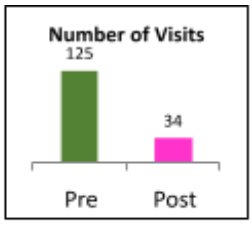


PRE	POST	DELTA	PERCENT REDUCTION

PAU + PQI, Visits with no Readmits Inpt and obs >23hr, PAU = 'Yes' and PQI = 'Yes'

Charges	$1,338,553	$400,528	$938,026	70%
Number of Visits	125	34	91	73%
Number of Patients	104	26	78	75%

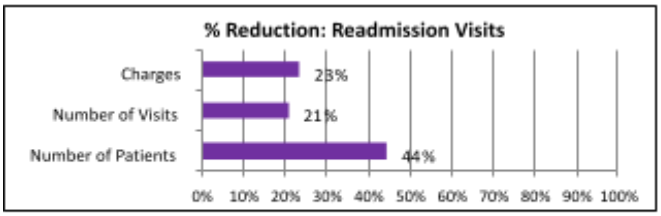


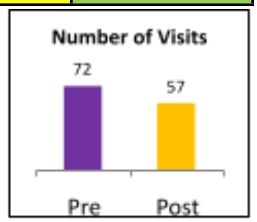


SECTION C: READMISSIONS ONLY DATA

Readmission Visit Readmit, Input + OBS > 23

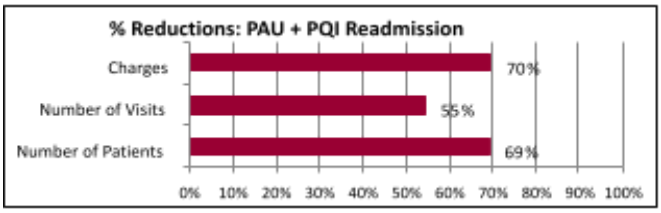
Charges	$1,046,330	$801,067	$245,263	23%
Number of Visits	72	57	15	21%
Number of Patients	63	35	28	44%

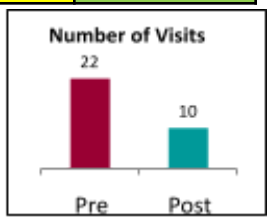




PAU + PQI Readmission PAU + PQI

Charges	$366,555	$111,151	$255,404	70%
Number of Visits	22	10	12	55%
Number of Patients	13	4	9	69%





MedStar St. Mary's Hospital
Explanation of Data: TLC-MD Care Coordination Hospital Admission Impact (Pre and Post)

Patient Panel: Combination of active cases under TLC-MD's Care Coordination and cases that have closed in the last 12 months.

SECTION A: Aggregate Data

Prior to enrolling in TLC-MD's Care Coordination program:

- **129** patients
- **568** hospital admissions

Total Relative Charges Before Care Coordination: **$3,329,659**

After enrolling in TLC-MD's Care Coordination program:

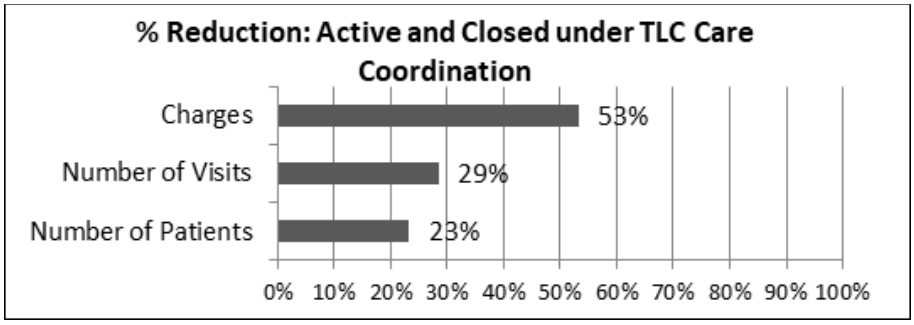
- **99** patients
- **406** hospital admissions

Total Relative Charges After Care Coordination: **$1,554,650**

Care Coordination relative impact:

- **53%** reduction in hospital admission charges
- **29%** reduction in hospital admissions
- **23%** reduction in the number of patients

Total Relative Cost Reduction: **$1,775,009**



Potentially Avoidable Admissions (PAU)

(Filters: IP and Obs>30; PAU=Yes)

This section provides a subset of the aggregate data described above.
PAU admissions includes all hospital admissions and readmissions among patients identified as potentially avoidable.

Prior to enrolling in TLC-MD's Care Coordination program:

- **171** patients with a PAU
- **263** hospital admissions

Total Relative Charges Before Care Coordination: **$3,112,436**

After enrolling in TLC-MD's Care Coordination program:

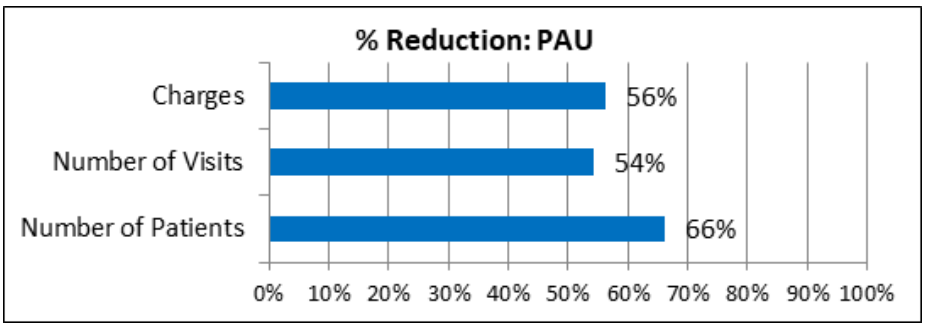
- **58** patients with a PAU
- **120** hospital admissions

Total Relative Charges After Care Coordination: **$1,365,919**

Care Coordination relative impact among patients with a PAU:

- **56%** reduction in hospital admission charges
- **54%** reduction in hospital admissions
- **66%** reduction in the number of patients

Total Relative Cost Reduction: **$1,746,516**


% Reduction: PAU
Charges
Number of Visits
Number of Patients
56%
54%
66%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

Potentially Avoidable (PAU) Admissions with a Prevention Quality Indicator (PQI)

(Filters: IP and Obs>30; PAU=Yes; PQI=Yes)

PAU and PQI admissions, includes all hospital admissions and readmissions with patients identified with a Potentially Avoidable Utilization (PAU) and Prevention Quality Indicator (PQI).

Prior to enrolling in TLC-MD's Care Coordination program:

- **117** patients with a PAU and PQI
- **147** hospital admissions

Total Relative Charges Before Care Coordination: **$1,705,108**

After enrolling in TLC-MD's Care Coordination program:

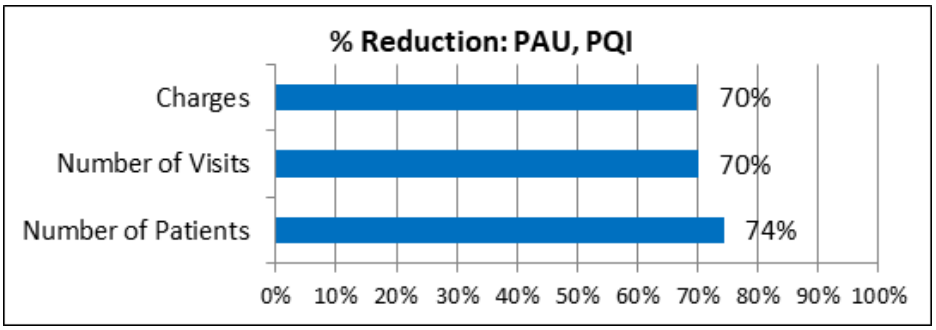
- **30** patients with a PAU and PQI
- **44** hospital admissions

Total Relative Charges After Care Coordination: **$511,679**

Care Coordination relative impact among patients with a PAU and PQI:

- **70%** reduction in hospital admission charges
- **70%** reduction in hospital admissions
- **74%** reduction in the number of patients

Total Relative Cost Reduction: **$1,193,429**



SECTION B: Admissions Only Data

Potentially Avoidable Admissions (PAU) ONLY with No Readmits

(Filters: IP and Obs>30; PAU= Yes; Readmission=No)

PAU Admissions ONLY, includes patients identified with a Potentially Avoidable Utilization that only had hospital admissions. No readmission visits were included.

Prior to enrolling in TLC-MD's Care Coordination program:
- **161** patients with a PAU
- **218** hospital admissions

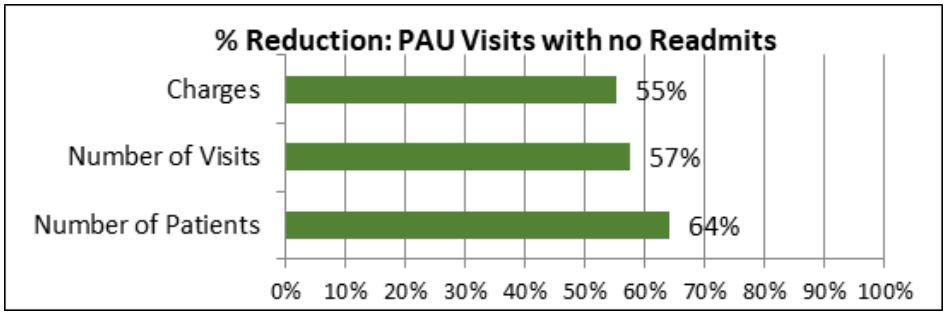
Total Relative Charges Before Care Coordination: **$2,344,463**

After enrolling in TLC-MD's Care Coordination program:
- **58** patients with a PAU
- **93** hospital admissions

Total Relative Charges After Care Coordination: **$1,052,088**

Care Coordination relative impact among patients with a PAU:
- **55%** reduction in hospital admission charges
- **57%** reduction in hospital admissions
- **64%** reduction in the number of patients

Total Relative Cost Reduction: **$1,292,374**



Potentially Avoidable (PAU) Admissions with a Prevention Quality Indicator (PQI) ONLY with No Readmits

(Filters: IP and Obs>30; PAU=Yes; PQI= Yes; Readmission=No)

PAU and PQI Admissions ONLY, includes patients identified with a Potentially Avoidable Utilization and Prevention Quality Indicator that only had hospital admissions. No readmission visits were included.

Prior to enrolling in TLC-MD's Care Coordination program:

- **104** patients with a PAU and PQI
- **125** hospital admissions

Total Relative Charges Before Care Coordination: **$1,338,553**

After enrolling in TLC-MD's Care Coordination program:

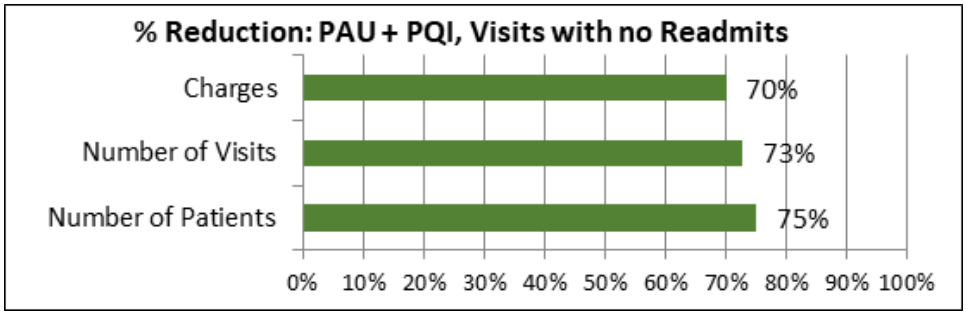
- **26** patients with a PAU and PQI
- **34** hospital admissions

Total Relative Charges After Care Coordination: **$400,528**

Care Coordination relative impact among patients with a PAU and PQI:

- **70%** reduction in hospital admission charges
- **73%** reduction in hospital admissions
- **75%** reduction in the number of patients

Total Relative Cost Reduction: **$938,026**



SECTION C: Readmissions Only Data

Readmissions ONLY

(Note: Some readmission data entries are missing in CRISP)

Readmissions ONLY, includes the total number of hospital admissions within 30 days of a prior hospital admission.

Prior to enrolling in TLC-MD's Care Coordination program:

- **63** patients
- **72** hospital readmissions

Total Relative Charges Before Care Coordination: **$1,046,330**

After enrolling in TLC-MD's Care Coordination program:

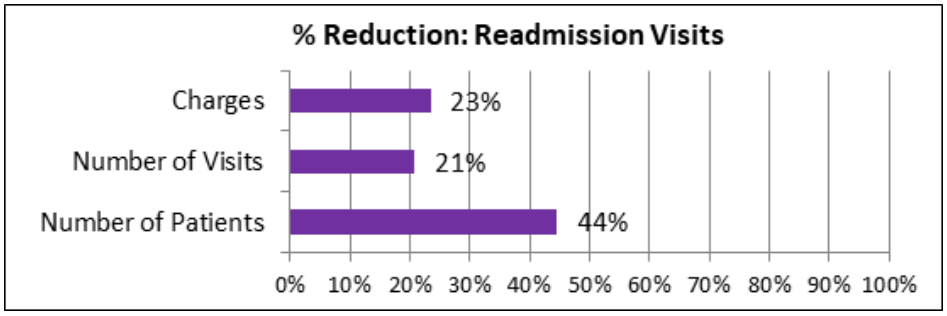
- **35** patients
- **57** hospital readmissions

Total Relative Charges After Care Coordination: **$801,067**

Care Coordination relative impact among all readmissions:

- **23%** reduction in hospital readmission charges
- **21%** reduction in hospital readmissions
- **44%** reduction in the number of patients

Total Relative Cost Reduction: **$245,263**



Potentially Avoidable Readmission with Prevention Quality Indicators

(Calculation: PAU and PQI Admissions MINUS PAU and PQI Admissions ONLY)

PAU and PQI Readmissions calculation indicates the number of hospital admissions within 30 days of a prior hospitalization among patients identified with a Potentially Avoidable Utilization and Prevention Quality Indicator.

Prior to enrolling in TLC-MD's Care Coordination program:

- **13** patients with a PAU and PQI
- **22** hospital readmissions

Total Relative Charges Before Care Coordination: **$366,555**

After enrolling in TLC-MD's Care Coordination program:

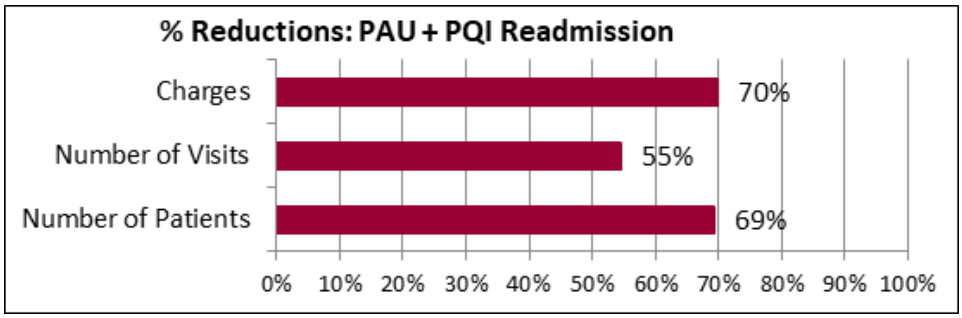
- **4** patients with a PAU and PQI
- **10** hospital readmissions

Total Relative Charges After Care Coordination: **$111,151**

Care Coordination relative impact among all readmissions:

- **70%** reduction in hospital readmission charges
- **55%** reduction in hospital readmissions
- **69%** reduction in the number of patients

Total Relative Cost Reduction: **$255,404**


% Reductions: PAU + PQI Readmission
Charges
Number of Visits
Number of Patients
70%
55%
69%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

TLC-MD Care Coordination Hospital Admission Impact MedStar Southern Maryland Hospital Center Executive Summary

Date Range: July 1, 2019 to June 30, 2020

The data provided in this report uses CRISP data panels to compare hospital admissions, readmissions, number of patients, and hospital charges from pre to post enrollment into TLC-MD. Data analysis revealed a significant trend in lower hospital utilization and hospital charges as result of care coordination. The most compelling findings were among patients designated with a PAU and PQI showing a 60% relative reduction in hospital admission charges, a 68% relative reduction in hospital admissions, and a 66% relative reduction in the number of patients seen.

These findings underscore the importance of coordinated outpatient care. Many patients with chronic conditions lack health insurance and access to primary care, resulting in repeat hospitalizations. Enrolling patients in TLC-MD Coordinated Care program can reduce the burden on local health care systems and improve the health and wellbeing of communities served in Southern Maryland.

Pre and Post Aggregate Analysis by Hospital

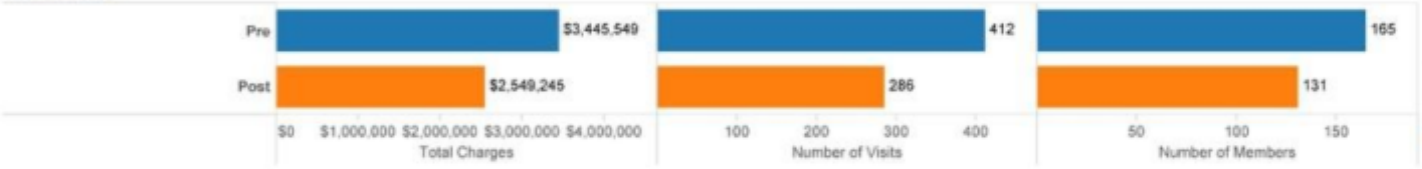
For MedStar Southern Maryland Hospital Center, 201 patients had pre and post visit data for the enrollment period.

Pre/Post Analysis

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

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

All Hospitals



Hospital Details

Number of Members with Visits during Analysis Period

201

Before or After Enrollment

Pre Post

Most Recent Payer Group
All

Time Period
6 Months

Visit Type
All

Sorting Option
Total Visits - After Enrollment

Hospital Name
Medstar Southern Maryland Hospital Ce..

Program Name
July 2020 Panel A Active plus Closed in..

Chronic Conditions
All Patients

N/A

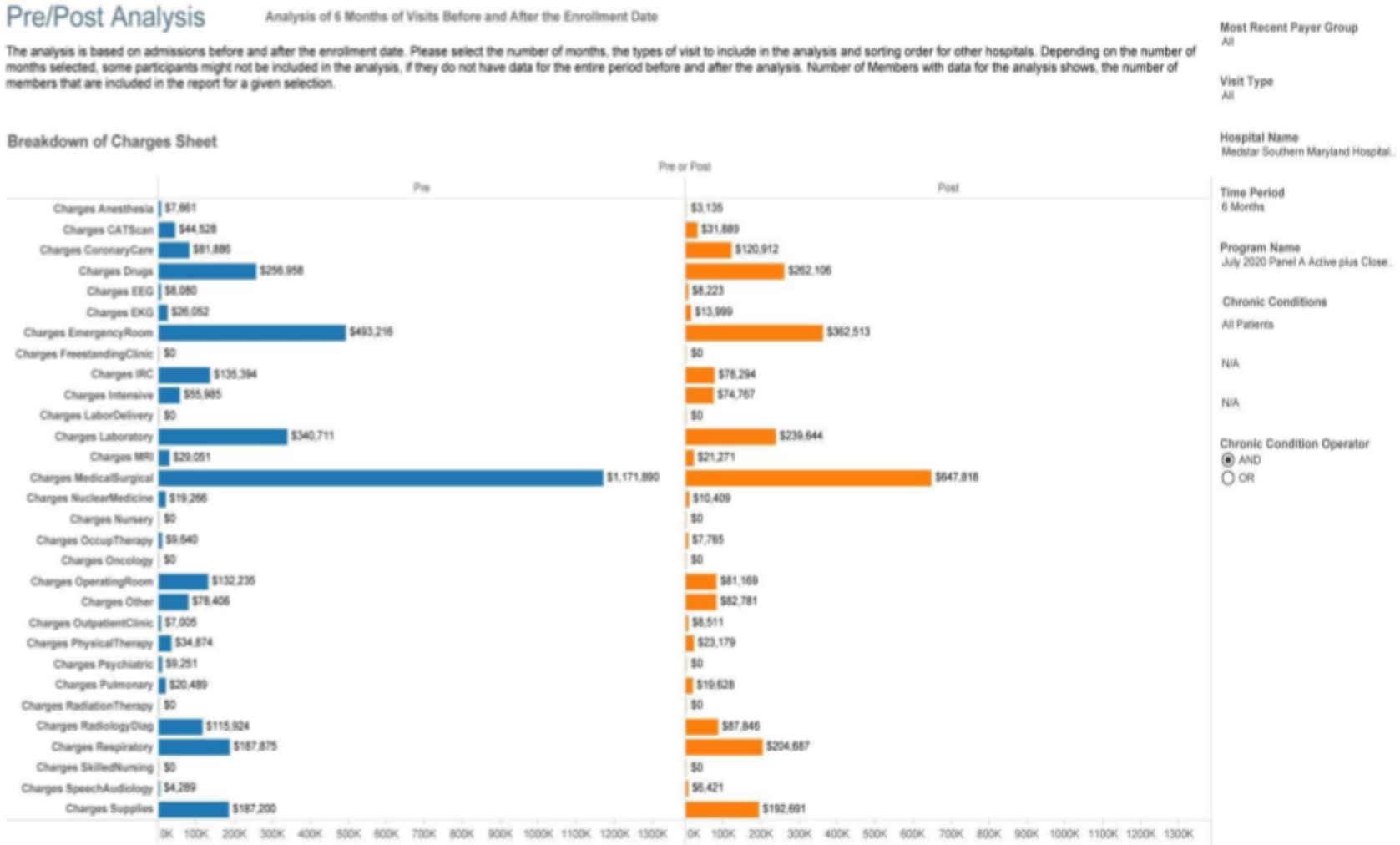
N/A

Chronic Condition Operator
(•) AND
( ) OR

*Dashboard generated in CRISP

Pre and Post Breakdown of Hospital Charges

This analysis shows a breakdown of hospital charges from pre to post enrollment into TLC-MD.

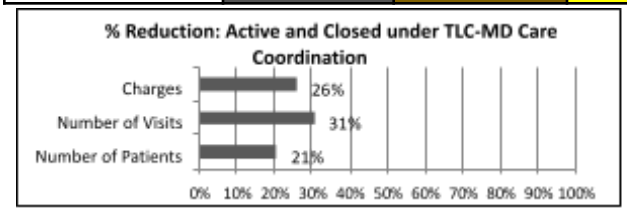


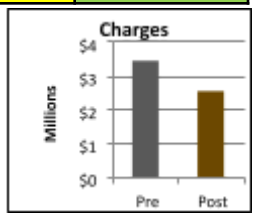
*Dashboard generated in CRISP

MedStar Southern Maryland Hospital Center TLC-MD Care Coordination
Hospital Admission Impact

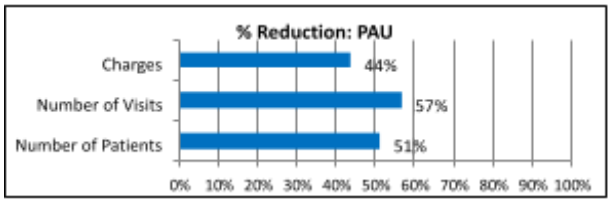
This table illustrates the impact of TLC-MD by Potentially Avoidable Utilization (PAU), Prevention Quality Indicators (PQI), and Readmissions.

	PRE	POST	DELTA	PERCENT REDUCTION
SECTION A: AGGREGATE DATA				
Active and Closed Last 12 Months under TLC-MD Care Coordination				
Charges	$3,445,549	$2,549,245	$896,304	26%
Number of Visits	412	286	126	31%
Number of Patients	165	131	34	21%

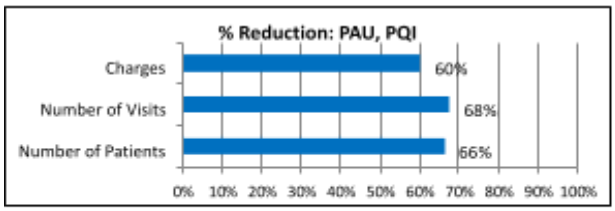


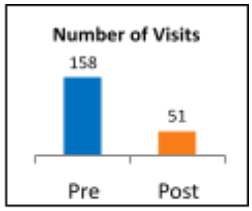


PAU	Inpt + Obs >23, PAU = 'Yes'			
Charges	$2,921,031	$1,641,230	$1,279,802	44%
Number of Visits	238	103	135	57%
Number of Patients	154	75	79	51%

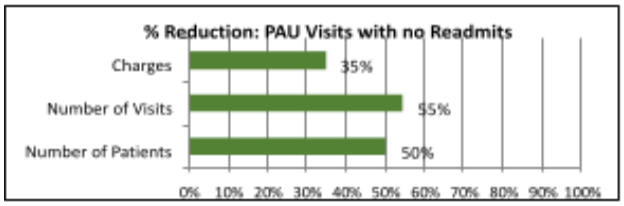


PAU, PQI	Inpt + Obs >23, PAU = 'Yes' and PQI = 'Yes'			
Charges	$1,810,162	$718,059	$1,092,103	60%
Number of Visits	158	51	107	68%
Number of Patients	125	42	83	66%

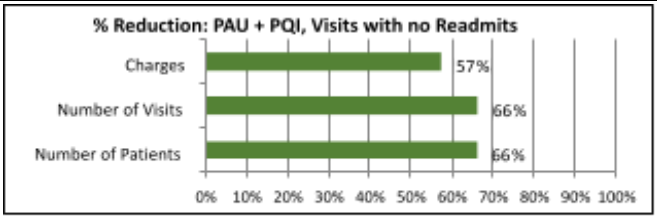


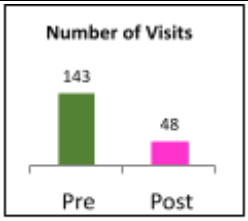


SECTION B: ADMISSIONS ONLY				
PAU Visits with no Readmits	Inpt and obs >23hr, PAU= 'Yes'			
Charges	$2,180,130	$1,420,572	$759,558	35%
Number of Visits	198	90	108	55%
Number of Patients	143	71	72	50%



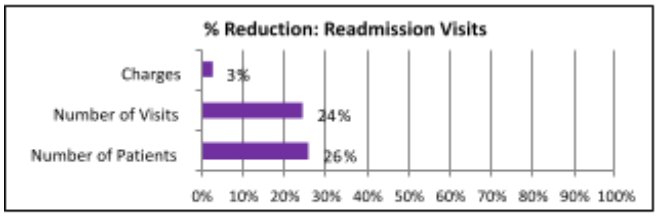
	PRE	POST	DELTA	PERCENT REDUCTION
PAU + PQI, Visits with no Readmits	Inpt and obs >23hr, PAU = 'Yes' and PQI = 'Yes'			
Charges	$1,572,385	$668,474	$903,911	57%
Number of Visits	143	48	95	66%
Number of Patients	118	40	78	66%



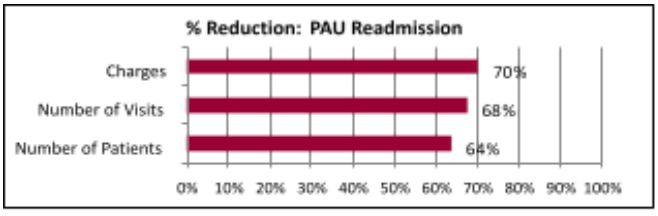


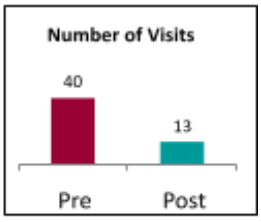
SECTION C: READMISSIONS ONLY

Readmission Visit	Readmit, Input + OBS > 23			
Charges	$705,363	$687,353	$18,010	3%
Number of Visits	41	31	10	24%
Number of Patients	31	23	8	26%

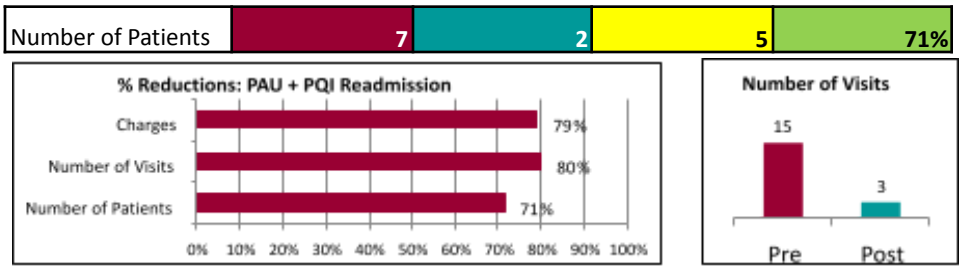


PAU Readmission	PAU Only			
Charges	$740,901	$220,658	$520,243	70%
Number of Visits	40	13	27	68%
Number of Patients	11	4	7	64%





PAU + PQI Readmission	PAU + PQI			
Charges	$237,777	$49,585	$188,192	79%
Number of Visits	15	3	12	80%



MedStar Southern Maryland Hospital Center Explanation of Data: TLC-MD Care Coordination Hospital Admission Impact (Pre and Post)

Patient Panel: Combination of active cases under TLC-MD's Care Coordination and cases that have closed in the last 12 months.

SECTION A: Aggregate Data

Prior to enrolling in TLC-MD's Care Coordination program:

- **165** patients
- **412** hospital admissions

Total Relative Charges Before Care Coordination: **$3,445,549**

After enrolling in TLC-MD's Care Coordination program:

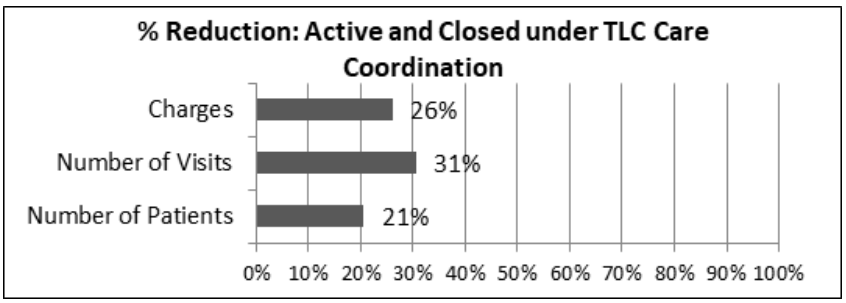
- **131** patients
- **286** hospital admissions

Total Relative Charges After Care Coordination: **$2,549,245**

Care Coordination relative impact:

- **26%** reduction in hospital admission charges
- **31%** reduction in hospital admissions
- **21%** reduction in the number of patients

Total Relative Cost Reduction: **$896,304**



Potentially Avoidable Admissions (PAU)

(Filters: IP and Obs>30; PAU=Yes)

This section provides a subset of the aggregate data described above.
PAU admissions includes all hospital admissions and readmissions among patients identified as potentially avoidable.

Prior to enrolling in TLC-MD's Care Coordination program:

- **154** patients with a PAU
- **238** hospital admissions

Total Relative Charges Before Care Coordination: **$2,921,031**

After enrolling in TLC-MD's Care Coordination program:

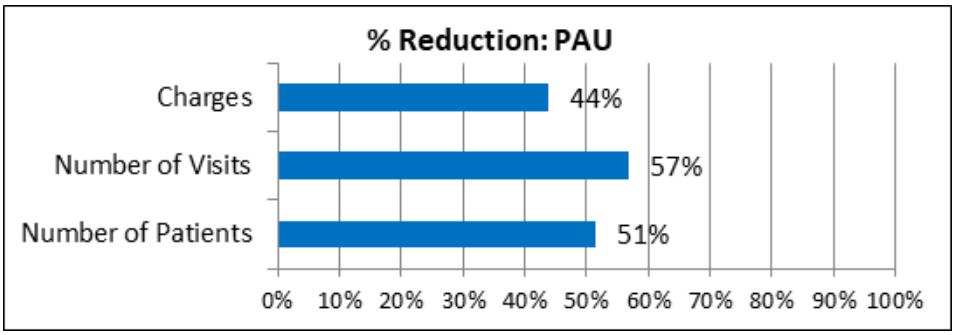
- **75** patients with a PAU
- **103** hospital admissions

Total Relative Charges After Care Coordination: **$1,641,230**

Care Coordination relative impact among patients with a PAU:

- **44%** reduction in hospital admission charges
- **57%** reduction in hospital admissions
- **51%** reduction in the number of patients

Total Relative Cost Reduction: **$1,279,802**



Potentially Avoidable (PAU) Admissions with a Prevention Quality Indicator (PQI)

(Filters: IP and Obs>30; PAU=Yes; PQI=Yes)

PAU and PQI admissions, includes all hospital admissions and readmissions with patients identified with a Potentially Avoidable Utilization (PAU) and Prevention Quality Indicator (PQI).

Prior to enrolling in TLC-MD's Care Coordination program:

- **125** patients with a PAU and PQI
- **158** hospital admissions

Total Relative Charges Before Care Coordination: **$1,810,162**

After enrolling in TLC-MD's Care Coordination program:

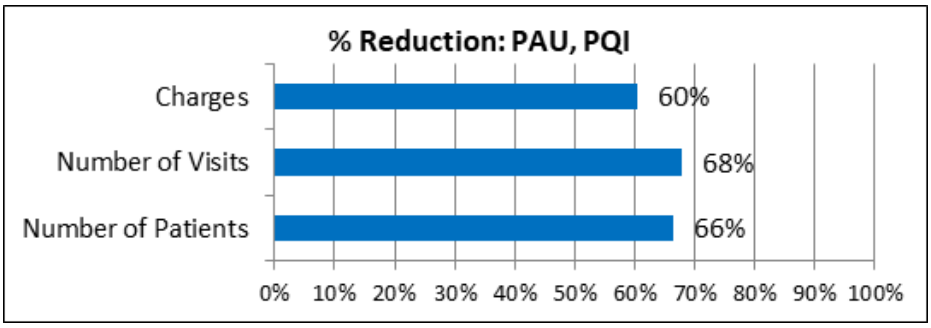
- **42** patients with a PAU and PQI
- **51** hospital admissions

Total Relative Charges After Care Coordination: **$718,059**

Care Coordination relative impact among patients with a PAU and PQI:

- **60%** reduction in hospital admission charges
- **68%** reduction in hospital admissions
- **66%** reduction in the number of patients

Total Relative Cost Reduction: **$1,092,103**



SECTION B: Admissions Only Data

Potentially Avoidable Admissions (PAU) ONLY with No Readmits

(Filters: IP and Obs>30; PAU= Yes; Readmission=No)

PAU Admissions ONLY, includes patients identified with a Potentially Avoidable Utilization that only had hospital admissions. No readmission visits were included.

Prior to enrolling in TLC-MD's Care Coordination program:
- **143** patients with a PAU
- **198** hospital admissions

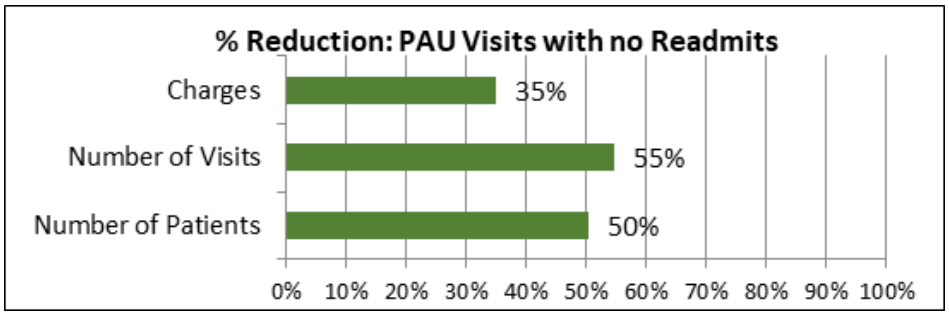
Total Relative Charges Before Care Coordination: **$2,180,130**

After enrolling in TLC-MD's Care Coordination program:
- **71** patients with a PAU
- **90** hospital admissions

Total Relative Charges After Care Coordination: **$1,420,572**

Care Coordination relative impact among patients with a PAU:
- **35%** reduction in hospital admission charges
- **55%** reduction in hospital admissions
- **50%** reduction in the number of patients

Total Relative Cost Reduction: **$759,558**



Potentially Avoidable (PAU) Admissions with a Prevention Quality Indicator (PQI) ONLY with No Readmits

(Filters: IP and Obs>30; PAU=Yes; PQI= Yes; Readmission=No)

PAU and PQI Admissions ONLY, includes patients identified with a Potentially Avoidable Utilization and Prevention Quality Indicator that only had hospital admissions. No readmission visits were included.

Prior to enrolling in TLC-MD's Care Coordination program:

- **118** patients with a PAU and PQI
- **143** hospital admissions

Total Relative Charges Before Care Coordination: **$1,572,385**

After enrolling in TLC-MD's Care Coordination program:

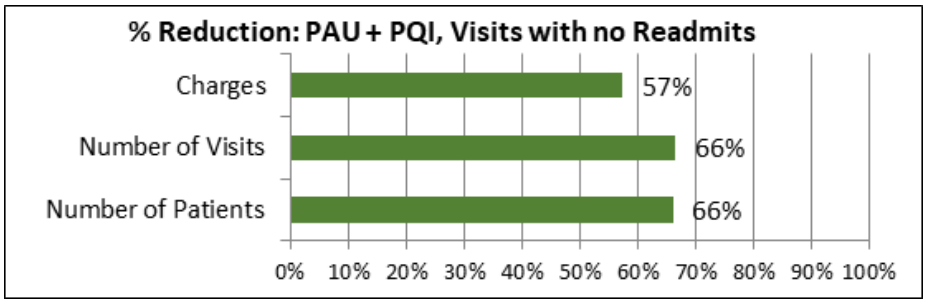
- **40** patients with a PAU and PQI
- **48** hospital admissions

Total Relative Charges After Care Coordination: **$668,474**

Care Coordination relative impact among patients with a PAU and PQI:

- **57%** reduction in hospital admission charges
- **66%** reduction in hospital admissions
- **66%** reduction in the number of patients

Total Relative Cost Reduction: **$903,911**



SECTION C: Readmissions Only Data

Readmissions ONLY

(Note: Some readmission data entries are missing in CRISP)

Readmissions ONLY, includes the total number of hospital admissions within 30 days of a prior hospital admission.

Prior to enrolling in TLC-MD's Care Coordination program:

- **31** patients
- **41** hospital readmissions

Total Relative Charges Before Care Coordination: **$705,363**

After enrolling in TLC-MD's Care Coordination program:

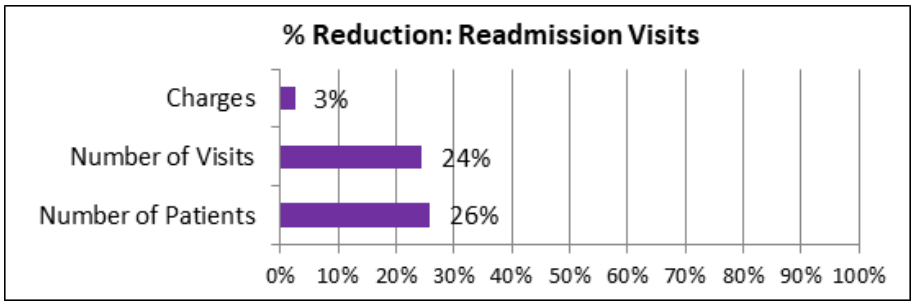
- **23** patients
- **31** hospital readmissions

Total Relative Charges After Care Coordination: **$687,353**

Care Coordination relative impact among all readmissions:

- **3%** reduction in hospital readmission charges
- **24%** reduction in hospital readmissions
- **26%** reduction in the number of patients

Total Relative Cost Reduction: **$18,010**



Potentially Avoidable Readmissions ONLY

(Calculation: PAU Admissions MINUS PAU Admissions ONLY)

PAU Readmissions ONLY calculation, indicates the number of hospital admissions within 30 days of a prior hospitalization, among patients identified with a Potentially Avoidable Utilization.

Prior to enrolling in TLC-MD's Care Coordination program:

- **11** patients with a PAU
- **40** hospital readmissions

Total Relative Charges Before Care Coordination: **$740,901**

After enrolling in TLC-MD's Care Coordination program:

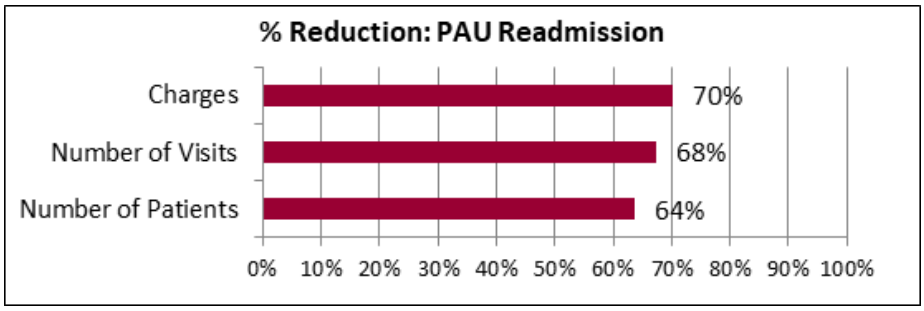
- **4** patients with a PAU
- **13** hospital readmissions

Total Relative Charges After Care Coordination: **$220,658**

Care Coordination relative impact among all readmissions:

- **70%** reduction in hospital readmission charges
- **68%** reduction in hospital readmissions
- **64%** reduction in the number of patients

Total Relative Cost Reduction: **$520,243**



Potentially Avoidable Readmission with Prevention Quality Indicators

(Calculation: PAU and PQI Admissions MINUS PAU and PQI Admissions ONLY)

PAU and PQI Readmissions calculation indicates the number of hospital admissions within 30 days of a prior hospitalization among patients identified with a Potentially Avoidable Utilization and Prevention Quality Indicator.

Prior to enrolling in TLC-MD's Care Coordination program:

- **7** patients with a PAU and PQI
- **15** hospital readmissions

Total Relative Charges Before Care Coordination: **$237,777**

After enrolling in TLC-MD's Care Coordination program:

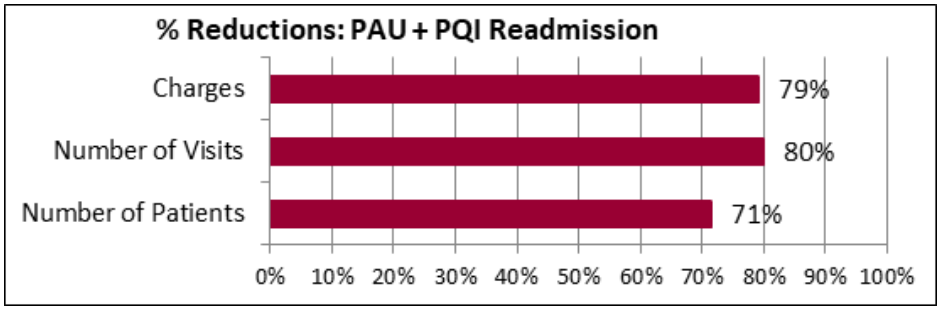
- **2** patients with a PAU and PQI
- **3** hospital readmissions

Total Relative Charges After Care Coordination: **$49,585**

Care Coordination relative impact among all readmissions:

- **79%** reduction in hospital readmission charges
- **80%** reduction in hospital readmissions
- **71%** reduction in the number of patients

Total Relative Cost Reduction: **$188,192**



TLC-MD Care Coordination Hospital Admission Impact UM-Prince George's Hospital Center Executive Summary

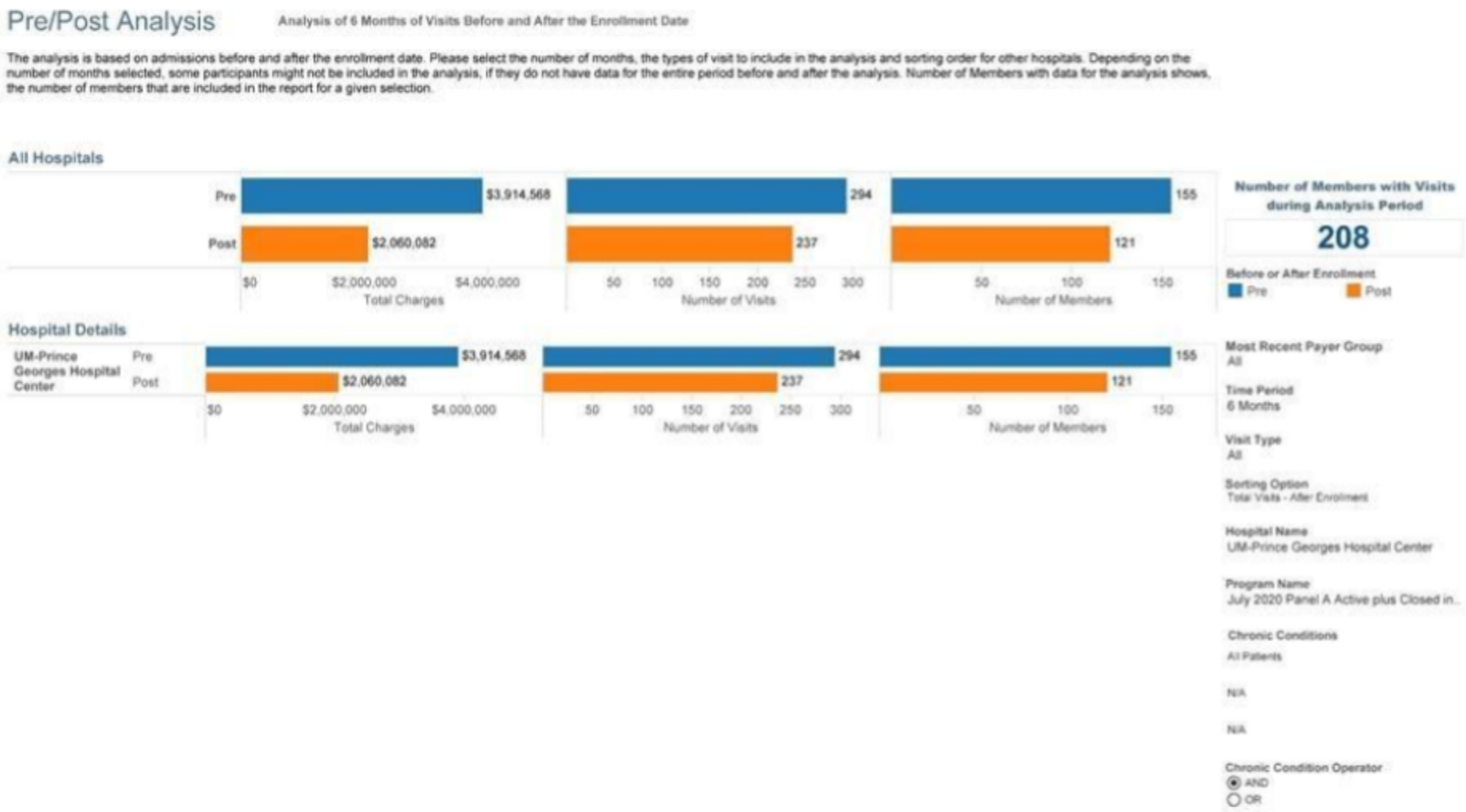
Date Range: July 1, 2019 to June 30, 2020

The data provided in this report uses CRISP data panels to compare hospital admissions, readmissions, number of patients, and hospital charges from pre to post enrollment into TLC-MD. Data analysis revealed a significant trend in lower hospital utilization and hospital charges as result of care coordination. The most compelling findings were among patients designated with a PAU and PQI showing a 75% relative reduction in hospital admission charges, a 71% relative reduction in hospital admissions, and a 69% relative reduction in the number of patients seen.

These findings underscore the importance of coordinated outpatient care. Many patients with chronic conditions lack health insurance and access to primary care, resulting in repeat hospitalizations. Enrolling patients in TLC-MD Coordinated Care program can reduce the burden on local health care systems and improve the health and wellbeing of communities served in Southern Maryland.

Pre and Post Aggregate Analysis by Hospital

For UM-Prince George's Hospital Center, 208 patients had pre and post visit data for the enrollment period.



*Dashboard generated in CRISP

Pre and Post Breakdown of Hospital Charges

This analysis shows a breakdown of hospital charges from pre to post enrollment into TLC-**MD**.

Pre/Post Analysis

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

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

Most Recent Payer Group
All

Visit Type
All

Hospital Name
UM-Prince Georges Hospital Center

Time Period
6 Months

Program Name
July 2020 Panel A Active plus Close..

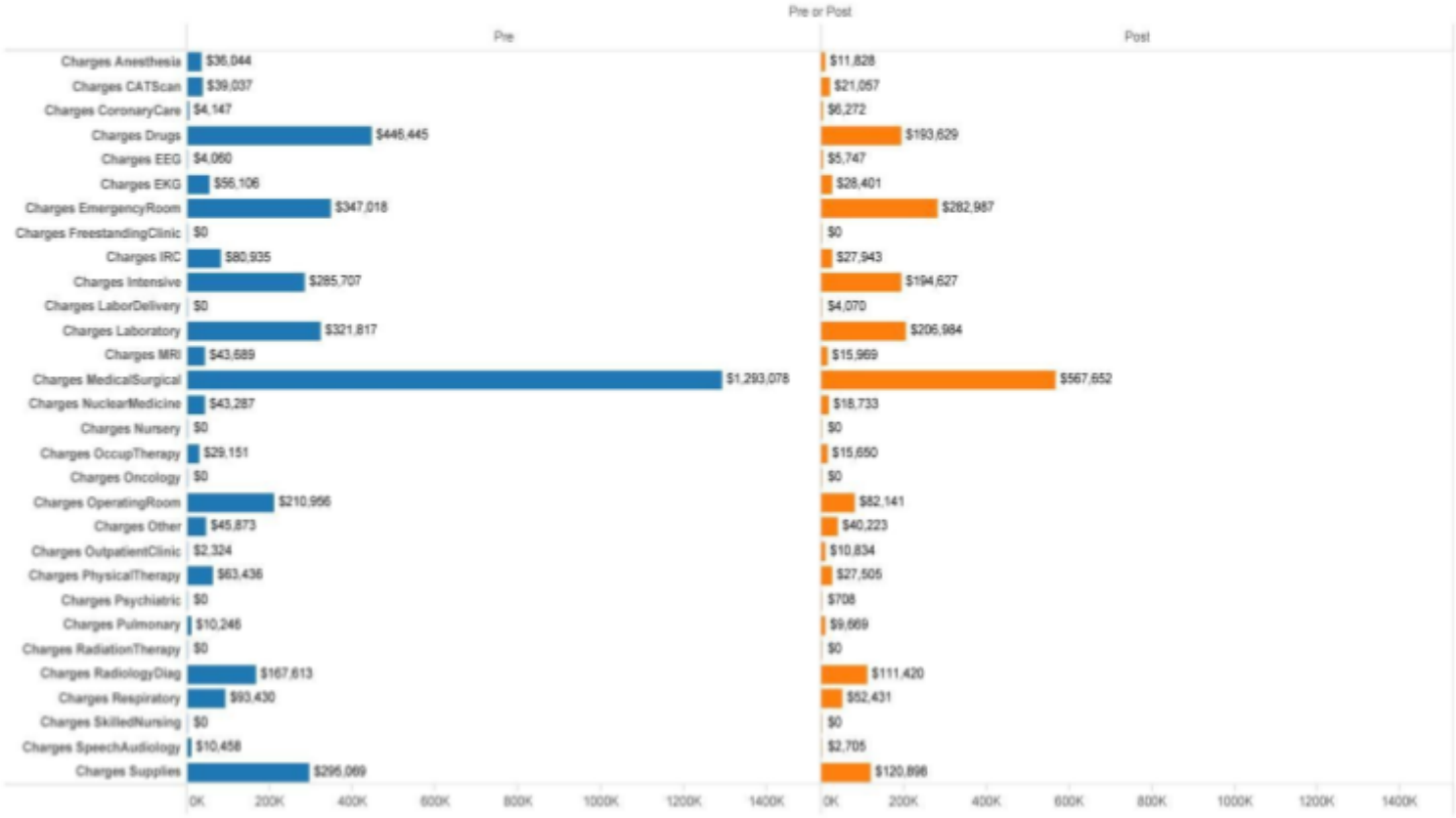
Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

Breakdown of Charges Sheet

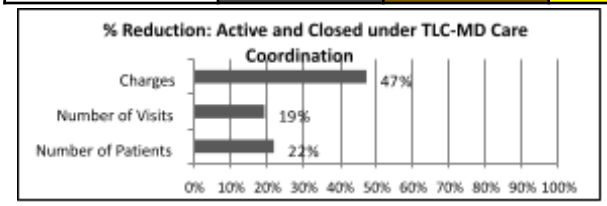


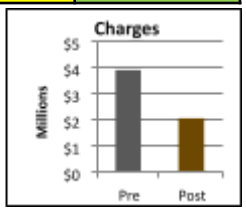
*Dashboard generated in CRISP

UM-Prince George's Hospital Center TLC-MD Care Coordination Hospital Admission Impact

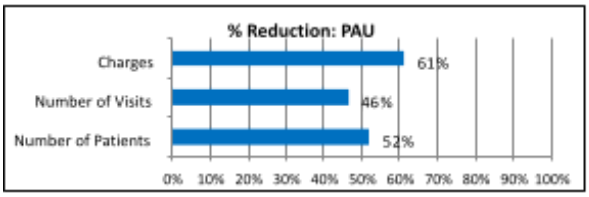
This table illustrates the impact of TLC-MD by Potentially Avoidable Utilization (PAU), Prevention Quality Indicators (PQI), and Readmissions.

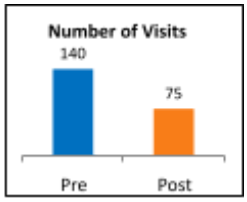
	PRE	POST	DELTA	PERCENT REDUCTION
SECTION A: AGGREGATE DATA				
Active and Closed Last 12 Months under TLC-MD Care Coordination				
Charges	$3,914,568	$2,060,082	$1,854,486	47%
Number of Visits	294	237	57	19%
Number of Patients	155	121	34	22%



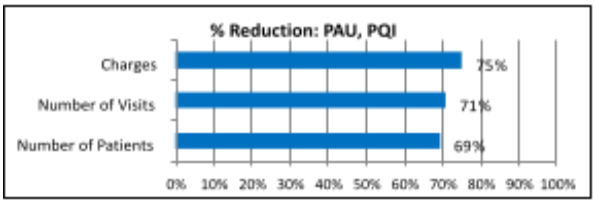


PAU	Inpt + Obs >23, PAU = 'Yes'			
Charges	$2,624,509	$1,017,851	$1,606,657	61%
Number of Visits	140	75	65	46%
Number of Patients	98	47	51	52%



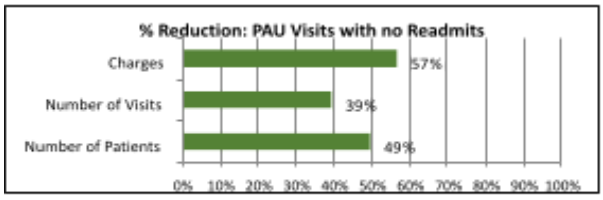


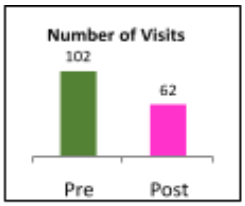
PAU, PQI	Inpt + Obs >23, PAU = 'Yes' and PQI = 'Yes'			
Charges	$1,321,782	$329,088	$992,694	75%
Number of Visits	72	21	51	71%
Number of Patients	62	19	43	69%



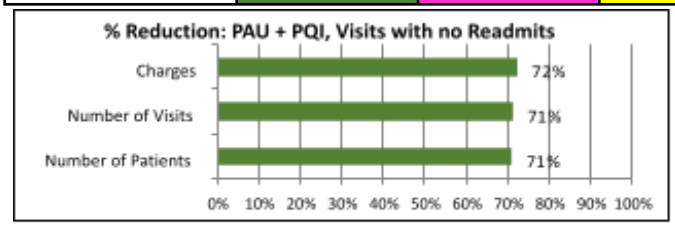
SECTION B: ADMISSIONS ONLY DATA

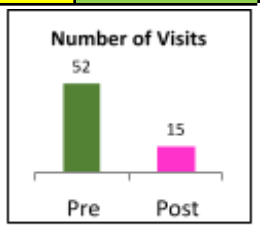
PAU Visits with no Readmits	Inpt and obs >23hr, PAU= 'Yes'			
Charges	$1,909,903	$830,643	$1,079,260	57%
Number of Visits	102	62	40	39%
Number of Patients	85	43	42	49%





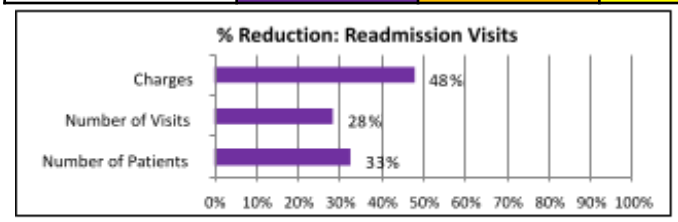
	PRE	POST	DELTA	PERCENT REDUCTION
PAU + PQI, Visits with no Readmits	Inpt and obs >23hr, PAU = 'Yes' and PQI = 'Yes'			
Charges	$932,538	$259,958	$672,580	72%
Number of Visits	52	15	37	71%
Number of Patients	48	14	34	71%

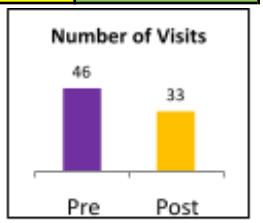




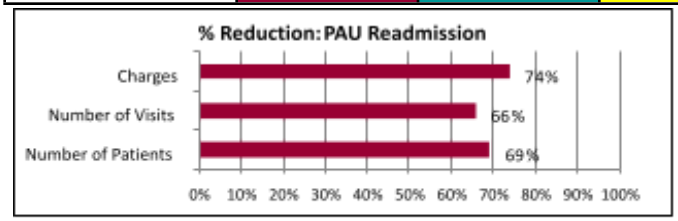
SECTION C: READMISSIONS ONLY DATA

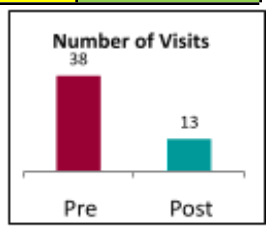
Readmission Visit	Readmit, Input + OBS > 23			
Charges	$944,991	$494,078	$450,913	48%
Number of Visits	46	33	13	28%
Number of Patients	40	27	13	33%





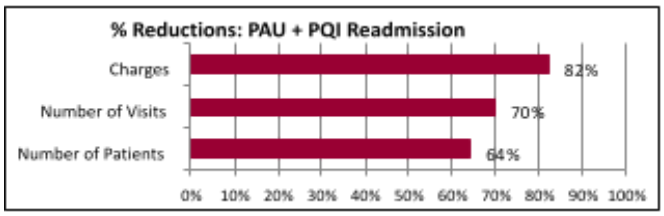
PAU Readmission	PAU Only			
Charges	$714,605	$187,208	$527,397	74%
Number of Visits	38	13	25	66%
Number of Patients	13	4	9	69%





PAU + PQI Readmission	PAU + PQI			
Charges	$389,244	$69,130	$320,113	82%

Number of Visits	20	6	14	70%
Number of Patients	14	5	9	64%



UM-Prince George's Hospital Center Explanation of Data: TLC-MD Care Coordination Hospital Admission Impact (Pre and Post)

Patient Panel: Combination of active cases under TLC-MD's Care Coordination and cases that have closed in the last 12 months.

SECTION A: Aggregate Data

Prior to enrolling in TLC-MD's Care Coordination program:

- **155** patients
- **294** hospital admissions

Total Relative Charges Before Care Coordination: **$3,914,568**

After enrolling in TLC-MD's Care Coordination program:

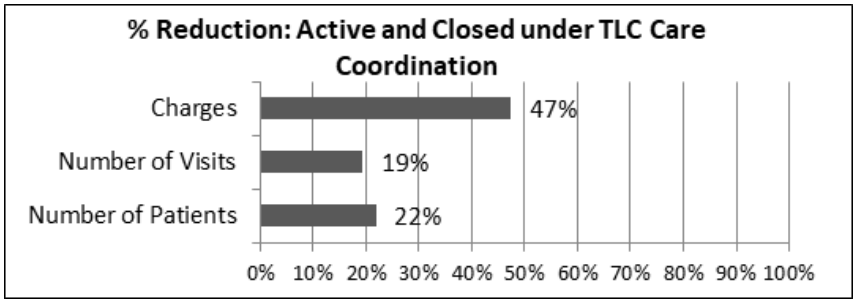
- **121** patients
- **237** hospital admissions

Total Relative Charges After Care Coordination: **$2,060,082**

Care Coordination relative impact:

- **47%** reduction in hospital admission charges
- **19%** reduction in hospital admissions
- **22%** reduction in the number of patients

Total Relative Cost Reduction: **$1,854,486**



Potentially Avoidable Admissions (PAU)

(Filters: IP and Obs>30; PAU=Yes)

This section provides a subset of the aggregate data described above.
PAU admissions includes all hospital admissions and readmissions among patients identified as potentially avoidable.

Prior to enrolling in TLC-MD's Care Coordination program:

- **98** patients with a PAU
- **140** hospital admissions

Total Relative Charges Before Care Coordination: **$2,624,509**

After enrolling in TLC-MD's Care Coordination program:

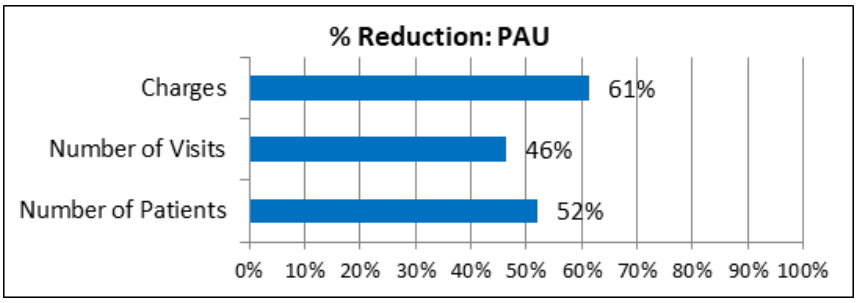
- **47** patients with a PAU
- **75** hospital admissions

Total Relative Charges After Care Coordination: **$1,017,851**

Care Coordination relative impact among patients with a PAU:

- **61%** reduction in hospital admission charges
- **46%** reduction in hospital admissions
- **52%** reduction in the number of patients

Total Relative Cost Reduction: **$1,606,657**


% Reduction: PAU
Charges
Number of Visits
Number of Patients
61%
46%
52%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

Potentially Avoidable (PAU) Admissions with a Prevention Quality Indicator (PQI)

(Filters: IP and Obs>30; PAU=Yes; PQI=Yes)

PAU and PQI admissions, includes all hospital admissions and readmissions with patients identified with a Potentially Avoidable Utilization (PAU) and Prevention Quality Indicator (PQI).

Prior to enrolling in TLC-MD's Care Coordination program:

- **62** patients with a PAU and PQI
- **72** hospital admissions

Total Relative Charges Before Care Coordination: **$1,321,782**

After enrolling in TLC-MD's Care Coordination program:

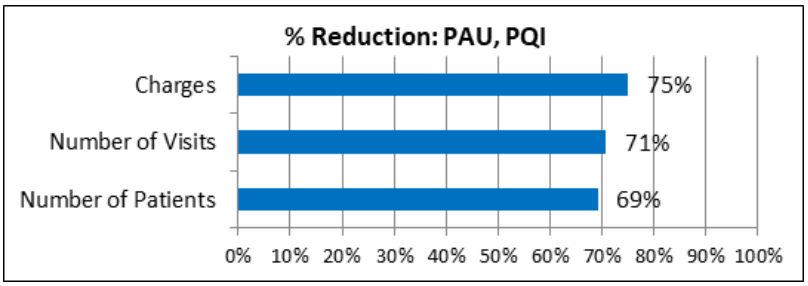
- **19** patients with a PAU and PQI
- **21** hospital admissions

Total Relative Charges After Care Coordination: **$329,088**

Care Coordination relative impact among patients with a PAU and PQI:

- **75%** reduction in hospital admission charges
- **71%** reduction in hospital admissions
- **69%** reduction in the number of patients

Total Relative Cost Reduction: **$992,694**



SECTION B: Admissions Only Data

Potentially Avoidable Admissions (PAU) ONLY with No Readmits

(Filters: IP and Obs>30; PAU= Yes; Readmission=No)

PAU Admissions ONLY, includes patients identified with a Potentially Avoidable Utilization that only had hospital admissions. No readmission visits were included.

Prior to enrolling in TLC-MD's Care Coordination program:

- **85** patients with a PAU
- **102** hospital admissions

Total Relative Charges Before Care Coordination: **$1,909,903**

After enrolling in TLC-MD's Care Coordination program:

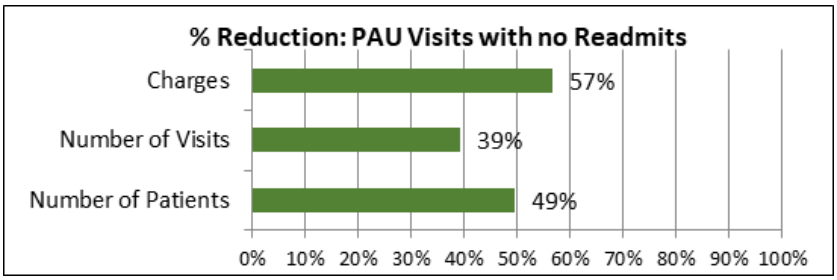
- **43** patients with a PAU
- **62** hospital admissions

Total Relative Charges After Care Coordination: **$830,643**

Care Coordination relative impact among patients with a PAU:

- **57%** reduction in hospital admission charges
- **39%** reduction in hospital admissions
- **49%** reduction in the number of patients

Total Relative Cost Reduction: **$1,079,260**



Potentially Avoidable (PAU) Admissions with a Prevention Quality Indicator (PQI) ONLY with No Readmits

(Filters: IP and Obs>30; PAU=Yes; PQI= Yes; Readmission=No)

PAU and PQI Admissions ONLY, includes patients identified with a Potentially Avoidable Utilization and Prevention Quality Indicator that only had hospital admissions. No readmission visits were included.

Prior to enrolling in TLC-MD's Care Coordination program:

- **48** patients with a PAU and PQI
- **52** hospital admissions

Total Relative Charges Before Care Coordination: **$932,538**

After enrolling in TLC-MD's Care Coordination program:

- **14** patients with a PAU and PQI
- **15** hospital admissions

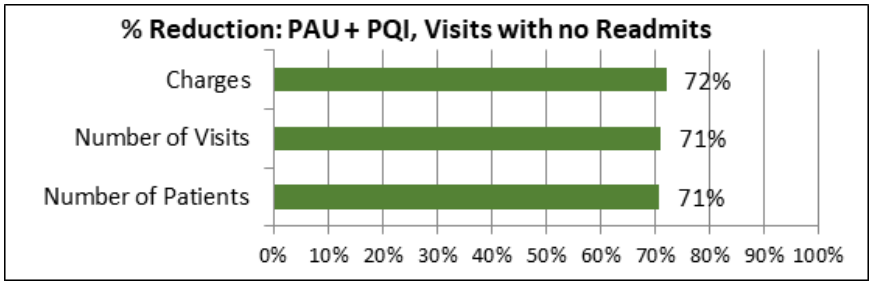
Total Relative Charges After Care Coordination: **$259,958**

Care Coordination relative impact among patients with a PAU and PQI:

- **72%** reduction in hospital admission charges

- **71%** reduction in hospital admissions
- **71%** reduction in the number of patients

Total Relative Cost Reduction: **$672,580**



SECTION C: Readmissions Only Data

Readmissions ONLY

(Note: Some readmission data entries are missing in CRISP)

Readmissions ONLY, includes the total number of hospital admissions within 30 days of a prior hospital admission.

Prior to enrolling in TLC-MD's Care Coordination program:

- **40** patients
- **46** hospital readmissions

Total Relative Charges Before Care Coordination: **$944,991**

After enrolling in TLC-MD's Care Coordination program:

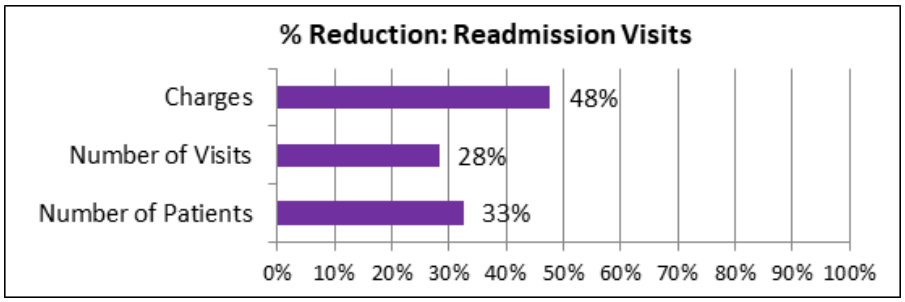
- **27** patients
- **33** hospital readmissions

Total Relative Charges After Care Coordination: **$494,078**

Care Coordination relative impact among all readmissions:

- **48%** reduction in hospital readmission charges
- **28%** reduction in hospital readmissions
- **33%** reduction in the number of patients

Total Relative Cost Reduction: **$450,913**



Potentially Avoidable Readmissions ONLY

(Calculation: PAU Admissions MINUS PAU Admissions ONLY)

PAU Readmissions ONLY calculation, indicates the number of hospital admissions within 30 days of a prior hospitalization, among patients identified with a Potentially Avoidable Utilization.

Prior to enrolling in TLC-MD's Care Coordination program:

- **13** patients with a PAU
- **38** hospital readmissions

Total Relative Charges Before Care Coordination: **$714,605**

After enrolling in TLC-MD's Care Coordination program:

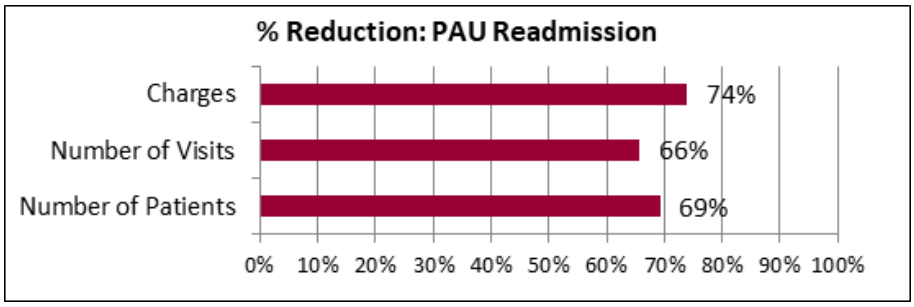
- **4** patients with a PAU
- **13** hospital readmissions

Total Relative Charges After Care Coordination: **$187,208**

Care Coordination relative impact among all readmissions:

- **74%** reduction in hospital readmission charges
- **66%** reduction in hospital readmissions
- **69%** reduction in the number of patients

Total Relative Cost Reduction: **$527,397**



Potentially Avoidable Readmission with Prevention Quality Indicators

(Calculation: PAU and PQI Admissions MINUS PAU and PQI Admissions ONLY)

PAU and PQI Readmissions calculation indicates the number of hospital admissions within 30 days of a prior hospitalization among patients identified with a Potentially Avoidable Utilization and Prevention Quality Indicator.

Prior to enrolling in TLC-MD's Care Coordination program:

- **14** patients with a PAU and PQI
- **20** hospital readmissions

Total Relative Charges Before Care Coordination: **$389,244**

After enrolling in TLC-MD's Care Coordination program:

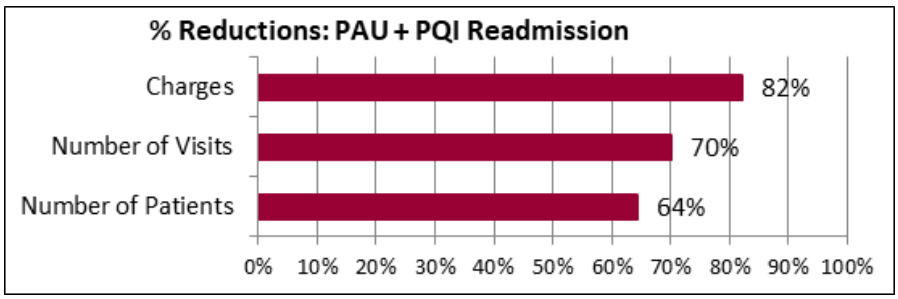
- **5** patients with a PAU and PQI
- **6** hospital readmissions

Total Relative Charges After Care Coordination: **$69,130**

Care Coordination relative impact among all readmissions:

- **82%** reduction in hospital readmission charges
- **70%** reduction in hospital readmissions
- **64%** reduction in the number of patients

Total Relative Cost Reduction: **$320,113**



TLC-MD Care Coordination Hospital Admission Impact Adventist Healthcare Fort Washington Medical Center Executive Summary

Date Range: July 1, 2019 to June 30, 2020

The data provided in this report uses CRISP data panels to compare hospital admissions, readmissions, number of patients, and hospital charges from pre to post enrollment into TLC-MD. Data analysis revealed a significant trend in lower hospital utilization and hospital charges as result of care coordination. The most compelling findings were among patients designated with a PAU and PQI showing a 71% relative reduction in hospital admission charges, a 69% relative reduction in hospital admissions, and a 76% relative reduction in the number of patients seen.

These findings underscore the importance of coordinated outpatient care. Many patients with chronic conditions lack health insurance and access to primary care, resulting in repeat hospitalizations. Enrolling patients in TLC-MD Coordinated Care program can reduce the burden on local health care systems and improve the health and wellbeing of communities served in Southern Maryland.

Pre and Post Aggregate Analysis by Hospital

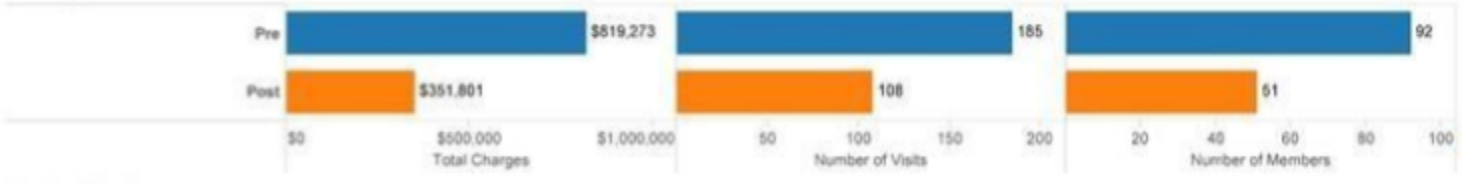
For Adventist HealthCare Fort Washington Medical Center , 110 patients had pre and post visit data for the enrollment period.

Pre/Post Analysis

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

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

All Hospitals



Hospital Details

Number of Members with Visits during Analysis Period

110

Before or After Enrollment
Pre Post

Most Recent Payer Group
All

Time Period
6 Months

Visit Type
All

Sorting Option
Total Visits - After Enrollment

Hospital Name
Adventist Healthcare Fort Washington ..

Program Name
July 2020 Panel A Active plus Closed in..

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

*Dashboard generated in CRISP

Pre and Post Breakdown of Hospital Charges

This analysis shows a breakdown of hospital charges from pre to post enrollment into TLC-MD.

Pre/Post Analysis

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

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

Most Recent Payer Group: All

Visit Type: All

Hospital Name: Adventist Healthcare Fort Washingto..

Time Period: 6 Months

Program Name: July 2020 Panel A Active plus Close..

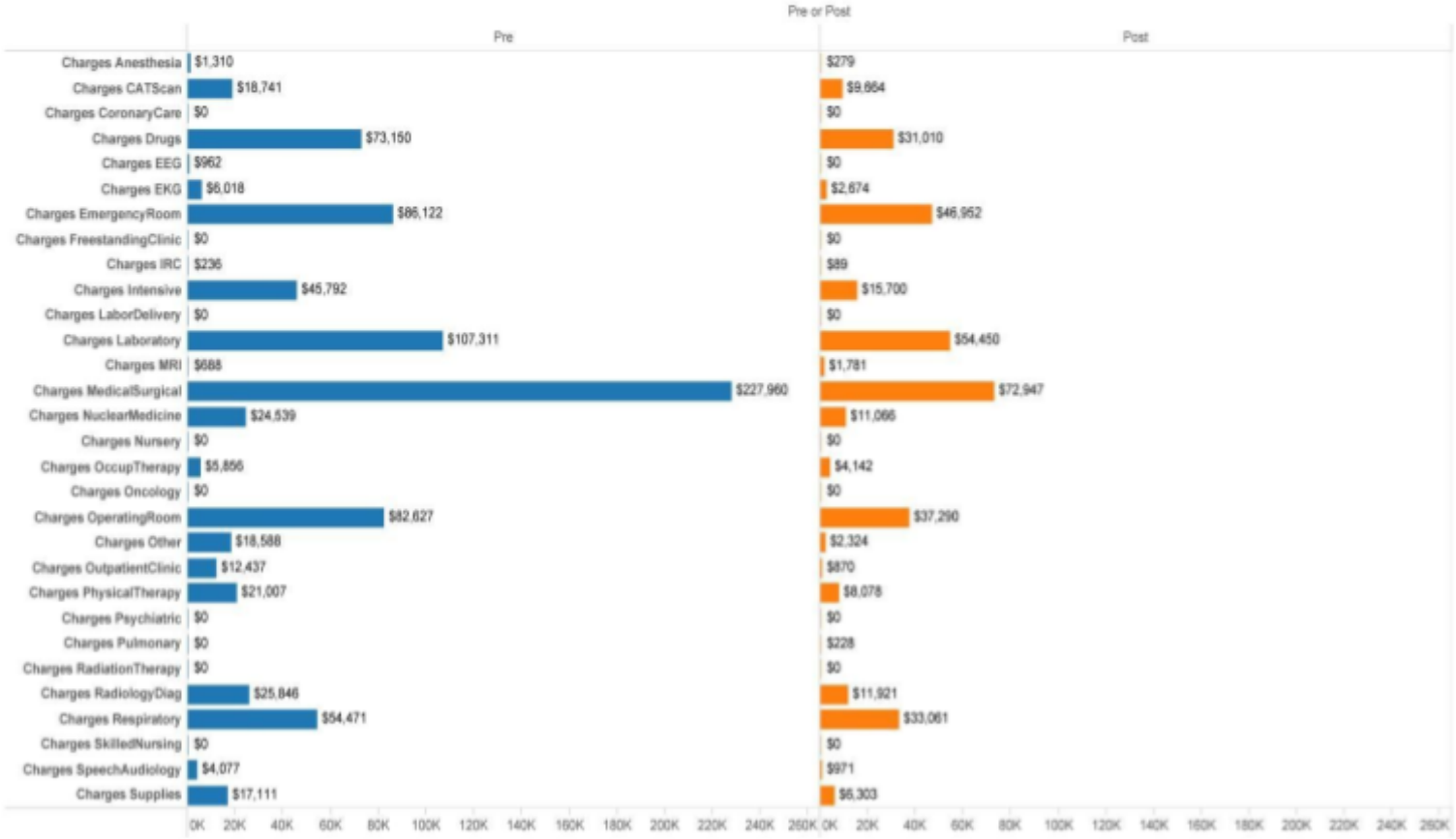
Chronic Conditions: All Patients

N/A

N/A

Chronic Condition Operator: (•) AND ( ) OR

Breakdown of Charges Sheet

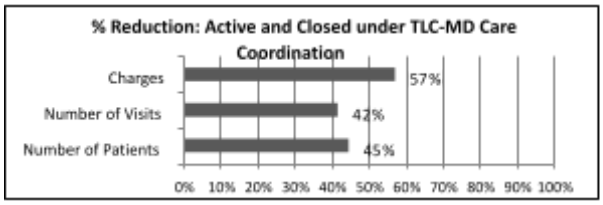


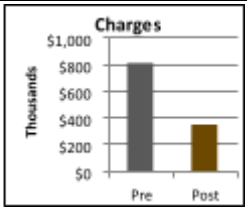
*Dashboard generated in CRISP

Adventist Healthcare Ft. Washington Medical Center TLC-MD Care Coordination
Hospital Admission Impact

This table illustrates the impact of TLC-MD Care Coordination by Potentially Avoidable Utilization (PAU), Prevention Quality Indicators (PQI), and Readmissions.

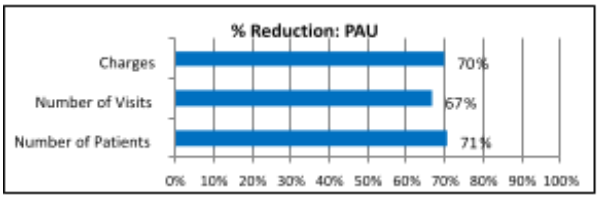
	PRE	POST	DELTA	PERCENT REDUCTION
SECTION A: AGGREGATE DATA				
Active and Closed Last 12 Months under TLC-MD Care Coordination				
Charges	$819,273	$351,801	$467,472	57%
Number of Visits	185	108	77	42%
Number of Patients	92	51	41	45%





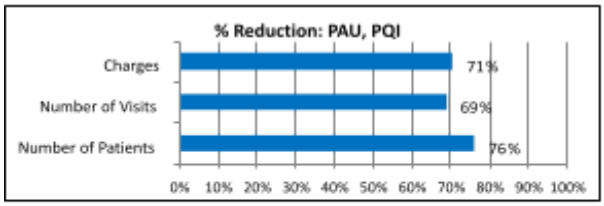
PAU Inpt + Obs >23, PAU = 'Yes'

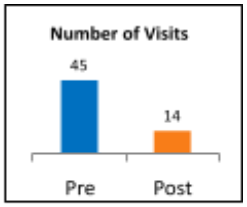
Charges	$552,434	$166,759	$385,675	70%
Number of Visits	63	21	42	67%
Number of Patients	51	15	36	71%



PAU, PQI Inpt + Obs >23, PAU = 'Yes' and PQI = 'Yes'

Charges	$370,964	$109,313	$261,652	71%
Number of Visits	45	14	31	69%
Number of Patients	42	10	32	76%

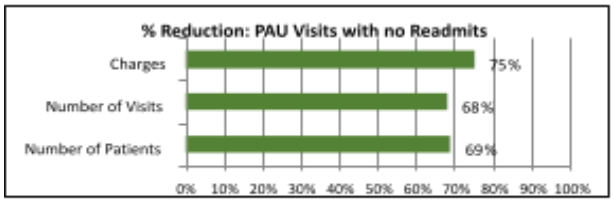


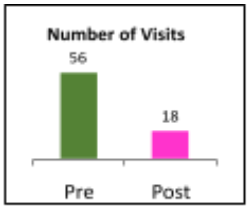


SECTION B: ADMISSIONS DATA ONLY

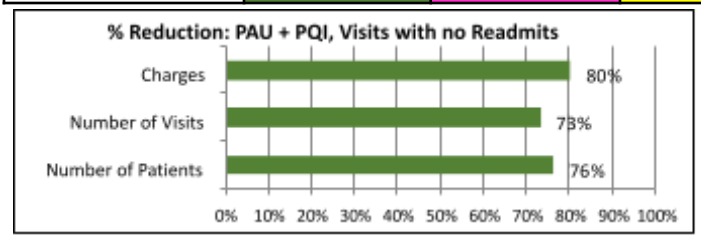
PAU Visits with no Readmits Inpt and obs >23hr, PAU= 'Yes'

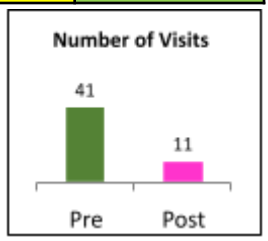
Charges	$497,932	$124,983	$372,948	75%
Number of Visits	56	18	38	68%
Number of Patients	48	15	33	69%





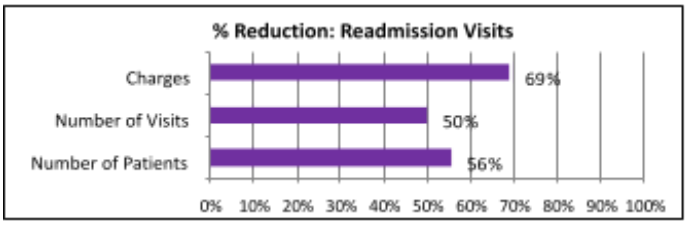
	PRE	POST	DELTA	PERCENT REDUCTION
PAU + PQI, Visits with no Readmits	Inpt and obs >23hr, PAU = 'Yes' and PQI = 'Yes'			
Charges	$341,083	$67,537	$273,546	80%
Number of Visits	41	11	30	73%
Number of Patients	38	9	29	76%

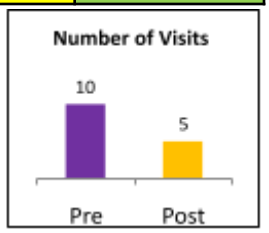




SECTION C: READMISSIONS DATA ONLY

Readmission Visit	Readmit, Input + OBS > 23			
Charges	$121,245	$37,619	$83,626	69%
Number of Visits	10	5	5	50%
Number of Patients	9	4	5	56%





Adventist Healthcare Ft. Washington Medical Center Explanation of Data: TLC-MD Care Coordination Hospital Admission Impact (Pre and Post)

Patient Panel: Combination of active cases under TLC-MD's Care Coordination and cases that have closed in the last 12 months.

SECTION A: Aggregate Data

This section includes aggregate data of number of patients, hospital admissions, and hospital charges. Data include both potentially avoidable and unavoidable visits.

Prior to enrolling in TLC-MD's Care Coordination program:

- **92** patients
- **185** hospital admissions

Total Relative Charges Before Care Coordination: **$819,273**

After enrolling in TLC-MD's Care Coordination program:

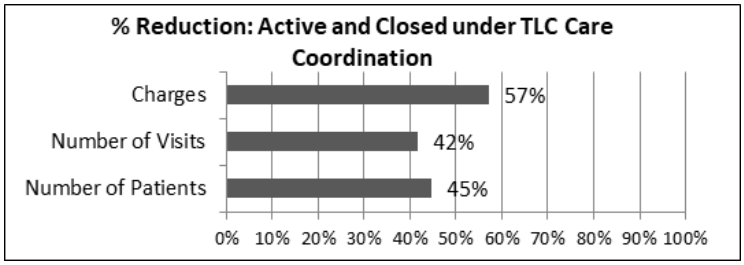
- **51** patients
- **108** hospital admissions

Total Relative Charges After Care Coordination: **$351,801**

Care Coordination relative impact:

- **57%** reduction in hospital admission charges
- **42%** reduction in hospital admissions
- **45%** reduction in the number of patients

Total Relative Cost Reduction: **$467,472**



Potentially Avoidable Admissions (PAU)

(Filters: IP and Obs>30; PAU=Yes)

This section provides a subset of the aggregate data described above.
PAU admissions includes all hospital admissions and readmissions among patients identified as potentially avoidable.

Prior to enrolling in TLC-MD's Care Coordination program:

- **51** patients with a PAU
- **63** hospital admissions

Total Relative Charges Before Care Coordination: **$552,434**

After enrolling in TLC-MD's Care Coordination program:

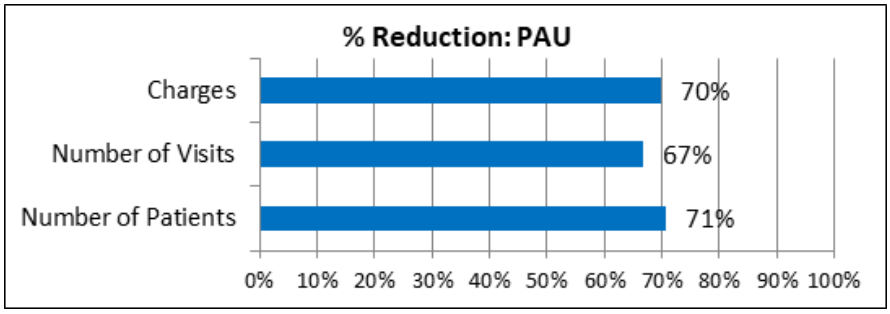
- **15** patients with a PAU
- **21** hospital admissions

Total Relative Charges After Care Coordination: **$166,759**

Care Coordination relative impact among patients with a PAU:

- **70%** reduction in hospital admission charges
- **67%** reduction in hospital admissions
- **71%** reduction in the number of patients

Total Relative Cost Reduction: **$385,675**



Potentially Avoidable (PAU) Admissions with a Prevention Quality Indicator (PQI)

(Filters: IP and Obs>30; PAU=Yes; PQI=Yes)

PAU and PQI admissions, includes all hospital admissions and readmissions with patients identified with a Potentially Avoidable Utilization (PAU) and Prevention Quality Indicator (PQI).

Prior to enrolling in TLC-MD's Care Coordination program:

- **42** patients with a PAU and PQI
- **45** hospital admissions

Total Relative Charges Before Care Coordination: **$370,964**

After enrolling in TLC-MD's Care Coordination program:

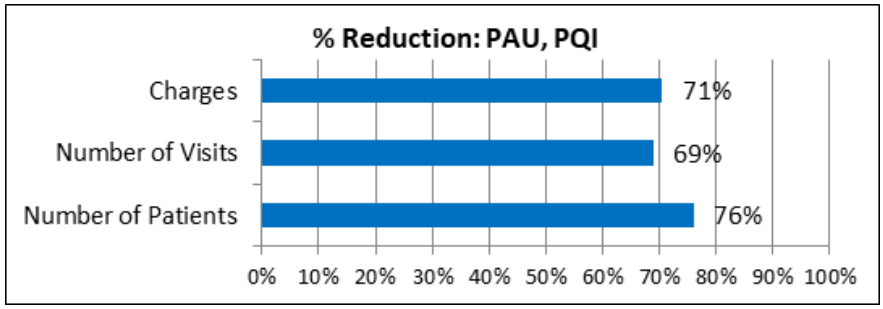
- **10** patients with a PAU and PQI
- **14** hospital admissions

Total Relative Charges After Care Coordination: **$109,313**

Care Coordination relative impact among patients with a PAU and PQI:

- **71%** reduction in hospital admission charges
- **69%** reduction in hospital admissions
- **76%** reduction in the number of patients

Total Relative Cost Reduction: **$261,652**



SECTION B: Admissions Only Data

Potentially Avoidable Admissions (PAU) ONLY with No Readmits

(Filters: IP and Obs>30; PAU= Yes; Readmission=No)

PAU Admissions ONLY, includes patients identified with a Potentially Avoidable Utilization that only had hospital admissions. No readmission visits were included.

Prior to enrolling in TLC-MD's Care Coordination program:
- **48** patients with a PAU
- **56** hospital admissions

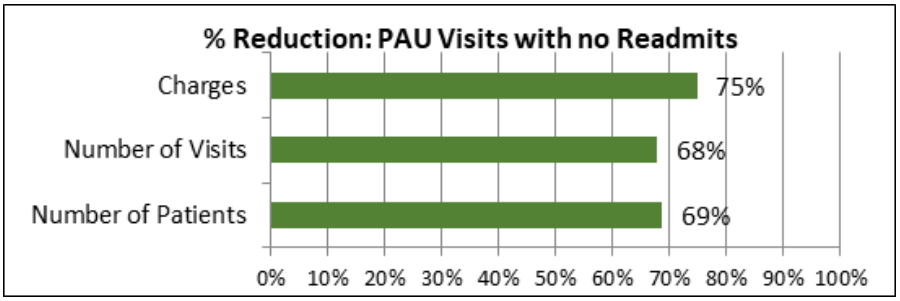
Total Relative Charges Before Care Coordination: **$497,932**

After enrolling in TLC-MD's Care Coordination program:
- **15** patients with a PAU
- **18** hospital admissions

Total Relative Charges After Care Coordination: **$124,983**

Care Coordination relative impact among patients with a PAU:
- **75%** reduction in hospital admission charges
- **68%** reduction in hospital admissions
- **69%** reduction in the number of patients

Total Relative Cost Reduction: **$372,948**



Potentially Avoidable (PAU) Admissions with a Prevention Quality Indicator (PQI) ONLY with No Readmits

(Filters: IP and Obs>30; PAU=Yes; PQI= Yes; Readmission=No)

PAU and PQI Admissions ONLY, includes patients identified with a Potentially Avoidable Utilization and Prevention Quality Indicator that only had hospital admissions. No readmission visits were included.

Prior to enrolling in TLC-MD's Care Coordination program:

- **38** patients with a PAU and PQI
- **41** hospital admissions

Total Relative Charges Before Care Coordination: **$341,083**

After enrolling in TLC-MD's Care Coordination program:

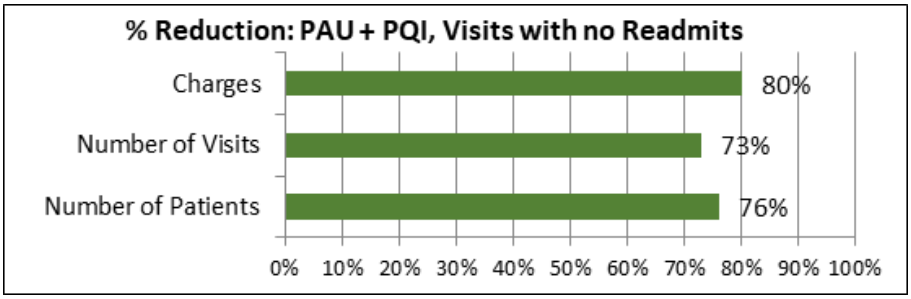
- **9** patients with a PAU and PQI
- **11** hospital admissions

Total Relative Charges After Care Coordination: **$67,537**

Care Coordination relative impact among patients with a PAU and PQI:

- **80%** reduction in hospital admission charges
- **73%** reduction in hospital admissions
- **76%** reduction in the number of patients

Total Relative Cost Reduction: **$273,546**



SECTION C: Readmissions Only Data

Readmissions ONLY

(Note: Some readmission data entries are missing in CRISP)

Readmissions ONLY, includes the total number of hospital admissions within 30 days of a prior hospital admission.

Prior to enrolling in TLC-MD's Care Coordination program:

- **9** patients
- **10** hospital readmissions

Total Relative Charges Before Care Coordination **$121,245**

After enrolling in TLC-MD's Care Coordination program:

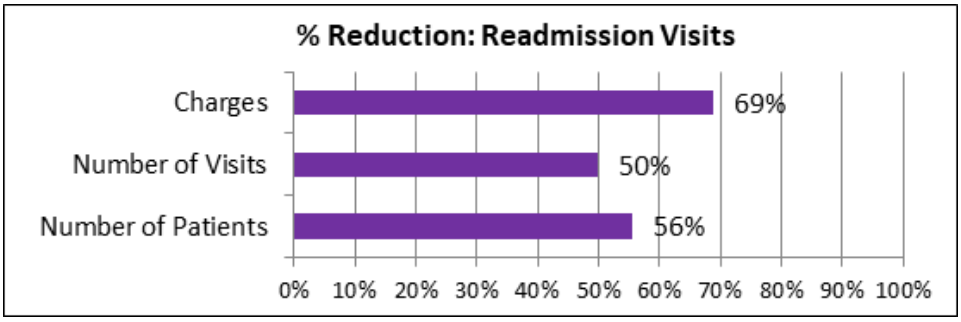
- **4** patients
- **5** hospital readmissions

Total Relative Charges After Care Coordination **$37,619**

Care Coordination relative impact among all readmissions:

- **69%** reduction in hospital readmission charges
- **50%** reduction in hospital readmissions
- **56%** reduction in the number of patients

Total Relative Cost Reduction: **$83,626**


% Reduction: Readmission Visits
Charges
Number of Visits
Number of Patients
69%
50%
56%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

TLC-MD Care Coordination Hospital Admission Impact UM-Laurel Medical Center Executive Summary

Date Range: July 1, 2019 to June 30, 2020

The data provided in this report uses CRISP data panels to compare hospital admissions, readmissions, number of patients, and hospital charges from pre to post enrollment into TLC-MD. Data analysis revealed a significant trend in lower hospital utilization and hospital charges as result of care coordination. The most compelling findings showed a 55% relative reduction in hospital admission charges among patients designated with a PAU.

These findings underscore the importance of coordinated outpatient care. Many patients with chronic conditions lack health insurance and access to primary care, resulting in repeat hospitalizations. Enrolling patients in TLC-MD Coordinated Care program can reduce the burden on local health care systems and improve the health and wellbeing of communities served in Southern Maryland.

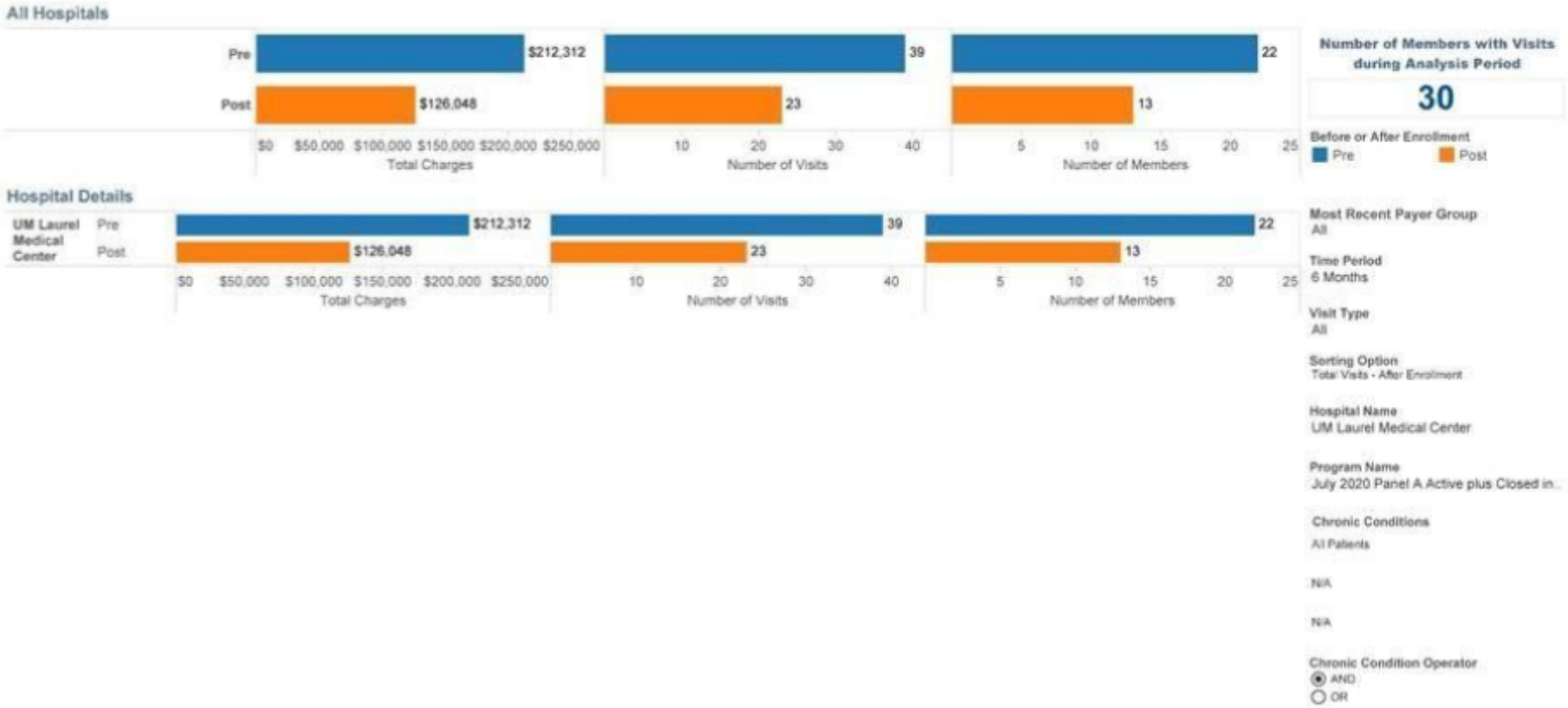
Pre and Post Aggregate Analysis by Hospital

For UM – Laurel, 30 patients had pre and post visit data for the enrollment period.

Pre/Post Analysis

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

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



*Dashboard generated in CRISP

Pre and Post Breakdown of Hospital Charges

This analysis shows a breakdown of hospital charges before (Pre) and after (Post) TLC-MD's Care Coordination enrollment period.

Pre/Post Analysis

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

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

Most Recent Payer Group
All

Visit Type
All

Hospital Name
UM Laurel Medical Center

Time Period
6 Months

Program Name
July 2020 Panel A Active plus Close..

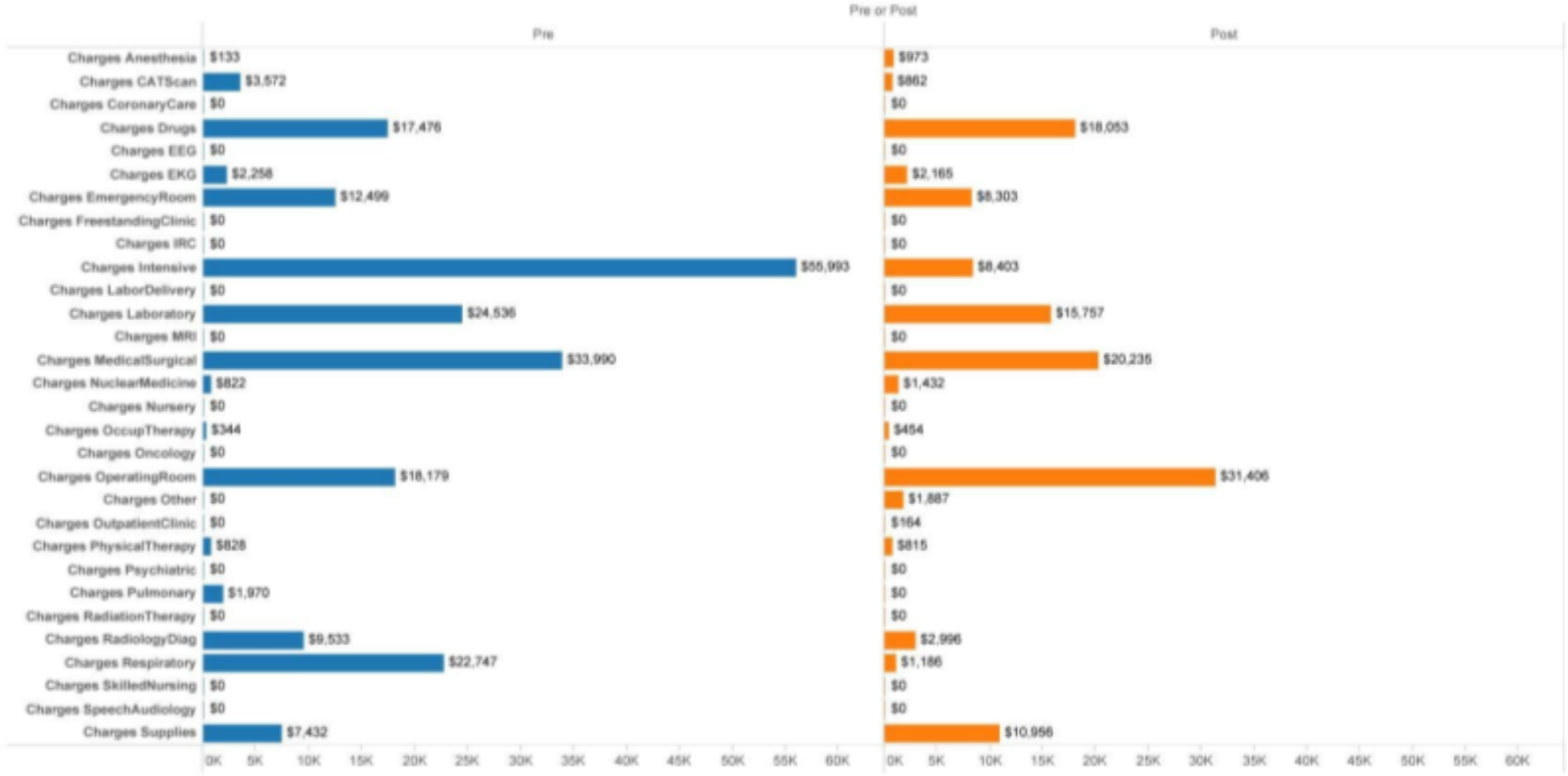
Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

Breakdown of Charges Sheet



*Dashboard generated in CRISP

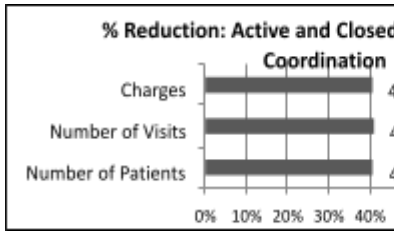
UM-Laurel Medical Center TLC-MD Care Coordination Hospital Admission Impact

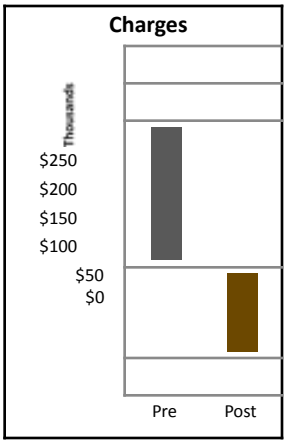
This table illustrates the impact of TLC-MD Care Coordination by Potentially Avoidable Utilization (PAU), Prevention Quality Indicators (PQI), and Readmissions.

SECTION A: AGGREGATE DATA

Active and Closed Last 12 Months under TLC-MD Care Coordination

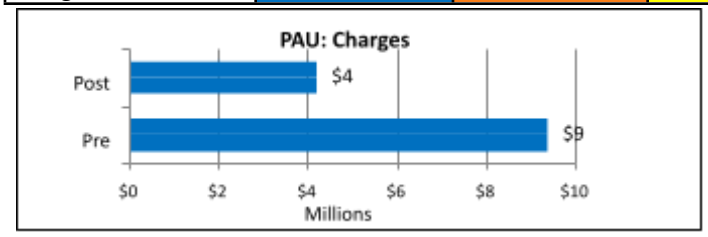
	PRE	POST	DELTA	PERCENT REDUCTION
Charges	$212,312	$126,048	$86,264	41%
Number of Visits	39	23	16	41%
Number of Patients	22	13	9	41%

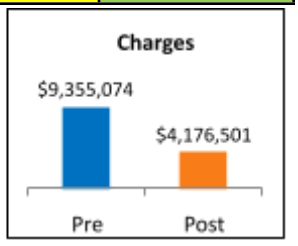




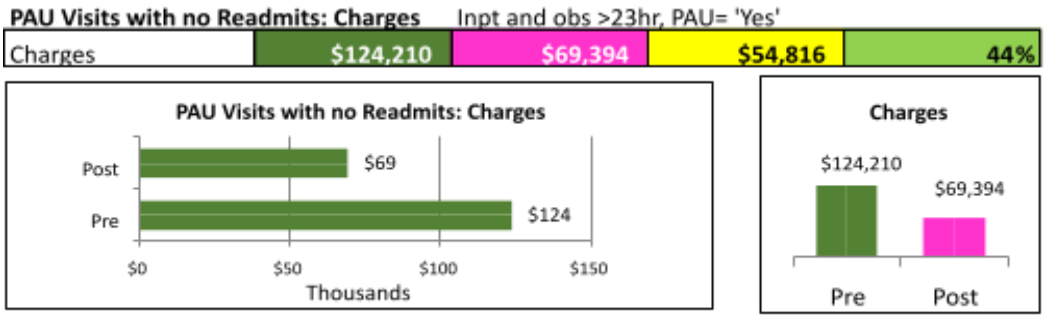
PAU: Charges Inpt + Obs >23, PAU = 'Yes'

Charges	$9,355,074	$4,176,501	$5,178,573	55%





SECTION B: ADMISSIONS DATA ONLY



UM-Laurel Medical Center Explanation of Data: TLC-MD Care Coordination Hospital Admission Impact (Pre and Post)

Patient Panel: Combination of active cases under TLC-MD's care coordination and cases that have closed in the last 12 months.

SECTION A: Aggregate Data

This section includes aggregate data on the number of patients, hospital admissions, and hospital charges. Data include both potentially avoidable and unavoidable visits.

Prior to enrolling in TLC-MD's Care Coordination program:

- **22** patients
- **39** hospital admissions

Total Relative Charges Before Care Coordination: **$212,312**

After enrolling in TLC-MD's Care Coordination program:

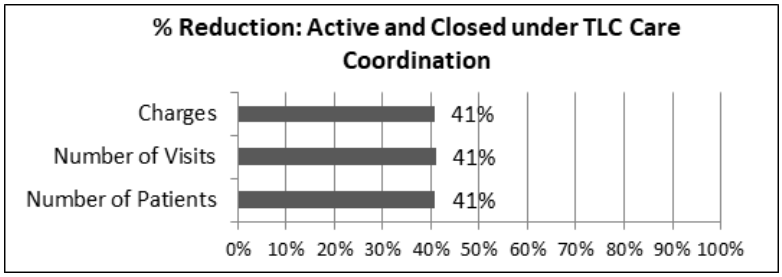
- **13** patients
- **23** hospital admissions

Total Relative Charges After Care Coordination: **$126,048**

Care Coordination relative impact:

- **41%** reduction in hospital admission charges
- **41%** reduction in hospital admissions
- **41%** reduction in the number of patients

Total Relative Cost Reduction: **$86,264**



Potentially Avoidable Admissions (PAU)

(Filters: IP and Obs>30; PAU=Yes)

This section provides a subset of the aggregate data described above.
PAU admissions includes all hospital admissions and readmissions among patients identified as potentially avoidable.

Prior to enrolling in TLC-MD's Care Coordination program:

Total Relative Charges Before Care Coordination: **$9,355,074**

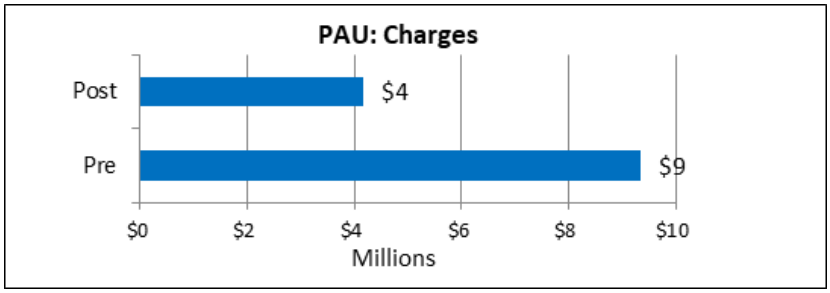
After enrolling in TLC-MD's Care Coordination program:

Total Relative Charges After Care Coordination: **$4,176,501**

Care Coordination relative impact among patients with a PAU:

- **55%** reduction in hospital admission charges

Total Relative Cost Reduction: **$5,178,573**



SECTION B: Admissions Only Data

Potentially Avoidable Admissions (PAU) ONLY with No Readmits

(Filters: IP and Obs>30; PAU= Yes; Readmission=No)

PAU Admissions ONLY, includes patients identified with a Potentially Avoidable Utilization that only had hospital admissions. No readmission visits were included.

Prior to enrolling in TLC-MD's Care Coordination program:

Total Relative Charges Before Care Coordination: **$124,210**

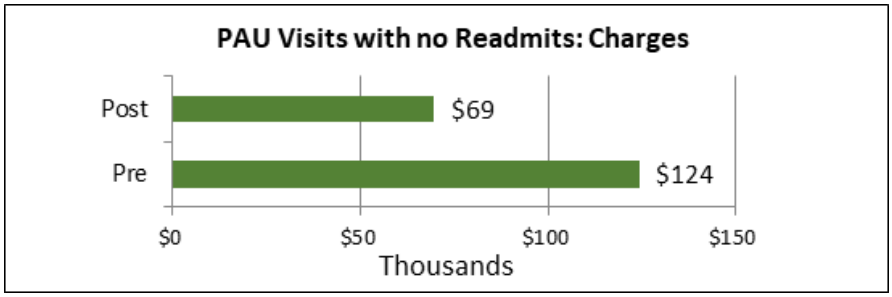
After enrolling in TLC-MD's Care Coordination program:

Total Relative Charges After Care Coordination: **$69,394**

Care Coordination relative impact among patients with a PAU:

- **44%** reduction in hospital admission charges

Total Relative Cost Reduction: **$54,816**



Background and Definitions

Totally Linking Care in Maryland (TLC-MD)

Totally Linking Care in Maryland (TLC-MD), a coalition of hospitals in counties across Southern Maryland in partnership with the state of Maryland, have joined forces. Instead of continuing to treat patients only when they suffer acute episodes and require a hospital admission, TLC-MD offers a comprehensive solution, including in-home and community-based services to ensure patients are supported post hospital discharge. This includes Care/Case Managers, Community Health Care Workers, pharmacist led Medication Management, Faith-based support, and more — that can help patients follow their long-term treatment plans, get their medication and stick to the recommended dosage schedule. With grants from the State of Maryland, the CDC, and other generous donors, TLC-MD is able to provide these services free of charge to medically eligible patients.

Source: https://www.TLC-MD.org/

Potentially Avoidable Utilization Savings Policy

The Maryland Health Services Cost Review Commission (HSCRC or Commission) operates a potentially avoidable utilization (PAU) savings policy as part of its portfolio of value-based payment policies. PAU is defined as hospital care that is unplanned and may be prevented through improved care, care coordination, or effective community-based care.

While hospitals have achieved significant progress in transforming the delivery system to date, there needs to be a continued emphasis on care coordination, improving quality of care, and providing care management for complex and high-needs patients. To this end, the current PAU Savings Policy includes readmissions and hospital admissions for ambulatory-care sensitive conditions in the PAU definition. Ambulatory care sensitive conditions are conditions for which good outpatient care could potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease, such as diabetes complications or community-acquired pneumonia. These admissions are measured using the Agency for Health Care Research and Quality's Prevention Quality Indicators (PQIs) measurement approach

Source: https://hscrc.maryland.gov/Pages/PAU-Savings.aspx

AHRQ Prevention Quality Indicators (PQIs)

The Prevention Quality Indicators (PQIs) are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.

(Examples: Diabetes long-term complications, bacterial pneumonia, heart failure, hypertension)

The PQIs can be used as a "screening tool" to help flag potential health care quality problem areas that need further investigation; provide a quick check on primary care access or outpatient services in a community by using patient data found in a typical hospital discharge abstract; and, help public health agencies, State data organizations, health care systems, and others interested in improving health care quality in their communities.

With high-quality, community-based primary care, hospitalization for these illnesses often can be avoided. Although other factors outside the direct control of the health care system, such as poor environmental conditions or lack of patient adherence to treatment recommendations, can result in hospitalization, the PQIs provide a good starting point for assessing quality of health services in the community. Because the PQIs are calculated using readily available hospital administrative data, they are an easy-to-use and inexpensive screening tool. They can be used to provide a window into the community — to identify unmet community health care needs, to monitor how well complications from a number of common conditions are being avoided in the outpatient setting, and to compare performance of local health care systems across communities.

Source: https://www.qualityindicators.ahrq.gov/modules/pqi_overview.aspx

PQI Technical Specifications:
PQI 01 Diabetes Short-term Complications Admission Rate
PQI 03 Diabetes Long-term Complications Admission Rate
PQI 05 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate
PQI 07 Hypertension Admission Rate
PQI 08 Heart Failure Admission Rate
PQI 11 Community Acquired Pneumonia Admission Rate
PQI 12 Urinary Tract Infection Admission Rate
PQI 14 Uncontrolled Diabetes Admission Rate
PQI 15 Asthma in Younger Adults Admission Rate
PQI 16 Lower-Extremity Amputation among Patients with Diabetes Rate

Source: https://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec_ICD10_v2019.aspx)

Readmissions Reduction Incentive Program (RRIP)

The Maryland Readmissions Reduction Incentive Program (RRIP) incentivizes hospitals to reduce avoidable readmissions by linking rewards and penalties to improvements in readmissions rates, and to attainment of relatively low readmission rates. Readmissions occur when a patient is discharged from a hospital and is admitted to any hospital within 30 days of the discharge. Source: https://hscrc.maryland.gov/Pages/init-readm-rip.aspx)

CRISP Data Reporting Guide

General Information

1. Individual patients identified using CRISP EID. The total number of members in the panel is the total number of patients on the panel that were matched to a CRISP EID and not necessarily the number unique patients on the panel. This can happen if invalid MRNs are provided.
2. Opt outs and 42-CFR patients are excluded from the visit level report.
3. 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.
4. If the admit date is on or before the program enrollment date, the visit will be considered part of the pre period. If the admit date is after the program enrollment date then the visit will be considered part of the post period.
5. Please note data for this report follows a one-group pre-post design with no control group. The limitation of this design is the inability to control for outside events and not being able to compare results for a similar population with no program exposure.
6. Patient mortality is not factored into analysis.

Data Sources

1. Inpatient and Outpatient Case Mix data from the Health Services Cost Review Commission (HSCRC)
2. NS panel information for programs uploaded using ENS MRNs

Source: https://crisphealth.org/