HSCRC Transformation Grant Budget FY2020 Report

Prepared by:

University of Maryland St. Joseph Medical Center

Due September 30th , 2020

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	*UM SJMG Transitional Care- Behavioral Health Center*
RP Hospital(s)	UM St. Joseph Medical Center
RP Point of Contact	Alice Siawlin Chan, Dir. Of Population Health
RP Interventions in FY 2020	*Pharmacological Management; Individual psychotherapy, Group therapy, Cognitive Behavioral Therapy, Dialectical Behavior therapy, Substance abuse therapy, and family support interventions*
Total Budget in FY 2020 *This should equate to total FY 2017 award*	FY 2020 Award: $825,840
Total FTEs in FY 2020	Employed: 12 FTE
	Contracted: - 2.1 for private psychiatry group - Various rolling employees with Maxim CBCM
Program Partners in FY 2020 *Please list any community-based organizations or provider groups, contractors, and/or public partners*	*Maxim CBCM, SJMG Primary Care Providers, VNA Home Health and The Center for Eating Disorders, Baltimore County Department of Health, Department of Aging, CRISP, Transformation Grant Regional Partnership Collaborative*

Overall Summary of Regional Partnership Activities in FY 2020

(Freeform Narrative Response: 1-3 Paragraphs):

Addressing and managing the behavioral health population has many unique challenges. In the initial two years of this program, we have made necessary refinements and improvements to the structure of

the program to better meet the needs of our patients and referrers with an enhanced handoff process. We learned that as a bridge clinic providing individual and group treatment for patients as well as case management services, it is much easier to facilitate a handoff to a community therapist accepting Medicare / Medicaid, however we are challenged to find an adequate number of community psychiatrists accepting new Medicare patients and this poses issues for throughput. In FY19, we reorganized our model to include 2 full time LCSWC psychotherapists, a psychiatrist and a psychiatric nurse practitioner to facilitate greater hours and access to care for our patients. In FY20, we faced the challenge of staffing turnover which created a minor gap in continual ramp up. We also mutually ended our relationship with Maxim CBCM on December 31st, 2019 with a smooth transition to build our own community health worker program internally at UM SJMC. The intent is to provide a comprehensive care coordination and documentation using a standard EMR with CRISP to provide quality care.

In terms of referrals, we continue to have strong partnerships with primary care providers, community health workers (CHWs) and VNA home health. PCPs in our community historically have managed mental health patients without adequate support, and now view the TCC-BHC as a resource to help in the management of complex cases. With the formation of MDPCP in 2019, many of our primary care providers in our Medical Group have utilized this resource to refer high risk patients for mental health evaluation and treatment.

We also work with our community partners who see patients in their home setting, identifying critical mental health needs for their clients. They are utilizing the TCC-BHC as a resource for comprehensive behavioral management. Most importantly, our main referral source is our inpatient psych unit which often allows earlier discharge by providing a supportive bridge clinic setting for them to continue the process of recovery with ongoing evaluation while transitioning back to the community. We recognize the severity substance abuse and opiate overdose in our community, and we are working diligently with the Baltimore County Department of Health and governmental agencies on a multitude of programs to curb this deadly epidemic.

In terms of patient management, we have found it useful to analyze differences in pre- and post- BHC health care utilization and follow outcomes to 12 months. In our Transitional Care Center, we address two population (somatic medicine and. behavioral health) in differing paradigms. In TCC-Medicine, we have been able to demonstrate that patients who received care at our center have a better outcome (reduced hospital utilization) than patients who returned directly to the community without TCC support following hospital discharge. Patients utilizing TCC-Medicine show improved outcomes over the 12 months period On average, patients visit TCC-Medicine an average of 2.5 times before transfer to a community provider. For TCC-Behavioral Health, patients *are managed for 90 days before discharge to a community provider. Although we do not have a comparison of this population to patients who were seen by their own providers, it is interesting to see an improved pre-post- utilization during the 90 days, with no huge difference at 12 months in comparison to the No Show population. In 2019, we have decided to roll up TCC-Med and BHC staffing since there is a high referral crossover between the two departments, and added a primary care provider (and additional PCP staffing) to augment community hand off support. You will see in the budget spreadsheet that this addition causes an increased in expense to the budgeted column.*

Intervention Program

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

Intervention or Program Name	*UM SJMG Transitional Care – Behavioral Health Center*
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	UM SJMC
Brief description of the Intervention *2-3 sentences*	- *At the Behavioral Health Center, the psychiatrist and psychiatric nurse practitioner perform a full diagnostic workup on each patient. A transitional treatment plan is developed with an emphasis on intensive relapse prevention and reintegration to community, with comprehensive case management. Each patient is assigned to a licensed clinical social worker who conducts individual psychotherapy, and patients are assigned to selected group therapies including cognitive behavioral therapy, dialectical behavior therapy, substance abuse therapies if indicated, and family counselling. Patients are seen for pharmacological visits by the psychiatrist or psychiatric nurse practitioner. The goal is to provide a high intensity treatment for up to 90 days which will prevent the need for re-hospitalization or repeating emergency room visits.*
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	- *UM SJMC, UM SJMG, Maxim CBCM, SJMG Primary Care Providers, VNA Home Health and The Center for Eating Disorders, Baltimore County Department of Health*
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*	# of Patients Served as of June 30, 2020: 316
	Denominator of Eligible Patients: 2+ IP or Obs>=24 or ED Visits Eligible for Readmit: 34,505

not entirely represent this intervention's targeted population. *Feel free to **also** include your partnership's denominator.*	Total patients referred from stakeholders: 422
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	See Appendix A
Intervention-Specific Outcome or Process Measures (optional) *These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership maintains and uses to analyze performance.* *Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.*	In CY19, the CAHPS score for the Transitional Care Center as a whole was 83.3%, at a national benchmark of 80th percentile.
Successes of the Intervention in FY 2020 *Freeform Narrative Response, up to 1 Paragraph*	The challenges of COVID in FY20 has required complex planning and use of telemedicine to provide optimal patient care to this population. Specifically for mental health, our ability to implement rapid telehealth consultation has allowed continuing quality care to this population. In addition, in a recent interview with patients in our Patient Family Advisory Council (PFAC), we found that our patients were very receptive and satisfied receiving their care via a telehealth format and may continue to be an important platform for ongoing care delivery to this population. In light of the current need for social distancing, a majority of the BHC services are rendered through the telehealth platform. Patients who are unable to participate using the technology can be seen with social distancing via an in-person visit. Our referral volume is now back to pre-COVID levels, and continues to grow.
Additional Freeform Narrative Response (Optional)	

Core Measures

Please fill in this information with the latest available data from the in the CRS Portal Tools for Regional Partnerships. For each measure, specific data sources are suggested for your use– the Executive Dashboard for Regional Partnerships, or the CY 2019 RP Analytic File (please specify which source you are using for each of the outcome measures).

Utilization Measures

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)	Using the Executive Dashboard, Hospital Charges per Capita for CY19=$332
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)	Using the Executive Dashboard, Hospital Discharges / 1000 for FY20 = 8
ED Visits per capita	**Ambulatory ED Visits per 1,000** Executive Dashboard: 'Regional Partnership per Capita Utilization' –	Using the Executive Dashboard, Outpatient ED Visits / 1000 for average 12 months of FY20 = 28

	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)	Using the Executive Dashboard, Unadjusted RA rate by Hospital for average 12 months of FY20=11.7%
PAU	**Potentially Avoidable Utilization** Executive Dashboard: '[Partnership] Quality Indicators' – Potentially Avoidable Utilization, reported as **sum** of 12 months of FY 2020 -or- Analytic File: 'TotalPAUCharges' (Column K)	Using the Executive Dashboard, the sum of 12 months of FY20 PAU = $23,186,599

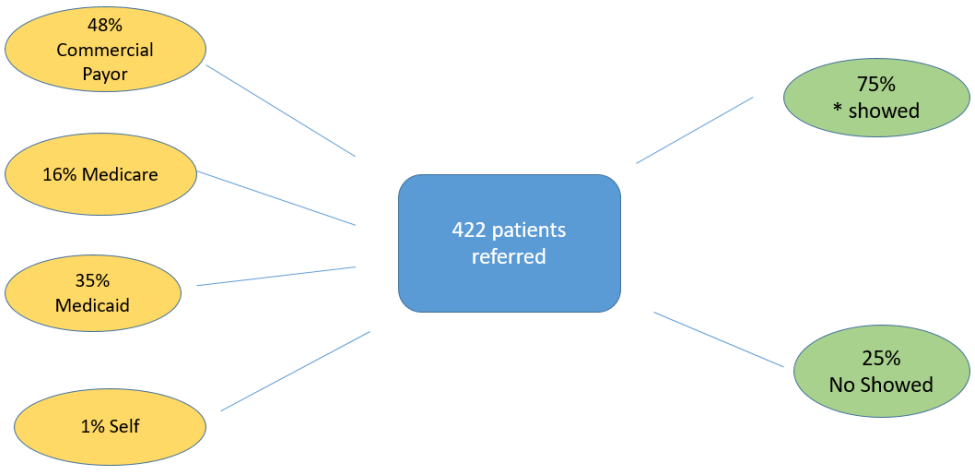
CRISP Key Indicators (Optional)

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.*	Average monthly % for most recent six months (Feb – July 2020) = 18%

Self-Reported Process Measures

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



*Showed" indicates patients completed at least 1 session to TCC-BH

Return on Investment – (Optional)

Annual Cost per Patient as calculated by:

At this time, we are unable to provide FY20's cost per patient information at this time as a result of complex COVID related operational and volume inconsistencies. We are in the process of reconciling cost per patient data examining the impact of Covid-19 on operations and volumes and will provide this data when available.

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.

Between the months of March and June, UM SJMC hospital volume saw a drastic COVID-19 related reduction in volume of 36% for adult admissions (excluding newborn/NICU), 40% for ER visits, and at least 40% for the Transitional Care Center at its peak. Most non-essential visits were temporarily deferred in the beginning stage of the pandemic, which resulted in reduced referrals and volumes. We were able to implement use of telehealth by April and outreach was resumed aggressively by our team to assist patients in such visits. Today, our Transitional Care Center and Behavioral health Center productivity have resumed to pre-COVID stage, with most of the visits and services performed via Telehealth. In October, we intend to start up our first virtual group therapy sessions.

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.

This funding opportunity has allowed UM SJMC to build an infrastructure to serve our mental health population within our community. Not knowing that five years later, a pandemic will hit our nation as well as globally, causing tremendous mental angst in almost all population, this Transitional Care Center has served as an anchor to our community, our hospital, primary care and specialty care offices and beyond during this time. At the peak of the pandemic where most ambulatory offices were halting visits, the TCC-Medicine and TCC-BHC were operating full time to outreach for at-risk patients in assisting to adapt to the stay-at-home order, managing their disease and medication telephonically or with telehealth, and providing careful necessary in-person visits to avoid any unnecessary hospitalization for patients.

In addition, for the past 4 years we have continuously shown successful outcomes in our 30-90 day post intervention population. Today, the need to be seen for mental health wellbeing in a timely manner is even more important. We will continue all of our existing services and will build upon our telehealth services to serve a larger demographic.

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.

We intend to build upon an array of virtual group therapy classes to serve a wider demographic and accommodate patients who may be challenged to arrive for an in-person visit. We will also be evaluating our capability to provide a longitudinal service for patients as an extension of our 90-day bridge program.

Appendix A: Pre-Post Analysis

Table 1. FY18-FY20 All payor panel. Pre –Post- analysis for Inpatient admission. *In FY20, the readmission rate for patients who showed up to at least 1 session is 4.1%, 3 fold lower than patients who no showed to an appointment. The longitudinal outcome shows that patients who completed at least a session fairs significantly better than the no-show cohort.*

	FY18		FY19		FY20	
(%)	No Show	Show	No Show	Show	No Show	Show
1 Mnth	18.5	5	10.9	7.8	**12.5**	**4.1**
3 Mnths	29.5	12.5	19.7	15.9	**19.6**	**10.1**
6 Mnths	39.8	21.1	31.8	27.5	**31.7**	**12.8**
12Mnths	50	36.4	26.3	25	*	*

Table 2. FY18-FY20 All payor panel. Pre –Post- analysis for ER / Obs>23Hr. *In FY20, the 30 day utilization rate for the no-show population is significantly reduced from historical reporting. It is possible that the pandemic plays a role in the reduction in overall utilization. Due to this trend, patients with at least 1 BHC session show no significant difference in ER / Obs utilization compared with the no-show cohort.*

	FY18		FY19		FY20	
(%)	No Show	Show	No Show	Show	No Show	Show
1 Mnth	54.1	36.7	38	20	**29.5**	**29.7**
3 Mnths	68.7	55.6	50.6	38.8	**47.9**	**39.7**
6 Mnths	71.4	65.7	56.9	51.5	**61.6**	**52.5**
12Mnths	71	79.8	73.3	61.4	*	*

Table 3. FY18-FY20 Medicare / Medicaid panel. Pre –Post- analysis for Inpatient admission. *In FY20, the readmission rate for both showed and no-show patients is negligible as unique patient count is <11.*

	FY18		FY19		FY20	
(%)	No Show	Show	No Show	Show	No Show	Show
1 Mnth	24.3	9.1	18.3	11.9	< 11 count	< 11 count
3 Mnths	40.3	22.6	30.1	26.3	**30**	**17.2**
6 Mnths	52.8	32.8	41.9	35.6	**44.8**	**22.1**
12Mnths	53.8	46.5	48.4	44.9	*	*

**Not enough data gathered for this time point*

Table 4. FY18-FY20 Medicare / Medicaid panel. Pre –Post- analysis for ER / Obs>23Hr. *The utilization rate for this panel of patient has been prominent in the last 3 years. It is interesting that for FY20, the no-show population did not have significant 30 day utilization after discharge. It is possible that the pandemic has played a role in patients staying out of hospitals.*

	FY18		FY19		FY20	
(%)	No Show	Show	No Show	Show	No Show	Show
1 Mnth	56.4	48.1	43.4	30.2	**< 11 count**	**47.7**
3 Mnths	66.7	65.7	61.2	48.5	**58.3**	**56.5**
6 Mnths	71.8	73.1	64.5	60	**82.4**	**64.5**
12Mnths	73.9	82.7	7.5	74.4	*	*

**Not enough data gathered for this time point*

Appendix D. Timeline of Program Implementation:

April 2016

- Interview with HSCRC, Final determination of Behavioral Health Center to be housed within Transitional Care Center.

May 2016

- Approval of HSCRC Funding

June 2016

- UM SJMG Ambulatory went Live on EPIC, along with Transitional Care Center
- Maxim Contract expansion:
    - Maxim Community Health Workers (CHW) expansion from inpatient access to Transitional Nurse Navigator and ambulatory offices.

July 2016

- Contracting process with Sheppard Pratt private psychiatry group and initiate recruitment process for the Behavioral Health Center (BHC).
- Standing meetings with BHC Steering Committee.
- Workflow processes with partners and stake holders for the BHC

Aug 2016

- Finalizing Contract with private psychiatry group, recruitment in process.
- Standing meetings with BHC steering committee for program development
- Finalize PCP and home health care screening criteria
    - Workflow standardization
    - Sub-acute partner workgroup

- Primary care provider work group

Sept 2016

- First LCSW-C hired to start September 12th, 2016 with 1 week internal training and orientation
- Standing meetings with BHC steering committee for program development
- Formation of population health steering committee
- Continual recruitment for LCSW-Cs, psychiatrist and psychologist

October 2016

- Started seeing patients in October by 1 LCSW-C: Target is Medicare discharged inpatient psych unit with existing psychiatrist relationship.
- Standing meetings with BHC steering committee for program development
- Continual recruitment
- Engage CRISP in developing dashboard for measurable outcomes

November 2016

- Psychiatrist joined Nov 17th, 2016
- Ramp up on patients, target: Medicare discharged inpatient psych unit with and without existing providers
- Standing meetings with BHC steering committee for program development
- UMMS high risk clinic workgroup collaborative

December 2016

- Ramp up on patients, target: Medicare discharged inpatient psych unit with and without existing providers and Transitional Care Center referrals
- Standing meetings with BHC steering committee for program development
- UMMS high risk clinic workgroup collaborative
- Continual recruitment

January 2017

- Ramp up on patients, target: Medicare discharged inpatient psych unit with and without existing providers and ED high utilizers with multiple chronic co-morbid condition, and Transitional Care Center referrals
- Standing meetings with BHC steering committee for program development
- UMMS high risk clinic workgroup collaborative
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February 2017

- Hired midlevel psych NP to conduct group therapy
- Start group therapy, CBT sessions
- Joined Bay Area Transformation Grant Collaborative for best practices and develop dashboard with CRISP

April 2017

- Hired 2nd LCSWC, patient volume increased, continual referral from inpatient discharged and ED high utilizers. New referrals from Transitional Care Center (UM SJMC high risk center) high risk Cancer Center patients with underlying behavioral health factors impacting chronic care.

June 2017

- Hired 3rd LCSWC, patient volume increased, continual referrals from existing sources, new referrals from PCPs and Visiting Nurse Association

(VNA) home health agency.

- Established relationship with Lyft ride to enable ease of patient transportation.

Jan - June 2018

- Increased awareness of service with PCP partners and community health workers, increase referrals
- April and May 2018, LCSWc turn over, bottle neck in psychiatrist med-management due to increased community referral, re-start recruiting and reorganization to consist of 2 LCSWC, 0.6FTE nurse practitioner and 0.6 FTE psychiatrist.
- Improve operational workflow and refine therapy programs to maximize clinical benefit and relapse prevention to clinic patients.
- Establish ongoing free support groups for current and prior patients of BHC.

July 2018 – Jun 2020

- Stabilized clinical staffing infrastructure with 2 FTE LCSWc, 0.5 FTE psychiatric nurse practitioner, 0.6 FTE psychiatrist.
- Becoming a hub for PCP referral as part of MDPCP program, increased referral by 50% by PCPs.