HSCRC Transformation Grant
Fiscal Year 2018 Final Report
Community Health Partnership of Baltimore

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Regional Partnership – Key Information

Regional Partnership Name: Community Health Partnership of Baltimore

Regional Partnership Hospitals: Revenue Percentages (%)

1. The Johns Hopkins Hospital: 52%
2. Johns Hopkins Bayview Medical Center: 18%
3. LifeBridge Sinai Hospital: 12%
4. Mercy Medical Center: 8%
5. MedStar Franklin Square Hospital: 7%
6. MedStar Harbor Hospital: 3%

Number of Interventions (henceforth called "Programs") in FY2018: Approved Budget Distribution

1. Management Services Organization / Johns Hopkins HealthCare LLC: 14.39%
2. Community Care Team (Community Health Workers, Care Managers, Health Behavior Specialists) / Sisters Together and Reaching, Inc.: 48.89%
3. Home-Based Primary Care / JHOME: 9.42%
4. Behavioral Health Bridge Team / Johns Hopkins Medicine: 8.15%
5. Homeless Convalescent Care / Healthcare for the Homeless: 6.16%
6. Neighborhood Navigators / The Men and Families Center: 10.96%
7. Patient Engagement Program – Provider Training / Johns Hopkins Medicine: 2.02%

Total FY2018 Budget: HSCRC Approved Budget

- Fiscal Year 2017 Award: $6,674,286 | Fiscal Year 2018 Award: $6,006,859

Total FTEs in FY2018

- Employed: 71.4 FTE employees (refer to Program sections for primary employer)

Key Community Partners in FY2018

1. Sisters Together and Reaching, Inc. (Community-Based Organizations (CBO))
2. The Men & Families Center (CBO)
3. Health Care for the Homeless (CBO, Federally Qualified Health Center)
4. Matrix Ventures LLC (Management Services Organization (MSO) Consultant)
5. Johns Hopkins Medicine
    a. Johns Hopkins HealthCare LLC (MSO)
    b. Department of Geriatrics (JHOME/Home-Based Primary Care)
    c. Department of Psychiatry (Bridge Team, Community Care Team: Behavioral Health)
    d. Johns Hopkins Community Physicians (Quality Transformation)
    e. Department of Cardiology (Medical direction for Community Care Team)
    f. Department of Physical Medicine and Rehabilitation (Patient Engagement Program)

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Overall Summary

Background

Baltimore is a City with complex health challenges with great disparities in healthcare outcomes. These disparities are evidence of the high need for collaborations between health systems and communities to address physical, behavioral, and social needs. The Community Health Partnership of Baltimore is uniquely positioned to improve this region's health. This regional partnership works with six of Baltimore's hospitals and three of Baltimore's CBOs. The Community Health Partnership of Baltimore is comprised of six programs to improve this population's health. In Fiscal Year 2018, the CHPB served over 5,000 people.

The Community Health Partnership of Baltimore is pleased to report the progress of Fiscal Year 2018, including program summaries, strategic initiatives, and performance (including quality and utilization).

Overall Summary of Regional Partnership Activities in Fiscal Year 2018

The Community Health Partnership of Baltimore (CHPB) focuses on complex Medicare Fee-For-Service (FFS) patients across 19 zip codes in Baltimore City. The CHPB's goal is to coordinate care for patients with complex medical, behavioral, and/or social challenges to improve their health outcomes. The CHPB addresses current gaps in the delivery of healthcare services that lead to poor health outcomes and high healthcare service utilization. The patients enrolled in CHPB's programs have demonstrated high utilization of hospital services in Baltimore City amongst CHPB Hospital Partners (i.e., The Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, LifeBridge Sinai Hospital, Mercy Medical Center, MedStar Franklin Square, MedStar Harbor Hospital). Of the six programs, five programs target CHPB patients. The sixth program provides patient engagement training for CHPB staff and hospital partner healthcare providers.

The CHPB's governance is comprised of influential population health leaders in Baltimore City. Governance includes a CHPB Steering Committee, Operating Committee, Finance Committee, and Analytics Committee. The CHPB Steering Committee's main objectives are to: provide oversight to the MSO leadership team; promote and support effective operations by enhancing communication and collaboration across hospitals; share best practices; identify and address opportunities for program improvement; identify potentially duplicative efforts and leverage economies across the Hospital Partners; and report performance to the HSCRC. The Steering Committee convened quarterly in Fiscal Year 2018. The CHPB Operating Committee's main objectives are to: assist with clinical program design, scope, staffing, resources, and workflows; design contingency and sustainability plans for clinical initiatives; and develop justifications for recommendations to the Steering Committee. This committee analyzes process performance and reporting for each program as well as recommends workflow improvements to healthcare services, patient identification, and reporting. The Operating Committee convened monthly in Fiscal Year 2018. The Finance Committee's main objectives are to: monitor the overall financial health of the CHPB, ensure the financial viability of the CHPB, and make recommendations to the Steering Committee related to all financial matters (including annual budget). The Finance Committee convened bimonthly in Fiscal Year 2018. The Analytics Committee's main objectives are to: track key performance and outcome metrics, monitor continuous quality improvement initiatives, and review ongoing data collection and reporting processes across the CHPB. The Analytics Committee convened every other month in Fiscal Year 2018. For the organizational chart of CHPB Governance, please refer to Appendix A – Organizational Chart of CHPB Governance.

In Fiscal Year 2018, the CHPB has been strategically focused on patient enrollment, process measurement, and further infrastructure development. The CHPB has designed Executive Report Card tools for CHPB's governance to evaluate performance on infrastructure, marketing, patient enrollment, budget management, and utilization targets. The Report Cards show that CHPB staffed and launched all programs, developed and soft-launched a marketing campaign, and improved patient enrollment during Fiscal Year 2018. The CRISP pre/post panel reports for the programs, show a general trend of decreased hospital utilization, both in cost and overall health spend for patients who have been enrolled in CHPB programs[1]. For Report Cards, refer to Appendix B – Report Cards.

The CHPB addresses care coordination needs through CHPB's partnerships with the Management Services Organization (MSO), community partners, and Hospital Partners. Behavioral health services are integrated across the programs. These include treatment for substance use disorder, addiction, mental illness, and dementia. Workforce development efforts have continued through recruitment, retention, and training of community-based healthcare workers, including professionals such as Community Health Workers, Nurse/Social Worker Care Managers, and Health Behavior Specialists. Curriculum for healthcare providers has been adapted to the needs of community-based care; more specifically, the Patient Engagement Program trains CHPB employees and Hospital Partner care teams using a provider-focused, behavior change curriculum. This curriculum teaches skills to enhance a patient's confidence in their ability to manage their own health. Additionally, a six-month, intensive marketing strategy was finalized in July 2018, in response to the needs identified across CHPB Hospital Partners and program stakeholders. Additionally, a six-month, intensive marketing strategy was finalized in July 2018, in response to the needs identified across CHPB Hospital Partners and program stakeholders. The CHPB website can be accessed here: CHPBaltimore.org. For the Marketing Plan, please refer to

Appendix C – Marketing Plan.

The CHPB hosted three major events in Fiscal Year 2018. In January 2018, the CHPB Inaugural Event convened all employees from the programs, Hospital Partner leadership, MSO, and community partners to share patient narratives from each program. In May 2018, the CHPB hosted a retreat to develop a care coordination strategy for Fiscal Year 2019; it convened key CHPB staff across all HPs and Interventions to focus on care coordination and operations. This retreat resulted in strategies to improve case load management, to enhance identification methods for high risk patients, and to leverage workforce development activities. In July 2018, the CHPB hosted a retreat to develop a data and reporting strategy for Fiscal Year 2019; it convened key CHPB staff skilled in analytics and reporting across all HPs and Interventions. For the Fiscal Year 2019 Strategic Framework (i.e., improved care coordination, patient enrollment, patient identification, and reporting), please refer to

Appendix D – Fiscal Year 2019 Strategic Framework.

[1] *CRISP Pre-Post Reports: Community Care Team, Bridge Team, Homeless Convalescent Care, Home Based Primary Care*

Management Services Organization

Name of Program
Management Services Organization (MSO)

Brief Description
The Management Services Organization (MSO) is operated by Johns Hopkins HealthCare LLC (JHHC). The Leadership Team of the MSO exists within JHHC's Office of Population Health. It consists of a dedicated Director, Senior Program Administrator, and Project Manager. Additional personnel within JHHC also contribute substantial amounts of time to the success of the CHPB in Fiscal Year 2018; these people included a Senior Financial Analyst, a Human Resources Specialist, and an Administrative Assistant. Johns Hopkins HealthCare LLC's Office of Population Health also employs a team of data and analytics specialists for the CHPB. The MSO also partners with a Continuous Quality Improvement team, employed by Johns Hopkins Community Physicians, and includes a Registered Nurse and a Performance Improvement Data Analyst. The MSO designs performance metrics and monitors processes of different programs. The MSO, through employment of a Clinical Nurse Screener, is the primary source of referrals and identification of Medicare beneficiaries for programs. Further, the MSO facilitates provider engagement and reports on outcomes to the Hospital Partners through an established governance process.

Partners
JHHC Office of Population Health
- Leadership
- Administrators
- Finance
- Human Resources
- Data & Analytics

Johns Hopkins Community Physicians
- Continuous Quality Improvement

Matrix Ventures LLC (CBO Consultant)

 # FTEs 2018
9.8 FTE

Successes
The MSO hired a full time Director, Senior Program Administrator, and Project Manager.

Lessons Learned
There are many individuals within JHHC's Office of Population Health who contribute their time towards CHPB's success. While all personnel listed in the above "Brief Description" are paid through CHPB funding, there are many individuals within JHHC's Office of Population Health who are not reflected in CHPB's budget but perform integral work directly relating to the CHPB. Any CHPB-related work completed by these individuals is therefore being funded through 'in-kind' support from JHHC's Office of Population Health.

The CHPB Steering Committee acknowledged that the MSO was providing in-kind services and therefore approved the Fiscal Year 2019 budget which reflects actual services being rendered. Included in the approval was compensation for CHPB work completed by the Director and Senior Administrator for JHHC's Office of Population Health Innovation & Transformation. These personnel provide CHPB metric expertise (on measuring "value"), manage CRISP reporting tools, and monitor overall trends within the CHPB catchment area.

Next Steps
The MSO's service contribution to the CHPB will continue to be monitored for appropriate funding. The CHPB Leadership will continue to ensure that services being delivered by MSO personnel are commensurate with the percentage of effort and funding.

CHPB's Six Programs

Community Care Team (CCT)

Name of Program
Community Care Team (CCT)

Hospital Partners Participating
All

Brief Description
The CCTs expand upon existing services of primary care providers to meet the needs of and coordinate care for a high-risk, Medicare population. The CCT deploys 10 teams regionally. Each team consists of a minimum of one Nurse/Social Worker Care Manager, two Community Health Workers, and one Health Behavior Specialist. The teams assess social, medical, and behavioral health needs of patients. The teams meet a patient's needs by connecting the patient to social resources, primary care, and other medical and behavioral health resources.

Partners
The CCT's partners include:
1. Sisters Together and Reaching, Inc. (CBO);
2. JHHC (MSO and Care Managers); and
3. Johns Hopkins Medicine (Health Behavior Specialists, Medical Director)

 # FTEs in 2018
Total number: 42.45 FTE
1. Sisters Together and Reaching, Inc. (CBO): 25.9 FTE
2. JHHC (Care Managers, Care Manager Program Manager): 11.0 FTE
3. Johns Hopkins Medicine (Health Behavior Specialists, Sr. Program Manager, Medical Director, Clinical Nurse Specialist): 5.55 FTE

 # Patients Served
*HSCRC Notes: Estimation using the Population category that best applies to the Intervention, from the CY 2017 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.*

Patients Served as of June 30, 2018	604 (Total patients receiving services and enrolled through CRISP High Utilizer lists and direct provider referrals during Fiscal Year 2018)
Denominator of Eligible Patients: 19 zip codes (CY2017 RP Analytic File)	74,445 Source: The total population is 74,445

	893 is the number of patients meeting 3/+ Inpatient/ observational stays, 19 zips, Medicare FFS criteria (File dates: Jan-June18)
Denominator: Identified as eligible and assigned to a team for outreach	1866 individuals Source: CHPB CCT Dashboard July 5, 2018

Program – Specific Outcome or Process Measure
HSCRC Note: These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership maintains and uses to analyze performance.

Process Measures*	**Number**
Total number of patients assigned to CCT for outreach	1866
Total number of patients receiving services and enrolled from CCT	604
Total number of patients currently enrolled into CCT	343
Total number of patients directly referred	197
Number of cases closed because all patient goals were met	52
Number of cases closed because patient was transferred to other care management	43
Number of patients refusing CCT services after patient identified for services	460
Number of patients who are deceased after patient identified for services	398
Number of patients not meeting program criteria after patient identified for services	208
Number of patients unable to locate after patient identified for services	310
Number of jobs created	42.45 FTE
Average age for enrolled patient	65.25 years
Average number of chronic conditions for enrolled patients (from CRISP High Utilizer data)	5.4
Number of CCT outreach letters sent	1736
Average number of successful CHW contacts per patient per month	3.2

**All numbers in this table represent the total during Fiscal Year 2018 only, not the total since the beginning of the CHPB as represented in the CCT dashboards that are generated monthly.*

Pre/Post Analysis for Program

Given the current challenges of uploading pre/post panels for a program that crosses multiple Hospital Partners, only a portion of the current CCT panel is represented in the CCT pre/post panel report. The total number of patients in the CCT panel contributing to this report are 184 patients; 161 patients have data available for analysis at 1 month, 132 have data available for analysis at 3 months, and 93 have data available at 6 months. In the three month pre/post report for the CCT, hospital visits decreased by 14% between three months pre-enrollment in the CCT and three months post-enrollment. The CRISP panel upload allows only a single hospital Medical Record Number (MRN) to be uploaded for each Panel. Patients with a Johns Hopkins MRN were the most prevalent patients enrolled into the CCT. Therefore, only patients with a Johns Hopkins MRN were represented in the pre/post panel for the CCT. The Johns Hopkins MRN panel was last updated on July 21, 2018. This represented all patients enrolled in the CCT for at least 30 days in Fiscal Year 2018 who had an established Johns Hopkins MRN. For pre- and post-enrollment reports (screenshots of summary and panel analysis), refer to Appendix E – Pre-Post Reports for CCT.

Currently, CHPB has not been able to fully leverage the CRISP pre/post reports; this is due to complications with uploading the whole panel of enrolled patients. The CHPB is actively working with CRISP to find solutions to upload members by MRN or ENS identifier in a way that represents the whole enrolled patient population. More work is planned with CRISP to identify new solutions for uploading the whole panel in the future. The pre/post report for CCT does not contain a comparison population, does not adjust for regression to the mean or outliers, and does not provide patient-level data that can be used to better understand the trends seen; this makes it difficult to interpret the results.

Successes

The CCT is fully operational and regionally deployed throughout Baltimore City. All CCT staff met every Monday to round on patients with substantial complexity. The rounds are conducted under the direction of CCT Medical Director, in addition to leadership for each program discipline: Community Health Worker, Care Manager (Nurse/Social Worker), and Health Behavioral Specialist (Social Worker). Hospital Partner teams within the CCT meet independently throughout the week to discuss enrolled patients.

The CCT has an established patient identification workflow, enabling the CHPB partner organization, STAR, to outreach eligible patients who have been identified as eligible from lists provided by each Hospital Partner. After STAR's Community Health Workers meet the eligible patient in their home and perform an assessment, further care coordination of medical and behavioral health needs is provided, as needed.

Lessons Learned

Reliance on historical utilization data from CRISP to identify patients using HSCRC criteria of 3/+ hospitalizations over 12 months in the 19 zip codes for Medicare FFS is a resource-intensive process when applied across multiple hospitals with overlapping patients and separate care coordination programs. This yields neither a timely identification of patients nor successful overall yield for enrollment. Meeting the patient where they are when they are in the hospital is a more successful way to identify and enroll patients, even though it results in a smaller number of individuals identified as eligible each month.

Applying these lessons learned, in March 2018, the CCT deployed a hospital in-reach strategy (i.e., "Inpatient Referral Strategy") for Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center. The Inpatient Referral Strategy (IRS) uses daily census lists from Hospital Partners; the CHPB applies its

eligibility criteria to these lists. Eligible patients are pended to the CCT Care Managers and Health Behavior Specialists within one hour. Within 24 hours, the Care Managers or Health Behavior Specialists visit the patient during their inpatient stay. They then contact the hospital unit manager, describe the CCT program to the patient, and coordinate disposition planning for the patient post-discharge. The IRS has been successful; over 35% of patients are enrolled after CCT staff outreach to them. To date, over 50 patients have been enrolled into the CCT through the IRS. For a report demonstrating CCT's success, refer to Appendix E – Pre-Post Reports for CCT.

Next Steps

Fiscal Year 2019 seeks to employ diverse strategies to increase the number of patients enrolled into the CCT. Several strategies are being explored to improve identification: (1) The IRS will continue at JHH and JHBMC. CHWs will be the primary discipline engaging patients during their inpatient stay, maximizing STAR's skills for patient engagement. The IRS will also be deployed for additional Hospital Partners, beyond JHH and JHBMC; (2) The CCT is planning a pilot with CRISP to test use of "blind panels" as a means of identifying newly eligible patients. Use of blind panels will allow the CHPB to set criteria for enrollment with CRISP; when patients are admitted to a Hospital Partner that meet this enrollment criteria, notifications will be sent to the CHPB to outreach the newly eligible patients for enrollment into appropriate programs; (3) The CHPB will explore ways to leverage Emergency Departments for patient outreach opportunities; (4) The CHPB will explore a post-acute strategy to target patients being discharged from Skilled Nursing Facilities (SNF) and leverage existing SNF Collaboratives to improve transitions of care and increased referrals for the CCT; and (5) The CHPB will explore potential use of daily outpatient discharge patient lists for outreach.

The MSO will work to improve reporting in Fiscal Year 2019 in collaboration with CRISP. CCT will improve process reporting to reflect the level of the program's intensity, including Sisters Together and Reaching Community Health Worker outreach in the community locating patients, caregivers, and their primary care providers, and the disposition of patient services. The MSO and CRISP will develop new filters for existing CRISP reporting tools that are more specific to the RP populations. The JHH and JHBMC are participating in the HSCRC Care Redesign Program and will be receiving limited CMS Claims data. The Hopkins Hospital Partners may give the MSO Research and Development Team access to claims data for the purpose of creating predictive risk modeling, return on investment, and utilization reporting. This potentially could be used to understand trends in a subset of the enrolled population.

Workforce Development strategies are being standardized across the CCT through targeted training. All CCT employees are required to take the Patient Engagement Program to improve the CCT's patient engagement skills in community-based and inpatient settings. Retention strategies for longitudinal stabilization of the CCT are being developed through retention bonuses and certificates of achievement for the CCT staff in Fiscal Year 2019.

Additional Information

Measuring "Return on Value"

The CHPB is championing an effort to qualitatively capture themes and perspectives that illuminate both the challenges and successes among CCT patients. STAR and the MSO formed a workgroup focused on assessing the value, or return of value, of the CCT. This group is developing a participatory measurement process that aims to identify key functions of the CCT that contribute to successes of the CCT; this includes methods for participant engagement, strategies for management and participant motivation, as well as better understanding the areas in which the healthcare system meets the needs of CCT participants. The CCT is specifically focused on the "Return on Value" of the CCT and the value proposition as it aligns to the following metrics to address the following five categories:

1. Community Relationship
2. Patient Capacity & Engagement
3. Patient & Community Health
4. Workforce Creation
5. Health System Optimization
6. Return on Value Aligned with Return on Investment

"Inez" - Example of Story Demonstrating Value of Program

The Community Care Team has worked with Inez since November 2017. The initial Community Health Worker assessment identified multiple social, behavioral health, and medical needs. After the Community Care Team discussed the patient, Inez was referred to the Health Behavior Specialist for depression. The Health Behavior Specialist's assessment found her to have suicidal ideation, auditory hallucinations, low self-esteem, poor sleep, and anxiety attacks that prevented her from engaging in the community. She had moved from Hagerstown and had been out of mental health treatment for several years without medication. With the assistance of the Health Behavior Specialist, Inez is now engaged with and remains stable in outpatient behavioral health treatment and is taking her medications as prescribed. Inez is engaged in the community through volunteering and also co-leads a women's support group at MedStar Harbor Hospital. She has taken steps to improve her health with the guidance and support of her Care Manager, including diet and exercise changes that have resulted in weight loss. The Care Manager connected Inez to a primary care provider at the Johns Hopkins Community Physicians in Remington where she has completed her initial appointment to establish care and has follow up appointments scheduled. The Community Care Team also assisted Inez with obtaining a new insurance card, clothing, and housing resources. Her only goal at this time is to pursue independent living and is currently on a wait list at an apartment complex.

"John" - Example of Story Demonstrating Value of Program

John is a 67 year old, single African American male who is a Vietnam Veteran. He has complex medical issues and difficulty managing his anger, which became more intense and frequent after returning home from Vietnam. This has negatively affected his medical well-being and caused increased sense of regret when becoming angry with family and friends.

John and the Health Behavior Specialist established a comfortable working relationship and set a goal to develop and strengthen his anger management skills. The Health Behavior Specialist and patient used an anger management workbook and met twice a month to complete and review skill building tasks. In addition to these skills and breathing techniques, John also uses prayer, music, and walking away to avoid his feelings of anger. He has learned to delay his responses to family members that trigger his anger, and to address them when he feels calm.

Bridge Team

Name of Program
Bridge Team

Hospital Partners Participating
All

Brief Description
The Bridge Team is a multi-disciplinary team that works with patients exhibiting complex psychiatric needs, substance use disorder (SUD), and other complex case management needs associated with behavioral health. The primary goal of the Bridge Team is to facilitate a successful transition to a medical home and effectively engage these patients in behavioral health services. The team consists of a Psychiatrist, a Health Behavior Specialist Team Lead, and two behavioral health Community Health Workers.

Partners
1. JHHC (Health Behavior Specialist Lead, two behavioral health Community Health Workers)
2. Johns Hopkins Medicine (Psychiatrist, Senior Program Manager)

 # FTEs in 2018
- Total Employees: 4.15 FTE
    - JHHC (Health Behavior Specialist Lead, Two behavioral health Community Health Workers): 3.0 FTE
    - Johns Hopkins Medicine (Psychiatrist, Senior Program Manager): 1.15 FTE

 # Patients Served
HSCRC Notes: Estimation using the Population category that best applies to the Intervention, from the CY 2017 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.*

Patients Served as of June 30, 2018	18
Denominator of Eligible Patients: 19 zip codes (CY2017 RP Analytic File)	There are 74,445 patients in the 19 zip code area, however to be eligible for the Bridge Team, patients must have a qualifying behavioral health concern, which is not available from CRISP.
Denominator Referred and Outreached (N.B., Referral based intervention)	99 individuals Source: CHPB Bridge Team Dashboard (July 5, 2018)

Program – Specific Outcome or Process Measure

HSCRC Note: 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.

Bridge Process Measure	Number
Total number of patients referred for treatment	99
Total number of enrolled (successful referrals for unique patients)	18
Total number of patients denied, including process measurement for denial reasons (insurance, existing engagement in BH treatment, does not meet HSCRC criteria, residential address is not in catchment)	See table below for denial reasons.
Number of unique HBS Interactions / Outreach attempts per month	664 Total 55 Average Per Month
Number of unique CHW interactions / Outreach attempts per month	302 Total 25 Average Per Month
Number of unique Psychiatrist interactions / month	30 Total 2.5 Average Per Month
Average length of treatment (days) for patients discharged by month's end	59
Number of patients discharged successfully (having completed all agreed upon goals)	9
Number of patients involuntarily discharged due to non-adherence	3
Number of jobs created	4.15 FTE

Denial Reason	Number of Patients
Insurance	9
Already engaged in mental health treatment	16
Zip Code	11
Does not meet high utilizer criteria	2
Transferred to CCT	2
Acuity: inadequacy of level of care able to be provided by team's staffing	5
Unable to locate	8
Alternative discharge plans made	7
Patients not voluntary	2
No plan to bridge patient to	1
Additional follow-up needed from referral source or patient	7
Total	70

Pre/Post Analysis for Program

The Bridge patient panel contains 18 patients for the time period July 2017 through May 2018. Fifteen (15) patients have data available for analysis.

The Bridge Team is resource-intensive with a low patient capacity. To that end, there have not been a substantial number of patients enrolled into the program; therefore, report findings are suppressed and/or limited. The pre/post Bridge program report does not contain a comparison population. The Bridge pre/post program report does not adjust for regression to the mean. For pre- and post-enrollment reports (screenshots of summary and panel analysis), refer to

Appendix F – Pre-Post Reports for Bridge.

The total number of patients in the Bridge panel contributing to this report are 15 patients; there is no data available after 1 month because the panel is under 11 patients for 3, 6, and 12 months. The average length of treatment for Bridge is 59 days. The 1 month post-analysis shows a 26.7% decrease in utilization.

Successes

Eighty-eight percent (88%) of the Bridge Team patients were successfully discharged having achieved all their goals. In Fiscal Year 2018, the Bridge Team substantially increased the number of enrolled patients by broadening the eligible referral base. The Bridge Team connected patients to appropriate services within varying systems of care; provided behavioral health consultation regarding discharge to Hospital Partner staff; and facilitated connections between patients and services in an efficient manner.

Lessons Learned

The Bridge Team has learned to be more proactive in their approach towards connecting with patients through in-reaching specific psychiatric hospital units. The Bridge Team has learned to better integrate themselves into the existing behavioral health landscape amongst CHPB's Hospital Partners. This facilitates the ability of a Health Behavior Specialist to refer patients to appropriate services in a more effective manner. The benefits of marketing Bridge Team services have been a worthy investment (although not immediately visible); marketing has clearly yielded improved referrals and patient enrollment to services. The increased awareness of Hospital Partners about the Bridge Team has led to increased, more appropriate referrals to the Bridge Team. The Bridge Team captured data regarding patients who were ineligible for services thereby leading to more inclusive eligibility criteria, increasing program participation.

Next Steps

A new Health Behavior Specialist is currently being recruited with the goal of expanding services. The Bridge Team aims to develop a protocol for in-reaching additional Hospital Partner-behavioral health-appropriate units. The Bridge Team will continue to track and problem solve identified barriers to enrollment to increase the number of enrolled patients.

Additional Information

"Paul" - Example of Story Demonstrating Value of Program

Paul is a 65 year old, divorced Caucasian male with multiple medical, psychiatric, and substance use comorbidities that include: Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, seizure disorder, asthma, traumatic brain injury, major depression, and benzodiazepine use disorder. He was also homeless. Paul had a long and successful work history, was married, and financially stable. When he experienced his traumatic brain injury, his life dramatically changed in all areas of functioning.

Most recently, Paul had been hospitalized for an exacerbation of depression symptoms which included suicidal ideation. The discharge plan included stepping down from the hospital to an intensive outpatient behavioral treatment program. Since an appointment with the intensive outpatient program was not immediately available, a referral was made to the Bridge team. Paul saw a provider from the Bridge Team on the day he was discharge. Paul engaged with the team and was able to identify goals he wanted to work on.

In meeting with Paul, it became apparent that multiple hospitalizations and housing instability resulted in constant disruption to his treatment and ability to develop a community-based support network. The Bridge team's task was to provide consistent and frequent interventions and to develop a coordinated treatment plan to address Paul's complex needs; this was done simultaneously as community-based providers actively engaged with Paul during his transition to long-term medical/ behavioral health care. Paul worked with the Bridge team a little over a month and a half. Upon discharge, all his short-term goals were met, which included: stable housing, consistent medication management, regular meals, obtain a phone, enroll in a transportation program, obtain a temporary state identification card, link to a long-term therapist and psychiatrist, participate in a Psychiatric Rehabilitation Program for five days a week, and engage with a new Primary Care Physician.

Neighborhood Navigators

Name of Program
Neighborhood Navigators

Hospital Partners Participating
1. The Johns Hopkins Hospital
2. Johns Hopkins Bayview Medical Center
3. MedStar Harbor Hospital

Brief Description
The Johns Hopkins Hospital has the only currently deployed Neighborhood Navigators program, which operates through the Men and Families Center (M&FC). The Neighborhood Navigators are trained volunteers who outreach clients around their 21205 neighborhood to engage residents about available healthcare and social service resources.

Partners
1. The M&FC (Executive Director, non-clinical Case Managers, Neighborhood Navigators)
2. Matrix Ventures LLC (CBO Consultant)

 # FTEs in 2018
Total employees: 3.6 FTE and 26 NNs
- The M&FC (Executive Director, non-clinical Case Managers): 3.6 FTE
    - Neighborhood Navigators: The Neighborhood Navigators are part-time employees that are paid monthly stipends; they are not FTE. There are 26 Neighborhood Navigators.

 # Patients Served
*HSCRC Notes: Estimation using the Population category that best applies to the Intervention, from the CY17 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.*

Clients Assessed as of June 30, 2018	3,518 Assessed* Please note: not all clients assessed by the Neighborhood Navigator Program receive case management services.
Denominator of Eligible Clients: 19 zip codes (CY2017 RP Analytic File)	10,808 individuals over the age of 20 This program is payer agnostic so eligible population is everyone over 18 years of age residing in 21205. Source: Baltimore City Census July 5, 2018 [Ages 20-85+] *Note: CY17 RP analytic file n/a for M&FC NN program*
Denominator Outreached ONLY	3,518 clients identified

(N.B., Neighborhood Navigator model outreaches patients)	

**Note: Neighborhood Navigator program assesses more clients because it is a less intensive program than other CHPB programs. It is also payer-agnostic and does not provide direct healthcare.*

Program – Specific Outcome or Process Measure

HSCRC Note: 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.

Neighborhood Navigator Process Measure	**Number**
Total number of clients assessed	3,518 Total 293 Average newly assessed per month

Top Ten Social Service Needs for Fiscal Year 2018

DESCRIPTION	**July 2017 - June 2018 # of Needs Identified During Assessment**	**July 2017 - June 2018 Ranking**
Employment and Training	1709	1
Housing Services	1538	2
Uninsured	683	3
Emergency Assistance	623	4
Re-Entry Services	583	5
Utility Bills	575	6
Identification Services	338	7
Dental Care	331	8
Vision Care	153	9
Transportation	112	10

Pre/Post Analysis for Program

Pre/post analysis is not available for the M&FC's Neighborhood Navigator program.

Successes

The M&FC continues intensive focus on stabilization of families through identification of social needs with follow up case management services. The M&FC is committed to holistic support for empowerment and self-sufficiency to its East Baltimore clients. The M&FC continues to broaden its dense network of local partners to help members address social and economic determinants of health, with particular focus on housing, utility assistance, and other resources necessary for well-being.

The Fiscal Year 2018 has shown a steady performance from the M&FC's Neighborhood Navigator program. Over Fiscal Year 2018, the Neighborhood Navigator program had 3,518 new residents being introduced to this unique neighborhood-based social support program. The program at M&FC showcases the work of an average of 19 Neighborhood Navigators, two (2) Case Managers, and a Case Management Supervisor working together to support clients across 22 service categories. These service categories include things such as: foreclosure and eviction prevention, utility shut-off, food pantry referrals, employment, and health insurance.

Lessons Learned

Managing Neighborhood Navigator retention is important for community presence and success. The Neighborhood Navigators are part-time employees who are paid monthly stipends; they are not full time employees. The program has experienced attrition over the last year. Several Neighborhood Navigators either moved from the target area, achieved full-time employment positions, left due to illness, or passed away. Hence, the number of Neighborhood Navigators has fluctuated from fully staffed at 26 down to 16. A total of five (5) new Neighborhood Navigators have been undergoing training and will engage clients in the new fiscal year. The M&FC is deploying an increasing number of in-service trainings that offer additional stipends. In addition, the CHPB is sponsoring opportunities for workforce training initiatives (e.g., Mental Health First Aid).

Next Steps

The M&FC is currently unable to report Neighborhood Navigator-referred clients who receive case management services; this is due to disparate data collection systems between Neighborhood Navigator and case management. The CHPB will sponsor the acquisition of special identification for the M&FC case management staff that will allow them to directly access the REDCap data collection system. This will both enhance service delivery as well as ensure improved reporting of the services provided to clients. The M&FC will be able to report how successful Neighborhood Navigators are through connection to social services and client needs.

In Fiscal Year 2019, CHPB aims to report on workforce development that occurs for the Neighborhood Navigators. As stated above, many Neighborhood Navigators move on to full time employment through the professional development they receive at M&FC. M&FC is a source of workforce development and professional attainment in the East Baltimore community.

<u>Johns Hopkins Bayview Medical Center / Neighborhood Navigator Expansion:</u>

In May 2018, Neighborhood Navigator program began expansion process. The Johns Hopkins Bayview Medical Center (JHBMC) identified Baltimore Medical System (BMS, FQHC: Highlandtown Clinic) as a potential partner organization with which to expand the Neighborhood Navigator program to the JHBMC catchment area. Since that time, there have been several planning sessions held between JHHC, JHBMC, and BMS to organize implementation of a JHBMC/BMS Neighborhood Navigator program with an aim to launch program by October 2018. Next steps include: building a budget, drafting a Memorandum of Understanding between JHHC, BMS, and JHBMC, recruiting for open positions, and training new staff. The M&FC will provide training to new staff.

MedStar Harbor Hospital / Neighborhood Navigator Expansion: Under development

Additional Information

"Mary" – A Gratitude Letter Demonstrating Value of Program

It is my pleasure to say thanks to your center for helping me in many ways.

One of your Neighborhood Navigators, Karim Butler, introduced me to the center. Neighborhood Navigator Rodney Williams has been a great help to me and my husband with work, home, and health. I'm so grateful for their help. Looking forward to many more blessings from this center. I'll pray for Men and Families Center. God bless you all!

Thanks,
Mary Parker

"Johnice" – *A Gratitude Letter Demonstrating Value of Program*

I want to thank the M&FC for having Mr. Rodney as a part of their staff. I want to recognize Mr. Rodney for assisting me with fulfilling my housing needs. Mr. Rodney referred me to a person who was able to give me a reference to obtain my apartment. I was worried about where I was going to reside, but now I can gratefully say that I reside in [an apartment] in East Baltimore. The apartment is nice, spacious and affordable. The location is also minutes from my church. Since I have been affiliated with M&FC, Mr. Rodney and the other staff have been polite and very helpful in job leads and there to listen to my day to day problems with suggestions and solutions that help brighten my day.

The M&FC is truly a blessing to me and to the citizens that surround the community.

Thanks again,
Johnice L. Powell

JHOME/ Home-Based Primary Care

Name of Program
JHOME/ Home-Based Primary Care

Hospital Partners Participating
1. JHBMC
2. JHH
3. LifeBridge Sinai Hospital

Brief Description
Home-Based Primary Care (JHOME) is a community-based program that provides home-based medical care, care management, caregiver support, counseling, and acute inpatient continuity to high-need, high cost, home-bound individuals on a longitudinal basis. This program builds on a historical foundation of the current JHBMC home-based primary care program to expand to JHH and Sinai Hospital. The multi-disciplinary team consists of a Program Director, Geriatrician, Certified Registered Nurse Practitioner, Social Worker, Registered Nurse, Practice Manager, Patient Service Coordinator, and a Licensed Practical Nurse.

Partners

- Johns Hopkins Medicine Department of Geriatrics (Program Director, Geriatrician, Certified Registered Nurse Practitioner, Social Worker, Registered Nurse, Practice Manager, Patient Service Coordinator, and a Licensed Practical Nurse)

 # FTEs in 2018
- Total: Johns Hopkins Medicine Department of Geriatrics (Program Director, Geriatrician, Certified Registered Nurse Practitioner, Social Worker, Registered Nurse, Practice Manager, Patient Service Coordinator, and a Licensed Practical Nurse): 6.3 FTE

 # Patients Served
*HSCRC Notes: Estimation using the Population category that best applies to the Intervention, from the CY 2017 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.*

Patients Served as of June 30, 2018	327
Denominator of Eligible Patients: 19 zip codes (CY2017 RP Analytic File)	While there are 74,445 patients in the 19 zip code area, only patients who live in JHH, JHBMC, and Sinai zip codes and who are homebound are eligible for this program. We currently do not have data to define this denominator.
Denominator Referred and Outreached	267 total referred individuals Note: Some patients were already enrolled in the program.

	Source: July 5, 2018

Program – Specific Outcome or Process Measures

JHOME Process Measure	**Number**
Total Number of Patients Referred	267
Total Number of Patients Enrolled	175
Total Number of Home Visits	2,191
Total Urgent Visits	91
Percent of Patients with Completed Annual Wellness Visits	79%
Total Inpatient Encounters	196
Total Number of ED Visits	212
Total Number of Deaths at Home and in Hospice	Average: 3 per month
Percentage of Deaths at Home and in Hospice	Average: 72%
Job creation	6.3

Pre/Post Analysis for Program

The total number of patients in the JHOME panel contributing to this report are 156 patients; 117 patients have been in the program for 12 months. Although the average length of treatment for JHOME is 15 months, the six month panel is more robust with 156 patients (compared with the 12 month panel's 117 patients) and therefore provides the most useful information. Hospital visits decreased by 21.8% in 6 months. The Pre/Post panel was last updated on July 10, 2018. The pre/post JHOME program report does not contain a comparison population. The JHOME pre/post program report does not adjust for regression to the mean.

For pre- and post-enrollment reports (screenshots of summary and panel analysis), refer to Appendix G – Pre-Post Reports for JHOME.

Successes

In Fiscal Year 2018, 327 total patients were seen for JHOME of which 188 patients were new JHOME patients. These patients received 2,200 visits from the JHOME team (including LPN, RN, and social worker visits). Remote Patient Monitoring (RPM) has been piloted on 3 JHOME patients to date. Nurses have been monitoring these devices. The JHOME RN evaluates new patients for eligibility of RPM use. The goal of RPM is to real-time manage patient needs where the entire JHOME Team can be better leveraged, in lieu of all services being through home visits.

Lessons Learned

Providing acute care continuity for a high-cost, home-bound population requires a strong multi-disciplinary team to provide home-based medical care, care management, caregiver support, and counseling. Approximately 75% of JHOME's patients pass away at home or in hospice. As a lessons learned, JHOME is building in more palliative care focus across the entire multi-disciplinary team. JHOME has observed an opportunity for collaboration with SNFs. Moving forward, JHOME will leverage the relationship with Levindale & Sinai as a mechanism to provide acute-care continuity.

Next Steps

JHOME has applied to be a Program Excellence Partner (PEP) with the Home Centered Care Institute (HCCI), the national accreditation body for home-based medical providers. This would be a distinction of honor for the program, as well as a way to learn from other national house call providers who would rotate through the program.

Further, a Patient and Family Advisory Council (PFAC) is under development for JHOME. JHOME and Johns Hopkins Home Care Group (JHHCG) leadership have been discussing the incorporation of JHOME patients and caregivers in the JHHCG PFAC. The JHHCG PFAC is dedicated to the improvement of quality and patient and family care; the advisory council is comprised of past and present patients, family, and staff members.

A Nurse Practitioner was hired in July to specifically meet the needs of the JHH-discharged patients who are homebound. In Fiscal Year 2019, JHOME looks forward to the new Nurse Practitioner taking on a substantial caseload; expanding the overall case capacity of this program specifically for the JHH.

Additional Information

None.

Convalescent Care

Name of Program
Convalescent Care

Hospital Partners Participating
All

Brief Description
Convalescent Care provides people experiencing homelessness who are discharged from a Hospital Partner a place to stay, rest, and recuperate from an acute illness or surgery. On the Convalescent Care unit, patients receive 12-hour-a-day nursing services (medication education, care coordination, and wound care) and social work services (to link patients to housing resources, income, mental health, and addiction services).

Partners
- Health Care for the Homeless (Nurses, medical providers, and social workers)

 # FTEs in 2018
- Health Care for the Homeless (Nurses, medical providers, and social workers): 4.4 FTE

 # Patients Served

# of Patient Served as of June 30, 2018	111
Denominator of Eligible Patients	2,669 Homeless individuals in Baltimore City, of that 2,230 are > 24 years of age Source: Maryland 2017 Point-In-Time Count Department of Housing and Community Development # homeless patients referred from Hospital Partners = Total Referrals = 344 individuals Source: CHPB Convalescent Care Dashboard (July 1 2017 - June 2018)

Pre/Post Analysis for Program
Of the 111 patients served by Convalescent Care for Fiscal Year 2018, 58 patients were included in the pre/post analysis. Six patients were not included because they were enrolled as a Healthcare for the Homeless patient after the data was uploaded into CRISP's pre-/post-panel report (6/9/18). Forty seven (47) patients were not included due to data matching errors between our Convalescent Care panel and our primary care panel due to CRISP database limitations. The average length of treatment for the Convalescent Care program is 36 days.

At three months post intervention there was a 12.2% decrease in visits. At three months post Convalescent Care program, 41 patients of the 58 patients had data available for analysis. For pre- and post-enrollment reports (screenshots of summary and panel analysis), refer to

Appendix H – Pre-Post Reports for Convalescent Care.

Program-Specific Outcome or Process Measures

Convalescent Care Process Measure	**Number**
Total Number of Patients Referred	355
Total Number of Accepted Referrals	157
Total Number of Patients Presenting for Care	111
Average Number/percent of Beds Filled Monthly (out of 12)	11 (90%)
Average Length of Stay per Month (days)	36
Number of Patients Who Saw a Primary Care Physician within 7 days of discharge from Convalescent Care	14 out of 76 patients discharged (18%)
Number/Percent of Patients with Follow Up to Behavioral Health within 14 days of discharge from Convalescent Care	12 out of 51 patients discharged (24%)
Number of Patients sent to ED from Health Care for the Homeless	11
Number of patients readmitted to Hospital from Health Care for the Homeless	13
Number of Patients Successfully Discharged from Unit	71

Successes

During this reporting period, HCH Convalescent Care was able to maintain an average daily census of 11 beds filled by Hospital Partners, which is at 90% capacity. Sixty-one percent (61%) of patients who presented for care completed the program. “Completion” means that the patient achieved their medical and behavioral health goals prior to discharge. Sixteen percent (16%) of patients left against medical advice and 14% were discharged for behavioral reasons, with a small minority (9%) discharged back to the hospital.

All patients who completed the Convalescent Care Program had a medical and behavioral health assessment by Health Care for the Homeless providers. Ideally, clients would remain engaged with medical and behavioral health care upon discharge from the Convalescent Care Program but achieving this remains a challenge (see below).

Starting in November 2017, Convalescent Care staff have had the opportunity to submit applications for permanent supportive housing through Baltimore City’s Coordinated Access process. Since that time, Health Care for the Homeless have submitted 35 referrals for eligible clients. The majority of clients continue to stay at the Weinberg Housing and Resource Center until they are able to obtain permanent housing.

Lessons Learned

Health Care for the Homeless has completed several performance improvement cycles to try to identify barriers to keeping clients connected to primary medical care and behavioral health care after discharge from this program. The barrier identified in the first cycle was the lack of timely appointment availability at the Health Care for the Homeless clinic, which Health Care for the Homeless has since corrected. The second cycle identified clients' lack of familiarity with the idea of having a primary care doctor. In April of 2018, Health Care for the Homeless began connecting Convalescent Care patients to Community Health Workers at the Health Care for the Homeless clinic. The Community Health Workers have been working to engage clients and provide a warm handoff from Convalescent Care to the Health Care for the Homeless outpatient clinic. They address social determinants of health and provide appointment reminders. Health Care for the Homeless hopes to report positive results from this intervention in the next reporting period.

Through the course of this project, Health Care for the Homeless has placed a greater emphasis on the importance of a timely response to hospitals referring to this program. Health Care for the Homeless has made improvements to the Convalescent Care referral mechanism. HCH continues to focus on the referral mechanism portal as an area of improvement.

Next Steps

The medical care at the Convalescent Care Program is overseen by the Chief Health Officer of Health Care for the Homeless, Dr. Nilesh Kalyanaraman. Convalescent Care has been recruiting for a Medical Director for Convalescent Care for the past year with a goal of focusing on improving clinical workflows and outcomes while expanding the range of services that Health Care for the Homeless can offer.

Over the next year, this program will continue to streamline its referral process so that it can provide a more timely response to referring HPs.

Additional Information

"Joseph" - Example of Story Demonstrating Value of Program

Joseph was living under a bridge and working outside until prolonged exposure to the winter cold resulted in frostbite on his hands and feet. He was referred by a local hospital to the Convalescent Care Program, where he was able to stay while getting the care he needed to avoid amputation and also heal his wounds. Program staff referred Joseph to a transitional housing program. They also connected him to primary medical care at Health Care for the Homeless, so he could address chronic health conditions he had long been neglecting.

"Anthony" - Example of Story Demonstrating Value of Program

Anthony was staying at a residential employment program and actively seeking a job when he suffered a stroke that left him permanently disabled in his mid-40s. He lost his spot in the program due to his inability to work, and was referred by a hospital to the Convalescent Care Program. Here, the nurses helped him manage his new medical conditions (including being on Coumadin, a blood thinner that requires frequent monitoring), and a social worker helped him adjust psychologically to being disabled at such a young age. Staff also helped him secure insurance, which allowed him to start a physical therapy program that had been delayed due to his lack of insurance. Anthony left the Convalescent Care Program for a transitional housing program for individuals with disabilities.

"Warren" - Example of Story Demonstrating Value of Program

Most of Warren's family members are deceased, so when he became acutely ill with liver disease and was no longer able to work, he had no support and nowhere to go. A referral to the Convalescent Care Program allowed him to recover from his liver disease, while also getting help for cognitive problems that resulted from a related chemical imbalance. Nurses and social workers helped Warren stabilize medically and regain most of his cognitive functioning; they also helped him apply for federal disability benefits. He was discharged to an assisted living program where he will live until he is approved for disability or able to go back to work.

Patient Engagement Program

Name of Program
Patient Engagement Program

Hospital Partners Participating
All

Brief Description
The Patient Engagement Program (PEP) trains providers and staff on the tactics and skills needed to facilitate patient engagement, affect health behavior change, and promote patient satisfaction. This includes training staff and physicians to utilize a number of strategies, including skill building, maintenance, and learner evaluation.

Partners

- Johns Hopkins Medicine (Faculty, Post-Doctoral Fellow)

 # FTEs in 2018

- Johns Hopkins Medicine (Faculty, Post-Doctoral Fellow): 0.7 FTE

 # Patients Served
Not applicable

Pre/Post Analysis for Program
Not applicable

Program-Specific Outcome or Process Measures

PEP Process Measure	Number of Providers
Providers Served/ CHPB & Partner Hospital Providers	189
Pre-Training Self-Evaluation	189
Post-Training Self-Evaluation	159

The Patient Engagement Program evaluated the outcome of its trainings based on five measures. Below are the results:

1. Importance of using PEP skills – On average, participants reported very high importance in using PEP skills in their practice, and this rating remains very high post-training (though not a statistically significant change).
2. Confidence in using PEP skills – On average, participants reported increased confidence in using PEP skills in their practice after training (statistically significantly).
3. Realistic use of PEP skills in practice – On average, participants reported an increased belief in their ability to realistically use PEP skills in practice after training (statistically significantly).
4. Knowledge and attitudes about PEP – On average, participants demonstrated an increased understanding of PEP knowledge and attitudes after training (statistically significantly).

5. PEP skills assessment – On average, participants demonstrated an increase in PEP skill acquisition after training (statistically significantly).

Successes

Outcomes from the PEP self-assessment suggest that before training, participants believe it is important to be using PEP skill in their practice (mean = 9.29/10) and this remains high post-training (mean = 9.40/10) (although not statistically changed post-training). After training, self-efficacy is maintained (importance) or improved slightly (confidence and realistic use), but knowledge and attitudes about, and use of, PEP skills improve statistically significantly.

The CHPB supported an annual Patient Engagement conference: "Third Annual Patient-Provider Collaboration Conference, Making Patient-Centered Care a Reality: The Journey Continues." The keynote address was delivered by Mr. John Colmers on "Achieving the Quadruple Aim – The Maryland Experiment." The CHPB's Director and STAR CEO co-presented a session on "Improving Community Engagement Using the Community Health Worker Model." The CHPB sponsored over 70 CHPB and HP staff to attend the conference. This conference was a collaborative effort with the Howard Health Regional Partnership.

Lessons Learned

Trainees overestimate their skills and knowledge prior to training. Outcomes from the PEP self-assessment suggest that before training, participants have high self-confidence in their knowledge about and ability to utilize PEP skills and believe that PEP skills are both important and realistic for their own practice. Actual baseline knowledge and attitudes are moderately low and skills are low. These findings reinforce CHPB's belief that all CHPB staff need to take PEP training, and to re-take the course every 12 months.

Acknowledging the time commitment to PEP, CHPB has worked with PEP staff to develop a 4-hour booster session. This incentivizes CHPB staff who've taken the 8-hour training, to re-take a shortened booster session every 12 months.

Next Steps

Given these positive results, it is vital that CHPB continues its PEP strategic planning process towards sustainability. In the last year, CHPB has begun to track which CHPB staff have taken PEP, as well as required all staff to take PEP every 12 months. To support this effort, faculty has expanded to meet high demands of this program. To additionally support the sustainability of PEP, CHPB is encouraging its staff to become trained to be a PEP Champion—through a train-the-trainer program.

The PEP leadership continues to modify training specific for community-based care, in alignment with community-based partners. The PEP currently has aggregate findings of self-assessment that represent all PEP participants, including CHPB staff. The CHPB looks forward to disaggregating findings so that they represent specifically CHPB staff feedback. The PEP is also developing a provider knowledge assessment and analysis of provider communication skills. The PEP is developing methods to measure patient outcomes including patient satisfaction.

The CHPB also has scheduled four trainings for Fiscal Year 2019 that seek to train all CHPB employees with 8- & 4- hour boosters (September, October, November, December). Online modules of the PEP training are being considered. New PEP Champions have been identified and begun their training; more PEP Champions will continue to be recruited. The CHPB hopes to also capture how many CHPB

employees move on to the maintenance program. Each program would have their own maintenance program. The PEP would measure conversion as well as satisfaction of the maintenance program.

Core Measures

HSCRC: 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 2017 RP Analytic File (please specify which source you are using for each of the outcome measures).

Utilization Measures

Utilization Measures are defined broadly by CRISP reports (representing either all individuals with Medicare FFS who have at least 3 hospitalizations and/or inpatient stays greater than 24 hours within a 19 zip code area, or the overall population of Medicare FFS in the 19 zip code area) and do not provide information specific to patients who have been enrolled by programs within CHPB. The utilization data is broken down by quarters to see trends in population over time however there is no comparison population and therefore conclusions cannot be drawn without outcomes.

Measure in RFP *(Table 1, Appendix A of the RFP)*	**Measure for FY 2018 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 2017 -or- Analytic File: 'Charges' over 'Population' (Column E / Column C)	From RP Analytic File_01Jan18_31July18 for 3+ IP or bs>=24 Visit Medicare FFS: = $88,349,248.7/74,445 population **= $1186.77/per capita**
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 2018 Once the June file is available we will have the average -or- Analytic File:	From RP Analytic File_01Jan18_31July18 for 3+ IP or bs>=24 Visit Medicare FFS: = 3822 visits/74,445 population **= 0.05 discharge per capita**

	'IPObs24Visits' over 'Population' (Column G / Column C)	
Total Health Care Cost per person	**Partnership TCOC per capita – Medicare** Total Cost of Care (Medicare CCW) Report 'Regional Partnership Cost of Care': 'Tab 4. PBPY Costs by Service Type' – sorted for CY 2017 and Total	**Average PBPY = $15,773** Total Costs = $1,217,891,543 Total Members = 307,869
ED Visits per capita	**Ambulatory ED Visits per 1,000** Executive Dashboard: 'Regional Partnership per Capita Utilization' – Ambulatory ED Visits per 1,000, reported as average 12 months of FY 2018 -or- Analytic File 'ED Visits' over 'Population' (Column H / Column C)	From RP Analytic File_01Jan18_31July18 for 3+ IP or bs>=24 Visit Medicare FFS: = 1,434 ED visits/74,445 population **= 0.02 ED visit per capita**

Quality Indicator Measures

Measure in RFP *(Table 1 in Appendix A of the RFP)*	**Measure for FY 2018 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 2018 -or-	From RP Analytic File_01Jan18_31July18 for 3+ IP or bs>=24 Visit Medicare FFS: = 1,056 IP Readmit/2,565 Eligible for Readmit **= 0.41 Readmissions, unadjusted**

	Analytic File: 'IP Readmit' over 'EligibleforReadmit' (Column J / Column I)	
PAU	**Potentially Avoidable Utilization** Executive Dashboard: '[Partnership] Quality Indicators' – Potentially Avoidable Utilization, reported as **sum** of 12 months of FY 2018 -or- Analytic File: 'TotalPAUCharges' (Column K)	From RP Analytic File_01Jan18_31July18 for 3+ IP or bs>=24 Visit Medicare FFS: **= $31,027,155.62 PAU Charges**

Core Process Measures (CRISP Key Indicators)

HSCRC: 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 2018 Reporting**	**Outcomes(s)**
Established Longitudinal Care Plan	**% of patients with Care Plan recorded at CRISP** Executive Dashboard: 'High Needs Patients – CRISP Key Indicators' – % of patients with Care Plan recorded at CRISP, reported as average monthly % for most recent six months of data *May also include Rising Needs Patients, if applicable in Partnership.*	2.7%
Portion of Target Population with Contact from Assigned	**Potentially Avoidable Utilization** Executive Dashboard: 'High Needs Patients – CRISP Key Indicators' –	31.7%

Care Manager	% 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.*	

Self-Reported Process Measures

Please describe any process measures that your RP is tracking, but are not currently captured under the Executive Dashboard. Some examples are include shared care plans, health risk assessments, patients with care manager who are not recorded in CRISP, etc. These can be by-intervention or by-partnership.

The CHPB has developed Report Card tools for Executive Leadership to evaluate performance for infrastructure, marketing, patient enrollment, budget management, and utilization targets. The CHPB Report Cards are developed for the overall CHPB and Hospital Partner-specific. For Report Cards, refer to Appendix B – Report Cards.

Return on Investment

HSCRC: Indicate how the Partnership is working to generate a positive return on investment (Free Response; please include your calculation). Please refer to the line-item definitions to complete the calculation by-intervention, if able.

Currently the CHPB is not reporting on return on investment (ROI). The CHPB is, however, exploring a calculation for ROI of CHPB and of each of the respective programs that comprise the CHPB overall programming.

To calculate ROI of CHPB, the ROI calculation in the original proposal included the following formula:

A. # of patients
B. Number of Medicare and dual eligible
C. Annual program cost /patient
D. Annual program cost (B x C); (Medicare cost/program)
E. Annual Charges (baseline)
F. Annual gross savings (15.21% x E)
G. Variable Savings (F x "X"%)
H. Annual net savings (1-ROI)(G/D) & (2-Dollars saved) (G-D)

Separately, the CHPB is exploring the ROI for each of the programs that comprise the overall CHPB. For these ROI calculations, the CHPB is exploring how to acquire data on a matching population in order to conduct a difference in difference methodology in order to understand how the costs of the each program compare to business as usual. This will inform the numerator of the ROI calculation. The ROI will compare the cost of each program to the savings in costs achieved, as calculated by the difference in difference equation described above. Please note that no current data made available through CRISP can be used for these calculations.

Conclusion

The CHPB moves into Fiscal Year 2019 eager to improve the health of Baltimore residents in a highly reliable, exceptionally efficient, and keenly patient-centered manner. The CHPB's programs aim to change the drivers of health in Baltimore City; these drivers historically led to high utilization of healthcare services and poor health outcomes.

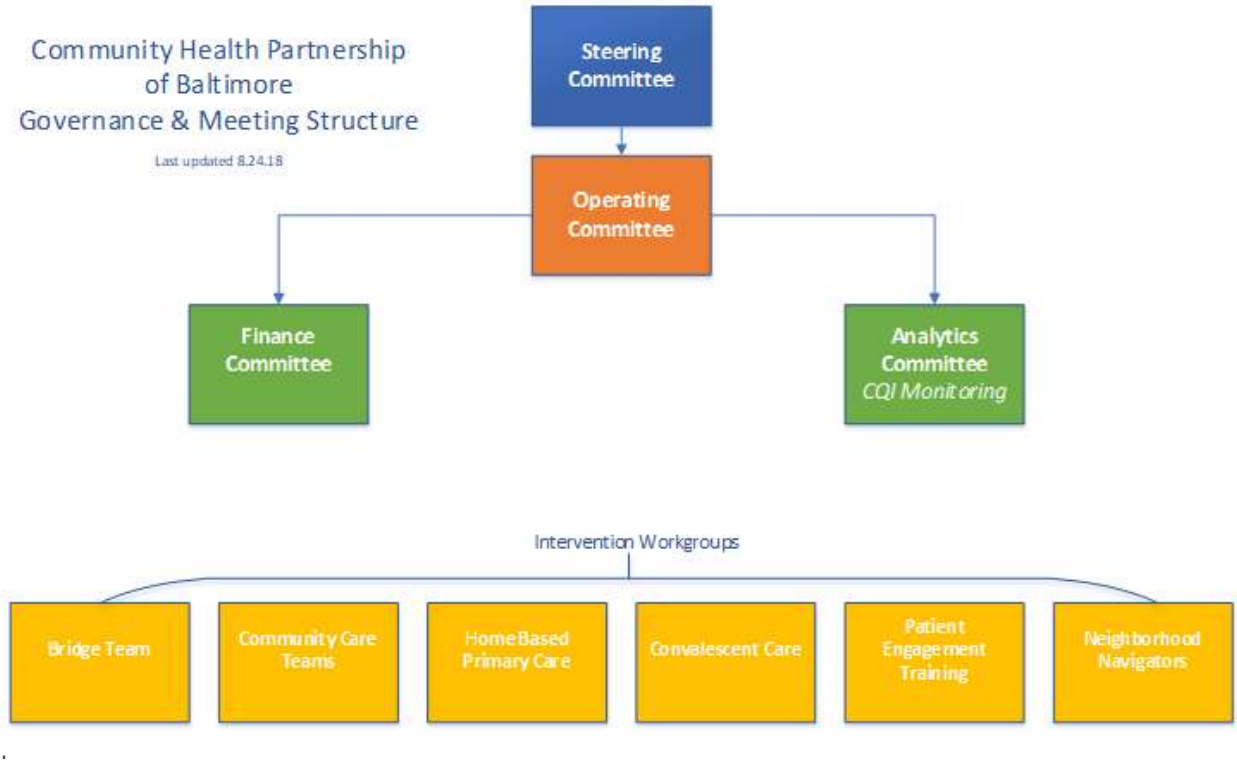
The CHPB will focus on increasing methods of patient identification in Fiscal Year 2019 to ensure CHPB's programs reach and maintain patient capacity as well as impact the greatest number of Baltimore City residents. CHPB will focus on methods of identifying patients earlier to outreach them during time of most need. Evaluation, scalability, and sustainability are concurrent goals of Fiscal Year 2019. Each program is developing long-term evaluation metrics that are complemented by short-term metric development (that will be fed back to PCPs, EDs, and other community partners). Integration of alternative funding through improved billing practices is being actively researched, particularly for JHOME and Bridge Team. The CHPB will continue efforts to advance meaningful and appropriate payment reform in an effort to create incentives for providing complementary social services to meet needs of patients. The CHPB aims to sustainably reduce hospital utilization under the Global Budget Revenue and then reinvest savings in CHPB's most valuable and high-performing programs. Community engagement through the development of a Community Advisory Board is an essential element of Fiscal Year 2019 strategy. This is in addition to sustained development of community-based workforce.

The Regional Partnership Learning Collaborative has been an essential component of the CHPB's growth and learning. The CHPB looks forward to continued partnership with the HSCRC and the payer community in support of transformative healthcare delivery strategies that align to the overall objectives of Maryland's unique Total Cost of Care Model. The CHPB Steering Committee will critically review care coordination and integration strategies among Hospital Partners to identify opportunities to leverage Maryland's emerging healthcare transformation initiatives.

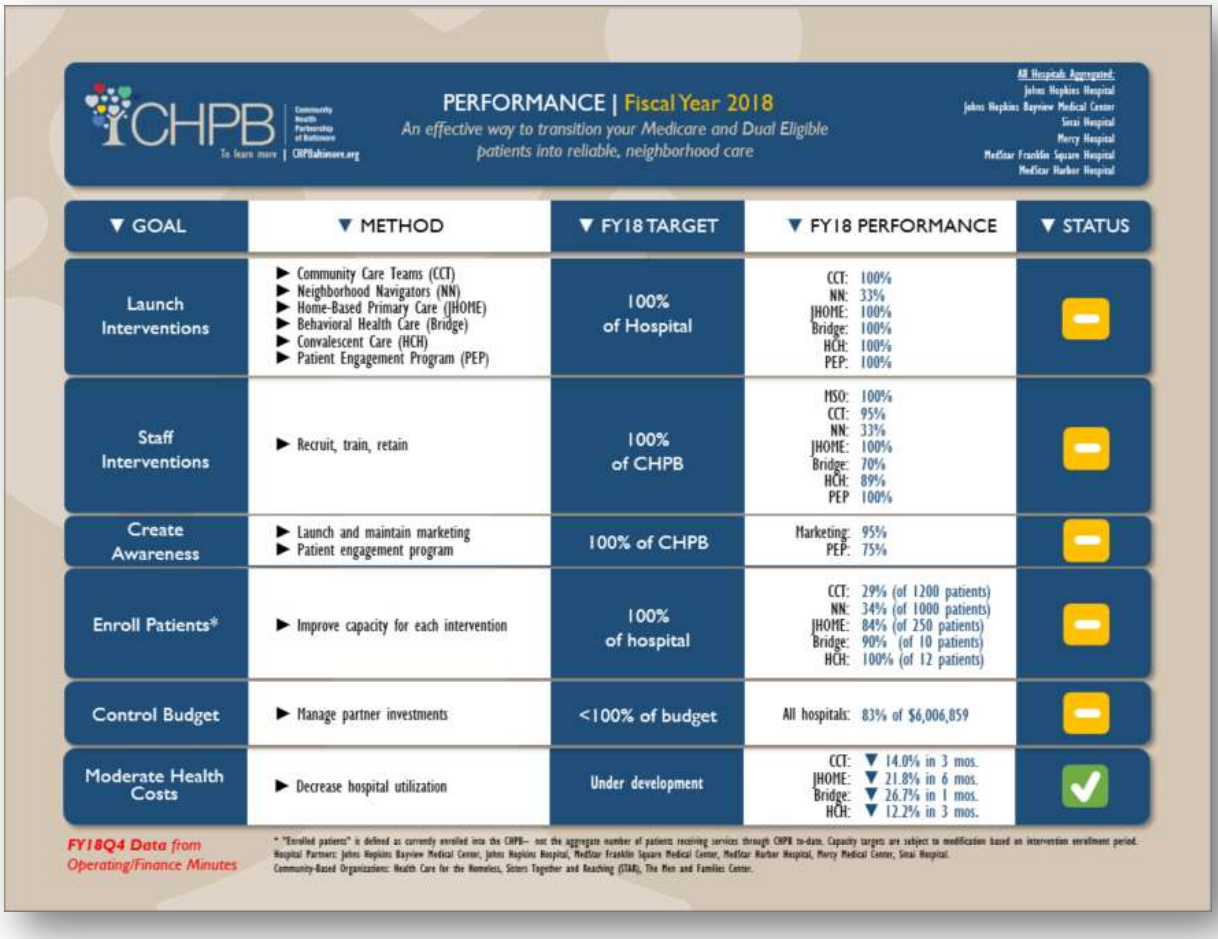
The CHPB looks forward to ensuring patients receive the *right care*, at the *right time*, in the *right setting*.

Appendices

Appendix A – Organizational Chart of CHPB Governance



Appendix B – Report Cards



CHPB Community Health Partnership of Baltimore
To learn more | CHPBaltimore.org

PERFORMANCE | Fiscal Year 2018

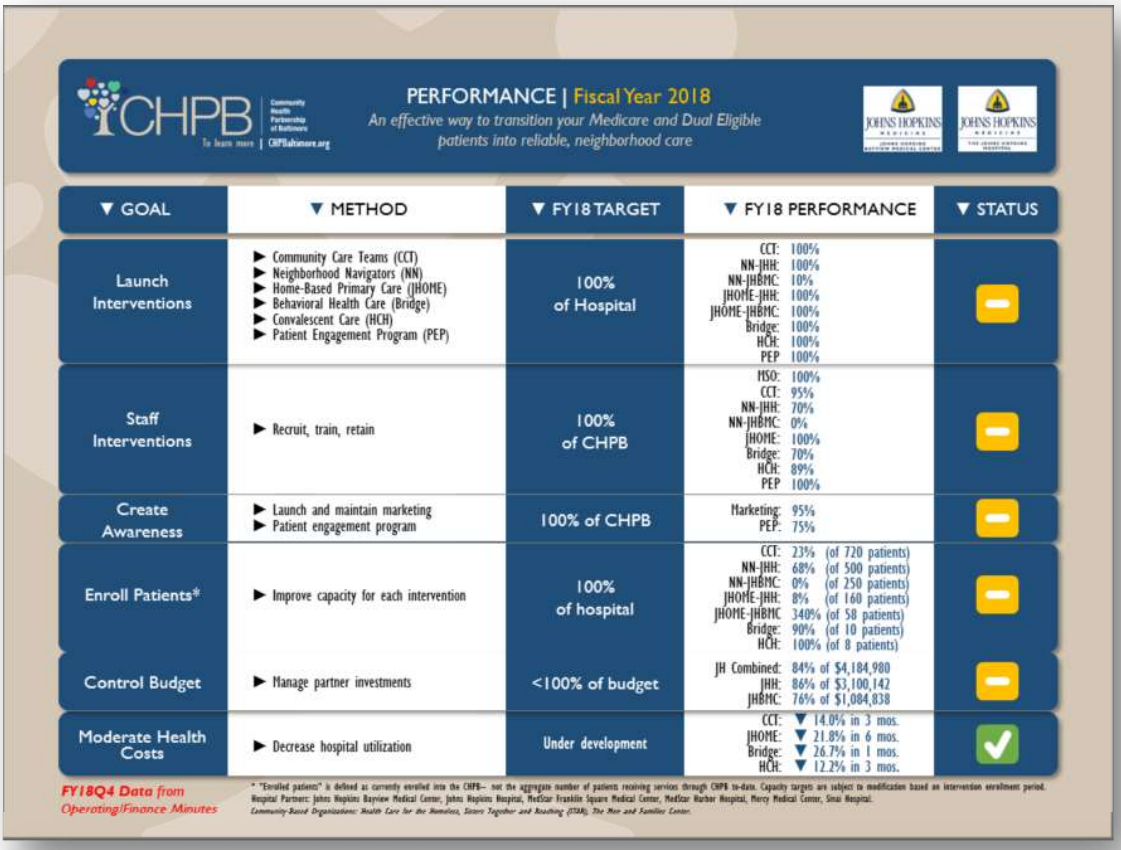
An effective way to transition your Medicare and Dual Eligible patients into reliable, neighborhood care

All Hospitals Aggregated:
Johns Hopkins Hospital
Johns Hopkins Bayview Medical Center
Sinai Hospital
Mercy Hospital
MedStar Franklin Square Hospital
MedStar Harbor Hospital

▼ GOAL	▼ METHOD	▼ FY18 TARGET	▼ FY18 PERFORMANCE	▼ STATUS
Launch Interventions	▶ Community Care Teams (CCT) ▶ Neighborhood Navigators (NN) ▶ Home-Based Primary Care (JHOME) ▶ Behavioral Health Care (Bridge) ▶ Convalescent Care (HCH) ▶ Patient Engagement Program (PEP)	100% of Hospital	CCT: 100% NN: 33% JHOME: 100% Bridge: 100% HCH: 100% PEP: 100%	–
Staff Interventions	▶ Recruit, train, retain	100% of CHPB	MSO: 100% CCT: 95% NN: 33% JHOME: 100% Bridge: 70% HCH: 89% PEP 100%	–
Create Awareness	▶ Launch and maintain marketing ▶ Patient engagement program	100% of CHPB	Marketing: 95% PEP: 75%	–
Enroll Patients*	▶ Improve capacity for each intervention	100% of hospital	CCT: 29% (of 1200 patients) NN: 34% (of 1000 patients) JHOME: 84% (of 250 patients) Bridge: 90% (of 10 patients) HCH: 100% (of 12 patients)	–
Control Budget	▶ Manage partner investments	<100% of budget	All hospitals: 83% of $6,006,859	–
Moderate Health Costs	▶ Decrease hospital utilization	Under development	CCT: ▼ 14.0% in 3 mos. JHOME: ▼ 21.8% in 6 mos. Bridge: ▼ 26.7% in 1 mos. HCH: ▼ 12.2% in 3 mos.	✓

FY18Q4 Data from Operating/Finance Minutes

* "Enrolled patients" is defined as currently enrolled into the CHPB-- not the aggregate number of patients receiving services through CHPB to-date. Capacity targets are subject to modification based on intervention enrollment period.
Hospital Partners: Johns Hopkins Bayview Medical Center, Johns Hopkins Hospital, MedStar Franklin Square Medical Center, MedStar Harbor Hospital, Mercy Medical Center, Sinai Hospital.
Community-Based Organizations: Health Care for the Homeless, Sisters Together and Reaching (STAR), The Men and Families Center.



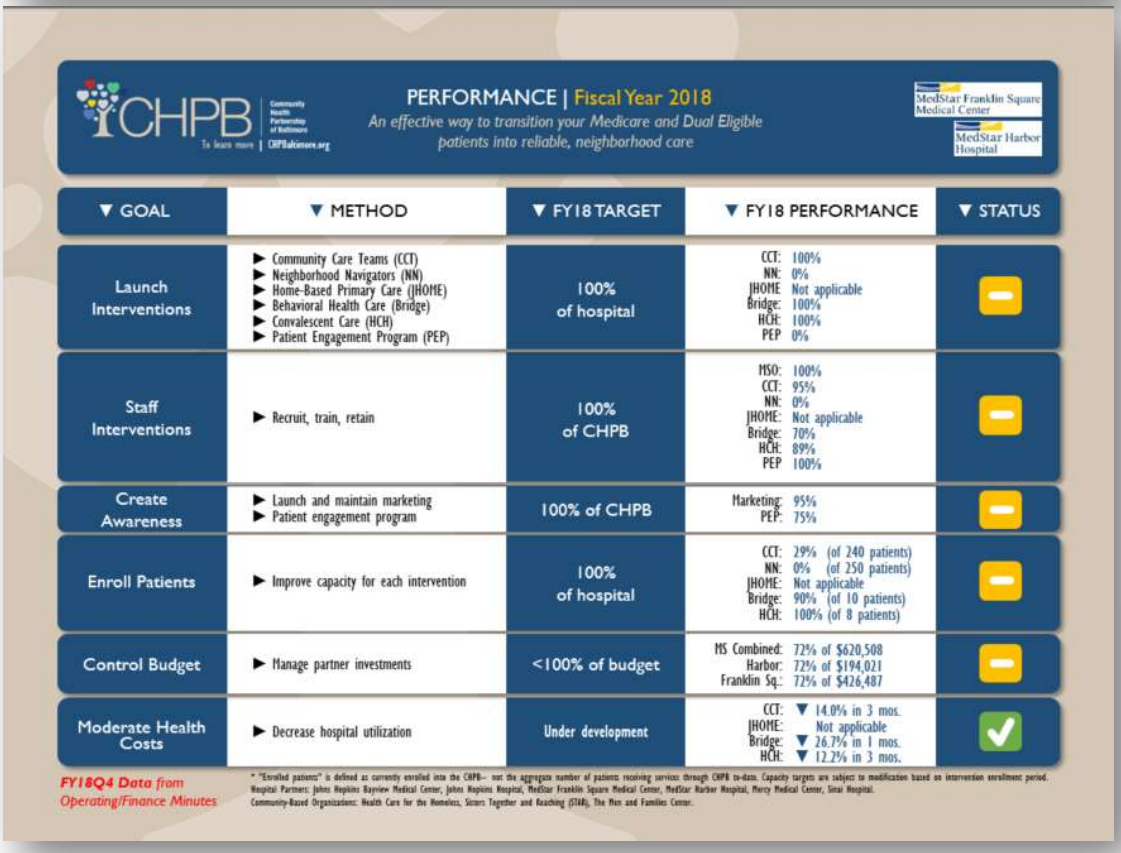
PERFORMANCE | Fiscal Year 2018

An effective way to transition your Medicare and Dual Eligible patients into reliable, neighborhood care

GOAL	METHOD	FY18 TARGET	FY18 PERFORMANCE	STATUS
Launch Interventions	▶ Community Care Teams (CCT) ▶ Neighborhood Navigators (NN) ▶ Home-Based Primary Care (JHOME) ▶ Behavioral Health Care (Bridge) ▶ Convalescent Care (HCH) ▶ Patient Engagement Program (PEP)	100% of Hospital	CCT: 100% NN-JHH: 100% NN-JHBMC: 10% JHOME-JHH: 100% JHOME-JHBMC: 100% Bridge: 100% HCH: 100% PEP 100%	–
Staff Interventions	▶ Recruit, train, retain	100% of CHPB	MSO: 100% CCT: 95% NN-JHH: 70% NN-JHBMC: 0% JHOME: 100% Bridge: 70% HCH: 89% PEP 100%	–
Create Awareness	▶ Launch and maintain marketing ▶ Patient engagement program	100% of CHPB	Marketing: 95% PEP: 75%	–
Enroll Patients*	▶ Improve capacity for each intervention	100% of hospital	CCT: 23% (of 720 patients) NN-JHH: 68% (of 500 patients) NN-JHBMC: 0% (of 250 patients) JHOME-JHH: 8% (of 160 patients) JHOME-JHBMC 340% (of 58 patients) Bridge: 90% (of 10 patients) HCH: 100% (of 8 patients)	–
Control Budget	▶ Manage partner investments	<100% of budget	JH Combined: 84% of $4,184,980 JHH: 86% of $3,100,142 JHBMC: 76% of $1,084,838	–
Moderate Health Costs	▶ Decrease hospital utilization	Under development	CCT: ▼ 14.0% in 3 mos. JHOME: ▼ 21.8% in 6 mos. Bridge: ▼ 26.7% in 1 mos. HCH: ▼ 12.2% in 3 mos.	✓

FY18Q4 Data from Operating/Finance Minutes

* "Enrolled patients" is defined as currently enrolled into the CHPB– not the aggregate number of patients receiving services through CHPB to-date. Capacity targets are subject to modification based on intervention enrollment period.
Hospital Partners: Johns Hopkins Bayview Medical Center, Johns Hopkins Hospital, MedStar Franklin Square Medical Center, MedStar Harbor Hospital, Mercy Medical Center, Sinai Hospital.
Community-Based Organizations: Health Care for the Homeless, Sisters Together and Reaching (STAR), The Men and Families Center.



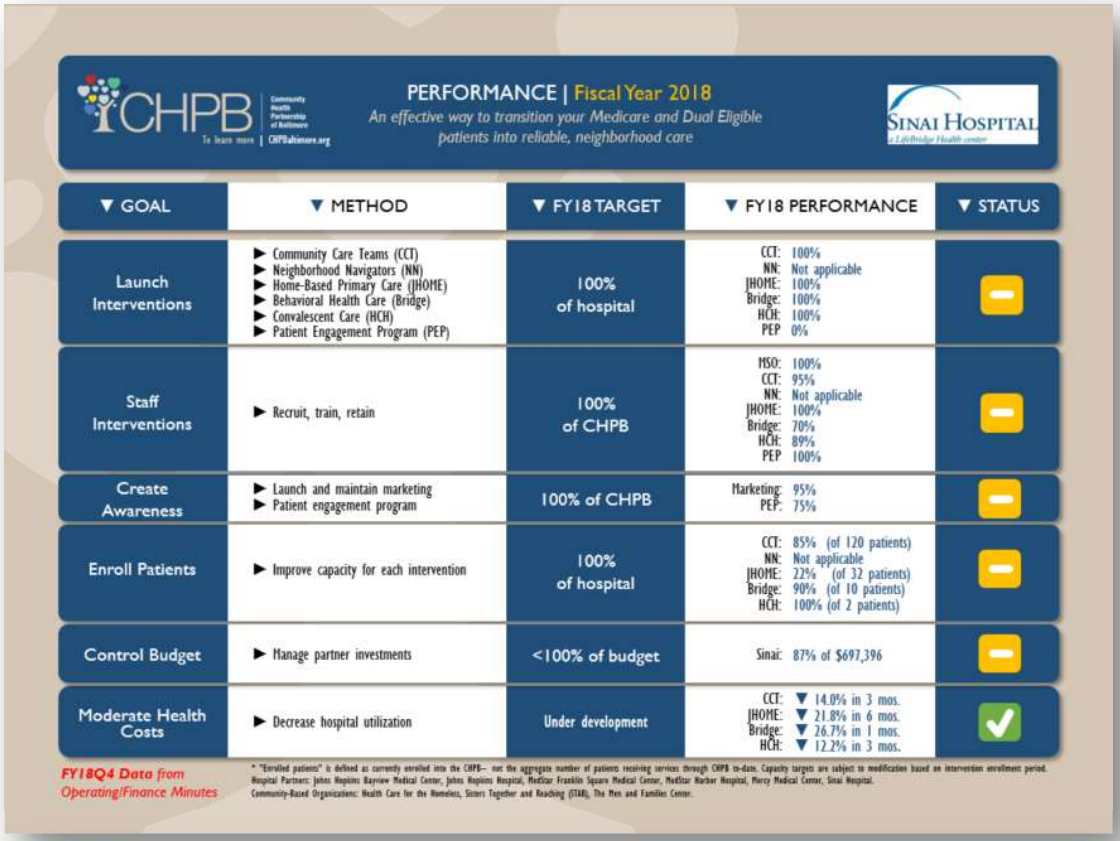
PERFORMANCE | Fiscal Year 2018

An effective way to transition your Medicare and Dual Eligible patients into reliable, neighborhood care

GOAL	METHOD	FY18 TARGET	FY18 PERFORMANCE	STATUS
Launch Interventions	▶ Community Care Teams (CCT) ▶ Neighborhood Navigators (NN) ▶ Home-Based Primary Care (JHOME) ▶ Behavioral Health Care (Bridge) ▶ Convalescent Care (HCH) ▶ Patient Engagement Program (PEP)	100% of hospital	CCT: 100% NN: 0% JHOME Not applicable Bridge: 100% HCH: 100% PEP 0%	–
Staff Interventions	▶ Recruit, train, retain	100% of CHPB	MSO: 100% CCT: 95% NN: 0% JHOME: Not applicable Bridge: 70% HCH: 89% PEP 100%	–
Create Awareness	▶ Launch and maintain marketing ▶ Patient engagement program	100% of CHPB	Marketing: 95% PEP: 75%	–
Enroll Patients	▶ Improve capacity for each intervention	100% of hospital	CCT: 29% (of 240 patients) NN: 0% (of 250 patients) JHOME: Not applicable Bridge: 90% (of 10 patients) HCH: 100% (of 8 patients)	–
Control Budget	▶ Manage partner investments	<100% of budget	MS Combined: 72% of $620,508 Harbor: 72% of $194,021 Franklin Sq.: 72% of $426,487	–
Moderate Health Costs	▶ Decrease hospital utilization	Under development	CCT: ▼ 14.0% in 3 mos. JHOME: Not applicable Bridge: ▼ 26.7% in 1 mos. HCH: ▼ 12.2% in 3 mos.	✓

FY18Q4 Data from Operating/Finance Minutes

* "Enrolled patients" is defined as currently enrolled into the CHPB– not the aggregate number of patients receiving services through CHPB to-date. Capacity targets are subject to modification based on intervention enrollment period.
Hospital Partners: Johns Hopkins Bayview Medical Center, Johns Hopkins Hospital, MedStar Franklin Square Medical Center, MedStar Harbor Hospital, Mercy Medical Center, Sinai Hospital.
Community-Based Organizations: Health Care for the Homeless, Sisters Together and Reaching (STAR), The Men and Families Center.



PERFORMANCE | Fiscal Year 2018

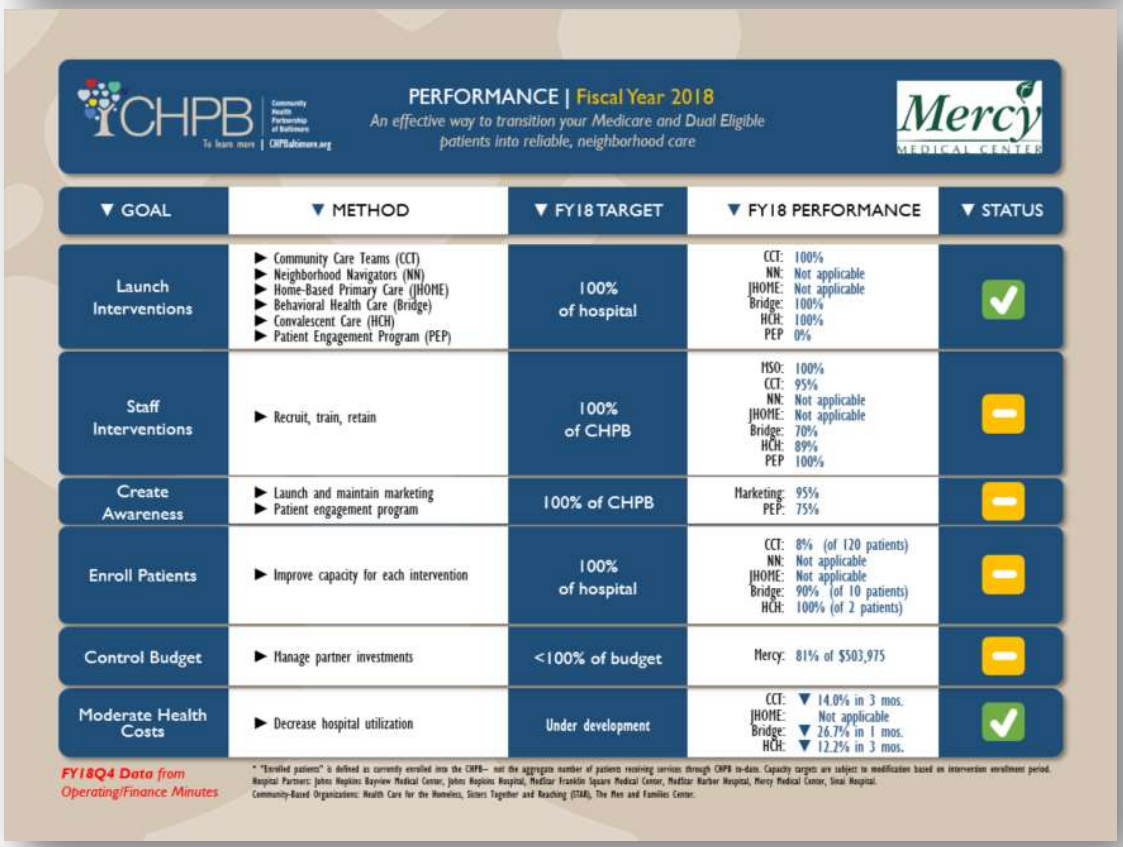
An effective way to transition your Medicare and Dual Eligible patients into reliable, neighborhood care

Sinai Hospital

GOAL	METHOD	FY18 TARGET	FY18 PERFORMANCE	STATUS
Launch Interventions	▶ Community Care Teams (CCT) ▶ Neighborhood Navigators (NN) ▶ Home-Based Primary Care (HOME) ▶ Behavioral Health Care (Bridge) ▶ Convalescent Care (HCH) ▶ Patient Engagement Program (PEP)	100% of hospital	CCT: 100% NN: Not applicable HOME: 100% Bridge: 100% HCH: 100% PEP 0%	–
Staff Interventions	▶ Recruit, train, retain	100% of CHPB	MSO: 100% CCT: 95% NN: Not applicable HOME: 100% Bridge: 70% HCH: 89% PEP 100%	–
Create Awareness	▶ Launch and maintain marketing ▶ Patient engagement program	100% of CHPB	Marketing: 95% PEP: 75%	–
Enroll Patients	▶ Improve capacity for each intervention	100% of hospital	CCT: 85% (of 120 patients) NN: Not applicable HOME: 22% (of 32 patients) Bridge: 90% (of 10 patients) HCH: 100% (of 2 patients)	–
Control Budget	▶ Manage partner investments	<100% of budget	Sinai: 87% of $697,396	–
Moderate Health Costs	▶ Decrease hospital utilization	Under development	CCT: ▼ 14.0% in 3 mos. HOME: ▼ 21.8% in 6 mos. Bridge: ▼ 26.7% in 1 mos. HCH: ▼ 12.2% in 3 mos.	✓

FY18Q4 Data from Operating/Finance Minutes

* "Enrolled patients" is defined as currently enrolled into the CHPB– not the aggregate number of patients receiving services through CHPB to-date. Capacity targets are subject to modification based on intervention enrollment period.
Hospital Partners: Johns Hopkins Bayview Medical Center, Johns Hopkins Hospital, MedStar Franklin Square Medical Center, MedStar Harbor Hospital, Mercy Medical Center, Sinai Hospital.
Community-Based Organizations: Health Care for the Homeless, Sisters Together and Reaching (STAR), The Men and Families Center.



PERFORMANCE | Fiscal Year 2018

An effective way to transition your Medicare and Dual Eligible patients into reliable, neighborhood care

Mercy Medical Center

GOAL	METHOD	FY18 TARGET	FY18 PERFORMANCE	STATUS
Launch Interventions	▶ Community Care Teams (CCT) ▶ Neighborhood Navigators (NN) ▶ Home-Based Primary Care (HOME) ▶ Behavioral Health Care (Bridge) ▶ Convalescent Care (HCH) ▶ Patient Engagement Program (PEP)	100% of hospital	CCT: 100% NN: Not applicable HOME: Not applicable Bridge: 100% HCH: 100% PEP 0%	✓
Staff Interventions	▶ Recruit, train, retain	100% of CHPB	MSO: 100% CCT: 95% NN: Not applicable HOME: Not applicable Bridge: 70% HCH: 89% PEP 100%	–
Create Awareness	▶ Launch and maintain marketing ▶ Patient engagement program	100% of CHPB	Marketing: 95% PEP: 75%	–
Enroll Patients	▶ Improve capacity for each intervention	100% of hospital	CCT: 8% (of 120 patients) NN: Not applicable HOME: Not applicable Bridge: 90% (of 10 patients) HCH: 100% (of 2 patients)	–
Control Budget	▶ Manage partner investments	<100% of budget	Mercy: 81% of $503,975	–
Moderate Health Costs	▶ Decrease hospital utilization	Under development	CCT: ▼ 14.0% in 3 mos. HOME: Not applicable Bridge: ▼ 26.7% in 1 mos. HCH: ▼ 12.2% in 3 mos.	✓

FY18Q4 Data from Operating/Finance Minutes

* "Enrolled patients" is defined as currently enrolled into the CHPB– not the aggregate number of patients receiving services through CHPB to-date. Capacity targets are subject to modification based on intervention enrollment period.
Hospital Partners: Johns Hopkins Bayview Medical Center, Johns Hopkins Hospital, MedStar Franklin Square Medical Center, MedStar Harbor Hospital, Mercy Medical Center, Sinai Hospital.
Community-Based Organizations: Health Care for the Homeless, Sisters Together and Reaching (STAR), The Men and Families Center.

Appendix C – Marketing Plan

CHPB Marketing Strategy
2018

Timeline

I. Development

A. **Dates:** March to July 2018
B. **Target audience:** CHPB Staff/ Hospital Partners
C. **Goal:** Develop marketing products that are accessible to prospective CHPB patients
D. **Metric:** Development of marketing products (target = 20 products produced)
E. **Evaluation:** 100% (20/20 products developed and in "final draft" form)
F. **Activities:**
   1) Listen to ideas for marketing products from target audience (March 2018)
   2) Gather content from historical documents, websites, etc. Summarize content and translate to accessible language (March 2018).
   3) Design drafts of each marketing product (March to April 2018)
   4) Review of content – completed by most interventions (March to April 2018)
   5) Review of design – completed by all interventions (formatting, images) (May 2018)
   6) Produce final drafts of each product (e.g., soft launch website, business cards, etc.) (June 2018).

II. Soft Launch

A. **Dates:** July to August 2018
B. **Target audience:** CHPB Staff/ Hospital Partners/ Patients (select)/ Referrers
C. **Goal:** Streamline our marketing products (e.g., tweaks to website, gather additional patient testimonials, conduct survey about accessibility of website/ materials)
D. **Metric:**
   a) Feedback on edits needed for products
   b) Self-reported accessibility of website from target audience
E. **Activities:**
   1) Introduce products to target audience (e.g., email, meetings).
   2) Open survey to gather feedback on accessibility of products (e.g., google forms).
   3) Revise products (as needed) (e.g., change font, reduce sentence length).
   4) Send products to printers.

III. Hard Launch

A. **Dates:** September 2018 onwards
B. **Target audience:** Patients (prospective)/ Referrers/ Public
C. **Goal:** Recruit more Patients into CHPB's 6 interventions.
D. **Metric:** % increase in enrollment to each CHPB intervention
E. **Activities:**
   1) CHPB Staff conduct roadshows to Hospital Partners to advertise interventions to Referrers
   2) Place "Staff Directory" in hospitals.
   3) Give Patients "Patient ID card."
   4) Engage social media, press, newsletters (e.g., MDH SHIP newsletter, press release, Facebook).

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Questions or Comments? CHPBaltimore@jhmi.edu

Products

#	Product Name	Audience	Print	Purpose	Status
1.	CHPBaltimore.org	Public	Electronic	Overview of CHPB	Soft launch
2.	CHPBaltimore@jhmi.edu	Public	N/A	General questions	Soft launch
3.	populationhealth@jhhc.com	Referrers	N/A	Referrals	Hard launch
4.	CHPB Telephone #	Patients (Prosp.) & Referrers	N/A	General questions/ referrals	Development
5.	CHPB Brochure	Referrers	Electronic & Hard copy	Overview of CHPB	Hard launch
6.	CHPB Executive Report Card	Hospital Partners	Electronic & Hard copy	Data on CHPB	Hard launch
7.	CHPB Intervention 1-Pagers: CCT	Patients (Prosp.)	Electronic & Hard copy	Overview of intervention	Soft launch
8.	CHPB Intervention 1-Pagers: NN	Patients (Prosp.)	Electronic & Hard copy	Overview of intervention	Soft launch
9.	CHPB Intervention 1-Pagers: CC	Patients (Prosp.)	Electronic & Hard copy	Overview of intervention	Soft launch
10.	CHPB Intervention 1-Pagers: JHOME	Patients (Prosp.)	Electronic & Hard copy	Overview of intervention	Soft launch
11.	CHPB Intervention 1-Pagers: PEP	Patients (Prosp.)	Electronic & Hard copy	Overview of intervention	Soft launch
12.	CHPB Intervention 1-Pagers: Bridge	Patients (Prosp.)	Electronic & Hard copy	Overview of intervention	Soft launch
13.	Business Cards - CCT	Patients	Hard copy	Awareness	Hard launch
14.	Business Cards - Bridge	Patients	Hard copy	Awareness	Hard launch
15.	Business Cards - NN	Patients	Hard copy	Awareness	Hard launch
16.	CHPB Appointment cards (blank cards)	Patients	Hard copy	Notetaking	Hard launch
17.	CCT Patient ID Cards	Patients & Referrers	Hard copy	Awareness	Soft Launch
18.	CCT Staff Directory	Patients & Referrers	Electronic & Hard copy	Awareness	Soft Launch
19.	CHPB Tote Bags	Staff	Hard copy	Appreciation	Development
20.	CHPB Table clothe	Public	Hard copy	Awareness	Development

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Questions or Comments? CHPBaltimore@jhmi.edu

Appendix D – Fiscal Year 2019 Strategic Framework

Community Health Partnership for Baltimore

Care Coordination and Data / Reporting Retreat

The Community Health Partnership of Baltimore (CHPB) thanks our participants for your active engagement in two productive Retreats 1: "Enrollment and Care Coordination" and 2: "Data and Reporting" in our second year of the CHPB. This document outlines a detailed summary and key themes and actionable findings of the Retreats.

Diversify sources of patient identification

Expand Inpatient Referral Strategy;

Enable CRISP Blind Panel process;

Leverage Hospital Partner (HP) daily patient discharge information; and

Outreach patients being discharged to/from a Skilled Nursing Facility (SNF).

Integrate workflow from partner to partner.

Improve reporting

Partner with CRISP to create new filters for existing CRISP Reporting Tools;

Listen to patient experience (e.g., measure patient self-efficacy, satisfaction, engagement); and

Leverage claims data.

Workforce development

Develop and implement CHPB orientation for all CHPB staff;

Standardize and monitor minimum training requirements for all CHPB staff; and

Create certificate or other recognition for "Top Performers."

Current Challenge: Patient identification

The CHPB Community Care Team (CCT) and Bridge Team are under-enrolled interventions. The CCT is 35% enrolled for its total capacity; the Bridge is 60% enrolled.

Ninety percent (90%) of the CCT's patients are identified through risk prediction; the remaining 10% are identified through referrals. The risk prediction process removes ineligible patients to provide improved patient information to the CCT's Community Based Organization, Sisters Together and Reaching, Inc. (STAR). This process relies upon CRISP, HPs, and the Johns Hopkins HealthCare LLC (JHHC) Management Services Organization (MSO) Analytics Team. The process for patient identification

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through risk prediction can take up to four (4) months. Due to data latency, up to 30% of patients refuse services and up to 30% have passed upon CHW outreach.

Additionally, JHOME (Home-Based Primary Care) is under-enrolled for Johns Hopkins Hospital. The target enrollment is 160 patients with a current JHH enrollment of 13 patients. Current J-Home patients largely comprise of JHBMC patients.

Potential Solution: Diversify sources of patient identification

Acute and Inpatient Strategies (1st and 2nd quarter FY2019)

Expand CRISP Inpatient Referral Strategy (IRS): Expand IRS to all HPs in addition to JHH and JHBMC. The IRS pilots will be customized to meet needs of each HP. Finalize training and workflows related to expansion of IRS. Provide continuous quality improvement for the existing IRS pilot at JHH & JHBMC. CHW will be primary discipline for in-reach for CCT. Additionally use IRS to identify patients for Bridge and JHOME.

Enable Blind Panel process: Partner with CRISP to enable Blind Panel process: CRISP automatically generates an alert when patients meet a set of criteria defined by the CHPB (e.g., when a patient with Medicare FFS who lives in CHPB zip codes is admitted to a HP for a second admission in the past 12 months). Develop workflows for how these patients would be outreached and enrolled in the CHPB. Work with HPs to determine process for identifying whether these patients are already enrolled in an existing care management program. This could also be used to identify individuals who are frequent emergency department (ED) users. Organize CCT, Bridge, and JHOME roadshows for Hospital Partners.

Outpatient strategy: Leverage daily discharge lists from Hospital Partners for CCT outreach. Understand the care coordination landscape to reduce duplication of transition guide work.

Integrate workflows from partner to partner: There is opportunity for CHPB's six interventions to refer patients to one another's programs. The CHPB website is a starting point to educate CHPB partners about one another's program before CHPB develops formal partner-to-partner referral workflows.

Post-Acute Strategies (3rd and 4th quarter FY2019)

Target patients being discharged to/from SNFs: Create a post-acute strategy to target patients being discharged to/from SNFs. Strategy seeks to reduce readmissions, ED visits, improve care transitions from hospital to SNF to home, and increase referrals to CHPB. Leverage Lifebridge's expertise as example for how this program could look; adapt to determine if current CHPB resources could be deployed accordingly.

Current Challenge: Reporting

Currently, our ability to report on patient utilization and outcomes is limited to data available in Chesapeake Regional Information System for our Patients (CRISP) or through intervention-specific dashboards; this does not include utilization or cost-related measures. The CRISP provides high-level data reporting on zip code area or aggregate panel information on pre/post cost and utilization trends; this data does not provide detailed data necessary to understand the impact of CHPB programs.

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Potential Solution: Improve reporting

Partner with CRISP to create new filters for existing CRISP Reporting Tools (1st and 2nd quarter FY19): There are many opportunities to leverage existing reporting features of CRISP. This includes adding CHPB-specific filters to existing CRISP reporting mechanisms, including Medicare Claim and Claim Line Feed (CCLF) reports.

Listen to patient experience (1st and 2nd quarter FY19): Seek patient feedback on how to better meet their needs by holding focus groups or conducting surveys to understand patient satisfaction with services offered by CHPB. Leverage Patient Engagement Program (PEP) data strategies to include patient self-efficacy measurement for patients who received services by a provider who received PEP training.

Leverage Claims Data (future opportunity): Leverage Center for Medicare and Medicaid Services (CMS) claims datasets from JHH/JHBMC, to the extent feasible, for reporting on Return on Investment, utilization, and cost-related outcomes.

Current Challenge: Workforce development

Recruitment of community-based providers and staff is critical to meeting our patients where they are; yet recruitment and retention of staff with this background is a challenge in the context of a complex health system and a competitive market. There is a need to equip all of our staff with a minimum, general understanding of CHPB, continue their professional development, as well as to express appreciation for staff who've demonstrated skill in navigating complex health systems, in the community, to meet patient needs.

Potential Solution: Workforce development (1st and 2nd quarter FY2019)

Develop and implement CHPB orientation for all CHPB staff: Develop and implement a CHPB orientation for CHPB staff. The goal of orientation would be to equip staff with a program overview Orientation is a one – two hour overview of program and its history.

Standardize and monitor training requirements for all CHPB staff: Identify trainings to be part of a CHPB core curriculum, as well as supplemental trainings (e.g., Patient Engagement Program, Mental Health First Aid, Opioid Overdose Response (i.e., Naloxone Training), Teach-Back, as examples). Encourage CHPB staff to identify training courses. Develop multi-disciplinary, intervention-specific onboarding. Apply PEP principles across all interventions.

Create certificate or other recognition for "Top Performers": Develop a CHPB / High-Performing Professional certificate based on exemplary performance measured by selected Key Performance Indicators, care planning goals, number of patients enrolled, and/or successful outreach strategies. Share tips from High Performers with entire CHPB; interview top performers for their tips and share through email to rest of CHPB.

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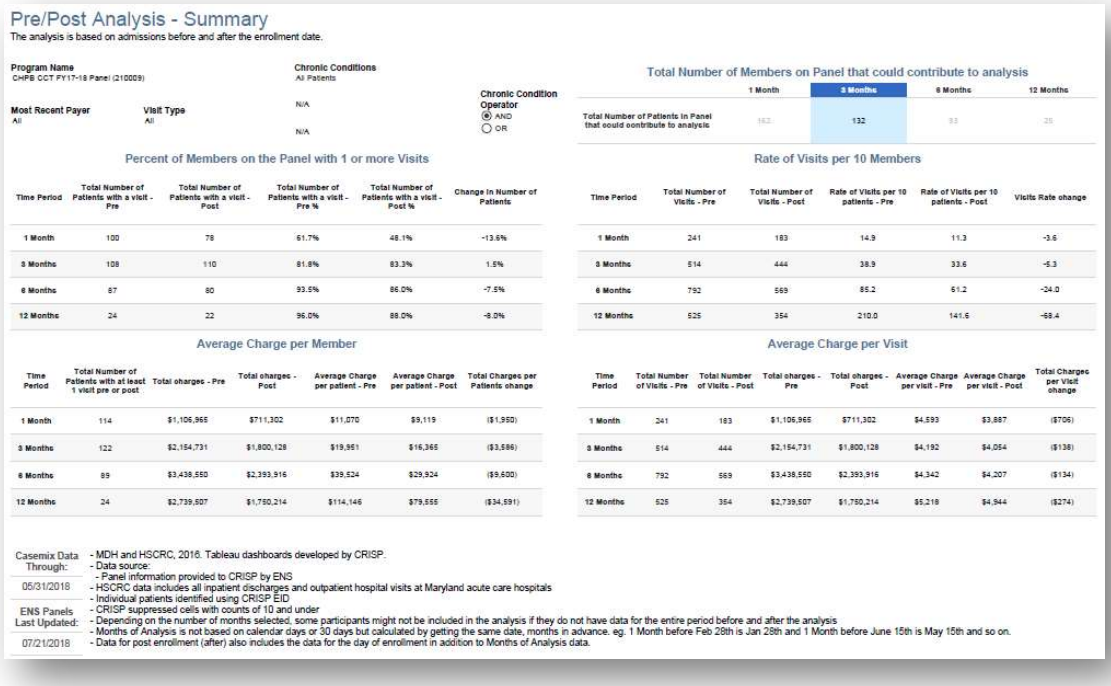
Appendix E – Pre-Post Reports for CCT

Note: The hospital details in this report reflect all hospitals where CHPB patients incurred costs/utilization.



Pre/Post Analysis - Summary

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

Program Name
CHPB CCT FY17-18 Panel (210009)

Chronic Conditions
All Patients

Most Recent Payer
All

Visit Type
All

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

Total Number of Members on Panel that could contribute to analysis

	1 Month	3 Months	6 Months	12 Months
Total Number of Patients in Panel that could contribute to analysis	162	132	93	28

Percent of Members on the Panel with 1 or more Visits

Time Period	Total Number of Patients with a visit - Pre	Total Number of Patients with a visit - Post	Total Number of Patients with a visit - Pre %	Total Number of Patients with a visit - Post %	Change in Number of Patients
1 Month	100	78	61.7%	48.1%	-13.6%
3 Months	108	110	81.8%	83.3%	1.5%
6 Months	87	80	93.5%	86.0%	-7.5%
12 Months	24	22	96.0%	88.0%	-8.0%

Rate of Visits per 10 Members

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Rate of Visits per 10 patients - Pre	Rate of Visits per 10 patients - Post	Visits Rate change
1 Month	241	183	14.9	11.3	-3.6
3 Months	514	444	38.9	33.6	-5.3
6 Months	792	569	85.2	61.2	-24.0
12 Months	525	354	210.0	141.6	-68.4

Average Charge per Member

Time Period	Total Number of Patients with at least 1 visit pre or post	Total charges - Pre	Total charges - Post	Average Charge per patient - Pre	Average Charge per patient - Post	Total Charges per Patients change
1 Month	114	$1,106,966	$711,302	$11,070	$9,119	($1,950)
3 Months	122	$2,154,731	$1,800,128	$19,951	$16,366	($3,586)
6 Months	89	$3,438,550	$2,393,916	$39,524	$29,924	($9,600)
12 Months	24	$2,739,507	$1,760,214	$114,146	$79,555	($34,591)

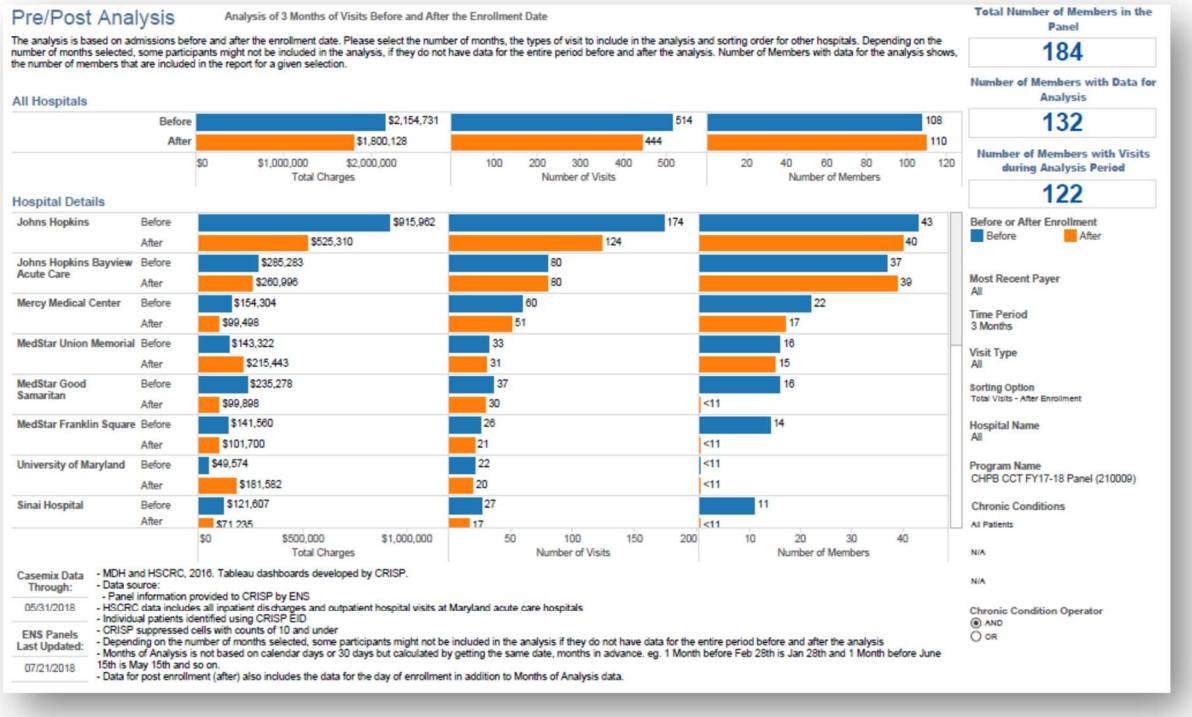
Average Charge per Visit

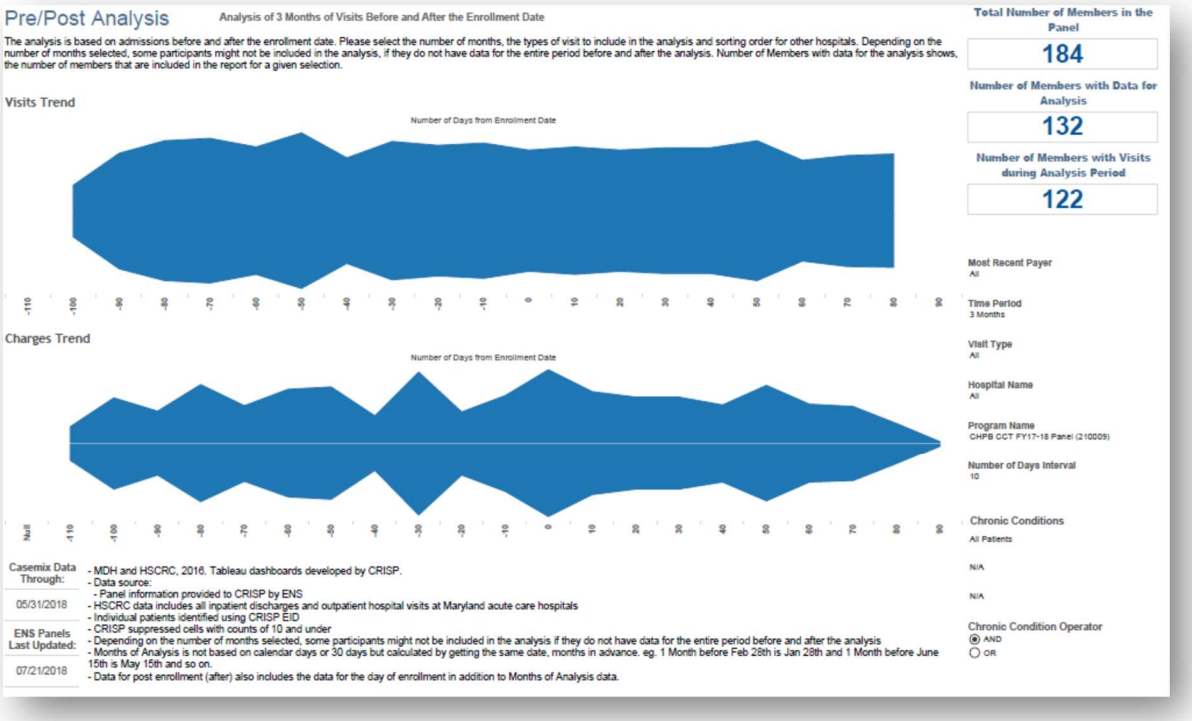
Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Total charges - Pre	Total charges - Post	Average Charge per visit - Pre	Average Charge per visit - Post	Total Charges per Visit change
1 Month	241	183	$1,106,966	$711,302	$4,593	$3,887	($706)
3 Months	514	444	$2,154,731	$1,800,128	$4,192	$4,054	($138)
6 Months	792	569	$3,438,550	$2,393,916	$4,342	$4,207	($134)
12 Months	525	354	$2,739,507	$1,760,214	$5,218	$4,944	($274)

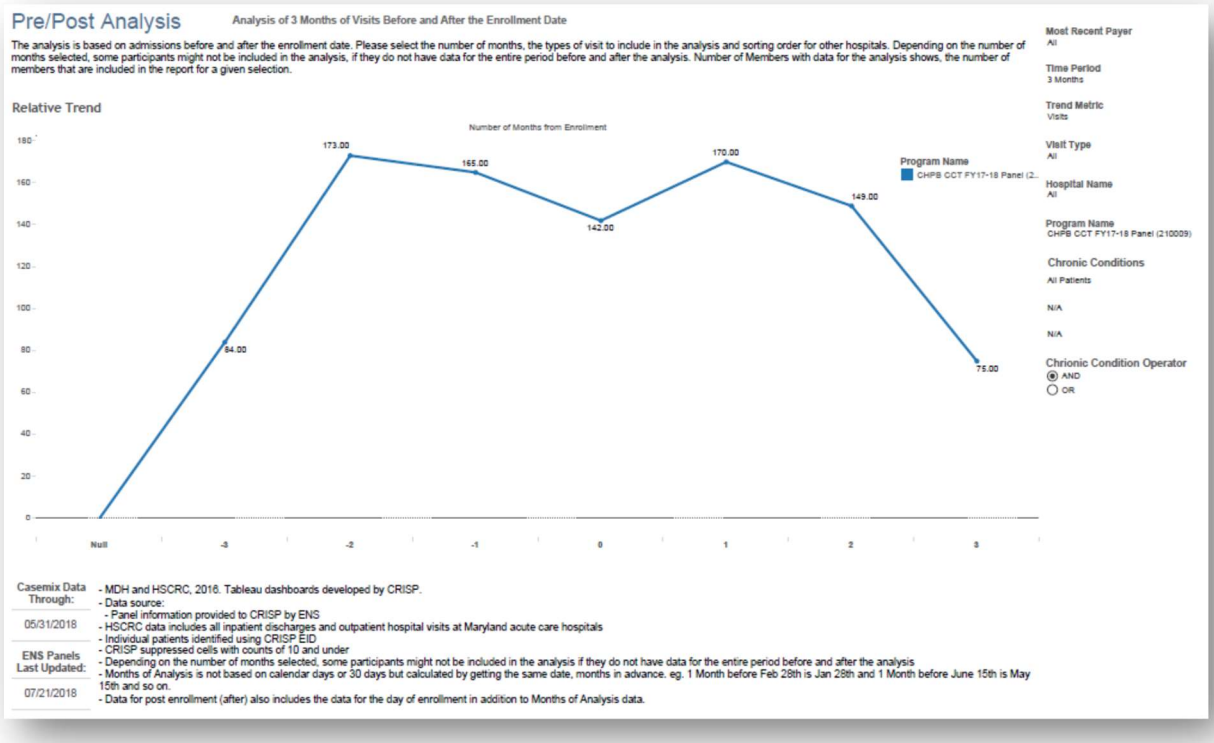
Casemix Data Through:
05/31/2018

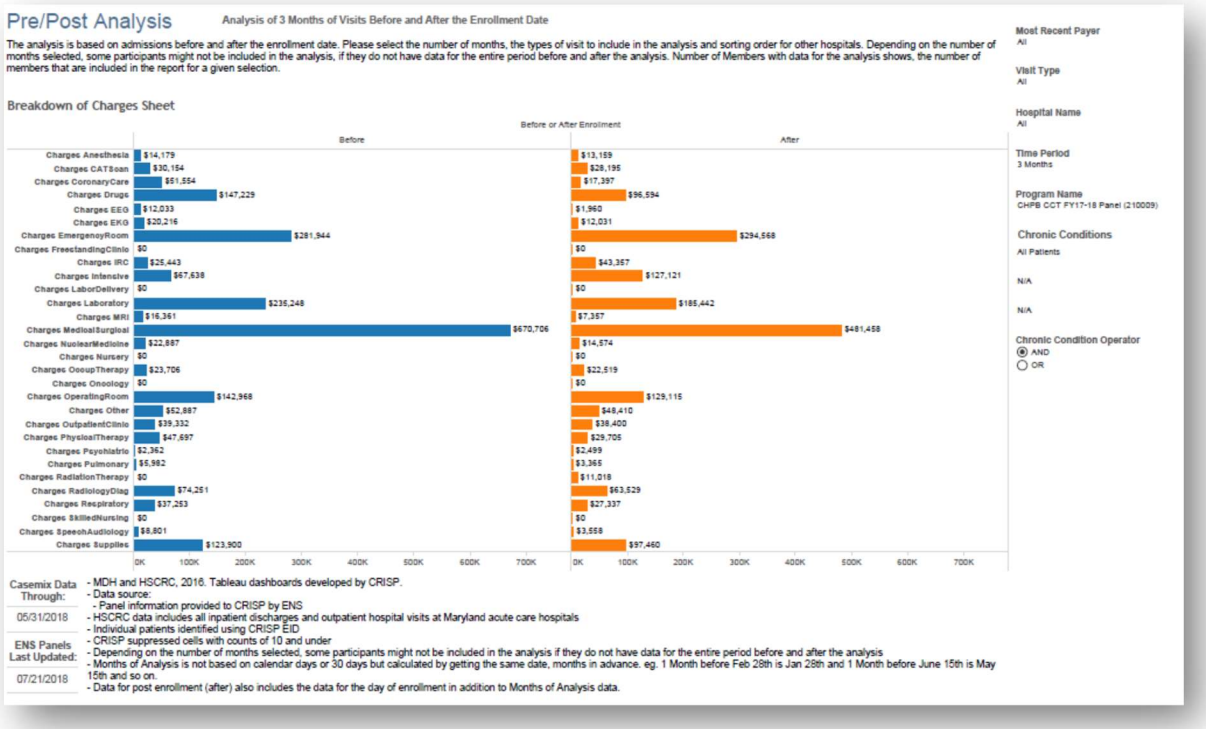
ENS Panels Last Updated:
07/21/2018

- MDH and HSCRC, 2018. Tableau dashboards developed by CRISP.
- Data source:
  - Panel information provided to CRISP by ENS
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
- Individual patients identified using CRISP EID
- CRISP suppressed cells with counts of 10 and under
- Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis
- Months of Analysis is not based on calendar days or 30 days but calculated by getting the same date, months in advance. eg. 1 Month before Feb 28th is Jan 28th and 1 Month before June 15th is May 15th and so on.
- Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.


Pre/Post Analysis
Analysis of 3 Months of Visits Before and After the Enrollment Date
The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they do not have data for the entire period before and after the analysis. Number of Members with data for the analysis shows, the number of members that are included in the report for a given selection.
All Hospitals
Before $2,154,731 514 108
After $1,800,128 444 110
$0 $1,000,000 $2,000,000 Total Charges
100 200 300 400 500 Number of Visits
20 40 60 80 100 120 Number of Members
Hospital Details
Johns Hopkins Before $915,962 174 43
After $525,310 124 40
Johns Hopkins Bayview Acute Care Before $285,283 80 37
After $260,996 80 39
Mercy Medical Center Before $154,304 60 22
After $99,498 51 17
MedStar Union Memorial Before $143,322 33 16
After $215,443 31 15
MedStar Good Samaritan Before $235,278 37 16
After $99,898 30 <11
MedStar Franklin Square Before $141,560 26 14
After $101,700 21 <11
University of Maryland Before $49,574 22 <11
After $181,582 20 <11
Sinai Hospital Before $121,607 27 11
After $71,235 17 <11
$0 $500,000 $1,000,000 Total Charges
50 100 150 200 Number of Visits
10 20 30 40 Number of Members
Casemix Data Through:
05/31/2018
ENS Panels Last Updated:
07/21/2018
- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
- Panel information provided to CRISP by ENS
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
- Individual patients identified using CRISP EID
- CRISP suppressed cells with counts of 10 and under
- Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis
- Months of Analysis is not based on calendar days or 30 days but calculated by getting the same date, months in advance. eg. 1 Month before Feb 28th is Jan 28th and 1 Month before June 15th is May 15th and so on.
- Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.
Total Number of Members in the Panel
184
Number of Members with Data for Analysis
132
Number of Members with Visits during Analysis Period
122
Before or After Enrollment
Before
After
Most Recent Payer
All
Time Period
3 Months
Visit Type
All
Sorting Option
Total Visits - After Enrollment
Hospital Name
All
Program Name
CHPB CCT FY17-18 Panel (210009)
Chronic Conditions
All Patients
N/A
N/A
Chronic Condition Operator
AND
OR

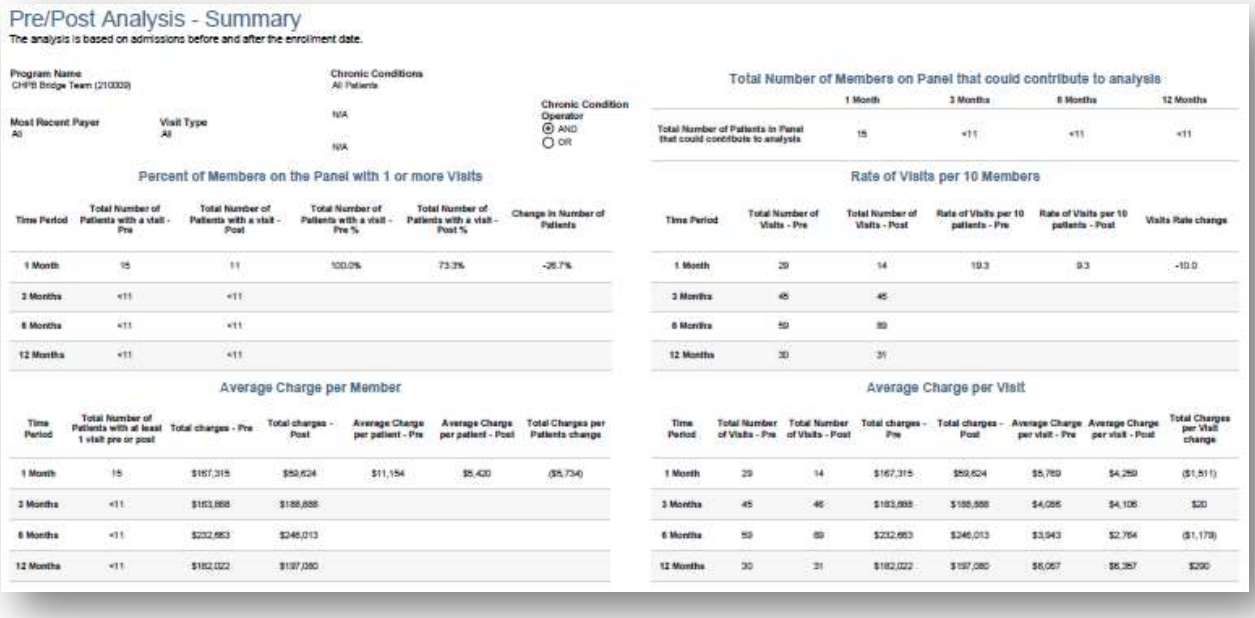

Pre/Post Analysis
Analysis of 3 Months of Visits Before and After the Enrollment Date
The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they do not have data for the entire period before and after the analysis. Number of Members with data for the analysis shows, the number of members that are included in the report for a given selection.
Visits Trend
Number of Days from Enrollment Date
Charges Trend
Number of Days from Enrollment Date
Casemix Data Through:
05/31/2018
ENS Panels Last Updated:
07/21/2018
- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
- Panel information provided to CRISP by ENS
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
- Individual patients identified using CRISP EID
- CRISP suppressed cells with counts of 10 and under
- Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis
- Months of Analysis is not based on calendar days or 30 days but calculated by getting the same date, months in advance. eg. 1 Month before Feb 28th is Jan 28th and 1 Month before June 15th is May 15th and so on.
- Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.
Total Number of Members in the Panel
184
Number of Members with Data for Analysis
132
Number of Members with Visits during Analysis Period
122
Most Recent Payer
All
Time Period
3 Months
Visit Type
All
Hospital Name
All
Program Name
CHPB CCT FY17-18 Panel (210009)
Number of Days Interval
10
Chronic Conditions
All Patients
N/A
N/A
Chronic Condition Operator
AND
OR


Pre/Post Analysis
Analysis of 3 Months of Visits Before and After the Enrollment Date
The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they do not have data for the entire period before and after the analysis. Number of Members with data for the analysis shows, the number of members that are included in the report for a given selection.
Relative Trend
Number of Months from Enrollment
180
160
140
120
100
80
60
40
20
0
173.00
165.00
142.00
170.00
149.00
84.00
75.00
Null
-3
-2
-1
0
1
2
3
Program Name
CHPB CCT FY17-18 Panel (2...
Most Recent Payer
All
Time Period
3 Months
Trend Metric
Visits
Visit Type
All
Hospital Name
All
Program Name
CHPB CCT FY17-18 Panel (210009)
Chronic Conditions
All Patients
N/A
N/A
Chronic Condition Operator
AND
OR
Casemix Data Through:
05/31/2018
ENS Panels Last Updated:
07/21/2018
- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
- Panel information provided to CRISP by ENS
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
- Individual patients identified using CRISP EID
- CRISP suppressed cells with counts of 10 and under
- Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis
- Months of Analysis is not based on calendar days or 30 days but calculated by getting the same date, months in advance. eg. 1 Month before Feb 28th is Jan 28th and 1 Month before June 15th is May 15th and so on.
- Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.


Pre/Post Analysis
Analysis of 3 Months of Visits Before and After the Enrollment Date
The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they do not have data for the entire period before and after the analysis. Number of Members with data for the analysis shows, the number of members that are included in the report for a given selection.
Breakdown of Charges Sheet
Before or After Enrollment
Before
After
Charges Anesthesia $14,179 $13,159
Charges CATScan $30,154 $28,195
Charges CoronaryCare $51,554 $17,397
Charges Drugs $147,229 $96,594
Charges EEG $12,033 $1,960
Charges EKG $20,216 $12,031
Charges EmergenoyRoom $281,944 $294,568
Charges FreestandingClinic $0 $0
Charges IRC $25,443 $43,357
Charges Intensive $67,638 $127,121
Charges LaborDelivery $0 $0
Charges Laboratory $236,248 $185,442
Charges MRI $16,361 $7,357
Charges MedicalSurgical $670,706 $481,458
Charges NuclearMedicine $22,887 $14,574
Charges Nursery $0 $0
Charges OccupTherapy $23,706 $22,519
Charges Oncology $0 $0
Charges OperatingRoom $142,968 $129,115
Charges Other $52,887 $48,410
Charges OutpatientClinic $39,332 $38,400
Charges PhysicalTherapy $47,697 $29,705
Charges Psychiatric $2,362 $2,499
Charges Pulmonary $5,982 $3,365
Charges RadiationTherapy $0 $11,018
Charges RadiologyDiag $74,251 $63,529
Charges Respiratory $37,263 $27,337
Charges SkilledNursing $0 $0
Charges SpeechAudiology $8,801 $3,558
Charges Supplies $123,900 $97,460
0K 100K 200K 300K 400K 500K 600K 700K
0K 100K 200K 300K 400K 500K 600K 700K
Most Recent Payer
All
Visit Type
All
Hospital Name
All
Time Period
3 Months
Program Name
CHPB CCT FY17-18 Panel (210009)
Chronic Conditions
All Patients
N/A
N/A
Chronic Condition Operator
AND
OR
Casemix Data Through:
05/31/2018
ENS Panels Last Updated:
07/21/2018
- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
- Panel information provided to CRISP by ENS
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
- Individual patients identified using CRISP EID
- CRISP suppressed cells with counts of 10 and under
- Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis
- Months of Analysis is not based on calendar days or 30 days but calculated by getting the same date, months in advance. eg. 1 Month before Feb 28th is Jan 28th and 1 Month before June 15th is May 15th and so on.
- Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.

Appendix F – Pre-Post Reports for Bridge

Note: The hospital details in this report reflect all hospitals where CHPB patients incurred costs/utilization.



Pre/Post Analysis - Summary

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

Program Name: CHPB Bridge Team (210009)
Chronic Conditions: All Patients
Most Recent Payer: All
Visit Type: All
Chronic Condition Operator: AND / OR

Total Number of Members on Panel that could contribute to analysis

	1 Month	3 Months	6 Months	12 Months
Total Number of Patients in Panel that could contribute to analysis	15	<11	<11	<11

Percent of Members on the Panel with 1 or more Visits

Time Period	Total Number of Patients with a visit - Pre	Total Number of Patients with a visit - Post	Total Number of Patients with a visit - Pre %	Total Number of Patients with a visit - Post %	Change in Number of Patients
1 Month	15	11	100.0%	73.3%	-26.7%
3 Months	<11	<11			
6 Months	<11	<11			
12 Months	<11	<11			

Rate of Visits per 10 Members

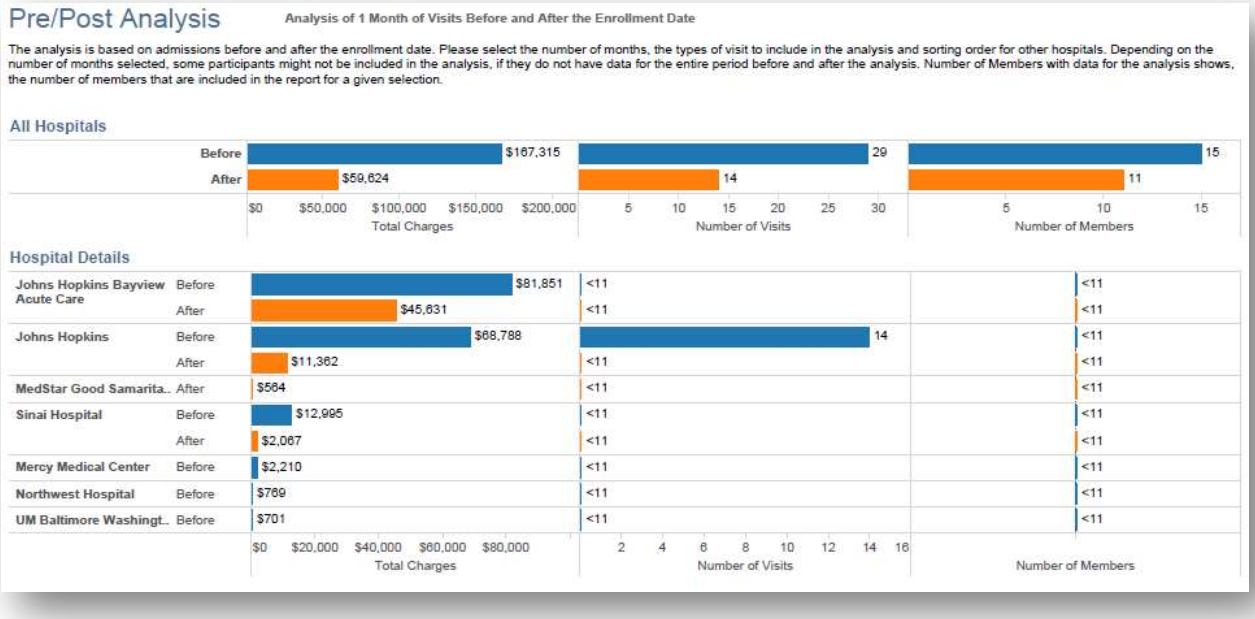
Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Rate of Visits per 10 patients - Pre	Rate of Visits per 10 patients - Post	Visits Rate change
1 Month	29	14	19.3	9.3	-10.0
3 Months	45	46			
6 Months	59	59			
12 Months	30	31			

Average Charge per Member

Time Period	Total Number of Patients with at least 1 visit pre or post	Total charges - Pre	Total charges - Post	Average Charge per patient - Pre	Average Charge per patient - Post	Total Charges per Patients change
1 Month	15	$167,315	$59,624	$11,154	$5,420	($5,734)
3 Months	<11	$183,888	$188,888			
6 Months	<11	$232,683	$246,013			
12 Months	<11	$182,022	$197,080			

Average Charge per Visit

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Total charges - Pre	Total charges - Post	Average Charge per visit - Pre	Average Charge per visit - Post	Total Charges per Visit change
1 Month	29	14	$167,315	$59,624	$5,769	$4,259	($1,511)
3 Months	45	46	$183,888	$188,888	$4,086	$4,106	$20
6 Months	59	59	$232,683	$246,013	$3,943	$2,764	($1,178)
12 Months	30	31	$182,022	$197,080	$6,067	$6,357	$290



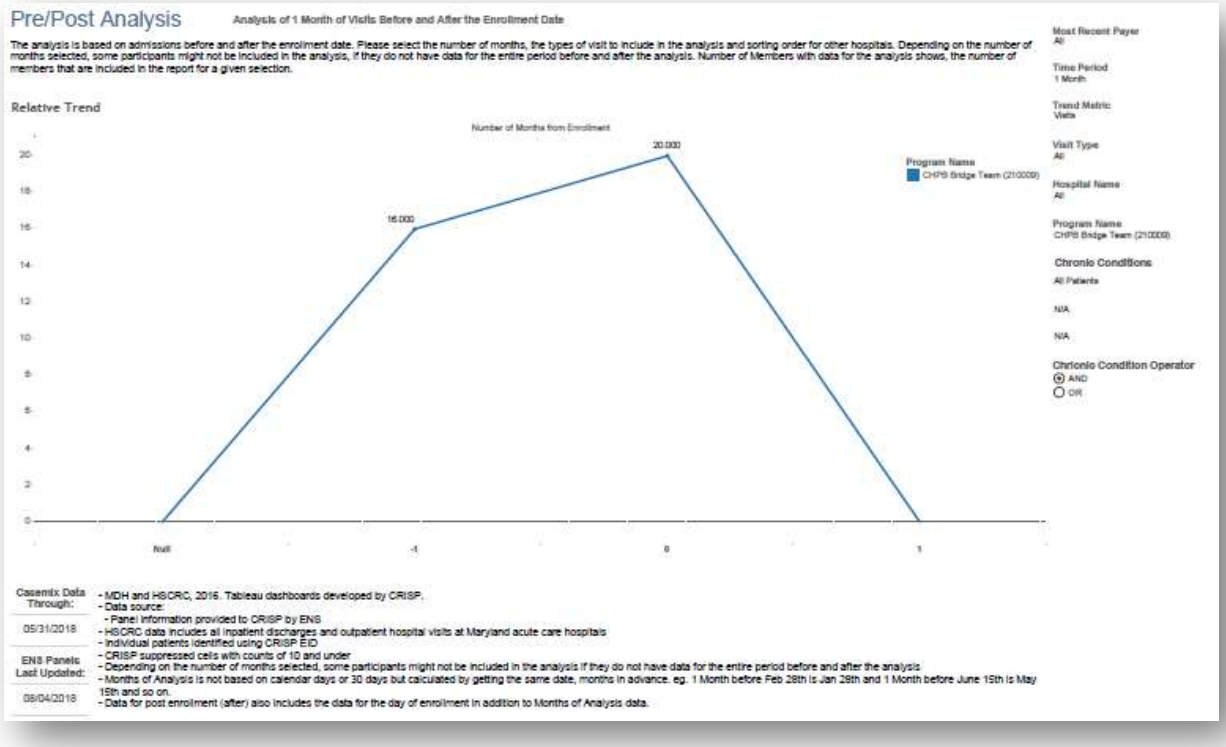
Pre/Post Analysis

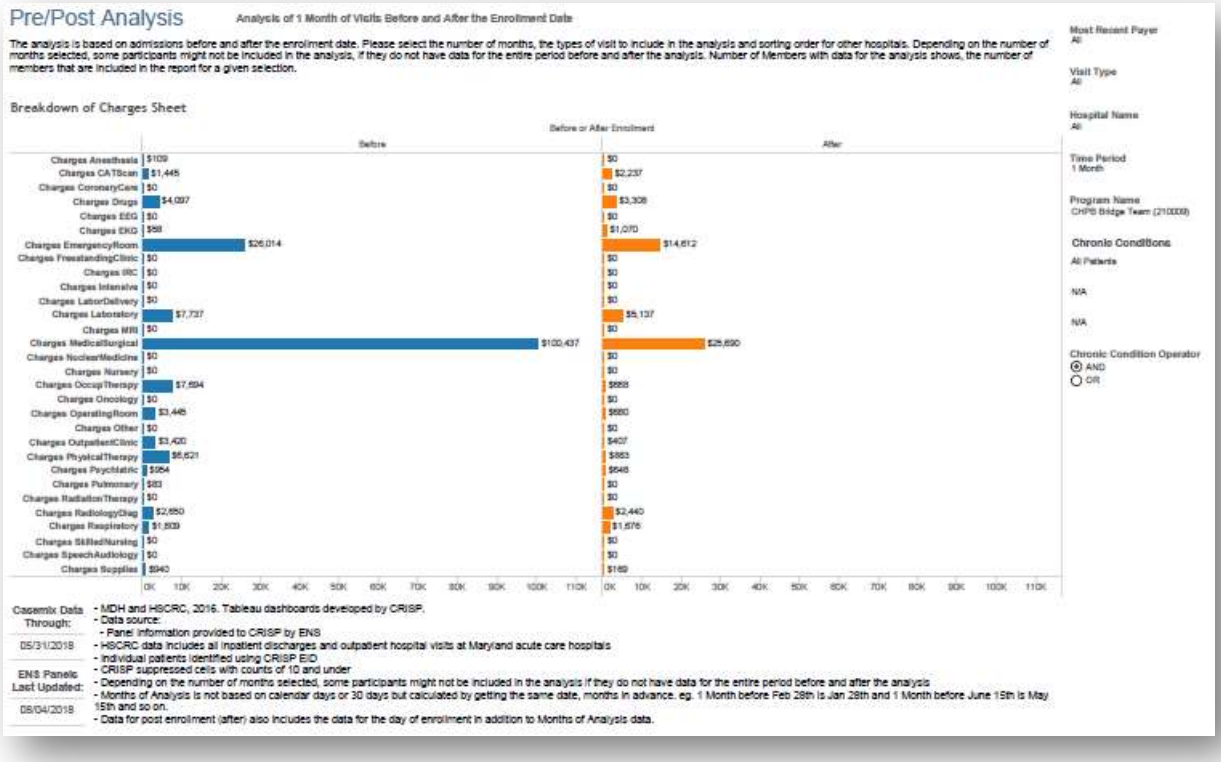
Analysis of 1 Month of Visits Before and After the Enrollment Date

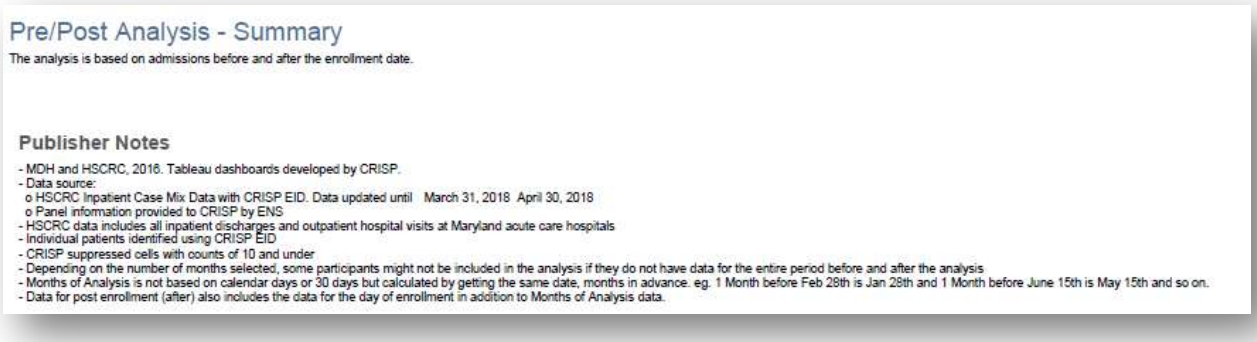
The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they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

All Hospitals

Hospital Details

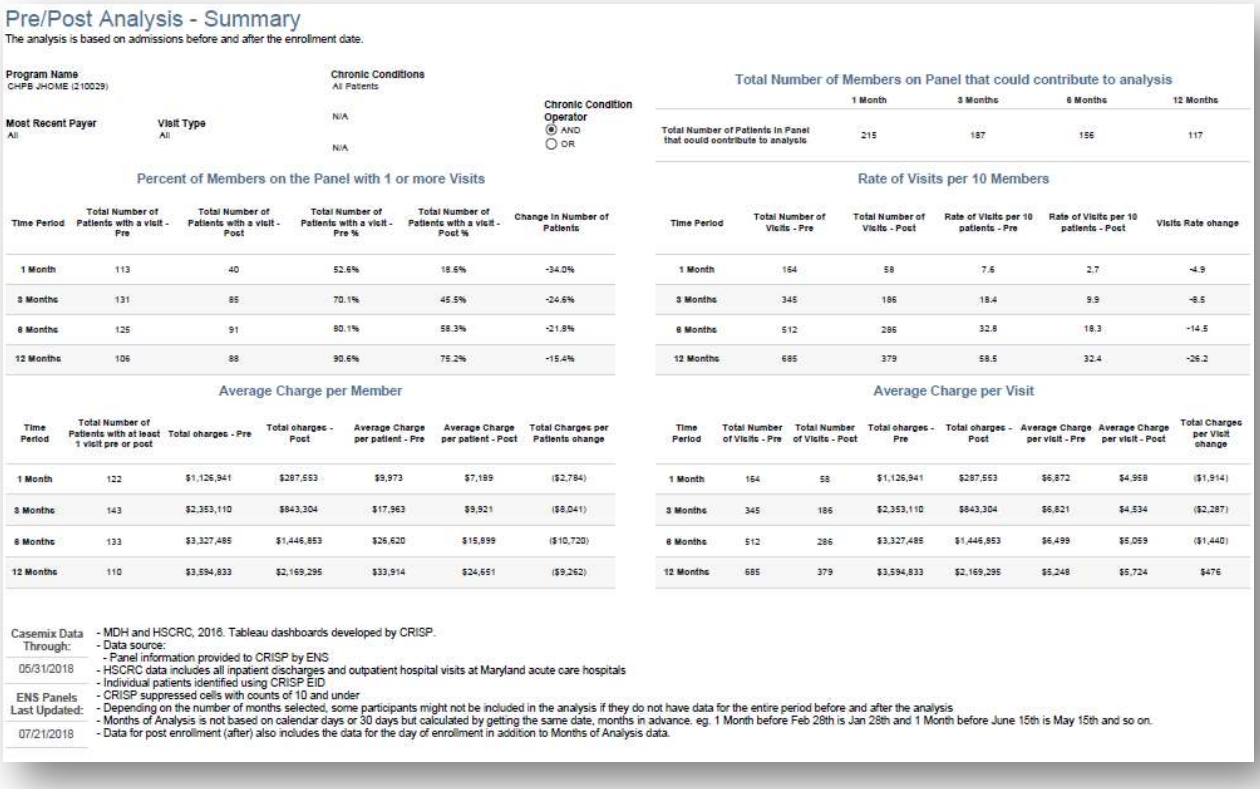

Pre/Post Analysis
Analysis of 1 Month of Visits Before and After the Enrollment Date
The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they do not have data for the entire period before and after the analysis. Number of Members with data for the analysis shows, the number of members that are included in the report for a given selection.
Relative Trend
Number of Months from Enrollment
16,000
20,000
Program Name
CHPS Bridge Team (210009)
Most Recent Payer
All
Time Period
1 Month
Trend Metric
Visits
Visit Type
All
Hospital Name
All
Program Name
CHPS Bridge Team (210009)
Chronic Conditions
All Patients
N/A
N/A
Chronic Condition Operator
AND
OR
Null
-1
0
1
Casemix Data Through:
05/31/2018
ENS Panels Last Updated:
08/04/2018
- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
- Panel information provided to CRISP by ENS
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
- Individual patients identified using CRISP EID
- CRISP suppressed cells with counts of 10 and under
- Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis
- Months of Analysis is not based on calendar days or 30 days but calculated by getting the same date, months in advance. eg. 1 Month before Feb 28th is Jan 28th and 1 Month before June 15th is May 15th and so on.
- Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.


Pre/Post Analysis
Analysis of 1 Month of Visits Before and After the Enrollment Date
The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they do not have data for the entire period before and after the analysis. Number of Members with data for the analysis shows, the number of members that are included in the report for a given selection.
Breakdown of Charges Sheet
Before or After Enrollment
Before
After
Charges Anesthesia $109 $0
Charges CATScan $1,445 $2,237
Charges CoronaryCare $0 $0
Charges Drugs $4,097 $3,308
Charges EEG $0 $0
Charges EKG $88 $1,070
Charges EmergencyRoom $26,014 $14,612
Charges FreestandingClinic $0 $0
Charges IRC $0 $0
Charges Intensive $0 $0
Charges LaborDelivery $0 $0
Charges Laboratory $7,737 $5,137
Charges MRI $0 $0
Charges MedicalSurgical $100,437 $25,690
Charges NuclearMedicine $0 $0
Charges Nursery $0 $0
Charges OccupTherapy $7,694 $668
Charges Oncology $0 $0
Charges OperatingRoom $3,445 $680
Charges Other $0 $0
Charges OutpatientClinic $3,400 $407
Charges PhysicalTherapy $6,621 $883
Charges Psychiatric $364 $648
Charges Pulmonary $83 $0
Charges RadiationTherapy $0 $0
Charges RadiologyDiag $2,650 $2,440
Charges Respiratory $1,839 $1,676
Charges SkilledNursing $0 $0
Charges SpeechAudiology $0 $0
Charges Supplies $940 $169
0K 10K 20K 30K 40K 50K 60K 70K 80K 90K 100K 110K
Most Recent Payer
All
Visit Type
All
Hospital Name
All
Time Period
1 Month
Program Name
CHPB Bridge Team (210008)
Chronic Conditions
All Patients
N/A
N/A
Chronic Condition Operator
AND
OR
Casemix Data Through:
05/31/2018
ENS Panels Last Updated:
05/04/2018
- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
- Panel information provided to CRISP by ENS
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
- Individual patients identified using CRISP EID
- CRISP suppressed cells with counts of 10 and under
- Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis
- Months of Analysis is not based on calendar days or 30 days but calculated by getting the same date, months in advance. eg. 1 Month before Feb 28th is Jan 28th and 1 Month before June 15th is May 15th and so on.
- Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.


Pre/Post Analysis - Summary
The analysis is based on admissions before and after the enrollment date.
Publisher Notes
- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
o HSCRC Inpatient Case Mix Data with CRISP EID. Data updated until March 31, 2018 April 30, 2018
o Panel information provided to CRISP by ENS
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
- Individual patients identified using CRISP EID
- CRISP suppressed cells with counts of 10 and under
- Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis
- Months of Analysis is not based on calendar days or 30 days but calculated by getting the same date, months in advance. eg. 1 Month before Feb 28th is Jan 28th and 1 Month before June 15th is May 15th and so on.
- Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.

Appendix G – Pre-Post Reports for JHOME

Note: The hospital details in this report reflect all hospitals where CHPB patients incurred costs/utilization.



Pre/Post Analysis - Summary

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

Program Name
CHPB JHOME (210029)

Chronic Conditions
All Patients

Chronic Condition Operator
(•) AND
( ) OR

Most Recent Payer
All

Visit Type
All

N/A

N/A

Total Number of Members on Panel that could contribute to analysis

	1 Month	3 Months	6 Months	12 Months
Total Number of Patients in Panel that could contribute to analysis	215	187	156	117

Percent of Members on the Panel with 1 or more Visits

Time Period	Total Number of Patients with a visit - Pre	Total Number of Patients with a visit - Post	Total Number of Patients with a visit - Pre %	Total Number of Patients with a visit - Post %	Change in Number of Patients
1 Month	113	40	52.6%	18.6%	-34.0%
3 Months	131	85	70.1%	45.5%	-24.6%
6 Months	125	91	80.1%	58.3%	-21.8%
12 Months	106	88	90.6%	75.2%	-15.4%

Rate of Visits per 10 Members

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Rate of Visits per 10 patients - Pre	Rate of Visits per 10 patients - Post	Visits Rate change
1 Month	164	58	7.6	2.7	-4.9
3 Months	345	186	18.4	9.9	-8.5
6 Months	512	286	32.8	18.3	-14.5
12 Months	685	379	58.5	32.4	-26.2

Average Charge per Member

Time Period	Total Number of Patients with at least 1 visit pre or post	Total charges - Pre	Total charges - Post	Average Charge per patient - Pre	Average Charge per patient - Post	Total Charges per Patients change
1 Month	122	$1,126,941	$287,553	$9,973	$7,189	($2,784)
3 Months	143	$2,353,110	$843,304	$17,963	$9,921	($8,041)
6 Months	133	$3,327,485	$1,446,853	$26,620	$15,899	($10,720)
12 Months	110	$3,594,833	$2,169,295	$33,914	$24,651	($9,262)

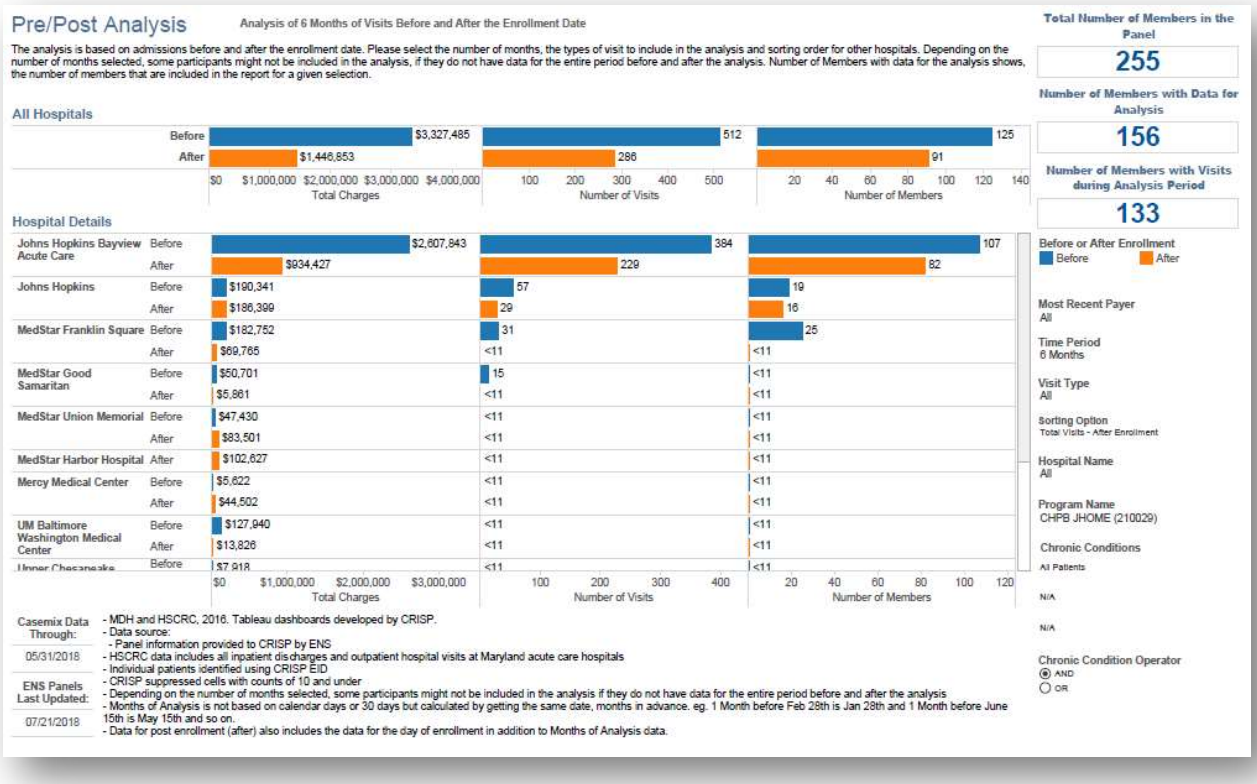
Average Charge per Visit

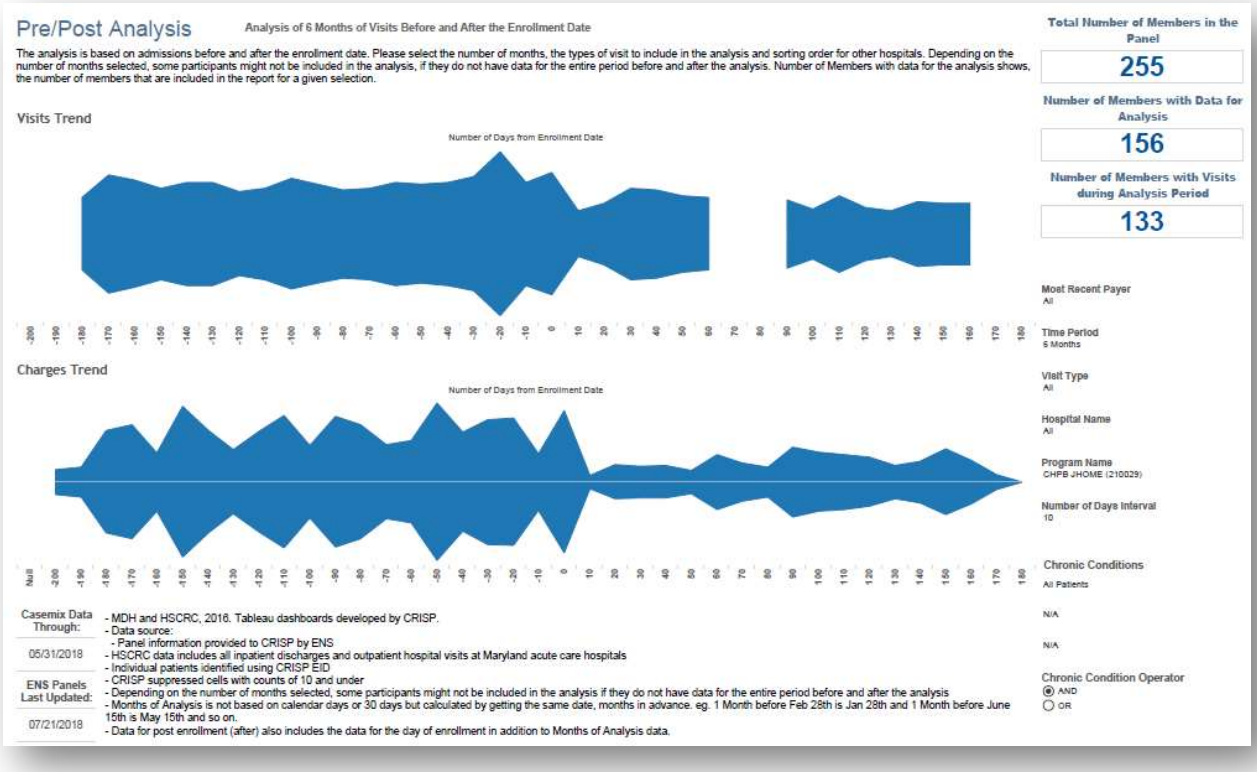
Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Total charges - Pre	Total charges - Post	Average Charge per visit - Pre	Average Charge per visit - Post	Total Charges per Visit change
1 Month	164	58	$1,126,941	$287,553	$6,872	$4,958	($1,914)
3 Months	345	186	$2,353,110	$843,304	$6,821	$4,534	($2,287)
6 Months	512	286	$3,327,485	$1,446,853	$6,499	$5,059	($1,440)
12 Months	685	379	$3,594,833	$2,169,295	$5,248	$5,724	$476

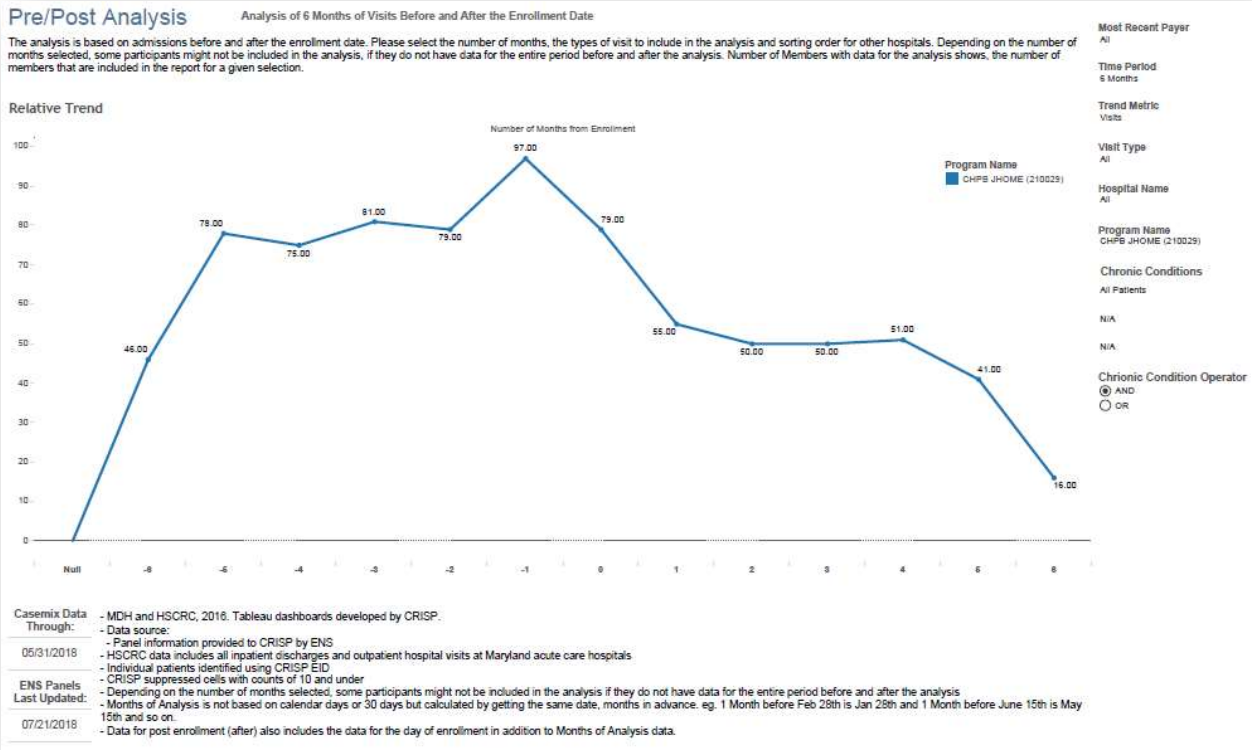
Casemix Data Through:
05/31/2018

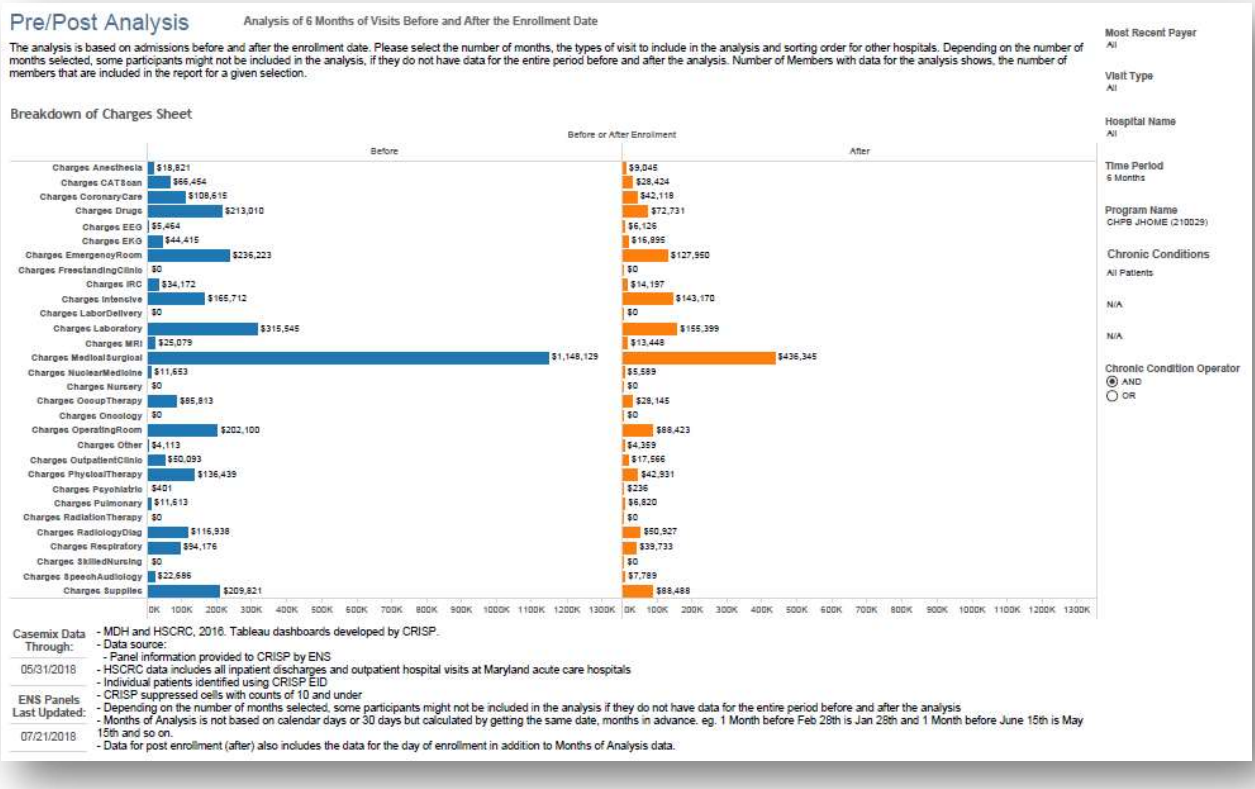
ENS Panels Last Updated:
07/21/2018

- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
- Panel information provided to CRISP by ENS
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
- Individual patients identified using CRISP EID
- CRISP suppressed cells with counts of 10 and under
- Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis
- Months of Analysis is not based on calendar days or 30 days but calculated by getting the same date, months in advance. eg. 1 Month before Feb 28th is Jan 28th and 1 Month before June 15th is May 15th and so on.
- Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.

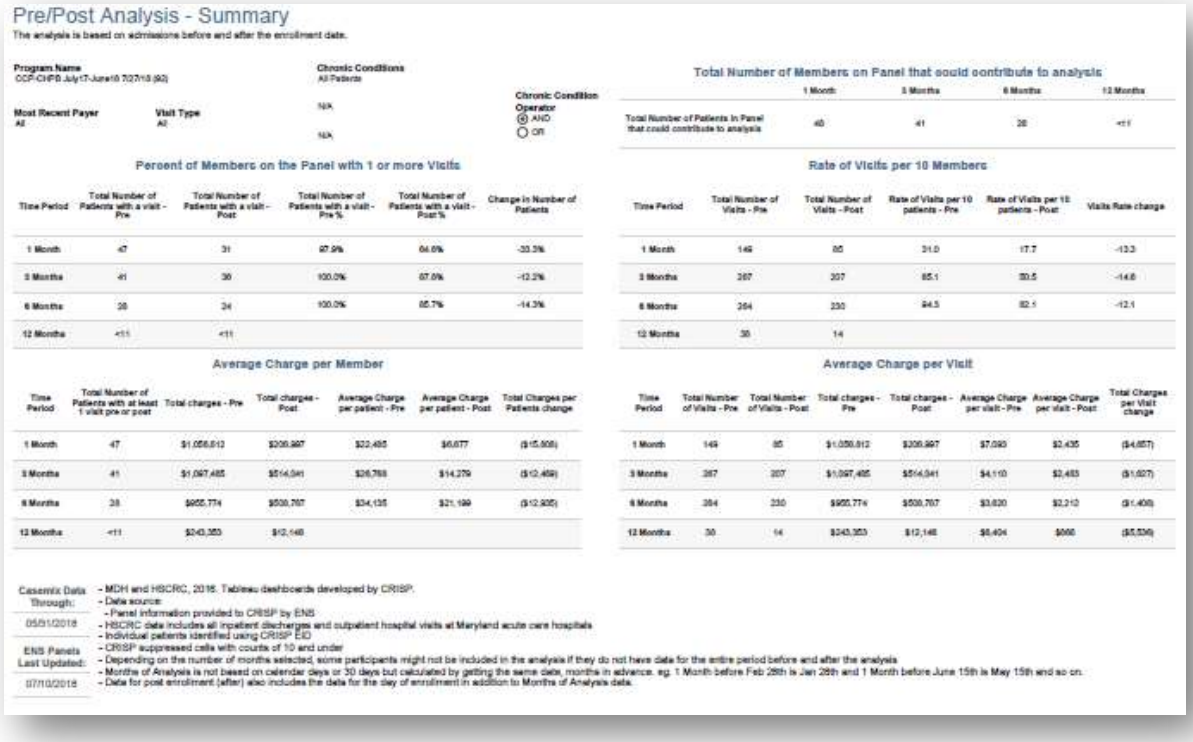

Pre/Post Analysis
Analysis of 6 Months of Visits Before and After the Enrollment Date
The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number 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
Before $3,327,485 512 125
After $1,446,853 286 91
Total Charges
Number of Visits
Number of Members
Hospital Details
Johns Hopkins Bayview Acute Care Before $2,607,843 384 107
After $934,427 229 82
Johns Hopkins Before $190,341 57 19
After $186,399 29 16
MedStar Franklin Square Before $182,752 31 25
After $69,765 <11 <11
MedStar Good Samaritan Before $50,701 15 <11
After $5,861 <11 <11
MedStar Union Memorial Before $47,430 <11 <11
After $83,501 <11 <11
MedStar Harbor Hospital After $102,627 <11 <11
Mercy Medical Center Before $5,622 <11 <11
After $44,502 <11 <11
UM Baltimore Washington Medical Center Before $127,940 <11 <11
After $13,826 <11 <11
Upper Chesapeake Before $7,918 <11 <11
Total Charges
Number of Visits
Number of Members
Casemix Data Through:
05/31/2018
ENS Panels Last Updated:
07/21/2018
- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
- Panel information provided to CRISP by ENS
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
- Individual patients identified using CRISP EID
- CRISP suppressed cells with counts of 10 and under
- Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis
- Months of Analysis is not based on calendar days or 30 days but calculated by getting the same date, months in advance. eg. 1 Month before Feb 28th is Jan 28th and 1 Month before June 15th is May 15th and so on.
- Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.
Total Number of Members in the Panel
255
Number of Members with Data for Analysis
156
Number of Members with Visits during Analysis Period
133
Before or After Enrollment
Before
After
Most Recent Payer
All
Time Period
6 Months
Visit Type
All
Sorting Option
Total Visits - After Enrollment
Hospital Name
All
Program Name
CHPB JHOME (210029)
Chronic Conditions
All Patients
N/A
N/A
Chronic Condition Operator
AND
OR


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.
Visits Trend
Number of Days from Enrollment Date
Charges Trend
Number of Days from Enrollment Date
Casemix Data Through:
05/31/2018
ENS Panels Last Updated:
07/21/2018
- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
- Panel information provided to CRISP by ENS
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
- Individual patients identified using CRISP EID
- CRISP suppressed cells with counts of 10 and under
- Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis
- Months of Analysis is not based on calendar days or 30 days but calculated by getting the same date, months in advance. eg. 1 Month before Feb 28th is Jan 28th and 1 Month before June 15th is May 15th and so on.
- Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.
Total Number of Members in the Panel
255
Number of Members with Data for Analysis
156
Number of Members with Visits during Analysis Period
133
Most Recent Payer
All
Time Period
6 Months
Visit Type
All
Hospital Name
All
Program Name
CHPB JHOME (210029)
Number of Days Interval
10
Chronic Conditions
All Patients
N/A
N/A
Chronic Condition Operator
AND
OR


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.
Relative Trend
Number of Months from Enrollment
Program Name
CHPB JHOME (210029)
46.00
78.00
75.00
81.00
79.00
97.00
79.00
55.00
50.00
50.00
51.00
41.00
16.00
Null
Most Recent Payer
All
Time Period
6 Months
Trend Metric
Visits
Visit Type
All
Hospital Name
All
Program Name
CHPB JHOME (210029)
Chronic Conditions
All Patients
N/A
N/A
Chronic Condition Operator
AND
OR
Casemix Data Through:
05/31/2018
ENS Panels Last Updated:
07/21/2018
- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
- Panel information provided to CRISP by ENS
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
- Individual patients identified using CRISP EID
- CRISP suppressed cells with counts of 10 and under
- Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis
- Months of Analysis is not based on calendar days or 30 days but calculated by getting the same date, months in advance. eg. 1 Month before Feb 28th is Jan 28th and 1 Month before June 15th is May 15th and so on.
- Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.


Pre/Post Analysis
Analysis of 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
Before or After Enrollment
Before
After
Charges Anesthesia $18,821 $9,045
Charges CATScan $66,454 $28,424
Charges CoronaryCare $108,615 $42,118
Charges Drugs $213,010 $72,731
Charges EEG $5,464 $6,126
Charges EKG $44,415 $16,895
Charges EmergencyRoom $236,223 $127,960
Charges FreestandingClinic $0 $0
Charges IRC $34,172 $14,197
Charges Intensive $165,712 $143,170
Charges LaborDelivery $0 $0
Charges Laboratory $315,545 $155,399
Charges MRI $25,079 $13,448
Charges MedicalSurgical $1,148,129 $436,345
Charges NuclearMedicine $11,653 $5,589
Charges Nursery $0 $0
Charges OccupTherapy $85,813 $28,145
Charges Oncology $0 $0
Charges OperatingRoom $202,100 $88,423
Charges Other $4,113 $4,369
Charges OutpatientClinic $50,093 $17,566
Charges PhysicalTherapy $136,439 $42,931
Charges Psychiatric $401 $236
Charges Pulmonary $11,613 $6,820
Charges RadiationTherapy $0 $0
Charges RadiologyDiag $116,938 $50,927
Charges Respiratory $94,176 $39,733
Charges SkilledNursing $0 $0
Charges SpeechAudiology $22,686 $7,789
Charges Supplies $209,821 $88,488
0K 100K 200K 300K 400K 500K 600K 700K 800K 900K 1000K 1100K 1200K 1300K
Most Recent Payer
All
Visit Type
All
Hospital Name
All
Time Period
6 Months
Program Name
CHPB JHOME (210029)
Chronic Conditions
All Patients
N/A
N/A
Chronic Condition Operator
AND
OR
Casemix Data Through:
05/31/2018
ENS Panels Last Updated:
07/21/2018
- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
- Panel information provided to CRISP by ENS
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
- Individual patients identified using CRISP EID
- CRISP suppressed cells with counts of 10 and under
- Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis
- Months of Analysis is not based on calendar days or 30 days but calculated by getting the same date, months in advance. eg. 1 Month before Feb 28th is Jan 28th and 1 Month before June 15th is May 15th and so on.
- Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.

Appendix H – Pre-Post Reports for Convalescent Care



Pre/Post Analysis - Summary

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

Program Name: CCP-CHPB July17-June18 7/27/18 (92)
Chronic Conditions: All Patients
Most Recent Payer: All
Visit Type: All
Chronic Condition Operator: (•) AND ( ) OR

Total Number of Members on Panel that could contribute to analysis

	1 Month	3 Months	6 Months	12 Months
Total Number of Patients in Panel that could contribute to analysis	40	41	28	<11

Percent of Members on the Panel with 1 or more Visits

Time Period	Total Number of Patients with a visit - Pre	Total Number of Patients with a visit - Post	Total Number of Patients with a visit - Pre %	Total Number of Patients with a visit - Post %	Change in Number of Patients
1 Month	47	31	97.9%	64.6%	-33.3%
3 Months	41	39	100.0%	87.8%	-12.2%
6 Months	28	24	100.0%	85.7%	-14.3%
12 Months	<11	<11			

Rate of Visits per 10 Members

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Rate of Visits per 10 patients - Pre	Rate of Visits per 10 patients - Post	Visits Rate change
1 Month	149	85	31.0	17.7	-13.3
3 Months	267	207	65.1	50.5	-14.6
6 Months	264	230	94.3	82.1	-12.1
12 Months	30	14			

Average Charge per Member

Time Period	Total Number of Patients with at least 1 visit pre or post	Total charges - Pre	Total charges - Post	Average Charge per patient - Pre	Average Charge per patient - Post	Total Charges per Patients change
1 Month	47	$1,056,912	$209,997	$22,485	$6,677	($15,808)
3 Months	41	$1,097,485	$514,941	$26,768	$14,279	($12,489)
6 Months	28	$955,774	$539,767	$34,135	$21,199	($12,935)
12 Months	<11	$243,353	$12,146			

Average Charge per Visit

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Total charges - Pre	Total charges - Post	Average Charge per visit - Pre	Average Charge per visit - Post	Total Charges per Visit change
1 Month	149	85	$1,056,912	$209,997	$7,093	$2,435	($4,657)
3 Months	267	207	$1,097,485	$514,941	$4,110	$2,483	($1,627)
6 Months	264	230	$955,774	$539,767	$3,620	$2,212	($1,408)
12 Months	30	14	$243,353	$12,146	$8,404	$868	($5,536)

Casemix Data Through: 05/31/2018
ENS Panels Last Updated: 07/10/2018

- MDH and HSCRC, 2018. Tableau dashboards developed by CRISP.
- Data source:
- Panel information provided to CRISP by ENS
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
- Individual patients identified using CRISP EID
- CRISP suppressed cells with counts of 10 and under
- Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis
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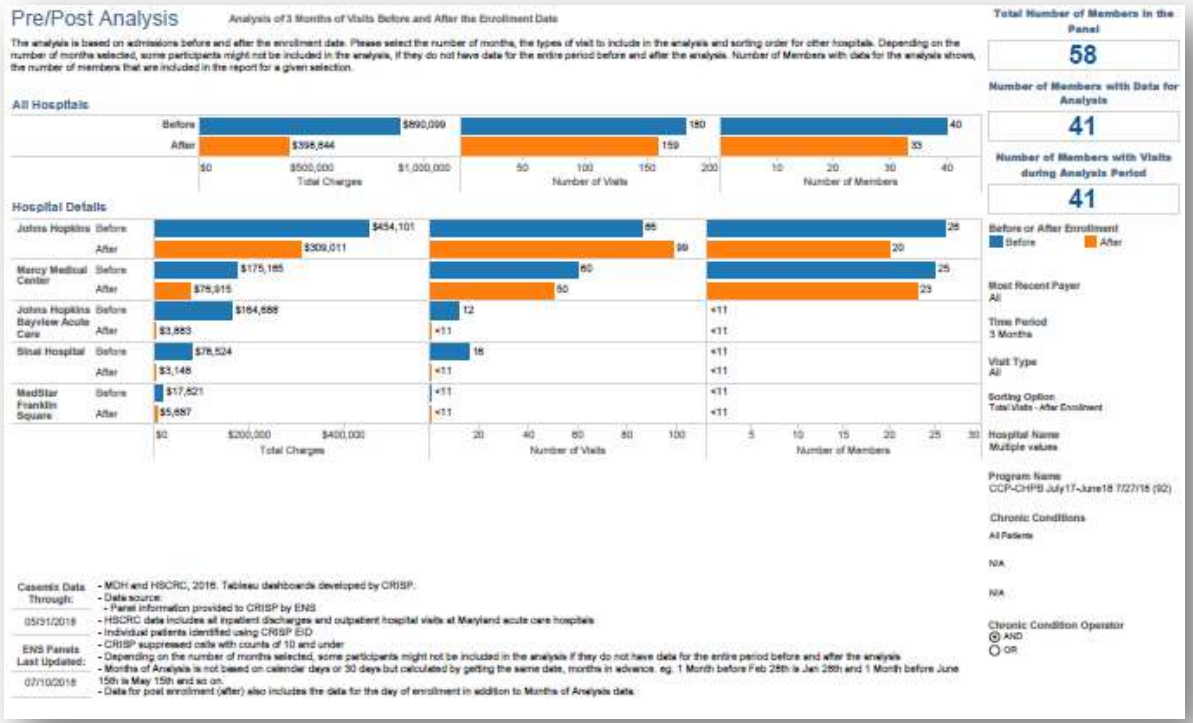
- Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.



Pre/Post Analysis

Analysis of 3 Months of Visits Before and After the Enrollment Date

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

All Hospitals

Hospital Details

Total Number of Members in the Panel: 58

Number of Members with Data for Analysis: 41

Number of Members with Visits during Analysis Period: 41

Before or After Enrollment: Before / After

Most Recent Payer: All

Time Period: 3 Months

Visit Type: All

Sorting Option: Total Visits - After Enrollment

Hospital Name: Multiple values

Program Name: CCP-CHPB July17-June18 7/27/18 (92)

Chronic Conditions: All Patients / N/A / N/A

Chronic Condition Operator: (•) AND ( ) OR

Casemix Data Through: 05/31/2018
ENS Panels Last Updated: 07/10/2018

- MDH and HSCRC, 2018. Tableau dashboards developed by CRISP.
- Data source:
- Panel information provided to CRISP by ENS
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
- Individual patients identified using CRISP EID
- CRISP suppressed cells with counts of 10 and under
- Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis
- Months of Analysis is not based on calendar days or 30 days but calculated by getting the same date, months in advance. eg. 1 Month before Feb 28th is Jan 28th and 1 Month before June 15th is May 15th and so on.
- Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.