HSCRC Transformation Grant

FY 2018 Report

The Health Services Cost Review Commission (HSCRC) is reviewing the following for FY 2018: this Report, the Budget Report, and the Budget Narrative. Whereas the Budget Report distinguishes between each hospital, this Report should describe all hospitals, if more than one, that are in the Regional Partnership.

# Regional Partnership Information

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| --- | --- |
| **Regional Partnership (RP) Name** | n/a |
| **RP Hospital(s)** | CalvertHealth Medical Center |
| **RP POC** | Margaret Fowler, It Takes a Village Program Coordination |
| **RP Interventions in FY 2018** |  |
| **Total Budget in FY 2018***Please insert FY 2017 award and FY 2018 award.*  | FY 2017 Award: $360,424 |
| FY 2018 Award: $324,382 |
| **Total FTEs in FY 2018** | Employed: |
| Contracted: |
| **Program Partners in FY 2018***Please list any community based organizations, contractors, and/or public partners* | Calvert County Office on Aging |

# Overall Summary of Regional Partnership Activities in FY 2018

(Free Response: 1-3 Paragraphs):

# Intervention Program

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

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| --- | --- |
| **Intervention or Program Name** | It Takes a Village |
| **RP Hospitals Participating in Intervention***Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.* | CalvertHealth Medical Center |
| **Brief description of the Intervention***2-3 sentences* | CalvertHealth will implement health and wellness “villages” co-located at three local senior centers in Calvert County. The Villages model creates an outlet for an improved quality of life among our rapidly growing aging population through improved patient experience, improved health of the population and a reduction in the need to resort to the hospital for all health care services.  |
| **Participating Program Partners**  | Calvert County Office On AgingWorld GymGiant Food, PharmacistWalmart PharmacistCalvert County Health Department |
| **Patients Served***Please estimate 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.* | # of Patients Served as of June 30, 2018: |
| Denominator of Eligible Patients: |
| **Pre-Post Analysis for Intervention** (optional)*If available, RPs may submit a screenshot or other file format of the Intervention’s Pre-Post Analysis.*  | Not yet measureable |
| **Intervention-Specific Outcome or Process Measures**(optional)*These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership maintains and uses to analyze performance.* *Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.* | The Village program continues to take a diverse range of services to each of the three Calvert County senior centers as well as to local town centers and faith-based partnering organizations to bring needed health services to our targeted population aligned with our HSCRC grant. Program participants are referred to appropriate program partners and as well as providers and services available at CalvertHealth. A summary of our year two progress to date includes:**Mobile Health Center Statistics**Total # of person seen: 339Number of locations where services were provided: 11Total number of referrals: Dental: 88 Social work: 7 Behavioral health: 17 PCM: 94 Breast center: 10 High risk lung clinic: 6 Care navigation: 26Screening/Exam: Blood pressure: 56 BMI: 19 Wounds: 1 Breast: 5 Skin cancer: 78 Urology: 1 Diabetes: 2 Dental: 106Ask the Nurse/Expert Program at the OOA Senior CentersSouthern Pines (south county) 255 Nurse: 192 Dietician: 23 Trainer: 5 Flu vaccine: 23 Falls prevention: 12Calvert Pines (central county) 204 Nurse: 111 Dietician: 28 Trainer: 20 Flu vaccine: 30 Falls prevention: 15North Beach (north county) 506 Nurse: 408 Dietician: 38 Trainer: 21 Flu vaccine: 30 Falls prevention: 9Health Concierge Care Coordinator North Beach Senior Center90 clients received services – 486 encounters of service Calvert Pines Senior Center74 clients received services – 336 encounters of service (Southern Pines Senior Center45 clients received services – 181 encounters of service  |
| **Successes of the Intervention in FY 2018***Free Response, up to 1 Paragraph* | Dentist on Mobile Health Center provided direct access to dental care and linked to Calvert Community Dental Care.Diabetes Prevention Program participants navigated to It Takes A Village RN, RD and Personal Trainer services to continue healthy lifestyle coaching.Expanding It Takes A Village partnership within underserved geographic area with faith based organizations and retail pharmacies.Building bridges and “links” to multiple community programs through navigation and “soft hand-offs” along a continuum of care. Social Worker has been instrumental in “connecting the dots” and creating synergy between partners and engaging community members. |
| **Lessons Learned from the Intervention in FY 2018***Free Response, up to 1 Paragraph* | Implementation of Conifer Population Health data tracking system has been challenging. Especially mapping of data between systems and development of reports to “bridge” data sharing between systems.  |
| **Next Steps for the Intervention in FY 2019***Free Response, up to 1 Paragraph* | Implement Nurse Information Line and Conifer Population Health SystemContinue with Dentist on Mobile Health CenterIntegrate Social Worker into Rock Steady program to navigate Parkinson’s patient to services at Senior Center. |
| **Additional Free Response** (Optional) |  |

# **PLEASE SEE TLC REPORT FOR CALVERT DATA**

# Core Measures:

Please fill in this information with the latest available data from the in the CRS Portal Tools for Regional Partnerships. For each measure, specific data sources are suggested for your use– the Executive Dashboard for Regional Partnerships, or the CY 2017 RP Analytic File (please specify which source you are using for each of the outcome measures).

## Utilization Measures

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| --- | --- | --- |
| 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) |  |
| 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-or-Analytic File:‘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 |  |
| 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) |  |

## Quality Indicator Measures

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| --- | --- | --- |
| 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-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) |  |

## CRISP Key Indicators (Optional)

These process measures tracked by the CRISP Key Indicators are new, and HSCRC anticipates that these data will become more meaningful in future years.

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| 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.* |  |
| Portion of Target Population with Contact from Assigned Care Manager | **Potentially Avoidable Utilization**Executive Dashboard:‘High Needs Patients – CRISP Key Indicators’ –% of patients with Case Manager (CM) recorded at CRISP, reported as average monthly % for most recent six months of data*May also include Rising Needs Patients, if applicable in Partnership.* |  |

## 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.

# Return on Investment

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.

[HSCRC is confirming by-intervention ROI calculation template]

# Conclusion

Please include any additional information you wish to share here. Free Response, 1-3 Paragraphs.