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 Summary Report should describe all hospitals, if more than one, that are in the Regional Partnership.

Regional Partnership Information

Regional Partnership (RP) Name	Nexus Montgomery
RP Hospital(s)	Holy Cross Hospital, Holy Cross Germantown Hospital, Washington Adventist Hospital, Adventist HealthCare Shady Grove Medical Center, Medstar Montgomery Medical Center, Johns Hopkins Suburban Hospital
RP POC	Jeff Goldman, VP Population Health, Director of Nexus Montgomery, Primary Care Coalition
RP Interventions in FY 2018	1. Wellness for Seniors at Home (WISH) 2. Hospital Care Transitions (HCT) 3. Severely Mentally Ill (SMI) 4. Specialty Care for the Uninsured (Project Access) 5. Skilled Nursing Facility (SNF) Alliance
Total Budget in FY 2018 *This should equate to total FY 2017 award*	FY 2018 Award: $7,668,683
Total FTEs in FY 2018	Employed: 22.28 FTE
	Contracted: 21.93 FTE
Program Partners in FY 2018 *Please list any community-based organizations or provider groups, contractors, and/or public partners*	Primary Care Coalition (PCC) The Coordinating Center (TCC) Cornerstone Montgomery SNF Alliance Members (37 Skilled Nursing Facilities)

Overall Summary of Regional Partnership Activities in FY 2018

(Free Response: 1-3 Paragraphs):

Nexus Montgomery continued to ramp up our initial programs in FY18. In addition, we launched several new initiatives that are consistent with the goals outlines in our regional partnership proposals. While

FY17 was fully focused on program roll outs, FY18 was a year where our programs began to mature and we are seeing early indications that we are tracking to achieve the programmatic objectives and return on investment. While we are encouraged by these results, we know there is much work to do to fully realize the potential of these programs, scale them, and sustain or improve the rate of return.

The Wellness and Independence for Seniors at Home (WISH) program has seen initial success in decreasing costs using the pre-post methodology, and our Return on Investment (ROI), while not yet positive, is on track with where we projected to be at the end of year one. Current performance data gives us confidence that the intervention is having a positive impact on seniors in our community. The challenge for FY19 is scaling the program population and increasing the program enrollment within the targeted Independent Living Facilities (ILFs).

Collectively, our Health Care Transitions (HCT) programs are also seeing 131 saved readmissions from the prior year baseline (2016). This ROI is also on track for where we expected to be at the end of year one. The associated Learning Collaborative has shared best practices, worked successfully on three joint project charters, and identified opportunities to collaborate. It was the Learning Collaborative that identified Skilled Nursing Facilities as a key partner in reducing readmission rates which led to the launch our Skilled Nursing Facility Alliance in FY18.

The Capacity Building for the Severely Mentally Ill (SMI) program has successfully implemented an Assertive Community Treatment (ACT) team, which has ramped up to near capacity over the year. Those who qualify for ACT team services historically have had numerous hospital touches in a year. While not yet universal, we are seeing evidence that utilization among the ACT team clients is declining. Additionally, we opened a new eight bed crisis house that has maintained a bed occupancy of greater than 90% throughout the year. We believe that nearly every admission to the Crisis House equates to an avoided hospital visit and potential admission. The recently started Behavioral Health Workgroup is improving the care coordination of the very highest SMI utilizers of hospital services.

In FY18 the Specialty Care for the Uninsured program, operated by Project Access provided 1,078 services to 373 uninsured patients coming out of one of the Nexus Hospitals in need of follow up specialty care. Through leveraging Project Access's pro bono network of providers 53% of services were given pro-bono, significantly amplifying the impact of the actual budgeted dollars. We believe that without access to specialty care, many of these patients would have returned to the hospital for the further treatment of the same issue.

Finally, as mentioned above, the Nexus Montgomery Skilled Nursing Facility (SNF) Alliance has successfully engaged 37 Skilled Nursing Facilities, 24 of whom completed all required steps for engagement, data use and quality improvement to be on the first Nexus preferred provider network. Nexus was able to give all SNFs access to data analytics through the use of PointRight and to train staff on Mental Health First Aid in response to their voiced need for increased behavioral health training.

While all of these programs are still growing and processes are being refined, we are proud to show early indications that we are on plan for our program measures and ROI. We expect these results to continue to improve in FY19 as we reach more people and scale our operations.

Intervention Program

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

Intervention or Program Name	Wellness and Independence for Seniors at Home (WISH)
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	All Nexus Hospitals
Brief description of the Intervention *2-3 sentences*	Wellness and Independence for Seniors at Home (WISH) helps eligible seniors optimize health, remain independent at home, and reduce avoidable hospital use by connecting them to the services they need before their health declines. Currently, eligible seniors are those living in the targeted Independent Living Facilities (ILFs). Working through lay health coaches that are backed by Registered Nurses, seniors at risk of declining health receive an assessment of their health and social risks. Those at high risk for hospitalization receive ongoing individualized health coaching based around mutually agreed upon self-management goals and are connected with community-based support to help keep them out of the hospital.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	The Coordinating Center (TCC) We also collaborate with: Participating Independent Living Facilities (See Appendix A)
Patients Served *Please estimate using the*	# of ILF Patients Served as of June 30, 2018: 1,398 (Ever Engaged)[1] Total # of Patients Served, ILF and Non-ILF, as of June 30, 2018: 1,884 (Ever Engaged)[1]

[1] Ever Engaged participants are individuals who have consented to participate in the program since October 2016. FY18 was the first full year of WISH focusing exclusively on independent living and senior housing facilities.

*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.*	Denominator of Eligible Patients[2]: **Program Denominator: 7,199** (Total Unique Beneficiaries in the ILF buildings from HQI, in 46 Independent Living Buildings (ILFs) RP Analytic File : 35,600 (2+ Chronic Conditions & Medicare FFS)
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	The Pre-Post Analysis for the WISH active program participants enrolled in FY18 and living in the eligible ILFs shows a decrease over three time periods (1, 3 and 6 months pre-post) across twelve categories of analysis (Total Number of Visits, Total Charges, Average Charges per Visit and Average Charges per Member – for inpatient, emergency and observation patients). The only exceptions to this are six month emergency department utilization and charges, six month in-patient average charges per visit, and three month average observation charges per member. This shows an overall impact on utilization and total charges through the intervention period, with a prolonged impact beyond the targeted 60 day length of the intervention period.

[2] The RP Analytic File population significantly overstates the population for this program, as it is not restricted to residents of the target ILFs. Additionally participants do not specifically require 2 chronic diseases to be eligible to become engaged – only an at risk score on the Care At Hand tool, though many of them will.

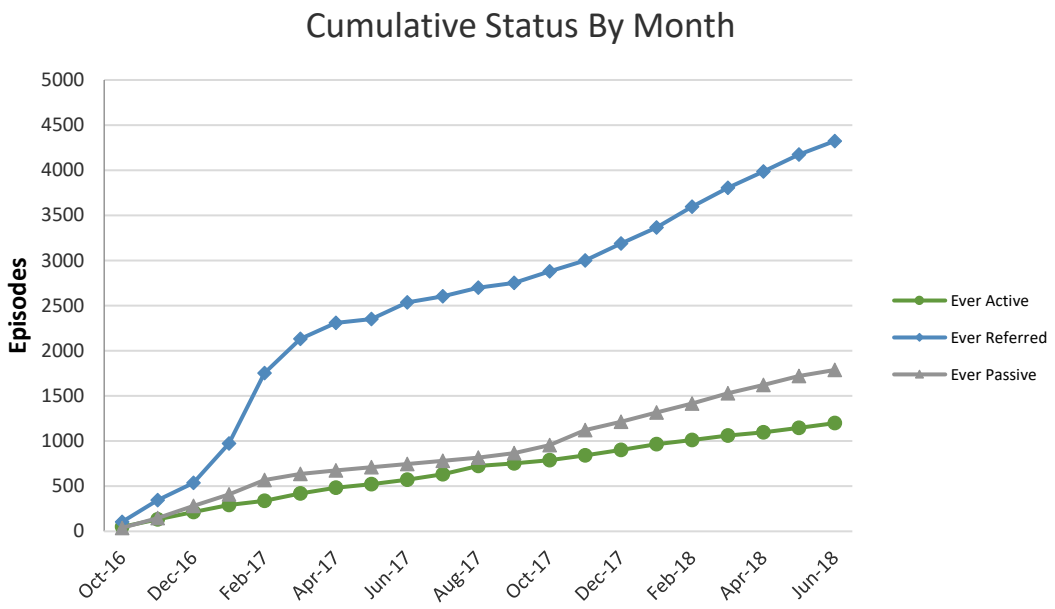
All Hospital Pre-Post	WISH Pre-Post FY18						
	n	Total Charges			Total Number of Visits		
		Pre	Post	Variance	Pre	Post	Variance
All Hospital 1 Month	482	$432,982	$138,377	$ (294,605)	84	45	-39
All Hospital 3 Month	373	$692,472	$306,411	$ (386,061)	102	76	-26
All Hospital 6 Month	216	$638,328	$454,192	$ (184,136)	90	83	-7
All Hospital 12 Month	<11						

In Patient Pre-Post	WISH Pre-Post FY18						
	n	Total Charges			Total Number of Visits		
		Pre	Post	Variance	Pre	Post	Variance
In Patient 1 Month	482	$341,578	$83,773	$ (257,805)	26	<11	
In Patient 3 Month	373	$571,477	$220,671	$ (350,806)	36	19	-17
In Patient 6 Month	216	$537,236	$361,673	$ (175,563)	38	25	-13
In Patient 12 Month	<11						

ED Pre-Post	WISH Pre-Post FY18						
	n	Total Charges			Total Number of Visits		
		Pre	Post	Variance	Pre	Post	Variance
ED 1 Month	67	$64,569	$35,036	$ (29,533)	51	31	-20
ED 3 Month	80	$86,120	$54,258	$ (31,862)	57	51	-6
ED 6 Month	62	$56,911	$62,180	$ 5,269	44	51	7
ED 12 Month	<11						

Obs Pre-Post	WISH Pre-Post FY18						
	n	Total Charges			Total Number of Visits		
		Pre	Post	Variance	Pre	Post	Variance
Obs 1 Month	11	$26,835	$19,568	$ (7,267)	<11	<11	
Obs 3 Month	14	$34,874	$31,482	$ (3,392)	<11	<11	
Obs 6 Month	14	$44,182	$30,338	$ (13,844)	<11	<11	
Obs 12 Month	<11						

Intervention-Specific Outcome or Process Measures (optional) *These are measures that may not have generic definitions across Partnerships or Interventions*	The WISH program participation has grown consistently through the year in terms of both number of episodes and referrals. A single client may have multiple episodes. As depicted in the chart below, the total number of Active client episodes in the program has been trending up through FY18, ending with a total of 1,198 at the end of the year. This represents an incremental increase of 625 Active episodes in FY18. Passive episodes, for clients who do not qualify for the 60 day intervention, and who receive period contacts to re-assess their needs and who may need an occasional referral or assistance from the coach, continued to trend up, ending the year at 1,787. This represents an incremental increase of 1,041 Passive episodes in FY18. The number of referrals received also continued to grow. Overall 24% of all residents in the ILF buildings have been referred to the WISH program and 13% of all residents have been engaged. The WISH intervention is designed to be a 60 day intervention, by the end of FY18

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 average period of engagement in the program was 64 days. The graph below includes clients from Independent Living Facilities and the community. 
Successes of the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	FY18 was the first full year of WISH focusing exclusively on independent living and senior housing facilities. Through this focus, the program coaches were able to meaningfully embed themselves into the culture of many of the targeted communities. This was achieved through significant on-site presence in the form of regular office hours, engagement promotions and over 160 outreach events promoting health and wellness. Referrals per month increased by 36 compared to FY17, from 111 to 147. Over the course of FY18, the number of engaged episodes More than doubled, increasing from 1,319 to 2,985. In the top quartile of buildings, over a third of residents are engaged with the program. Enrolled clients have been shown to have a number of positive outcomes including high satisfaction with services provided, reduced hospital utilization post intervention, and improved Patient Activation Measure (PAM) scores. These PAM scores indicate an expected 12% decrease in the risk of hospitalization and a 12% improvement in medication adherence. WISH ROI, which is based on trends in Medicare part A hospital claims paid for all residents of the targeted buildings, shows a positive ROI to HSCRC and Medicare of 1.95. Accounting for variable cost savings, the ROI to Hospitals was on track with original projections at .98.
Lessons Learned from the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	Initial engagement of prospective clients has been more challenging than originally anticipated. As a result, WISH program staff have spent significantly more time working to engage with referral sources and potential clients compared to the original vision. The program invested in Motivational Interview training for coaches to improve their engagement skills and developed strategic messaging to more effectively present the program to prospective clients. The risk profile of referred clients has also been healthier than originally anticipated, requiring that a coach engage with four new clients to identify one Active client. The remaining clients are engaged by the coach but are initial enrolled as Passive. As coaches have become more ingrained into the culture of the buildings, they

	have also spent more time than anticipated providing brief episodes of support to these Passive clients. This support is similar in substance to how a coach works with active clients, but may be as brief as one or two interactions with clients who, on average, have a lower hospitalization risk. We believe this work is valuable to support engagement and has long-term benefits for the health of the individual clients and overall building population. The program has created a new category of engaged client to recognize and track this effort over time. Finally, WISH has learned the different types of seniors housing buildings are more likely than others to engage with the program. The most important factors for engagement success are local champions (either staff or clients) and low income buildings. For FY19, we have developed new communications materials targeted at potential clients, building champions, and family members to help accelerate the rate of active client growth.
Next Steps for the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	As demonstrated by the successes described previously, Nexus believes there is evidence to show the WISH program is having a positive impact on those individuals who it is able to enroll. The most pressing program challenge is the need to increase enrollment to reach full capacity for staff deployed and ensure a healthy long-term ROI. Early in FY19, the program will begin deploying a strategic communications plan to increase awareness of and engagement with WISH. Staff will also receive additional training on consultative "selling" and overcoming objections. Currently, two of three budgeted teams have been staffed. Even with these additional effort, we believe it is unlikely that WISH will require a third team to cover independent living and senior housing facilities. A pilot is anticipated for mid-year FY19 to determine the best way to deploy the resources for the third team, and if successful, full deployment would occur at the end if FY19.
Additional Free Response (Optional)	

Intervention or Program Name	Hospital Care Transitions (HCT)
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	All Nexus Hospitals
Brief description of the Intervention *2-3 sentences*	Each Nexus hospital operates a Hospital Care Transition (HCT) program to support patients transitioning from the hospital to another care setting – be it home or another facility such as Long Term Care or Skilled Nursing. Through Nexus, each hospital was able to expand their existing programs to serve more patients at high risk of re-hospitalization. In addition,

	Nexus established a learning collaborative that brings together hospital care transition staff to share data and best practices, as well as to identify additional areas for collaboration.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	Each hospital has a long established list of community partners that support its Care Transitions Program. This list is extensive and covers the vast majority of services in the community and is constantly being updated.
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*	# of Patients Served as of June 30, 2018: 5,460[3] Denominator of Eligible Patients: **Program Denominator: 13,291** (Eligible Discharges per CRISP Nexus Extract) RP Analytic File: 106,017 (2+ IP, Obs 24+ or ED)[4]

[3] The patients served is all the patients served in the HCT program, not just the incremental patients served

[4] The program denominator is made up of patients with an eligible discharge from one of the six Nexus hospitals, they are predominantly made up of patients from the Med/Surg departments and they are patients who screen at higher risk for a re-admission and who are being discharged home. The closest match to this population in the RP Analytic file was the 2+IP, Obs 24+ or ED population, but this pool significantly over-estimates the denominator as they are not necessarily all al higher risk for re-admission, nor do they specifically need 2+ utilizations to be in the HCT program.

partnership's denominator.	
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 Available – this is not a population that is currently paneled at the Partnership level in CRISP. This program is specifically designed to impact at the population level the Risk Adjusted 30 day readmission rate, rather than a broader total cost in care (though it should ultimately impact TCOC as well). Nexus Montgomery believes this would not be a useful measure in that enrollment is triggered by a hospital stay, which would skew the data by having a high cost event in the immediate pre-enrollment timeframe.
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 HCT Program Metrics are: 1. Return on Investment (ROI) – this is detailed in the final section. 2. Change in O/E Ratio The Observed versus Expected readmission rate for eligible patients discharged from the 6 Nexus hospitals improved from 1.13 in CY16 to 1.07 in CY17. 3. Total Enrollment in the HCT programs. 5,460 patients were enrolled in the HCT programs across the 6 hospitals.
Successes of the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	One of the successes of this program in FY18 is the work done by the Learning Collaborative. The leads for the Hospital Care Transition programs from each of the 6 hospitals came together on a monthly basis. Initially their work focused on learning from each other's different approaches to care transitions. This led to the formalization of their work under three specific charters: HCT capacity building, Resource Management Vendor Selection and Symptom Management piloting.

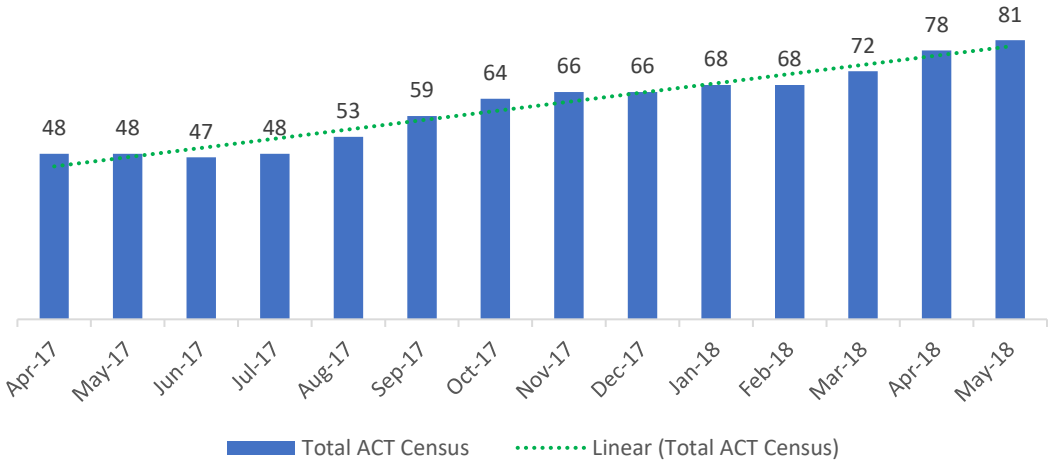
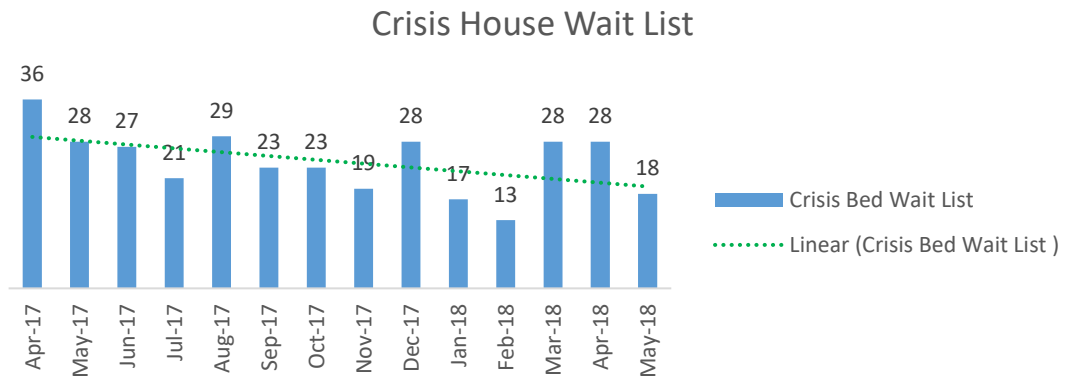
	The HCT capacity building has worked on establishing the framework to go beyond assessing the effectiveness of their individual programs, but also to be able to take the outcome data, the cost data and the different program elements to be able to identify and make recommendations around best practices. This work will continue into FY19. The capacity building work also focused in on the staff level and identified the need for additional motivational interviewing training for their front end staff. This was provided over a 6 month period. The Resource Management Vendor Selection has led the Learning Collaborative to recommend Aunt Bertha as a mechanism to improve the management of community referrals – both in terms of assessing the volume and effectiveness of community referrals, but also to be able to assess gaps in community resources. The third charter focused on symptom management, especially on addressing in the community the symptoms that typically bring patients back to the hospital but that could be better managed in the community. The structure of this pilot is currently being designed.
Lessons Learned from the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	One of the challenges with the HCT program has been finding a common mechanism to evaluate the unique nature of each hospitals' programs. Establishment of this framework has been an iterative process driven by learning the nuances of each other's programs.
Next Steps for the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	The next steps for the HCT program and Learning Collaborative are threefold; firstly the evaluation of the HCT programs to identify best practices in terms of outcomes and cost savings, secondly to roll out Aunt Bertha as the resource management tool and thirdly to pilot, evaluate and make recommendations around a symptom management intervention.
Additional Free Response (Optional)	

Intervention or Program Name	Severely Mentally Ill (SMI)
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	All Nexus Hospitals
Brief description of the Intervention *2-3 sentences*	The SMI program has 3 main components. The first component increased the availability of Crisis beds through opening the 8 bed Layhill Crisis House, which is managed by Cornerstone Montgomery. There are now three total Crisis Houses (24 beds), which serve patients experiencing a mental health crisis that traditionally would have been housed in the hospital due to a lack of safe alternative. The second added a third Assertive Community Treatment (ACT) team in Montgomery County. The new ACT team is also managed by Cornerstone Montgomery. ACT teams provide ongoing care and support for up to 100 patients in the community who are at risk of hospitalization by coordinating services for a broad range of needs, including housing and employment. The third, the Nexus Montgomery Behavioral Health Integration Manager, was hired to bring together a behavioral health workgroup to facilitate interagency coordination to reduce hospital use by patients with severe mental illness who are high utilizers of the hospitals. This work group facilitated by the Nexus Montgomery Behavioral Health Integration Manager and is made up of staff from the 6 Nexus hospitals, Cornerstone Montgomery, members of Emergency Medical Services (EMS) and other community behavioral health providers.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	Cornerstone Montgomery We also collaborate with: Montgomery County EMS Healthcare for the Homeless Beacon Health Options
Patients Served *Please estimate using the Population category that best applies to the*	# of Patients Served as of June 30, 2018: ACT: 81 Crisis House: 486 admissions, 299 patients Behavioral Health Workgroup: 21 (the workgroup started meeting in November 2017 and has met 7 times. It started discussing patients in April 2018, it discusses 5-10 cases per meeting)

*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.*	These populations are not mutually exclusive, but also are not significantly overlapping. Denominator of Eligible Patients: **Program Denominator: 1750** (All patients with SMI diagnosis per CRISP Nexus Extract)[5] RP Analytic File: 14,466(3+ IP or Obs >=24 Visits)[6]
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	The panels are already being uploaded into CRISP, we are working through some issues connecting to the panels of ACT and Crisis House clients. This analysis will be limited in that it will not include visits with a co-occurring Substance Use Disorder.
Intervention-Specific Outcome or Process Measures (optional)	Nexus Montgomery started a new ACT team and it is now nearly full – an ACT team has a maximum enrollment of 100 individuals. The chart below highlights the steady growth of the ACT team, which is limited to a maximum addition of 4-6 new clients per month.

[5] This population is, by our estimation, about 40% less that the actual number, due to the hiding of the patients with co-occuring Substance Use Disorders. We would need access to this information to be able to report an accurate number.

[6] The program denominator is significantly smaller than the RP Analytic File denominator – which is a high utilizer population, but not limited to patient with a diagnosis of Severe Mental Illness. Additionally, although the SMI population has a tendency to be a high utilizing population, with the exception of the Behavioral Health Workgroup, they do not require 3 or more utilizations to be eligible for the ACT Team or Crisis House.

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.	 1. Crisis House Wait List The Crisis House Wait List has come steadily down through FY18, although demand for beds is still greater than supply.  The Crisis House has been consistently well utilized; occupancy has ranged from 93%-99% for the full year. [7] Ninety percent of admissions to the crisis house would have otherwise been hospitalized; the total avoided hospital days for this year with each day a patient stays in the Crisis House being a day they are not in the hospital, the total avoided hospital days in this year is 6889.
Successes of the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	FY18 has seen a number of successes for the SMI program. The ACT team by the end of the year has almost met their maximum enrollment of 100, ending at 81. Crisis House referrals continued to increase, while occupancy remained high and wait lists came down. Improved coordination of care was a focus, as a result, Cornerstone Montgomery started to empanel their patients with CRISP and enter care alerts for all patients on the ACT team. The Behavioral \Health Workgroup started meeting, consisting of the behavioral health leads at the Nexus hospitals, Cornerstone Montgomery and other involved community partners to

[7] A fire in one of the group homes affected occupancy in May 2018, as residents of the group home were temporarily re-housed in the crisis house.

	focus on improved coordination of services for the highest utilizing SMI population. These meetings include intensive case review and joint care coordination planning.
Lessons Learned from the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	Lessons learned focused around coordination of services. We identified a need to improve the awareness of the hospital ED staff of the availability of the Crisis Houses to improve the volume of ED referrals. The overall need for better coordination of behavioral health services was the driver behind creating the position of the Behavioral Health Integration Manager (BHIM).
Next Steps for the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	For FY19, there are a number of key focuses: Improving the referrals from the ED direct to the Crisis Houses through increased awareness of the services by the ED teams and continuing to develop the Behavioral Health Workgroup to better coordinate and streamline services for the highest utilizing population. Working with Cornerstone and other community providers to improve communication and integration into hospital workflow for non-emergent clients. Leveraging technology to improve dissemination of resources. The BHIM continues to work with hospitals and other community organizations around reducing fragmentation of services.
Additional Free Response (Optional)	

Intervention or Program Name	Specialty Care for the Uninsured (Project Access)
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	All hospitals
Brief description of the Intervention *2-3 sentences*	Project Access is a specialty care referral network that coordinates with primary care clinics, specialty physicians, diagnostic facilities and local hospitals to arrange timely and affordable specialty care for uninsured people who have household income <250% FPL. Through Nexus, Project Access expanded the availability of these services for patients who have had hospital contact in the past 60 days and who need follow up specialty care for a related diagnosis. Specialty care is available to patients in Prince George's County zip codes in the Nexus targeted area, regardless of hospital contact. Any patient who is not already connected with Primary Care is referred to a primary care physician at a local community health center. Patients must maintain a relationship with a primary care provider to remain eligible for ongoing specialty care through Project Access. Patients may be referred directly from the hospital for urgent specialty needs, or from the primary care clinic.

Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	PCC Pro bono and contracted (paid) Project Access Network
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: In FY 2018 (July 1, 2017 through June 30, 2018): Project Access served 373 Nexus Montgomery patients • 212 Montgomery County residents (57%) • 161 Prince George's County residents (43%) Denominator of Eligible Patients: **Program Denominator: 44,347** (CY17 patients with at least one encounter in the Nexus CRISP extract who were flagged as Self Pay or Charity) RP Analytic File: 257,909 (all payer)[8]
Pre-Post Analysis for Intervention (optional)	We hope to be able to look at this analysis. Currently we are encountering difficulties uploading a panel to CRISP, as Project Access is not technically a provider, and therefore is unable to upload a panel into CRISP.

[8] The RP Analytic file does not have an appropriate population – as this intervention is limited to patients who have no insurance and who have had a hospital utilization in the past 60 days and need follow up specialty care.

If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.	
Intervention-Specific Outcome or Process Measures (optional) *These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership maintains and uses to analyze performance. Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.*	Project Access arranged 1078 Nexus Montgomery appointments (26% of all Project Access appointments) • 659 Montgomery County residents (61%) • 420 Prince George's County residents (39%) *Appointments are understated because pro bono providers may provide follow-up care without informing Project Access. The estimated service rate (referrals served versus referrals received) was 81%, with an average of 2.89 specialty encounters per patient. The estimated no show rate for specialty services was less than 2%. As expected, the Nexus Montgomery patients utilizing Project Access were a higher acuity population – they represented 22% of overall Project Access utilization, but 32% of total cost. Project Access continues to leverage their Pro Bono network with 53% of the total cost of services received being donated pro-bono ($161,113 in paid direct patient services, $183,221 in pro-bono direct patient services).
Successes of the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	Hundreds of patients and their families benefitted from this intervention. Here is one patient story: **Cardiac Defibrillator Obtained Pro Bono** A patient with hospital utilization for cardiac rhythm issues was referred to cardiologist, who advised that patient required an implantable defibrillator. PA worked with a network cardiology practice and a manufacturer who agreed to donate the defibrillator (estimated $10,000 value).
Lessons Learned from the Intervention in FY 2018	As expected, the Nexus Montgomery population was in fact a higher acuity population than the original one served by Project Access. Project Access' expansion to serve Nexus Montgomery required multiple process improvements in referral processes, technology and reporting systems, as well as contract amendments and provider education to expand the population served by Project Access.

Free Response, up to 1 Paragraph	
Next Steps for the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	Continue to expand the network to meet specialty care demand; will focus on recruiting pro bono providers. Recruitment materials were designed in FY 18.
Additional Free Response (Optional)	

Intervention or Program Name	SNF Alliance
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	All
Brief description of the Intervention *2-3 sentences*	The SNF Alliance brings together 37 Skilled Nursing Facilities from Montgomery County and Prince George's County who receive the majority of SNF Referrals from the Nexus Hospitals. Through the Alliance they were provided with and continue to utilize PointRight to track their data around 30 day readmissions and other quality metrics. The initial months of the SNF Alliance focused on getting everyone trained on PointRight and having the teams identify an area for quality improvement focused on reducing readmissions. SNFs were also provided with the opportunity to send staff to Mental Health First Aid training, responding to the need identified by the facilities for additional education around behavioral health. The Alliance meets collectively on a monthly basis and through FY19 will be focused on work around best practices and has so far discussed SNF to home transitions.
Participating Program Partners *Please list the relevant community-based organizations or provider groups,*	Skilled Nursing Facilities (See Appendix B)

contractors, and/or public partners	
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: 15,005 (PointRight Annual Post-Acute (Short Term Rehab) volume May17-April 18) Denominator of Eligible Patients: **Program Denominator: 15,005** (Total annual post-acute volume at SNFS) Secondary Denominator: 37 Skilled Nursing Facilities RP Analytic File: 21,658 (2+ IP or Obs >=24 or ED Visits & Medicare FFS)[9]
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	Nexus Montgomery does not intend to do a pre-post analysis for this population. We believe this would not be a useful measure in that enrollment is triggered by a 3+ day hospital stay, which would skew the data by having a high cost event in the immediate pre-enrollment timeframe.

[9] The RP Analytic File does not have an appropriate population – the 2+IP or Obs >=24 or ED Visits & Medicare FFS is the closest applicable population, but over-estimates by not being limited to those admitted to a SNF, it also doesn't capture the required 3 day admission to be eligible for a SNF admission. The SNF admission can also occur after only a single hospital utilization, if it results in a qualifying stay.

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 key intervention-specific metrics we will be measuring for this program are: 30 day Readmission rates from SNF, Patients sent from SNF to Nexus hospital ER, Patients sent from SNF for an Obs admission and Patient sent from SNF to Nexus hospital for an In Patient admission. Due to the program starting in the fall of 2017 and the 6-9 month time lag in the HQI data, we only have baseline data currently for this intervention. These metrics will be reported in the next report.
Successes of the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	There were a number of successes of this program in FY18, the first was in getting all the participating Skilled Nursing Facilities to implement PointRight as a single common platform for tracking readmission and quality data. Nexus Montgomery funded the implementation costs and first year costs of PointRight for all participating SNFs. The SNFs also took advantage of monthly web trainings on PointRight and all SNFs were offered the opportunity of a one hour session with PointRight to drill down into their own facility's data and optimize their use of the PointRight data for quality improvement. Another success was the getting 24 of the 37 participating SNFs to complete the seven established steps of engaging with Nexus – which started with getting their data into PointRight and ended with implementing a quality improvement (QI) initiative focused on readmission reduction. Nexus Montgomery provided the SNFs will a performance improvement consultant who held the initial focus group meetings and worked with each of the SNFs on their individual QI plans. As a result of the initial focus groups held with the SNFs, behavioral health was raised as an area of need for the SNFs and identified as an important driver of readmissions. Nexus therefore provided Mental Health First Aid training for the SNFs. In FY18 the first 2 of a planned 10 sessions were held.

Lessons Learned from the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	One of the key lessons learned in FY18 for the SNF Alliance was importance of engaging one on one with the facilities as well as in the collective setting. This resulted in 2 individual meetings being planned with each facility to better understand their services and unique challenges. The other important lesson was the impact of turn over at the facilities. Transition of Administrator and Director of Nursing positions, the sale of a building to another entity or a change in provider group has been seen to always negatively impact the readmission rate of participating SNFs. Turnover of staff, including the Administrator and Director of Nursing positions has been high in a number of SNFs with some having 3-4 transitions of key administrative positions in a year.
Next Steps for the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	As a result of the individual meetings with the SNFs and their identification of an initial quality improvement project, in FY19 we will be establishing Affinity Groups of 6-8 SNFs who are focusing on similar areas for improvement. This will enable them to learn from each other as they establish best practices. Each Affinity Group will be sponsored by one of the hospitals to assist with resources as needed. Four of the larger SNFs with higher readmission rates will also have a more intensive intervention consisting of monthly meetings and bi-weekly check-ins to help them leverage the data in PointRight to identify and act upon areas of opportunity for reducing readmissions. If this more focused work with the four SNFs produces the anticipated result, this more intensive approach will be spread to other SNFs.
Additional Free Response (Optional)	

Core Measures

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

Utilization Measures

For this reporting, we have opted to use the Regional Partnership Analytic File. For data requested for the time period FY18 we have used the final data currently available in CRISP for July 17-March 18. Due to the challenges of the populations in the RP Analytic Files and the reasons given above for them being a very significant over-estimation of the program population, these metrics are not something we are using at the program level to evaluate our programs internally. However, we are including this data at the all payer level in the board dashboard to maintain a view of this as the overall population level.

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)	For this reporting, we have opted to use the Regional Partnership Analytic File. Below are each data element for each population that is appropriate for the five core programs. We do not believe these measures best reflect populations served by the programs below. Project Access: All Payer: $1,599 (per year) WISH: 2+Chronic Condition + Medicare: $3,798 Severely Mentally Ill: 3+IP or Obs>=24: $349 Hospital Care Transitions: 2+ IP or Obs>=24: $910 SNF Alliance: 2+IP or Obs>=24 or ED visits +Medicare: $2,824
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)	For all FY18 metrics we are using the final data available for July 17-March 18. Project Access: All Payer: 62.34 (this is a 1% reduction in discharges from the prior year when annualized) WISH: 2+Chronic Condition + Medicare: 137.9 (this is a 4.2% reduction in discharges from the prior year when annualized) Severely Mentally Ill: 3+IP or Obs>=24: 11.66 (this is a 13.6% reduction in discharges from the prior year when annualized) Hospital Care Transitions: 2+ IP or Obs>=24: 32.88 (this is a 7.9% reduction in discharges from the prior year when annualized)

		SNF Alliance: 2+IP or Obs>=24 or ED visits +Medicare: 103.6 (this is a 9.5% reduction in discharges from the prior year when annualized)
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	$10,039
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)	Project Access: All Payer: 180.7 (this is a 1.6% reduction in visit per 1000 from the prior year when annualized) WISH: 2+Chronic Condition + Medicare: 144.45 (this is a 0.3% reduction in visit per 1000 from the prior year when annualized) Severely Mentally Ill: 3+IP or Obs>=7.09 (this is a 16.6% reduction in visit per 1000 from the prior year when annualized) Hospital Care Transitions: 2+ IP or Obs>=24: 90.56 (this is a 10.5% reduction in visit per 1000 from the prior year when annualized) SNF Alliance: 2+IP or Obs>=24 or ED visits +Medicare: 111.98 (this is a 7.2% reduction in visit per 1000 from the prior year when annualized)

Quality Indicator Measures

For this reporting, we have opted to use the Regional Partnership Analytic File. For FY18 was have used the Final data currently available in CRISP for July 17-March 18.

Measure in RFP	**Measure for FY 2018 Reporting**	**Outcomes:**

(Table 1 in Appendix A of the RFP)		For each of these measures, the populations used are not representative of our intervention populations as they are considerably broader in all instances, as described in the intervention section above
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)	Although this is comparing 9 months of data with 12 months of data, it looks as if the readmission rate has increased across all populations. Project Access: All Payer: 10.32% (this is a 0.1% increase from the prior year) WISH: 2+Chronic Condition + Medicare: 15.61% (this is an increase of 1.0% from the prior year) Severely Mentally Ill: 3+IP or Obs>=24: 36.4% (this is a 9.3% increase from the prior year) Hospital Care Transitions: 2+ IP or Obs>=24: 18.1% (this is a 6.3% increase from the prior year) SNF Alliance: 2+IP or Obs>=24 or ED visits +Medicare: 21.7% (this is a 7.4% increase from the prior year)
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)	Project Access: All Payer: $172,840,352 ($230,453,803 on an annualized basis) WISH: 2+Chronic Condition + Medicare: $75,028,112 ($100,037,483 on an annualized basis) Severely Mentally Ill: 3+IP or Obs>=24: $93,479,936 ($124,639,915 on an annualized basis) Hospital Care Transitions: 2+ IP or Obs>=24: $146,141,856 ($194,855,808 on an annualized basis)

		SNF Alliance: 2+IP or Obs>=24 or ED visits +Medicare: $65,986,004 ($87,981,339 on an annualized basis

CRISP Key Indicators (Optional)

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

Measure in RFP *(Table 1 in Appendix A of the RFP)*	**Measure for FY 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.*	Not Applicable
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.*	Not Applicable

Self-Reported Process Measures

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

process measures should be included in 'Intervention Program' section and don't need to be included here.

All Nexus process measures are evaluated and reported at the intervention level, so they have already been described above.

Return on Investment

Indicate how the Partnership is working to generate a positive return on investment. Free Response, please include your calculation if applicable.

We are currently calculating Return on Investment for a number of our programs. The Methodology for each is outlined below.

WISH

The WISH ROI methodology calculates ROI at the population level. The population being all residents of the target Independent Living Facilities. The Gross Savings for this metric is the difference in total Hospital Payments by Medicare (as reported to us by HQI) for residents in those buildings between CY16 and CY17.

Metric	Calculation Methodology	Data
Cost	Program Cost on ILF clients	$1,614,288
Gross Savings	Program Year total hospital cost – Baseline Year total hospital cost	$3,154,996
Variable Savings	Gross Savings * 50%	$1,577,498
Net Savings (Program cost)	Variable Savings – Cost	-$36,790
ROI: WISH (based on cost)	Variable Savings / Cost	0.98

This ROI exceeds what had been projected in the proposal for Year 1 to come in at 0.77.

HCT Program

The HCT ROI methodology uses the Risk Adjusted Readmission Rate. It calculates the difference in the baseline and program year ratios between Observed Readmissions and Expected Readmissions. It then uses this difference in the ratio to calculate the saved readmissions for the year. This saved readmission number is then multiplied by the average cost of a readmission to get the gross savings. A variable savings of 50% of the gross savings is utilized to calculate the ROI.

This methodology is shown below with the HCT data. One of the challenges we have had with establishing the framework for measuring the HCT ROI is establishing an appropriate baseline population. For the two hospital systems that used the Nexus funding to expand already existing HCT programs, the baseline used was their HCT program in the prior year, for the other two hospital systems the Medicare population for the prior year was used as their baseline.

Metric	Calculation Methodology	Data
Baseline O/E	Observed Readmissions/Expected Readmissions for Baseline	1.13
Intervention O/E	Observed Readmissions/Expected Readmissions for Intervention	1.07[10]
Difference in O/E	Intervention O/E – Baseline O/E	0.06
Saved Readmissions	Difference in O/E * Expected Readmissions in Intervention period	131
Nexus Costs		$1,162,326
Gross Savings	Saved Readmissions * Average Cost of Readmission	$1,849,982
Variable Savings	Gross Savings * 50%	$924,911
Net Savings	Variable Savings – Nexus HCT Costs	-$237,335
ROI	Variable Savings/Nexus HCT Costs	0.80

While this is approaching the projected ROI at this point of 1.18 the challenges with the baseline population for some hospitals have likely diluted the impact.

Conclusion

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

[10] The O/E ratio is driven by a high proportion of highest acuity patients, which includes SNF discharges, leading to an O/E ratio of greater than 1 as defined by the state model.

Appendix A – WISH Independent Living Facilities

Andrew Kim House

Arcola Towers

Asbury Methodist Village

Avondale Park

Bauer Park Apartments

Bedford Court

Bethany House

Brooke Grove Retirement Village

Charter House Senior Apartments

Chelsea Tower

Churchill Senior Living

Covenant Village

Elizabeth House

Five Star Premiere Residences

Forest Oak Towers

Friends House Retirement Community

Hampshire Village

Holly Hall

Homecrest House

Inwood House

Kensington Park Senior Living

Lakeview House

Manor Apartments

Oaks at Olde Towne

Randolph Village

Revitz House

Riderwood Retirement

Ring House

Rolling Crest Commons

The Bonifant

The Oaks at Four Corners

The Villages at Rockville

Town Center Apartments

Victory Court

Victory Crest

Victory Crossing

Victory Forest

Victory Haven

Victory House of Palmer Park

Victory Oaks

Victory Terrace

Victory Tower

Waverly House

Willow Manor at Cloppers Mill

Willow Manor at Colesville

Willow Manor at Fair Hill Farm

Appendix B – SNF Alliance

Althea Woodland Nursing Home

Bethesda Health & Rehabilitation Center

Friends Nursing Home

Oakview Rehabilitation and Nursing Center

The Village at Rockville

Hebrew Home of Greater Washington

Genesis - Crescent Cities Center

Genesis - Fairland Center

Genesis - Fox Chase Rehab and Nursing Center

Genesis - Layhill Center

Genesis - Shady Grove Center

Genesis - Sligo Creek Center

Hillhaven Nursing Center

Asbury Methodist Village

Sanctuary at Holy Cross

Erikson Living

HCR Manor Care- Bethesda

HCR Manor Care- Chevy Chase

HCR Manorcare - Adelphi

HCR Manorcare - Hyattsville

HCR Manorcare - Largo

HCR Manorcare - Silver Spring

HCR Manorcare-Potomac

HCR ManorCare-Wheaton

Bel Pre Health & Rehab Center

Collingswood Nursing and Rehab

Kensington Healthcare Center

Cadia Springbrook

Cadia Silver Spring

Cadia Hyattsville

Potomac Valley Nursing and Wellness Center

Brooke Grove Foundation

Regency Care of Silver Spring

Sunrise - Bedford Court

Sunrise - Brighton Garden Tuckerman Lane

Arcola Health and Rehabilitation Center

Montgomery Village

Appendix C

Pre/Post Analysis - Summary

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

Program Name
ad hoc July 17 thru June 18 (5887)

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

Most Recent Payer
All

Visit Type
Multiple values

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	482	373	216	<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	72	36	14.9%	7.5%	-7.5%
3 Months	79	52	21.2%	13.9%	-7.2%
6 Months	59	49	27.3%	22.7%	-4.6%
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	84	45	1.7	0.9	-0.8
3 Months	102	76	2.7	2.0	-0.7
6 Months	90	83	4.2	3.8	-0.3
12 Months	<11	<11			

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	93	$432,982	$138,377	$6,014	$3,844	($2,170)
3 Months	109	$692,472	$306,411	$8,765	$5,893	($2,873)
6 Months	79	$638,328	$454,192	$10,819	$9,269	($1,550)

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	84	45	$432,982	$138,377	$5,155	$3,075	($2,079)
3 Months	102	76	$692,472	$306,411	$6,789	$4,032	($2,757)
6 Months	90	83	$638,328	$454,192	$7,093	$5,472	($1,620)

Casemix Data Through:
05/31/2018

ENS Panels Last Updated:
06/09/2018

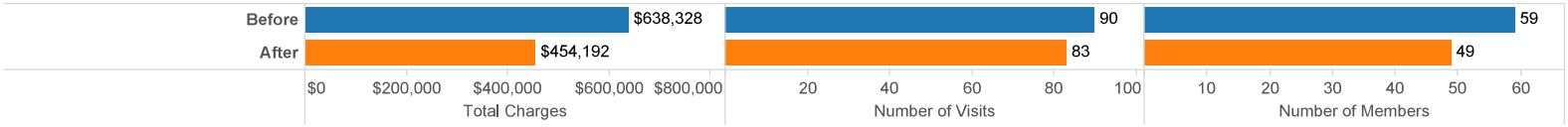
- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
  - Panel information provided to CRISP by ENS
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
- Individual patients identified using CRISP EID
- CRISP suppressed 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

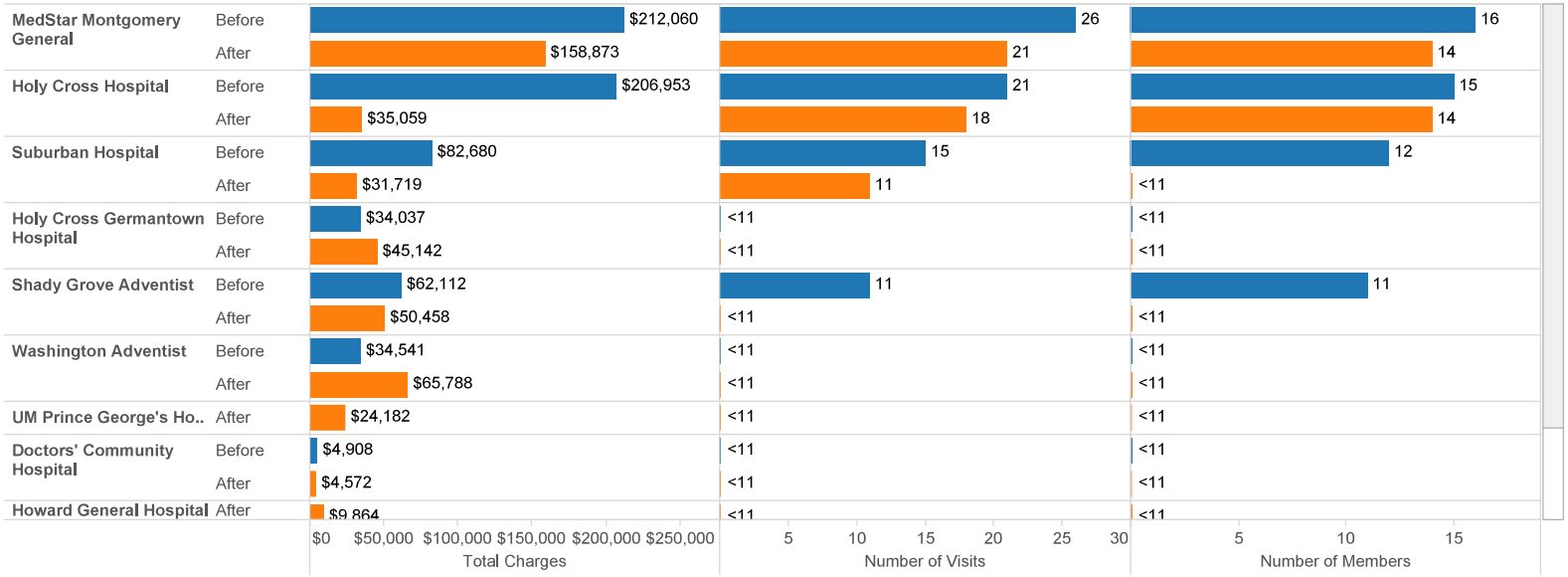
Analysis of 6 Months of Visits Before and After the Enrollment Date

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



Hospital Details



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Total Number of Members in the Panel

545

Number of Members with Data for Analysis

216

Number of Members with Visits during Analysis Period

79

Before or After Enrollment

Before After

Most Recent Payer
All

Time Period
6 Months

Visit Type
Multiple values

Sorting Option
Total Visits - After Enrollment

Hospital Name
All

Program Name
ad hoc July 17 thru June 18 (5887)

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator

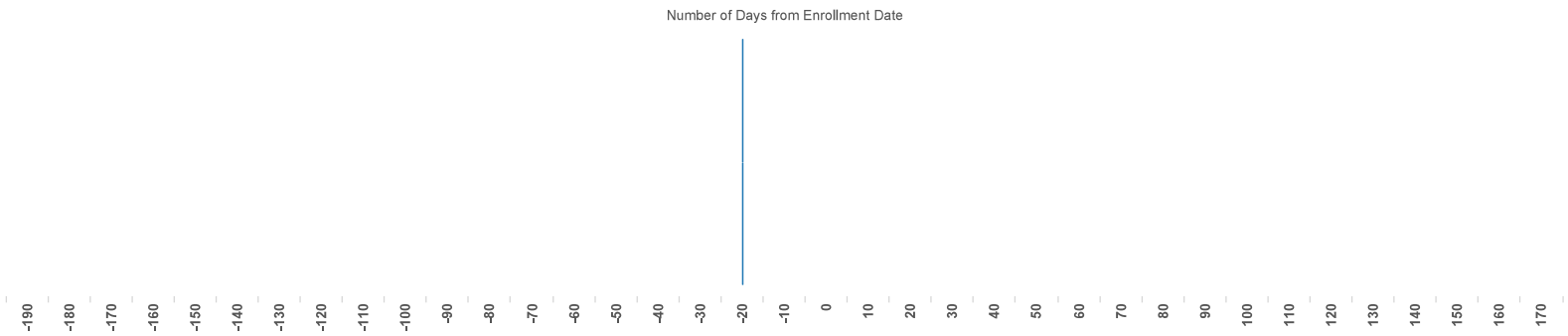
(•) AND
( ) OR

Pre/Post Analysis

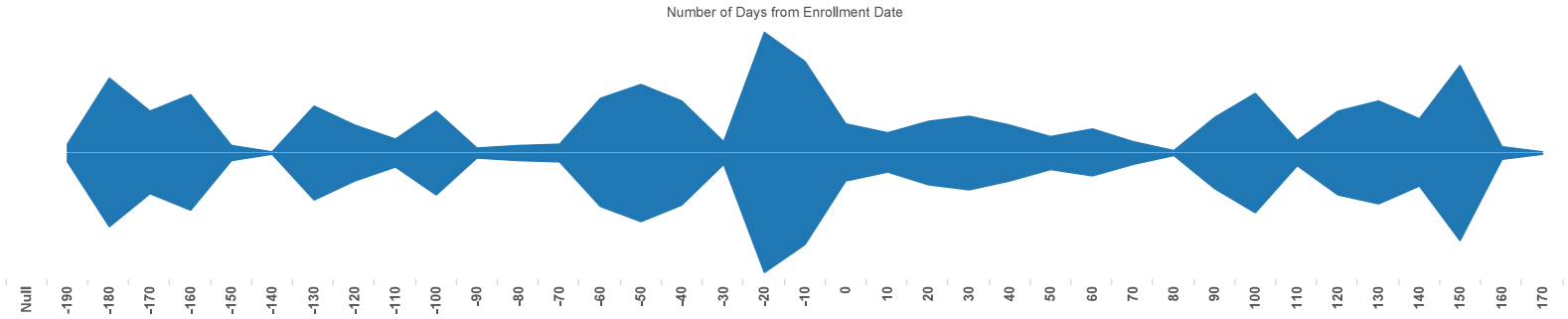
Analysis of 6 Months of Visits Before and After the Enrollment Date

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



Charges Trend



Total Number of Members in the Panel

545

Number of Members with Data for Analysis

216

Number of Members with Visits during Analysis Period

79

Most Recent Payer
All

Time Period
6 Months

Visit Type
Multiple values

Hospital Name
All

Program Name
ad hoc July 17 thru June 18 (5887)

Number of Days Interval
10

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

Casemix Data Through:

05/31/2018

ENS Panels Last Updated:

06/09/2018

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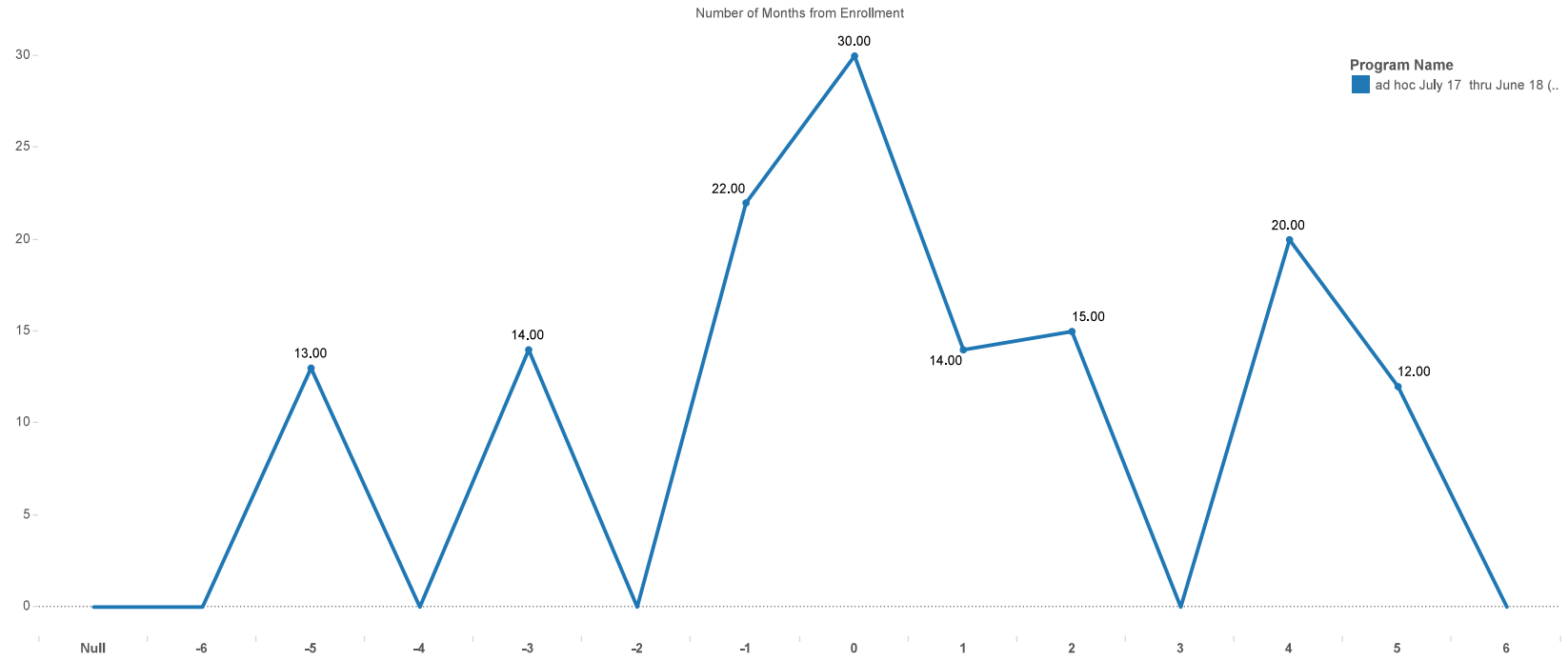
Relative Trend



Most Recent Payer
All

Time Period
6 Months

Trend Metric
Visits

Visit Type
Multiple values

Hospital Name
All

Program Name
ad hoc July 17 thru June 18 (5887)

Chronic Conditions
All Patients

N/A

N/A

Chrionic Condition Operator
(•) AND
( ) OR

Casemix Data Through:
05/31/2018

ENS Panels Last Updated:
06/09/2018

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Pre/Post Analysis

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Most Recent Payer
All

Visit Type
Multiple values

Hospital Name
All

Time Period
6 Months

Program Name
ad hoc July 17 thru June 18 (5887)

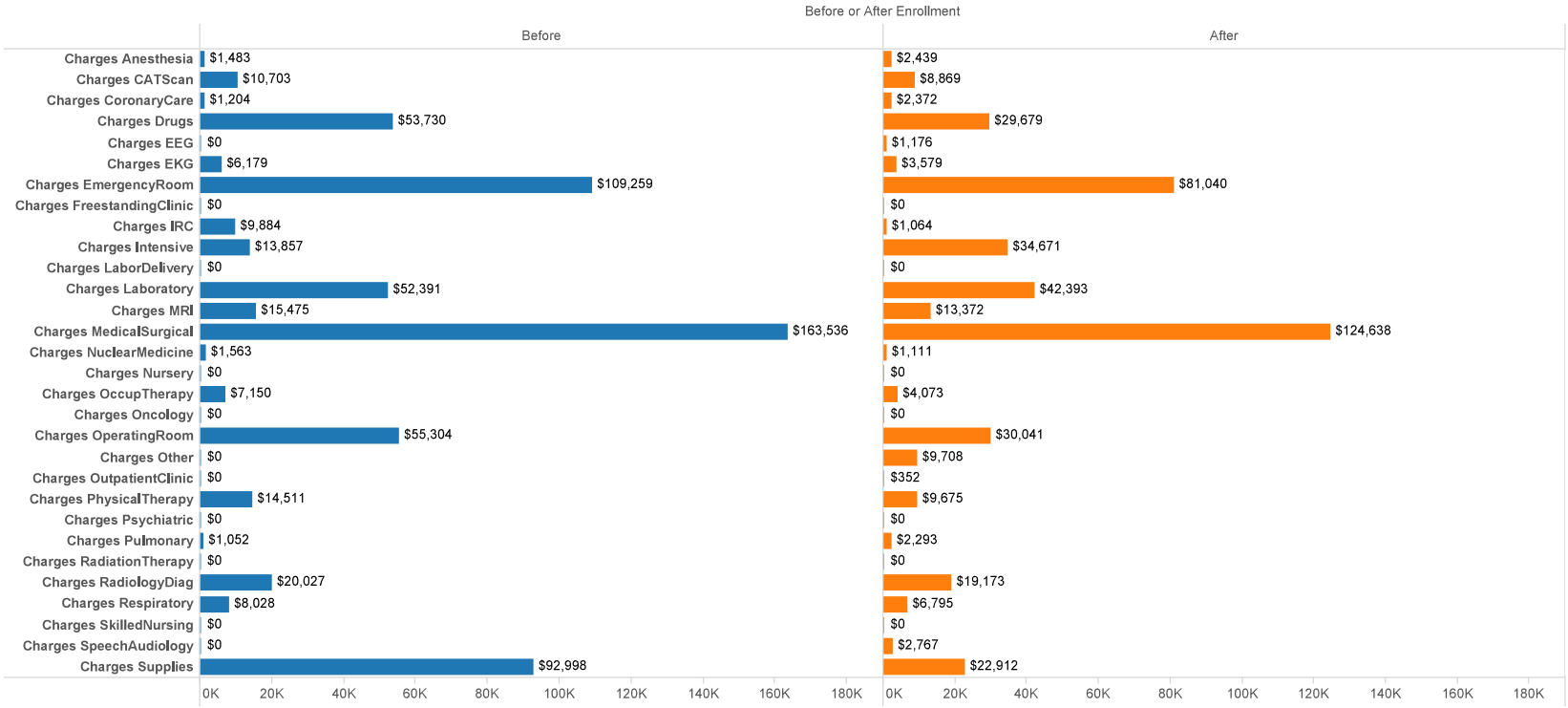
Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

Breakdown of Charges Sheet



Casemix Data Through:
05/31/2018

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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 - Summary

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

Program Name
ad hoc July 17 thru June 18 (5887)

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

Most Recent Payer
All

Visit Type
IP

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	482	373	216	<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	23	<11	4.8%		
3 Months	28	17	7.5%	4.6%	-2.9%
6 Months	27	19	12.5%	8.8%	-3.7%
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	26	<11	0.5		
3 Months	36	19	1.0	0.5	-0.5
6 Months	38	25	1.8	1.2	-0.6
12 Months	<11	<11			

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	29	$341,578	$83,773	$14,851	$8,377	($6,474)
3 Months	38	$571,477	$220,671	$20,410	$12,981	($7,429)
6 Months	37	$537,236	$361,673	$19,898	$19,035	($862)

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	26	<11	$341,578	$83,773	$13,138		
3 Months	36	19	$571,477	$220,671	$15,874	$11,614	($4,260)
6 Months	38	25	$537,236	$361,673	$14,138	$14,467	$329

Casemix Data Through:
05/31/2018

ENS Panels Last Updated:
06/09/2018

- 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
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Pre/Post Analysis - Summary

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

Program Name
ad hoc July 17 thru June 18 (5887)

Chronic Conditions
All Patients

Most Recent Payer
All

Visit Type
ED

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	67	80	62	<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	45	27	67.2%	40.3%	-26.9%
3 Months	46	42	57.5%	52.5%	-5.0%
6 Months	35	39	56.5%	62.9%	6.5%
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	51	31	7.6	4.6	-3.0
3 Months	57	51	7.1	6.4	-0.8
6 Months	44	51	7.1	8.2	1.1
12 Months	<11	<11			

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	67	$64,569	$35,036	$1,435	$1,298	($137)
3 Months	80	$86,120	$54,258	$1,872	$1,292	($580)
6 Months	62	$56,911	$62,180	$1,626	$1,594	($32)

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	51	31	$64,569	$35,036	$1,266	$1,130	($136)
3 Months	57	51	$86,120	$54,258	$1,511	$1,064	($447)
6 Months	44	51	$56,911	$62,180	$1,293	$1,219	($74)

Casemix Data Through:
05/31/2018

ENS Panels Last Updated:
06/09/2018

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Pre/Post Analysis - Summary

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

Program Name
ad hoc July 17 thru June 18 (5887)

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

Most Recent Payer
All

Visit Type
OBS > 23

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	11	14	14	<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	<11	<11			
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	<11	<11			
3 Months	<11	<11			
6 Months	<11	<11			
12 Months	<11	<11			

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	11	$26,835	$19,568			$1,058
3 Months	14	$34,874	$31,482	$3,875	$5,247	$1,372
6 Months	14	$44,182	$30,338	$5,523	$4,334	($1,189)

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	<11	<11	$26,835	$19,568			
3 Months	<11	<11	$34,874	$31,482			
6 Months	<11	<11	$44,182	$30,338			

Casemix Data Through:
05/31/2018

ENS Panels Last Updated:
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