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	Total Elder Care Collaborative (TEC-C)
RP Hospital(s)	The MedStar House Call Program (MHCP) is the primary entity in the collaboration. MedStar Good Samaritan Hospital and MedStar Union Memorial Hospital serve as the affiliated hospitals for the local staff Baltimore City, Maryland.
RP POC	Julie Beecher, AVP Operations
RP Interventions in FY 2018	Expansion of MHCP service model in Baltimore City
Total Budget in FY 2018 *This should equate to total FY 2017 award*	FY 2018 Award: $1,863,492
Total FTEs in FY 2018	Employed: MedStar House Call Program employed 27.14 FTEs in FY'18. Of those, 7 FTEs were solely devoted to Baltimore house call team.
	Contracted: MedStar House Call Program contracted 0.48 FTEs in FY'18 for temporary outreach work.
Program Partners in FY 2018 *Please list any community-based organizations or provider groups, contractors, and/or public partners*	See list of program partners under intervention section in report. They include a wide array of partners in transportation, housing, health care, social services, and legal assistance.

Overall Summary of Regional Partnership Activities in FY 2018

The Total Elder Care Collaborative (TEC-C) was initiated to demonstrate the efficacy and scalability of the MedStar House Call Program (MHCP) – previously known as MedStar Total Elder Care (MTEC) – model of home-based primary care; therefore, the activities of the collaborative overlaps entirely with the activities of the MHCP entity.

Jan-March 2016

- Built financial and organizational infrastructure and recruited key clinical and support staff

April-June 2016

- Lead physician started work in April, 2016
- Triage nurse, care coordinator, and nurse practitioner hired
- Procured clinician laptops and negotiated information services (IS) support
- Began outreach and relationship-building efforts with community partners

July-September 2016

- Began official patient care services
- 2nd Physician and Operations Manager were hired
- Intensive outreach efforts with emergency rooms, assisted living facilities, and primary care providers
- Built and refined tracking tools through various MedStar Clinical Systems
- Secured space for office on MedStar Good Samaritan campus
- Identified and expanded community partnerships and resources

October- December 2016

- Identified and expanded community partnerships and resources
- Social worker hired in October- Team #1 fully staffed
- Transitioned to a new Electronic Health Record (Med Connect) in November, 2016
- Ongoing coordination with CRISP on need for accurate real-time alerts
- Developed plans for total cost & outcomes evaluation with external health economist group
- Ongoing dialogue with HSCRC and CRISP on data available to MedStar health system

January- March 2017

- Switched to incremental weekly census uploads to CRISP to better capture utilization events
- Collaborated with MedStar hospital leadership to recruit patients from HSCRC high-utilizers list.

April-June 2017

- Renovation completed of new office space
- Consulted MedStar Institute for Innovation (MI2) on patient recruitment
- Created new Outreach liaison position with incentives for meeting practice growth targets
- Collaborated with MedStar marketing team to deploy online advertising and track metrics
- Began collaboration with JEN Associates on study of the impact of house calls on patient outcomes and overall costs

July-December 2017

- Hired outreach liaison for community outreach and patient recruitment
- Created toolkit for scheduling outreach, screening patients, and documenting referral sources
- Submitted IRB approval to conduct study on patient outcomes and overall costs; CMS claims data will be purchased using HSCRC funding for outcomes data purposes.
- Worked with CRISP and MedStar hospitals to improve the consistency of real-time utilization alerts
- Mobilized MedStar marketing for name 'rebranding' to MedStar House Call Program & targeted marketing campaign in January, 2018. Includes radio advertisement, direct postcard mailing, social media, and online search optimization.
- Continued grass-roots efforts to build referral networks with care managers, discharge planners, and primary care providers with high risk patients.
- Started Year 6 of the IAH demonstration in October, 2017

January - June 2018

- Hired new operations manager for DC practice
- Embarked on project to transition population tracking functionality into the EHR
- Initiated negotiations with Senior living facilities in the area to provide medical services

Intervention Program

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

Intervention or Program Name	MedStar House Call Program (MHCP)
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	MHCP is not a hospital-based program. Rather, the program enrolls qualified patients in the Baltimore City community. Criteria are as follows: • Live in one of 8 zip codes • Age 65 or older • 2 or more serious chronic illnesses • Functional impairment in ADLs or IADLs • Change primary care to MHCP team • High-cost events in past year
Brief description of the Intervention *2-3 sentences*	MHCP is a multidisciplinary approach to providing primary care to geriatric patients who have difficulty getting out of the home. In addition to medical services, we provide transitions of care, and coordination of social services as needed.
Participating Program Partners *Please list the relevant community-based organizations or provider groups,*	• **Transportation**: Action in Maturity, MedStar Transport • **Home PT/OT, Skilled Nursing & Hospice**: MedStar VNA, Hopkins Home Care, Gilchrist Hospice, VITA Hospice

contractors, and/or public partners	• **Sub specialists & inpatient rehabs**: all the local sub-acute facilities • **Hospital & ER care**: all local hospitals where our patients might land. Notified via CRISP alerts. Our physicians provide inpatient care at MedStar Good Samaritan Hospital. • **Labs & Radiology**: Providers draw labs-in home and use MedStar Good Samaritan lab to process. Initially the team tried LabCorp, but results weren't easily available to clinicians. Mobile radiology services through Mobile Medical • **Delivery of Medication and Equipment**: through local Medicare agencies. MedStar Pharmacy at Good Samaritan hospital provides home delivery and customized blister packaging for patients who opt for that service. Otherwise, any local pharmacy partners with our clinicians and receives electronic prescriptions. • **Social Services & Legal**: triaged through MedStar House Call social worker to various community agencies. Guardianship attorney (on contract by MedStar) engaged when appropriate for patient/family situation. • **Housing:** Over 100 group homes and senior assisted living facilities were identified in our catchment. Our staff has cultivated relationships with many of them to foster awareness and referrals. They routinely offer ice cream socials, participate in health fairs, and community events. Stadium Place, St. Mary's Roland View, Walker Mews, & Kirkwood House are a few of the senior residence facilities that are strong 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: **196** Denominator of Eligible Patients: Difficult to get at denominator since we do not have a reliable data source to identify potential patients. We have touched over 4,000 elders through outreach activities in Baltimore since inception. The practice has screened but not enrolled 172 patient inquires. Of those, • 17 were not eligible because of type of health insurance plan • 28 were not eligible because they did not meet the 'frailty' screen for home-based primary care • 72 were out of zip code catchment and referred to another primary care provider

	• 55 were eligible, but declined A marketing campaign that included radio, direct mail, print advertisement, search engine marketing and social media ran in January 2018 for 8 weeks with the goal to increase community awareness of our services. Since inception, the MedStar House Call Program website has received 2,559 'clicks' with 401 users going to web pages to find out if eligible and learn about our services.
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	We are actively working with a health economist group at Westat (formerly JEN Associates) on a study of the impact of MHCP care on total costs.
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.*	Please see comments under Self-Reported Process Measures
Successes of the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	• Fully staffed, superb clinical care team with capacity to manage complex, co-morbid, frail patients at home. Team can manage 300-350 patients. • Increased community awareness and proven ability to establish trust from care team. • Engaged collaborative partners across health, housing, social service, and government sectors.
Lessons Learned from the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	• Slower patient enrollment than anticipated. We are still not at full capacity for one clinical care team. HSCRC funds are needed to support operational ramp-up to full patient census capacity. • Some confusion in the local community on how to transfers patients/families to appropriate health care. • Delay in finding adequate office space and implementing a modest capital renovation. • HSCRC hospital attribution model does not match how patients actually receive primary care in various

	community settings. We are working with hospital and community partners to identify and enroll appropriate patients in MedStar House Call Program (MHCP). • Prevention Quality Index (PQI) metric issues- These are difficult to report since MHCP accepts all patients who meet geographic and risk criteria without regard to HSCRC hospital attribution. MHCP can check patient census against MedStar PQI reports, but can miss patients attributed to other hospitals. • We are unable to access total cost data by patient in order to calculate Total Costs savings.
Next Steps for the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	• Outreach—We will continue an outreach plan to ERs, Senior living facilities, and the family caregiver community. This has shown slow but steady success in FY18. • We will adjust growth plan and staffing for FY20 to realistic patient volume targets • We explored a DUA amendment to permit access to claims data for this project so we can measure total cost savings. We opted to use HSCRC funds to purchase Medicare claims data, since the amendment seemed prohibitive. Although this involves more time and expense, we feel this evaluation is important to state policymakers and health systems. • Guidance on HSCRC plans for next 2-3 years. The new Baltimore team depended on assistance from HSCRC Implementation grant for start-up costs and this remains vital for the future.
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

*In measures, "patient-years" is used in place of "per capita" since patients may be enrolled in MHCP for a few weeks or a few years. Patient-years is defined as total number of years that patients are active in the MHCP program thru June 30, 2018 (FY18).

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)~~	**Unable to report** The only source of all-site hospital cost information is the CRISP PaTH reports. The PaTH data is summarized by patient, without date of service, so we cannot determine whether the cost was incurred during MHCP enrollment. Also, PaTH reports provide only year-long data on the active census – leaving out information on disenrolled patients. *MHCP is working with health economist group (JEN/Westat) on a matched-cohort study of the impact of the MHCP care on total costs.*
Total hospital admits per patient-year	**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)~~	**Admits in Reporting Period: 80** **Admits per Patient-Year*: 0.73** This data was pulled from downloaded CRISP ENS alerts. This is the only way to pull utilization data on patients *during their period of enrollment* in our program.
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~~	**Unable to report** Currently, MHCP has no access to total health care cost data (claims). CRISP has access but is unable to share under the present data use agreement (DUA).
ED Visits per	**Ambulatory ED Visits per 1,000**	**ED Visits in Reporting Period:** 177

capita	~~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)~~	**ED Visits per Patient-Year*:** 1.62 This data was pulled from downloaded CRISP ENS alerts. This is the only way to pull utilization data on patients *during their period of enrollment* in our program. ED visits in CRISP are counted regardless if patient is admitted to hospital. CRISP data structure does not lend itself to identifying which ED visits and admissions are part of the same episode. So, this number is likely over-estimated.

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-~~ ~~Analytic File:~~ ~~'IP Readmit' over 'EligibleforReadmit'~~ ~~(Column J / Column I)~~	**Readmissions:** 13.8% of all admissions within the MHCP population in the reporting period were readmissions The MHCP readmission rate compares favorably to the national all-cause 30 day readmission rate for patients 65+ (Kaiser) especially considering the practice targets the "sickest of the sick." *As of the time of writing, data is only current through March 2018.*
Prevention Quality Index (referred to originally as PAU)	**Potentially Avoidable Utilization** ~~Executive Dashboard:~~ ~~'[Partnership] Quality Indicators' –~~ ~~Potentially Avoidable Utilization, reported as **sum** of 12 months of FY 2018~~ ~~-or-~~	**Utilizations Related to Ambulatory-Care Sensitive Condition (ASC):** 102 per 1,000 patients or 10.2% To standardize this number for comparison against the Dartmouth Atlas benchmark for the region, we took our 20 ASC-related utilizations for the reporting period and divided by the 196 patients touched and extrapolated to 1,000 patients.

	~~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.

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.*	**100%** MHCP care teams transitioned to a new EHR in November 2016 (MedConnect) as part of a MedStar system initiative. All clinical notes, advanced directives, key family contacts, and goals of care are completed in EMR.
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.*	**N/A** Weekly patient care team meetings are ongoing. All new patients, unstable patients, inpatients, patients in SAR, and deaths are discussed each week by the MHCP team. MHCP team is the 'care manager' for the patient. In fact, our team works to stop additional care management provided by various health insurers and navigators since it confuses the patient/family and sometimes leads to fragmented care.

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, 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.

See the MedStar FY'18 year-end report for program specific measures. They include:

- F/U house call within 2 days of a hospital or ED visit (94%)
- Medication reconciliation completed within 2 days after transition from hospital or ED (94%)
- Cause of program exit (Death is the leading cause of program exit).
- Death data (Most die at home as planned. Some in hospital or inpatient hospice. 69% used hospice services. 81% had DNR code status).
- Provider satisfaction/retention (The 2018 associate survey this year showed an overall engagement score of 98 points—5 points higher than 2017 and 21 points higher than US Norm).

Return on Investment

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

MedStar engaged Westat (formerly JEN Associates) to partner with MHCP and analyze the return on investment. We should have some preliminary results in late 2019. Our biggest hurdle has been purchasing and preparing the Medicare FFS data.

Our questions include:

1. Do MHCP services reduce total payments and adverse outcomes for high-risk patients compared with a control population not receiving these services?
2. Do MHCP participants record better outcomes than nonparticipants?
   In which areas do MHCP participants demonstrate a benefit?
   More specifically, does MHCP participation reduce:
   a. Total annual health care payments?
   b. Total annual payments by service category for hospital, physician, hospice and other providers?
   c. Total (all-cause) hospital admissions (episodes and lengths of stay)?
   d. Emergency department visits that do not result in hospitalization?
   e. Hospital readmissions within 30 days?
   f. Potentially avoidable hospitalizations for ambulatory sensitive conditions?
   g. Inpatient acute discharges to SNF, rehab facilities or nursing homes?
   h. Days at home (non-institutional days)?
   i. Hospice use (in-home and facility)?
   j. Mortality rate?
3. Do certain MHCP sub-populations fare better than others?
   What are the characteristics of patients most likely to have successful outcomes after enrolling in HBPC? In particular, is the impact of MHCP participation related to:
   a. Age?
   b. Gender?
   c. Overall severity of illness (HCC)?
   d. Overall severity of disability (JEN Frailty Index)?
   e. Length of HBPC enrollment?

We will gladly provide and present our findings with HSCRC once available.

Conclusion

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

We appreciate the HSCRC investment in MedStar's House Call Program's expansion to Maryland. Our greatest strength is our caring and skilled medical, social work, and administrative staff. Our teams do whatever it takes to help frail elders and their families live with dignity in their own home. We have successfully put that new team together in Baltimore and have good patient outcomes thus far. We anticipate similar outcomes in total cost of care. That said, finding and engaging appropriate patients and families in Baltimore has been slower and harder than anticipated. The HSCRC investment has helped us remain viable as we gain trust in communities, and new reimbursement models evolve. We look forward to ongoing dialogue with HSCRC on future investment and best-practice care models for high cost populations.