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	West Baltimore Collaborative (WBC)
RP Hospital(s)	University of Maryland Medical Center, University of Maryland Medical Center Midtown Campus, Saint Agnes Healthcare, Bon Secours Hospital
RP POC	Meredith Truss meredith.truss@umm.edu 410-328-9708
RP Interventions in FY 2018	Community-based care coordination for Medicare patients whose chronic illnesses have led to frequent utilization of services at one or more hospitals.
Total Budget in FY 2018 *This should equate to total FY 2017 award*	FY 2018 Award: $1,782,501 FY 2018 Budget: $1,980,555 FY 2017 Award: $1,980,555
Total FTEs in FY 2018	Employed: 1.0
	Contracted: 7.0
Program Partners in FY 2018 *Please list any community-based organizations or provider groups, contractors, and/or public partners*	HealthCare Access Maryland (HCAM): HCAM is the contracted vendor who the WBC relies on to outreach, enroll, and provide care coordination and supportive services to qualified Medicare patients across all four hospital sites. Chesapeake Regional Information System for our Patients (CRISP): Patients who meet WBC criteria based on case mix data are uploaded into ENS PROMPT, which triggers an alert to the hospital sites and HCAM when a patient visits one of the WBC hospitals. This allows hospital staff and HCAM to identify and outreach patients in close to real-time. CRISP has also developed a "WBC enrolled" panel for HCAM to monitor

	utilization. The WBC director regularly works with CRISP to monitor utilization of WBC eligible and enrolled patients, including use of the pre/post utilization report tool based on an enrolled ENS panel, which is a relatively unique use case for this report. Lyft: The WBC has contracted with Lyft to provide transportation to enrolled patients to medical and related appointments until they are connected to sustainable, permanent sources of transportation. Federally Qualified Health Centers (FQHCs): The WBC held monthly meetings between January and June 2018 that included four FQHCs that serve the community: Total Health Care, Baltimore Medical System, Chase Brexton, and Healthcare for the Homeless. During joint meetings the WBC and FQHCs coordinate management of joint patients, review referral systems and outcomes, and discuss challenges within the patient population.

Overall Summary of Regional Partnership Activities in FY 2018

(Free Response: 1-3 Paragraphs):

Fiscal Year 2018 was the first full year of operations for the West Baltimore Collaborative and significant progress was made. The first several months of FY18 were focused on developing partnerships, onboarding staff, establishing technological support via CRISP, and creating processes and workflows. Several committees that were formed during FY17 began to meet monthly, including the Governance Committee (WBC hospital executives), Management/Operations Committee (hospital implementation leads, HCAM, CRISP), and Medical Advisory Committee (hospital clinical representatives, FQHCs, HCAM). During the first half of the year HCAM worked extensively with each of the four hospital sites to integrate vendor staff on-site for referrals and outreach, including creating workflows and providing training on the use of EMRs. Staff at HCAM and the hospitals were also trained in the use of ENS PROMPT to identify and track WBC-eligible patients. Initially CRISP updated case mix eligibility data in ENS PROMPT approximately every three months, which led to some patients no longer being eligible at the time of referral due to changes in eligibility during the delay. Supplemental workflows were developed at each site to refer additional patients to the WBC, to offset this challenge. However, by March 2018 CRISP had begun to update case mix data in ENS PROMPT monthly for more accurate eligibility, so in the spring all hospitals migrated to reliance on ENS PROMPT as the primary source of referrals. This refinement and standardization of the referral workflow across sites has increased HCAM's outreach efficiency and reduced the number of ineligible referrals to the program.

HCAM began to enroll patients in October 2017, and as of June 30, 2018 they had enrolled 214 patients and completed care coordination for 131 patients- see pre/post attachment and intervention-specific measures below for patient outcomes. Once personnel were in place, HCAM's enrollment pace was on track to reach 300 patients per year. In February 2018, CRISP developed a WBC-enrolled panel in ENS PROMPT for HCAM to use to monitor encounters for enrolled patients. The WBC director worked with HCAM in February and March to develop and refine a monthly data dashboard to track performance and

identify trends. Each month the WBC Management Committee meets via teleconference to review the dashboard and to discuss successes and areas for improvement. To enhance the WBC's ability to monitor utilization patterns and outcomes for enrolled patients, in the spring of 2018 the Collaborative began the recruitment process for a Senior Population Health Analyst. The WBC anticipates hiring an analyst during the first quarter of FY19.

The WBC also began to explore additional ways to support patients during FY18. In February HCAM began to use Lyft's Concierge service to schedule transportation for clients to medical and support service appointments, and between March and June 2018 a total of 173 rides had been scheduled with 149 completed. Preliminary analysis suggests that the use of Lyft provided significant savings over alternative commercial conveyance. The WBC Governance Committee also worked with HCAM in May during negotiation of the FY19 contract to establish a fund to address patient needs such as out-of-pocket medical costs (e.g. appointment and prescription co-pays), durable medical equipment not covered by insurance, and fees associated with applications for support services and legal documents.

Intervention Program

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

Intervention or Program Name	HCAM Care Coordination
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	All: University of Maryland Medical Center, University of Maryland Medical Center Midtown Campus, Saint Agnes Healthcare, Bon Secours Hospital
Brief description of the Intervention *2-3 sentences*	WBC hospitals refer eligible patients to HCAM via ENS PROMPT for outreach. Once enrolled, HCAM conducts a post-discharge home visit to review the patient's needs and to create a care plan and home visit schedule. HCAM staff provide home-based care coordination and care management for 90 days, including health education, assessment of barriers to health, medication reconciliation, transportation, assistance with medical appointments, and navigation to social/support services and community resources. The ultimate goal is the successful transition to primary or specialty care medical homes with sufficient behavioral health and other support to address social determinants and barriers to health.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	All: HCAM, CRISP, Lyft, FQHCs

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: 214 patients enrolled, 131 patients completed care coordination
	Denominator of Eligible Patients: 2,763 patients (Per CY17 RP Analytic File: 2,763 patients in the West Baltimore Collaborative Regional Partnership category with 2+ IP or Obs>=24 or ED Visits, and Medicare FFS) The actual denominator is less than 2,763 patients as this analytic file category does not include a filter for chronic conditions, which is an additional WBC eligibility requirement.
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 WBC has worked extensively with CRISP on the capacity to generate a pre/post analysis report based on the WBC-enrolled ENS PROMPT patient panel. This has enabled the WBC to review utilization of the combined panel of enrolled patients across all four hospital sites without separating into hospital-based panels, which is critical for the WBC as the program model defines eligible patients as those who are shared by two or more hospital sites. The challenge associated with accessing data in this manner is that it is dependent upon CRISP linking case mix data with ENS PROMPT panel data, which generally causes a delay of several weeks to months. A pre/post analysis summary is included with this report to demonstrate a selection of utilization trends among enrolled patients. The report is based on a panel of patients enrolled through June 4, 2018. The majority of data falls within three months pre/post, as the WBC did not begin enrolling patients until fall 2017; the number of patients with six months of data before and after enrollment when the report was generated was not sufficient for analysis. Highlights include: • Total hospital charges decreased 64.7% in the month following enrollment vs. the month prior. • Total inpatient + observation >23 hours visits decreased 61.3% in the month following enrollment vs. the month prior, and total inpatient charges decreased 66.1% during the same time. • Inpatient visits/charges and ED visits/charges decreased during the three months following enrollment vs. prior. • Outpatient visits remained stable during the three months following enrollment, while outpatient charges decreased.

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 WBC director monitors a monthly dashboard of HCAM performance measures. Measures and outcomes for FY18 include the following: • # of patients referred to HCAM: 1,643 • # of referrals not eligible: 594 (majority were patients referred by hospitals outside of ENS PROMPT referral process) • # of referrals who declined services: 422 (majority were patients who indicated no interest or no need) • # of referrals who accepted services: 222 • # of referrals who enrolled: 214 • % of eligible referrals who enrolled in WBC (i.e. clients): 20.6% • # of home visits scheduled: 514 • # of home visits successfully completed: 451 (88%) • % of client care plan goals successfully met at time of client case closure: 77%* *Each WBC client has a core set of standard care plan goals for the program: • Confirm or connect to PCP/Medical Home • Confirm medical coverage • Decrease ED visits • Connect to supportive services In addition, care coordinators add tailored goals for each client as appropriate, such as connect to substance use treatment, connect to dental care, etc. The WBC also collects data from HCAM about the types of supportive services and resources that clients are connected with. During FY17, the four types of services that clients were most frequently connected with were transportation (55 clients via Lyft), long-term case management (28 clients), financial assistance (26 clients), and food/nutrition support (23 clients).
Successes of the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	The WBC achieved significant success during FY18. During the first half of the year all vendor contracts were executed, and HCAM had begun to enroll patients into the program. After several months of pilot-testing various referral processes and methods, the hospitals implemented standardized processes to identify and refer eligible patients through ENS PROMPT, which has increased efficiency and reduced the number of ineligible referrals. Importantly, the WBC has begun to see some promising trends in utilization

	among enrolled clients including a 48% decrease in all visit types and a 65% decrease in total charges in the month following enrollment (see pre/post attachment). FY18 has also been a significant year for partnership development, including working closely with CRISP and the FQHCs in West Baltimore.
Lessons Learned from the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	It is important for the WBC to view enrolled patients as a single panel, as patients frequently cross hospitals and one of the program criteria is that patients have utilized two or more hospitals in the partnership. CRISP has been very responsive in granting access and troubleshooting the use of the CRS pre/post utilization report for the WBC-enrolled ENS PROMPT multi-hospital panel. One lesson learned during FY18 is that viewing enrolled patients as one panel presents challenges in the ability to identify readmissions for those patients, as readmissions are not included in the pre/post report and patients may appear on multiple hospital HSCRC readmissions reports making it difficult to de-duplicate at the patient level. The WBC is in the process of hiring an analyst during FY19 to assist in monitoring and analyzing outcomes. Another lesson learned is that frequent communication between HCAM and other hospital-based transitional care programs is essential to avoid overwhelming patients and duplicating efforts. HCAM has anecdotally reported that patients sometimes refuse services if they have been approached by hospital transitional care staff, so the WBC began to collect and monitor data on this in April. In addition to daily communication, the WBC has monthly scheduled calls with HCAM and all hospital-based WBC leads. Staff turnover has been a challenge that HCAM has addressed by onboarding and cross-training WBC staff at multiple hospital sites to fill in as vacancies occur.
Next Steps for the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	The WBC has planned several new initiatives during FY19. The hiring of a new Senior Population Health Analyst will enhance the Collaborative' s ability to monitor utilization and outcomes of patients. As mentioned above, a client support fund has been established to address needs and barriers that prevent patients from following through with discharge and care plans. The Governance Committee is planning to facilitate an annual meeting with staff from each WBC hospital and HCAM to discuss progress, enhance coordination, and provide professional development opportunities. The Governance Committee is also considering expanding eligibility criteria to increase the WBC's reach and impact in the community.

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

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)	Charges: 122,515,681.55 Population: 18,832 Charges per capita: 6,505.72 Source: CY 2017 RP Analytic File
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)	Inpatient/Obs Visits: 4,324 Population: 18,832 Discharges per 1,000: 229.61 Source: CY 2017 RP Analytic File
Total Health Care Cost per person	**Partnership TCOC per capita – Medicare**	West Baltimore Collaborative: $16,221 per beneficiary for CY 2017

	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	Source: Total Cost of Care Regional Partnership Cost of Care Report
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)	ED Visits: Population: 18,832 ED visits per 1,000: 328.22 Source: CY 2017 RP Analytic File

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)	Inpatient readmits: 622 Eligible for readmit: 3,140 Readmission rate: 19.81% Source: CY 2017 RP Analytic File
PAU	**Potentially Avoidable Utilization**	Total PAU charges: $27,877,722.66

	Executive Dashboard: '[Partnership] Quality Indicators' – Potentially Avoidable Utilization, reported as **sum** of 12 months of FY 2018 -or- Analytic File: 'TotalPAUCharges' (Column K)	Source: CY 2017 RP Analytic File

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.*	June: 4.4% May: 3.7% April: 3.7% March: 3.5% February: 3.2% January: 2.9% Average: 3.6% Source: Executive Dashboard for Regional Partnerships
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.*	June: 37.9% May: 38.6% April: 38.0% March: 36.0% February: 35.8% January: 31.0% Average: 36.2% Source: Executive Dashboard for Regional Partnerships

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.

None to report, all reported as intervention-specific measures 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.

The WBC partner hospitals maintain level funding for the Collaborative at the FY17 award amount, even as the award is reduced annually to share savings with payors. The hospitals work under the assumption that the program is generating savings to direct to the management and support of shared patients, which has been confirmed in pre/post analysis of charges thus far. As of June 2018, 89 enrolled patients with 3 months of utilization before and after enrollment had generated $427,104 fewer charges after enrollment (see attached pre/post); extrapolating this reduction to 214 patients results in a more dramatic estimated decrease in charges. It is premature at this time to calculate a return on investment given the time that the WBC and HCAM required during FY18 to recruit, train, and embed staff at the partner hospitals to achieve sufficient enrollment. However, the WBC director and Governance Committee will monitor changes in charges throughout FY19 once the WBC has a panel of patients with 6 and 12 months of pre/post data. The WBC anticipates that an accurate, positive return on investment will be calculated and generated in FY19.

Conclusion

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

Fiscal year 2018 was a year of successes and challenges for the WBC, as the Collaborative worked to optimize processes across hospital sites and meet enrollment targets. The WBC ended the year fully staffed and on track to enroll close to 300 patients over 12 months, based on average monthly enrollment as of June 2018. As the pace of enrollment increased in 2018, the WBC plans to expand the number of patients who enroll in care coordination in FY19 and may also expand eligibility criteria for the program to include dual-eligible patients and those with Medicaid. The WBC Governance Council is optimistic for FY19 as pre/post utilization analysis on the enrolled patient panel has shown promising trends, and many of the FY18 challenges have been addressed or are in the process of being mitigated. The WBC looks forward to expansion of the HCAM care coordination program, more robust data and outcome analysis capabilities with a new Senior Population Health Analyst coming on board, and consideration of new interventions to improve the health of our shared complex Medicare patients.