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	Howard Health Partnership (HHP)
RP Hospital(s)	Howard County General Hospital (HCGH)
RP POC	Elizabeth Edsall Kromm, Vice President of Population Health and Advancement; phone 410-740-7734; email ekromm@jhmi.edu Tracy Novak, Director of Population Health Programs; phone 410-720-8762; email tnovak2@jhmi.edu
RP Interventions in FY 2018	1. Community Care Team (CCT) 2. Primary Care referral pathway to the CCT 3. Elder Medical Care 4. Remote Patient Monitoring (RPM) 5. Behavioral Health Rapid Access Program (RAP) 6. Skilled Nursing Facility (SNF) Collaborative including Infectious Disease pilot 7. Journey to Better Health (J2BH) 8. Educational Resources/Classes
Total Budget in FY 2018 *This should equate to total FY 2017 award*	FY 2018 Award: **$1,321,432 awarded (10% less than FY17) plus $545,098 carryover = $1,866,530**
Total FTEs in FY 2018	Employed: **17.35 FTE**
	Contracted: 4 positions that worked a variety of hours including Interventions and Analytics Manager (1 month, July 2017), Quality Improvement Analyst and Performance Improvement Analyst from Continuous Quality Improvement team, and Nurse Practitioner for Infectious Disease pilot at SNF
Program Partners in FY 2018 *Please list any community-based organizations or provider groups, contractors, and/or public partners*	Berkeley Research Group, LLC; CRISP; Centennial Medical Group; Columbia Medical Practice; Ellicott City Healthcare; 16 Faith communities; Foreign-Born Information and Referral Network (FIRN); Gilchrist Services; Horizon Foundation; Howard County

	Health Department; Howard County Local Health Improvement Coalition (LHIC); Howard County Office on Aging and Independence; Johns Hopkins Armstrong Institute; Johns Hopkins Community Physicians; Johns Hopkins Home Care Group; Johns Hopkins Medicine; Johns Hopkins University; Lorien Health Systems; Maryland Primary Care Physicians; Dr. Scott Maurer's practice; Way Station Inc.

Overall Summary of Regional Partnership Activities in FY 2018

(Free Response: 1-3 Paragraphs):

The Howard Health Partnership (HHP) had a very successful year and engaged over 2,100 patients across its interventions and classes, recognizing some people may have participated in more than one.

One intervention and three team members were recognized by the State of Maryland, Johns Hopkins Health System and Baltimore Magazine for wonderful care and compassion provided to help high-risk patients and their families better manage illness, improve health and avoid preventable hospital encounters. In November 2017, Katherine Talbert, RN, Care Management Program Manager, received the *Johns Hopkins School of Nursing Community Outreach Nurse Shining Star Award* that recognized her commitment to engaging in local community health programs such as the Community Care Team (CCT), the primary intervention of HHP. In April 2018, Megan Cullen, Community Health Nurse on CCT, received the *Excellence in Nursing Award for Community Care* from the Baltimore Magazine for consistently going above and beyond to serve patients who are socially isolated or lost to care. In May 2018, Howard County General Hospital awarded Matt Stevens, Community Social Worker on CCT, with an *Excellence in Patient Experience Award*, honoring him for consistently demonstrating compassionate caring relationships with patients, families, peers and colleagues. Also in May 2018, CCT received a *Governor's Citation* from the secretary of health, Robert Neall, on behalf of Governor Larry Hogan to recognize the team's expertise and compassion, stating "In honor of the commitment and professionalism demonstrated by this multi-disciplinary team and as our citizens join in expressing our great respect and gratitude for your contributions to Howard County and our state." This recognition is a testament to the impact HHP is having on residents of Howard County.

During the last quarter of FY18, the HHP Management Team prepared to continue to best serve Medicare patients in an ever-changing health care environment that will focus on total cost of care. The team convened a large meeting with its governance members on June 11, 2018, where an expanded strategic intervention framework was approved with programs aligned across the continuum of care, including prevention and end-of-life. In addition, HHP Leadership worked closely with Accountable Care Organizations (ACOs) across our market related to the Maryland Primary Care Program (MDPCP) with a goal of HHP providing our successful care management and care coordination services as part of a Care Transformation Organization's (CTO) offerings to primary care practices that apply and are accepted into MDPCP.

Intervention Program 1: Community Care Team (CCT)

Intervention or Program Name	Community Care Team (CCT) (*Includes Embedded Community Health Worker and Nurse in the hospital*)
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	Howard County General Hospital
Brief description of the Intervention *2-3 sentences*	The Howard County Community Care Team (CCT) serves adult Howard County residents who have Medicare or are dually eligible with Medicaid who have had two or more encounters (inpatient, emergency or observation) at HCGH within the past year. Patients and their caregivers receive program benefits for 30-90 days by a multi-disciplinary team that provides home-based care coordination services. Community health workers (CHW), nurses and a social worker deliver services including health education, disease-specific management, medication reconciliation, connection to and coordination with health care providers, and extensive social support and advocacy with linkages to appropriate community resources. A CHW is embedded in the hospital to visit patients' bedsides in order to enroll them in the program.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	CRISP; Centennial Medical Group; Columbia Medical Practice; FIRN; Gilchrist Services; Howard County Health Department; Howard County - Local Health Improvement Coalition (LHIC); Johns Hopkins Community Physicians (Howard County locations); Johns Hopkins Home Care Group; Johns Hopkins Medicine; Maryland Primary Care Physicians; Dr. Scott Maurer's practice.
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: FY18**: 545**
	Denominator of Eligible Patients: **39,111 - Medicare FFS** Alternative Denominator: **2,868** - Calculated by consulting group Berkeley Research Group (BRG), this is the number of eligible patients who meet the RP criteria of 1) Howard County Resident, 2) Medicare or Dual-Eligible, 3)2 or more HCGH encounters (ED/IP/Obs stay) in CY2017.
Pre-Post Analysis for Intervention (optional)	Pre-post included as attachment on pages 21-25.

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.*	1. Acceptance Rate: **38%, (50% in FY18 Q4)** 2. Graduation Rate: **93.1%** 3. Graduation Satisfaction Rate**: 100%** 4. 30 Day All-Cause readmission rate: **14.2%** 5. % CCT clients who mark top box response to Discharge Information question on HCAHPS: **92.5% (top decile nationally)** *Note: Readmission data are preliminary and partial year due to CRISP data run-out.*
Successes of the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	During FY18, CCT increased program capacity by hiring two additional community-based CHWs and one hospital-embedded CHW while maintaining high quality services. The number of patients served increased from FY17 and quality measures like patient satisfaction, graduation rate and readmission rates continued to meet targets. The program manager, a nurse and social worker on the team all received awards of excellence and the entire team was issued a Governor's Citation in May 2018.
Lessons Learned from the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	Acceptance of CCT services by eligible patients was a challenge in FY18. Acceptance rates increased as outreach staff gained more experience and used refined clinical screening criteria (for example, outreaching patients who were likely to benefit from care coordination). Acceptance rate increased significantly at the end of the year (from 34% in Q1 to 50% in Q4) after hiring a hospital-embedded CHW with prior experience and refining the clinical screening process.
Next Steps for the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	CCT will continue to work towards a high acceptance rate by engaging hospital departments to become experts on the program. CCT will conduct in-services and train hospital staff (RNs, MDs, SWs, CMs) to promote the program to patients and family members. CCT hopes to expand to provide care coordination services for several Care Transformation Organizations (CTOs) under the MDPCP.
Additional Free Response (Optional)	To enhance the efficacy and efficiency of the CCT program, care management staff used supportive tools including CRISP, CAREAPP (a resource database and bidirectional referral system), HALO Communications (a secure text messaging service offered by CRISP)

	and the Patient Activation Measure. Kate Talbert, Care Management Program Manager, was nominated to participate on the State of Maryland's Community Health Workgroup Stakeholder Workgroup.

Intervention Program 2: Primary Care referral pathway to the CCT

Intervention or Program Name	Primary Care referral pathway to the CCT
RP Hospitals Participating in Intervention	Howard County General Hospital
Brief description of the Intervention	The Primary Care referral pathway to the CCT works to improve communication across care settings, focusing on specific strategies to strengthen care coordination efforts for the HHP target population between primary care, specialty care, and HCGH. It facilitates referrals to HHP interventions, communicates initiatives, shares information on community resources, and collaborates with Johns Hopkins Continuous Quality Improvement (CQI) team.
Participating Program Partners	Centennial Medical Group; Columbia Medical Practice; Johns Hopkins Armstrong Institute; Johns Hopkins Community Physicians (Howard County locations); Maryland Primary Care Physicians; Dr. Scott Maurer's practice
Patients Served	# of Patients Served as of June 30, 2018: **140 in FY18**
	Denominator of Eligible Patients: **39,111 - Medicare FFS** Alternative Denominator: **2,868** - Calculated by consulting group Berkeley Research Group (BRG), this is the number of eligible patients who meet the RP criteria of 1) Howard County Resident, 2) Medicare or Dual-Eligible, 3)2 or more HCGH encounters (ED/IP/Obs stay) in CY2017
Pre-Post Analysis for Intervention (optional)	None
Intervention-Specific Outcome or Process Measures (optional)	% of patients, by practice site, with Transitional Care Management Follow-Up Appointment Rate (within 14 days): ● Dr. Scott Maurer' practice: **36.4%** ● Columbia Medical Practice: **51.9%** ● Centennial Medical Group: **77.8%** ● Maryland Primary Care Physicians - Columbia: **61.3%** ● Johns Hopkins Community Physicians at Howard County: **64.7%** Overall: **58.0%**

Successes of the Intervention in FY 2018	Primary care partnerships increased from two practices in FY17 to five practices in FY18. A Practice Engagement Coordinator (PEC) worked with the practices to establish referral pathways, standardize communication between CCT and the providers and other practice-based services, provide reports to practices on their patients in care management and educate providers on HHP and other community-based services. The PEC worked alongside the CQI team to support practice transformation at two practices. One of the quality improvement projects is a basis for the PEC's LEAN Greenbelt Certification.
Lessons Learned from the Intervention in FY 2018	In FY18, HHP focused on tailoring the level of support to primary care practices in order to meet each practices' unique goals. The level of readiness for transformation varied among the five practices, making it difficult to standardize work for the Provider Engagement Coordinator. Most practices looked to the HHP for expertise on the various health policy initiatives- for example, Total Cost of Care, Care Redesign and MDPCP.
Next Steps for the Intervention in FY 2019	The level of engagement with primary care practices will depend largely on the outcome of the MDPCP. Our strategy is to work more closely with the practices who are naturally aligned with HCGH through MDPCP and the Medicare Performance Adjustment (MPA).
Additional Free Response (Optional)	To enhance the efficacy and efficiency of the CCT program, care management staff used supportive tools including CRISP, CAREAPP (a resource database and bidirectional referral system), HALO Communications (a secure text messaging service offered by CRISP).

Intervention Program 3: Elder Medical Care

Intervention or Program Name	Elder Medical Care
RP Hospitals Participating in Intervention	Howard County General Hospital
Brief description of the Intervention *2-3 sentences*	Provided through Gilchrist Services, the program is led by a physician, Certified Registered Nurse Practitioner (CRNP) in collaboration with a social worker to provide in-home medical care for homebound elderly with advanced illnesses or conditions. It offers guidance on advance care planning and navigating the health care system as well as emotional support, education on living with serious illness and respite for caregivers.
Participating Program Partners	Gilchrist Services

Patients Served	# of Patients Served as of June 30, 2018: **FY18: 65**
	Denominator of Eligible Patients: **39,111**
Pre-Post Analysis for Intervention (optional)	Pre-post included as attachment on page 26.
Intervention-Specific Outcome or Process Measures (optional)	Acceptance Rate: **50.8%** 30 Day All-Cause Readmission rate: **13.2%** Patient Satisfaction: **97%** *(data available thru Dec. 31st 2017)* *Note: Readmission data are preliminary and partial year due to CRISP data run-out.*
Successes of the Intervention in FY 2018	The Elder Medical Care program continued to experience growth with an overall rate of 25% in their average daily census and a smaller growth rate of 13% for patients served in the Howard County area during FY18. The program also continued to expand ancillary services available to patients who worked collaboratively primary care providers, including lab services, behavioral health professionals, Community Service Coordinators and interventions by pharmacists on a case-by-case basis. This enabled the team to provide even more clinical interventions in the home setting.
Lessons Learned from the Intervention in FY 2018	One of the ongoing lessons continued to be the partnership needed from the primary care providers in the community to assist with transition or co-management of their patients. The providers are pivotal in initiating referrals and working with the patients/families to establish rapport with the Elder Medical Care team. This could also enable referrals to the program to be made earlier in the progression of the disease state when patients and their caregivers are initially experiencing issues with getting in to see their PCP's instead of after they are homebound.
Next Steps for the Intervention in FY 2019	The Elder Medical Care program will continue to work on refining referral process, explore ways of applying the program to meet the needs and requests of partners and communities, and continue to expand clinical capabilities.
Additional Free Response (Optional)	None

Intervention Program 4: Remote Patient Monitoring (RPM)

Intervention or Program Name	Remote Patient Monitoring (RPM)
RP Hospitals Participating in Intervention	Howard County General Hospital
Brief description of the Intervention	Home-based program for patients with heart failure or COPD with daily monitoring by RN case manager of biometric & symptom data. This allows for immediate feedback to patient and care team as needed, and provides an opportunity for disease education. The nurse case manager monitors data and interacts with patient and care team.
Participating Program Partners	Johns Hopkins Home Care Group
Patients Served	# of Patients Served as of June 30, 2018: **FY18: 63**
	Denominator of Eligible Patients: **39,111 (Medicare FFS)** Alternative denominator: **492** patients - number of HCGH Medicare/Dually eligible for Medicaid patients with an inpatient stay for CHF or COPD in FY18.
Pre-Post Analysis for Intervention (optional)	Pre-post included as attachment on page 27.
Intervention-Specific Outcome or Process Measures (optional)	30 Day All-Cause Readmission rate: **11.4%** *Note: Readmission data are preliminary and partial year due to CRISP data run-out.*
Successes of the Intervention in FY 2018	Program leadership developed written educational materials about the program for HCGH physicians, clinical staff and patients to explain the program in a succinct, yet thorough manner. This helped to increase referrals into the program. Ongoing collaboration with CCT, inpatient teams at HCGH and the Patient Access Line (PAL) nurses also helped to encourage RPM referrals throughout the year.
Lessons Learned from the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	Given the dynamic nature of discharge planning, program leaders found that ongoing education and in-person visits are necessary to keep RPM "top of mind" for case management, hospitalists, and home care coordinators. Moreover, RPM program administrators found that when physicians speak with their patients at the bedside prior to discharge, there is an increase acceptance rate of RPM post-discharge. Another significant lesson learned

	was the need to develop enhanced data collection method to document the RPM referral rate for all patients discharged from HCGH.
Next Steps for the Intervention in FY 2019	Increase program referrals throughout HCGH by providing quarterly education with various teams including case management, physicians, home care coordinators and CCT to ensure a thorough understanding of the program and its many benefits. Program leaders will also conduct education with community cardiology groups to promote the benefits of the program in the Howard County community. Another goal for FY19 is to enhance data collection to be able to monitor the conversion rate in real time. (The conversion rate is the percentage of patients that accepted RPM divided by the total number of patients that were offered RPM). Lastly, the program plans to expand to include monitoring for Diabetes Mellitus (DM). Future considerations include thinking outside the box to consider RPM solutions for patients with other diagnoses such as hypertension and hypotension.
Additional Free Response (Optional)	None

Intervention Program 5: Behavioral Health Rapid Access Program (RAP)

Intervention or Program Name	Behavioral Health Rapid Access Program (RAP)
RP Hospitals Participating in Intervention	Howard County General Hospital
Brief description of the Intervention	RAP is designed to provide access to urgent, outpatient, crisis stabilization services within two business days of referral for adults (18 years and older) who present in the Emergency department, on the inpatient psychiatric unit or on a medical unit and are in need of immediate access to varying levels of psychiatric treatment. The service links patients to the level and type of care needed to prevent further emotional distress and decompensation that would otherwise result in accessing more acute levels of care. Services are provided through Way Station, a subsidiary of Sheppard Pratt at the Columbia, Maryland site. Patients are able to receive up to 9 treatment sessions that include prescriber and therapy, regardless of their ability to pay. Way Station assists patients who need a higher level of outpatient care or treatment beyond the 9 sessions provided through RAP.
Participating Program Partners	Horizon Foundation (co-funder along with HCGH); Way Station, Inc.; Grassroots Crisis Intervention Center

Patients Served	# of Patients Served as of June 30, 2018: FY18: **416 Referrals, 236 Enrollees**
	Denominator of Eligible Patients: **384,210 - All Payer** Alternative denominator: **2,089 -** number of HCGH ED Patients receiving behavioral health treatment in the ED.
Pre-Post Analysis for Intervention (optional)	Pre-post included as attachment on page 28.
Intervention-Specific Outcome or Process Measures (optional)	% who attend first appointment: **61%** 30 Day All-Cause Readmission rate: **9.1%** *Note: Readmission data are preliminary and partial year due to CRISP data run-out.*
Successes of the Intervention in FY 2018	The collaboration and effective communication between the hospital and Way Station has allowed for adapting the program to best meet the needs of the patients. Timely linkages to psychiatric care for patients discharged from the hospital through the use of a cloud-based scheduling system allows appointments to be scheduled 24 hours a day by hospital staff with Way Station, improving transitions for patients from the hospital to care in the community. A successful system for communication between the hospital and Way Station was put in place that enabled Way Station to view relevant information from patient's medical records.
Lessons Learned from the Intervention in FY 2018	Adaptations were made to the Way Station intake process that allowed for the first patient visit to occur with a prescriber versus a therapist, which assisted in more quickly stabilizing patients. An outreach system was designed and executed by Way Station to increase engagement with patients and decrease the number of patients that do not attend their appointments.
Next Steps for the Intervention in FY 2019	CRISP is partnering with Way Station to create a pre/post reporting system for patients with behavioral health needs. Continued efforts on data are in place for FY19 which will include a completed CRISP panel of patients referred to Way Station through RAP, as well as more specific outcome measures on the course and success of treatment. The development of a patient satisfaction survey that measures the transition experience from hospital to Way Station will also be explored further.
Additional Free Response (Optional)	RAP has been and is funded by HCGH and the Horizon Foundation, not Transformation Implementation Program (TIP) dollars.

Intervention Program 6: Skilled Nursing Facility (SNF) Collaborative

Intervention or Program Name	Skilled Nursing Facility (SNF) Collaborative and Infectious Disease (ID) pilot
RP Hospitals Participating in Intervention	Howard County General Hospital
Brief description of the Intervention	HHP launched a SNF Collaborative workgroup that meets quarterly to improve patient health outcomes of HCGH patients transferred to participating SNFs. Participants include representatives from the 4 SNFs where most patients go (3 Lorien sites and Ellicott City Healthcare Center). Since infectious disease is one of the most common causes of potentially avoidable readmissions, we completed a 16-month pilot where physicians from the Johns Hopkins University Infectious Disease (ID) team provided on-site consultations weekly at the Lorien Columbia site. The ID physicians worked collaboratively with Lorien physicians to provide post-discharge follow-up and antimicrobial stewardship review and consultation. As appropriate, the ID physicians also provided supplemental education and training to facility staff on infections disease and septicemia-related care.
Participating Program Partners	Ellicott City Healthcare Center, Gilchrist Services, Johns Hopkins University, Lorien Health System
Patients Served	# of Patients Served as of June 30, 2018: **FY18: 142**
	Denominator of Eligible Patients: **39,111**
Pre-Post Analysis (optional)	Pre-post included as attachment on page 29.
Intervention-Specific Outcome or Process Measures (optional)	30-Day All-Cause Readmission Rate (4 Howard County based SNFs): **16.2%** 30-Day ED Revisit Rate (4 Howard County based SNFs): **7.8%** ID Program 30-Day All-Cause Readmission Rate: **12.63%** *Note: Readmission data are preliminary and partial year due to CRISP data run-out.*
Successes of the Intervention in FY 2018	The ID pilot provided best-in-class antimicrobial stewardship due to weekly review of every antibiotic prescribed at the facility by an ID specialist. It also provided best-in-class management of long term antibiotics due to (1) consistent, timely and correct lab monitoring to prevent drug toxicity; and (2) assessment of adequacy of treatment at the end of a course of long term antibiotics. It also provided high quality on-site, infectious disease-related education of nursing facility staff (MD's, RN's GNA's) plus access to an ID specialist to give advice on acute infections that developed in the facility.

Lessons Learned from the Intervention in FY 2018	It is a challenge to scale this impactful intervention so it can touch more patients and at multiple facilities in an economically viable manner.
Next Steps for the Intervention in FY 2019	The Collaborative will work on developing standardized protocols and procedures for patients that transition from (1) hospital to SNF and (2) SNF to home. It will also establish standardized procedures and protocols for communicating between the hospital, SNFs, and other community providers with a focus on the first 72 hours of SNF care.
Additional Free Response (Optional)	Due to the 10% reduction in TIP funding each year, HHP Leadership decided not to continue this pilot in FY19. However, Lorien Health System sees value and may provide financial support, similar to what they do in other markets.

Intervention Program 7: Journey to Better Health (J2BH)

Intervention or Program Name	Journey to Better Health (J2BH)
RP Hospitals Participating in Intervention	Howard County General Hospital
Brief description of the Intervention	The Journey to Better Health (J2BH) program works with Howard County faith-based organizations and congregations to support the health of their members and other Howard County residents. J2BH offers chronic disease prevention and management strategies to their members tailored to their needs. Program strategies include: ● Chronic Disease Screenings and Education: Conduct screenings for hypertension, obesity and pre-diabetes and classes on chronic disease self-management within the congregations. Class offerings include Living Well with Chronic Disease, Living Healthy with Hypertension, Living Well with Diabetes, Cancer Self-Management, and Mental Health First Aid Training. ● Volunteer Support for significant health events: Offer access to the Member Care Support Network (MCSN) which aims to pair members with trained volunteer Community Companions.
Participating Program Partners	Abiding Savior Lutheran Church; Atholton Seventh Day Adventist Church; Bethany Church; Bethany United Methodist; Bridgeway Community Church; Celebration Church; Christ Memorial Presbyterian Church; Church of the Resurrection; First Baptist Church of Guilford; Glen Mar United Methodist Church; Iglesias De Dios Pentecostal; New Hope Adventist Church; North American Division Seventh-day Adventist Church; Oneness Ministries; St John Baptist Church; St. John the Evangelist Roman Catholic Church

Patients Served	# of Patients Served as of June 30, 2018: **FY18: 777**
	Denominator of Eligible Patients: **384,210**
Pre-Post Analysis for Intervention (optional)	None – Due to the nature of this program, not all participants are hospital patients. We therefore cannot perform a Pre/Post Analysis with CRISP data.
Intervention-Specific Outcome or Process Measures (optional)	1. Total number of congregations: **21** (61.5% increase over FY17) 2. J2BH Participation Satisfaction Rate: **93%** 3. Number of people screened: **719** 4. Member Care Support Network members: **170** 5. New Member Care Support Network volunteers trained: **25**
Successes of the Intervention in FY 2018	J2BH increased capacity in FY18. The program held more events, screened and educated more participants and grew the volunteer and membership bases as compared to FY17. The program accomplished this through enhanced marketing and promotion, expanding program delivery beyond faith-based organizations to include community members and organizations, offering a broader array of evidence-based classes and aligning with the existing Volunteer Services department within the hospital.
Lessons Learned from the Intervention in FY 2018	J2BH learned about the intricacies of partnering with the community and existing hospital departments. For the community, J2BH identified that community partners are diverse in their goals and needs. For faith-based organizations, clergy buy-in is critical to the success of the partnership. For health education classes, the program learned the importance of selecting the appropriate timing and host site to ensure participation. The volunteer network also learned the importance of formalizing the process for volunteer recruitment, vetting and training and expanding its' volunteer base beyond congregations.
Next Steps for the Intervention in FY 2019	Strategies to strengthen and grow J2BH in FY19 include: ● Establish a Clergy Council in partnership with the Chaplaincy Department of HCGH. ● Utilize the Howard County Local Health Improvement Coalition to promote health education events and identify more host sites. ● Offer additional trainings and leadership opportunities to keep volunteers engaged and active.
Additional Free Response (Optional)	The Member Care Support Network continued to use CRISP ENS to receive notifications when a member was hospitalized. The network also encouraged volunteers to get access to CAREAPP for resource and referral identification. J2BH serves a population broader than the HHP target, meaning all residents of Howard County. The program is funded by the Howard County Health Department, not TIP.

Intervention Program 8: HHP Educational Resources and Classes

Intervention or Program Name	HHP Educational Resources and Classes a. Patient Engagement Program (PEP) b. Powerful Tools for Caregivers (PTC) c. Medicare Refresher class d. Living Well e. Mental Health First Aid (MHFA) f. National Diabetes Prevention Program (NDPP)
RP Hospitals Participating in Intervention	Howard County General Hospital
Brief description of the Intervention	The HHP offers classes to providers, patients and caregivers to support engaging patients in their health care. The Johns Hopkins Medicine Patient Engagement Program (PEP) is a comprehensive, in-person, skills-based program that teaches health care providers how to change their team's culture, engage their patients as partners in health care and communicate in a way that motivates patients to engage in healthier behaviors. Powerful Tools for Caregivers (PTC) is an evidence-based class for family caregivers that offers tools and strategies to better handle the unique challenges caregivers face. The Medicare Refresher class provides Medicare beneficiaries with an in-depth explanation about their health insurance. Living Well courses teach patients with chronic disease about their disease and coaches them on healthy behaviors. Mental Health First Aid (MHFA) is an 8-hour education program that introduces participants to risk factors and warning signs of mental illnesses, builds understanding of their impact, and overviews common supports. National Diabetes Prevention Program (NDPP) was developed by the Centers for Disease Control and Prevention program for people with prediabetes to participate in evidence-based, affordable, and high-quality lifestyle change programs to reduce their risk of type 2 diabetes and improve overall health.
Participating Program Partners	Johns Hopkins Medicine, Howard County Office on Aging and Independence, Howard County Local Health Improvement Coalition, FIRN
Patients Served	# of Patients Served as of June 30, 2018: Powerful Tools for Caregivers class attendees: **20** Medicare Refresher class attendees: **77** Living Well class attendees: **104** Mental Health First Aid class attendees: **105** National Diabetes Prevention Program attendees: **20**
	Denominator of Eligible Patients: **384,210**
Pre-Post Analysis for Intervention	None – Due to the nature of this program, not all participants are hospital patients. We therefore cannot perform a Pre/Post Analysis with CRISP data.

Intervention-Specific Outcome or Process Measures (optional)	**Patient Engagement Program (PEP):** PEP training participation for CCT staff: **100%** **Powerful Tools for Caregivers (PTC):** Participant Satisfaction: **100%** Capacity: **74%** **Living Well:** Participant Satisfaction: **98%** Capacity: **61%** **Mental Health First Aid:** Capacity: **48%**
Successes of the Intervention in FY 2018	**Patient Engagement Program (PEP):** HHP staff have embraced both the PEP's training and maintenance. All staff were trained in FY18, and Laura Torres, Behavioral Health Program Manager, became a faculty trainer. Additionally, two CCT staff members serve as PEP champions and lead monthly skills maintenance exercises for the entire division. Tracy Novak became the PEP Program Manager for Johns Hopkins Medicine in November 2018. HHP's partners Columbia Medical Practice and Howard County General Hospital (social workers and case managers) were trained in FY18 and participate in the maintenance program. **Powerful Tools for Caregivers (PTC):** continues to make a difference in caregiver's lives, especially in terms of their self-confidence with decision making and the realization they do not need to face it alone. Caregivers come to the class to gain knowledge about how to manage their journey more easily through communication, and to use tools to relieve the many stresses they encounter. Another success was the attendance of 7 male participants. More men are recognizing and embracing their roles as caregivers. Many class participants attend other Office on Aging and Independence (OAI) events and educational sessions, exemplifying their willingness to look for resources and assistance to help them through their journey. Seven new leaders were trained, which expands capacity to deliver more classes to the community. **Medicare Refresher (MR):** The MR class was featured in a hospital newsletter, resulting in a large attendance spike. Participant evaluations indicate the class is helpful to develop a better understanding of how Medicare coverage works and what to consider when looking at options during enrollment periods. **Living Well:** offered a diversity of classes including Chronic Disease, Diabetes and Cancer. All classes except Cancer were offered in both English and Spanish. **Mental Health First Aid:** Participant evaluations noted classes as informative, helpful, and beneficial in educating Howard County residents and reducing stigma around Mental Health.

	National Diabetes Prevention Program: Many participants met their health goals due to their participation in course (e.g., losing weight and decreasing A1C levels).
Lessons Learned from the Intervention in FY 2018	**Patient Engagement Program (PEP):** One of the barriers to participation is the time commitment needed for the initial training. Sharing outcome and impact data will be useful to get buy-in from new stakeholders. **Powerful Tools for Caregivers (PTC):** People who took the class are more aware of the strain caregiving can have on their own physical and mental health and the need to be equipped to take care of themselves. The goal is to empower the caregivers and make sure their own well-being is their focus. **Medicare Refresher:** After initial marketing in the HCGH county-wide newsletter, enrollment dropped and some classes have to been cancelled due to low registration numbers. We need to focus on additional marketing strategies and collaborative with partners to promote. **Living Well:** Seasonality impacts attendance and need for increased marketing/promotion to encourage attendance. **Mental Health First Aid:** Filling the classes to capacity can be challenging as well as getting all participants who registered to attend. **National Diabetes Prevention Program:** Meeting the needs of patients with low literacy and English proficiency is challenging, especially because there are reading and journaling assignments. Helping participants to feel comfortable discussing matters that may feel culturally inappropriate can also be difficult. Inclement weather and summer vacation months also impact attendance.
Next Steps for the Intervention in FY 2019	**Patient Engagement Program (PEP):** plan to launch online modules to expand the capacity and scalability of the program. Leadership will develop a data collection and reporting strategy. HHP plans to offer the program to additional primary care practices and skilled nursing facility staff. **Powerful Tools for Caregivers (PTC):** plan to offer a day class in addition to our evening classes and expand to offer a class for parents of children with disabilities. Promotion will also be expanded beyond local caregiving community and community partners to include statewide and national organizations such as National Alliance for Caregiving, Alzheimer's Association, Association for Community Living, etc. **Medicare Refresher:** Work with community partners to expand class promotion and consider additional marketing on social media. Consider renaming the class and revising course description to attract more participants.

	Living Well: HHP may offer a Chronic Pain class in FY19, and plans to do more marketing to encourage more class registration. **Mental Health First Aid:** HHP will expand offering to include Youth Mental Health First Aid. **National Diabetes Prevention Program:** unknown
Additional Free Response (Optional)	None

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)	CY17 (RP Analytic File): $2,274 - All Payer Source file: 1)RP_AnalyticFile_01JAN17_31DEC17_Yearly, Accessed 7/26/2018
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)	July 2017- March 2018 (RP Analytic File): 70 - All Payer Source files: 1)RP_AnalyticFile_01JAN17_31DEC17_Monthly (accessed 9/10/2018), and 2)RP_AnalyticFile_01JAN18_30JUN18_Monthly Accessed 9/10/2018

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	CY17 (TCOC Report on CRISP): $9,932 - All Payer
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)	July 2017- March 2018 (RP Analytic File): 155 - All Payer Source files: 1)RP_AnalyticFile_01JAN17_31DEC17_Monthly (accessed 9/10/2018), and 2)RP_AnalyticFile_01JAN18_30JUN18_Monthly Accessed 9/10/2018

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)	July 2017- March 2018 (RP Analytic File): 10.3% - All Payer Source files: 1)RP_AnalyticFile_01JAN17_31DEC17_Monthly (accessed 9/10/2018), and 2)RP_AnalyticFile_01JAN18_30JUN18_Monthly Accessed 9/10/2018
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)	July 2017- March 2018 (RP Analytic File): $55,224,084 - All Payer Source files: 1)RP_AnalyticFile_01JAN17_31DEC17_Monthly

		(accessed 9/10/2018), and 2)RP_AnalyticFile_01JAN18_30JUN18_Monthly Accessed 9/10/2018

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 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 reporting
Portion of Target Population with Contact from Assigned Care Manager	**% of patients with Case Manager recorded at CRISP** 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 reporting

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.

Number of HHP Governance Meetings in FY18: 12 Meetings

Number of Hours of HHP Governance Meetings in FY18: 17.5 hours

Number of HHP Governance Committee Members in FY18: 67 governance members attended at least one governance meeting in FY18 plus 13 guests.

Leveraging Other Networks: HHP Leadership participates on a CAREAPP Network hosted by the Howard County Health Department to monitor and expand use of CAREAPP, a web-based risk assessment screening tool and community resources database with a bi-directional referral tracking system. The CAREAPP Network includes 25 community partner organizations including community service agencies, government organizations, educational institutions, and healthcare centers in Howard County, working

in partnership with the Howard County Health Department to optimize care coordination for Howard County residents.

Return on Investment

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

Since the CCT is the main intervention in HHP, we recently conducted an internal cohort analysis looking at HCGH inpatient, outpatient, and observation utilization 90 days before CCT enrollment and 90 days after CCT enrollment using FY17 HCGH-only data. There was a 47% reduction of hospital encounters and decreased utilization of ED and Observation stays, despite the hospital overall having increased ED and Observation stay volume during FY17. This demonstrates a 65% reduction in HCGH hospital charges. With a variable cost factor applied, the result is approximately $1.2 million in potentially avoidable costs to HCGH (about $4k per patient).

Conclusion

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

HHP has leveraged a number of CRISP reports for internal monitoring as well as for regulatory reporting. Recognizing that CRISP cannot create custom reports for each Partnership, we would like to note some of the limitations of these reports on our analysis of HHP impact.

> <u>Pre/Post Analyses:</u> We have concerns that Pre/Post panels might incorrectly imply programmatic impact, since the panels do not include matched cohorts for statistical comparison. Additionally, any utilization reductions in the post period might be artificially inflated due to the lack of available data on deaths. For interventions geared towards the elderly or especially frail, this could have a significant impact.
>
> <u>Population Denominators:</u> The overall Medicare population for our target zip codes is roughly 39,000 beneficiaries, however HHP focuses only on a high and rising risk patient population of roughly 3,000 Medicare beneficiaries. Population-based metrics might fail to show the full impact of HHP interventions, given the discrepancy in the denominator.

We are eager to evolve the regional partnership to meet the needs of the Total Cost of Care model and the Maryland Primary Care Program. We believed in the HSCRC's approach to develop population health management infrastructure through the creation of these regional partnerships and feel that significant gains have been made here in Howard County. We are concerned, however, that the structure of MDPCP will counteract the gains made to provide effective care management for Medicare beneficiaries , especially in a heterogeneous provider environment such as what exists here in Howard. The regional partnership was beginning to align the hospital with primary and specialty care providers along with the post-acute network to transform our health system. MDPCP will fragment the hospital/provider relationship, especially when multiple CTOs are operating in the same geographic region. Our hospital will be at risk for these beneficiaries through MPA, but depending on the medical home and CTO participation, we might not have any levers to use to drive practice and care transformation.

Pre/Post Analysis - Summary

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

Program Name
CCT (210048)

Chronic Conditions
All Patients

N/A

N/A

Most Recent Payer
All

Visit Type
All

Chronic Condition Operator
◉ AND
○ OR

Total Number of Members on Panel that could contribute to analysis

	1 Month	3 Months	6 Months	12 Months
Total Number of Patients in Panel that could contribute to analysis	459	459	393	224

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	401	160	87.4%	34.9%	-52.5%
3 Months	448	262	97.6%	57.1%	-40.5%
6 Months	389	286	99.0%	72.8%	-26.2%
12 Months	224	187	100.0%	83.5%	-16.5%

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	661	299	14.4	6.5	-7.9
3 Months	1,262	764	27.5	16.6	-10.8
6 Months	1,713	1,176	43.6	29.9	-13.7
12 Months	1,610	1,169	71.9	52.2	-19.7

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	411	$4,768,895	$1,212,542	$11,893	$7,578	($4,314)
3 Months	451	$7,933,114	$3,927,295	$17,708	$14,990	($2,718)
6 Months	391	$9,756,464	$6,684,310	$25,081	$23,372	($1,709)
12 Months	224	$7,774,298	$6,654,291	$34,707	$35,584	$878

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	661	299	$4,768,895	$1,212,542	$7,215	$4,055	($3,159)
3 Months	1,262	764	$7,933,114	$3,927,295	$6,286	$5,140	($1,146)
6 Months	1,713	1,176	$9,756,464	$6,684,310	$5,696	$5,684	($12)
12 Months	1,610	1,169	$7,774,298	$6,654,291	$4,829	$5,692	$864

Casemix Data Through:
06/30/2018

ENS Panels Last Updated:
07/21/2018

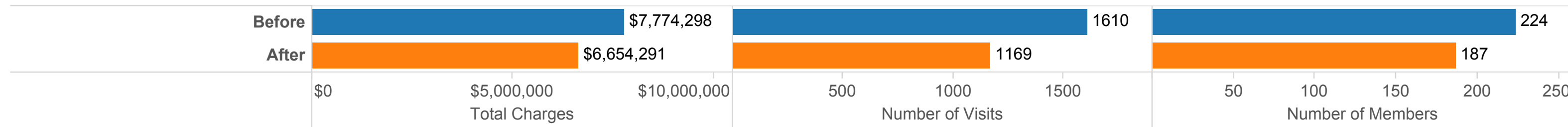
- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
  - Panel information provided to CRISP by ENS
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
- Individual patients identified using CRISP EID
- CRISP suppressed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

Pre/Post Analysis

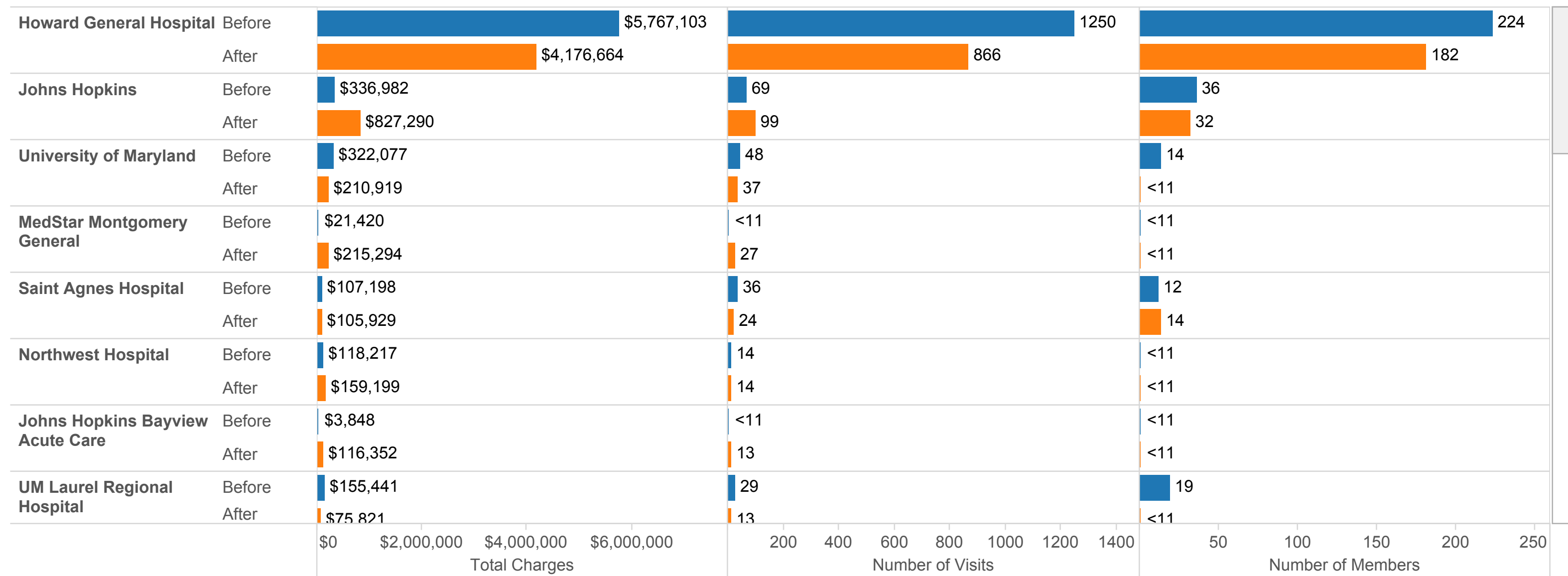
Analysis of 12 Months of Visits Before and After the Enrollment Date

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

All Hospitals



Hospital Details



Total Number of Members in the Panel
459

Number of Members with Data for Analysis
224

Number of Members with Visits during Analysis Period
224

Before or After Enrollment
Before After

Most Recent Payer
All

Time Period
12 Months

Visit Type
All

Sorting Option
Total Visits - After Enrollment

Hospital Name
All

Program Name
CCT (210048)

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
AND
OR

Casemix Data Through:
06/30/2018
ENS Panels Last Updated:
07/21/2018

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Pre/Post Analysis

Analysis of 12 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.

Total Number of Members in the Panel

459

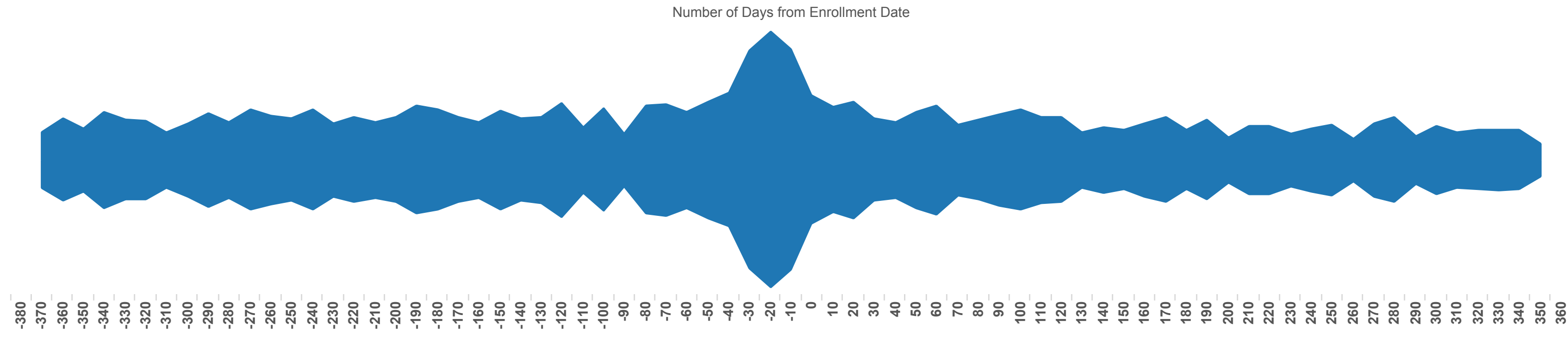
Number of Members with Data for Analysis

224

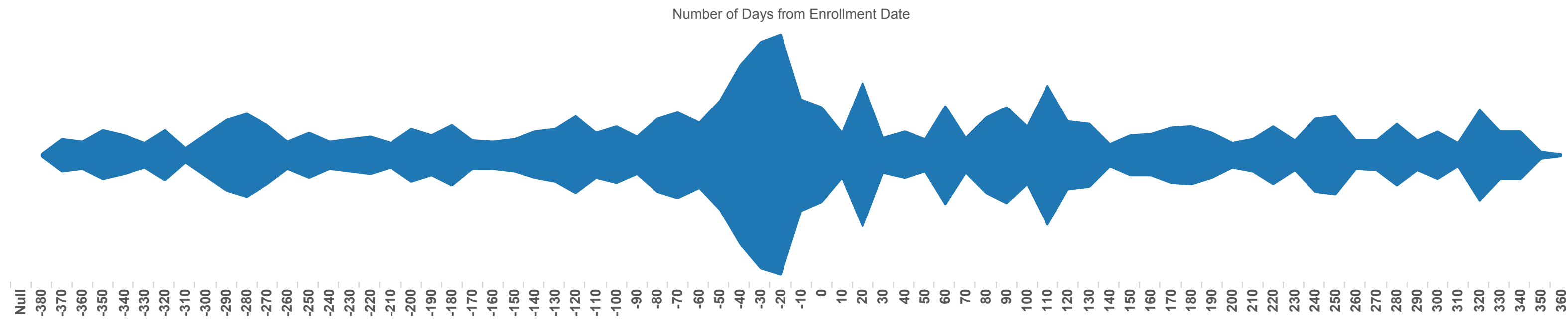
Number of Members with Visits during Analysis Period

224

Visits Trend



Charges Trend



Most Recent Payer
All

Time Period
12 Months

Visit Type
All

Hospital Name
All

Program Name
CCT (210048)

Number of Days Interval
10

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
- (•) AND
- ( ) OR

Casemix Data Through:
06/30/2018
ENS Panels Last Updated:
07/21/2018

- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
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- Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.

Pre/Post Analysis

Analysis of 12 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.

Most Recent Payer
All

Time Period
12 Months

Trend Metric
Visits

Visit Type
All

Hospital Name
All

Program Name
CCT (210048)

Chronic Conditions

All Patients

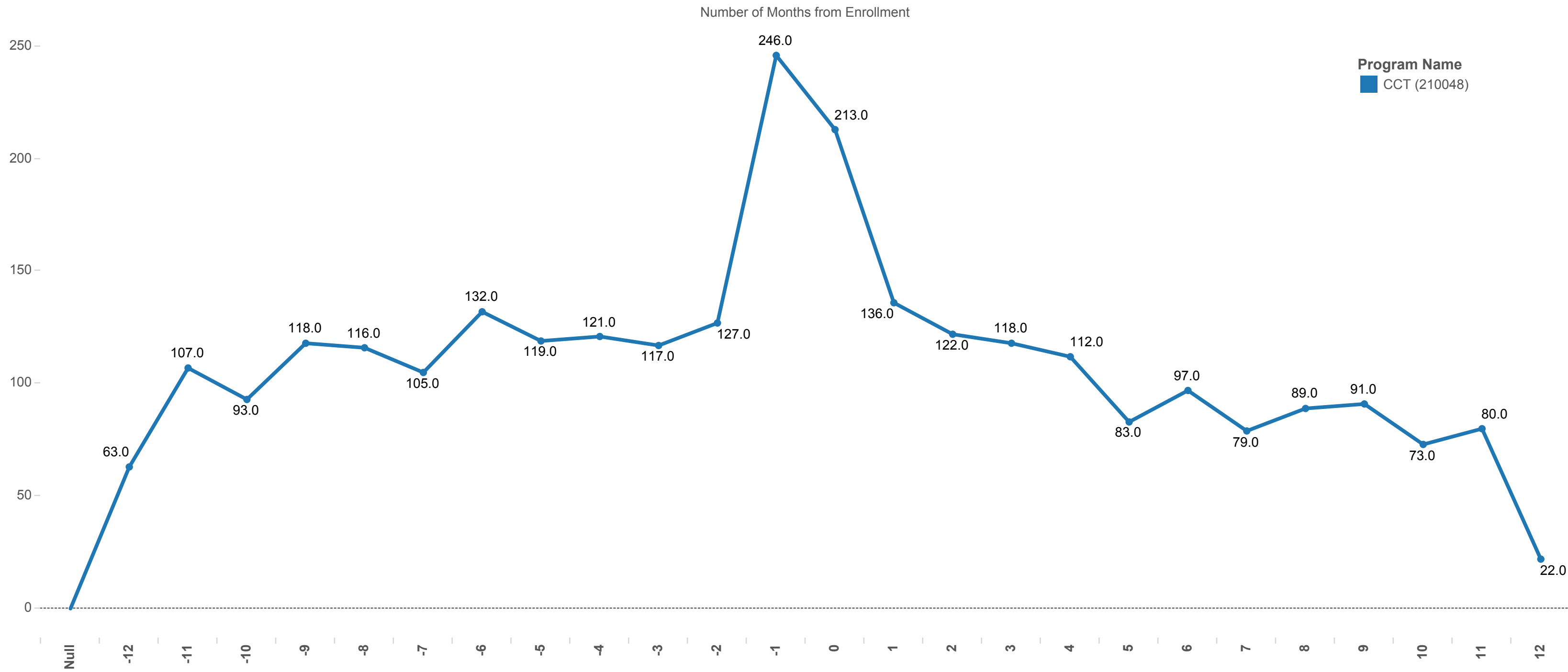
N/A

N/A

Chrionic Condition Operator

- (●) AND
- ( ) OR

Relative Trend



Casemix Data Through:
06/30/2018
ENS Panels Last Updated:
07/21/2018

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

Pre/Post Analysis

Analysis of 12 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.

Most Recent Payer
All

Visit Type
All

Hospital Name
All

Time Period
12 Months

Program Name
CCT (210048)

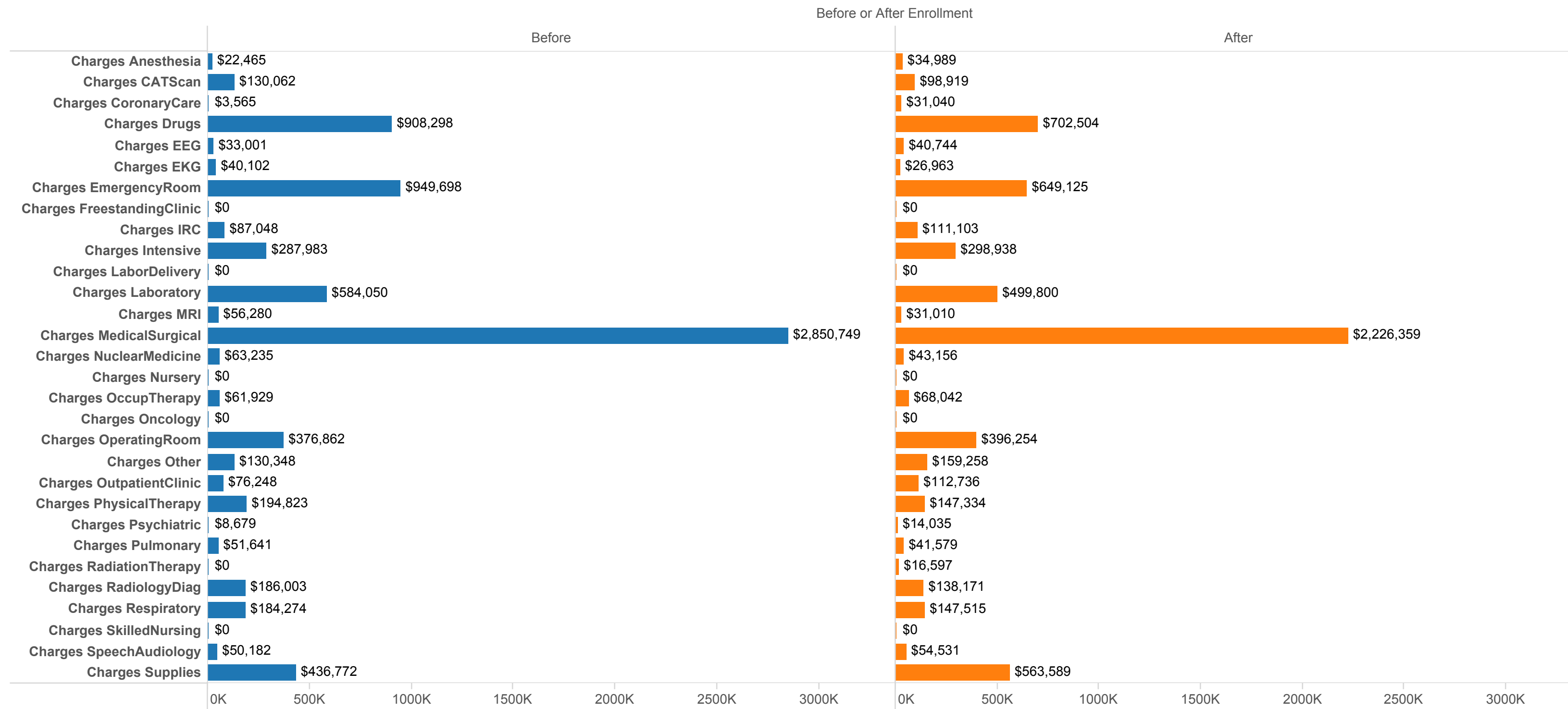
Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
◉ AND
○ OR

Breakdown of Charges Sheet



Charge	Before	After
Charges Anesthesia	$22,465	$34,989
Charges CATScan	$130,062	$98,919
Charges CoronaryCare	$3,565	$31,040
Charges Drugs	$908,298	$702,504
Charges EEG	$33,001	$40,744
Charges EKG	$40,102	$26,963
Charges EmergencyRoom	$949,698	$649,125
Charges FreestandingClinic	$0	$0
Charges IRC	$87,048	$111,103
Charges Intensive	$287,983	$298,938
Charges LaborDelivery	$0	$0
Charges Laboratory	$584,050	$499,800
Charges MRI	$56,280	$31,010
Charges MedicalSurgical	$2,850,749	$2,226,359
Charges NuclearMedicine	$63,235	$43,156
Charges Nursery	$0	$0
Charges OccupTherapy	$61,929	$68,042
Charges Oncology	$0	$0
Charges OperatingRoom	$376,862	$396,254
Charges Other	$130,348	$159,258
Charges OutpatientClinic	$76,248	$112,736
Charges PhysicalTherapy	$194,823	$147,334
Charges Psychiatric	$8,679	$14,035
Charges Pulmonary	$51,641	$41,579
Charges RadiationTherapy	$0	$16,597
Charges RadiologyDiag	$186,003	$138,171
Charges Respiratory	$184,274	$147,515
Charges SkilledNursing	$0	$0
Charges SpeechAudiology	$50,182	$54,531
Charges Supplies	$436,772	$563,589

Casemix Data Through:
06/30/2018

ENS Panels Last Updated:
07/21/2018

- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
  - Panel information provided to CRISP by ENS
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
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- Months of Analysis is not based on calendar days or 30 days but calculated by getting the same date, months in advance. eg. 1 Month before Feb 28th is Jan 28th and 1 Month before June 15th is May 15th and so on.
- Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.

Pre/Post Analysis - Summary

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

Program Name
EMC-ActiveFY18 (210048)

Chronic Conditions
All Patients

N/A

N/A

Most Recent Payer
All

Visit Type
All

Chronic Condition Operator
◉ AND
◯ OR

Total Number of Members on Panel that could contribute to analysis

	1 Month	3 Months	6 Months	12 Months
Total Number of Patients in Panel that could contribute to analysis	55	49	39	26

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	20	13	36.4%	23.6%	-12.7%
3 Months	32	19	65.3%	38.8%	-26.5%
6 Months	28	17	71.8%	43.6%	-28.2%
12 Months	19	16	73.1%	61.5%	-11.5%

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	24	22	4.4	4.0	-0.4
3 Months	70	46	14.3	9.4	-4.9
6 Months	90	47	23.1	12.1	-11.0
12 Months	89	59	34.2	22.7	-11.5

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	22	$225,828	$83,647	$11,291	$6,434	($4,857)
3 Months	34	$479,768	$159,475	$14,993	$8,393	($6,599)
6 Months	29	$627,753	$195,516	$22,420	$11,501	($10,919)
12 Months	20	$577,657	$442,446	$30,403	$27,653	($2,750)

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	24	22	$225,828	$83,647	$9,409	$3,802	($5,607)
3 Months	70	46	$479,768	$159,475	$6,854	$3,467	($3,387)
6 Months	90	47	$627,753	$195,516	$6,975	$4,160	($2,815)
12 Months	89	59	$577,657	$442,446	$6,491	$7,499	$1,009

Casemix Data Through:
06/30/2018

ENS Panels Last Updated:
07/21/2018

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

Pre/Post Analysis - Summary

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

Program Name
RPM-FY18 (210048)

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
◉ AND
◯ OR

Most Recent Payer
All

Visit Type
All

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	53	41	28	<11

Percent of Members on the Panel with 1 or more Visits

Time Period	Total Number of Patients with a visit - Pre	Total Number of Patients with a visit - Post	Total Number of Patients with a visit - Pre %	Total Number of Patients with a visit - Post %	Change in Number of Patients
1 Month	53	18	100.0%	34.0%	-66.0%
3 Months	41	20	100.0%	48.8%	-51.2%
6 Months	28	16	100.0%	57.1%	-42.9%
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	76	25	14.3	4.7	-9.6
3 Months	92	51	22.4	12.4	-10.0
6 Months	103	53	36.8	18.9	-17.9
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	53	$632,309	$202,759	$11,930	$11,264	($666)
3 Months	41	$746,170	$546,278	$18,199	$27,314	$9,115
6 Months	28	$824,605	$521,633	$29,450	$32,602	$3,152

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	76	25	$632,309	$202,759	$8,320	$8,110	($210)
3 Months	92	51	$746,170	$546,278	$8,111	$10,711	$2,601
6 Months	103	53	$824,605	$521,633	$8,006	$9,842	$1,836

Casemix Data Through:
06/30/2018

ENS Panels Last Updated:
07/21/2018

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

Pre/Post Analysis - Summary

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

Program Name
Program1 - FY18 (210048)

Chronic Conditions
All Patients

N/A

N/A

Most Recent Payer
All

Visit Type
All

Chronic Condition Operator
◉ AND
○ OR

Total Number of Members on Panel that could contribute to analysis

	1 Month	3 Months	6 Months	12 Months
Total Number of Patients in Panel that could contribute to analysis	202	162	118	<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	199	27	98.5%	13.4%	-85.1%
3 Months	161	55	99.4%	34.0%	-65.4%
6 Months	118	59	100.0%	50.0%	-50.0%
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	288	48	14.3	2.4	-11.9
3 Months	310	117	19.1	7.2	-11.9
6 Months	321	154	27.2	13.1	-14.2
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	201	$1,309,453	$145,004	$6,580	$5,371	($1,210)
3 Months	162	$1,306,640	$867,361	$8,116	$15,770	$7,654
6 Months	118	$1,094,670	$1,027,965	$9,277	$17,423	$8,146

Average Charge per Visit

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Total charges - Pre	Total charges - Post	Average Charge per visit - Pre	Average Charge per visit - Post	Total Charges per Visit change
1 Month	288	48	$1,309,453	$145,004	$4,547	$3,021	($1,526)
3 Months	310	117	$1,306,640	$867,361	$4,215	$7,413	$3,198
6 Months	321	154	$1,094,670	$1,027,965	$3,410	$6,675	$3,265

Casemix Data Through:
06/30/2018

ENS Panels Last Updated:
08/04/2018

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

Pre/Post Analysis - Summary

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

Program Name
ID Program-FY18 (210048)

Chronic Conditions
All Patients

N/A

N/A

Most Recent Payer
All

Visit Type
All

Chronic Condition Operator
◉ AND
◯ OR

Total Number of Members on Panel that could contribute to analysis

	1 Month	3 Months	6 Months	12 Months
Total Number of Patients in Panel that could contribute to analysis	119	102	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	91	36	76.5%	30.3%	-46.2%
3 Months	86	50	84.3%	49.0%	-35.3%
6 Months	58	47	93.5%	75.8%	-17.7%
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	135	52	11.3	4.4	-7.0
3 Months	204	119	20.0	11.7	-8.3
6 Months	250	162	40.3	26.1	-14.2
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	96	$2,631,421	$448,262	$28,917	$12,452	($16,465)
3 Months	91	$3,080,553	$761,955	$35,820	$15,239	($20,581)
6 Months	59	$3,029,891	$899,202	$52,239	$19,132	($33,108)

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	135	52	$2,631,421	$448,262	$19,492	$8,620	($10,872)
3 Months	204	119	$3,080,553	$761,955	$15,101	$6,403	($8,698)
6 Months	250	162	$3,029,891	$899,202	$12,120	$5,551	($6,569)

Casemix Data Through:
05/31/2018

ENS Panels Last Updated:
07/10/2018

- 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.