HSCRC Transformation Grant

FY 2018 Report

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

Regional Partnership Information

Regional Partnership (RP) Name	Northeast Region
RP Hospital(s)	University of Maryland Upper Chesapeake Health System (UMUCHS) Union Hospital of Cecil County (UHCC)
RP POC	Colin Ward, Vice President Population Health & Clinical Integration
RP Interventions in FY 2018	• Post Discharge Clinics • Community Based Care Management • Information Technology/Data Warehouse
Total Budget in FY 2018 *Please insert FY 2017 award and FY 2018 award.*	FY 2017 Award: $2,692,430
	FY 2018 Award: $2,423,228
Total FTEs in FY 2018	Employed: 26
	Contracted: No Contracted FTEs Contracts in place with SecureNetMD & Applied Data Group for IT and analytic support
Program Partners in FY 2018 *Please list any community based organizations, contractors, and/or public partners*	• Healthy Harford/Healthy Cecil • CRISP • Cecil County Government- Dept. of Community Services-Office on Aging • Cecil County Health Dept. • Harford County Emergency Services- Department of Public Safety • Harford County Government- Dept. of Community Services- Office on Aging • Harford County Health Dept. • Primary Care and Specialty Physician Practices • United Way of Central Maryland, Meals on Wheels • Paris Foundation, Inc. • Lorien Health • Calvert Manor

	• Elkton Transitional Care • Amedysis Home Health • Visiting Nurses Association • Senior housing complexes (Harford/Cecil)

Overall Summary of Regional Partnership Activities in FY 2018

(Free Response: 1-3 Paragraphs):

The University of Maryland Upper Chesapeake Health (UMUCH) and Union Hospital of Cecil County (UHCC) Regional Partnership (RP) work to address the medical and social needs of high utilizer patients and those with multiple chronic conditions. The RP has deployed people, processes and technology that help identify and support patients in the pursuit of optimal health. The partnership leverages post-discharge clinics and community-based care teams while implementing telehealth programs and a shared (CRISP-hosted) care management documentation system. Patients are engaged at a Post Discharge Clinic (UHCC or UMUCH Comprehensive Care Center) and/or the Community-based Care Teams (WATCH Program).

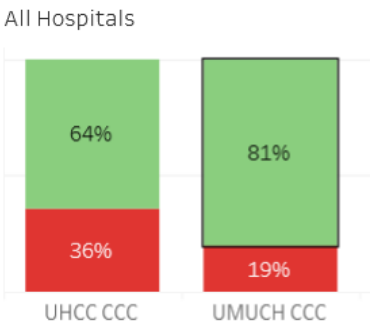
The RP interventions target Medicare and dual-eligible patients with multiple visits to the hospital and/or two or more chronic conditions. Through the first 24 months of the program, the RP has discovered that patients are more likely to become engaged with the program following a hospital visit. Another strength of the RP has been the numerous community partnership developed.

Intervention Program

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

Intervention or Program Name	• Post Discharge Clinics (Comprehensive Care Center)
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	UMUCH UHCC
Brief description of the Intervention *2-3 sentences*	The Post Discharge Clinics (at UMUCH and UHCC) monitors the patient's immediate needs after discharge from the emergency department or inpatient units, develops a comprehensive medical and social support treatment plan, and provides follow-up for 30 days. Teams of nurses, a social worker, community health worker and pharmacist support patients in the comprehensive care center clinic in person, via telephone, or in the patient's home through telehealth/video calls.

Participating Program Partners	• Primary Care and Specialty Physician Practices • Meals on Wheels of Central Maryland • Harford & Cecil County Offices on Aging • Harford & Cecil County Health Departments • Shoprite Stores (Grocery Store Tours, Healthy Eating Education Program) • Amedysis • Bayada • Skilled Nursing Facilities: Lorien, Citizens, Sava • Harford County Department Social Services • Harford County Court Systems and private attorneys
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.*	The RP program is designed to funnel Medicare patients from hospitals, community partners and physician practices to the PDC and then on to the WATCH teams. The goal is to identify patients that have chronic conditions or utilization issues, as well as newly diagnosed patients with high risk conditions such as COPD and CHF. As a result, almost any one of the approximately 41,400 Medicare beneficiaries could be eligible for the PDC intervention as the first step in the process. Our internal data Warehouse shows that the PDCs engaged with 4,150 patients (Medicare: 2,536) in FY 18. (Note: PDCs provide services to all-payer population. The WATCH Team is focused exclusively on Medicare or dual eligible patients)
	Denominator of Eligible Patients: 41,411 Medicare beneficiaries in the community are considered eligible because their first trip to the hospital without prior diagnosis of chronic condition, may result in a person being identified as high risk and in need to PDC services
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	The chart below shows the percent of patients (in green) that did not have any hospital utilization after the RP intervention from Union Hospital Comprehensive Care Center and the UMUCH Comprehensive Care Center. The RP observed that 81% of the patients engaged in the UMUCH PDC intervention and 61% of the UHCC PDC intervention did not return to the hospital (ED visit, observation or IP admission) at all in the subsequent 90 days.

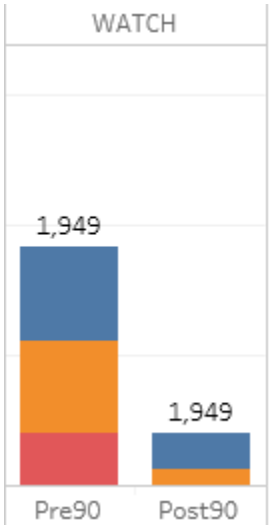
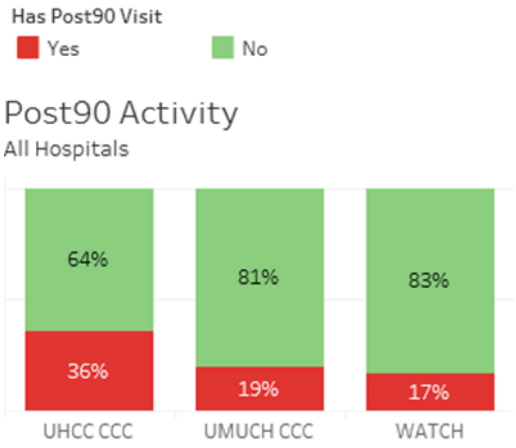
Intervention-Specific Outcome or Process Measures (optional) *These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership maintains and uses to analyze performance. Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.*	Over 5,000 referrals were received in the PDCs (all-payer). All of the referrals were screened, and risk stratified (based on an algorithm of 30-day readmissions, chronic diseases, high care alerts, high utilization and high risk). Patients were then provided information, assisted with PCP referrals and connected to other community services (such as diabetes education). Of the 5,000 referrals received, approximately 2,700 Medicare patients were formally engaged into the PDCs for comprehensive treatment and support. (Note: UHCC Clinic operates on a limited schedule and served approximately 200 patients in the program year; UMUCH PDC intervened with approximately 4,400) 
Successes of the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	Using a report from the RP's data warehouse, Medicare patients receiving interventions show a 74.7% reduction in all hospital utilization when comparing the 90 days post intervention to the 90 days before engagement. Significantly, the 1,858 enrolled Medicare patients show a 90% reduction in bedded stays, most of which also start with a visit to the emergency department.
Lessons Learned from the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	By utilizing the Data Warehouse and monitoring real-time readmissions, the PDC recognized that patients with different clinical conditions are vulnerable at different times after hospital discharge. As a result, the community health workers working in the PDC were redeployed to the inpatient units for face-to-face engagement to ensure that engagement could begin as soon as possible after discharge. The personal interaction improved the likelihood of the patient engaging in services through the PDCs, enabling the nurses and social workers to provide comprehensive interventions.
Next Steps for the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	The use of telehealth (Zoom) was implemented in FY18. Over the course of the year, the number of Zoom and Vivify (remote patient monitoring) contacts increased. In Program Year 3, the PDC will employ a broader adoption of remote patient monitoring from the PDC.
Additional Free Response (Optional)	

Intervention Program

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

Intervention or Program Name	• Community-Based Care Management- Wellness Action Teams of Cecil & Harford (WATCH)

RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	UMUCH UHCC
Brief description of the Intervention *2-3 sentences*	The Regional Partnership funds the Community-Based Care Management Program (CBCM) called Wellness Action Teams of Cecil & Harford counties (WATCH). The CBCM serve as the bridge between the post-discharge clinic, primary care physicians and community providers. The goal is to extend the total length of time that patients receive care management and coordination with the goal of reducing readmission. WATCH is comprised of four teams of nurses, social workers, pharmacist, and community health workers which engage clients into services across Cecil & Harford counties. WATCH provides ongoing care management, care coordination, medication reconciliation, health coaching and assistance to remove barriers to health (food insecurity, transportation, housing, medications, etc.).
Participating Program Partners	• Cecil County Government- Dept. of Community Services- Office on Aging • Cecil County Health Dept. • Harford County Government- Dept. of Community Services- Office on Aging • Harford County Health Dept. • Harford County Emergency Services- Department of Public Safety • Harford County Community College • Primary Care and Specialty Physician Practices • United Way of Central Maryland, Meals on Wheels • Paris Foundation • Lorien Health • Calvert Manor • Amedysis Home Health • Visiting Nurses Association • Numerous Senior Housing Complexes • Geriatric Assistance Information Network (GAIN)

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 July 1, 2017 - June 30, 2018: 1,949 *(RP Data Warehouse)*  Denominator of Eligible Patients: 41,411 Medicare beneficiaries in the community are considered eligible because their first trip to the hospital without prior diagnosis of chronic condition, may result in a person being identified as high risk and in need to PDC services
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	The RP observed that 83% of the patients engaged in the Community-Based Care Management Teams (WATCH Program) intervention did not return to the hospital (ED visit or bedded stay) in the subsequent 90 days. The chart below shows the percent of patients (in green) that did not have hospital utilization after the intervention began within the Union Hospital Comprehensive Care Center, and the UMUCH Comprehensive Care Center and then onto the Watch Program. 

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.*	A clinical pharmacist serves a key role with the Post Discharge Clinics and Watch Program. In FY18, the pharmacist provided services to 188 clients with over 457 interventions. Services included: • Review of patient medications • Reconciliation with discharge paperwork • Medication education: name, route, use, duration, administration technique, side-effects, storage, refills • Medication adherence counseling • Medication cost recommendations Data collected on patients by the pharmacist: • Average # of prescription medications per patient: 12.18 • Average # of Over the Counter medications per patient: 3.13 The CY 17 RP Analytics file indicates that an average of 5,700 Medicare beneficiaries per month have two or more chronic conditions. The pharmacist typically engaged only those with 10 or greater medications or high risk medications, as indicated in the CCDA files shared by CRISP into the RP's data warehouse. Services/Intervention/Education included the following: **Service/Intervention/ Education** | **Number of Instances** Inhaler Education | 25 Diabetic Education | 27 Incorrect Dose | 34 Unnecessary Medication | 23 Duplication | 15 Missing Therapy | 34 Administration technique | 14 Drug Interaction | 37 High Risk Medication Education | 63 Adverse Drug Reaction | 31 High Cost Medication | 46 Nonadherence/Adherence Issues | 44 Other | 64 **Total # of Interventions** | 457

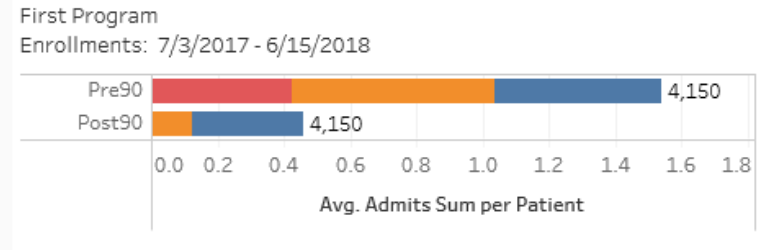
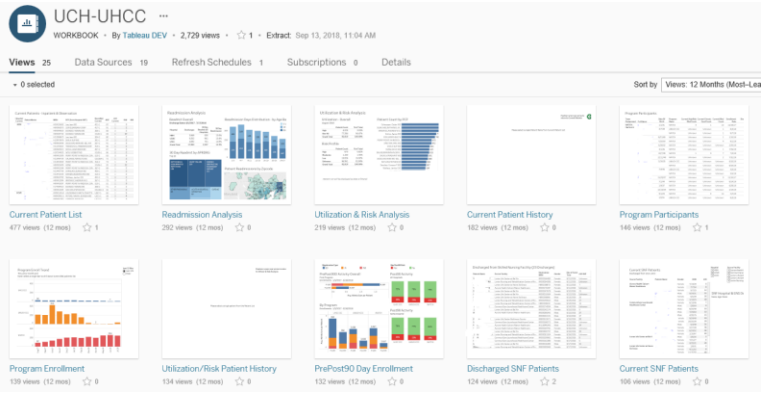
Successes of the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	Removing barriers is an important intervention the Watch Program provides which helps people improve their overall health and reduce the likelihood of readmission. Through the RP, clients are able to access Client Support (after all other options are exhausted). In FY18, 126 people accessed the Client Support totaling $5,522. The top three types of request include: durable medical equipment (such as walkers and blood pressure cuffs), transportation to medical appointments, and assistance with medications. To highlight a typical and successful Watch Program intervention, a case example is provided: An 88-year-old gentleman (high utilizer of ED services) who takes 16+ medications stated that, “he does not know what his medications are or why he is taking them.” He stated, "the doctors tell me to take medicine, and I just take them, sometimes." The client’s confusion after discharge affected his ability to recover and remain stable at home. The client did not use a medication planner and relied on others to pick up his medications. The pharmacist completed a Comprehensive Medication Review, educated the client about his medications, and arranged for his medications to be delivered in a bubble pack. The Watch team followed the client for 60 days in his home to reinforce health/ medication education and address additional barriers to care. The client has remained out to the ED since the team’s intervention.
Lessons Learned from the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	Engagement of clients in the community can be challenging when other community providers (such as Home Health agencies) are concurrently involved. Clients have declined services (initially) because it was overwhelming having multiple service providers in the home simultaneously. As a result, the community-based care teams have established solid working relationships with the home health agencies to ensure smooth transitions of care while promoting assertive care of clients.
Next Steps for the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	The Watch Program and the Harford County Department of Public Safety/Emergency Medical Services (EMS) are partnering to target frequent 911 callers living in Havre de Grace (Harford County). Emergency Medical Technicians and paramedics will actively identify people who lack access to primary care, struggle with the complexities of their chronic illness, and have barriers to care. The EMS will work closely with the Watch Team to conduct

	joint home visits with the goal of improving the patient's overall quality of life and reduce 911 calls.
Additional Free Response (Optional)	

Intervention Program

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

Intervention or Program Name	• Information Technology (Crisp Connectivity & Data Warehouse
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	UMUCH UHCC
Brief description of the Intervention *2-3 sentences*	A Data Warehouse has been developed and is operational for UMUCH, UHCC and community partners. The integration of health care and community provider organizations through the Data Warehouse, allows for real-time monitoring of high risk/high utilizer patients. This dynamic system mimics the HSCRC readmission calculation and allows for hospital and community partners to rapidly address patients in the hospitals and community.
Participating Program Partners	• Harford County Health Department • Harford County Government - Department of Community Services/Office on Aging • Cecil County Government-Department of Community Services/Office on Aging
Patients Served *Please estimate using the Population category that best applies to the*	# of Patients Served July 1, 2017 - June 30, 2018: 4,150 (2,536 Medicare) *Note: Chart below depicts service period July 3, 2017 – June 15, 2018*

Intervention, from the CY 2017 RP Analytic Files. *HSCRC acknowledges that the High Utilizer/Rising Risk or Payer designations may over-state the population, or may not entirely represent this intervention's targeted population.* *Feel free to **also** include your partnership's denominator.*	 Denominator of Eligible Patients: 41,411. Any Medicare patient that has a hospital encounter could be eligible for analysis using the system, provided that a referral has been made to the PDC or WATCH programs.
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	This is an enabling intervention, thus the pre/post 90 day data is reflected in the prior intervention sections.
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 Data Warehouse is fully operational for the RP. The system provides lists and data about current patients in the hospitals and SNFs so that the PDCs, CBCT and community agencies (Harford/Cecil Counties Office on Aging, Harford County Health Dept.) can "mine" for cases. Screen shots of the Data Warehouse show the depth of information available to support the RP: 

Successes of the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	This supporting intervention has enabled the PDCs and the WATCH teams to make modifications to the manner in which they respond to patient needs. The inclusion of the CRISP provided CCDA data makes for a more refined patient stratification and outreach process. This includes medications and problem list data from the primary care provider. This has resulted in a stronger integration of the pharmacist into the care teams.
Lessons Learned from the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	Although it has been a relatively smooth process to develop the data warehouse and visualizations, it can still be a challenge to have team members make the data part of their daily workflow. This includes sharing information with providers in a manner that is consistent with their workflow. Our strategy has been to highlight the value in a few of the tabs so that the team views it daily, then add more tabs (new data visualizations) after people become comfortable in the system.
Next Steps for the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	The RP aims to incorporate claims data and add discrete information from other sources to further refine the patient stratification process. This will occur in conjunction with the roll out of the new MDPCP program in our 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)

CY	Total (IP) Hospital Cost - Partnership IP Charges			
Month	All Patients - 2017	All Patients - 2016	Medicare Patients - 2017	Medicare Patients - 2016
Average	$86,428,043	$81,042,050	$35,283,884	$33,059,349
Change from previous year	6.6%		6.7%	
	RP	RP	State	State
	ALL	Medicare	ALL	Medicare
CY 17	$ 86,428,042.92	$35,283,884	$3,226,052,895	$1,324,479,998
% Change	6.65%	6.73%	4.41%	5.02%

CY	Total (IP) Hospital Cost per Capita - Partnership IP Charges per Capita			
Month	All Patients - 2017	All Patients - 2016	Medicare Patients - 2017	Medicare Patients - 2016
Average	$254	$239	$104	$97
Change from previous year	6.6%		6.6%	
Comparison	RP	RP	State	State
	ALL	Medicare	ALL	Medicare
CY 17	254	104	255	105
% Change	6.60%	6.60%	4.40%	4.80%

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'

FY 18	Total (IP) Hospital Discharges- Total Discharges			
Month	All Patients - 2018	All Patients - 2017	Medicare Patients - 2018	Medicare Patients - 2017
Average	2692.8	2766.4	1087.7	1162.4
Change from previous year	-2.7%		-6.4%	
	RP	RP	State	State
	ALL	Medicare	ALL	Medicare
FY 18	2,693	1,088	113,865	42,282
% Change	-2.66%	-6.43%	-1.47%	-8.14%

FY 18	Total (IP) Hospital Discharges per Capita - Total Discharges per 1,000			
Month	All Patients - 2018	All Patients - 2017	Medicare Patients - 2018	Medicare Patients - 2017
Average	7.9	8.2	3.1	3.3
Change from previous year	-3.1%		-7.5%	
	RP	RP	State	State
	ALL	Medicare	ALL	Medicare
FY 18	7.9	3.1	9.1	3.3
% Change	-3.06%	-7.50%	0.00%	-16.67%

<table>
<tr><td></td><td>(Column G / Column C)</td><td></td></tr>
<tr><td>Total Health Care Cost per person</td><td>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</td><td>
Total Health Care Cost Per Person - Partnership TCOC and IP Cost per Capita for Medicare
<table>
<tr><th></th><th>PBPY TCOC
2017</th><th>2016</th></tr>
<tr><td>Partnership</td><td>$2,770</td><td>$2,727</td></tr>
<tr><td>% Change</td><td>1.6%</td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>State</td><td>$2,768</td><td>$2,652</td></tr>
<tr><td>% Change</td><td>4.4%</td><td></td></tr>
</table>
<table>
<tr><th></th><th>PBPY IP
2017</th><th>2016</th></tr>
<tr><td>Partnership</td><td>$858</td><td>$903</td></tr>
<tr><td>% Change</td><td>-5.0%</td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>State</td><td>$915</td><td>$902</td></tr>
<tr><td>% Change</td><td>1.4%</td><td></td></tr>
</table>
</td></tr>
<tr><td>ED Visits per capita</td><td>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)</td><td>
<table>
<tr><th>FY</th><th colspan="2">ED Visits - Ambulatory ED Visits</th><th></th><th></th></tr>
<tr><th>Month</th><th>All Patients - 2018</th><th>All Patients - 2017</th><th>Medicare Patients - 2018</th><th>Medicare Patients - 2017</th></tr>
<tr><td>Average</td><td>10678.8</td><td>11004.7</td><td>2837.8</td><td>2817.4</td></tr>
<tr><td rowspan="2">Change from previous year</td><td>-3.0%</td><td></td><td>0.7%</td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>RP</td><td>RP</td><td>State</td><td>State</td></tr>
<tr><td></td><td>ALL</td><td>Medicare</td><td>ALL</td><td>Medicare</td></tr>
<tr><td>FY 18</td><td>10,679</td><td>2,838</td><td>449,151</td><td>104,626</td></tr>
<tr><td>% Change</td><td>-2.96%</td><td>0.72%</td><td>-2.88%</td><td>-0.06%</td></tr>
</table>
<table>
<tr><th>FY</th><th colspan="2">ED Visits per Capita - Ambulatory ED Visits per 1,000</th><th></th><th></th></tr>
<tr><th>Month</th><th>All Patients - 2018</th><th>All Patients - 2017</th><th>Medicare Patients - 2018</th><th>Medicare Patients - 2017</th></tr>
<tr><td>Average</td><td>31.6</td><td>32.3</td><td>8.4</td><td>8.4</td></tr>
<tr><td rowspan="2">Change from previous year</td><td>-2.3%</td><td></td><td>0.0%</td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>RP</td><td>RP</td><td>State</td><td>State</td></tr>
<tr><td></td><td>ALL</td><td>Medicare</td><td>ALL</td><td>Medicare</td></tr>
<tr><td>FY 18</td><td>31.6</td><td>8.4</td><td>35.3</td><td>8.2</td></tr>
<tr><td>% Change</td><td>-2.32%</td><td>0.00%</td><td>-3.20%</td><td>0.00%</td></tr>
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</td></tr>
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Quality Indicator Measures

<table>
<tr><th>Measure in RFP
(Table 1 in Appendix A of the RFP)</th><th>Measure for FY 2018 Reporting</th><th>Outcomes(s)</th></tr>
<tr><td>Readmissions</td><td>Unadjusted Readmission rate by Hospital
(please be sure to filter to include all hospitals in your RP)

Executive Dashboard: ‘[Partnership] Quality Indicators’ – <u>Unadjusted Readmission Rate by Hospital</u>, reported as average 12 months of FY 2018

-or-

Analytic File: ‘IP Readmit’ over ‘EligibleforReadmit’ (Column J / Column I)</td><td>
<table>
<tr><th colspan="5">Unadjusted Readmission Rates</th></tr>
<tr><th>Month</th><th>RP- FY 18</th><th>State - FY 18</th><th>RP- FY 17</th><th>State - FY 17</th></tr>
<tr><td>Average</td><td>10.8%</td><td>11.7%</td><td>11.2%</td><td>12.1%</td></tr>
<tr><td>Same Yr Difference</td><td>8.9%</td><td></td><td>7.6%</td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>RP</td><td>RP</td><td>State</td><td>State</td></tr>
<tr><td></td><td>FY 18</td><td>FY 17</td><td>FY 18</td><td>FY 17</td></tr>
<tr><td>CY 17</td><td>10.8%</td><td>11.2%</td><td>11.7%</td><td>12.1%</td></tr>
<tr><td>Improvement</td><td>3.80%</td><td></td><td>3.17%</td><td></td></tr>
</table>
</td></tr>
<tr><td>PAU</td><td>Potentially Avoidable Utilization

Executive Dashboard: ‘[Partnership] Quality Indicators’ – <u>Potentially Avoidable Utilization</u>, reported as sum of</td><td>
<table>
<tr><th colspan="5">PAU - Charges</th></tr>
<tr><th>Month</th><th>RP- FY 18</th><th>RP - FY 17</th><th>State- FY 18</th><th>State - FY 17</th></tr>
<tr><td>Total</td><td>$ 104,146,646</td><td>$ 96,241,284</td><td>$4,637,108,510</td><td>$ 4,480,427,613</td></tr>
<tr><td>Improvement</td><td>-8.21%</td><td></td><td>-3.50%</td><td></td></tr>
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	12 months of FY 2018 -or- Analytic File: 'TotalPAUCharges' (Column K)	

CRISP Key Indicators (Optional)

These process measures tracked by the CRISP Key Indicators are new, and HSCRC anticipates that this 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' – <u>% of patients with Care Plan recorded at CRISP</u>, reported as average monthly % for most recent six months of data	**% with Care Plan at CRISP (Jan-June '18)** **Month** / **RP High Need** / **State High Need** / **RP Rising Risk** / **State Rising Risk** Average: 26.5% / 3.7% / 5.2% / 0.5% 22.8% / 4.7% Difference

	May also include Rising Needs Patients, if applicable in Partnership.	
Portion of Target Population with Contact from Assigned Care Manager	**Potentially Avoidable Utilization** Executive Dashboard: 'High Needs Patients – CRISP Key Indicators' – <u>% of patients with Case Manager (CM) recorded at CRISP</u>, reported as average monthly % for most recent six months of data *May also include Rising Needs Patients, if applicable in Partnership.*	**% with Case Manager at CRISP (Jan-June '18)** **Month** / **RP High Need** / **State High Need** / **RP Rising Risk** / **State Rising Risk** Average: 26.2% / 26.8% / 14.5% / 14.8% Difference: -0.6% / -0.3%

Self-Reported Process Measures

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

Intervention-Specific Outcome or Process Measures	**Outcomes**
The PDCs will conduct depression screenings for all patients with a PHQ2.	All Post Discharge Clinic patients are screened for depression. The goal is to identify patients with behavioral health needs and provide appropriate interventions. • 4,651 PHQ -2 completed in the PDC • 2,271 PHQ 2 – completed by the Watch Program If the result of the PHQ2 is positive, patients are administered a PHQ9. A subsequent positive PHQ9 test, results in an immediate referral to licensed social workers. All CHF and COPD patients are automatically screened with the PHQ9. Based on evidence-based practice research, the CHF/COPD population have a higher risk for depression.
High risk patients will have a Care Plan developed.	Based on an algorithm, patients who are high risk are assigned a nurse to generate a care plan. 1,080 patients had care plans developed in the PDCs. These care plans represent a comprehensive assessment, interventions and goals related to their health needs and community barriers.

Return on Investment

Indicate how the Partnership is working to generate a positive return on investment (Free Response; please include your calculation)

The UHCC-UMUCH Regional Partnership has demonstrated success in helping Medicare beneficiaries in Cecil and Harford counties optimize their health outside of the hospital setting. By integrating interventions among providers along the continuum and leveraging common communication, documentation and analytics tools, the combined programs yield benefit to patients, providers and payers.

Preliminarily, the return on investment from the hospital perspective looks promising. Using the Pre/Post 90 day data, the RP has avoided nearly 7,400 hospital days in FY 18. With a variable cost of $450 per day, this leads to a cost savings of more than $3.3M and generates an ROI at the hospital level of 1.37. This return was generated even after the reduction of 10% of the initial award from Program Year 1 to Program Year 2. Understanding that this savings does not accrue to the payer easily under the GBR, the RP will work the HSCRC to determine a calculation that reflects the return from the payer perspective in Program Year 3.

Medicare Bedded Stay Reductions	
Avoided Stays	2,498.0
ALOS (blended)	2.96
Days Saved	7,394.0
Variable Cost Savings	450
Savings	$ 3,327,283
FY 18 RP Grant	$ 2,423,228
ROI	1.37

Conclusion

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

The UMUCH/UHCC Regional Partnership is a person-centered, multi-disciplinary model of care. The RP was designed to be comprehensive, use resources effectively, develop targeted initiatives and leverage community-based resources through partnerships. The goal remains to extend the reach of the treatment network beyond the hospital setting, creating stronger community partnerships and leveraging the treatment services already available in the community. The RP recognizes the need to continue to integrate health care providers and supporting organizations engaged with common patients to create a more patient-centered and efficient system of care.

The RP continues to work with health care partners and community partners to foster improved data sharing, provide real-time access to support patients, and build a robust system of care beyond the walls of the hospital system. After two years of implementation, the RP interventions appear to be associated with reductions in hospital utilization.