HSCRC Regional Partnership Transformation Grant

FY 2019 Report

The Health Services Cost Review Commission (HSCRC) is reviewing the following for FY 2019: 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	Community Health Partnership of Baltimore
RP Hospital(s)	1. The Johns Hopkins Hospital 2. Johns Hopkins Bayview Medical Center 3. LifeBridge Sinai Hospital 4. Mercy Medical Center 5. MedStar Franklin Square Hospital 6. MedStar Harbor Hospital
RP POC	Linda Dunbar, PhD, RN, Vice President, Population Health Johns Hopkins HealthCare LLC ldunbar1@jhmi.edu
RP Interventions in FY 2019	1. Community Care Team 2. Home-Based Primary Care / JHOME 3. Behavioral Health Bridge Team 4. Homeless Convalescent Care 5. Neighborhood Navigators 6. Patient Engagement Program/ Provider Training
Total Budget in FY 2019 *This should equate to total FY 2019 award*	FY 2019 Award: $5,339,429
Total FTEs in FY 2019	Employed: 87.5 FTE
	Contracted: 41.5 FTE 46 part-time stipend employees
Program Partners in FY 2019 *Please list any community-based organizations or provider groups, contractors, and/or public partners*	1. Sisters Together and Reaching, Inc. 2. The Men & Families Center 3. Health Care for the Homeless 4. Matrix Ventures LLC 5. Johns Hopkins Medicine

Overall Summary of Regional Partnership Activities in FY 2019

(Free Response: 1-3 Paragraphs):

The Community Health Partnership of Baltimore (CHPB) focuses on Medicare fee-for-service (FFS) patients across Baltimore City, coordinating care for residents with complex medical, behavioral, and/or social challenges. CHPB seeks to address social determinants of health so patients can focus on leading healthy lives. Utilizing a care team approach, in addition to other issue-specific interventions, CHPB offers patients services that are tailored to their needs.

In FY2019, CHPB focused strategically on increasing enrollment in the Community Care Team (CCT) and Behavioral Health Bridge Team (Bridge) interventions. We piloted new ways to identify patients for outreach, focusing on those who had recently visited an emergency department or who were identified in the inpatient setting. These strategies were developed as part of a quality improvement effort to examine whether our predictive modeling approach for identifying patients was working efficiently. When appropriate, we also loosened eligibility criteria for specific interventions. These strategies proved successful in helping us augment enrollment.

Conservative estimates for each initiative's return on investment (ROI) are provided in this report. We are proud to present ROIs greater than 1.0. In keeping with the HSCRC's prescribed methodology, and estimating that only 50% of the cost reductions are attributable to these interventions, we calculate ROIs ranging from 1.47-3.47. We continue to build on the evidence-based models we have implemented to best address the needs of Baltimore City residents.

CHPB partner hospitals continued to strengthen relationships with community-based organizations, including Sisters Together and Reaching (STAR), the Men and Families Center (MFC), and Health Care for the Homeless (HCH). At the same time, we fostered new relationships in the community and began discussions about partnering together to provide enhanced services for our patients in FY2020. We look forward to serving the community in new and innovative ways in the coming year.

Intervention Program 1: Community Care Team

Intervention or Program Name	Community Care Team (CCT)
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	All
Brief description of the Intervention *2-3 sentences*	The CCTs expand upon existing services of primary care providers to meet the needs of and coordinate care for a high-risk, Medicare population. Each team consists of a minimum of one Nurse/Social Worker Care Manager, two Community Health Workers, and one Health Behavior Specialist. The teams

	assess social influencers of health, medical, and behavioral health needs of patients. The teams meet a patient's needs by connecting the patient to primary care, resources to abate social barriers, and other medical and behavioral health resources.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	Sisters Together and Reaching, Inc. Matrix Ventures LLC Johns Hopkins Medicine (various departments)
Patients Served *Please estimate using the Population category that best applies to the Intervention, from the CY 2018 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, 2019: 738 patients were enrolled and receiving CCT services during the year, regardless of enrollment date
	Denominator of Eligible Patients: From RP Analytic Files: Out of a population of 74,445 individuals with Medicare FFS in our Partnership area, 2,263 patients met CCT's initial criteria (3+ Inpatient or Observation visits, Medicare FFS) Total referrals: Of all those referred via various referral/identification streams, 929 patients were screened and deemed eligible for outreach. Please see Diagram 1.0 in Appendix A for more information on how the total enrolled population was drawn from eligible populations within the total population of Medicare FFS beneficiaries in the RP catchment zip codes.
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	While pre/post intervention reports are only available for individuals enrolled in the CCT who have a common MRN, panel analysis on the 161 individuals who had a Hopkins MRN (the most common MRN among the population) showed significant post CCT enrollment reductions in both hospital utilization and charges that appear to persist or even improve over time. In this summary, we choose to focus on a 6 month pre/post period, since our intervention is intended to create both short- and longer- term results, and 6 months in a pre- period is more representative of the patient's prior utilization than one or three months, which may only show an acute episode and not persistent high utilization. Twelve month pre- and post- reports will be important to consider once a higher number of individuals reach 12 months since enrollment in the CCT (currently, 41 individuals with a Hopkins MRN have 12 months of data in the pre and post periods). Considering the 100 individuals who had 6 or more months of post data, we found that the number of patients with 1 or more visits dropped by 3%, the rate of visits per 10 members dropped by 14.4 visits (14.8% decrease), the average charges per member dropped by $12,903 (30.1% decrease in

charges per member), and the average charge per visit was reduced by $868 (20.6% decrease). Please refer to the Pre Post Summary Analysis for more information on the reductions in visits and charges after enrollment in the CCT at 1, 3, 6, and 12 months.

When examining total hospital charges and visits pre post, we find that at 6 months, the total hospital charges in the post period are reduced by $1,328,475.42 (32.3% reduction) after enrollment in the CCT as compared to total charges across the 6 months prior to CCT enrollment. Further, the number of hospital visits dropped by 144 visits (14.8% decrease) in the 6 months after enrollment in the CCT as compared to the 6 month pre period. Each hospital serving as a partner in CHPB saw a significant reduction in hospital charges pre/post for individuals enrolled in the CCT at 6 months. For more information on these numbers, as well as for the visual month by month trends in pre/post visits and charges, please refer to the CCT 6 month Panel Analysis as well as the 6 month relative trend analyses for hospital visits and charges.

Please see Appendix B for the CCT's 6 Month Pre/Post Analysis Report from CRISP.

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.

Process Measures	Number
Total number of patients deemed eligible for CCT outreach, after screening process	929
Total number of patients enrolled and receiving CCT services during the year, regardless of enrollment date	738
Total number of newly enrolled CCT patients during the year	428
Total number of patients enrolled in CCT on June 30, 2019	240
Number of cases closed because all patient goals were met	73
Number of cases closed because patient was transferred to other care management program (i.e.: working with care managers at hospital or primary care clinic)	136
Number of cases refusing CCT services after patient was referred	371
Number of patients who were deceased after patient referred	101
Number of cases not meeting program criteria after patient was referred	54

	Number of cases unable to locate after patient was referred	323
	Average age for enrolled patient	62.3 years old
	Average number of chronic conditions for enrolled patients (from CRISP High Utilizer data)	4
	Average number of successful CHW contacts per patient per month	Approx. 2.9
Successes of the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	• Implementation of new outreach strategies: 1) utilizing referrals from inpatient providers, 2) using EMR and CRISP data to identify patients currently in the inpatient setting, and 3) outreaching patients who had recently visited an ED (EMR data); all strategies led to increases in CCT enrollment and enabled care teams to meet patients in the hospital prior to being discharged to the community setting, where they may have had an opportunity to more easily lose contact with the care team • Creation of a Task Force to help maintain structure and organization of interdisciplinary team meetings; this strengthened input and ownership of program operations among front-line staff • Increased education among providers and community partners about the availability and role of CCT services • Improved marketing and visibility for hospital clinicians and community partners • Launch of Care Conferences, an all-CCT staff meeting; steady attendance among all teams; systems for continual feedback from staff about topics covered and ideas for future presentations; increased staff awareness of community resources (e.g., dental clinics, behavioral health crisis response) • Enhanced efforts around networking with community resources, leading to guest speakers at Care Conference meetings; opportunities for symbiotic relationships between community agencies and the CCT • Led by STAR CHWs, enhanced opportunities for face-to-face community-building; activities included neighborhood walks, community health festival, and health education sessions hosted in/around STAR office • Implementation of a documentation system that allows the CCTs to improve communication and leads to increased collaboration • Creation of over 37 jobs since program began (refer to Table 1.0 in Appendix A) • Consistent positive feedback from patients about the program's impact on their lives (see Patient Stories in Appendix A); care team members are trusted partners to patients, never judging their circumstances; CHWs report that building trust with the care team leads to patients' increased trust of medical providers • CHWs made 331 referrals to 70 external partners/organizations to assist with patients' social influencers of health (refer to Tables 2.0 and 3.0 in	

	Appendix A); they focused on teaching patients *how* to use the resources they are connecting them to so they feel empowered to continue seeking support on their own • HBSs made 51 referrals to 32 partner organizations for mental health and/or substance use support (refer to Table 4.0 in Appendix A)
Lessons Learned from the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	• The importance of care team cohesion and unity in engaging the patient; ensuring weekly team "huddles" are prioritized • Care team members report that face-to-face interactions with patients are more effective and a more efficient way to build trust, than telephonic encounters. • Predictive modeling approach for identifying patients was not working efficiently in meeting enrollment targets, which led to new outreach strategies • Hospital providers were appreciative for the opportunity to refer patients directly to the CCT; this has led to increased trust between groups • Care managers, health behavior specialists, and community health workers all report to different managers, which can create vulnerabilities around clear operational expectations and accountability; developed all-staff Care Conferences to communicate with program staff in the same forum • Given documentation system differences for behavioral health component, the scope and breadth of work done by HBSs can appear to be under-reported to our leaders and operational teams. • Social barriers that cannot be met easily or readily for patients can lead to significant setbacks in engagement with CCT. • Impact of past trauma is a predictor of engagement, trust, and health outcomes • Impact of social inequality and social injustices within the community is a predictor of engagement, trust, and health outcomes
Next Steps for the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	• Unified staffing plan among CCT teams, including clear team assignments and more frequent communication regarding coverage and caseloads • Re-assess use of current CHPB website and utility/function with hospital partners, clinical staff, and Baltimore residents; identify opportunities to increase awareness of CHPB services • Pilot new methods to identify patients for outreach and increase referrals • With hospital partners, explore the possibility of physically locating care team members in the emergency departments
Additional Free Response (Optional)	Using data from the Summary Report in CRISP, we saw a savings of $12,903 in the 6 month pre/post cohort. Given the smaller number of individuals for whom we had a common MRN and at least 6 months of data since enrollment (N=100), we extrapolate a 6 month ROI using the following methods.

	Using a conservative approach that attributes only 50% of the savings directly to the CCT and attributes the rest to factors other than the CCT (regression to mean, other programs, life factors, etc.), we calculate an ROI for the 738 individuals enrolled in the program by multiplying the average savings per person in the 6 month cohort in CRISP times the number of individuals enrolled (738). Next, we subtract the total savings calculated in the last step from the cost of the CCT per year, then divide that number by the 6 month cost of the program to calculate an estimated ROI. The estimated ROI on the 738 individuals enrolled is 1.68, and would be 4.35 if we did not discount by 50% to be conservative. We apply this same methodology in other sections as well.

ROI (based on 6-month pre/post savings)	
Average reduction in per member charges at 6 months from Pre/Post Reports in CRISP	$12,903.00
Per member reduction in charges discounted by 50%	$6,451.50
Members enrolled in CCT	738
Total cost of CCT program (for 6 months)	$1,779,747
Total member savings at 6 months	$4,761,207.00
6 Month ROI	1.68

Intervention Program 2: Home-Based Primary Care / JHOME

Intervention or Program Name	Home-Based Primary Care / JHOME
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	Johns Hopkins Bayview Medical Center Johns Hopkins Hospital LifeBridge Sinai Hospital
Brief description of the Intervention *2-3 sentences*	Home-Based Primary Care (JHOME) is a community-based program that provides home-based medical care, care management, caregiver support, counseling, and acute inpatient continuity to high-need, high cost, home-bound individuals on a longitudinal basis. The multi-disciplinary team

	consists of a Program Director, Geriatrician, Certified Registered Nurse Practitioner, Social Worker, Registered Nurse, Practice Manager, Patient Service Coordinator, and a Licensed Practical Nurse.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	Johns Hopkins Medicine Department of Geriatrics
Patients Served *Please estimate using the Population category that best applies to the Intervention, from the CY 2018 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, 2019: 359 were enrolled and receiving JHOME services during the year, regardless of enrollment date
	Denominator of Eligible Patients: From RP Analytics Files: Out of a population of 74,445 individuals with Medicare FFS in the RP area, only those who are homebound are eligible for this intervention. As this number is not readily available, we instead will use total referrals as the denominator of eligible patients. There were a total of 277 total referrals to this intervention in FY19. The JHOME team continued to manage patients who were enrolled in FY18, in addition to newly referred patients.
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 JHOME patient panel contains 317 patients for the time period July 2018 through June 2019. In this summary, we use the CRISP pre/post data for the 235 patients with data for analysis 6 months before and after enrollment. The total acute care charges associated with this cohort were $3,160,165 before enrollment and $1,296,739 after enrollment. Johns Hopkins Bayview Medical Center, the referring hospital for the majority of the patients, saw a decrease of 54% in total charges. MedStar Franklin Square saw a 92% decrease in total charges. The breakdown of charges analysis shows decreases in ER (57%), medical/surgical procedures (68%), operating room (23%), and physical therapy (76%) were among the largest associated decreases before and after enrollment. The number of patient visits to the hospital also decreased. Total visits for this cohort decreased by 49%, from 571 to 289. This decrease was consistent across Johns Hopkins Bayview (44% decrease), Johns Hopkins

<table>
<tr><td></td><td>Hospital (40% decrease), both MedStar hospitals, and Mercy Medical Center (decreases, but % not reportable). The decrease is mainly attributed to the comprehensive medical care provided by the JHOME's interdisciplinary team in managing the patients' chronic conditions in their home. Additionally, the intervention's ability to provide same day urgent visits to the patients has played significant role in preventing hospital admissions. Thus, decreasing the number of visits. Moreover, 75% of JHOME patients who died in the past year died at home or in hospice facilities. About 53% of deaths took place in the comfort of their home with their family members. This percentage is higher than the average (approx. 25%) reported in peer-reviewed literature.

Please see Appendix B for JHOME's 6 Month Pre/Post Analysis Report from CRISP.</td></tr>
<tr><td>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.</td><td>
<table>
<tr><th>JHOME Process Measure</th><th>Number</th></tr>
<tr><td>Total Number of Patients Newly Referred</td><td>277</td></tr>
<tr><td>Total Number of Patients Newly Enrolled</td><td>167</td></tr>
<tr><td>Total Number of Home Visits</td><td>2,396</td></tr>
<tr><td>Total Urgent Visits</td><td>82</td></tr>
<tr><td>Percent of Patients with Completed Annual Wellness Visits</td><td>52%</td></tr>
<tr><td>Total Inpatient Encounters</td><td>282 (average 22/month)</td></tr>
<tr><td>Total Number of ED Visits</td><td>270 (average 23/month)
Note: ED visits included those that turned into inpatient admissions</td></tr>
<tr><td>Total Number of Deaths at Home and in Hospice</td><td>49</td></tr>
<tr><td>Percentage of Deaths at Home and in Hospice</td><td>49/65 = 75%</td></tr>
</table>
</td></tr>
<tr><td>Successes of the Intervention in FY 2019</td><td>• JHOME expanded the number of unique individuals served from 327 to over 350; demonstrating the ability to recruit new participants to JHOME is important for our goal of sustainability and meeting the community's needs</td></tr>
</table>

<table>
<tr><td>Free Response, up to 1 Paragraph</td><td>

- JHOME expanded by hiring a new nurse practitioner and is in the process of hiring individuals to take the place of team members that retired in the past year.
- JHOME successfully transitioned within Johns Hopkins Medicine from a program housed within the Division of Geriatrics to being integrated into the larger health system. The employment of most JHOME team members subsequently transitioned at the same time. The team was able to maintain enrollment and support for patients amidst the changes.
- JHOME expanded beyond the service area that it had originally served to include patients around Sinai Hospital.

</td></tr>
<tr><td>Lessons Learned from the Intervention in FY 2019
Free Response, up to 1 Paragraph</td><td>

- Expansion of service area helped to develop processes and strategies to serve patients that are more remote from JHOME's base of operations; this is a starting point for scaling/spreading further in the future
- Increased use of real-time data (CRISP) to help improve care outcomes, rather than just relying on the information available through the EMR
- Implementation of annual wellness visits in order to screen patients for important medical conditions, incorporating advanced care planning

</td></tr>
<tr><td>Next Steps for the Intervention in FY 2020
Free Response, up to 1 Paragraph</td><td>

- Streamline a referral and intake process and allow for more efficient patient scheduling by creating a website and on-line database; the new website will also be an opportunity to work on improving branding and updating materials
- Work to more efficiently utilize each member of the team; as we onboard and hire new staff, re-establish responsibilities to ensure teams and processes are cohesive and efficient
- Explore opportunities to use EMR data and other sources of real-time data to guide strategy and development as the program expands
- Develop and implement a patient survey to receive feedback about the program and opportunities to better serve patient/caregiver needs

</td></tr>
<tr><td>Additional Free Response (Optional)</td><td>

<table>
<tr><th colspan="2">ROI (based on 6-month pre/post savings)</th></tr>
<tr><td>Average reduction in per member charges at 6 months from Pre/Post Reports in CRISP</td><td>$8,318</td></tr>
<tr><td>Per member reduction in charges discounted by 50%</td><td>$4,159</td></tr>
<tr><td>Members enrolled in JHOME</td><td>359</td></tr>
<tr><td>Total cost of JHOME program (for 6 months)</td><td>$854,588/2 = $427,294</td></tr>
</table>

</td></tr>
</table>

	Total member savings at 6 months	$1,493,081
	6 month ROI	2.49

Intervention Program 3: Behavioral Health Bridge Team

Intervention or Program Name	Behavioral Health Bridge Team
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	All
Brief description of the Intervention *2-3 sentences*	The Bridge Team is a multi-disciplinary team that works with patients exhibiting complex psychiatric needs, substance use disorder (SUD), and other complex care management needs associated with behavioral health. The primary goal of the Bridge Team is to facilitate a successful transition to a medical home and engage patients in behavioral health services. The team consists of a Psychiatrist, a Health Behavior Specialist Team Lead, a Health Behavior Specialist, and two behavioral health Community Health Workers.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	Johns Hopkins Medicine
Patients Served *Please estimate using the Population category that best applies to the Intervention, from the CY 2018 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*	# of Patients Served as of June 30, 2019: 34
	Denominator of Eligible Patients: Total from RP Analytics Files: Out of a population of 74,445 individuals with Medicare FFS in the RP area, only those who meet psychiatric criteria are eligible for this intervention. As this number is not readily available, we instead will use total referrals as the denominator of eligible patients. There were a total of 84 referred to this program.

intervention's targeted population. *Feel free to **also** include your partnership's denominator.*	
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	The Bridge Team patient panel contains 28 patients for the time period July 2018 through June 2019. In this summary, we use the CRISP pre/post data for the 11 patients with data for analysis 6 months before and after enrollment. Patients were not included in CRISP's reporting if they were enrolled less than 2 months, and/or their MRN was not able to be located in CRISP's system. The patients enrolled in the Bridge intervention had $553,101 in total charges prior to enrollment and $195,721 after enrollment, showing a reduction of $357,380 over 6 months and a decrease of $32,489 per patient. Reductions in costs were seen across all hospitals (Johns Hopkins Hospital: 66% decrease, Johns Hopkins Bayview: 78% decrease, Mercy Medical Center: 60% decrease). Charges were highest for this cohort the month before they were enrolled in the Bridge Team, indicating they may have been identified for outreach as a result of their recent increased utilization. The number of total visits (of all types) increased from 96 before enrollment to 176 after enrollment, perhaps indicating increased attention from providers and/or increased engagement from these 11 chronically ill patients. This increase in visits is inclusive of follow-ups and behavioral health support provided by HBSs and CHWs who work to provide a holistic approach to meeting patients' needs. They often connect patients directly with primary care physicians and specialists, with attention to individuals' needs for linkage to appropriate level of service. Please see Appendix B for the Bridge Team's 6 Month Pre/Post Analysis Report from CRISP.

Intervention-Specific Outcome or Process Measures (optional)
These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership

Process Measure 2019	Number
Total number of phone consultations for potential referrals	111
Total number of patients referred	84
Total number of patients enrolled	34
Total number of patients ineligible	48 (see table below for denial reasons)
Total number of patients eligible who were lost to care before enrollment	29

maintains and uses to analyze performance. Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.

(could not locate during one-month period of attempting)	
Total number of HBS interactions/encounters	1342
Average number of HBS outreach attempts per month	112
Total number of CHW interactions/encounters	583
Average number of CHW outreach attempts per month	49
Number of unique psychiatric evaluations done by Psychiatrist (does not include consults with team, rounding, and other care coordination)	31
Average length of treatment (days) for patients discharged by month's end	86
Number of patients discharged successfully (having completed all agreed upon goals)	21
Number of patients involuntarily discharged due to non-adherence	4

Ineligibility Reason	Number of Patients
Insurance	8
Already engaged in mental health treatment	7
Transferred to CCT	2
Alternative discharge plans made	15
Patients not voluntary	11
No transitional program identified for patient (nothing to bridge patient to)	5
Total	48

Successes of the Intervention in FY 2019
Free Response, up to 1 Paragraph

- There was a 62% increase in the number of patients enrolled in the Bridge team from FY18 to FY19.
- The team hired an additional full-time HBS.
- Developed and implemented a protocol for in-reaching to additional hospital partner units as a way to increase enrollment

<table>
<tr><td></td><td>

With CHWs, piloted outreaching patients who had low acuity, high ED utilization
Successfully discharged 84% of enrolled patients, having achieved care goals, including connection to outpatient behavioral health programs
Patients routinely expressed increased engagement with Bridge Team staff, noting they often found they could trust the team more than other providers; this helped the team address additional barriers to adherence that had otherwise been challenging for patients to overcome.
Developed and strengthened collaborative relationships with hospital-based social workers, resulting in increased identification of patients who might benefit from this intervention

</td></tr>
<tr><td>Lessons Learned from the Intervention in FY 2019
Free Response, up to 1 Paragraph</td><td>

Understanding the initiative's impact on outcomes measures is important to Bridge leaders and staff; the "bigger picture" perspective brings everyone back to a common goal.
Educating providers about the availability of the Bridge team, and in-reaching patients in the acute care setting have both been valuable and will continue; though somewhat time-intensive, they lead to increased identification of patients.
As needed, Bridge team member provide valuable consults to medical and behavioral health providers throughout the care continuum, especially related to this population.
Expanding enrollment criteria to include additional zip codes increased referrals and enrollment; while the current focus is Medicare FFS, the Bridge team's model could serve patients across payors (some stakeholders have requested this).
There is a need for increased education and understanding of the behavioral health system of care as it relates to discharge planning.

</td></tr>
<tr><td>Next Steps for the Intervention in FY 2020
Free Response, up to 1 Paragraph</td><td>

With support from quality improvement analyst, identify and monitor outcome measures related to the Bridge team's work, including staff in the discussion (include CRISP pre/post reports).
In coordination with the JHH Department of Psychiatry, understand issues surrounding the ability to provide long-term injectable medications when indicated; as patients have increasingly expressed need for this, we will cultivate a deeper understanding of the issue to eventually develop a resolution across the continuum.

</td></tr>
<tr><td>Additional Free Response (Optional)</td><td>
<table>
<tr><th colspan="2">ROI (based on 6-month pre/post savings)</th></tr>
<tr><td>Average reduction in per member charges at 6 months from Pre/Post Reports in CRISP</td><td>$32,489</td></tr>
</table>
</td></tr>
</table>

	Per member reduction in charges discounted by 50% — $16,245 Members enrolled in Bridge — 34 Total cost of Bridge program (for 6 months) — $446,809/2 = $223,405 Total member savings at 6 months — $552,330 6 Month ROI — 1.47

Intervention Program 4: Convalescent Care

Intervention or Program Name	Convalescent Care
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	All
Brief description of the Intervention *2-3 sentences*	Convalescent Care provides people experiencing homelessness who are discharged from a hospital partner a place to stay, rest, and recuperate from an acute illness or surgery. On the Convalescent Care unit, patients receive 12-hour-a-day nursing services (medication education, care coordination, and wound care) and social work services (to link patients to housing resources, income, mental health, and addiction services).
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	Health Care for the Homeless

Patients Served *Please estimate using the Population category that best applies to the Intervention, from the CY 2018 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, 2019: 101
	Denominator of Eligible Patients: Total from RP Analytic Files: Out of a population of 74,445 individuals with Medicare FFS in the RP area, only those who are homeless and being discharged from the hospital are eligible for this intervention. The total referrals of individuals leaving the hospital in need of convalescent care were 375.
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 CCP patient panel contains 60 patients for the time period July 2018 through June 2019. In this summary, we use the CRISP pre/post data for the 42 patients with data for analysis 6 months before and after enrollment. Patients were not included in CRISP's reporting if they were enrolled less than 2 months, and/or their MRN was not able to be located in CRISP's system. The patients enrolled in the CCP intervention had $1,755,315 in total charges prior to enrollment and $1,066,882 after enrollment, showing a reduction of $688,433 over 6 months and an average decrease of $16,391 per patient. Reductions in costs were seen across partner hospitals (Johns Hopkins Hospital: 45% decrease, Johns Hopkins Bayview: 16% decrease, Mercy Medical Center: 45% decrease, MedStar Franklin Square: 54% decrease, Sinai Hospital: 88 % decrease), with the exception of MedStar Harbor Hospital, which had a $5,164 increase in total charges. The number of total visits increased slightly from 346 before enrollment to 364 after enrollment. This increase in visits was not significant, nor was it consistent across the hospital partners (Johns Hopkins Hospital: decrease from 173 to 169; Mercy Medical Center: increase from 70 to 90; Johns Hopkins Bayview Medical Center: increase from 71 to 76; MedStar Franklin Square: increase from 12 to 17). Please see Appendix B for Convalescent Care's 6 Month Pre/Post Analysis Report from CRISP.

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.

Convalescent Care Process Measure	Number
Total Number of Patients Referred	375
Total Number of Accepted Referrals	130
Total Number of Patients Presenting for Care	101
Average Number/percent of Beds Filled Monthly (out of 12)	11
Average Length of Stay per Month (days)	40
Number of Patients Who Saw a Primary Care Physician within 7 days of discharge from Convalescent Care	9
Number/Percent of Patients with Follow Up to Behavioral Health within 14 days of discharge from Convalescent Care	12
Number of Patients sent to ED from Health Care for the Homeless	21
Number of patients readmitted to Hospital from Health Care for the Homeless	24
Number of Patients Successfully Discharged from Unit	65

Successes of the Intervention in FY 2019
Free Response, up to 1 Paragraph

- Maintained 92% occupancy rate
- Completion rate of 65% for psychosocially complex patients

Lessons Learned from the Intervention in FY 2019
Free Response, up to 1 Paragraph

- Demand for this intervention was higher than supply of available beds; only about 1 out of every 4 referrals was accepted

Next Steps for the Intervention in FY 2020
Free Response, up to 1 Paragraph

- Development/planning for program expansion
- CCP has an opportunity to improve response time for their referral screening process; faster turnaround times can be especially important for this population

<table>
<tr><td></td><td>

- CCP has an opportunity to improve care continuity by providing clinicians tools and opportunities to connect more often and more efficiently

</td></tr>
<tr><td>Additional Free Response (Optional)</td><td>Given all 6 hospitals' support and enthusiasm for CCP's ability to meet patients' needs and to deliver high-quality care, CHPB leadership is devoted to scaling this intervention in FY20. CHPB leadership has asked HCH to develop plans and a timeline for expanding their capacity to enroll patients.

<table>
<tr><th colspan="2">ROI (based on 6-month pre/post savings)</th></tr>
<tr><td>Average reduction in per member charges at 6 months from Pre/Post Reports in CRISP</td><td>$18,504</td></tr>
<tr><td>Per member reduction in charges discounted by 50%</td><td>$9,252</td></tr>
<tr><td>Members enrolled in CCP</td><td>101</td></tr>
<tr><td>Total cost of CCP program – clinical services only (for 6 months)</td><td>$417,944/2 = $208,972</td></tr>
<tr><td>Total member savings at 6 months</td><td>$934,452</td></tr>
<tr><td>6 Month ROI</td><td>3.47</td></tr>
</table>
</td></tr>
</table>

Intervention Program 5: Neighborhood Navigators

Intervention or Program Name	Neighborhood Navigators
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	Johns Hopkins Hospital Johns Hopkins Bayview Medical Center MedStar Harbor Hospital
Brief description of the Intervention *2-3 sentences*	The Men and Families Center (MFC) in East Baltimore hires and trains Neighborhood Navigators and Case Coordinators. Neighborhood Navigators (NNs) are present in/around the 21205 zip code, serving people they encounter regardless of whether or not the individual's address is in 21205. The majority of their clients reside in the 21202, 21205, 21213, and 21231 zip codes. NNs engage them in discussions about available healthcare and social service resources that might help meet their needs. Case Coordinators (CCs),

<table>
<tr><td></td><td>located at MFC, are available to provide more direct assistance to clients (i.e.: helping them enroll in health insurance, helping them to find employment, etc.).</td></tr>
<tr><td>Participating Program Partners
Please list the relevant community-based organizations or provider groups, contractors, and/or public partners</td><td>The Men & Families Center
Matrix Ventures LLC</td></tr>
<tr><td rowspan="2">Patients Served
Please estimate using the Population category that best applies to the Intervention, from the CY 2018 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.</td><td># of Patients Served as of June 30, 2019:
3,848 patients served</td></tr>
<tr><td>Denominator of Eligible Patients: According to the American Community Survey, as of 2017, there were 14,766 individuals residing in the 21205 area where the Neighborhood Navigators were deployed. The eligible population could be much larger, given the NN serve any individuals in need of assistance who they encounter in 21205, regardless of address of residence.</td></tr>
<tr><td>Pre-Post Analysis for Intervention (optional)
If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.</td><td>N/A</td></tr>
<tr><td>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;</td><td>
<table>
<tr><th colspan="2">HSCRC FY19 NN MFC Summary 7/1/18 - 6/30/19</th></tr>
<tr><th>Neighborhood Navigator Process Measure</th><th>Number</th></tr>
<tr><td>Total number of clients served</td><td>3848</td></tr>
<tr><td>Average newly assessed per month</td><td>320</td></tr>
<tr><th>Identified Needs</th><th>7/1/2018 - 6/30/2019</th></tr>
<tr><td>Housing Services</td><td>1257</td></tr>
<tr><td>Employment and Training</td><td>1198</td></tr>
<tr><td>Uninsured</td><td>641</td></tr>
<tr><td>Utility Bills</td><td>535</td></tr>
<tr><td>Re-entry Services</td><td>381</td></tr>
</table>
</td></tr>
</table>

operationalized care teams; etc.

Dental Care	336
ID Services	287
Vision Care	198
Emergency Assistance	188
Transportation	131

The following table reports on the work of the Case Coordinators at MFC during quarter 4 of FY19. This is the first reportable quarter for this work, though the Case Coordinators have been with MFC since the start of the intervention. MFC will continue to collect/store data in this new data management system, making it easier to pull reports and monitor process measures in the future.

Services identified by Case Coordinators	4/1/19 - 6/30/19
Total # of CC Encounter Forms entered	142
Total # of clients (unique) serviced by CC who were referred by NN	88
Total # of Case Coordinators	2

Needs Addressed by Case Coordinators, after referred by NNs	4/1/19 - 6/30/19		
	Total number newly identified	Total number initiated support, regardless of identification date	Total number completed, regardless of identification date
Employment and Education	75	29	39
Housing Services	42	31	11
Utility Bills:	33	33	24
• Energy Assistance Applications	10	10	7
• Financial Assistance Applications	23	23	17
ID Services	10	10	10
Re-entry Services	11	6	5
Emergency Assistance	3	3	3
Disability Application	1	1	0
Find a doctor/making an appointment	1	1	1
Insurance Services	1	1	0
Medications	1	1	1
Substance Use	1	1	0

	Transportation | 1 | 1 | 1
Successes of the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	• During FY19 NNs made 4,320 total encounter contacts and 1,080 of these were follow-up contacts. • The holistic support provided by NNs and CCs at MFC helps people improve their family condition, which CHPB teams have witnessed over and over again in FY19. Refer to sample stories from NNs and CCs in Appendix A. • MFC was able to engage many family members of residents who initially sought support; the scope of their work radiates to friends and family when they see the ways they build trust and support residents
Lessons Learned from the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	• In FY19, MFC assisted many individuals in having their records expunged; they learned this can add $3000-$5000 more to individuals' annual salaries • NNs and CCs reported working with families seeking to move from renting to homeownership, which was largely spurred by the financial literacy classes taught at MFC; given the positive feedback of this program, they plan to encourage more residents to take advantage of the free classes • In FY19, NNs said they believed many of the residents they served would benefit from behavioral health services; NNs said that addressing these needs would reduce the frequency with which they seek assistance for issues such as eviction and inability to pay utility bills • Building trust with NNs through follow-up encounters increases their utilization of all services offered at MFC; follow-up encounters with NNs seem to positively impact individuals' health behavior change
Next Steps for the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	• Continue to seek opportunities to scale and spread the NN intervention, including identifying potential partners and sources of funding • Increase the use of REDCap software to capture how often and how long it takes to meet residents' needs after needs have been identified • With support from CHPB analysts, create a GeoMap of encounters using REDCap data to visualize needs
Additional Free Response (Optional)	The FY19 budget included funds to expand the NN intervention in and around MedStar's hospitals. This money was not spent because a suitable community partner could not be identified. The budget also included funds to expand the intervention in/around Bayview Hospital. A suitable community partner was identified, however leaders decided to not move forward given the regional partnerships would only be funded through FY20.

Intervention Program 6: Patient Engagement Program

Intervention or Program Name	Patient Engagement Program
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	All
Brief description of the Intervention *2-3 sentences*	The Patient Engagement Program (PEP) is a comprehensive, in-person, skills-based training program that teaches nurses, physicians, social workers, and other 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.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	Johns Hopkins Medicine
Patients Served *Please estimate using the Population category that best applies to the Intervention, from the CY 2018 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, 2019: This intervention does not directly serve patients, but rather CHPB and hospital partner staff. CHPB Interventions' Staff: 69 CHPB Hospital Partners' Staff: 127 • The Johns Hopkins Hospital (50) • Johns Hopkins Bayview Medical Center (40) • LifeBridge Sinai Hospital (8) • Mercy Medical Center (3) • MedStar Franklin Square Hospital/Harbor Hospital (26)
	Denominator of Eligible Patients: N/A
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file*	N/A

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.*	Staff were encouraged to fill out surveys before and after Patient Engagement Training sessions. Using this data, we assess the self-reported impact the training had on certain skills. Because not everyone filled out both pre- and post- surveys, there is missing data in the below summary. Among intervention staff (n = 69), a majority of the participants were female, and none were of Hispanic or Latino origin. Forty percent of the participants were African-American and 20% were White. In addition, 27.5% were between the ages of 25-34, 12.5% were between the ages of 35-44, and 11.3% were between the ages of 45-54. • Self-Efficacy: no meaningful improvement • Importance of using patient engagement skills: no meaningful improvement • How realistic is it to use patient engagement skills: meaningful improvement • Knowledge and Attitudes: meaningful improvement • Patient Engagement Skills: meaningful improvement • There was no significant difference in improvement for the groups that received the 4-hour booster training and the 8-hour training. • Participants are "highly satisfied" on all aspects of training Among hospital staff (n=129) who were training with online modules and a live workshop, participants reported being "highly satisfied" with all aspects of the training. • Self-Efficacy: no meaningful improvement • Knowledge and Attitudes: trend of improvement • Patient Engagement Skills: meaningful improvement
Successes of the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	• Developed and launched an e-learning curriculum that improves sustainability of PEP and decreases the time spent doing live training from 8 hours to 4 hours • All new CHPB staff and all staff who had not been trained in over a year attended a PEP live workshop • All staff who had been trained within FY18 were offered a PEP booster workshop • All CHPB Hospital Partners identified a team(s) who participated in PEP and are currently engaged in a maintenance program • Among CHPB intervention staff and hospital partners who were trained, we saw a consistent improvement in communication skills after training;

	staff were better equipped to engage patients in healthcare targeted goals as a result of the training

Lessons Learned from the Intervention in FY 2019
Free Response, up to 1 Paragraph
	• Initial enthusiasm for focusing on patient engagement is very high immediately after trainings; without participation in maintenance activities, it can be difficult to sustain
	• Building PEP into onboarding of new CHPB staff and re-training of existing staff is vital.
	• Involving leaders/managers in the trainings helps to continue enthusiasm for PEP.
	• Results seen here are similar to results found in FY2018 and consistent with results found in other groups:
	  ○ Trainees overestimate their skills and knowledge prior to training.
	  ○ Training improves communication skills, knowledge, and how realistic people believe it is to use in their daily work.
	  ○ Trainees enjoy the training and would recommend it to colleagues.
	  ○ Booster trainings are helpful to improve skills of people who have already been trained.
	• Moving from 8-hour live trainings to 4-hour live trainings + 2-hour modules are showing similar improvements in skills and knowledge

Next Steps for the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	• Moving into FY20, we will include a 2-hour booster offered 6 months after initial training • We plan to collect post-tests at multiple time points (3 months, 6 months, 12 months) to determine how communication skills and knowledge are maintained after the initial training. • We plan to customize PEP trainings to target improved success in enrolling patients into the partnership.
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 2018 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 2019 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 2018 -or- Analytic File: 'Charges' over 'Population' (Column E / Column C)	Using Medicare FFS population in the RP Analytic file, Charges over Population = $9,073.58 hospital charges per capita
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 2019 -or- Analytic File: 'IPObs24Visits' over 'Population' (Column G / Column C)	Using Medicare FFS population in the RP Analytic file, Hospital Discharges per 1000/population of Medicare FFS = 0.296
ED Visits per capita	**Ambulatory ED Visits per 1,000** Executive Dashboard: 'Regional Partnership per Capita Utilization' –	Using Medicare FFS population in the RP Analytic file, Hospital Discharges per 1000/population of Medicare FFS = 0.356

	Ambulatory ED Visits per 1,000, reported as average 12 months of FY 2019 -or- Analytic File 'ED Visits' over 'Population' (Column H / Column C)	

Quality Indicator Measures

Measure in RFP *(Table 1 in Appendix A of the RFP)*	**Measure for FY 2019 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 2019 -or- Analytic File: 'IP Readmit' over 'EligibleforReadmit' (Column J / Column I)	Using Medicare FFS population in the RP Analytic file, IP Readmissions/Number eligible for readmissions = 0.356
PAU	**Potentially Avoidable Utilization** Executive Dashboard: '[Partnership] Quality Indicators' – Potentially Avoidable Utilization, reported as **sum** of 12 months of FY 2019 -or- Analytic File: 'TotalPAUCharges' (Column K)	Using Medicare FFS population in the RP Analytic file PAU charges = $121,164,155.40

CRISP Key Indicators (Optional)

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

Measure in RFP *(Table 1 in Appendix A of the RFP)*	**Measure for FY 2019 Reporting**	**Outcomes(s)**
Portion of Target Population with Contact from Assigned Care Manager	**Potentially Avoidable Utilization** Executive Dashboard: 'High Needs Patients – CRISP Key Indicators' – % of patients with Case Manager (CM) recorded at CRISP, reported as average monthly % for most recent six months of data *May also include Rising Needs Patients, if applicable in Partnership.*	Not reported

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.

Return on Investment – (Optional)

Annual Cost per Patient as calculated by:

Total Patients Served (all interventions) / Total FY 2019 Expenditures (from FY 2019 budget report)

5,080 total patients served

Total FY2019 expenditures = $6,760,931

Using the formula above provides the per patient cost of the program. For more information on the ROIs for specific interventions, including cost-savings for patients served, please see the "Additional Information" sections in the program summaries above.

Conclusion

CHPB leadership looks forward to continuing program operations in FY20 in accordance with our original RFP submission. CHPB's operational plan has been updated slightly each year, but continues to offer the

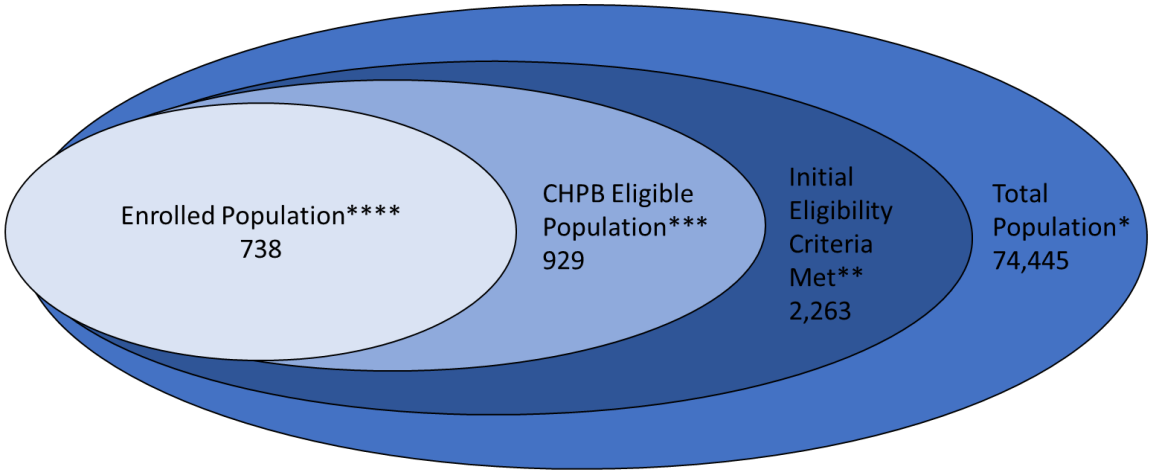
same set of interventions outlined in the original proposal. We continually examine and refine interventions to maximize efficiency and benefit to the patients and providers the partnership brings together. We are proud of the impact we are making in East Baltimore and look forward to continuing discussions about expanding our reach with partners in West Baltimore.

As of the end of FY19, we acknowledge that MedStar Harbor and MedStar Franklin Square hospitals no longer wish to participate in the regional partnership model. We have been fortunate to draw on their leadership and strong relationships in the community, and understand competing priorities at each hospital can cause shifts in focus and resources.

In the coming months, CHPB partners look forward to responding to HSCRC's opportunity to re-bid for new awards beginning in FY21. We are in the early stages of identifying best practices from current initiatives as well as speaking with other urban health systems about innovative models of care that have shown promise in addressing social needs for similar chronically complex patients. CHPB's partner hospitals and community-based organizations are united in our commitment to caring for the residents of Baltimore City, and look forward to upcoming discussions to continue this work with the HSCRC.

APPENDIX A

Diagram 1.0 Community Care Team Enrollment



*Total Population: From RP Analytic file, represents the total population of Medicare FFS in RP zip code area
**Patient Population: From RP Analytic file, represents individuals with Medicare FFS with 3+ Inpatient/Outpatient visits
***CHPB eligible population: Determined from CHPB data. Among those who met initial eligibility criteria, the CHPB applied further criteria, such as not deceased, not already in an active CM program, has valid contact information, lives in RP zip code area, etc. Many of the individuals in CRISP identified as "initially eligible" were deceased or otherwise not appropriate upon further review.
****Enrolled Population: Determined from CHPB data.Individuals who were outreached, determined to be eligible, and agreed to participate in the intervention

Table 1.0 Community Care Team Jobs Created

Position	Average Number of Positions
Community Health Worker	18.3
Community Health Worker Supervisor	2.0
Community Health Worker Administrator	0.5
Community Health Worker Program Manager	1.0
Community Health Worker Director	0.4
Care Manager	7.7
Care Manager Program Manager	1.0
Health Behavior Specialist	4.1
Health Behavior Specialist Lead	1.0

Senior Program Manager, Health Behavior Specialist	0.3
Medical Director	0.6
Clinical Nurse	0.3

Community Care Team Patient Stories

These stories paint a picture of the care team's commitment to getting to know their patients, and working tirelessly to help address the issues they're facing. Community Health Workers, Care Managers, and Health Behavior Specialists work collaboratively to provide wrap-around support to CHPB patients.

Story 1 – Scheduling and Attending a Patient's Appointment

A man in his 60s had recently visited the ED, complaining of shoulder pain. A CHW received a referral for him a few days later. The patient hadn't seen his primary care provider (PCP) in a while. The CHW was able to contact the provider's office and learned that the patient, did, in fact, have an appointment scheduled. The only issue was that it wasn't for 3 more months. The patient's shoulder pain was intense. The CHW was able to work with the office to schedule an appointment for the following week. The patient was thankful, and requested the CHW attend the appointment with him.

While waiting to be seen, the patient and CHW got to know each other. After a while, the CHW learned that, in addition to accessing care, he had additional social-related needs. The patient was enrolled in the Community Care Team intervention and began working with a Care Manager, in addition to maintaining strong ties to the CHW. The team has been able to connect him with a variety of resources in the city.

Story 2 – Scheduling and Attending a Patient's Appointment (patient's name has been changed)

Sitting down with her Community Health Worker (CHW), Wil, Ms. Johnson reflects on having several different health issues – diabetes, vertigo, back pain, and homelessness. Upon mentioning 'homelessness' she takes a long pause. Wil graciously affirms her noting that in the beginning, when she enrolled in the Community Care Team program, that there was a lot going on.

Upon enrollment in the Community Care Team Ms. Johnson entered into a partnership with Wil. Collaboratively Wil and Ms. Johnson discussed and identified her priorities for wellbeing: housing and removing herself from an abusive relationship.

Housing was a rollercoaster of emotion. There was lots of paperwork, identifying the right place and time to turn it in, then waiting. Then the paperwork would expire because it couldn't be processed in time by the housing authority or it would be misplaced and Ms. Johnson would complete the paperwork again. Ms. Johnson notes that it was very frustrating and how she leaned on Wil during this time. "I called you crying that I didn't even want the place anymore and that I was just going to find somewhere else to go. But you told me to just hang in there and let him do what you [Wil] do to get me into a home." A year later, Wil has assisted Ms. Johnson with acquiring the down payment, establishing

utilities, and navigating the order of steps needed to be taken to move into a new apartment. She is happily settling in, and in a new development which she calls "awesome!"

To reach these goals, Ms. Johnson and Wil developed plans of action (care plans) in order to accomplish her self-defined goals. Wil began to connect the dots of supportive services, community partners, and Ms. Johnson's own skills to seek resources that best fit her needs and readiness.

During this time, Ms. Johnson had several unexpected mental health crises requiring visits to the emergency department. These visits prompted support from a licensed clinical counselor who supported her through identifying the root causes of her stress – homelessness and intimate partner violence. The counselor, with Ms. Johnson's permission, looked for programs to support her leaving her relationship. Ultimately, Ms. Johnson was able to leave the abusive relationship and continued to work with the counselor in one-on-one sessions throughout her transition.

Ms. Johnson even referred her son to the program and he was able to talk with Wil about his own needs and goal establishing a continuum of care for Ms. Johnson's family. Unfortunately, violence killed Ms. Johnson's son as she was getting ready to move into her new home. Wil attended the memorial service because "…if you [Ms. Johnson] are going through something, I am going through something."

Ms. Johnson's partnership with Wil is based on trust built out of consistency. She admits to wanting to quit given the complex and barrier-ridden nature of the housing system, but she trusts Wil. His perseverance has modeled a skill that Ms. Johnson now embodies. She enrolled in a different kind of program, a medical technician training program at the Baltimore City Community College. Now a graduate of both the Community Care Team program and Baltimore City Community College, she affirms the value of the service provided by the Community Care Team, noting that the program offers support from the beginning to the end even when the pathway to the goals is not linear or immediately realized. From beginning to end, Ms. Johnson received and continues to utilize the following supports and services, which today, she coordinates for herself:

- Acquiring an emotionally supportive service animal
- Scheduling and utilizing mobility to travel to doctors' appointments
- Maintaining her household including rent, utilities, and other lifestyle supports

Table 2.0 Community Health Worker Referrals to External Organizations* for Support around Social Influencers of Health

Referral Type	Count of patients receiving referral
Food	41
Housing	32

Housing Services: Eviction Assistance, Housing Repair, Occupational Adjustments, Rental Assistance	6
Social Services	42
Transportation	204
Behavioral Health (Mental Health & Substance Use Disorder) & Treatment	4
Walk In Employment	2

*Community Health Workers at STAR are able to directly assist in addressing needs around social influencers. When they feel an external organization might be better equipped to serve the patient, they provide a warm hand-off and continue to follow the patient to ensure their needs are addressed.

Table 3.0 Community Health Worker Referral Organizations for Support around Social Influencers

Category	Organization
Food Assistance	Amazing Grace Church
	Baltimore Food Rescue
	Franciscan Center
	Meals on Wheels
	Moveable Feast
	Mt. Pleasant Food Pick Up
	New Life Pantry
	Salvation Army
	The Door
	Transforming Life Church of God
Housing	300 N Apartments
	Baltimore Housing Light Program
	Catholic Charities
	Daniel Allen Housing
	HUBS
	Lakewood Towers
	Light and Intake Assessment Unit
	Mount Clare
	Parkside Gardens Apartment
	Renaissance at Reservoir Hill
	Rescue Element Assisted Living
	Ruscombe Gardens Apartment
	STAR internal program referral
	SHARP-Leadenhall

	Skyline Properties
	The Chateau and River Apartments
	Weinberg Center/St. Ambrose
Housing Services: Eviction Assistance, Repair, Occupational Adjustments, Rental Assistance	USA Rehab
	AIDS Action of Baltimore City
	Baltimore City CAP Rental Assistance Program
	Franciscan Center
	Salvation Army
Social Services	Anne Arundel County Social Services
	Assurance Wireless
	Baltimore City Training Center
	Benefit Data Trust
	BP Trust
	Brothers of Boaz
	Caring Hands AMDC
	Center for Urban Families
	Department of Disability Services
	Detroit/Baltimore Water Program
	Department of Public Works
	Department of Social Services
	Energy Assistance
	Goodwill
	HUBS
	Living Classrooms
	Maryland Partnership
	Maryland Relay/Telecommunications Access
	MTA Mobility
	New Life Pantry
	SNAP Applications
	Payee Program
	Quit Now
	Safe Link Phone Application
	Social Security Administration
	Supplemental Insurance Help
	The Image Center of Maryland
	Veterans Affairs Pension Office
	Water Bill Reduction Assistance
	Zion Baptist Church Energy Services
Transportation	MTA Mobility
	New Life Pantry
	Safe Ride
	901 Broadway

Behavioral Health & SUD Treatment	Penn North
	Unlimited Bounds-Placed
Walk In Employment	Cups Coffee
	Living Classrooms

Table 4.0 Community Care Team Referral Organizations for Mental Health and/or Substance Use Support

Organization
Apex Counseling Center
Aspire Wellness
Baltimore Crisis Response
Baltimore Medical System Highlandtown
Bayview Community Psychiatry Program
Bayview Chemical Dependency Unit
Bayview Intensive Outpatient Program (IOPA)
Bridge Team
Center for Addiction Medicine (CAM)
Dundalk Counseling
Epilepsy Center
Faith Health Center
Franklin Square Outpatient Mental Health Clinic
Gilchrist
Harbor Outpatient Behavioral Health
Harbor Hospital Partial Hospital Program
Harford Bel Air Community Center
Harford Bel Air OMHC
Johns Hopkins Community Psychiatry Program
Johns Hopkins Sickle Cell Clinic
Key Point Health Services
Lincoln Trail Behavioral Health in Kentucky
Mosaic
National Pike Counseling
Pathways Counseling
Peace of Mind Counseling
Pro Bono Counseling
Roberta's House
Turning Point
Union Memorial Counseling Center
University of MD
1800-Quit-Now

Patient Stories from MFC Neighborhood Navigators and Case Coordinators

Story 1 - Helping Families One Generation at a Time (employment)

In winter 2019, a woman came into Men & Families Center (MFC) for help to find a job. She had been laid off the month before, and was struggling to support her family. Her mother, who had previously been helped by MFC for assistance getting her electricity turned back on, had recommended MFC.

The MFC case coordinator helped her begin the process to acquire a GED. Also, through relationships with local employers MFC was able to immediately connect her with a job, which she started right away. These local companies know that if MFC recommends a person for a job, they are "employment ready," and give them a chance to prove themselves.

With the new job, she was able to stay in her home, pay her bills, and support her family without the need for government assistance. She also sent her two teenage sons to the case coordinator; they, too, were connected with age-appropriate jobs and are now working part-time while attending school. By helping her grandmother with her electricity, MFC began a process that helped three generations of the same family to improve their lives and enhance the stability of their community.

Story 2 - Emergency Assistance & Beyond (housing)

In spring 2019, a MFC case coordinator received a call that someone needed help at 10:00pm. The client was referred by the Maryland States Attorney, the Baltimore Police Department, and the Mayor's Office of Human Services. The client had escaped a long-term domestic abuse situation; she was now hiding out and living in her car.

The case coordinator made an emergency placement into the Mayor's Shelter and imparted short-term financial assistance to get her through the first few days. Jane was immediately connected with behavioral health services and began therapy.

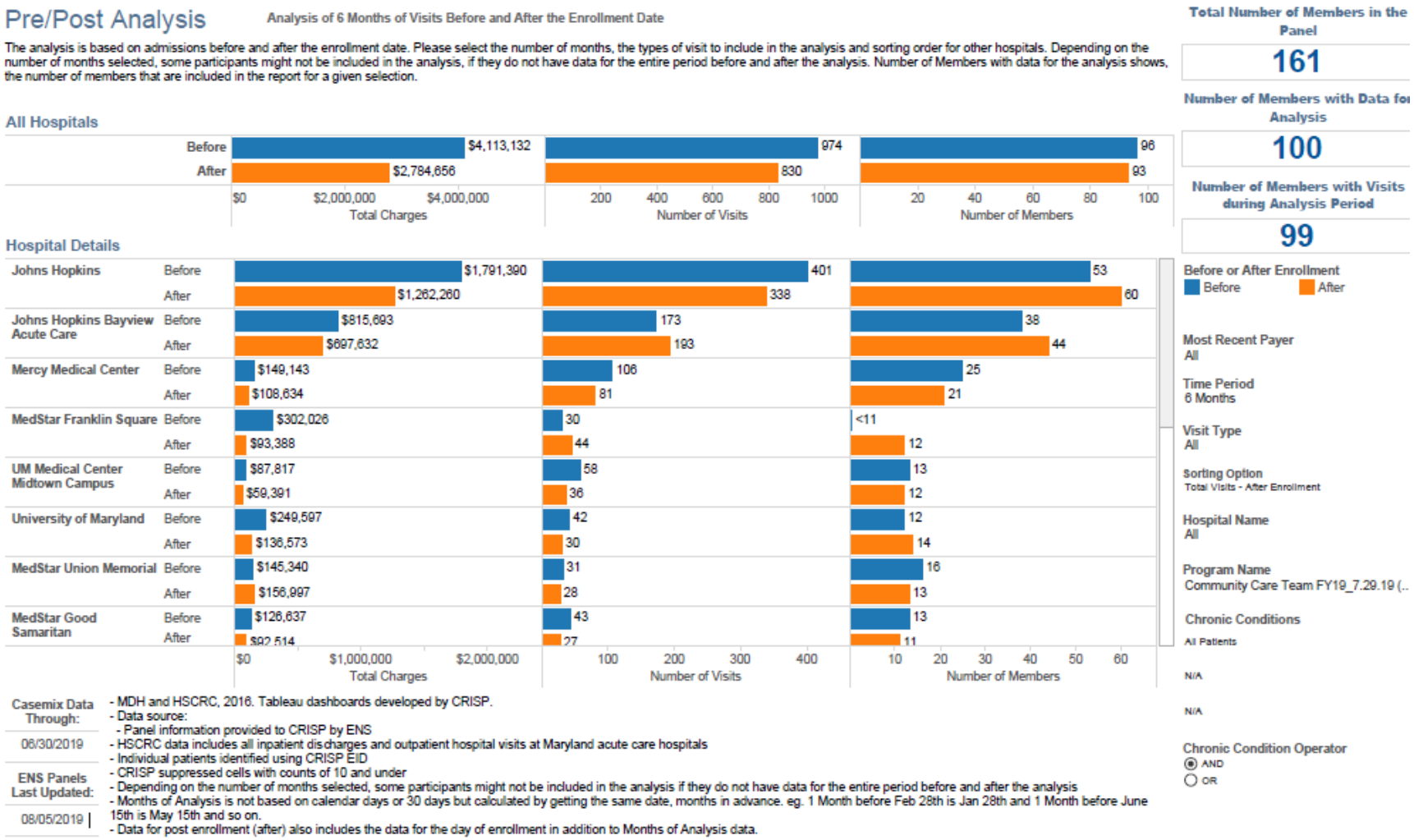
Due to MFC relationships with Baltimore landlords, within a week, permanent housing was found for her, and she was already moved in and could begin her new life. Jane was connected with a domestic abuse support group and has begun attending meetings, removing her from the feeling of isolation, and building the positive support she needs.

Story 3 - Neighborhood Navigator Connection to the Community through Family & Friends

Part of what makes Neighborhood Navigators effective are their local connections to reach neighbors, friends, and even family members who need help to overcome issues they're facing. Ida Hopkins is a Neighborhood Navigator who embodies this philosophy. Beyond those she connects with door-to-door, she has also referred 40 family members and 25 of her friends to MFC. They have received assistance with housing, energy restoration, water bill assistance, child support, record expungement, job placement, services for the blind, eviction prevention, domestic violence, community service hours, employment services, home improvement resources, and senior services.

MFC has been able to assist all the people Ida has referred and continues to receive referrals from her grandchildren. Many lives have been touched by Ms. Hopkins, an extraordinary Neighborhood Navigator.

APPENDIX B

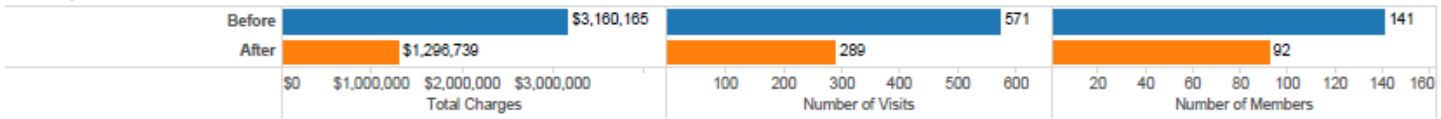

Pre/Post Analysis
Analysis of 6 Months of Visits Before and After the Enrollment Date
The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they do not have data for the entire period before and after the analysis. Number of Members with data for the analysis shows, the number of members that are included in the report for a given selection.
All Hospitals
Before
After
$4,113,132
$2,784,656
974
830
96
93
$0
$2,000,000
$4,000,000
Total Charges
200
400
600
800
1000
Number of Visits
20
40
60
80
100
Number of Members
Hospital Details
Johns Hopkins
Before
After
$1,791,390
$1,262,260
401
338
53
60
Johns Hopkins Bayview Acute Care
Before
After
$815,693
$697,632
173
193
38
44
Mercy Medical Center
Before
After
$149,143
$108,634
106
81
25
21
MedStar Franklin Square
Before
After
$302,026
$93,388
30
44
<11
12
UM Medical Center Midtown Campus
Before
After
$87,817
$59,391
58
36
13
12
University of Maryland
Before
After
$249,597
$136,573
42
30
12
14
MedStar Union Memorial
Before
After
$145,340
$156,997
31
28
16
13
MedStar Good Samaritan
Before
After
$126,637
$92,514
43
27
13
11
$0
$1,000,000
$2,000,000
Total Charges
100
200
300
400
Number of Visits
10
20
30
40
50
60
Number of Members
Casemix Data Through:
06/30/2019
ENS Panels Last Updated:
08/05/2019
- 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.
Total Number of Members in the Panel
161
Number of Members with Data for Analysis
100
Number of Members with Visits during Analysis Period
99
Before or After Enrollment
Before
After
Most Recent Payer
All
Time Period
6 Months
Visit Type
All
Sorting Option
Total Visits - After Enrollment
Hospital Name
All
Program Name
Community Care Team FY19_7.29.19 (..
Chronic Conditions
All Patients
N/A
N/A
Chronic Condition Operator
AND
OR

Pre/Post Analysis

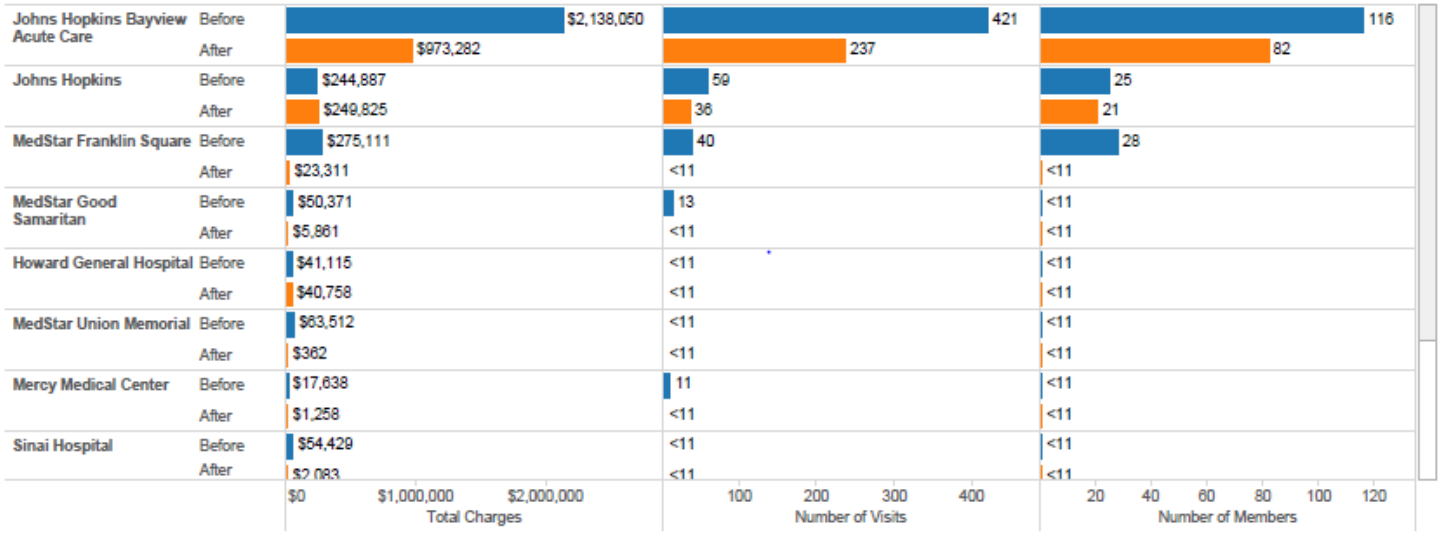
Analysis of 6 Months of Visits Before and After the Enrollment Date

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

All Hospitals



Hospital Details



Total Number of Members in the Panel
317

Number of Members with Data for Analysis
235

Number of Members with Visits during Analysis Period
150

Before or After Enrollment
Before After

Most Recent Payer
Medicare FFS

Time Period
6 Months

Visit Type
All

Sorting Option
Total Visits - After Enrollment

Hospital Name
All

Program Name
CHPB JHOME (210029)

Chronic Conditions
All Patients

N/A

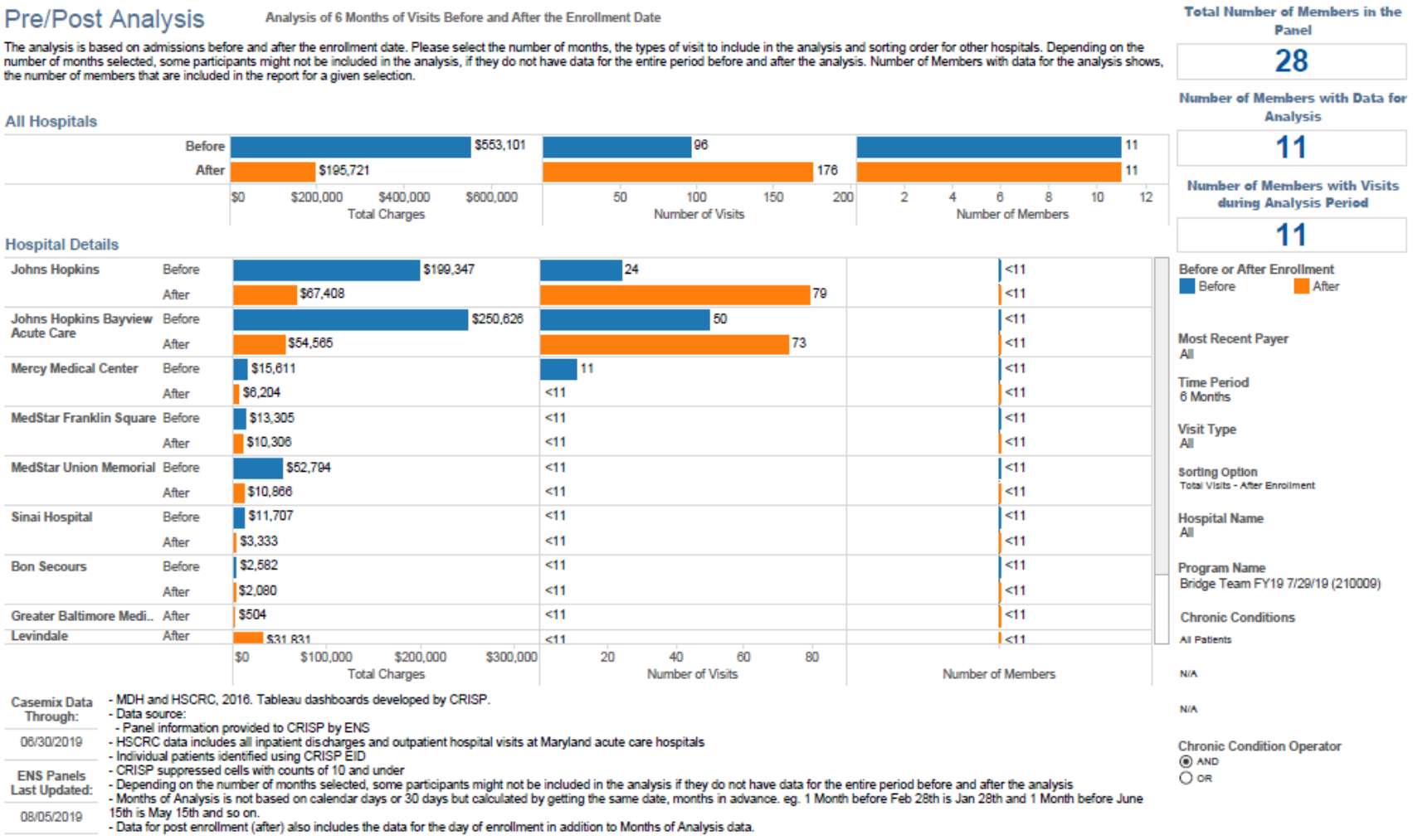
N/A

Chronic Condition Operator
(•) AND
( ) OR

Casemix Data Through:
06/30/2019

ENS Panels Last Updated:
08/05/2019

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

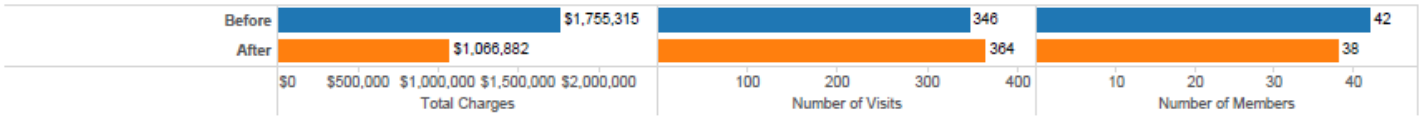

Pre/Post Analysis
Analysis of 6 Months of Visits Before and After the Enrollment Date
The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they do not have data for the entire period before and after the analysis. Number of Members with data for the analysis shows, the number of members that are included in the report for a given selection.
All Hospitals
Before
After
$553,101
$195,721
96
176
11
11
$0
$200,000
$400,000
$600,000
Total Charges
50
100
150
200
Number of Visits
2
4
6
8
10
12
Number of Members
Hospital Details
Johns Hopkins
Before
After
$199,347
$67,408
24
79
<11
Johns Hopkins Bayview Acute Care
Before
After
$250,626
$54,565
50
73
<11
Mercy Medical Center
Before
After
$15,611
$6,204
11
<11
<11
MedStar Franklin Square
Before
After
$13,305
$10,306
<11
<11
<11
MedStar Union Memorial
Before
After
$52,794
$10,866
<11
<11
<11
Sinai Hospital
Before
After
$11,707
$3,333
<11
<11
<11
Bon Secours
Before
After
$2,582
$2,080
<11
<11
<11
Greater Baltimore Medi..
After
$504
<11
<11
Levindale
After
$31,831
<11
<11
$0
$100,000
$200,000
$300,000
Total Charges
20
40
60
80
Number of Visits
Number of Members
Casemix Data Through:
06/30/2019
ENS Panels Last Updated:
08/05/2019
- 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.
Total Number of Members in the Panel
28
Number of Members with Data for Analysis
11
Number of Members with Visits during Analysis Period
11
Before or After Enrollment
Before
After
Most Recent Payer
All
Time Period
6 Months
Visit Type
All
Sorting Option
Total Visits - After Enrollment
Hospital Name
All
Program Name
Bridge Team FY19 7/29/19 (210009)
Chronic Conditions
All Patients
N/A
N/A
Chronic Condition Operator
AND
OR

Pre/Post Analysis

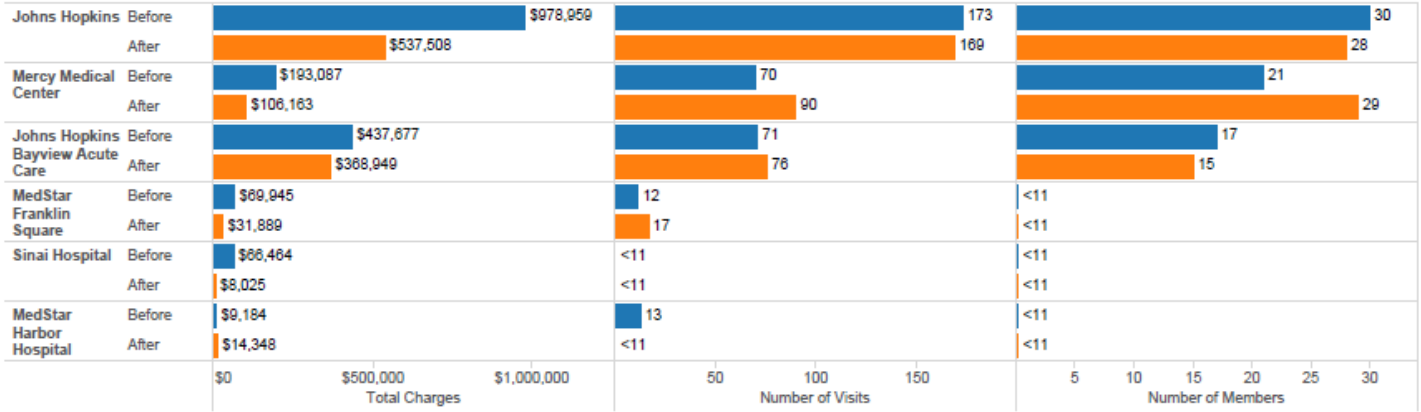
Analysis of 6 Months of Visits Before and After the Enrollment Date

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

All Hospitals



Hospital Details



Total Number of Members in the Panel
60

Number of Members with Data for Analysis
42

Number of Members with Visits during Analysis Period
42

Before or After Enrollment
Before
After

Most Recent Payer
All

Time Period
6 Months

Visit Type
All

Sorting Option
Total Visits - After Enrollment

Hospital Name
Multiple values

Program Name
CCP Cohort July18_April19 (92)

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

Casemix Data Through:
06/30/2019

ENS Panels Last Updated:
08/05/2019

- 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.