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	
RP Hospital(s)	CalvertHealth Medical Center
RP POC	Melissa Carnes, Grant Development Coordinator
RP Interventions in FY 2019	1
Total Budget in FY 2019 *This should equate to total FY 2017 award*	FY 2019 Award: $288,340
Total FTEs in FY 2019	Employed: 11
	Contracted: 1
Program Partners in FY 2019 *Please list any community-based organizations or provider groups, contractors, and/or public partners*	Calvert County Office on Aging Southern Pines Senior Center Calvert Pines Senior Center North Beach Senior Center CalvertHealth Medical Group Asbury Solomons World Gym Community Life Center of Southern Calvert County Calvert County Health Department Calvert County Health Ministry Network Team Silverwood Apartments Yardley Hill Housing Development Weis Pharmacy - Lusby Walmart Prince -Frederick Pharmacy Giant Pharmacy – Dunkirk Project Echo Homeless Shelter Calvert County Library – Prince Frederick Safe Nights Program

Overall Summary of Regional Partnership Activities in FY 2019

(Free Response: 1-3 Paragraphs):

CalvertHealth continues to reach the local Medicare, Medicaid and uninsured eligible target population to bring health and wellness services throughout Calvert County in an effort to meet the main principles of our Villages program: take the care where it is needed most, address locally identified needs, utilize available resources, expand a long-standing relationship with the local Office on Aging, build upon successful programs using engaged staff and volunteers and create a platform for growth of the program. Services continue to be delivered at the three Calvert County Office on Aging Senior Centers (located in north, central and southern Calvert) and partnerships continue with churches, food pantries, underserved neighborhoods and town centers. Program staff includes: social workers, registered nurses, dieticians, personal trainer, weight loss/diabetes counselors, a benefits/insurance counselor, a physician and a health care concierge (providing health risk assessments, screenings, and referrals for care coordination). In FY19, a total of 1,087 people were seen through the Villages program at the senior centers; an additional 649 people, age 50 and over, were served on the CalvertHealth Mobile Health Unit via 139 visits to other locations throughout Calvert.

Intervention Program

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

Intervention or Program Name	CalvertHealth Transformations Grant – It Takes a Village
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	CalvertHealth Medical Center
Brief description of the Intervention *2-3 sentences*	The It Takes a Village program continues to provide a diverse range of health services to each of the three Calvert County Senior Centers, as well as to local town centers and faith-based partnering organizations to bring needed health services to our targeted population aligned with our HSCRC grant. Program participants are referred to appropriate program partners, including providers and services available at CalvertHealth.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	Calvert County Office on Aging Southern Pines Senior Center Calvert Pines Senior Center North Beach Senior Center CalvertHealth Medical Group Asbury Solomons World Gym Community Life Center of Southern Calvert County

	Calvert County Health Department Calvert County Health Ministry Network Team Silverwood Apartments Yardley Hill Housing Development Weis Pharmacy - Lusby Walmart Prince -Frederick Pharmacy Giant Pharmacy – Dunkirk Project Echo Homeless Shelter Calvert County Library – Prince Frederick Safe Nights Program
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: 2,005
	Denominator of Eligible Patients: 10,055 (Source of denominator, as requested by HSCRC: RP Analytic file of 01Jan2018-31Dec18_yearly downloaded from CRISP on 09/10/2019; Medicare FFS; Column C-Population)
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	
Intervention-Specific Outcome or Process Measures (optional) *These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership maintains and uses to analyze performance.* *Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.*	**IT TAKES A VILLAGE PROGRAM STATISTICS** July 2018 – June 2019 Total number of people seen: 1,087 Number of locations served: 3 <u>Southern Pines Senior Center:</u> 319 Nurse – 152 Dietician – 127 Personal trainer – 30 Social worker – 12 <u>Calvert Pines Senior Center</u>: 253 Nurse – 93 Dietician – 131 Personal trainer – 25 Social worker - 4 <u>North Beach Senior Center:</u> 515 Nurse – 338

	Dietician – 150 Personal trainer – 24 Social worker – 3 Additionally, members of the target populations were seen on the CalvertHealth Mobile Health Unit throughout Calvert at partnering organizations, churches and businesses in an effort to avoid ED utilization and connect people needing care to physicians, specialists and local health resources. **COMMUNITY MOBILE HEALTH CENTER STATISTICS** July 2018 – June 2019 Number of locations served: 139 Number of community members served : 918 Male: 272 (over age 50 = 167) Female: 646 (over age 50 = 482) Total # of referrals issued: 86 Falls prevention education: 39 Outpatient rehabilitation: 11 PCP Office: 16 Dental Clinic : 39 Diabetes class: 6 Smoking cessation: 5 Urgent Care: 3 Behavioral Health Social Worker encounters: 3 Blood pressure screenings: 339 Health Risk Assessments: 23 Resource information: 12 Flu vaccines: 151 Pneumonia vaccines: 32 Glucometers given: 15 Benefits enrollment: 1 Skin cancer screenings: 58 Lung cancer screenings: 19 Dental screenings: 157 Hepatitis A vaccines: 3 Dietary supplement presentation: 59
Successes of the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	Development of a community coordination care team and continuum of care for Diabetes in collaboration with Calvert County Health Department, Office on Aging , CalvertHealth Medical Center (Calvert Cares and Ask The Experts) and Faith based organizations; offering evidenced based self-management programs as well as hospital based programs

	and navigating participants to programs based upon their readiness to learn; provided low cost, no commitment fitness membership through World Gym to provide access to physical activity to help with weight loss and reduce complications of diabetes; provided free glucose meters and taught participants how to utilize them to monitor blood glucose and reinforced important of maintaining glycemic control; added Rock Steady to Functionally Fit component and World Gym partner provided low cost matinee gum membership for care takers and Parkinson participant to use fitness facility as they improved their fitness condition.
Lessons Learned from the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	IT continues to be a challenge to implement with multiple reporting system to coordinate such as: State BCC grant database, Meditech, EQHealth, CRISP and Conifer system data mapping, exporting data and enrollment of participants was a barrier and would suggest expanding CRISP platform to include community participation data. This also impacted ability to implement Nurse Information Line due to inability to document (however the population targeted for the nurse info line was served in a face-to-face strategy which proved effective.) State regulated health awareness testing continued to be a challenge to get approved due to competing priorities. Finding a part-time NP provider was a major barrier and had to be innovative utilizing other models to deliver services. Increasing our partnership with other community and health care professionals allowed us to reach more individuals for a more diverse variety of health and wellness services. Flu clinics at the food pantries were a huge success and in FY20, 3 out of the 4 pantries will sponsor these vaccinations for those with no insurance - partnerships with local pharmacies expanded beyond medication management to include flu and pneumonia vaccinations were important since our local health department is no longer offer flu clinics to the general public.
Next Steps for the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	For FY20, our goals are: (1) to get the cholestech and glucometer up and running on the mobile health unit, (2) to partner with all food pantries for the flu vaccination program for those with no insurance coverage and (3) to complete IT installation on the mobile unit and work with IS to get a documentation platform built in Meditech for seamless use with people receiving care on the unit.
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)	Charges: $75,794,836.84 Population: 10,055 Charges per capita: $7,538.02 Source: CY 2018 RP Analytic File
Total Hospital Discharges per capita	**Total Discharges per 1,000** Executive Dashboard: 'Regional Partnership per Capita Utilization' – Hospital Discharges per 1,000, reported as average 12 months of FY 2019 -or- Analytic File: 'IPObs24Visits' over 'Population' (Column G / Column C)	Inpatient/OBS Visits: 3,140 Population: 10,055 Discharges per 1,000: 312.28 Source: CY 2018 RP Analytic File
ED Visits per capita	**Ambulatory ED Visits per 1,000** Executive Dashboard: 'Regional Partnership per Capita Utilization' – Ambulatory ED Visits per 1,000, reported as average 12 months of FY 2019	ED Visits: 5,140 Population: 10,055 ED visits per 1,000: 511.18 Source: CY 2018 RP Analytic File

	-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)	Inpatient Readmits: 309 Eligible for readmit: 2189 Readmission Rate: 14.11% Source: CY 2018 RP Analytic File
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)	Total PAU Charges: $10,618,873.79 Source: CY 2018 RP Analytic File

CRISP Key Indicators (Optional)

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

Measure in RFP *(Table 1 in Appendix A of the RFP)*	**Measure for FY 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.*	June 2019: 36.9% May 2019: 39.6% April 2019: 38.1% March 2019: 36.0% February 2019: 36.8% January 2019: 35.0% Average: 37.1% Source: Executive Dashboard for Regional Partnerships

Self-Reported Process Measures

Please describe any partnership-level process measures that your RP may be tracking but are not currently captured under the Executive Dashboard. Some examples are shared care plans, health risk assessments, patients with a 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.

Within each geographic areas (northern, central and southern) exist a community coordination care team which includes health care professionals such as a Registered Nurse, Registered Dietitian, Social Worker, Community Health Workers, Personal Trainers as well as community based resources provided by non-profits to meet the needs of that community and to handle program tracking, navigation, referrals and "care plans" which are kept within each respective organization. We have built capacity within each geographic area to assist with expanding the network of support to assist with caring for the target population. The unifying factors for each geographic location are the healthcare professionals and Mobile Health Center contained in this grant. Once a centralized data collection tool is developed and implemented with unified care plans, additional outcome measures can be collected.

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)

2,005 patients / $512,652 (with carryover funding from previous years)

2,005 patients / $288,340 (without carryover funding from previous years)

Conclusion

Please include any additional information you wish to share here. As a reminder, Commissioners are interested in tying RP annual activities to the activities initially proposed in the RFP. Free Response, 1-3 Paragraphs.

Reaching the target population at the senior centers, a key element of the Villages grant program since inception, has been an instrumental factor in our program's success to date. Although we do not "only" serve the target population at the local senior centers (we have expanded our reach to other areas in need in our county), we have had success in bringing services throughout our county to serve the health needs of the community as we work to prevent re-admissions and avoid misuse of the ED.

One of our many success stories includes:

- We navigated a homeless man to the Calvert Community Dental Care clinic in southern Calvert County. We saw him several times for blood pressure monitoring as well. The client had issues with drugs and alcohol and due to those issues had been incarcerated numerous times and homeless many times. We had the Hepatitis A vaccine on the mobile unit, due to a partnership with the Calvert County Health Department, and the client met criteria to receive the vaccine - he was offered the vaccine and accepted (and was educated on getting the second dose in 6 months.) We continued to see client on a monthly basis at the same location. He gave us updates about getting into the Dental Clinic – his dental issues were resolved, his oral health has improved, and we were able to work with him to get his blood pressure under control.
- We provided a glucometer to a client whose own glucometer had stopped working and she did not have the money to buy a new one. She had not checked her blood sugar in several days and has a known diagnosis of Type II diabetes and cancer. She was instructed on the proper use of our glucometer - her blood sugar was taken and the result was 388. We were able to navigate her to free program partners to help control her diabetes (at no cost to her).