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	Greater Baltimore Medical Center
RP Hospital(s)	Greater Baltimore Medical Center
RP POC	Sarah Fogler, Senior Director of Population Health
RP Interventions in FY 2019	Expansion and Management of Chronic Conditions Through Improved Integration of Mental Health Services, Palliative Care Services, and Care Coordination
Total Budget in FY 2019 *This should equate to total FY 2017 award*	FY 2019 Award: $1,692,105
Total FTEs in FY 2019	Employed: 13
	Contracted: 11
Program Partners in FY 2019 *Please list any community-based organizations or provider groups, contractors, and/or public partners*	Sheppard Pratt Health System; Mosaic Community Services; Gilchrist; Baltimore County Health Department; GBMC's Post-Acute Care Network; St. Joseph Medical Center; Lorien at Home; Notre Dame; Brick Bodies; Catholic Charities; John's Hopkins

Overall Summary of Regional Partnership Activities in FY 2019

(Free Response: 1-3 Paragraphs):

The Behavioral Health Enhanced Patient-Centered Medical Home (BHE-PCMH) – This initiative builds upon the patient-centered medical home model operating in GBMC's primary care practices by embedding mental health professionals in the practices. In partnership with Sheppard Pratt, mental health professionals are embedded in the GBMC primary care practices, which provides for ready access to behavioral health consultants and psychiatric consultation services. The initiative also integrates behavioral health resources into the inpatient setting by providing psychiatric consultation and post-

discharge mental health and community linkage support.

Palliative Care and Elder Medical Care (formerly Support Our Elders) – This initiative is supported by a strong partnership between Gilchrist and MedStar, where patients with advanced and complex chronic disease are provided with clinical and social support in their homes, whether in independent living or in a facility-based environment. This program also provides clinical staff for palliative care efforts in 2 nursing homes within the services area.

Expansion of Care Coordination and Care Management Services – This initiative supports both inpatient and ambulatory care management services. The inpatient care management focus is on high-utilizer patients and preventing unnecessary inpatient admissions. The ambulatory care management focus is on preventative health care, care management and coordination, and population health management within GBMC's employed primary care practices. Efforts have emphasized helping patients achieve and maintain better health with tactics in place to reduce avoidable hospital utilization, eliminate gaps in care for routine screenings, and improve quality outcomes for patients with chronic conditions.

Intervention Program

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

Intervention or Program Name	Expansion and Management of Chronic Conditions Through Improved Integration of Behavioral Health Services
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	Greater Baltimore Medical Center
Brief description of the Intervention *2-3 sentences*	Mental health professionals are embedded in GBMC primary care practices to provide screening, short-term intervention, and ongoing counseling/behavioral management. Specialty outpatient psychiatric services and consultation services are provided at GBMC's medical homes and psychiatrists also provide evaluations on inpatient and ER patients and provide post-discharge mental health support (time-limited services). Finally, patients are referred to community based programs and services for longer-term support.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	Sheppard Pratt Health System; Mosaic community services
Patients Served *Please estimate using the Population category that best applies to the*	Numerator, # of Patients Served as of June 30, 2019: 2,682 Over 6,000 patient visits with behavioral health consultants;

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.*	more than 500 visits with psychiatry; and nearly 200 patient visits with a substance abuse consultant.
	Denominator, # of Eligible Patients: Nearly 54,000 patients screened for depression (measure specification aligned with Medicare Shared Savings Program quality measure PREV-12), anxiety (GAD-7), and/or substance use (NIDA).
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	See Appendix A.
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.*	Outcomes measures (other than the pre-/post-analysis) include: • More than 50,000 unique patients screened using NIDA; more than 13,600 unique patients screened using PHQ-9; and more than 21,500 patients screened using GAD-7 s • Using the Active patient registry, patients have experienced a 43% reduction in anxiety scores and a 27% reduction in depression scores.
Successes of the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	Successes in FY 2019 include: additional practice sites eligible for behavioral health services including aligned Maryland Primary Care Program practices, Complex Care, and Pediatrics; an increase in the volume of behavioral health and psychiatry referrals and visits; an increase in the rate of screening and a reduction in patient depression and anxiety; reduced inpatient, ED, and observation stay cost and utilization; increased awareness and adoption of the program among primary care and specialty providers, patients, and the community; and the successful launch of new behavioral health tracking registry available through the organization's electronic medical record.
Lessons Learned from the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	Lessons learned in FY 2019 include: gaining a better understanding of how to obtain primary care and specialty provider buy-in to the program; refining the practice workflows and scheduling to ensure increased access to the embedded mental health professionals; the need for

	improved predictive analytics to proactively identify patients that could benefit from behavioral/mental health referral, consultation, and treatment; and the utility of "huddling" with the practice care team on potential and current behavioral health patients.
Next Steps for the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	Next steps in FY 2020 include: continued focus on increasing referrals and completed visits, given there is a no-show rate of 8.4 % for behavioral health appointments and no-show rate of 12 % for psychiatry appointments; implementation of the SBIRT protocol and continued refinement of practice workflows to ensure that behavioral health embedded staff are truly integrated into the practice locations and can actively participate in the care team huddles; and, an increased sophistication in behavioral health predictive analytics and capitalizing on the patient targeting approach introduced in FY 2019.
Additional Free Response (Optional)	

Intervention or Program Name	Expansion and Management of Chronic Conditions Through Palliative Services and Elder Medical Care
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	Greater Baltimore Medical Center
Brief description of the Intervention *2-3 sentences*	GBMC's Gilchrist Services, in partnership with MedStar's Total Elder Care (TEC) program, has expanded the program Elder Medical Care (formerly Support Our Elders). Medicare patients who are unable to make frequent visits to the primary care physician are currently supported at home by a rounding interdisciplinary team including physicians, nurse practitioners, social workers, and administrative coordinators who can care for complex chronic conditions within the patient's home. Gilchrist Services has also expanded the palliative care program in partnership with area nursing homes, which provides palliative services by a nurse practitioner to

	better manage symptoms and discuss patient care plans.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	• Allegeant • Baltimore County Health Department • Care Progress, LLC • Catholic Charities • Evergreen Health • Health Care for All Coalition • Keswick Multi-Care Center • MedStar • Notre Dame School of Pharmacy • Lorien at Home • Diamond Lab Services
Patients Served *Please estimate using the Population category that best applies to the Intervention, from the CY 2017 RP Analytic Files.* *HSCRC acknowledges that the High Utilizer/Rising Risk or Payer designations may over-state the population, or may not entirely represent this intervention's targeted population.* *Feel free to **also** include your partnership's denominator.*	# of Patients Served as of June 30, 2019: 550 patients
	Denominator of Eligible Patients: More than 14,000 Medicare beneficiaries
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	See Appendix B.
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.	
Successes of the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	The Elder Medical Care Home Services program continued to experience growth with an overall rate of 25% in our average daily census during FY 2019. The program also continued to expand the ancillary services available to our patients who worked collaboratively the primary care providers. These additional services include: lab services, behavioral health professionals, Community Service Coordinators and interventions by pharmacists on a case by case basis which enabled the team to provide even more clinical interventions in the home setting.
Lessons Learned from the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	The ongoing lesson identified during FY 2019 continues to be highlighting the partnership needed from the primary care providers in the community to assist with transition or co-management of their patients. The existing primary care providers are pivotal in initiating referrals and working with the patients/families to establish rapport with the Elder Medical Care Home Services team. This could also enable referrals to the program to be made earlier in the progression of the disease state as the patients and their caregivers are initially experiencing issues with getting in to see their primary care providers versus once they have been homebound for a significant period of time.
Next Steps for the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	In FY 2020, the Elder Medical Care Home Services program will continue to work on refinement of the referral process, data collection, analysis of trends, and how best to utilize our program to meet the needs and requests of our partners and the communities they live in along with expanding clinical capabilities.
Additional Free Response (Optional)	

Intervention or Program Name	Expansion and Management of Chronic Conditions Through Care Coordination

RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	Greater Baltimore Medical Center
Brief description of the Intervention *2-3 sentences*	GBMC has been working to expand its hospital-based care management function to focus on high-utilizer patients and preventing unnecessary inpatient admissions. Additionally, care management/coordination support is fully integrated in all 10 of the GBMC employed primary care practices. Through the addition of an inpatient case manager for high-utilizers, as well as additional care coordination staff in each primary care practice, the team works with patients proactively to meet their individual needs, in an effort to avoid unnecessary emergency department use, inpatient hospital admissions, and/or avoidable readmissions.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	
Patients Served *Please estimate using the Population category that best applies to the Intervention, from the CY 2017 RP Analytic Files.* *HSCRC acknowledges that the High Utilizer/Rising Risk or Payer designations may over-state the population, or may not entirely represent this intervention's targeted population.* *Feel free to **also** include your partnership's denominator.*	# of Patients Served as of June 30, 2019: 13,125 (as defined by the number of unique ambulatory patient care management touches)
	Denominator of Eligible Patients: More than 14,500 Medicare beneficiaries
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	See Appendix C (for early results associated with the Complex Care Clinic)
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.*	Process measures include: • Increase in colon cancer screening rates from 65% to 70% • Increase in breast cancer screening rates from 71% to 76% • Reduction in patients with uncontrolled diabetes (A1c greater than 9) from 27% down to 20%.

Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.	• More than 12,200 transition of care calls were made by the care management team, which include medication reconciliation, follow-up appointment scheduling, etc. • Successful bi-directional integration with CRISP where panels are submitted and ENS notifications are received daily for care team follow-up. • In the inpatient setting, GBMC has experienced a total of 357 "Great Saves" in the ED due to case management intervention.
Successes of the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	Successes in FY 2019 include: improved quality of care as evidenced by steady improvement in key clinical quality measures including: an improved promotion of health and wellness as evidenced by demonstrated reductions in gaps in care; development of a targeted care management approach on high-risk and clinically complex patients; the launch of a Complex Care Clinic to focus on high-intensity, and in many cases high-utilizing patients; and EMR development enabling cross-continuum and cross-system communication on high-utilizers.
Lessons Learned from the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	Lessons learned in FY 2019 include: a need for increased attention on inpatient utilization to ensure the total cost of care goals are met through, in part, GBMC's advanced primary care/care management efforts; challenges associated with needing to refine existing workflows while also launching new workflows in support of the MDPCP (e.g. social determinants of health, clinical care pathways for diabetes and hypertension, and SBIRT); challenges integrating a cross-continuum approach to care management of GBMC patients.
Next Steps for the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	Next steps in 2020 include: Launch new, and strengthen existing workflows, required by the MDPCP (e.g., pharmacy integration, coordinated referral management, etc.); ensure limited care management resources are brought to bear on patients in most need of intervention; integrate cross-continuum care steps into developed clinical care pathways.
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)	Regional Partnership per Capita Utilization' – Hospital Charges per Capita CY18: $321 hospital charges per capita FY19: $324 hospital charges per capita Data Used from: Executive Dashboard for Regional Partnerships for FY19 (July 2018 – June 2019) and also run for CY18 (Jan 2018 0 Dec 2019)
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)	Regional Partnership per Capita Utilization' – Hospital Discharges per 1,000, reported as average 12 months of FY 2019 10 hospital discharges per 1000 Data Used from: Executive Dashboard for Regional Partnerships for FY19 (July 2018 – June 2019)
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	Regional Partnership per Capita Utilization' – Ambulatory ED Visits per 1,000, reported as average 12 months of FY 2019 35 outpatient ED visits per 1000

	-or- Analytic File 'ED Visits' over 'Population' (Column H / Column C)	Data Used from: Executive Dashboard for Regional Partnerships for FY19 (July 2018 – June 2019)

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)	[Partnership] Quality Indicators' – Unadjusted Readmission Rate by Hospital, reported as average 12 months of FY 2019 11.9% unadjusted readmission rate Data Used from: Executive Dashboard for Regional Partnerships for FY19 (July 2018 – June 2019)
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)	'[Partnership] Quality Indicators' – Potentially Avoidable Utilization, reported as **sum** of 12 months of FY 2019 $23,200,301 potentially avoidable utilization Data Used from: Executive Dashboard for Regional Partnerships for FY19 (July 2018 – June 2019)

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.*	% of patients with Case Manager (CM) recorded at CRISP, reported as average monthly % for most recent six months of data 21.85%

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)

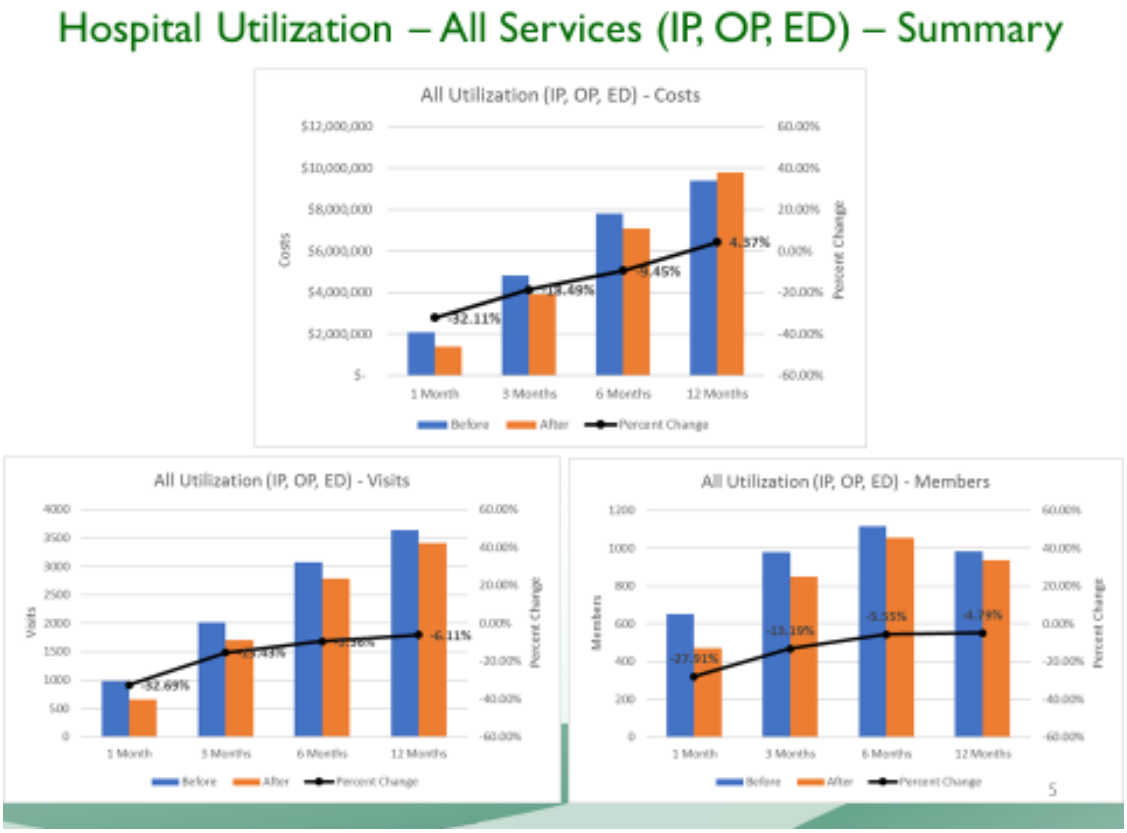
Annual Cost per Patient as calculated by:

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

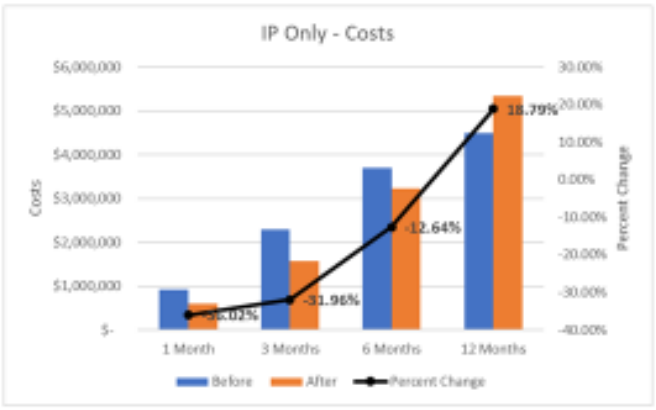
Conclusion

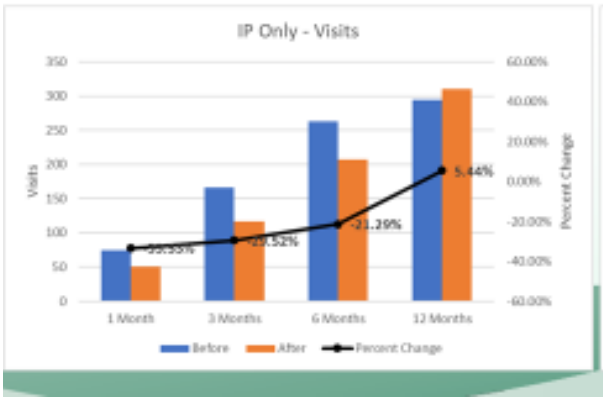
Please include any additional information you wish to share here. As a reminder, Commissioners are interested in tying RP annual activities to the activities initially proposed in the RFP. Free Response, 1-3 Paragraphs.

Appendix A. Pre-/Post-Analysis on Expansion and Management of Chronic Conditions Through Improved Integration of Behavioral Health Services

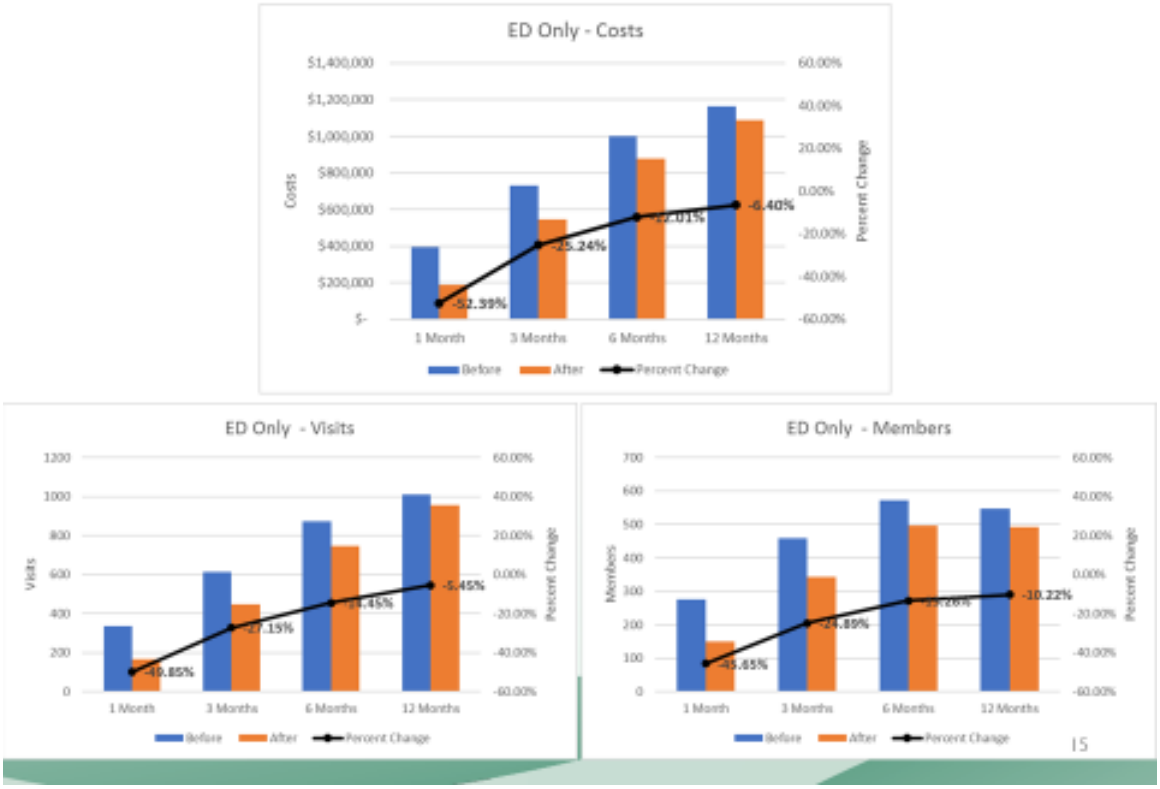


Hospital Utilization – Inpatient Only – Summary



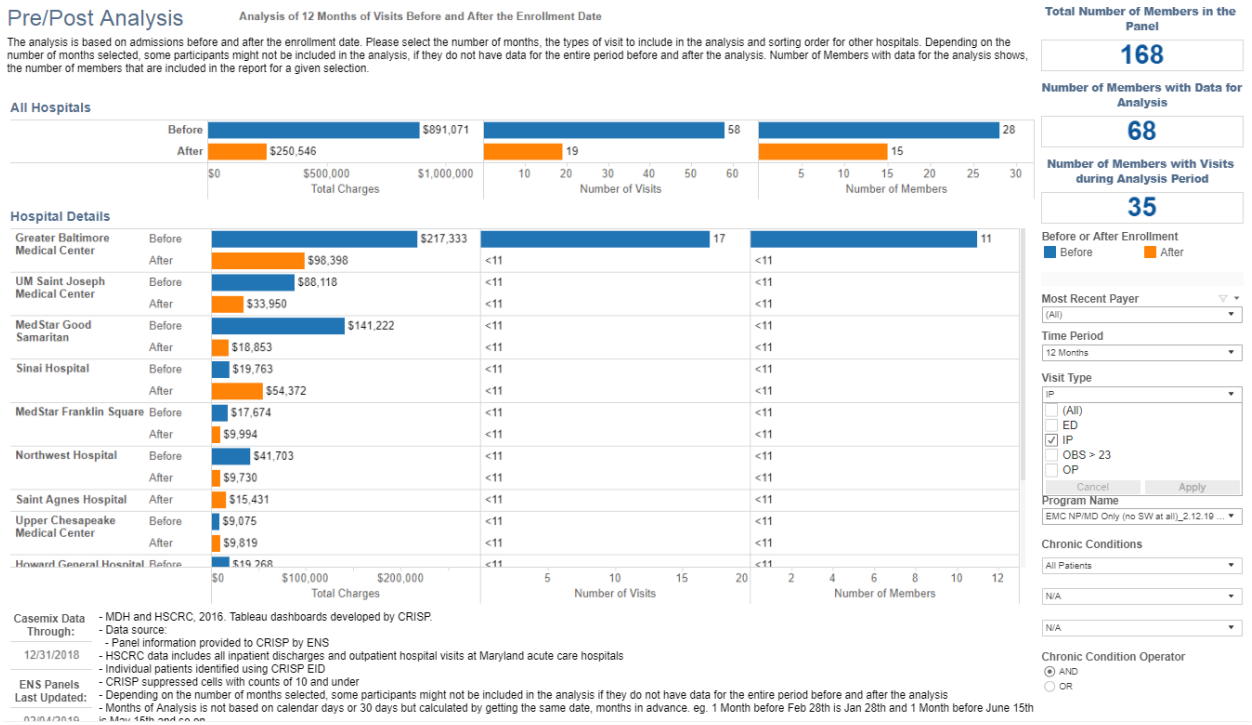


Hospital Utilization – ED Only – Summary

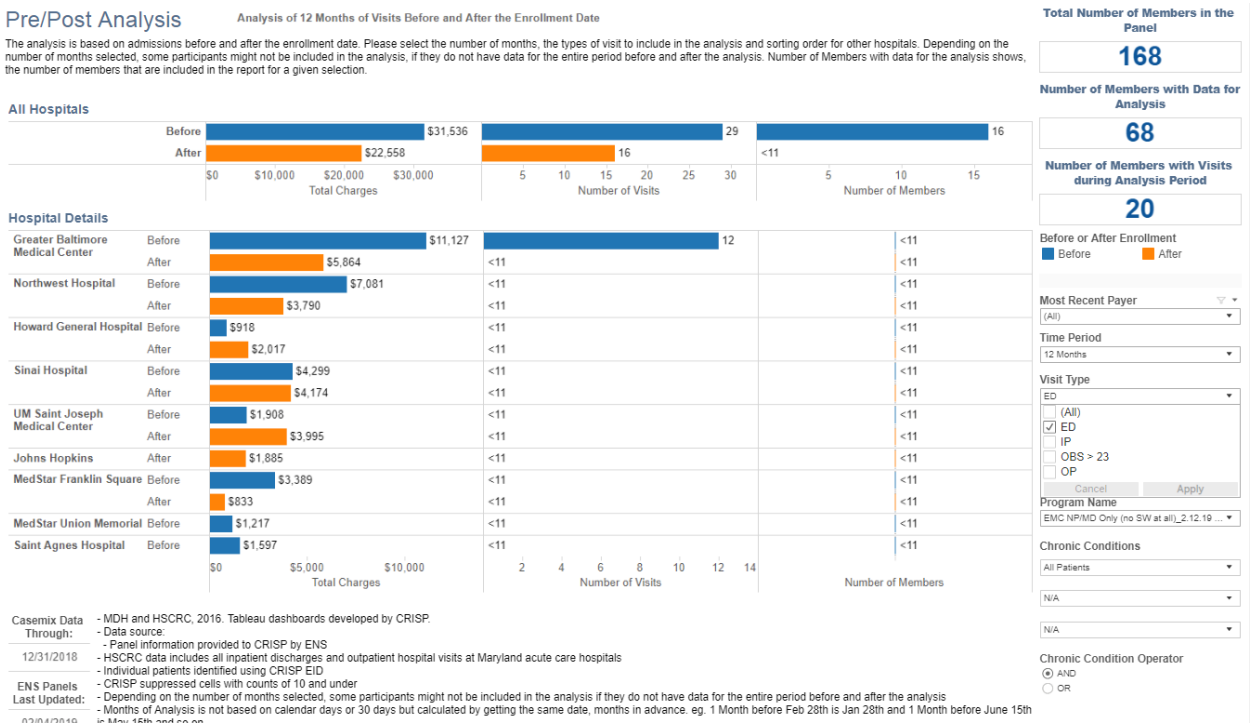


Appendix B. Pre/Post Analysis on Expansion and Management of Chronic Conditions Through Palliative Services and Elder Medical Care

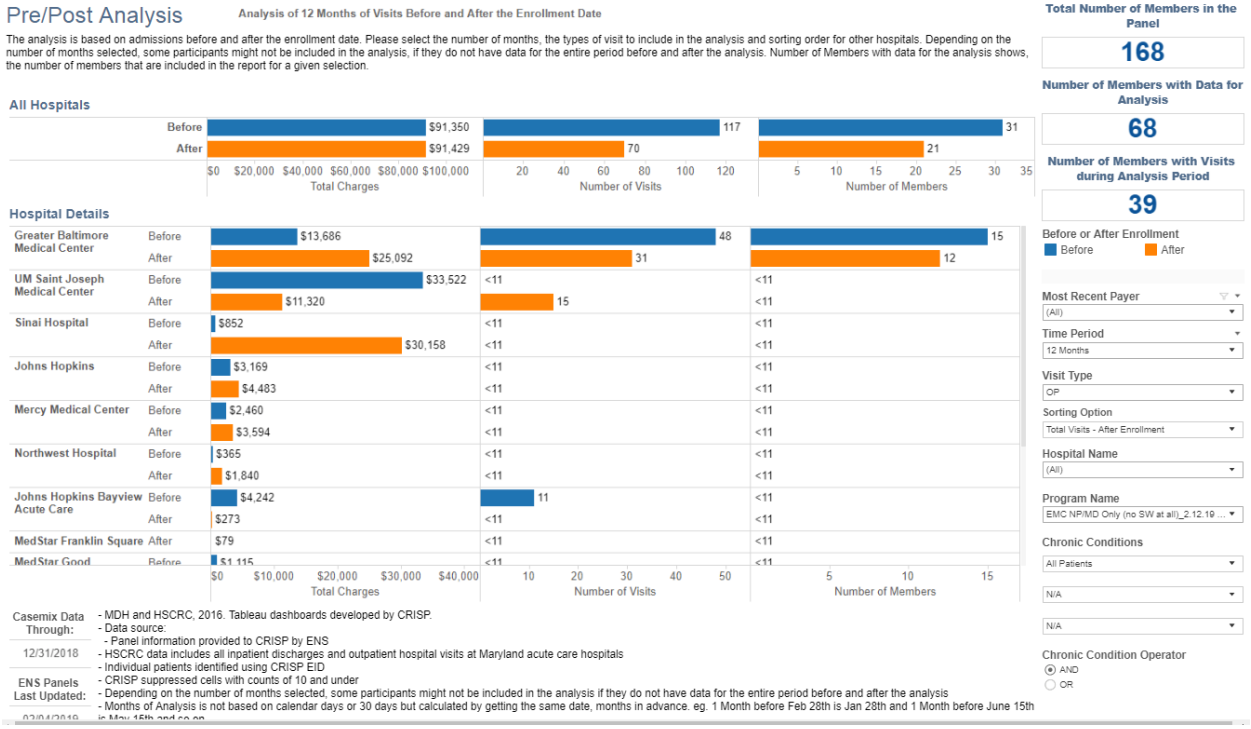
Inpatient – 12 Months



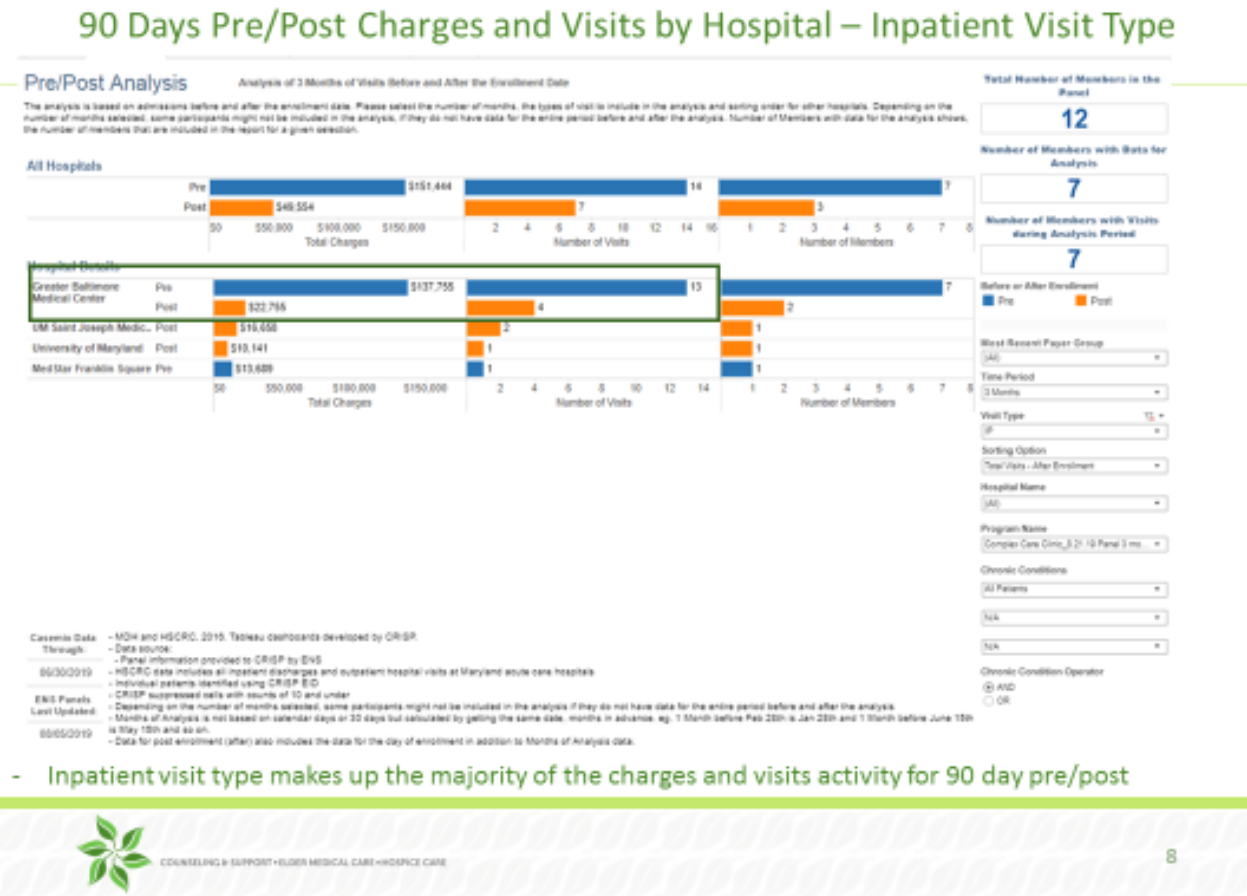
Emergency Department – 12 Months



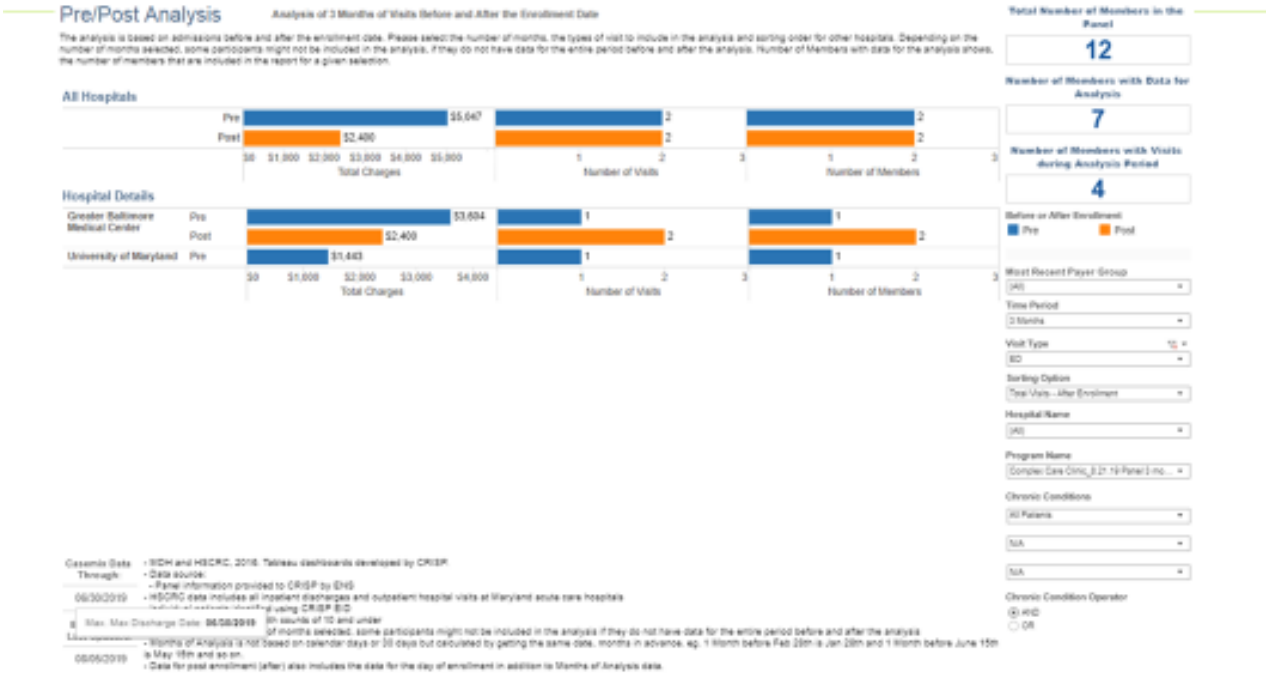
Outpatient – 12 Months



Appendix C. Pre/Post Analysis on Expansion and Management of Chronic Conditions Through Care Coordination, Complex Care Clinic



90 Days Pre/Post Charges and Visits by Hospital – ED Visit Type



- Since only 7 patients can contribute to a 90 days pre/post, minimal ED activity at this time