

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	Howard Health Partnership (HHP)
RP Hospital(s)	Howard County General Hospital (HCGH)
RP POC	Tracy Novak, Director of Population Health; phone 410-720-8762; email tnovak2@jhmi.edu
RP Interventions in FY 2019	<ol style="list-style-type: none"> 1. Community Care Team (CCT) 2. Elder Medical Care 3. Remote Patient Monitoring (RPM) 4. Behavioral Health Rapid Access Program (RAP) 5. Journey to Better Health (J2BH) 6. Behavioral Health Navigators 7. Advance Care Planning 8. Educational Resources/Classes
Total Budget in FY 2019 <i>This should equate to total FY 2017 award</i>	FY 2019 Award: \$1,174,606 awarded (20% less than FY17)
Total FTEs in FY 2019	Employed: 15.95 FTE
	Contracted: 0
Program Partners in FY 2019 <i>Please list any community-based organizations or provider groups, contractors, and/or public partners</i>	Berkeley Research Group, LLC; CRISP; Cardiovascular Specialists of Central Maryland; Centennial Medical Group; Columbia Medical Practice; Ellicott City Healthcare; 24 faith-based organizations; Foreign-Born Information and Referral Network (FIRN); Gilchrist Services; Horizon Foundation; Howard County Health Department; Howard County Local Health Improvement Coalition (LHIC); Howard County Office on Aging and Independence; Johns Hopkins Community Physicians; Johns Hopkins Home Care Group; Johns Hopkins Medicine; Johns Hopkins University; Lorien Health Systems; Maryland Primary Care Physicians; Dr. Scott Maurer’s practice; Way Station Inc.

Overall Summary of Regional Partnership Activities in FY 2019

(Free Response: 1-3 Paragraphs):

The Howard Health Partnership (HHP) had a very successful year and engaged over **4,700** patients across its interventions and classes, recognizing some people may have participated in more than one. Our Community Care Team (CCT) and the Journey to Better Health Program were selected by The Daily Record as a 2019 Healthcare Heroes in the Community Outreach category for their impact on the Howard County residents they serve. Dan Demmitt, a CCT Community Health Worker, received the 2019 Patient Experience Award for Positive Patient Experience from Howard County General Hospital. Dan was commended for the “exemplary care” that he provides to patients and families.

We found opportunities to leverage and promote HHP’s infrastructure for other Total Cost of Care initiatives. For example, we formed close partnerships with multiple Accountable Care Organizations (ACOs) across our market to assist with their Care Transformation Organization’s (CTO) application for the Maryland Primary Care Program. Via subcontracts with at least one CTO, we will dedicate CCT staff to several practices for care management services to attributed beneficiaries as well as providing other HHP wrap-around interventions/services. In January, we met with public health officials from Korea to present the impact of HHP interventions on residents of Howard County. We discussed how we utilize community health workers and partner with faith-based organizations to improve chronic disease self-management and decrease utilization of hospital emergency departments and inpatient days. We also worked collaboratively with the Health Department and Howard County Department of Fire and Rescue Services to develop a funding proposal for a multi-tiered intervention that would, in part, utilize CCT to reduce EMS high utilizers for consideration by Howard County government.

Members of the HHP governance structure remain very engaged. The HHP Provider Alignment Workgroup collaborated to create service level agreements focused on cardiology to clarify expectations across primary care, specialty care, emergency department (ED) and hospital-based staff. The HHP Skilled Nursing Facility (SNF) Collaborative developed a 24-hour SNF contact call list for ED staff to contact when questions arise in an effort to reduce admissions. We coordinated time for ED leadership to tour SNFs so they understand their diagnostic capabilities with the goal of reducing testing in the ED.

Intervention Program 1: Community Care Team (CCT)

Intervention or Program Name	Community Care Team (CCT) <i>(Includes Embedded Community Health Worker in the hospital)</i>
RP Hospitals Participating in Intervention	Howard County General Hospital
Brief description of the Intervention <i>2-3 sentences</i>	The Howard County Community Care Team (CCT) serves adult Howard County residents who have Medicare or are dually eligible with Medicaid who have had two or more encounters (inpatient, emergency or observation) at HCGH within the past year. Patients and their caregivers receive program benefits for

	<p>30-90 days by a multi-disciplinary team that provides home-based care coordination services. Community health workers (CHW), nurses and a social worker deliver services including health education, disease-specific management, medication reconciliation, connection to and coordination with health care providers, and extensive social support and advocacy with linkages to appropriate community resources. A CHW is embedded in the hospital to visit patients’ bedsides in order to enroll them in the program.</p>
<p>Participating Program Partners <i>Please list the relevant community-based organizations or provider groups, contractors, and/or public partners</i></p>	<p>CRISP; Centennial Medical Group; Columbia Medical Practice; FIRN; Gilchrist Services; Howard County Health Department; Howard County - Local Health Improvement Coalition (LHIC); Johns Hopkins Community Physicians (Howard County locations); Johns Hopkins Home Care Group; Johns Hopkins Medicine; Maryland Primary Care Physicians; Dr. Scott Maurer’s practice.</p>
<p>Patients Served <i>Please estimate using the Population category that best applies to the Intervention, from the CY 2018 RP Analytic Files.</i> <i>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.</i> <i>Feel free to also include your partnership’s denominator.</i></p>	<p># of Patients Served as of June 30, 2019: 359 enrolled, 639 eligible referred</p> <hr/> <p>Denominator of Eligible Patients: 39,112 - Medicare FFS</p> <p>Alternative Denominator: 3,332 - This is the number of eligible patients who meet the RP criteria of 1) Howard County Resident, 2) Medicare or Dual-Eligible, 3) 2 or more HCGH encounters (ED/IP/Obs stay) in CY2018.</p>
<p>Pre-Post Analysis for Intervention (optional) <i>If available, RPs may submit a screenshot or other file format of the Intervention’s Pre-Post Analysis.</i></p>	<p>Pre-post analyses are included as an attachment on pages 18-21.</p>
<p>Intervention-Specific Outcome or Process Measures (optional) <i>These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership maintains and uses to analyze performance.</i> <i>Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.</i></p>	<ol style="list-style-type: none"> 1. Acceptance Rate: 50% 2. Graduation Rate: 87% 3. 30 Day All-Cause readmission rate: 12.3% <p><i>Note: Readmission data are preliminary and partial year due to CRISP data run-out.</i></p>

<p>Successes of the Intervention in FY 2019 <i>Free Response, up to 1 Paragraph</i></p>	<p>A Difference in Differences Analysis showed enrollment in CCT is associated with decreased hospital charges per patient at 1, 3 and 12 months post-enrollment in the program. Patients enrolled in CCT cost an average of \$12,414 less per patient over 12 months. Enrollment in CCT is associated with a short-term increase in hospital visits (2% at 3 months) but a longer-term decrease in hospital visits (-6.3% at 12 months).</p>
<p>Lessons Learned from the Intervention in FY 2019 <i>Free Response, up to 1 Paragraph</i></p>	<p>Acceptance rates increased as outreach staff gained more experience and used refined clinical screening criteria (for example, outreaching patients who were likely to benefit from care coordination).</p>
<p>Next Steps for the Intervention in FY 2020 <i>Free Response, up to 1 Paragraph</i></p>	<p>CCT will continue to provide care coordination services for several Care Transformation Organizations (CTOs) under the MDPCP.</p>
<p>Additional Free Response (Optional)</p>	<p>To enhance the efficacy and efficiency of the CCT program, care management staff used supportive tools including CRISP, CAREAPP (a resource database and bidirectional referral system) and HALO Communications (a secure text messaging service offered by CRISP).</p>

Intervention Program 2: Elder Medical Care

<p>Intervention or Program Name</p>	<p>Elder Medical Care</p>
<p>RP Hospitals Participating in Intervention</p>	<p>Howard County General Hospital</p>
<p>Brief description of the Intervention <i>2-3 sentences</i></p>	<p>Provided through Gilchrist Services, the program is led by a physician, Certified Registered Nurse Practitioner (CRNP) in collaboration with a social worker to provide in-home medical care for homebound elderly with advanced illnesses or conditions. It offers guidance on advance care planning and navigating the health care system as well as emotional support, education on living with serious illness and respite for caregivers.</p>
<p>Participating Program Partners</p>	<p>Gilchrist Services</p>
<p>Patients Served</p>	<p># of Patients Served as of June 30, 2019: FY19: 63 Denominator of Eligible Patients: 39,112 (Medicare FFS)</p>
<p>Pre-Post Analysis for Intervention (optional)</p>	<p>Pre-post analyses are included as an attachment on pages 22-25.</p>

Intervention-Specific Outcome or Process Measures (optional)	30 Day All-Cause Readmission rate: 14.4% <i>Note: Readmission data are preliminary and partial year due to CRISP data run-out.</i>
Successes of the Intervention in FY 2019	The Elder Medical Care program continued to expand ancillary services available to patients who worked collaboratively with primary care providers, including lab services, behavioral health professionals, Community Service Coordinators and pharmacists. This enabled the team to provide even more clinical interventions in the home setting.
Lessons Learned from the Intervention in FY 2019	One of the ongoing lessons continued to be the partnership needed from the primary care providers in the community to assist with transition or co-management of their patients. The providers are pivotal in initiating referrals and working with the patients/families to establish rapport with the Elder Medical Care team. This could also enable referrals to the program to be made earlier in the progression of the disease state when patients and their caregivers are initially experiencing issues with getting in to see their PCP's instead of after they are homebound.
Next Steps for the Intervention in FY 2020	HHP leadership is partnering with the Johns Hopkins Home Care Group to bring a new home-based primary care model named JHOME to Howard County. This model will be integrated with the CCT to provide longitudinal services. Patients at or nearing the point of palliative care will continue to be referred to Gilchrist's Elder Medical Care program.
Additional Free Response (Optional)	Elder Medical Care is funded by Gilchrist Services.

Intervention Program 3: Remote Patient Monitoring (RPM)

Intervention or Program Name	Remote Patient Monitoring (RPM)
RP Hospitals Participating in Intervention	Howard County General Hospital
Brief description of the Intervention	Home-based program for patients with heart failure, COPD or diabetes with daily monitoring by RN of biometric & symptom data. This allows for immediate feedback to patient and care team as needed, and provides an opportunity for disease education. The nurse monitors data and interacts with patient and care team.

Participating Program Partners	Johns Hopkins Home Care Group
Patients Served	# of Patients Served as of June 30, 2019: 114 Denominator of Eligible Patients: 39,112 (Medicare FFS) Alternative denominator: 680 patients - number of HCGH Medicare/Dually eligible for Medicaid patients with an inpatient stay for CHF or COPD in FY18.
Pre-Post Analysis for Intervention (optional)	Pre-post analyses are included as an attachment on pages 26-29.
Intervention-Specific Outcome or Process Measures (optional)	30 Day All-Cause Readmission rate: 14.8% <i>Note: Readmission data are preliminary and partial year due to CRISP data run-out. Data for RPM only available for patients enrolled through Q3 of FY19.</i>
Successes of the Intervention in FY 2019	Program leadership expanded the program to include diabetes. Ongoing collaboration with CCT, inpatient teams at HCGH and the Patient Access Line (PAL) nurses helped to encourage RPM referrals throughout the year.
Lessons Learned from the Intervention in FY 2019 <i>Free Response, up to 1 Paragraph</i>	Given the dynamic nature of discharge planning, ongoing education and in-person visits are necessary to keep RPM “top of mind” for case management, hospitalists, and home care coordinators. When physicians speak with their patients at the bedside prior to discharge, there is an increase acceptance rate of RPM post-discharge.
Next Steps for the Intervention in FY 2020	Maximize referrals to RPM, especially for patients discharged with CHF and stroke.
Additional Free Response (Optional)	None

Intervention Program 4: Behavioral Health Rapid Access Program (RAP)

Intervention or Program Name	Behavioral Health Rapid Access Program (RAP)
RP Hospitals Participating in Intervention	Howard County General Hospital
Brief description of the Intervention	RAP provides access to urgent, outpatient, crisis stabilization services within two business days of referral for adults (18 years and older) who present in the ED, on the inpatient psychiatric unit or on a medical unit and are in need of immediate access to

	<p>varying levels of psychiatric treatment. The service links patients to the level and type of care needed to prevent further emotional distress and decompensation that would otherwise result in accessing more acute levels of care. Services are provided through Way Station, a subsidiary of Sheppard Pratt at the Columbia, Maryland site. Patients are able to receive up to 9 treatment sessions that include prescriber and therapy, regardless of their ability to pay. Way Station assists patients who need a higher level of outpatient care or treatment beyond the 9 sessions provided through RAP.</p>
Participating Program Partners	Way Station, Inc.; Grassroots Crisis Intervention Center
Patients Served	<p># of Patients Served as of June 30, 2019: 429 Referrals, 222 Enrollees</p> <p>Denominator of Eligible Patients: 384,210 - All Payer</p> <p>Alternative denominator: 2,778 - number of HCGH ED Patients receiving behavioral health treatment in the ED.</p>
Pre-Post Analysis for Intervention (optional)	Pre-post analyses are included as an attachment on pages 30-33.
Intervention-Specific Outcome or Process Measures (optional)	<p>% who attend first appointment: 52%</p> <p>30 Day All-Cause Readmission rate: 2.7%</p> <p><i>Note: Readmission data are preliminary and partial year due to CRISP data run-out.</i></p>
Successes of the Intervention in FY 2019	The collaboration and effective communication between the hospital and Way Station has allowed for adapting the program to best meet the needs of the patients. Timely linkages to psychiatric care for patients discharged from the hospital through the use of a cloud-based scheduling system allows appointments to be scheduled 24 hours a day by hospital staff with Way Station, improving transitions for patients from the hospital to care in the community.
Lessons Learned from the Intervention in FY 2019	There are often barriers for patients connecting with outpatient mental health services in the community following a hospital visit. It is important that both the referring and receiving agencies facilitate a smooth transition of care and follow up with patients who do not attend the outpatient appointment.
Next Steps for the Intervention in FY 2020	HCGH will use Behavioral Health Navigators to engage patients prior to their discharge from the hospital and support their participation in outpatient therapy by addressing any barriers to

	care and offering encouragement. The receiving agency will provide phone calls to patients that did not attend their initial appointment and work with them to reschedule.
Additional Free Response (Optional)	RAP is funded by HCGH.

Intervention Program 5: Journey to Better Health (J2BH)

Intervention or Program Name	Journey to Better Health (J2BH)
RP Hospitals Participating in Intervention	Howard County General Hospital
Brief description of the Intervention	<p>The Journey to Better Health (J2BH) program works with Howard County faith-based organizations to support the health of their members. J2BH offers chronic disease prevention and management strategies to their members tailored to their needs. Program strategies include:</p> <ul style="list-style-type: none"> ● Chronic Disease Screenings and Education: Conduct screenings for hypertension, obesity and pre-diabetes and classes on chronic disease self-management within the congregations. Class offerings include Living Well with Chronic Disease, Living Healthy with Hypertension, Living Well with Diabetes, Cancer Self-Management, and Mental Health First Aid Training. ● Volunteer Support for significant health events: Offer access to the Member Care Support Network (MCSN) which aims to pair members with trained volunteer Community Companions.
Participating Program Partners	Abiding Savior Lutheran Church; Atholton Seventh Day Adventist Church; Bethany Church; Bethany United Methodist; Bridgeway Community Church; Celebration Church; Christ Memorial Presbyterian Church; Church of the Resurrection; First Baptist Church of Guilford; Glen Mar United Methodist Church; Iglesias De Dios Pentecostal; New Hope Adventist Church; North American Division Seventh-day Adventist Church; Oneness Ministries; St John Baptist Church; St. John the Evangelist Roman Catholic Church
Patients Served	<p># of Patients Served as of June 30, 2019: FY19: 1,034</p> <p>Denominator of Eligible Patients: 384,210</p>
Pre-Post Analysis for Intervention (optional)	None – Due to the nature of this program, not all participants are hospital patients. We therefore cannot perform a Pre/Post Analysis with CRISP data.

<p>Intervention-Specific Outcome or Process Measures (optional)</p>	<ol style="list-style-type: none"> 1. Total number of congregations: 24 2. J2BH Participation Satisfaction Rate: 100% 3. Number of people screened: 823 4. Member Care Support Network members: 240 5. New Member Care Support Network volunteers trained: 32
<p>Successes of the Intervention in FY 2019</p>	<p>J2BH continued to increase its capacity in FY19 by holding more health care events, screening and educating more participants, and training more volunteers. On June 27th J2BH received The Daily Record’s 2019 Health Care Heroes award for Community Outreach and Education. J2BH was highlighted during Howard County Health Officer’s quarterly “The Doctor Is In” podcast where our program coordinator shared details about the program and how to get involved.</p>
<p>Lessons Learned from the Intervention in FY 2019</p>	<p>A minimum of 25 volunteers is needed to support 250 members however volunteer turnover continues to be a challenge. As volunteers move out of state, get new jobs and go on to higher education institutions, the need for more volunteers continues to be a top priority for the J2BH Member Care Support Network. For the future, we will work closely with the hospital’s Marketing team to explore new opportunities for volunteer recruitment.</p>
<p>Next Steps for the Intervention in FY 2020</p>	<p>HCGH is currently seeking to hire a Director of Spiritual Care who will support J2BH with community faith outreach and engagement of clergy leadership. HCGH’s Population Health Department has restructured its Health Promotion division and will use the foundational infrastructure of the J2BH program to deliver services (events, screenings, classes, MCSN) beyond faith-based organizations to meet the needs of Howard County residents.</p>
<p>Additional Free Response (Optional)</p>	<p>J2BH serves a population broader than the HHP target, meaning all residents of Howard County. It is funded by the Howard County Health Department.</p>

Intervention Program 6: Behavioral Health Navigators (BHN)

<p>Intervention or Program Name</p>	<p>Behavioral Health Navigators (BHN)</p>
<p>RP Hospitals Participating in Intervention</p>	<p>Howard County General Hospital</p>
<p>Brief description of the Intervention</p>	<p>As patients with behavioral health issues (diagnosed mental illness and/or substance use disorder) enter the hospital’s ED, Behavioral Health Navigators (BHNs) assist by providing information and make connections to community resources with the goal of successfully engaging them in treatment. This includes referrals and linkages to mental health treatment, substance use treatment, support groups and housing programs. BHN</p>

	services consist of a screening that identifies non-medical needs, completing referrals, assistance with scheduling post discharge mental health or drug treatment appointments, and follow up phone calls within 48 hours of discharge from the ED to ensure linkages have successfully occurred.
Participating Program Partners	Howard County Government.
Patients Served	# of Patients Served starting January 1 thru as of June 30, 2019: 316
	Denominator of Eligible Patients: 384,210 Alternative denominator: 2,778 - number of HCGH ED Patients receiving behavioral health treatment in the ED.
Pre-Post Analysis for Intervention (optional)	Pre-post analyses are included as an attachment on pages 34-37.
Intervention-Specific Outcome or Process Measures (optional)	None
Successes of the Intervention in FY 2019	The BHNs have assisted with bed placement at inpatient psychiatric facilities, which has had a positive impact on patient throughput at HCGH.
Lessons Learned from the Intervention in FY 2019	The importance of fostering connections with community providers creates strong partnerships that result in smoother/more efficient transitions for HCGH psychiatric patients. Face-to-face presentations have served to increase awareness of the BHN program and ensure success.
Next Steps for the Intervention in FY 2020	There are cases where patients who are appropriate for BHN intervention are not referred by social/psych evaluators, our goal for FY20 is to every patient who gets discharged from the psych ED is connected with a BHN to ensure follow up post-discharge.
Additional Free Response (Optional)	Funding is provided by the Howard County Government.

Intervention Program 7: Advance Care Planning (ACP)

Intervention or Program Name	Advance Care Planning
RP Hospitals Participating in Intervention	Howard County General Hospital

Brief description of the Intervention	An Advance Care Planning Coordinator meets bedside with patients to educate them about Advance Directives (AD) and ensure their end-of-life wishes are appropriately documented in the EMR. The coordinator targets patients who are 65+ years old who either 1) don't have an AD, 2) have an AD, but don't have it on file in the hospital's EMR (Epic). She works with them to either create/update their Advance Directive or assists in uploading it to Epic.
Participating Program Partners	The Horizon Foundation
Patients Served	<p># of Patients Served as of June 30, 2019: 2,634</p> <p>Denominator of Eligible Patients: 39,112 (Medicare FFS)</p> <p>Alternative denominator: 6,483 - number of HCGH inpatients 65 or older receiving treatment in FY19.</p>
Pre-Post Analysis for Intervention (optional)	None
Intervention-Specific Outcome or Process Measures (optional)	<p>Since January 1, 2018 thru June 30, 2019:</p> <ul style="list-style-type: none"> • 242 Family members of a HCGH patients requested more info about ACP and 34 completed their AD. • 142 Community Members participated in ACP office hours.
Successes of the Intervention in FY 2019	The ACP Coordinator increased the number of ADs being completed and collected by patients in the past fiscal year. Her bedside conversations with patients and their families has helped to educate them on what an AD is and the importance of completing one; increasing the number of ADs completed by both patients and family members. The Coordinator role has also increased awareness among hospital staff and with community members.
Lessons Learned from the Intervention in FY 2019	It is difficult to have a conversation about ADs because of the content of the document and due to the misinformation about what an AD is. The Coordinator developed various approaches to the discussion in FY19 that take into consideration cultural and spiritual beliefs, fears and medical diagnosis that have assisted patients in completing ADs.
Next Steps for the Intervention in FY 2020	The Coordinator will expand her services to reach a broader audience by providing presentations about ADs in the community and attending HCGH sponsored wellness screenings that include information and assistance around ADs.
Additional Free Response (Optional)	The ACP Coordinator serves a population broader than the HHP target, meaning all HCGH inpatients and residents of Howard County who attend monthly office hours. The program is funded by the Horizon Foundation.

Intervention Program 8: HHP Educational Resources and Classes

Intervention or Program Name	HHP Educational Resources and Classes a. Patient Engagement Program (PEP) b. Powerful Tools for Caregivers (PTC) d. Living Well (Chronic Disease Self-Management Programs) e. Mental Health First Aid (MHFA)
RP Hospitals Participating in Intervention	Howard County General Hospital
Brief description of the Intervention	The HHP offers classes to providers, patients and caregivers to support engaging patients in their health care. <u>The Johns Hopkins Medicine Patient Engagement Program (PEP)</u> is a comprehensive, web-based and in-person, skills-based program that teaches health care providers how to change their team’s culture, engage their patients as partners in health care and communicate in a way that motivates patients to engage in healthier behaviors. <u>Powerful Tools for Caregivers (PTC)</u> is an evidence-based class for family caregivers that offers tools and strategies to better handle the unique challenges caregivers face. <u>Living Well</u> courses teach patients with chronic disease about their disease and coaches them on healthy behaviors. <u>Mental Health First Aid (MHFA)</u> is an 8-hour education program that introduces participants to risk factors and warning signs of mental illnesses, builds understanding of their impact, and overviews common supports.
Participating Program Partners	Johns Hopkins Medicine, Howard County Office on Aging and Independence, Howard County Local Health Improvement Coalition, FIRN
Patients Served	# of Patients Served as of June 30, 2019: Powerful Tools for Caregivers class attendees: 40 Living Well class attendees: 145 Mental Health First Aid class attendees: 221 Denominator of Eligible Patients: 384,210
Pre-Post Analysis for Intervention	None – Due to the nature of this program, not all participants are hospital patients. We therefore cannot perform a Pre/Post Analysis with CRISP data.
Intervention-Specific Outcome or Process Measures (optional)	Patient Engagement Program (PEP): PEP training participation for CCT staff: 100% Powerful Tools for Caregivers (PTC): Participant Satisfaction: 90% Capacity: 83%

	<p>Living Well: Participant Satisfaction: 82% Capacity: 100%</p> <p>Mental Health First Aid: Capacity: 100%</p>
<p>Successes of the Intervention in FY 2019</p>	<p>Patient Engagement Program (PEP): HHP staff have embraced the PEP’s training and maintenance. All staff were trained in FY19. Two CCT staff members continue serve as PEP champions and lead monthly skills maintenance exercises. Columbia Medical Practice and some hospital inpatient staff (social workers and case managers) are trained and participate in the maintenance program. In FY19, we developed and launched e-learning curriculum with self-paced training so that in-person learning time is reduced from 8 hours to 4. Online learning is now a prerequisite for the 4 hour in-person PEP skills learning and practice. PEP also developed an electronic pre and post survey as well as a pilot data collection project, and launched a new website.</p> <p>Powerful Tools for Caregivers (PTC): Continued to make a difference in caregiver’s lives, especially in terms of their self-confidence with decision making and the realization they do not need to face it alone. Caregivers come to the class to gain knowledge about how to manage their journey more easily through communication, and to use tools to relieve the many stresses they encounter.</p> <p>Living Well: Offered a diversity of classes including Chronic Disease, Diabetes and Cancer. HHP also offered a Chronic Pain class in FY19 and plans to do more marketing to encourage more class registration. All classes except Cancer and Pain Management were offered in both English and Spanish.</p> <p>Mental Health First Aid: HHP expanded offerings to include Youth Mental Health First Aid, and two HHP staff members were trained to offer the course. Another HHP staff member got trained in Adult Mental Health First Aid. Participant evaluations noted classes as informative, helpful, and beneficial in educating Howard County residents and reducing stigma around Mental Health.</p>
<p>Lessons Learned from the Intervention in FY 2019</p>	<p>Patient Engagement Program (PEP): Sharing outcome and impact data will be useful to get buy-in from new stakeholders.</p> <p>Powerful Tools for Caregivers (PTC): People who took the class are more aware of the strain caregiving can have on their own physical and mental health and the need to be equipped to take care of themselves. The goal is to empower the caregivers and make sure their own well-being is their focus.</p> <p>Living Well: Seasonality impacts attendance and need for increased marketing/promotion to encourage attendance.</p>

	Mental Health First Aid: Filling the classes to capacity can be challenging as well as getting all participants who registered to attend.
Next Steps for the Intervention in FY 2020	Patient Engagement Program (PEP): Focus on developing a data collection and reporting strategy. Powerful Tools for Caregivers (PTC): identify funding to create web-based skills training class in order to reach more family caregivers.
Additional Free Response (Optional)	We tried the Diabetes Prevention Program (DPP) in Howard County but had much better success with Living Well/Chronic Disease Self-Management programs (CDSMP) because it is much shorter (6 weeks). We learned the target population does not want to commit to a long program.

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).

Measure in RFP <i>(Table 1, Appendix A of the RFP)</i>	Measure for FY 2019 Reporting	Outcomes(s)
Total Hospital Cost per capita	Partnership IP Charges per capita Executive Dashboard: 'Regional Partnership per Capita Utilization' – <u>Hospital Charges per Capita</u> , reported as average 12 months of CY 2018 -or- Analytic File: 'Charges' over 'Population' (Column E / Column C)	\$2,753 Source file: RP_AnalyticFile_01JUN18_31MAY19_Monthly_20190711 and RP_AnalyticFile_01AUG18_31JUL19_Monthly_20190909
Total Hospital Discharges per capita	Total Discharges per 1,000 Executive Dashboard: 'Regional Partnership per Capita Utilization' – <u>Hospital Discharges per 1,000</u> , reported as average 12 months of FY 2019 -or- Analytic File: 'IPObs24Visits' over 'Population'	107.24 Source file: RP_AnalyticFile_01JUN18_31MAY19_Monthly_20190711 and RP_AnalyticFile_01AUG18_31JUL19_Monthly_20190909

	(Column G / Column C)	
ED Visits per capita	<p>Ambulatory ED Visits per 1,000</p> <p>Executive Dashboard: ‘Regional Partnership per Capita Utilization’ – <u>Ambulatory ED Visits per 1,000</u>, reported as average 12 months of FY 2019 -or- Analytic File ‘ED Visits’ over ‘Population’ (Column H / Column C)</p>	<p>244.88</p> <p>Source file: RP_AnalyticFile_01JUN18_31MAY19_Monthly_20190711 and RP_AnalyticFile_01AUG18_31JUL19_Monthly_20190909</p>

Quality Indicator Measures

Measure in RFP <i>(Table 1 in Appendix A of the RFP)</i>	Measure for FY 2019 Reporting	Outcomes(s)
Readmissions	<p>Unadjusted Readmission rate by Hospital (please be sure to filter to include all hospitals in your RP)</p> <p>Executive Dashboard: ‘[Partnership] Quality Indicators’ – <u>Unadjusted Readmission Rate by Hospital</u>, reported as average 12 months of FY 2019 -or- Analytic File: ‘IP Readmit’ over ‘EligibleforReadmit’ (Column J / Column I)</p>	<p>10.4%</p> <p>Source file: RP_AnalyticFile_01JUN18_31MAY19_Monthly_20190711 and RP_AnalyticFile_01AUG18_31JUL19_Monthly_20190909</p>
PAU	<p>Potentially Avoidable Utilization</p> <p>Executive Dashboard: ‘[Partnership] Quality Indicators’ – <u>Potentially Avoidable Utilization</u>, reported as sum of 12 months of FY 2019 -or- Analytic File: ‘TotalPAUCharges’ (Column K)</p>	<p>\$88,526,629</p> <p>Source file: RP_AnalyticFile_01JUN18_31MAY19_Monthly_20190711 and RP_AnalyticFile_01AUG18_31JUL19_Monthly_20190909</p>

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	<p>Potentially Avoidable Utilization</p> <p>Executive Dashboard: ‘High Needs Patients – CRISP Key Indicators’ – <u>% of patients with Case Manager (CM) recorded at CRISP</u>, reported as average monthly % for most recent six months of data</p> <p><i>May also include Rising Needs Patients, if applicable in Partnership.</i></p>	None

Self-Reported Process Measures

Please describe any partnership-level process measures that your RP may be tracking but are not currently captured under the Executive Dashboard. Some examples are shared care plans, health risk assessments, patients with care manager who are not recorded in CRISP, etc. By-intervention process measures should be included in ‘Intervention Program’ section and don’t need to be included here.

Number of HHP Governance Meetings in FY19: 11 Meetings

Number of Hours of HHP Governance Meetings in FY19: 17.5 hours

Number of HHP Governance Committee Members in FY19: 66 governance members attended at least one governance meeting in FY19 plus 13 guests.

Leveraging Other Networks: HHP Leadership participates on a CAREAPP Network hosted by the Howard County Health Department to monitor and expand use of CAREAPP, a web-based risk assessment screening tool and community resources database with a bi-directional referral tracking system. The CAREAPP Network includes 34 community partner organizations including community service agencies, government organizations, educational institutions, and healthcare centers in Howard County, working in partnership with the Howard County Health Department to optimize care coordination for Howard County residents.

Return on Investment – (Optional)

A Difference in Differences Analysis showed enrollment in HHP’s Community Care Team (CCT) is associated with decreased hospital charges per patient at 1, 3 and 12 months post-enrollment in the program. Patients enrolled in CCT cost an average of \$12,414 less per patient over 12 months. Enrollment in CCT is associated with a short-term increase in hospital visits (2% at 3 months) but a longer-term decrease in hospital visits (-6.3% at 12 months).

Conclusion

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.

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

Pre/Post Analyses: We have concerns that Pre/Post panels might incorrectly imply programmatic impact, since the panels do not include matched cohorts for statistical comparison. Additionally, any utilization reductions in the post period might be artificially inflated due to the lack of available data on deaths. For interventions geared towards the elderly or especially frail, this could have a significant impact. This is the reason we undertook the difference in differences analyses with our primary intervention, the Community Care Team. See the Return on Investment section above for details.

Population Denominators: The overall Medicare population for our target zip codes is roughly 39,000 beneficiaries, however HHP focuses only on a high and rising risk patient population of roughly 3,000 Medicare beneficiaries. Population-based metrics might fail to show the full impact of HHP interventions, given the discrepancy in the denominator.

While there are perceptions that Regional Partnerships had great variation in their successes, the Howard Health Partnership team was deliberate and strategic in developing and deploying our intervention framework and utilized the funding to help leverage other community partnerships and other sources of funding. We are concerned that the proposed future Regional Partnership funding streams are too narrow and will shrink the gains we've made in terms of building a supporting infrastructure to drive population health management.

Pre/Post Analysis - Summary

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

Program Name CCT-FY19-E (210048)	Chronic Conditions All Patients	Chronic Condition Operator <input checked="" type="radio"/> AND <input type="radio"/> OR
Most Recent Payer All	Visit Type All	N/A
		N/A

Total Number of Members on Panel that could contribute to analysis

	1 Month	3 Months	6 Months	12 Months
Total Number of Patients in Panel that could contribute to analysis	358	307	233	73

Percent of Members on the Panel with 1 or more Visits

Time Period	Total Number of Patients with a visit - Pre	Total Number of Patients with a visit - Post	Total Number of Patients with a visit - Pre %	Total Number of Patients with a visit - Post %	Change in Number of Patients
1 Month	319	123	89.1%	34.4%	-54.7%
3 Months	300	170	97.7%	55.4%	-42.3%
6 Months	233	175	100.0%	75.1%	-24.9%
12 Months	73	59	100.0%	80.8%	-19.2%

Rate of Visits per 10 Members

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Rate of Visits per 10 patients - Pre	Rate of Visits per 10 patients - Post	Visits Rate change
1 Month	490	198	13.7	5.5	-8.2
3 Months	747	450	24.3	14.7	-9.7
6 Months	874	620	37.5	26.6	-10.9
12 Months	444	375	60.8	51.4	-9.5

Average Charge per Member

Time Period	Total Number of Patients with at least 1 visit pre or post	Total charges - Pre	Total charges - Post	Average Charge per patient - Pre	Average Charge per patient - Post	Total Charges per Patients change
1 Month	330	\$3,863,090	\$927,475	\$12,110	\$7,540	(\$4,570)
3 Months	304	\$5,705,369	\$2,340,467	\$19,018	\$13,767	(\$5,250)
6 Months	233	\$6,475,995	\$3,465,363	\$27,794	\$19,802	(\$7,992)
12 Months	73	\$2,711,437	\$2,341,273	\$37,143	\$39,683	\$2,540

Average Charge per Visit

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Total charges - Pre	Total charges - Post	Average Charge per visit - Pre	Average Charge per visit - Post	Total Charges per Visit change
1 Month	490	198	\$3,863,090	\$927,475	\$7,884	\$4,684	(\$3,200)
3 Months	747	450	\$5,705,369	\$2,340,467	\$7,638	\$5,201	(\$2,437)
6 Months	874	620	\$6,475,995	\$3,465,363	\$7,410	\$5,589	(\$1,820)
12 Months	444	375	\$2,711,437	\$2,341,273	\$6,107	\$6,243	\$137

Casemix Data - MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.

Through:

07/31/2019

- 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

ENS Panels

Last Updated:

09/15/2019

- 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 1 Month of Visits Before and After the Enrollment Date

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

Total Number of Members in the Panel

358

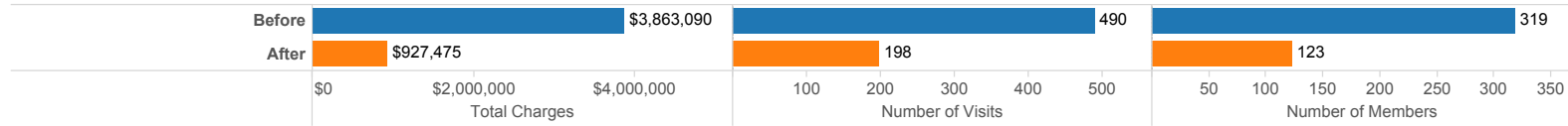
Number of Members with Data for Analysis

358

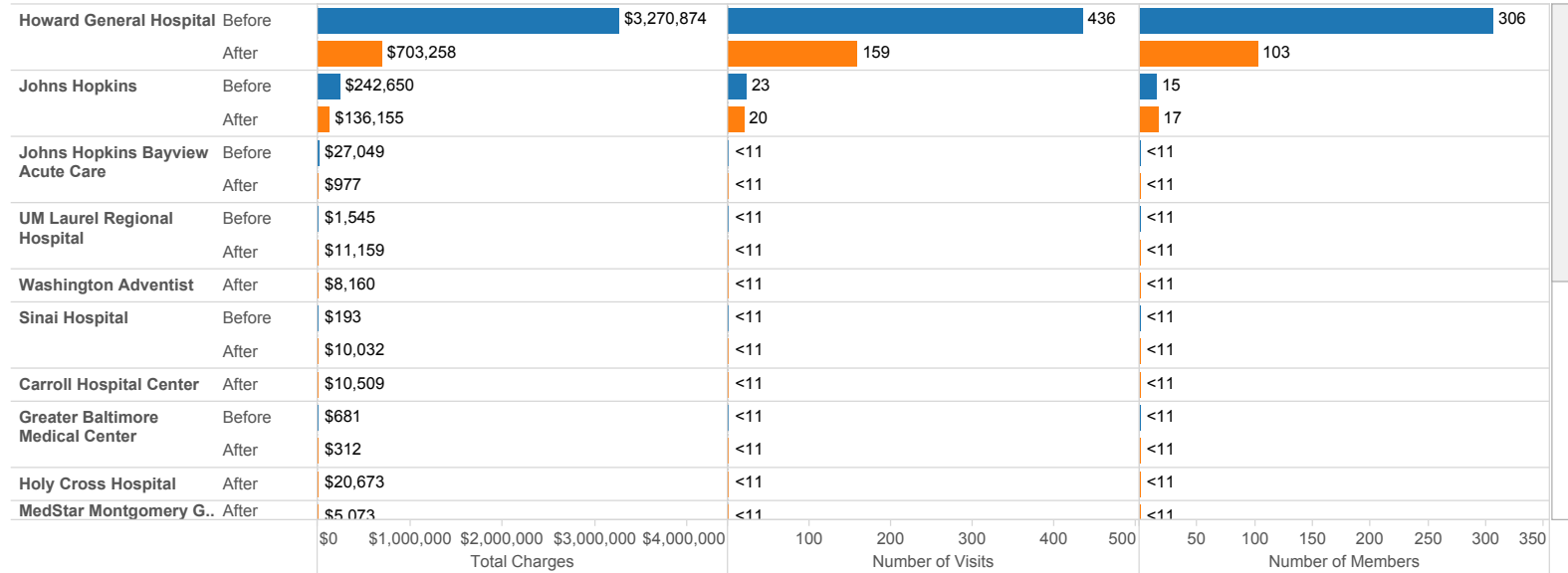
Number of Members with Visits during Analysis Period

330

All Hospitals



Hospital Details



Before or After Enrollment
 Before After

Most Recent Payer
All

Time Period
1 Month

Visit Type
All

Sorting Option
Total Visits - After Enrollment

Hospital Name
All

Program Name
CCT-FY19-E (210048)

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator

AND
 OR

Casemix Data Through:

07/31/2019

ENS Panels Last Updated:

09/15/2019

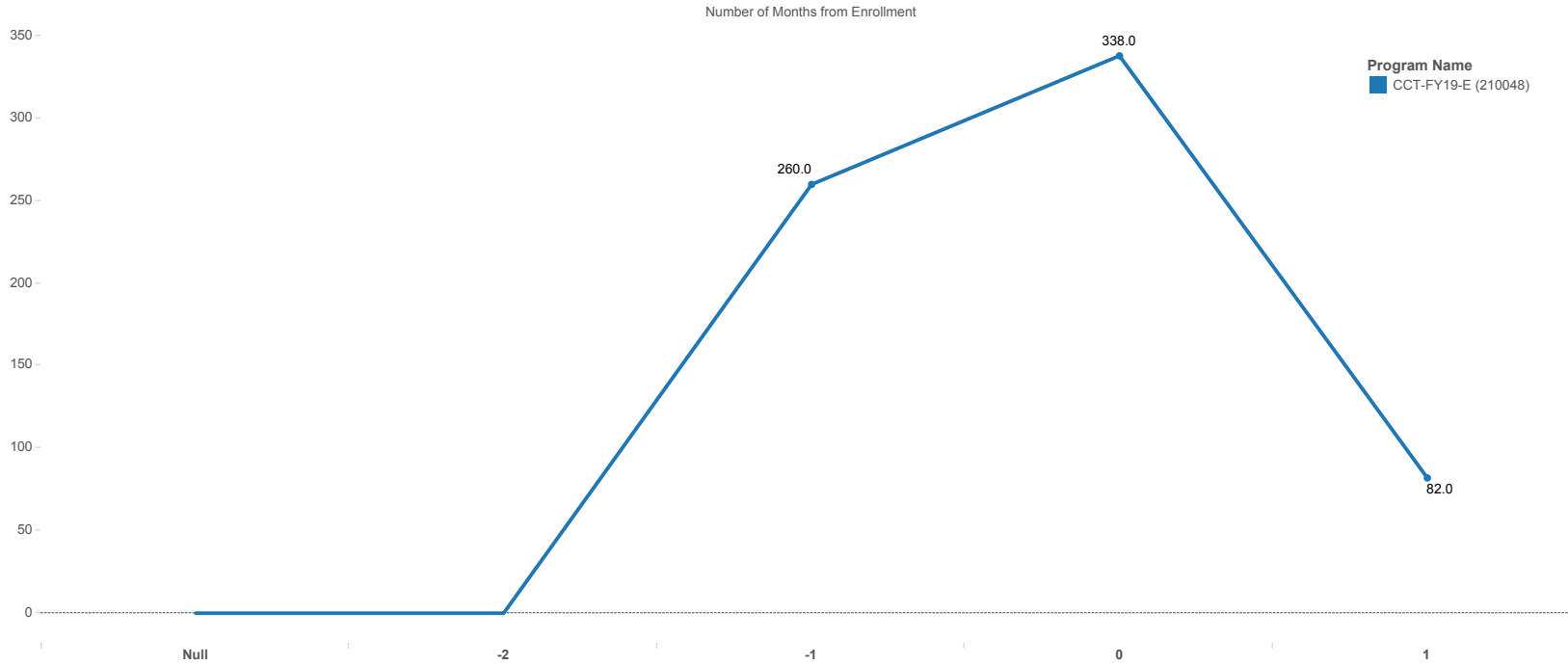
- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
 - Panel information provided to CRISP by ENS
 - HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
 - Individual patients identified using CRISP EID
 - CRISP suppressed 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 1 Month 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.

Relative Trend



Most Recent Payer

All

Time Period

1 Month

Trend Metric

Visits

Visit Type

All

Hospital Name

All

Program Name

CCT-FY19-E (210048)

Chronic Conditions

All Patients

N/A

N/A

Chronic Condition Operator

AND

OR

Casemix Data Through: - 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

ENS Panels Last Updated: - 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 1 Month of Visits Before and After the Enrollment Date

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

Most Recent Payer

All

Visit Type

All

Hospital Name

All

Time Period

1 Month

Program Name

CCT-FY19-E (210048)

Chronic Conditions

All Patients

N/A

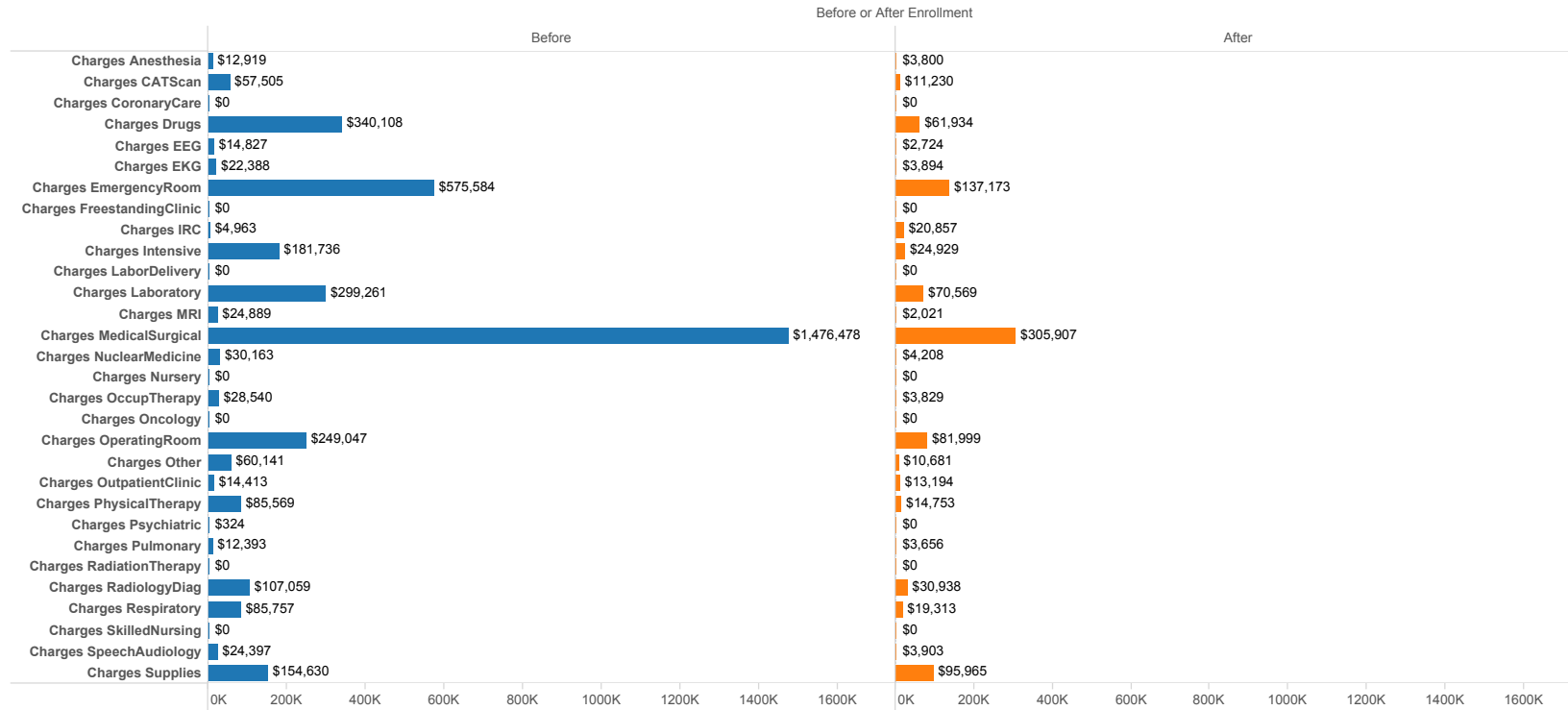
N/A

Chronic Condition Operator

AND

OR

Breakdown of Charges Sheet



Casemix Data - MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.

Through:

07/31/2019

ENS Panels

Last Updated:

09/15/2019

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

Pre/Post Analysis - Summary

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

Program Name EMC-FY19-E (210048)	Chronic Conditions All Patients	Chronic Condition Operator <input checked="" type="radio"/> AND <input type="radio"/> OR
Most Recent Payer All	Visit Type All	N/A
		N/A

Total Number of Members on Panel that could contribute to analysis

	1 Month	3 Months	6 Months	12 Months
Total Number of Patients in Panel that could contribute to analysis	33	33	21	<11

Percent of Members on the Panel with 1 or more Visits

Time Period	Total Number of Patients with a visit - Pre	Total Number of Patients with a visit - Post	Total Number of Patients with a visit - Pre %	Total Number of Patients with a visit - Post %	Change in Number of Patients
1 Month	17	13	51.5%	39.4%	-12.1%
3 Months	23	17	69.7%	51.5%	-18.2%
6 Months	17	11	81.0%	52.4%	-28.6%
12 Months	<11	<11			

Rate of Visits per 10 Members

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Rate of Visits per 10 patients - Pre	Rate of Visits per 10 patients - Post	Visits Rate change
1 Month	29	15	8.8	4.5	-4.2
3 Months	73	30	22.1	9.1	-13.0
6 Months	85	21	40.5	10.0	-30.5
12 Months	23	15			

Average Charge per Member

Time Period	Total Number of Patients with at least 1 visit pre or post	Total charges - Pre	Total charges - Post	Average Charge per patient - Pre	Average Charge per patient - Post	Total Charges per Patients change
1 Month	20	\$291,994	\$63,768	\$17,176	\$4,905	(\$12,271)
3 Months	25	\$796,569	\$203,138	\$34,633	\$11,949	(\$22,684)
6 Months	17	\$790,188	\$141,136	\$46,482	\$12,831	(\$33,651)
12 Months	<11	\$337,269	\$116,126			

Average Charge per Visit

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Total charges - Pre	Total charges - Post	Average Charge per visit - Pre	Average Charge per visit - Post	Total Charges per Visit change
1 Month	29	15	\$291,994	\$63,768	\$10,069	\$4,251	(\$5,818)
3 Months	73	30	\$796,569	\$203,138	\$10,912	\$6,771	(\$4,141)
6 Months	85	21	\$790,188	\$141,136	\$9,296	\$6,721	(\$2,576)
12 Months	23	15	\$337,269	\$116,126	\$14,664	\$7,742	(\$6,922)

Casemix Data - MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.

Through:

07/31/2019

- 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

ENS Panels

Last Updated:

09/15/2019

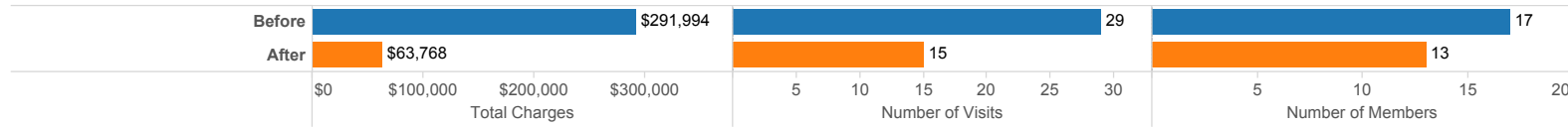
- Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis
- Months of Analysis is not based on calendar days or 30 days but calculated by getting the same date, months in advance. 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

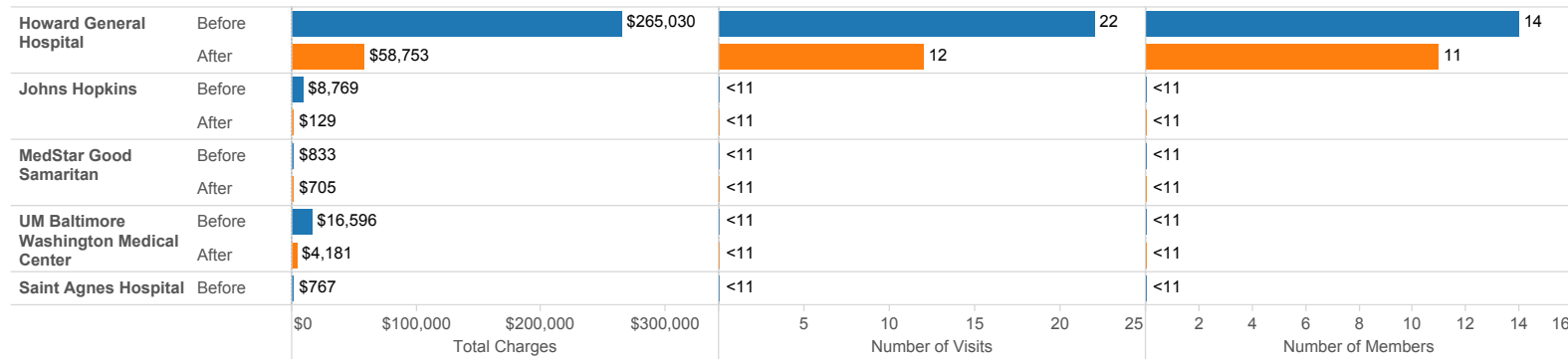
Analysis of 1 Month of Visits Before and After the Enrollment Date

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

33

Number of Members with Data for Analysis

33

Number of Members with Visits during Analysis Period

20

Before or After Enrollment
 Before After

Most Recent Payer
All

Time Period
1 Month

Visit Type
All

Sorting Option
Total Visits - After Enrollment

Hospital Name
All

Program Name
EMC-FY19-E (210048)

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
 AND
 OR

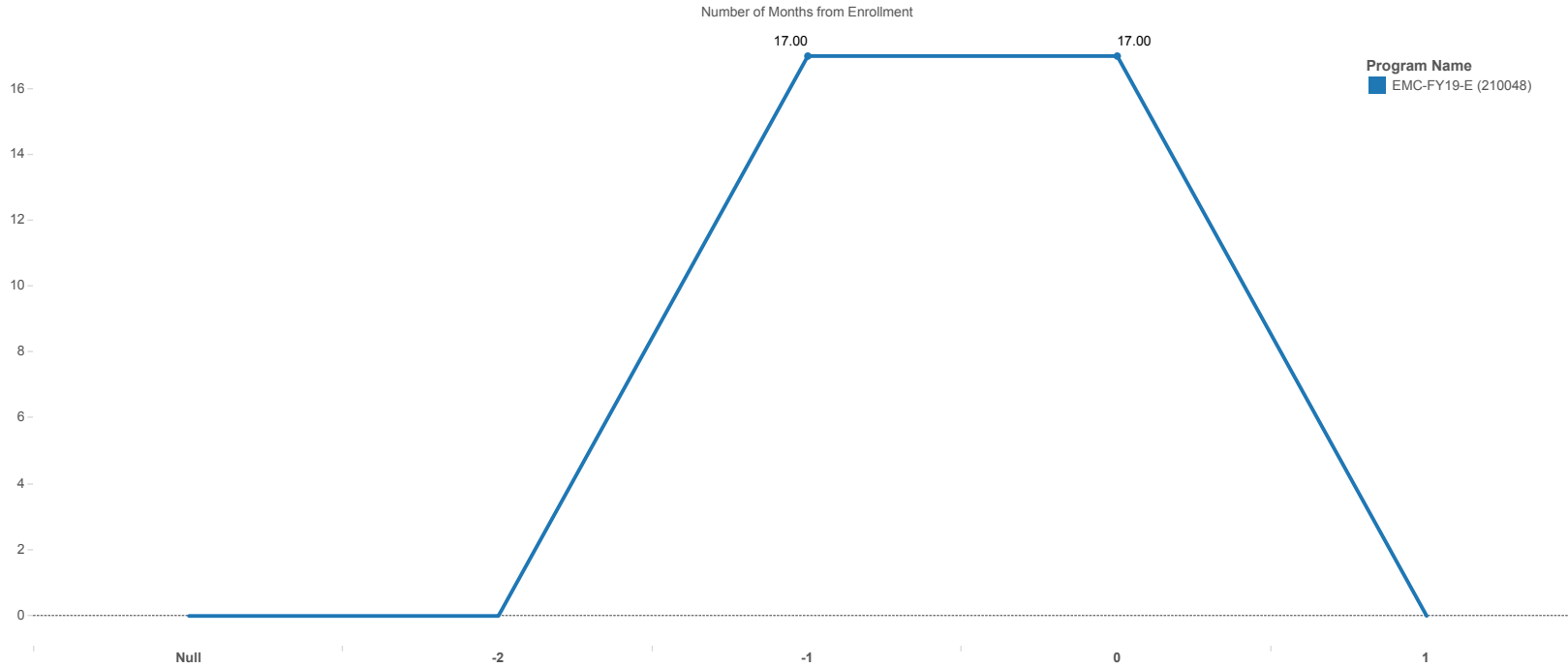
- Casemix Data Through:** 07/31/2019
- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
 - Data source:
 - Panel information provided to CRISP by ENS
- ENS Panels Last Updated:** 09/15/2019
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care 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 1 Month 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.

Relative Trend



Most Recent Payer

All

Time Period

1 Month

Trend Metric

Visits

Visit Type

All

Hospital Name

All

Program Name

EMC-FY19-E (210048)

Chronic Conditions

All Patients

N/A

N/A

Chronic Condition Operator

AND

OR

Casemix Data Through:

07/31/2019

ENS Panels Last Updated:

09/15/2019

- 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 1 Month of Visits Before and After the Enrollment Date

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

Most Recent Payer

All

Visit Type

All

Hospital Name

All

Time Period

1 Month

Program Name

EMC-FY19-E (210048)

Chronic Conditions

All Patients

N/A

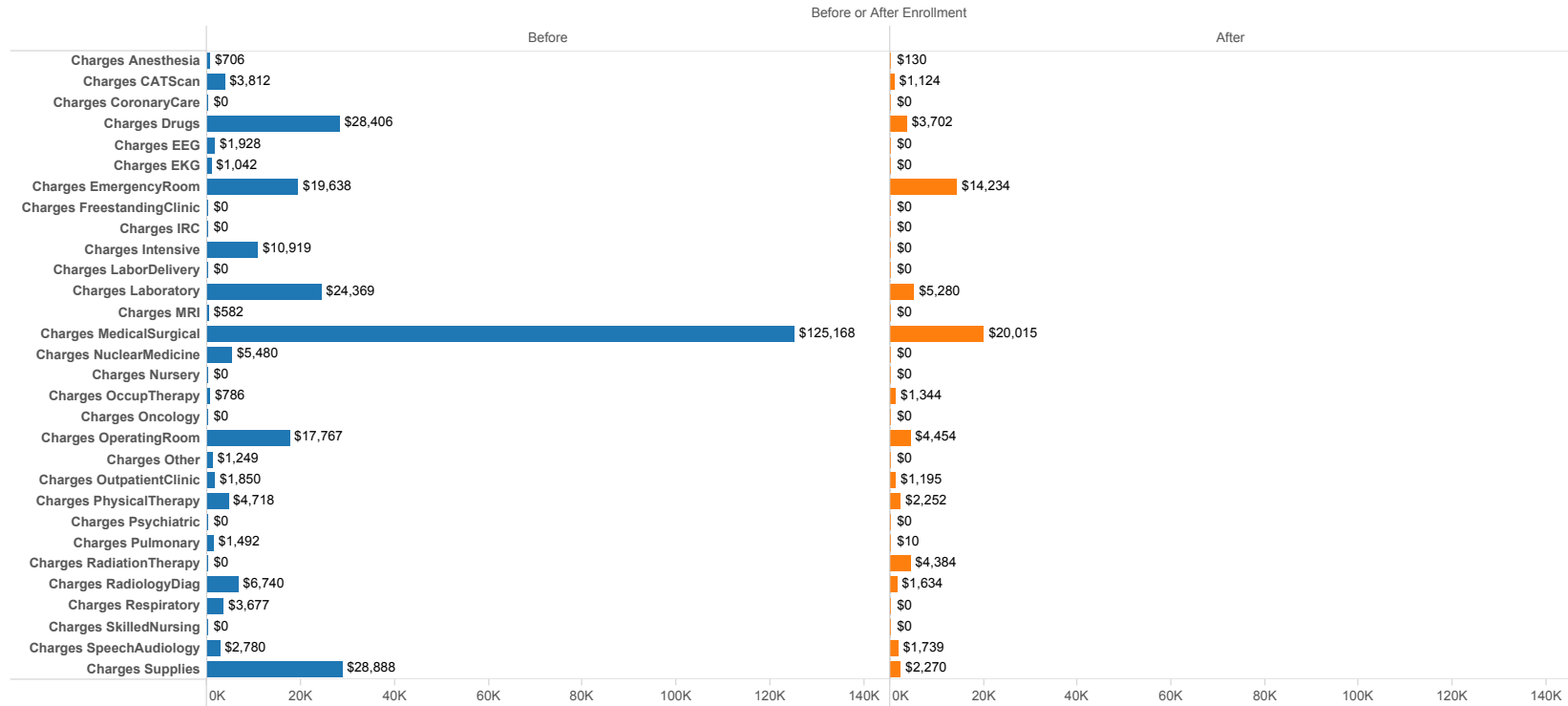
N/A

Chronic Condition Operator

AND

OR

Breakdown of Charges Sheet



Casemix Data - MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.

Through:

07/31/2019

ENS Panels

Last Updated:

09/15/2019

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

Pre/Post Analysis - Summary

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

Program Name RPM (210048)	Chronic Conditions All Patients	Chronic Condition Operator <input checked="" type="radio"/> AND <input type="radio"/> OR
Most Recent Payer All	Visit Type All	N/A
		N/A

Total Number of Members on Panel that could contribute to analysis

	1 Month	3 Months	6 Months	12 Months
Total Number of Patients in Panel that could contribute to analysis	74	74	61	11

Percent of Members on the Panel with 1 or more Visits

Time Period	Total Number of Patients with a visit - Pre	Total Number of Patients with a visit - Post	Total Number of Patients with a visit - Pre %	Total Number of Patients with a visit - Post %	Change in Number of Patients
1 Month	74	33	100.0%	44.6%	-55.4%
3 Months	74	49	100.0%	66.2%	-33.8%
6 Months	61	47	100.0%	77.0%	-23.0%
12 Months	11	<11	100.0%		

Rate of Visits per 10 Members

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Rate of Visits per 10 patients - Pre	Rate of Visits per 10 patients - Post	Visits Rate change
1 Month	132	51	17.8	6.9	-10.9
3 Months	220	140	29.7	18.9	-10.8
6 Months	259	198	42.5	32.5	-10.0
12 Months	49	54	44.5	49.1	4.5

Average Charge per Member

Time Period	Total Number of Patients with at least 1 visit pre or post	Total charges - Pre	Total charges - Post	Average Charge per patient - Pre	Average Charge per patient - Post	Total Charges per Patients change
1 Month	74	\$1,104,569	\$257,222	\$14,927	\$7,795	(\$7,132)
3 Months	74	\$1,677,717	\$904,331	\$22,672	\$18,456	(\$4,216)
6 Months	61	\$1,604,815	\$1,253,691	\$26,308	\$26,674	\$366
12 Months	11	\$260,269	\$306,066			\$10,346

Average Charge per Visit

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Total charges - Pre	Total charges - Post	Average Charge per visit - Pre	Average Charge per visit - Post	Total Charges per Visit change
1 Month	132	51	\$1,104,569	\$257,222	\$8,368	\$5,044	(\$3,324)
3 Months	220	140	\$1,677,717	\$904,331	\$7,626	\$6,460	(\$1,166)
6 Months	259	198	\$1,604,815	\$1,253,691	\$6,196	\$6,332	\$136
12 Months	49	54	\$260,269	\$306,066	\$5,312	\$5,668	\$356

Casemix Data - MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.

Through:

07/31/2019

- 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

ENS Panels

Last Updated:

09/15/2019

- 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 1 Month of Visits Before and After the Enrollment Date

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

Total Number of Members in the Panel

74

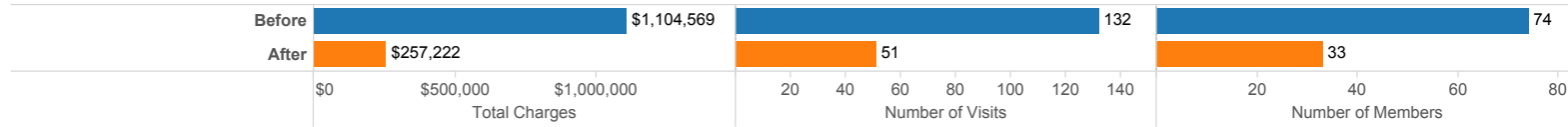
Number of Members with Data for Analysis

74

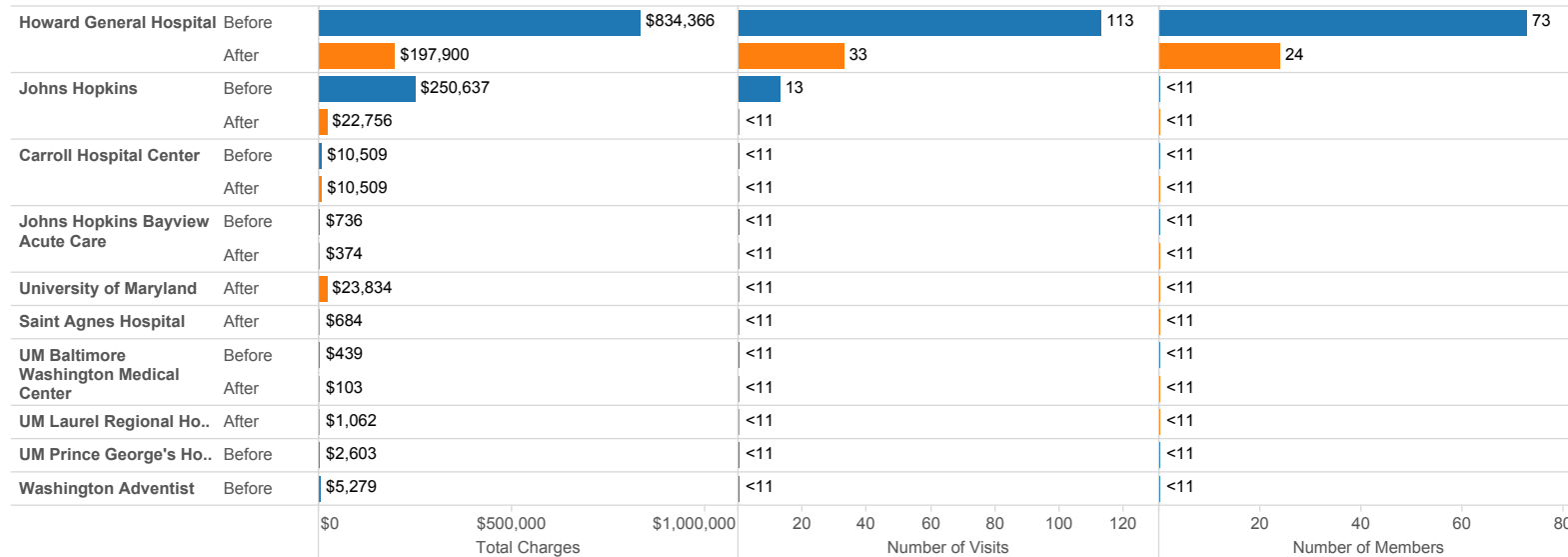
Number of Members with Visits during Analysis Period

74

All Hospitals



Hospital Details



Before or After Enrollment
■ Before ■ After

Most Recent Payer
All

Time Period
1 Month

Visit Type
All

Sorting Option
Total Visits - After Enrollment

Hospital Name
All

Program Name
RPM (210048)

Chronic Conditions

All Patients

N/A

N/A

Chronic Condition Operator

AND
 OR

Casemix Data Through: - MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
 - Data source:

07/31/2019 - Panel information provided to CRISP by ENS
 - HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals

ENS Panels Last Updated:

09/15/2019

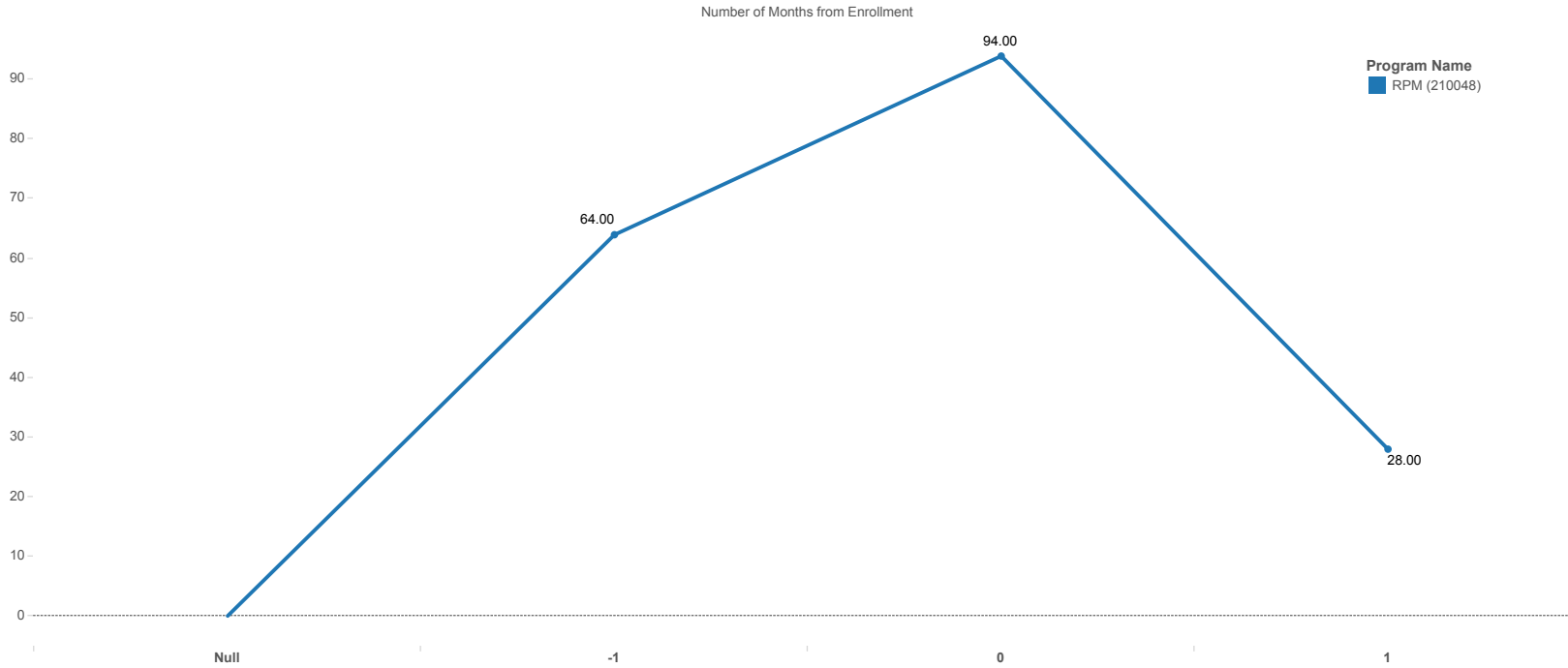
- Individual patients identified using CRISP EID
 - CRISP suppressed cells with counts of 10 and under
 - Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis
 - Months of Analysis 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 1 Month 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.

Relative Trend



Most Recent Payer

All

Time Period

1 Month

Trend Metric

Visits

Visit Type

All

Hospital Name

All

Program Name

RPM (210048)

Chronic Conditions

All Patients

N/A

N/A

Chronic Condition Operator

AND

OR

Casemix Data Through:

- 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

ENS Panels

Last Updated:

- 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.

09/15/2019

- 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 1 Month of Visits Before and After the Enrollment Date

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

Most Recent Payer

All

Visit Type

All

Hospital Name

All

Time Period

1 Month

Program Name

RPM (210048)

Chronic Conditions

All Patients

N/A

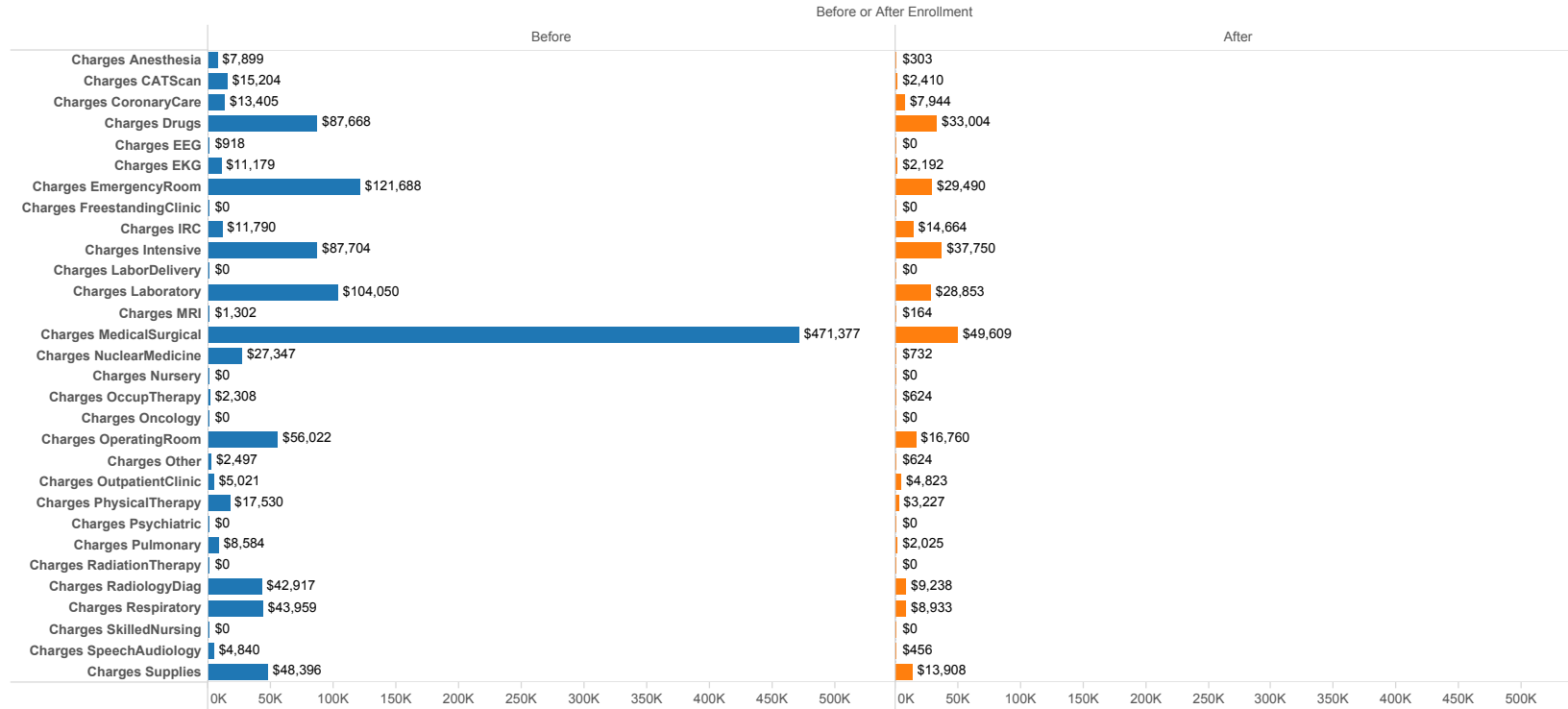
N/A

Chronic Condition Operator

AND

OR

Breakdown of Charges Sheet



Casemix Data - MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.

Through:

07/31/2019

ENS Panels

Last Updated:

09/15/2019

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

Pre/Post Analysis - Summary

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

Program Name Program 1-FY19-E (210048)	Chronic Conditions All Patients	Chronic Condition Operator <input checked="" type="radio"/> AND <input type="radio"/> OR
Most Recent Payer All	Visit Type All	N/A
		N/A

Total Number of Members on Panel that could contribute to analysis

	1 Month	3 Months	6 Months	12 Months
Total Number of Patients in Panel that could contribute to analysis	222	192	137	30

Percent of Members on the Panel with 1 or more Visits

Time Period	Total Number of Patients with a visit - Pre	Total Number of Patients with a visit - Post	Total Number of Patients with a visit - Pre %	Total Number of Patients with a visit - Post %	Change in Number of Patients
1 Month	217	37	97.7%	16.7%	-81.1%
3 Months	189	61	98.4%	31.8%	-66.7%
6 Months	134	60	97.8%	43.8%	-54.0%
12 Months	30	19	100.0%	63.3%	-36.7%

Rate of Visits per 10 Members

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Rate of Visits per 10 patients - Pre	Rate of Visits per 10 patients - Post	Visits Rate change
1 Month	282	50	12.7	2.3	-10.5
3 Months	326	145	17.0	7.6	-9.4
6 Months	285	172	20.8	12.6	-8.2
12 Months	82	94	27.3	31.3	4.0

Average Charge per Member

Time Period	Total Number of Patients with at least 1 visit pre or post	Total charges - Pre	Total charges - Post	Average Charge per patient - Pre	Average Charge per patient - Post	Total Charges per Patients change
1 Month	219	\$898,561	\$81,001	\$4,141	\$2,189	(\$1,952)
3 Months	190	\$1,046,551	\$376,224	\$5,537	\$6,168	\$630
6 Months	135	\$912,012	\$503,566	\$6,806	\$8,393	\$1,587
12 Months	30	\$366,387	\$251,776	\$12,213	\$13,251	\$1,038

Average Charge per Visit

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Total charges - Pre	Total charges - Post	Average Charge per visit - Pre	Average Charge per visit - Post	Total Charges per Visit change
1 Month	282	50	\$898,561	\$81,001	\$3,186	\$1,620	(\$1,566)
3 Months	326	145	\$1,046,551	\$376,224	\$3,210	\$2,595	(\$616)
6 Months	285	172	\$912,012	\$503,566	\$3,200	\$2,928	(\$272)
12 Months	82	94	\$366,387	\$251,776	\$4,468	\$2,678	(\$1,790)

Casemix Data - MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.

Through:

07/31/2019

- 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

ENS Panels

Last Updated:

09/15/2019

- 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 1 Month of Visits Before and After the Enrollment Date

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

Total Number of Members in the Panel

222

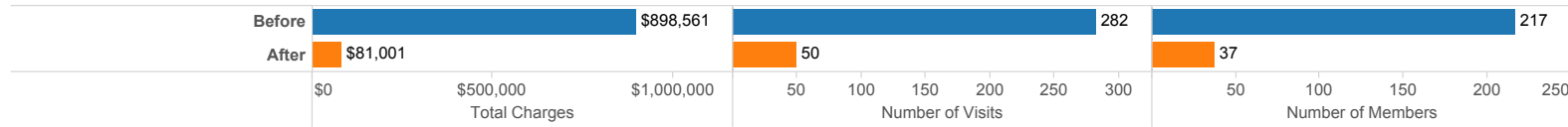
Number of Members with Data for Analysis

222

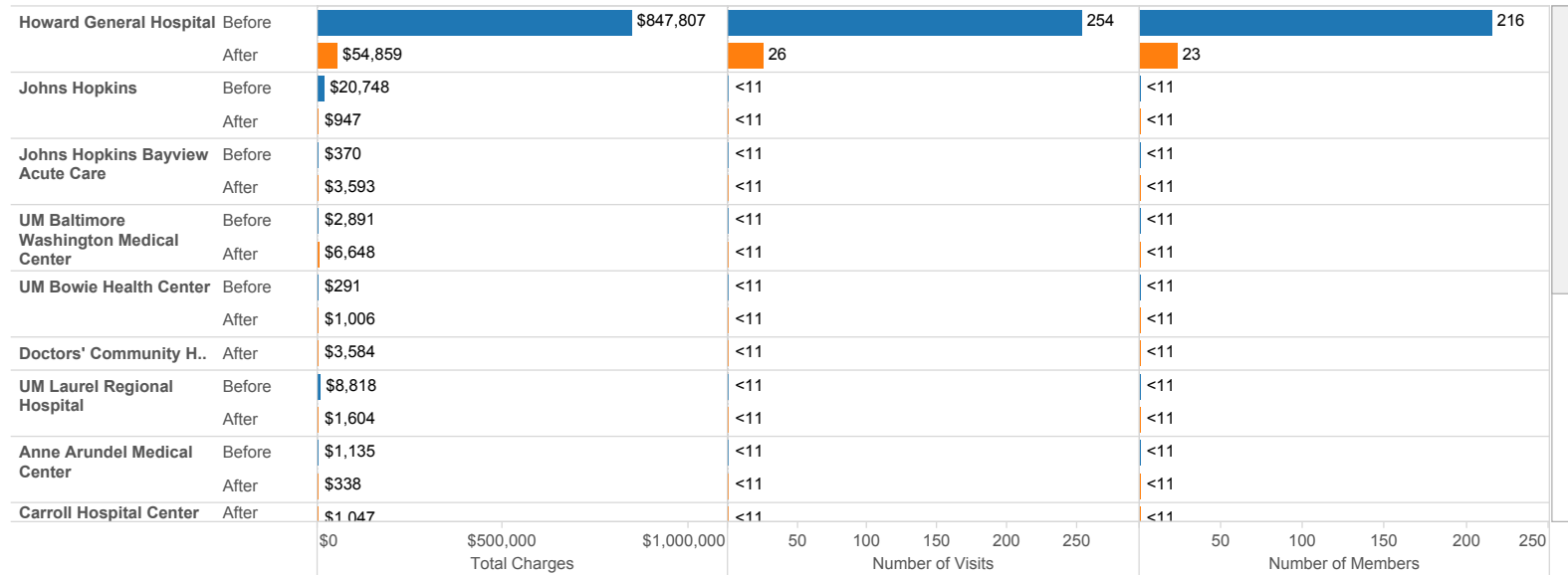
Number of Members with Visits during Analysis Period

219

All Hospitals



Hospital Details



Before or After Enrollment
 Before After

Most Recent Payer
All

Time Period
1 Month

Visit Type
All

Sorting Option
Total Visits - After Enrollment

Hospital Name
All

Program Name
Program 1-FY19-E (210048)

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator

AND
 OR

Casemix Data Through: - MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
 - Data source:
 - Panel information provided to CRISP by ENS

07/31/2019 - 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

ENS Panels Last Updated: - 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.

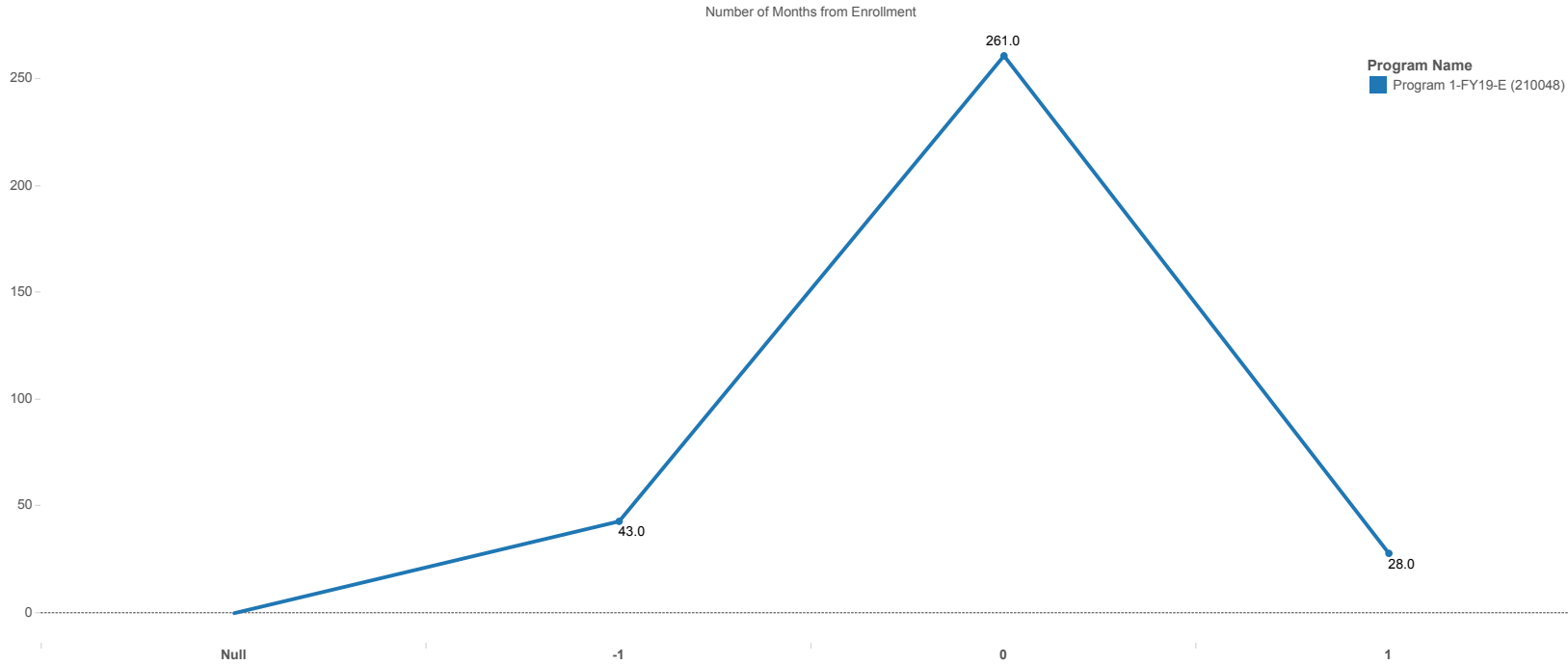
- Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.

Pre/Post Analysis

Analysis of 1 Month 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.

Relative Trend



Most Recent Payer

All

Time Period

1 Month

Trend Metric

Visits

Visit Type

All

Hospital Name

All

Program Name

Program 1-FY19-E (210048)

Chronic Conditions

All Patients

N/A

N/A

Chronic Condition Operator

AND

OR

Casemix Data Through: - 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

ENS Panels Last Updated: - 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 1 Month of Visits Before and After the Enrollment Date

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

Most Recent Payer

All

Visit Type

All

Hospital Name

All

Time Period

1 Month

Program Name

Program 1-FY19-E (210048)

Chronic Conditions

All Patients

N/A

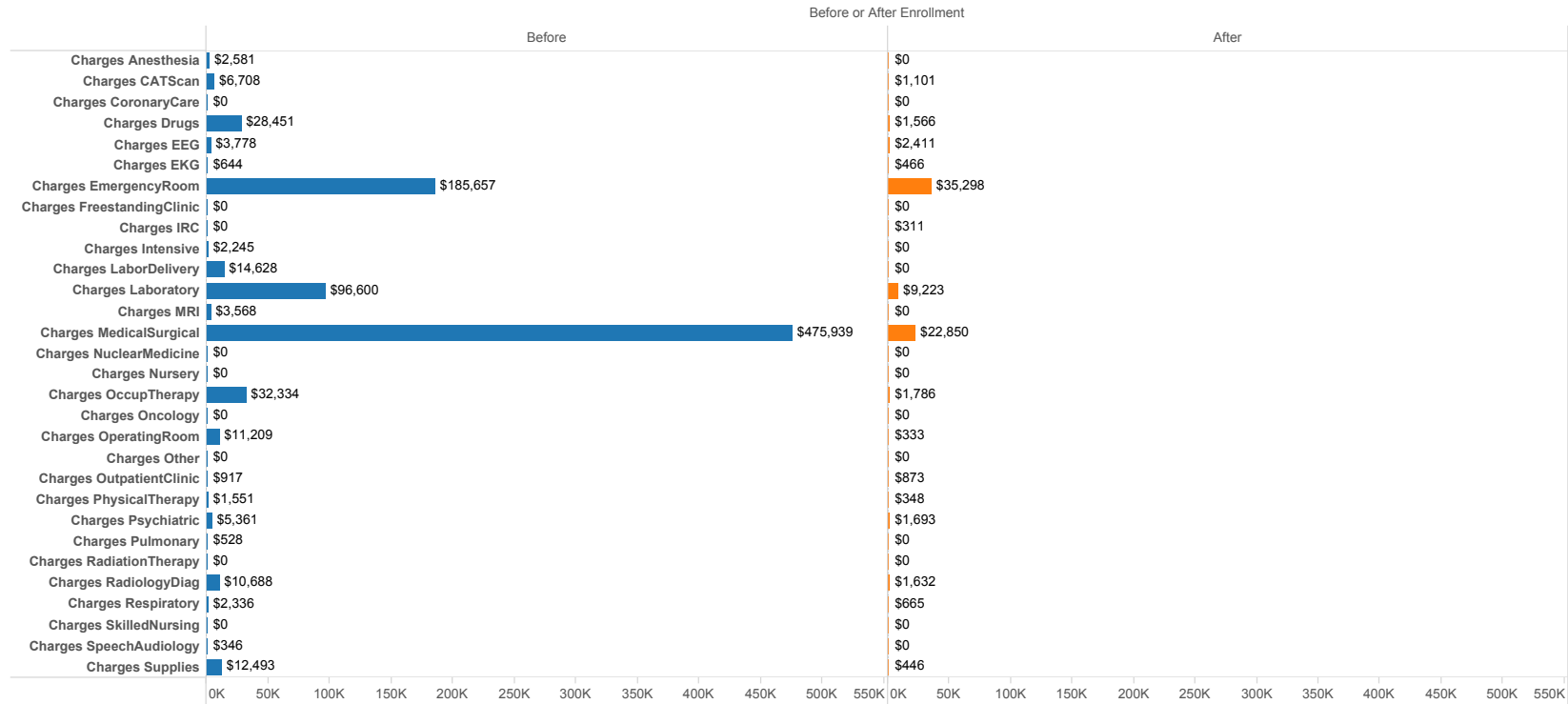
N/A

Chronic Condition Operator

AND

OR

Breakdown of Charges Sheet



Casemix Data - MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.

Through:

07/31/2019

ENS Panels

Last Updated:

09/15/2019

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

Pre/Post Analysis - Summary

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

Program Name Program3-ED-FY19 (210048)	Chronic Conditions All Patients	Chronic Condition Operator <input checked="" type="radio"/> AND <input type="radio"/> OR
Most Recent Payer All	Visit Type All	N/A
		N/A

Total Number of Members on Panel that could contribute to analysis

	1 Month	3 Months	6 Months	12 Months
Total Number of Patients in Panel that could contribute to analysis	304	212	75	<11

Percent of Members on the Panel with 1 or more Visits

Time Period	Total Number of Patients with a visit - Pre	Total Number of Patients with a visit - Post	Total Number of Patients with a visit - Pre %	Total Number of Patients with a visit - Post %	Change in Number of Patients
1 Month	297	61	97.7%	20.1%	-77.6%
3 Months	210	68	99.1%	32.1%	-67.0%
6 Months	75	39	100.0%	52.0%	-48.0%
12 Months	<11	<11			

Rate of Visits per 10 Members

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Rate of Visits per 10 patients - Pre	Rate of Visits per 10 patients - Post	Visits Rate change
1 Month	453	101	14.9	3.3	-11.6
3 Months	440	195	20.8	9.2	-11.6
6 Months	245	120	32.7	16.0	-16.7
12 Months	<11	<11			

Average Charge per Member

Time Period	Total Number of Patients with at least 1 visit pre or post	Total charges - Pre	Total charges - Post	Average Charge per patient - Pre	Average Charge per patient - Post	Total Charges per Patients change
1 Month	302	\$652,275	\$357,262	\$2,196	\$5,857	\$3,661
3 Months	211	\$750,250	\$587,963	\$3,573	\$8,647	\$5,074
6 Months	75	\$413,349	\$326,509	\$5,511	\$8,372	\$2,861

Average Charge per Visit

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Total charges - Pre	Total charges - Post	Average Charge per visit - Pre	Average Charge per visit - Post	Total Charges per Visit change
1 Month	453	101	\$652,275	\$357,262	\$1,440	\$3,537	\$2,097
3 Months	440	195	\$750,250	\$587,963	\$1,705	\$3,015	\$1,310
6 Months	245	120	\$413,349	\$326,509	\$1,687	\$2,721	\$1,034

Casemix Data - MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.

Through:

07/31/2019

- 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

ENS Panels

Last Updated:

09/15/2019

- 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 1 Month of Visits Before and After the Enrollment Date

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

Total Number of Members in the Panel

304

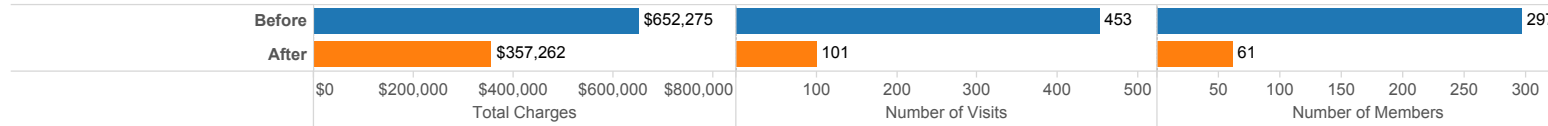
Number of Members with Data for Analysis

304

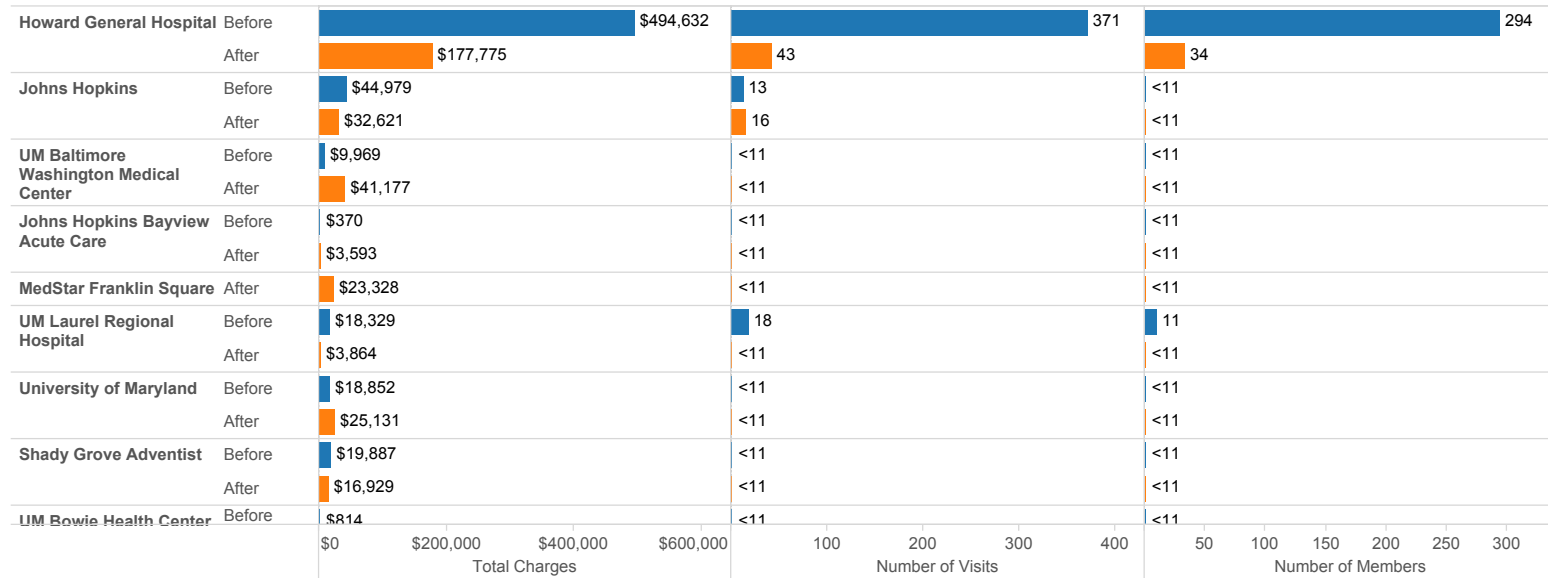
Number of Members with Visits during Analysis Period

302

All Hospitals



Hospital Details



Before or After Enrollment
■ Before ■ After

Most Recent Payer
All

Time Period
1 Month

Visit Type
All

Sorting Option
Total Visits - After Enrollment

Hospital Name
All

Program Name
Program3-ED-FY19 (210048)

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator

AND
 OR

Casemix Data Through: - MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
 - Data source:

07/31/2019 - Panel information provided to CRISP by ENS
 - HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals

ENS Panels Last Updated: 09/15/2019
 - 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.

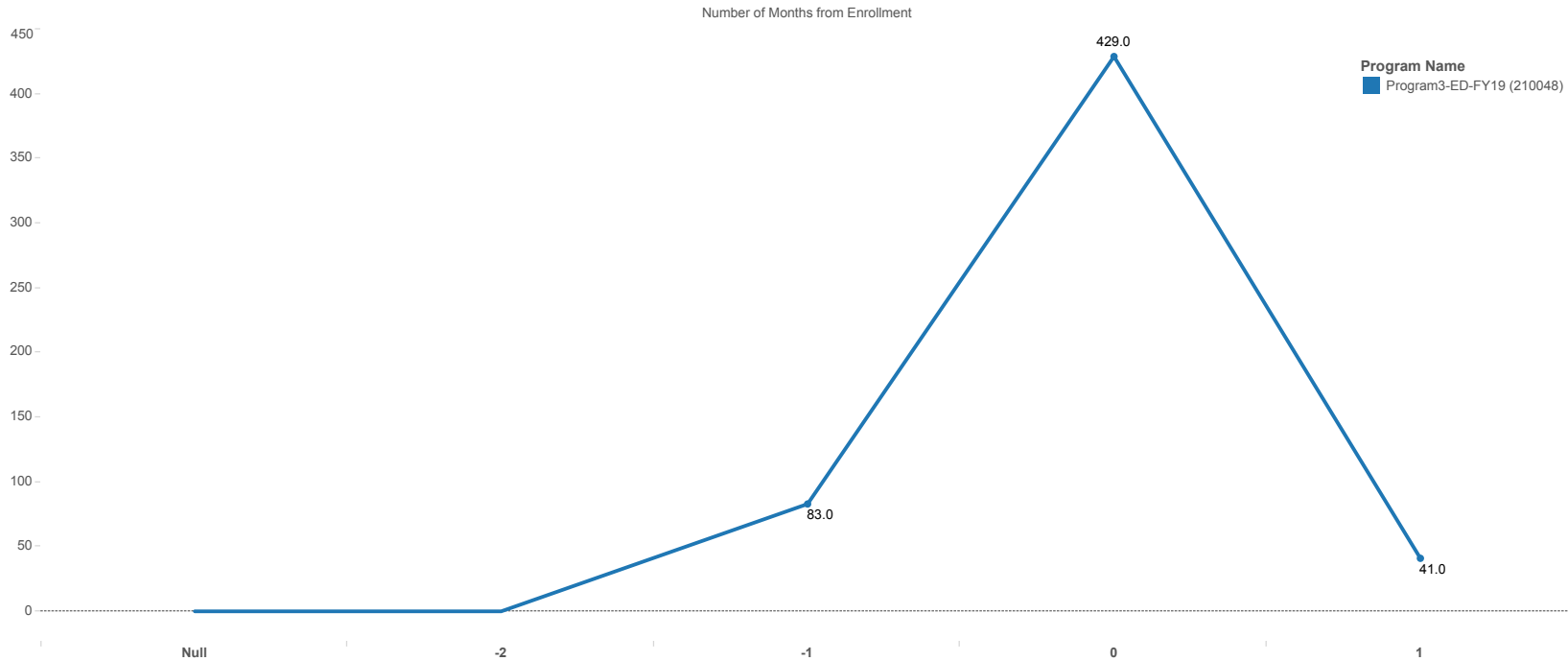
- Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.

Pre/Post Analysis

Analysis of 1 Month 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.

Relative Trend



- Most Recent Payer: All
- Time Period: 1 Month
- Trend Metric: Visits
- Visit Type: All
- Hospital Name: All
- Program Name: Program3-ED-FY19 (210048)
- Chronic Conditions: All Patients
- N/A
- N/A
- Chronic Condition Operator:
 - AND
 - OR

Casemix Data Through: - 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

ENS Panels Last Updated:

- 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 1 Month of Visits Before and After the Enrollment Date

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

Most Recent Payer

All

Visit Type

All

Hospital Name

All

Time Period

1 Month

Program Name

Program3-ED-FY19 (210048)

Chronic Conditions

All Patients

N/A

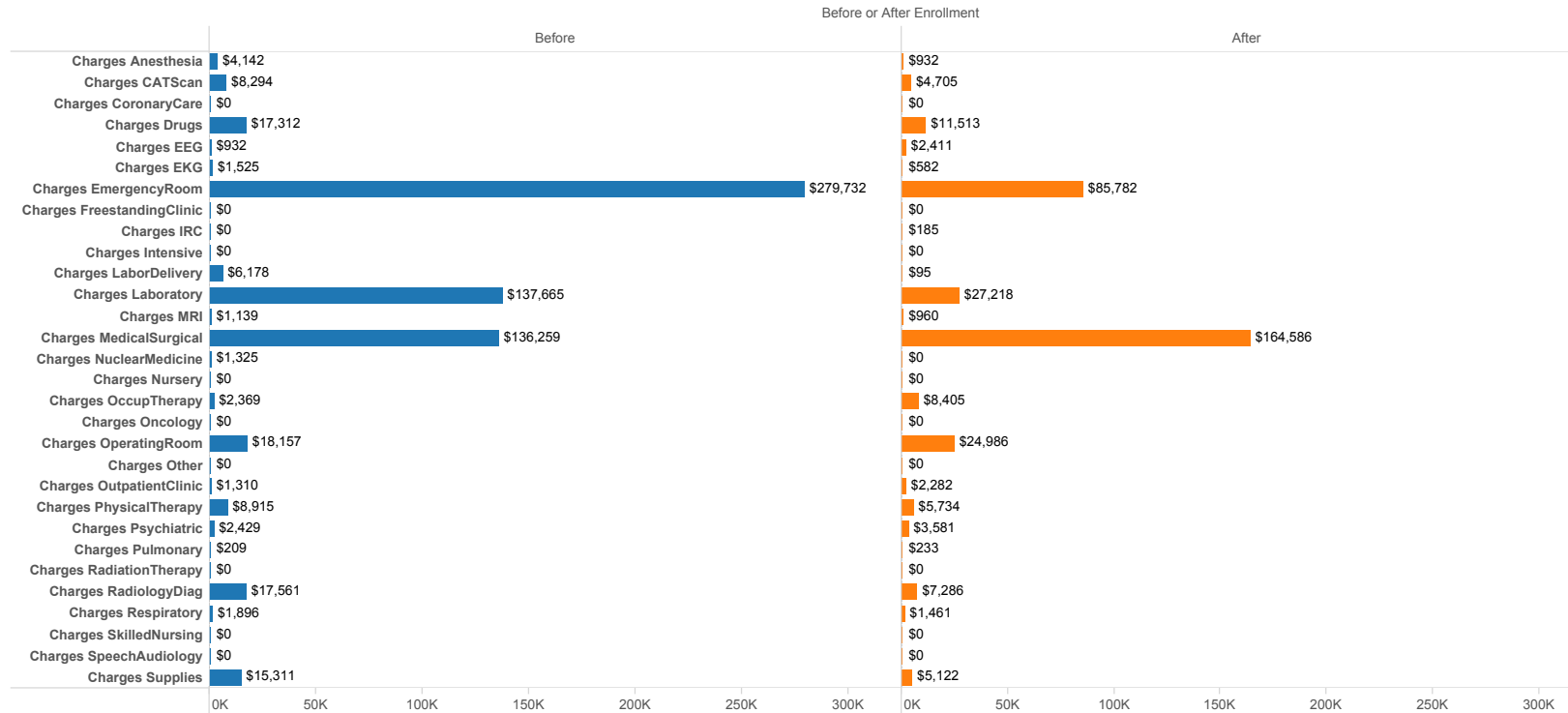
N/A

Chronic Condition Operator

AND

OR

Breakdown of Charges Sheet



Casemix Data - MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.

Through:

07/31/2019

ENS Panels

Last Updated:

09/15/2019

- 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.