HSCRC Regional Partnership Transformation Grant

FY 2019 Report

Regional Partnership Information

Regional Partnership (RP) Name	**LifeBridge Health System**
RP Hospital(s)	• Sinai Hospital of Baltimore • Northwest Hospital • Carroll Hospital
RP POC	Sharon McClernan, RM, BSN, MBA, MHA Vice President for Clinical Integration AVP of Population Health sharong@carrollhospitalcenter.org
RP Interventions in FY 2019	• Community Care Coordination – Sinai Hospital of Baltimore and Northwest Hospital • Emergency Department Navigation – Sinai Hospital of Baltimore and Northwest Hospital • Behavioral Health Navigation – Carroll Hospital • Coordination of Care in Elderly population
Total Budget in FY 2019 *This should equate to total FY 2017 award*	**APPENDIX A: LifeBridge Health 2019 HSCRC Transformation Implementation Budget and Expenditures**

Hospital Site	FY2019 Amount
Sinai	$565,510
Northwest	$318,004
Carroll	$196,803
TOTAL Budget	**$1,080,317**

Total FTEs in FY 2019	Employed: 16.8 FTEs
	Contracted: None
Program Partners in FY 2019 *Please list any community-based organizations or provider groups, contractors, and/or public partners*	1. The Coordinating Center 2. Absolute Care 3. DeVita 4. Season's Hospice 5. Pulse 6. Future Care

	7. Home Care Maryland 8. Access Carroll 9. Community Health Partnership of Baltimore (CHPB) 10. Carroll Lutheran Village

Overall Summary of Regional Partnership Activities in FY 2019

(Free Response: 1-3 Paragraphs):

The Transformation Grant Funds have been instrumental in growing and enhancing services across Sinai, Northwest and Carrol. In partnership, the hospitals are working together more collaboratively to strategize around ways to meet our aligned utilization and financial goals, share best practices, and coordinate services to better meet the needs of our shared and individual patient populations. All of the programs are successful due to the robust collaboration with our community and system-wide partners and the dedication of our team members.

Sinai and Northwest's Community Care Coordination and ED Navigation programs have added FTEs affording the ability to expanded services to additional high and rising risk populations. Community Care Coordination's model shifted from a model that had a team of all disciplines assigned to a case to one that assigned a primary with other disciplines being pulled in as needed. This shift allows for a more scalable program, disciplines practicing at the top of their scope and resource efficiency. The program has also developed more strategic relationships with community partners (Absolute Care and The Coordinating Center) to establish system alerts and workflows to improve communication and coordination for shared patients.

At Carroll Hospital, the behavioral health navigator has been an important addition to the team to focus on meeting the needs of the high-risk patients in the community. Providing care coordination services in a senior continuing care community has allowed a unique focus on prevention and quality of life for those independent living residents. Outpatient palliative care is imperative to address the complex needs of the population while focusing on symptom management, improving quality of life and honoring patient's wishes for goals of care.

HSCRC Regional Partnership Transformation Grant

FY 2019 Report

Intervention Program

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

Intervention or Program Name	Community Care Coordination
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	LifeBridge Health System Hospitals • Sinai Hospital of Baltimore (Core Program Sponsor) • Northwest Hospital • Carroll Hospital
Brief description of the Intervention *2-3 sentences*	Community Care Coordination is an ambulatory community-based care management program serving high, moderate/ rising at-risk patients accessing health care services through LifeBridge Health System hospitals or partnering facilities. The program provides individualized interventions; meeting each patient where they are in their health care journey. The Community Care Coordination team focuses on improving the medical, behavioral and social health of identified patients. The multi-disciplinary team of Registered Nurses (RNs), Social Workers (SWs), and Community Health Workers (CHWs) engage patients at various points of service across the health care continuum and throughout the community. Interventions and services are delivered via face to face and telephonic encounters. The team works collaboratively with other care team members and community agencies to address drivers for the over and under-utilization of health care services.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	Program Partners through the CHPB: 1. Sisters Together and Reaching, Inc. (Community Care Team) 2. Health Care for the Homeless 3. Behavioral Health Bridge Team 4. Patient Engagement Program Training 5. **Table 1. Program Community Partners**
Patients Served *Please estimate using the Population category that best applies to the Intervention, from the CY 2018 RP Analytic Files.*	# of Patients Served as of June 30, 2019: 694
	Denominator of Eligible Patients: Unknown

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.*	
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	**APPENDIX B: Community Care Coordination Program (Sinai and Northwest) Results with Comparison Group**
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.*	**Touchpoint:** / **Count:** Bedside Visit: 295 Care Plan Update: 232 Community Outreach: 84 CRISP Follow Up: 1 Home Visit: 650 Office Visit: 519 Others: 207 Phone call: 6,275 Referral: 352 Resource follow up: 674 Transportation Assistance: 742 Total number of touchpoints: 10,031
Successes of the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	• Established relationships with external partners, Absolute Care and The Coordinating Center, for the purposes of collaboration and coordination of shared patients • Began disease specific rounds with service lines • Developed team-based model assignment to service lines and PCPs for direct care coordination team connections for continuity and follow-up. • Established high-risk list delivery process for payer groups • Piloted a modified health related social needs being initiates in provider practices resulting in program referral identification and improve communication and coordination for our patients

Lessons Learned from the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	• Defining the intervention population is key in maintaining focused interventions for front end staff and referral sources. • A mixed model of face to face and telephonic interventions can be a more successful program strategy. • Aligning discipline resources so that everyone practices at the top of their license not only provides a more efficient program but also supports and maintains staff engagement.
Next Steps for the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	• Integrate care coordination functions with LifeBridge Community Practices • Develop Palliative Care Program • Better leverage CRISP functionality to support day to day care coordination efforts. • Explore new documentation systems that will meet programs' integration and analytical needs.
Additional Free Response (Optional)	LBH Community Care Coordination (CCC) Patient success stories of programmatic impact: ***Story #1*** Mr. E has a past medical history of Hypertension and a Stroke in July 2018. Mr. E was referred December 2019 by Department of Neurology for concerns related to lack of insurance, safety, managing care and knowledge deficits. CCC SW assisted with connection to Sinai Community Care for primary care; Wal-Mart's $4 prescription co-pay list; patient financial assistance; engagement with Department of Aging for ongoing support and assistance; assistance obtaining documents for work furlough and application for Home Depot financial fund to help pay medical bills and directives and linkage to SHIP for enrollment in Medicare A-D in addition to accompaniment to all appts to assist with recommendations. Mr. E is now connected with no ED visits or admissions since enrollment. Mr. E was living with a friend and felt that was not wanted there. A CHW was brought in on the team to assist with housing options and transportation needs. Mr. E has often expressed his gratitude for the program's support.

	Story #2 Mr. W has a past medical history of Afibrillation, Alcohol related Dementia, Hypertension, and Colon Cancer was referred July 2019 by inpatient Case Manager after leaving against medical advice from Northwest Hospital and returned to Sinai by police. Mr. W had frequent admissions related to Hypertension and disorientation. He lives on his own and was drinking a high quantity of alcohol daily which impacted his cognition, safety and management of health. Mr. W had no BGE when CCC became involved. The RN and SW became involved; assisted with the Fuel Fund to restore his BGE; provided medication management; linked to all recommended specialist; educated and encouraged participation from sons to help manage health; assisted with mobility approval; connected to Adult Protective Services related to self-neglect and case management to assistance with substance use disorder. The CCC team conducted home visits and accompanied him to all appts to ensure compliance and follow-up. Mr. W now has wrap around support, takes medication as prescribed, drinks much less, sees PCP and all Specialist per plan of care.

Intervention or Program Name	Emergency Department Navigation
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	• Sinai Hospital of Baltimore • Northwest Hospital
Brief description of the Intervention *2-3 sentences*	The Community Health Workers in ED Navigation see patients that are high utilizers of the ED and are more than likely to be readmitted to the hospitals within 30 days. Interventions with patients include assessing barriers to medical care, addressing transportation issues, assisting with medication issues, finding patients a Primary Care Provider, Psychiatrist or Specialist, making medical appointments and linking patients to community resources. Patients are followed for 30 days from discharge form the Emergency Room and can be transitioned to the Community Care Coordination program for ongoing care management needs.

HSCRC Regional Partnership Transformation Grant

FY 2019 Report

<table>
<tr><td>Participating Program Partners
Please list the relevant community-based organizations or provider groups, contractors, and/or public partners</td><td>Table 1. Program Community Partners</td></tr>
<tr><td rowspan="2">Patients Served
Please estimate using the Population category that best applies to the Intervention, from the CY 2018 RP Analytic Files.
HSCRC acknowledges that the High Utilizer/Rising Risk or Payer designations may over-state the population, or may not entirely represent this intervention's targeted population.
Feel free to also include your partnership's denominator.</td><td># of Patients Served as of June 30, 2019:
<table><tr><td>Sinai</td><td>1,231</td></tr><tr><td>Northwest</td><td>1,016</td></tr></table></td></tr>
<tr><td>Denominator of Eligible Patients:
<table><tr><td>Sinai</td><td>4,515</td></tr><tr><td>Northwest</td><td>4,815</td></tr></table></td></tr>
<tr><td>Pre-Post Analysis for Intervention
(optional)

If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.</td><td>APPENDIX C: Emergency Department Care Management (Sinai and Northwest) Results with Comparison Group</td></tr>
<tr><td>Intervention-Specific Outcome or Process Measures
(optional)
These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership maintains and uses to analyze performance.
Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.</td><td></td></tr>
<tr><td>Successes of the Intervention in FY 2019
Free Response, up to 1 Paragraph</td><td>The interventions of Community Health Workers in the ED at both Northwest and Sinai have had a tremendous impact on reducing hospital readmissions. Patients have been able to receive 30 days of short term care management services to address their social determinants to their health care disparities. Transportation assistance has enabled patients successfully compliance with medical appointments and establish a medical home. Care Coordination intervention have been provided to ensure that all medical needs and</td></tr>
</table>

	barriers to treatment are met. Additional successful interventions include lineage with community resources addressing housing, food, clothing, employment, substance abuse treatment, psychiatric treatment, education and work force development training.
Lessons Learned from the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	The interventions and work of Community Care Health Workers in the ED Navigation program has demonstrated the importance of care coordination. Community Health Workers have been able to complete assessments identify social determinants of health. What has been learned during this year beyond community resources and addressing patient barriers, is the positive impact of the art of motivational interviewing and active listen skills. Community Health Care Workers establish short term relationships with patients and connect them to care and resources while empowering them to appropriately navigate the health care system for care. Furthermore, we have learned that face to face interaction with patients and providing transitional support to patients improves overall quality of care.
Next Steps for the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	• Continue to hone interventions and motivational interviewing techniques. • Explore and develop resource connections for desperately needed legal services and immigration services • Establish work development programs and educational resources for CHWs • Provide opportunities for more community resource agencies to visit our hospitals to share and collaborate

Intervention or Program Name	Behavioral Health Navigation – Carroll Hospital
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	Carroll Hospital
Brief description of the Intervention *2-3 sentences*	The Behavioral Health Navigator is a Social Worker, LCSW-C, who is part of the Behavioral Health department. She provides Care Coordination Services for high risk patients who have behavioral health and substance use issues.

<table>
<tr><td></td><td>Referrals come through an automated documentation system, from the inpatient and outpatient BH units, physicians as well as identified of high risk patients.</td></tr>
<tr><td>Participating Program Partners
Please list the relevant community-based organizations or provider groups, contractors, and/or public partners</td><td>• Access Carroll
• Carroll County Health Department</td></tr>
<tr><td rowspan="2">Patients Served
Please estimate using the Population category that best applies to the Intervention, from the CY 2018 RP Analytic Files.
HSCRC acknowledges that the High Utilizer/Rising Risk or Payer designations may over-state the population, or may not entirely represent this intervention's targeted population.
Feel free to also include your partnership's denominator.</td><td># of Patients Served as of June 30, 2019

BH Navigator
<table><tr><td>Unique patients</td><td>248</td></tr><tr><td>Encounters</td><td>2,436</td></tr></table></td></tr>
<tr><td>Denominator of Eligible Patients: Unknown</td></tr>
<tr><td>Pre-Post Analysis for Intervention
(optional)
If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.</td><td>APPENDIX D: Number of visits 90 days before navigation and 90 days after navigation (only for those patients who have had at least 90 days since their case was opened).</td></tr>
<tr><td>Intervention-Specific Outcome or Process Measures
(optional)

These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership maintains and uses to analyze performance.
Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.</td><td>Utilization before and after intervention by Navigator
Success stories are tracked and shared on a regular basis.</td></tr>
<tr><td>Successes of the Intervention in FY 2019
Free Response, up to 1 Paragraph</td><td>The Behavioral Health Navigator has successfully worked with patients to refer to treatment and provide resources. In addition, she networks with community agencies and internal partners to coordinate care in the most appropriate and cost effective setting to promote positive patient outcomes.</td></tr>
</table>

HSCRC Regional Partnership Transformation Grant

FY 2019 Report

Lessons Learned from the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	More than one full time FTE for Behavioral Health Navigation is needed to meet the needs.
Next Steps for the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	Continue to grow the program and cross train other individuals to cover for BH Navigator.

Intervention or Program Name	Coordination of Care in Elderly Population
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	Carroll Hospital
Brief description of the Intervention *2-3 sentences*	Through a partnership between Carroll Lutheran Village (CLV) and Carroll Hospital, a Care Coordinator was hired by CLV to provide care coordination services to independent living residents of CLV. Referrals and made from the residents themselves, from physicians, from the hospital and from identification of high risk patients.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	• Carroll Hospital • Carroll Lutheran Village
Patients Served *Please estimate using the Population category that best applies to the Intervention, from the CY 2018 RP Analytic Files.* *HSCRC acknowledges that the High Utilizer/Rising Risk or Payer designations may over-state the population, or may not entirely represent this intervention's targeted population.* *Feel free to **also** include your partnership's denominator.*	# of Patients Served as of June 30, 2019: Unique patients: 251 Encounters: 2,643
	Denominator of Eligible Patients: Unknown
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	Included in overall Navigator data.

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.*	Utilization before and after intervention by Navigator Success stories are tracked and shared on a regular basis Obtaining accurate specific pre and post intervention data for this specific program has been difficult post Cerner Go Live. This is currently being worked on.
Successes of the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	The Care Coordinator has become the person that residents seek out when they need resources. She has been able to proactively identify and reach out to patients as well as educate on health needs and community resources.
Lessons Learned from the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	A Care Coordinator in this setting is a valuable resource to direct care to the most appropriate setting and reduce unnecessary hospital utilization as well as proactively identify health issues and refer patients to their physicians.
Next Steps for the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	Meet with CLV to determine and encourage support of the program going forward.

Intervention or Program Name	Outpatient Palliative Care Program (OPPC)
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	Carroll Hospital
Brief description of the Intervention *2-3 sentences*	The OPPC Care Nurse works with individuals who are diagnosed with chronic illness. She collaborates with physicians, NPs and other providers to coordinate symptom management and provides resources and support to patients and families in the outpatient setting.

HSCRC Regional Partnership Transformation Grant

FY 2019 Report

Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	• Carroll Hospital, • Carroll Hospice, • Skilled Nursing Facilities • Home Care Agencies • Physicians
Patients Served *Please estimate using the Population category that best applies to the Intervention, from the CY 2018 RP Analytic Files.* *HSCRC acknowledges that the High Utilizer/Rising Risk or Payer designations may over-state the population, or may not entirely represent this intervention's targeted population.* *Feel free to **also** include your partnership's denominator.*	<table><tr><td>Unique patients</td><td>396</td></tr><tr><td>Encounters</td><td>3,834</td></tr></table> Patients referred directly from OPPC to Hospice in FY 2019 - 158
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	Specific data is unavailable at this time due to post-Cerner go live. This is being worked on**.**
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.*	Not yet available, but to come: • Volume of unique patients and encounters • Pre and post intervention hospital utilization • Number of advanced directives obtained • # of referrals to hospice
Successes of the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	Working with individual patients; addition of a NP resource who can see patients in the home; engagement of primary care physicians in palliative care principles; working with Skilled nursing facilities providing education and consults in the SNFs; collaborating with home care agencies by taking referrals, providing education for staff; providing Advanced Directives days where community members can learn about Advanced Directives, complete their own advanced directive and have that scanned into the medical record.

Lessons Learned from the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	• Need more OPPC resources • Need RN, Social Worker, Chaplain and NP resources
Next Steps for the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	Evaluate program both at the hospital and system levels to determine best model and promote efficiencies.

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 APPENDIX E, F & G: Detailed Dashboards

<table>
<tr><th>Measure in RFP
(Table 1, Appendix A of the RFP)</th><th>Measure for FY 2019 Reporting</th><th>Outcomes(s)</th></tr>
<tr><td>Total Hospital Cost per capita</td><td>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)</td><td>Year to Date Per Capital Utilization through June 2019

<table><tr><td>Sinai</td><td>$424, 5.3% unfavorable variance</td></tr><tr><td>Northwest</td><td>$171, 3.8% unfavorable variance</td></tr><tr><td>Carroll</td><td>$151, 0.7% unfavorable variance</td></tr></table></td></tr>
<tr><td>Total Hospital Discharges per capita</td><td>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</td><td>Year to Date Per Capital Utilization through June 2019

<table><tr><td>Sinai</td><td>10, -7.2% favorable variance</td></tr><tr><td>Northwest</td><td>6, -11.1% favorable variance</td></tr></table></td></tr>
</table>

	-or- Analytic File: 'IPObs24Visits' over 'Population' (Column G / Column C)	<table><tr><td>Carroll</td><td>7, 1.8% unfavorable variance</td></tr></table>
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 -or- Analytic File 'ED Visits' over 'Population' (Column H / Column C)	**Year to Date Per Capital Utilization through June 2019** <table><tr><td>Sinai</td><td>42, -0.8% favorable variance</td></tr><tr><td>Northwest</td><td>35, -6.7% favorable variance</td></tr><tr><td>Carroll</td><td>30, -1.6% favorable variance</td></tr></table>

Quality Indicator Measures APPENDIX H: 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)	**June 2019 rate, with variance compared to June 2018** <table><tr><td>Sinai</td><td>10.4%, 10.8% unfavorable variance</td></tr><tr><td>Northwest</td><td>8.4%, -27.9% favorable variance</td></tr><tr><td>Carroll</td><td>12.6%, 0% variance</td></tr></table>

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)	<table><tr><td>Sinai</td><td>$29,086,981, 6.2% unfavorable variance</td></tr><tr><td>Northwest</td><td>$19,042,774, -7.8% favorable variance</td></tr><tr><td>Carroll</td><td>$19,678,756, -16.9% favorable variance</td></tr></table>

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.*	

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

As LifeBridge continues this mission of improving quality and reducing total cost of care, we look forward to strengthening our regional community partner relationships. We will seek out and welcome more opportunities to collaborate and coordinate services with other health care facilities and community-based organizations providing needed services to those we all serve. We will also continue to partner with CRISP to find solutions that improves this region's access to health information, supports longitudinal care planning and optimizes care coordination with our health care partners.

Throughout this fiscal year, we will be relying heavily on analytics that will inform data driven interventions. Identifying and stratifying high and rising risk patients to engage for interventions will be the focus for all of our programs. As we look to scale, we will continue to strategize to find evidence based, effective and more efficient ways to provide vastly needed services. We will work with our provider community to develop workflows that support risk identification at the point of service to promote communication, collaboration and/ or referral to care coordination or community resources.

Approaching the conclusion of the grant in its current structure, we remain energized to continue the work of helping to mitigate social barriers and improve health outcomes of our communities and look forward to future grant opportunities that will support this work.

APPENDIX A: LifeBridge Health 2019 HSCRC Transformation Implementation Budget and Expenditures

As demonstrated in the attached budgetary documents LifeBridge Health (LBH) has designed a comprehensive Transformation Implementation Program budget for year two of the award, per HSCRC requirements. The following accounts for the outlined budget projections for this past fiscal year and also highlights in-kind investments made in the program by LBH.

As was discussed in the accompanying report, we anticipate that we will continue to increase staffing and operational expenditures as the program matures and as we scale our efforts across the LBH enterprise. The budget documents present a combined request from all three acute-care hospitals in the LifeBridge Health network:

Hospital Site	FY2019 Amount
Sinai	$565,510
Northwest	$318,004
Carroll	$196,803
TOTAL Budget	**$1,080,317**

Cost per intervention:
Our overall programmatic goal is to optimize care coordination services for high utilizers through a system-wide approach which integrates:

1. A community care coordination model of RN's and Social Workers. (In fiscal year 2019, we added a Manager, 1 RN, 1 SW, and two community health workers to this staffing matrix to support continued program growth.) This team will continue to work with high utilizers identified by the hospital as well as by primary care and specialty clinics within the LifeBridge network.
2. Care Navigation in the Emergency Departments at Sinai and Northwest
3. Increased utilization of our already integrated, professionally staffed, 24/7 call center.
4. Behavioral Health Navigation at Carroll Hospital.
5. Partnership with a local CCRC in Carroll County to expand care coordination services to over 600 Medicare beneficiaries at that site.

The total cost for these interventions is **$1,472,542.**

Cost per category: The costs for each of the key categories identified in the Healthcare Transformation Implementation Plan Request for Proposals (RFP) are as follows (for all interventions combined):

Workforce: **$1,206,845.** The staffing plan was designed based on our funding parameters and staffing model. We initially utilized the Berkeley Research Group (BRG) to provide a staffing matrix framework to support the program build, based on evidence-based practices and BRG's expertise on the Maryland All-Payer system. As the program has continued to mature and evolve,

we continue to evaluate appropriate staffing ratios based upon patient acuity and psycho-social complexity.

The departments involved in Clinical Transformation activities include Population Health and Care Management – both of which will continue to support the workforce for this program. In fiscal year 2019 will include Ambulatory Quality will also be encompassed within our division.

- **Information Technology (IT): $49,336**. The majority of these costs are related to clinical call center support and standard technology components for all new-hired personnel. These costs are detailed in the budget document in HSCRC's format and include such items as computers, printers, call center licenses, and cell phones.

- **Other implementation activities**: **$129,844.** Other costs primarily include Patient transportation and education, pharmacy support and staff travel, training and supplies. Overtime we will continue to refine this line item as we have been identifying intra-system synergies to contain these cost elements.

- **Indirect costs: $86,517**. LBH is using a 10% facilities & administration (F&A) rate for this proposal, even though the calculated F&A rate for each hospital is over 20% per IRS Form 990. LBH appreciates that funding available for the Transformation Implementation Program is extremely limited given the scale of work necessary to meet the goals of the All-Payer Model. This funding for overhead is the same rate that LBH accepts for NIH Cooperative Group Clinical Oncology trials that strive to provide an extremely significant public benefit with relatively limited funds.

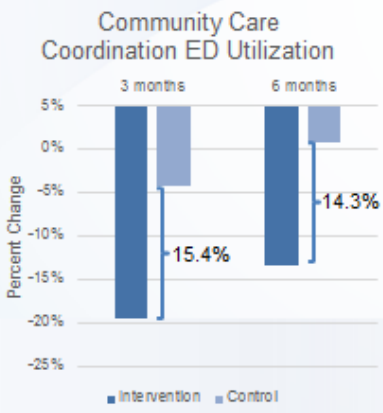
  LBH's F&A rate is aligned with CFR 2 Part 200.420 regarding costs that are "incurred for common or joint objectives and therefore cannot be identified readily and specifically with a particular sponsored project, an instructional activity, or any other institutional activity." These include depreciation and interest cost associated with the institution's physical plant; operating and maintenance costs such as utility/facility costs (rent, heat, electricity, etc.); security costs; custodial costs; and common administrative functions such as payroll and purchasing.

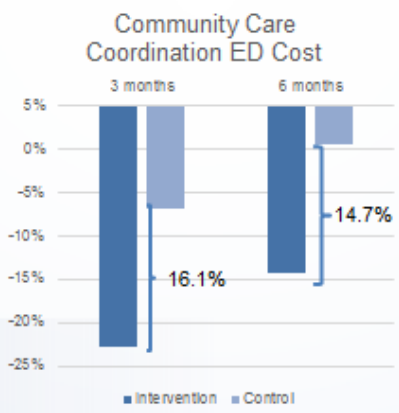
- **In-Kind:** LifeBridge contributed **$77,981** towards the total program budget of **$1,080,317** for this fiscal year. Overall management of this program necessitates significant analytic-based support in conjunction with operation and fiscal management. Consequently, the level of in-kind investment on behalf of LBH is instrumental in ensuring operational effectiveness and programmatic success.

APPENDIX B: Community Care Coordination Program (Sinai and Northwest) Results with Comparison Group (source: CRISP Pre/Post Panel)

The Community Care Coordination Program (CCC) reduces ED utilization and readmissions

Intervention	Control
Medicare patients with 2+ inpatient, observations, or ED visits, in 2017 or 2018 at Sinai or Northwest	Medicare patients with an admission episode in 2017 at Sinai or Northwest as identified through the CRISP MADE tool and not in the intervention group

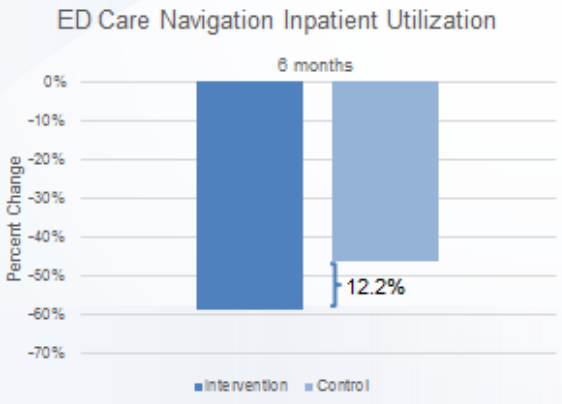


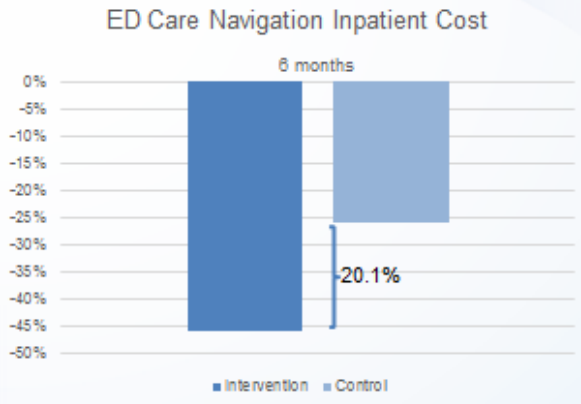


APPENDIX C: Emergency Department Care Management (Sinai and Northwest) Results with Comparison Group (source: CRISP Pre/Post Panel)

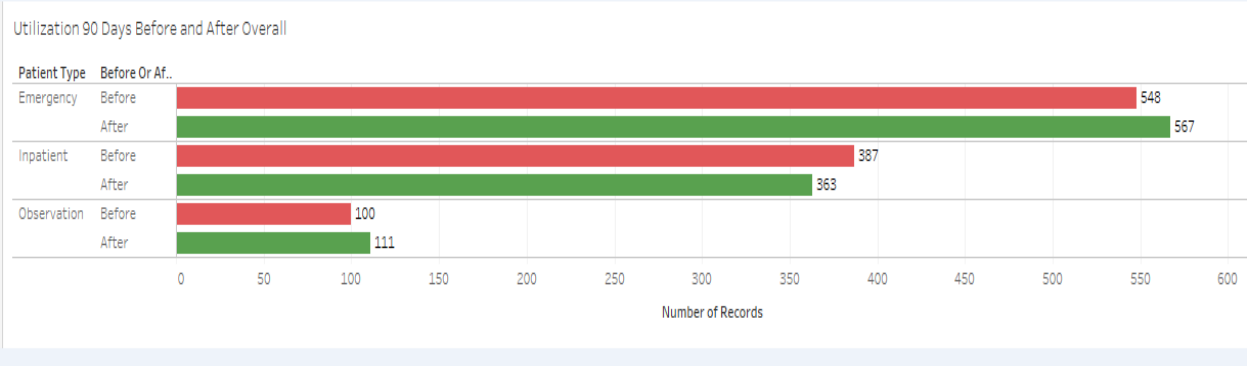
Emergency Department Care Management reduces inpatient utilization

Intervention	Control
Patients with ED visits at Sinai or Northwest identified as high risk for readmission and seen by an ED care navigator	Patients with ED visits in 2018 at Sinai or Northwest, identified as high risk for 30 day readmission and never seen by an ED care navigator
Most recent encounter is index date	Most recent encounter is index date





APPENDIX D: Number of visits 90 days before navigation and 90 days after navigation (only for those patients who have had at least 90 days since their case was opened).



APPENDIX E: Detailed Dashboard – Sinai Hospital

Detailed Dashboard

Month: June, 2019 | Regional Partnership: Lifebridge | Hospital Name: Sinai Hospital | Payer: All Payer

25, 75 Percentiles
Zero

Regional Partnership
Hospital
State

Lifebridge Utilization - June, 2019

Metric	Jun 18	Jun 19	Variance
Total Hospital Charges	$42,326,331	$43,893,584	3.7%
Inpatient Discharges	1,132	983	-13.2%
Outpatient ED Visits	4,555	4,246	-6.8%

YTD Hospital Utilization

Jun 18	Jun 19	Variance
$264,166,492	$278,194,768	5.3%
6,944	6,443	-7.2%
27,996	27,760	-0.8%

Regional Partnership Per Capita Utilization - June, 2019

Per Capita Utilization at Selected Hospitals for Lifebridge

Metric	Jun 18	Jun 19	Variance
Hospital Charges per Capita	$65	$67	3.7%
Hospital Discharges per 1000	2	1	-13.2%
Outpatient ED Visits per 1000	7	6	-6.8%

YTD Hospital Per Capita Utilization

Jun 18	Jun 19	Variance
$403	$424	5.3%
11	10	-7.2%
43	42	-0.8%

APPENDIX F: Detailed Dashboard – Northwest Hospital

Lifebridge Utilization - June, 2019

Metric	Jun 18	Jun 19	Variance	
Total Hospital Charges	$17,829,198	$18,151,010	1.8%	↑
Inpatient Discharges	678	628	-7.4%	↓
Outpatient ED Visits	4,097	3,664	-10.6%	↓

YTD Hospital Utilization

Jun 18	Jun 19	Variance	
$108,006,082	$112,088,577	3.8%	↑
4,365	3,882	-11.1%	↓
24,732	23,080	-6.7%	↓

Regional Partnership Per Capita Utilization - June, 2019

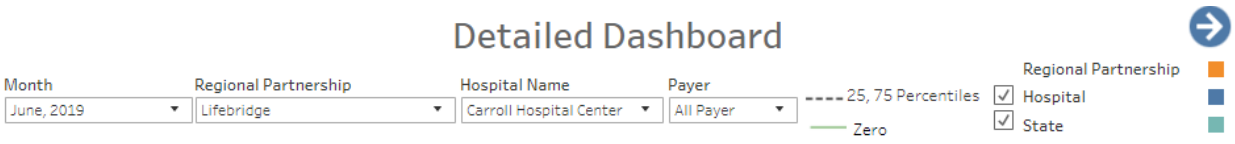
Per Capita Utilization at Selected Hospitals for Lifebridge

Metric	Jun 18	Jun 19	Variance	
Hospital Charges per Capita	$27	$28	1.8%	↑
Hospital Discharges per 1000	1	1	-7.4%	↓
Outpatient ED Visits per 1000	6	6	-10.6%	↓

YTD Hospital Per Capita Utilization

Jun 18	Jun 19	Variance	
$165	$171	3.8%	↑
7	6	-11.1%	↓
38	35	-6.7%	↓

APPENDIX G: Detailed Dashboard – Carroll Hospital



Lifebridge Utilization - June, 2019

Metric	Jun 18	Jun 19	Variance
Total Hospital Charges	$15,450,753	$15,034,491	-2.7%
Inpatient Discharges	774	793	2.5%
Outpatient ED Visits	3,265	3,208	-1.7%

YTD Hospital Utilization

Jun 18	Jun 19	Variance
$97,955,041	$98,688,794	0.7%
4,819	4,905	1.8%
19,618	19,305	-1.6%

Regional Partnership Per Capita Utilization - June, 2019

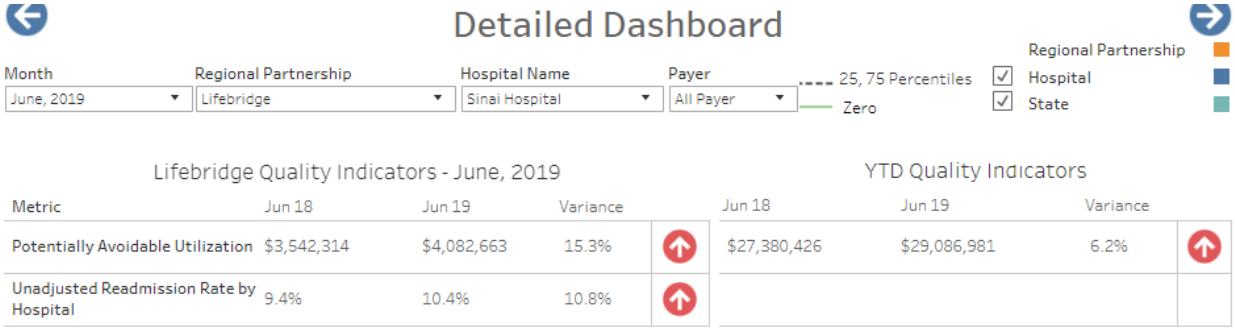
Per Capita Utilization at Selected Hospitals for Lifebridge

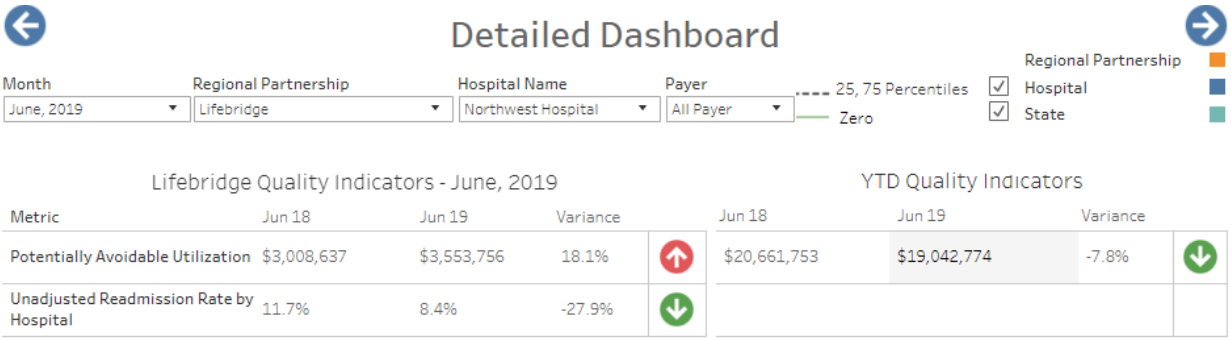
Metric	Jun 18	Jun 19	Variance
Hospital Charges per Capita	$24	$23	-2.7%
Hospital Discharges per 1000	1	1	2.5%
Outpatient ED Visits per 1000	5	5	-1.7%

YTD Hospital Per Capita Utilization

Jun 18	Jun 19	Variance
$149	$151	0.7%
7	7	1.8%
30	29	-1.6%

APPENDIX H: Quality Indicator Measures





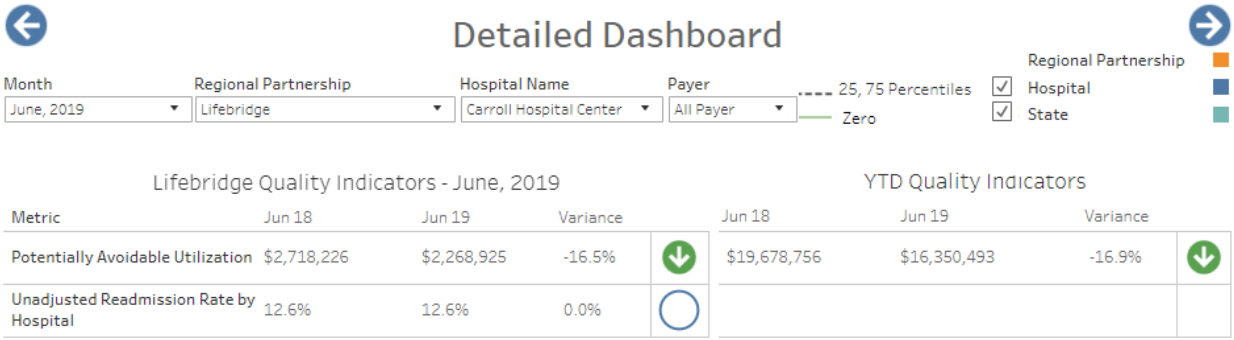


Table 1. Program Community Partners

Homeless Shelters & Services
Weinberg Housing and Resource Center-Code Blue Shelter
Health Care for the Homeless
Our Daily Bread Employment Center
Eastern Family Resource Center
Baltimore County Westside Men's Shelter
Food
Baltimore City Social Services
Baltimore County Social Services
Community Assistance Network
Maryland Food Bank
Langston Hughes Community Resource Center
Calvary Baptist Church
Transforming Life Outreach Ministry
Transportation
MTA Mobility
Uber
Legal/ Hispanic Services
Esperanza Center Maryland Legal Aid
Primary Care
Chase Brexton
Sinai Community Care Clinic
Sinai Community Care Clinic
Jai Medical Center
Dental Services
Kool Smiles
University of MD Dental School
Keypoint Health Services
Psychiatry
Mosaic
Sinai Outpatient Psychiatry
JHBMC Acute Psychiatry Unit
JHBMC Chemical Dependency Unit (CDU)
JHH Intensive Treatment Unit (ITU)
JHH Motivational Behaviors Unit (MBU)

Recovery Network
S and S Counseling Services
Starting Point
New Horizon Health Services Inc.
BH Health Services Inc.
North Carroll Counselling Center
Walter P Carter Center
Substance Abuse Treatment
A.F. Whitsitt Center
Alliance Incorporated
American Addictions Center
Avery Road (under Mountain Manor)
Christopher Place
Chrysalis House
Delphi Behavioral Health Group
Father Martin's Ashley/Ashley Addiction
Gaudenzia- Park Heights
Helping Up Mission (HUM)*
Hilltop Recovery Center
Hope House- Crownsville
Hope House- Laurel
Hudson Health
Massie Unit
MCVET (MD Center for Veteran Education Training)
Mountain Manor- Baltimore
Mountain Manor- Emmitsburg
Pathways (through AAMC)
Powell Recovery Center
Recovery Network
Right Turn of Maryland
Serenity Acres
Shoemaker (under Mountain Manor)
South Baltimore Station*
The Salvation Army Adult Rehabilitation Center
Tuerk House
Warwick Manor Behavioral Health
Beacon House (Frederick Rescue Mission)
Bridge House
Bright Hope House

Build Fellowship, Inc.
Caton House
Chip House
Damascus House
Four States, Christian Mission, Inc.
Fresh Start Recovery House
Friendship House
Hamilton House
I Say No 2, Inc.
Mann House
Nazareth House
Olson House
Prodigal Son House
Seton Hill Station Treatment Center
Wells House Inc.
Valley House
Building Veterans
Recovery Houses
Bright Hope House
Daysprings
Gale House
Homecoming Project Inc.
My Sister's Center for Women
Marian House
Martha's Place
Beginning Effective Recovery Together (BERT)
Mattie B. Uzzle Center
The W House
A Step Forward, Inc.
Beginning Effective Recovery Together (BERT)
Bridge House
Evolve Life Centers
I Can, We Can
Our New House, Inc.
Our New House, Inc.
Port Recovery
Project PLASE
Wakefield House