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	Nexus Montgomery
RP Hospital(s)	Adventist HealthCare Shady Grove Medical Center, Washington Adventist Hospital, Holy Cross Germantown Hospital, Holy Cross Hospital, Medstar Montgomery Medical Center, and Suburban Hospital, a member of Johns Hopkins Medicine
RP POC	Susan Donovan, Managing Director, Nexus Montgomery
RP Interventions in FY 2019	1. Wellness for Seniors at Home (WISH) 2. Hospital Care Transitions (HCT) 3. Severely Mentally Ill (SMI) 4. Specialty Care for the Uninsured (Project Access) 5. Skilled Nursing Facility (SNF) Alliance 6. Community Advance Directives Program
Total Budget in FY 2019 *This should equate to total FY 2017 award*	FY 2019 Award: $7,663,683
Total FTEs in FY 2019	Employed: 23.43
	Contracted: 21.23
Program Partners in FY 2019 *Please list any community-based organizations or provider groups, contractors, and/or public partners*	Primary Care Coalition (PCC) Cornerstone Montgomery Jewish Social Service Agency (JSSA) Sheppard Pratt Health System SNF Alliance Members (37 Skilled Nursing Facilities) The Coordinating Center (TCC) There are many additional community partners involved with Nexus Montgomery, including other local nonprofits and public health

	departments. In addition, CRISP and Health Quality Innovators are working with Nexus Montgomery to provide data support.

Overall Summary of Regional Partnership Activities in FY 2019

(Free Response: 1-3 Paragraphs):

In FY19, Nexus Montgomery continued to build on the success of its existing infrastructure and programming. Across the five active programs, Nexus touched 23,330 individuals. Initial programs matured and adapted in response to evaluation. New initiatives, consistent with the goals of our regional partnership proposal, were launched and expanded.

The Wellness and Independence for Seniors at Home (WISH) program has engaged with over 2,200 individuals living in targeted communities. Enrolled individuals, who are proactively engaged in the community, experience a decline in hospital utilization as measured in a pre/post analysis. WISH demonstrated a positive return on investment, even as caseloads were lower than model expectations. In FY19, Nexus completed a process to right-size WISH based on the consistently observed need for the program. These changes should help increase ROI even further in future years.

The Hospital Care Transitions program continued to work on best practice sharing with focused discussions on shared pain points. The individual hospital programs continued their capacity building and program consolidation. Their programs saw an additional 1,400 discharges and improved on their reported ROI from 0.80 to 0.98, with 245 saved readmissions.

The Capacity Building for the Severely Mentally Ill (SMI) program, maintained gains from the original ACT team and Crisis House and expanded efforts with new initiatives. The Behavioral Health Workgroup brought together hospital and community providers to improve care coordination for 95 of the highest-utilizing individuals with SMI. Nexus contracted with Sheppard Pratt to develop a new, 16-bed Crisis House as demand continued to outpace capacity of this service and the current Crisis House produced a strong cumulative ROI of 7.42.

In FY19, Specialty Care for the Uninsured, operated by Project Access, provided 903 specialty care appointments for 369 unique patients at risk of returning to a Nexus hospital. In addition to paid visits, Project Access leverages an extensive network of pro-bono providers and discounted services. In total, the values of services provided through the program are more than double the direct financial investment.

The Skilled Nursing Facility (SNF) Alliance has successfully engaged 37 Skilled Nursing Facilities, 32 of whom completed all required steps for engagement, data use and quality improvement to be on the first Nexus preferred provider network. SNF Alliance efforts have contributed to a decrease in 331 rehospitalizations from SNFs, this was strongly driven by the 6 SNFs prioritized by Nexus for additional support based on the size of the savings opportunity.

In FY19, Nexus began implementation of a Community Advanced Care Planning program which seeks to improve quality of care at the end-of-life and to ensure that providers can respect patient's wishes. Through this program, Nexus will engage a range of community partners to promote conversations about end-of life care options, provide tools to aid in advance care planning and documentation, and

expand the use of electronic storage and retrieval services. Program design is underway, and Nexus expects to begin facilitated trainings in FY20.

Nexus has ambitious goals; aiming to engage with thousands of individuals and drive systems change that results in population-wide improvements. In FY19, we continued to see the results of these efforts not only through improvements for individuals engaged with interventions, but also with hospital and total cost of care savings in program target populations. These efforts contribute to In the Nexus target geographic areas, overall hospital utilization is decreasing, often at rates faster than state and national benchmarks.

Intervention Program

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

Intervention or Program Name	Wellness and Independence for Seniors at Home (WISH)
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	All Nexus Hospitals
Brief description of the Intervention *2-3 sentences*	Wellness and Independence for Seniors at Home (WISH) helps eligible seniors optimize health, remain independent at home, and reduce avoidable hospital use by connecting them to the services they need before their health declines. Currently, eligible seniors are those living in the targeted Independent Living Facilities (ILFs). Working through lay health coaches that are backed by Registered Nurses, seniors at risk of declining health receive an assessment of their health and social risks. Those at high risk for hospitalization receive ongoing individualized health coaching based around mutually agreed upon self-management goals and are connected with community-based support to help keep them out of the hospital.

Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	1. The Coordinating Center (TCC) 2. We also collaborate with: Participating Independent Living Facilities (See Appendix A)
Patients Served *Please estimate using the Population category that best applies to the Intervention, from the CY 2018 RP Analytic Files[1]. 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*	# of Patients Served as of June 30, 2019: FY19: 879[2] Cumulative Total: 2,316
	Denominator of Eligible Patients: **Program Denominator: 6,871** (Total Unique Beneficiaries in the ILF Buildings, from HQI, resident in 46 Independent Living Facilities) RP Analytic File: 46,853 patients (2+ Chronic Conditions & Medicare FFS)[3]

[1] Note: There is no annual total in the RPAF – this number is a cumulative total of each month for FY19

[2] Ever Engaged participants are individuals who have consented to participate in the program since October 2016. WISH has been focusing exclusively on the Independent Living Facilities since FY18.

[3] The RP Analytic File population significantly overstates the population for this program, as it is not restricted to residents of the target ILFs. Additionally, participants do not specifically require 2 chronic diseases to be eligible to become engaged – only an at-risk score on the Care At Hand tool, though many of them will.

partnership's denominator.	
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	The full Pre-Post report is included in Appendix B. This is a challenging metric for the WISH program, as once engaged, participants remain engaged in the WISH program and cycle through active and passive episodes based on need. The Pre-Post report only captures from their original enrollment date, so participants roll out of the report after 12 months. Due to this, of our total number of 2,282 ever enrolled participants, only 487 are captured in the pre-post report. We are evaluating using our CRISP extract to examine a longer time period. The WISH intervention has shown a positive impact on Medicare payments and hospital utilization for 6 months following enrollment. As a result, we focus on the 1, 3- and 6-month time periods. For FY19 we saw an overall decrease in visits – especially for Inpatient visits at the 1- and 3-month mark, and ED visits through all time periods. The increase in Obs visits is very small (2-3) compared to the population size.
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*	WISH program participation has grown consistently through FY19 in terms of both the number of episodes, clients and the number of referrals. A single client may have multiple episodes during a year, at both in active status; (level 1: intensive 60-day intervention) and in passive status (levels 2 and 3: level 3 is a passive monitoring state with level 2 being a short-term intervention around a specific health need). The total number of new active client episodes in the program has been trending up through FY19, ending with a total of 439 at the end of the year.

WISH Pre-Post Reporting

FY19

All Hospital Pre-Post	n	Total Charges per Visit			Total Number of Visits			Average Charges per Visit			Average Charges per Member			% decrease in visits
		Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	
All Hospital 1 Month	487	$792,640	$217,498	$ (575,142)	123	45	-78	$6,452	$4,833	$ (1,619)	$8,443	$6,042	$ (2,401)	-63%
All Hospital 3 Month	487	$1,138,198	$835,207	$ (302,991)	206	162	-44	$5,525	$5,156	$ (369)	$9,329	$9,491	$ 162	-21%
All Hospital 6 Month	487	$1,735,498	$1,921,527	$ 186,029	340	313	-27	$5,104	$6,139	$ 1,035	$10,269	$14,129	$ 3,860	-8%

FY19

In Patient Pre-Post	n	Total Charges per Visit			Total Number of Visits			Average Charges per Visit			Average Charges per Member			% decrease in visits
		Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	
In Patient 1 Month	487	$589,523	$144,907	$ (444,616)	37	11	-26	$15,933	$13,173	$ (2,760)	$17,339	$13,173	$ (4,166)	-70%
In Patient 3 Month	487	$792,742	$572,847	$ (219,895)	54	39	-15	$14,680	$14,688	$ 8	$18,436	$17,901	$ (535)	-28%
In Patient 6 Month	487	$1,223,878	$1,412,796	$ 188,918	73	84	11	$16,765	$16,819	$ 54	$22,664	$24,359	$ 1,695	15%

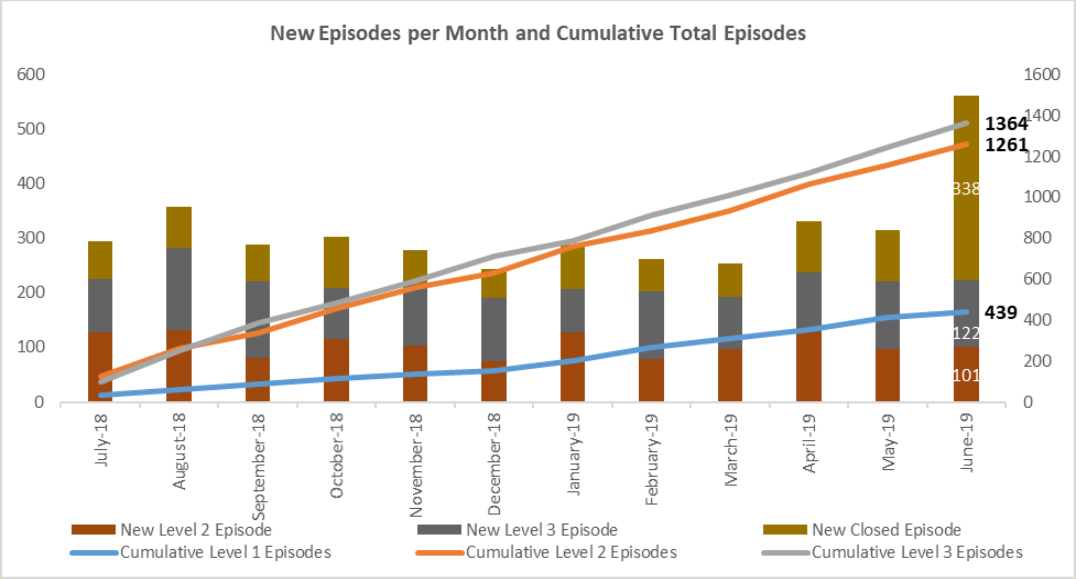
FY19

ED Pre-Post	n	Total Charges per Visit			Total Number of Visits			Average Charges per Visit			Average Charges per Member			% decrease in visits
		Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	
ED 1 Month	63	$65,090	$18,459	$ (46,631)	51	16	-35	$1,183	$972	$ (211)	$1,276	$1,154	$ (122)	-69%
ED 3 Month	105	$126,724	$69,574	$ (57,150)	74	43	-31	$1,306	$1,070	$ (236)	$1,712	$1,618	$ (94)	-42%
ED 6 Month	151	$196,983	$139,241	$ (57,742)	109	74	-35	$1,231	$1,160	$ (71)	$1,807	$1,882	$ 75	-32%

FY19

Obs Pre-Post	n	Total Charges per Visit			Total Number of Visits			Average Charges per Visit			Average Charges per Member			% decrease in visits
		Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	
Obs 1 Month	434	$139,027	$54,132	$ (84,895)	31	15	-16	$4,485	$3,609	$ (876)	$5,561	$3,609	$ (1,952)	-52%
Obs 3 Month	412	$218,731	$192,786	$ (25,945)	55	58	3	$3,977	$3,324	$ (653)	$5,912	$4,590	$ (1,322)	5%
Obs 6 Month	389	$314,637	$369,489	$ 54,852	107	109	2	$2,941	$3,390	$ 449	$5,333	$6,057	$ 724	2%

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



Since the program started, WISH has engaged a total of 2,316 individuals, 1,374 of whom received the active intervention.

This translated to increased penetration in the Independent Living Facilities, with 34buildings having more than 25% of their residents engaged in the WISH program, 15 of whom had greater than 50% engagement. The total engagement across all ILFs is 26.5%. This is a significant improvement over FY18 where total engagement was 13%, 17 buildings had over 25% engagement, only 2 of whom had greater than 50% engagement

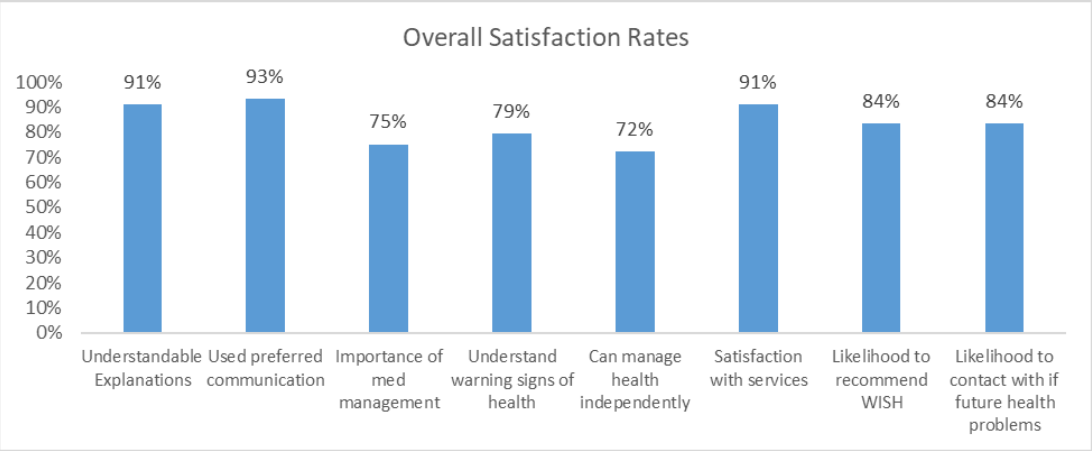
Number of Buildings by Engagement Cohort			
	FY17	FY18	FY19
High Engagement (>50%)	0	2	15
Medium Engagement (26-50%)	1	15	19
Low Engagement (0-25%)	42	30	10

Referrals continued to grow during FY19 with 1,433 referrals received, resulting in 13 buildings having more than 75% of their residents referred to the WISH program, a further 22 having more than 50% of their residents referred. The average referral rate across all ILFs is 55%

Number of Buildings by Referral Cohort			
	FY17	FY18	FY19
High Referral (>75%)	0	2	12
Medium High Referral (51-75%)	0	10	21
Medium Low Referral (26-50%)	0	20	7

	Low Referral (0-25%)	43	15	3

WISH client surveys show high levels of satisfaction with the program, with 91% of clients reporting to be satisfied with the services they receive and 84% likely to recommend WISH to others. The coaches score particularly strongly around communication with clients.



Successes of the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	In the program's second year of focusing exclusively on independent living and senior housing facilities, the WISH program maintained consistent levels of active engagement with building residents. -As demonstrated above, engagement continued to grow through FY19. Relationships and engagement with building staff continued to improve in FY19. WISH conducted an independent survey of key building staff and, based on feedback received, developed a regular monthly meeting and quarterly goal setting process with each building. Regular meetings and strategy discussions were also established with several large housing groups that oversee multiple WISH buildings. This year all the ILF Resident Managers were invited to attend a learning breakfast to increase engagement and program education. WISH staff noted an uptick in engagement from building staff after the event, which will now be held annually.
Lessons Learned from the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	In the first half of FY2019, Nexus invested in improved outreach strategies, including new models of partnerships with senior community leadership and direct to consumer communications. These strategies provided incremental gains but did not produce the ongoing engagement needed to be operating at full capacity. As a result, Nexus developed an updated staffing and infrastructure model based on observed program engagement. In this updated model, which began on July 1, 2019, the program will continue to take on new clients and support the needs of building residents as it has done in the past. WISH engagement is typically higher in buildings that have fewer on-site services and lower income residents. In buildings with existing services, WISH has worked closely with staff to integrate with and not duplicate building services.
Next Steps for the Intervention in FY 2020	• Continue to maintain point-in-time engagement levels at targeted buildings with updated staffing model, • Increasing visibility within the buildings, through health promotions and health education events, to increase engagement and program awareness.

Free Response, up to 1 Paragraph	• As WISH begins to saturate some buildings, consider other environments (additional buildings, home health collaboration, etc.) where WISH could be deployed in order to maintain or increase point-in-time engagement.
Additional Free Response (Optional)	

Intervention or Program Name	Hospital Care Transitions (HCT)
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	All Nexus Hospitals
Brief description of the Intervention *2-3 sentences*	Each Nexus hospital operates a Hospital Care Transition (HCT) program to support patients transitioning from the hospital to another care setting – be it home or another facility such as Long-Term Care or Skilled Nursing. Through Nexus, each hospital has been able to expand their existing HCT programs to serve more patients at high risk of re-hospitalization. In addition, Nexus established a learning collaborative which brings together hospital care transition staff to share data and best practices, as well as to identify additional areas for collaboration.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	Each hospital has a long-established list of community partners that support its Care Transitions Program. This list is extensive and covers the vast majority of services in the community and is constantly being updated.

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: FY19: 6,874[4] Cumulative: 12,732[5]
	Denominator of Eligible Patients: **Program Denominator:** 56,751 RP Analytic File: 207,753 (2+IP, Obs 24+ or ED) [6]
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the*	Not available – this is not a population that is paneled at the Partnership level in CRISP. The program is specifically designed to impact at the population level the Risk Adjusted 30-day readmission rate, rather than a broader cost of care (though it should ultimately impact this as well). Enrollment is triggered by a hospital stay, skewing the data by having a high cost event in the immediate pre-enrollment timeframe. As a result, Nexus Montgomery, believes this would not be a useful measure in this instance.

[4] The patients served is all the patients served in the HCT program, not just the incremental patients served

[5] The is a sum of the FY data, it is not possible to obtain an unduplicated count

[6] The program denominator is made up of patients with an eligible discharge from one of the six Nexus Hospitals, they are predominantly made up of patients from the Med/Surg departments and they are patients who screen at higher risk of a re-admission and who are being discharged home. The closest match to this population in the RP Analytic File was the 2+IP, Obs 24+ or ED population, but this pool significantly over-estimates the denominator as they are not necessarily all at higher risk for re-admission, or even readmission eligible, nor does someone specifically need 2+ utilizations to be in the HCT Program.

Intervention's Pre-Post Analysis.	
Intervention-Specific Outcome or Process Measures (optional) *These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership maintains and uses to analyze performance. Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.*	The HCT Program Metrics are: 1. Return on Investment (ROI) – this is detailed in the final section 2. Change in the O/E Ratio The Observed versus Expected readmission rate for eligible patients discharged from the 6 NMRP hospital improved from 1.14 in FY16 to 1.0 in FY18 3. Total Enrollment in the HCT Programs. 6,874 eligible discharge patients were enrolled in the HCT programs across the 6 hospitals. 4. Saved Readmissions: With a decrease in the O:E ratio of 0.14, the HCT program produced 245 saved readmissions in FY18.
Successes of the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	One of the successes of this program in FY19 was the work being done by the Learning Collaborative. The Learning Collaborative brings together the leads from each of the 6 hospitals Care Transition programs on a monthly basis with the goal of shared learning about the successes and challenges of their individual programs to identify best practices that are applicable across the 6 hospitals. Hospitals discussed each month a key pain point and responses to the pain point – topics included the placement of medical patients in post-acute care who also have co-occurring behavioral health conditions, the management of CRISP care alerts, resources for uninsured patients and screening for social determinants of health. The Learning Collaborative honed the methodology for the Return on Investment Calculation for the HCT programs and used this to drive discussions around best practices within the HCT programs and their respective impact. This involved an analysis of the components of each hospital's programs and a comparison with national best practices.

	The HCT programs also participated in shared training for their frontline staff, including behavioral health screening and resources.
Lessons Learned from the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	There were several lessons learned in FY19 around the ability to use the CRISP data and ROI alone to identify the core program elements from each hospital driving decreases in readmissions. The lag on the CRISP and hospital data makes the data less actionable and with the unique differences between the programs it is impossible to draw concrete links between specific program elements and ROI. Through review of the data, it was evident that Care Transition programs had different impacts on the medical and behavioral health population. This led to a change in the methodology to assess impact, assessing saved readmissions in each population before summing at the hospital level, due to statistically significantly different baseline and program data and the varying proportion between hospitals of behavioral health patients included in their care transitions programs.
Next Steps for the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	With the Board, the learning collaborative piece of the HCT program has been evaluated and some strategies for FY20 have been mapped out. The HCT team leads will still meet regularly to discuss responses to pain points and to use data to evaluate the comparative successes of their programs. Added to this is bringing the front line HCT staff together on a quarterly basis to share best practices across the 6 hospitals programs, provide opportunities for shared learning and to facilitate improved communication between the teams. As opportunities are identified, the HCT programs through the learning collaborative will utilize all the program development resources of Nexus Montgomery to propose programmatic solutions to shared challenges.
Additional Free Response (Optional)	

Intervention or Program Name	Severely Mentally Ill (SMI)
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate*	All Nexus Hospitals

which of the RP Hospitals are participating.	
Brief description of the Intervention *2-3 sentences*	The SMI program has 3 main components. The first component increased the availability of Residential Crisis beds, which serve patients experiencing a mental health crisis that traditionally would have been housed in the hospital due to a lack of a safe alternative. An eight bed Crisis House, which is managed by Cornerstone Montgomery, opened in FY18. A new 16 bed Crisis house, to be managed by Sheppard Pratt Health System, is in development. The second component added a third Assertive Community Treatment (ACT) team in Montgomery County. The new ACT team is also managed by Cornerstone Montgomery. ACT teams provide ongoing care and support for up to 100 patients in the community who are at risk of hospitalization through coordinating services for a broad range of needs, including housing and employment. Finally, the third SMI component, the Nexus Montgomery Behavioral Health Integration Manager, was hired to bring together a behavioral health workgroup to facilitate interagency coordination to reduce hospital use by patients with severe mental illness who are high utilizers of the hospitals. This work group facilitated by the Nexus Montgomery Behavioral Health Integration Manager and is made up of staff from the 6 Nexus hospitals, Cornerstone Montgomery, members of Emergency Medical Services (EMS) and other community behavioral health providers.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	Cornerstone Montgomery Sheppard Pratt Health System We also collaborate with: Beacon Health Options CRI (Choice, Respect, Independence) Montgomery County EMS Montgomery County Healthcare for the Homeless Mindoula Health Urban Behavioral Associates Vesta, Inc
Patients Served *Please estimate using the Population category that best applies to the Intervention, from the CY*	# of Patients Served as of June 30, 2019: <u>ACT</u> FY19: 88 Cumulative: 104 <u>Crisis House</u> [7] FY19: 603 Cumulative:1,060 <u>Behavioral Health Workgroup</u> FY19: 95 Cumulative: 116

[7] This is a sum of admissions across years, it is not possible to obtain an unduplicated count of patients

*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.*	Total SMI program: FY19: 786[8] Cumulative: 1,280[9]
	Denominator of Eligible Patients: **Program Denominator:** 3,354 RP Analytic File: 28,440 (3+IP or Obs>=24)[10]
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	The Pre-Post analysis is currently limited to members of the ACT team. We are continuing to work with our partner Cornerstone to establish a panel for the Crisis House to have a pre-post analysis for them. The full report is attached in Appendix C

[8] This is a sum across the 3 SMI programs, it is not possible to obtain an unduplicated count of patients
[9] This is a sum across the 3 SMI programs, summed across the financial years, it is not possible to obtain an unduplicated count of patients.
[10] The program denominator is significantly smaller than the RP Analytic File denominator – which is a high utilizer population, but not limited to patients with a diagnosis of Severe Mental Illness. Additionally, although the SMI population has a tendency to be a high utilizing population, with the exception of the Behavioral Health Workgroup, they do not require 3 or more utilizations to be eligible for the ACT Team or Crisis House.

ACT Pre-Post Reporting

FY19

All Hospital Pre-Post	n	Total Charges per Visit			Total Number of Visit			Average Charges per Visit			Average Charges per Member			
		Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	% decrease in visits
All Hospital 1 Month	70	$310,611	$51,452	$ (259,159)	63	32	-31	$4,930	$1,608	$ (3,322)	$10,711	$2,708	$ (8,003)	-49%
All Hospital 3 Month	70	$647,408	$175,819	$ (471,589)	178	88	-90	$3,637	$1,998	$ (1,639)	$13,488	$5,861	$ (7,627)	-51%
All Hospital 6 Month	70	$1,036,455	$481,546	$ (554,909)	363	165	-198	$2,855	$2,918	$ 63	$14,567	$10,944	$ (3,623)	-55%
All Hospital 12 Month	63	$1,436,989	$877,791	$ (559,198)	489	244	-245	$2,939	$3,598	$ 659	$23,950	$17,914	$ (6,036)	-50%

FY19

In Patient Pre-Post	n	Total Charges per Visit			Total Number of Visit			Average Charges per Visit			Average Charges per Member			
		Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	% decrease in visits
In Patient 1 Month	70	$266,584	$34,604	$ (231,980)	18	<11	n.a. <11	$14,810	<11	n.a. <11	$19,042	$11,535	$ (7,507)	n.a. <11
In Patient 3 Month	70	$523,848	$107,893	$ (415,955)	48	12	-36	$10,913	$8,991	$ (1,922)	$18,709	$11,988	$ (6,721)	-75%
In Patient 6 Month	70	$786,264	$363,593	$ (422,671)	80	34	-46	$9,828	$10,694	$ 866	$21,250	$16,527	$ (4,723)	-58%
In Patient 12 Month	63	$1,061,818	$706,690	$ (355,128)	114	64	-50	$9,314	$11,042	$ 1,728	$30,338	$22,084	$ (8,254)	-44%

FY19

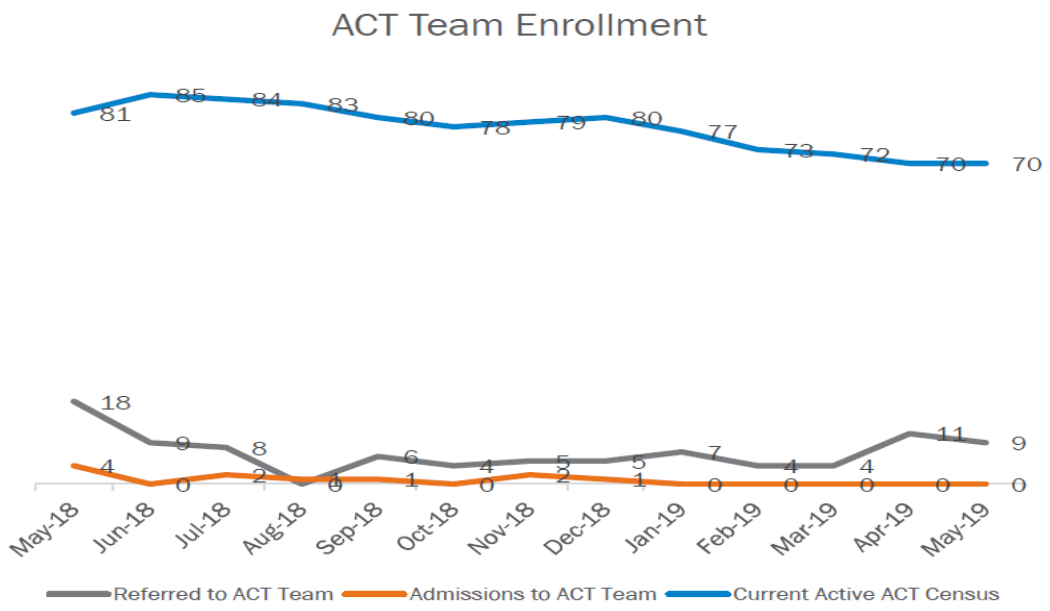
ED Pre-Post	n	Total Charges per Visit			Total Number of Visit			Average Charges per Visit			Average Charges per Member			
		Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	% decrease in visits
ED 1 Month	29	$36,215	$16,848	$ (19,367)	43	29	-14	$842	$581	$ (261)	$1,811	$991	$ (820)	-33%
ED 3 Month	54	$111,534	$47,089	$ (64,445)	126	71	-55	$885	$663	$ (222)	$2,594	$1,744	$ (850)	-44%
ED 6 Month	60	$214,694	$95,591	$ (119,103)	273	124	-149	$783	$771	$ (12)	$4,051	$2,516	$ (1,535)	-55%
ED 12 Month	61	$285,423	$141,463	$ (143,960)	353	170	-183	$809	$832	$ 23	$5,007	$3,368	$ (1,639)	-52%

FY19

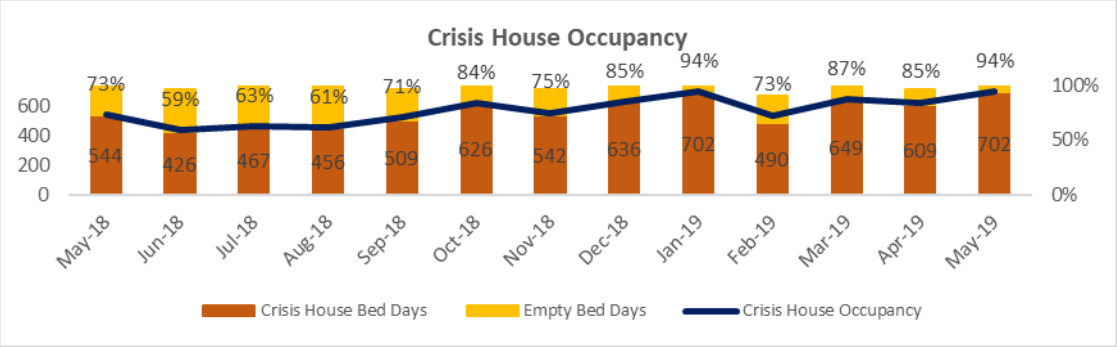
Obs Pre-Post	n	Total Charges per Visit			Total Number of Visit			Average Charges per Visit			Average Charges per Member			
		Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	% decrease in visits
Obs 1 Month	42	$7,813	n.a. <11	n.a. <11	<11	<11	n.a. <11	n.a. <11	n.a. <11	n.a. <11	n.a. <11	n.a. <11	n.a. <11	n.a. <11
Obs 3 Month	25	$12,026	$20,837	$ 8,811.00	<11	<11	n.a. <11	n.a. <11	n.a. <11	n.a. <11	n.a. <11	n.a. <11	n.a. <11	n.a. <11
Obs 6 Month	22	$35,496	$22,362	$ (13,134.00)	<11	<11	n.a. <11	n.a. <11	n.a. <11	n.a. <11	$5,071	$3,727	$ (1,344.00)	n.a. <11
Obs 12 Month	20	$89,748	$29,638	$ (60,110.00)	22	<11	n.a. <11	$4,079	n.a. <11	n.a. <11	$7,479	$3,293	$ (4,186.00)	n.a. <11

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.

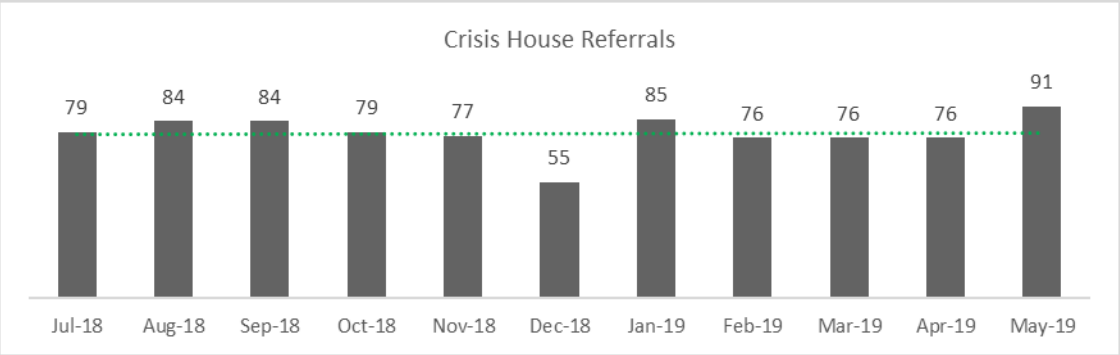
Active ACT team enrollment has fallen over the year from 81 to 70. As the referral data indicates, ACT services are still needed and sought after by hospitals for the most acute SMI patients. However, Cornerstone Montgomery had several operational challenges in FY19. As a result, their ability to accept new patients stalled and they experienced several staff turnovers. As a response, Cornerstone Montgomery restructured the organization and their teams. There is now a chief of programs who oversees the ACT team and crisis houses. The Cornerstone Montgomery team initiated a streamlined process to have one single intake coordinator with clinical expertise. They are now active participants in the Nexus Behavioral Health Workgroup and have since re-initiated intakes. Based on those changes, we expect to see an upward trend of ACT team enrollment in FY20.



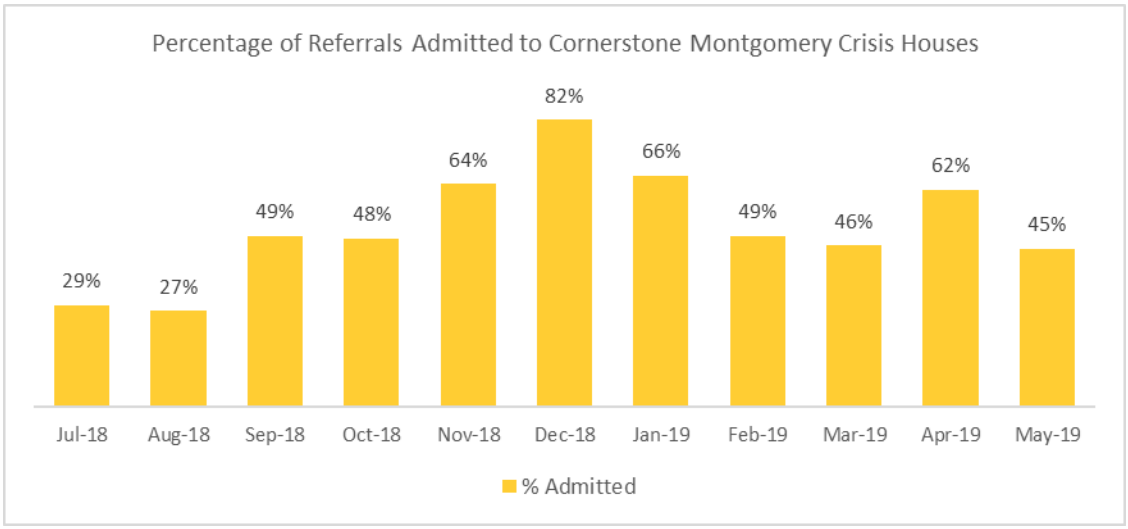
The Crisis house has had 435 admissions, 153 of which were to the Layhill Crisis House. After 3 months of no admissions due to a fire in one of the group homes, which necessitated in rehousing those residents in the crisis house, occupancy rates have been high, and the wait list has been low.



There continues to be a strong stream of referrals.



However, on average, less than 50% of referrals are admitted to the crisis house, indicating a need for the additional, 16 bed crisis house in development.

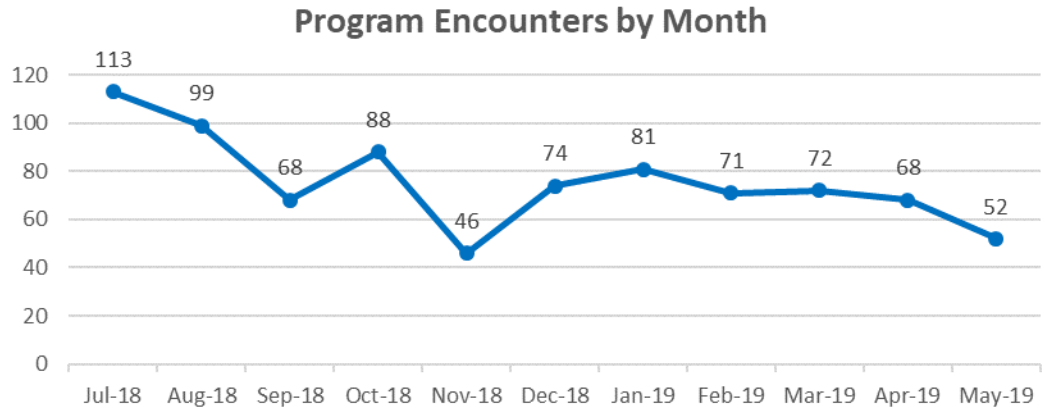
	
Successes of the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	Demand for Nexus supported Behavioral Health services remains high. There continues to be a strong stream of referrals to the Crisis House and ACT teams. As originally envisioned, Nexus approved additional capacity building efforts in FY19, including a 16 bed Crisis House and consulting to support same-day access to several Outpatient Mental Health Clinic. Similar to previous Nexus investments in this population, these programs involve limited, upfront funding from Nexus that provides an ongoing return. This allows Nexus to continue to make new investments to expand capacity in the community. The Nexus Behavioral Health Integration Manager (BHIM) continues to support connectivity between hospital behavioral health teams and community-based resources. Through those efforts, the BHIM has facilitated processes to optimize existing resources without requiring additional Nexus investment. For example, the co-location of psychiatry and pharmacy services at a local homeless shelter to support homeless patients discharged without an existing community-based care provider.
Lessons Learned from the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	The Nexus team had several takeaways from our experience with the Cornerstone Montgomery Crisis House. Despite involvement from the Nexus BHIM, the rate of referrals to Crisis House from the Emergency Departments was low. Because of this challenge, the new Crisis House will include staffing for 1.5 FTE of a hospital liaison role, to actively identify and connect patients from the Emergency Departments. In addition, the BHIM continues to serve as a bridge between community behavioral health and hospital operations. Historically, these groups have had integration challenges. Consequently, we see the easiest to manage referrals continue to increase and referrals that require additional trust and collaboration, such as ED diversions, continue to be limited. The Behavioral Health Workgroup has begun bringing these groups into a single forum to build relationships and trust to address these historical barriers.
Next Steps for the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	The focus for FY20 will be the development of the new, 16 bed Crisis House and implementation of same-day access in partner Outpatient Mental Health Clinic.

Additional Free Response (Optional)	

Intervention or Program Name	Specialty Care for the Uninsured (Project Access)
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	All hospitals
Brief description of the Intervention *2-3 sentences*	Project Access is a specialty care referral network that coordinates with primary care clinics, specialty physicians, diagnostic facilities and local hospitals to arrange timely and affordable specialty care for uninsured people who have household income <250% FPL. Through Nexus, Project Access expanded the availability of these services for patients who have had hospital contact in the past 60 days and who need follow up specialty care for a related diagnosis. Specialty care is available to patients in Prince George's County zip codes in the Nexus targeted area, regardless of hospital contact. Any patient who is not already connected with Primary Care is referred to a primary care physician at a local community health center. Patients must maintain a relationship with a primary care provider to remain eligible for ongoing specialty care through Project Access. Patients may be referred directly from the hospital for urgent specialty needs, or from the primary care clinic.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	PCC Pro bono and contracted (paid) Project Access Network
Patients Served	# of Patients Served as of June 30, 2019: FY19: 369 (plus an additional 176 referred to other specialty programs) Cumulative: 750

*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.*	Denominator of Eligible Patients: **Program Denominator:** 35,262 RP Analytic File: 814,469 (all payer)[11]
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	We are working with CRISP on being able to have a panel of these patients for reporting purposes. NMRP intends to use the 3, 6- and 12-month pre-post report to evaluate the impact of this program on hospital utilization, removing the 1-month pre/post utilization, as enrollment in the program is triggered by a hospital event.
Intervention-Specific Outcome or Process Measures (optional)	Project Access received 1,026 referrals in FY19 and arranged 903 appointments for 369 patients. The total appointments are understated as pro bono providers may provide follow up care without informing Project Access. Additionally, 176 patients were referred to other more appropriate specialty programs. An estimated 102 pro bono appointments were leveraged for this population, with an estimated value of $347,368. Overall, Project Access provided an estimated $515,000 of services for an investment of $250,000.

[11] The RP Analytic File does not have an appropriate population – as this intervention is limited to patients who have no insurance and who have a hospital utilization in the past 60 days and need follow up specialty care.

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.	The estimated service rate (referrals served versus referrals received) was 85%, up from 81% in FY18. On average patients had 2.5 appointments per referral.  The budget for this program was carefully managed through FY19 and concern for tracking over the monthly budget led to the decline in the monthly encounters at the end of the financial year.
Successes of the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	Project Access made great strides to improve the quality of the program to enhance efficiency and patient experience. A guidebook was created and distributed to all participating physicians that outlined the program and identified resources available to assist with scheduling and billing assistance. Updated patient brochures were distributed to referring primary care clinics and local physicians to include new physicians and services added to the network. In addition, there has been a 23% increase in services rendered since the program launched in FY16, although there was a 9% decrease FY18-19.This decrease was the result of ensuring more of the Project Access patients were initially linked with a primary care clinic and by establishing clinical referral guidelines by specialty and diagnosis for the primary care clinics so that initial workups were done at the clinic prior to referring to the specialist, thus reducing at least 1 follow up appointment with the specialist. Project access negotiated rate reductions in targeting practices and recruited a pro bono nephrology practice to meet referral needs. Additionally, they obtained free and discounted diagnostic testing for genetic and other very expensive lab testing.
Lessons Learned from the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	Direct referrals from hospitals had a major impact on the decrease in patients for FY19. By hosting learning sessions and getting in front of the right audience (i.e. case managers, social works, etc.) more patients were referred to Project Access by connecting first to a primary care clinic before being referred on to specialty care services. Updating the materials was important so that all stakeholders would have current information and be able to direct patients to the right care facility within the Project Access Network.

Next Steps for the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	Continuing to grow the Project Access network with both paid and pro bono physicians is top priority for FY20. Since patients stay in the Project Access program if there is a need for specialty care, network growth is necessary for the program to continue to serve new patients. Continuing to support the Enhanced referral guidelines to have priority labs and other workup completed prior to a patient's specialty appointment will improve care and focus during the patient's initial appointment and reduce the need for additional appointments.
Additional Free Response (Optional)	

Intervention or Program Name	Skilled Nursing Facility (SNF) Alliance
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	All
Brief description of the Intervention *2-3 sentences*	The Skilled Nursing Facility (SNF) Alliance brings together 37 SNFs from Montgomery County and Prince George's County who receive the majority of SNF Referrals from the Nexus Hospitals. Through the Alliance SNFs were provided with and continue to utilize PointRight to track their data around 30-day re-hospitalizations and other quality metrics. The initial focus for the SNF Alliance was getting SNF staff trained on PointRight and having the teams identify an area for quality improvement focused on reducing re-hospitalizations. SNFs were also provided with the opportunity to send staff to Mental Health First Aid training, responding to the need identified by the facilities for additional education around behavioral health. The Alliance meets collectively on a monthly basis and through FY19 was focused on work around best practices and a program to support SNF to home transitions.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors,*	Skilled Nursing Facilities (See Appendix D)

and/or public partners	
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: FY19: 12,985 (PointRight Annual Post-Acute (Short Term Rehab) volume FY 19) Cumulative: 27,985[12]
	Denominator of Eligible Patients: **Program Denominator: 12,985** (Total annual post-acute volume at SNFs) RP Analytic File: 43,239 (2+IP or Obs>=24 or ED Visits & Medicare FFS)[13]
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	Nexus Montgomery does not intend to do a pre-post analysis for this population. We believe this would not be a useful measure in that enrollment is triggered by a 3+ day hospital stay, which would skew the data by having a high cost event in the immediate pre-enrollment timeframe.

[12] This is a sum of FY admission data, it is not possible to obtain an unduplicated count of patients, or across years

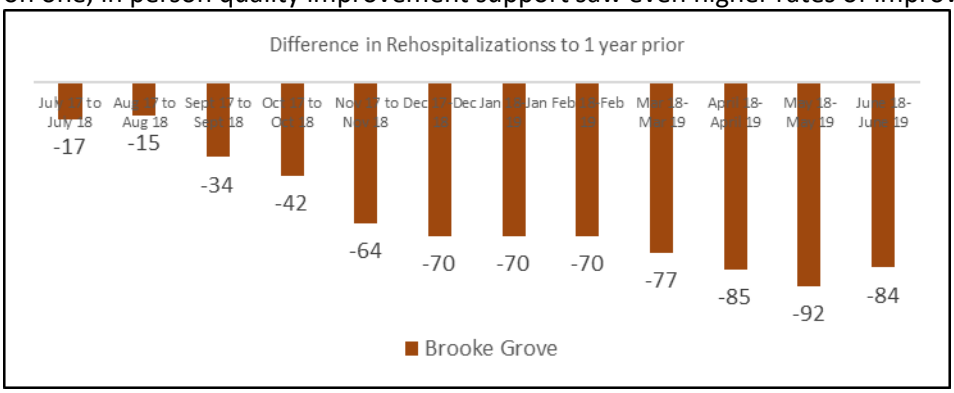
[13] The RP Analytic File does not have an appropriate population – the 2+IP or Obs>=24 or ED Visits & Medicare FFS is the closest applicable population, but over-estimates by not being limited to those then admitted to a SNF, it also doesn't capture the required 3 day admission to be eligible for a SNF admission. The SNF admission can also occur after only a single hospital utilization, if it results in a qualifying stay.

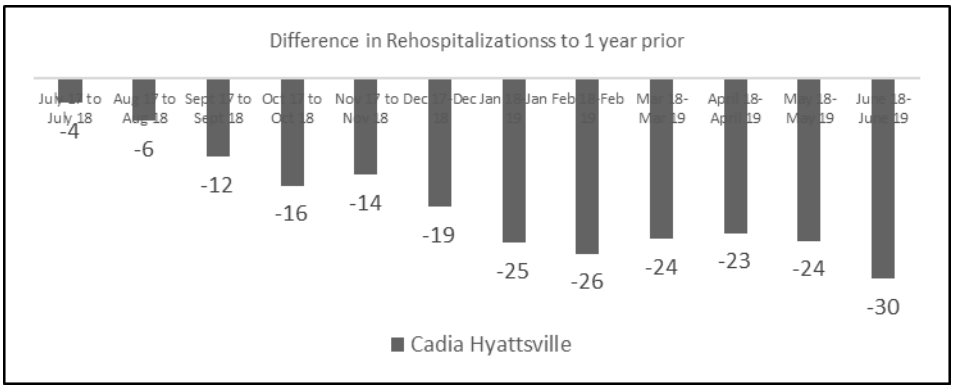
Intervention-Specific Outcome or Process Measures (optional)
These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership maintains and uses to analyze performance. Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.

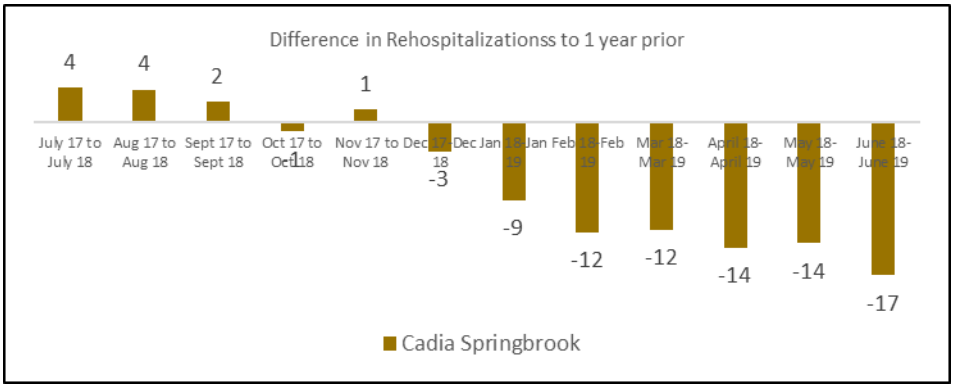
The key intervention-specific metric for this program is the risk adjusted 30-day rehospitalization rate from SNF using the PointRight Pro30 methodology.

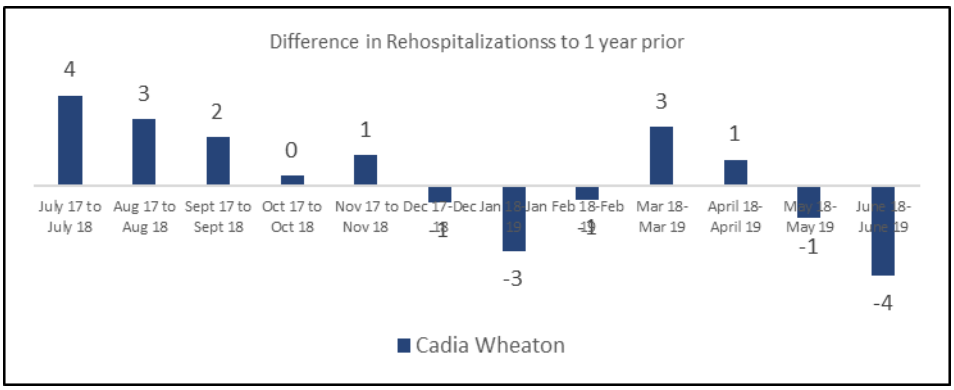
The absolute reduction in rehospitalization in FY19 from the baseline of FY18 is 412 rehospitalizations, with a reduction in risk adjusted rehospitalizations of 331.

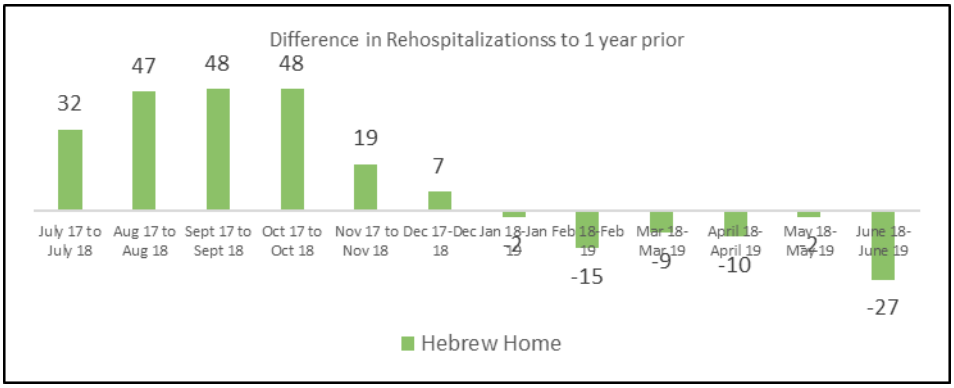
While we saw an overall decrease in rehospitalizations, the SNFs who were identified as high impact (higher than average rehospitalization rate and large volume) and who received one on one, in person quality improvement support saw even higher rates of improvement.

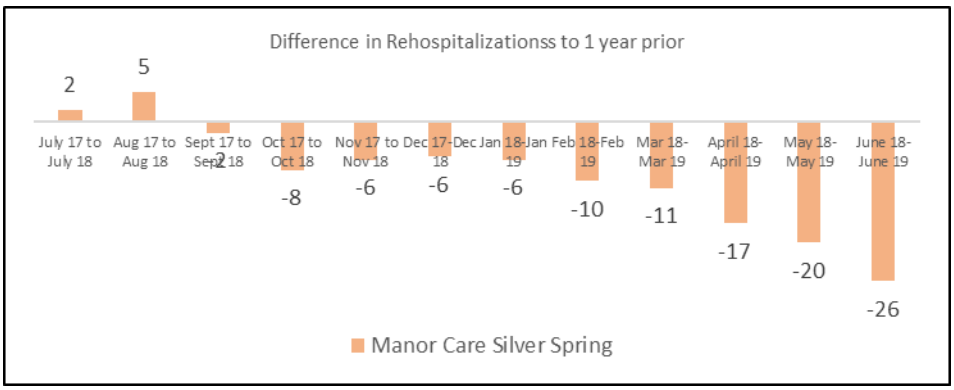












Successes of the Intervention in FY 2019
Free Response, up to 1 Paragraph

In FY19, there were several successes in the SNF Alliance program. We completed the process of getting all 37 SNFs to implement PointRight as a single common platform for tracking rehospitalization rates as well as quality data.

Nexus Montgomery continued the process of having a single preferred provider list across all Partnership hospitals. By the end of the year 32 of the 37 SNFs had completed the steps required to be on the preferred provider list.

The SNF Alliance undertook two projects this year to address issues that were driving their rehospitalization rate. In order to address the rehospitalizations within the first 48 hours of admission to a SNF, a workgroup was formed with co-chairs from the hospitals and SNFs that looked at ensuring the SNFs have all the information they need to achieve a successful

	admission. This workgroup finalized their recommendations and the hospitals are in the process of training their staff to ensure all information is included in discharge documentation to SNFs. The second project formed another workgroup with co-chairs from Nexus partner hospitals and SNFs focusing on those patients that need to be sent from the SNF back to the hospital. The SNFs report that they often sent a patient back to the emergency department to receive a specific intervention that they could not provide at the SNF but that did not require admission. However, the hospital would often admit the patient because the information sent from the SNF with the patient was not easily navigated in the context of the ED. To address this, the workgroup created and is currently implementing use of a single, brightly colored cover sheet which goes with the patient to the ED. The sheet contains all pertinent patient clinical information, whether the SNF can take them back, and the direct number of the physician from the SNF who recommended the transfer back to the ED. A key success during this year has been selecting six of our high volume, high readmission SNFs to receive focused quality improvement support, with a focus on readmission prevention. As a result of this, all the selected SNFs have seen a reduction in rehospitalization. The success of this intervention has led to the dedication of additional resources to this effort in FY20. The QI support with Cadia Springbrook was impactful, as the Cadia company brought all their facilities to the table to drive improvement at all their facilities, not just the one selected for the intervention. In addition to the focused work, we continued to have regular monthly meetings for all the SNFs where they shared best practices and successful projects at their SNFs, we had a variety of topics presented from Behavioral Health, to the upcoming Patient Driven Payment Model (PDPM) changes, which will change the reimbursement structure for SNFs. We hosted quarterly meetings for the for the staff responsible for the clinical coding that is used to drive the PointRight Risk Adjustment Methodology with PointRight staff to help them dig down into the PointRight data, using it to validate their submissions for accuracy and to identify areas for improvement.
Lessons Learned from the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	One of the biggest challenges in FY19 continued to be staff turnover within the skilled nursing facilities. Turnover of leadership staff at the SNFs was observed FY19. However, this was compounded by the sale of six of the SNFs to other companies. This has necessitated continued relationship building between Nexus Montgomery and the SNFs and is typically associated with an initial increase in rehospitalizations in the ownership transition period. High turnover rates have also led to disruptions in the availability of SNF PointRight data usage at these facilities due to needing to re-sign contracts with new owners and the terms of their conditions of sale dictating limits to the historical data they were able to return. High turnover in staff was also a challenge, leading to an on-going need to provide training and set up new log-in information for new staff. To address this need, PointRight are offering quarterly office hours on the day after the monthly SNF Alliance meeting for SNFs to utilize, with a total of 14 slots per session.

Next Steps for the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	This intervention will continue in FY20 with SNF Alliance meetings. The workgroups will be focused on specific Alliance-wide improvement projects, and an expansion of the focused quality improvement support for key SNFs. Through the lessons learned with the focused QI work in FY19, we have engaged with the six Manor Care facilities as a group to support their improvement activities as was done with the Cadia buildings in FY19. Additionally, Nexus Montgomery is in the pilot phase of a SNF to Home program with 6 SNFs and 2 private duty home care agencies, to address readmissions after a patient has been discharged home from a participating SNF. Medicare claims data demonstrates two specific issues after being discharged from a SNF, including 1) that a majority of readmissions to hospital settings occur in the first three days post-SNF discharge, and 2) while readmission rates are very low for those receiving skilled home care within 48 hours, only a third of patients receive care in this time frame. The SNF to home pilot is focused on those patients with no caregiver, limited family support, and those previously discharged from a Nexus Montgomery partner hospital before going to a SNF. To ensure a safe landing in the home, the pilot will provide four to five hours of a private duty certified nursing assistant (CNA) to accompany the patient at home to assist with cleaning, shopping for groceries/medications, and remove trip hazards. CNAs will then continue to follow up with the patient and ensure Medicare home health services are initiated. The program is anticipated to yield a significant decrease in readmissions post SNF discharge.
Additional Free Response (Optional)	

Intervention or Program Name	Community Based Advanced Directive Program
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	All
Brief description of the Intervention *2-3 sentences*	Nexus is seeking to improve quality of care at the end-of-life and to ensure that providers can respect their patient's wishes by launching a new community-wide campaign that will increase awareness of advanced care planning and remove barriers to completing advanced

	directives. Based on data from the Dartmouth Atlas[14], there is a TCOC savings opportunity of $31 M at NMRP hospitals if Medicare spending in the last two years of life is brought down to the MD average. Nexus has identified a lead, community-based implementation partner, Jewish Social Services Agency, which will collaborate with a range of community partners to promote conversations about end-of life care options, provide tools to aid in advance care planning and documentation, increase the completion rate of Advanced Directives, and expand the use of electronic storage and retrieval services so that patient's needs can be met at the time of need.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	Jewish Social Services Agency (JSSA) <u>Steering Committee – Affiliated Member Organizations</u> Adventist HealthCare Care for Your Health, Inc. Caring Matters Catholic Charities of the Archdiocese of Washington Cedar Lane Unitarian Universalist Church Holy Cross Health MedStar Montgomery Medical Center Montgomery County DHHS Oasis Pan Asian Volunteer Health Clinic Prince George's Healthcare Alliance Suburban Hospital
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,*	# of Patients Served as of June 30, 2019: Expect to begin serving patients in FY20
	Denominator of Eligible Patients: **Program Denominator:** To be developed RP Analytic File: 814,469 (all payer)[15]

[14] www.atlasdata.arthmouth.edu

[15] This program is a population-based intervention, therefore the All Payer file is the closest fit within the RP Analytic File, however, the recipients of the training and educational materials are a small subset of this denominator.

*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.*	This program does not intend to use the Pre-Post analysis as it is a long-term population intervention that is not expected to result in an immediate difference in utilization.
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;*	This program will measure success in terms of an improvement in knowledge of who can be a medical decision maker and of what medical care they would like during a medical crisis. Success will also be demonstrated by the number of participants who appoint a medical decision maker and who document either their medical decision maker or their care wishes. This will be measured through participant survey at different points of the training process. The impact of the program on community will be measured through the number of patients admitting to a Nexus Montgomery hospital, who reside in a Nexus Montgomery zip code, who have a documented advance directive. It is anticipated that we will be able to use CRISP to access this data. Looking at the long-term view we plan to use the Dartmouth Atlas to look at the change in cost of care in the last 2 years of life. The data lag from the Dartmouth Atlas mean this is a long-term program perspective and will not be useful for more immediate program evaluation.

operationalized care teams; etc.	
Successes of the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	In FY19, after a competitive bid process, Nexus Montgomery selected JSSA as the lead program implementation partner for the Community Advanced Care Planning program. JSSA is a nonsectarian, nonprofit health and social service agency that has been working across the Greater Washington metropolitan area for more than 120 years. In FY19, JSSA hired a Project Coordinator to oversee implementation of the program. A Steering Committee, including equal representation from community- and hospital-based programs was chartered to guide program development. Additionally, the Project Coordinator has spoken with over 30 individual stakeholder and six community groups. The program has developed key messaging, which was created utilizing community and expert input, and a program training curriculum which will customize national, best practice models for the unique Nexus community.
Lessons Learned from the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	Implementation in progress. We expect to be able to report on lessons learned in the FY20 report.
Next Steps for the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	Once the program curriculum is finalized, JSSA will begin testing the model on internal audiences. The program uses a train-the-facilitator approach, in which representatives from a wide range of community organizations, such as religious institutions and service providers, are trained to facilitate advanced care planning sessions with their constituencies. In FY20, an initial group of community partners will be engaged, trained and participate in a learning collaborative to provide feedback and support ongoing improvement in the program. Nexus will also engage in conversations with local primary care providers to develop a model for this program that could be utilized in the practice setting.
Additional Free Response (Optional)	

Core Measures

Please fill in this information with the latest available data from the in the CRS Portal Tools for Regional Partnerships. For each measure, specific data sources are suggested for your use– the Executive Dashboard for Regional Partnerships, or the CY 2018 RP Analytic File (please specify which source you are using for each of the outcome measures).

Utilization Measures

Measure in RFP	**Measure for FY 2019 Reporting**	**Outcomes(s)**

(Table 1, Appendix A of the RFP)		
Total Hospital Cost per capita	**Partnership IP Charges per capita** Executive Dashboard: 'Regional Partnership per Capita Utilization' – Hospital Charges per Capita, reported as average 12 months of CY 2018 -or- Analytic File: 'Charges' over 'Population' (Column E / Column C)	For this reporting, we have opted to use the Regional Partnership Analytic File. Below is each data element for each population that is appropriate for the six core programs. As noted in the Intervention Program section, we do not believe these measures best reflect populations served by the programs below. This metric is reported for the full period of CY 2018 **Roll up (All Payer): $1,640 (7.3% increase over baseline CY15)** Project Access: All Payer: as roll up WISH: 2+Chronic Conditions & Medicare: $3,266 (11.4% **decrease** over baseline CY15) Severely Mentally Ill: 3+IP or Obs>=24: $352 (2.3% **increase** over baseline CY15) Hospital Care Transitions: 2+IP or Obs>=24 or ED Visits: $921 (4.9% **increase** over baseline CY15) SNF Alliance: 2+IP or Obs>=24 or ED Visits & Medicare FFS: $2,818 (5.6% **increase** over baseline CY15) Community Advance Directives: All Payer: as roll up
Total Hospital Discharges per capita	**Total Discharges per 1,000** Executive Dashboard: 'Regional Partnership per Capita Utilization' – Hospital Discharges per 1,000, reported as average 12 months of FY 2019 -or-	This metric is reported for the 9 months of FY19 for which we have final data. The comparison is against the first 9 months of FY16 **Roll up (All Payer): 41** (4.7% **decrease** over baseline FY16) Project Access: All Payer: as roll up

	Analytic File: 'IPObs24Visits' over 'Population' (Column G / Column C)	WISH: 2+ Chronic Conditions & Medicare: 87 (17.1% **decrease** over baseline FY16) Severely Mentally Ill: 3+IP or Obs>=24: 10 (equal to baseline FY16) Hospital Care Transitions: 2+IP or Obs>=24 or ED Visits: 25 (3.8% **decrease** over baseline FY16) SNF Alliance: 2+IP or Obs>=24 or ED Visits & Medicare FFS: 75 (7.4% **decrease** over baseline FY16) Community Advance Directives: All Payer: as roll up
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)	This metric is reported for the 9 months of FY19 for which we have final data. The comparison is against the first 9 months of FY16 **Roll up (All Payer): 179** (4.3% **decrease** over baseline FY16) Project Access: All Payer: as roll up WISH: 2+ Chronic Conditions & Medicare: 84 (41.3% **decrease** over baseline FY16) Severely Mentally Ill: 3+IP or Obs>=24: 9 (equal to baseline FY16) Hospital Care Transitions: 2+IP or Obs>=24 or ED Visits: 99 (4.8% **decrease** over baseline FY16) SNF Alliance: 2+IP or Obs>=24 or ED Visits & Medicare FFS: 124 (10.7% **increase** over baseline FY16) Community Advance Directives: All Payer: as roll up

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)	For this reporting, we have opted to use the Regional Partnership Analytic File. Below is each data element for each population that is appropriate for the six core programs. We do not believe these measures best reflect populations served by the programs below. This metric is reported for the 9 months of FY19 for which we have final data. The comparison is against the first 9 months of FY16 **Roll up (All Payer): 10.3%** (1.9% **decrease** over baseline FY16) Project Access: All Payer: as roll up WISH: 2+Chronic Conditions & Medicare FFS: 14.8% (1.7% **decrease** over baseline FY16) Severely Mentally Ill: 3+IP or Obs>=24: 33.4% (1.1% **decrease** over baseline FY16) Hospital Care Transitions: 2+IP or Obs>=24 or ED Visits: 17.0% (4.4% **decrease** over baseline FY16) SNF Alliance: 2+IP or Obs>=24 or ED Visits & Medicare FFS: 19.0% (4.4% **decrease** over baseline FY16) Community Advance Directives: All Payer: as roll up
PAU	**Potentially Avoidable Utilization** Executive Dashboard:	This metric is reported for the 9 months of FY19 for which we have final data. The

	'[Partnership] Quality Indicators' – Potentially Avoidable Utilization, reported as **sum** of 12 months of FY 2019 -or- Analytic File: 'TotalPAUCharges' (Column K)	comparison is against the first 9 months of FY16 **Roll up (All Payer): $179,448,654** (3.7% **increase** over baseline FY16) Project Access: All Payer: as roll up WISH: 2+Chronic Conditions & Medicare FFS: $73,799,110 (1.1% **decrease** over baseline FY16) Severely Mentally Ill: 3+IP or Obs>=24: $110,387,788 (9.5% **increase** over baseline FY16) Hospital Care Transitions: 2+IP or Obs>=24 or ED Visits: $160,357,847 (6.0% **increase** over baseline FY16) SNF Alliance: 2+IP or Obs>=24 or ED Visits & Medicare FFS: $256,445,473 (6.8% **increase** over baseline FY16) Community Advance Directives: All Payer: as roll up

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	Not Applicable

	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.

All Nexus process measures are evaluated and reported at the intervention level, so they have already been described above.

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)

Annual Cost per Patient	FY18	FY19
Annual Cost	$7,928,805	$7,631,758
WISH	$1,329	$1,086
HCT	$336	$301
SMI	$1,487	$1,112
Specialty Care for the Uninsured	$666	$658
SNF Alliance	$0	$19
Community Advanced Directives	n.a.	n.a.
Partnership Total	$340	$327

In addition to the data required above, we are also calculating Return on Investment for a number of our programs. The methodology for each is outlined below along with the most recent available data.

WISH

Return on Investment is measured at the program target population level for the WISH population. Savings are calculated as the difference between the target cost and the actual cost. The target cost is calculated as: (baseline per beneficiary cost * current beneficiaries) *inflation factor. The inflation factor used for CY16-17 was the percent increase in per beneficiary Medicare cost for Montgomery County. The inflation factor used for CY17-18 was the MPA increase in Medicare total cost of care for Nexus Attributed beneficiaries of 4%. The baseline year for this program is FY16.

Gross Savings: Target Medicare Payments – Current Period Medicare Payments
Variable Savings (Part A only): Gross Savings *50%
Net Savings: Variable Savings – Total Program Cost
ROI: Variable Savings/Total Program Cost

Since October 2017 we have been able to receive both Medicare Part A and Medicare Part B payments. As a result, Return on Investment for this program is assessed at 3 different levels: Medicare Part A payments only, Medicare Part B payments only and combined Medicare Part A and B payments. Each is a stand-alone metric, with the full program cost used for the ROI calculation.

Medicare Part A	**CY18**
Program Cost	$2,558,635
Gross Savings	$1,561,218
Variable Savings	$780,609
Net Savings	-$1,778,026
ROI	0.31

Medicare Part B	**CY18**
Program Cost	$2,558,635
Gross Savings	$2,949,785
Variable Savings	na
Net Savings	$391,150
ROI	1.15

Combined Medicare Parts A&B	**CY18**
Program Cost	$2,555,635
Gross Savings	$4,511,003
Part A Variable Savings + Part B Gross Savings	$3,730,394
Net Savings	$1,171,759
ROI	1.46

Through this methodology, the WISH program after it's ramp up year, is showing a strong ROI for total Medicare Part A & B, with the savings being more strongly seen in Part B payments.

HCT Program

Return on Investment for the HCT programs are measured at the program enrolled population level. Saved readmissions are calculated by the difference in the Observed versus Expected readmission (O:E) ratio for the enrolled participants versus the O:E ratio in the baseline period. The saved readmissions is then multiplied by the average readmission cost for each hospital to produce a gross savings number.

Difference in O:E Ratio: Baseline O:E ratio – Current O:E ratio
Saved Readmissions: Expected Readmissions * Difference in O:E
Gross Savings: Saved Readmissions*Average Readmission Cost
Variable Savings: Gross Savings * 50%
Net Savings: Variable Savings – Program Cost
ROI: Variable Savings/Program Cost

HCT Program	FY 2018
Baseline O/E	1.14
Intervention O/E	1.00
Difference in O/E	0.14
Saved Readmissions	245
Nexus Costs	$1,849,038
Gross Savings	$3,368,696
Variable Savings	$1,684,348
Net Savings	-$164,690
ROI	0.91

The HCT programs are seeing an increased number of saved readmissions of 245 over FY17 with 168 and getting closer to returning a positive ROI. The ROI for this program is being strongly influenced by a larger improvement in the O/E ratio in the behavioral health population (0.48).

SMI Program

Return on Investment is measured at the program target population level for all patients touching a Nexus Montgomery Hospital who have 10 or more hospital encounters in a rolling 12-month period for which that encounter has a primary SMI diagnosis. Savings are calculated on the total difference in all payer charges for In Patient, Emergency Department and Observation visits between the baseline period and the current period, adjusted for total beneficiaries.

Gross Savings: (Baseline Period Charges/Total Baseline Patients) *Total Current Patients – Current Period Charges
Variable Savings: Gross Savings *50%
Net Savings: Variable Savings – Total Program Cost
ROI: Variable Savings/Total Program Cost

SMI Population Measure	CY 2017	CY 2018
Nexus Costs	$272,153	$135,667
Baseline Period Charges	$2,376,036	$2,376,036
Baseline with current bene adjustment	$3,244,694	$3,512,956
Current Period Charges	$2,700,789	$3,505,839
Gross Savings	$543,905	$7,117
Variable Savings	$271,953	$3,559
Net Savings	-$200	-$132,108
ROI	1.0	0

Much of the work with the behavioral health workgroup to focused on the high utilizing population across hospitals started towards the end of CY 2018. While at the population level, we did not see a Return on Investment in CY 2018, provisional data we have for the beginning of CY 2019 shows an improvement in savings. When compared to CY17 there is a large change in cost. The Adventist Behavioral Health Hospital merged into Shady Grove Adventist Medical Center at the end of August 2018 and has made an impact on the data. We need to monitor the data over the next year to see the impact of this change.

For the SMI program, we also calculate Return on Investment for the Crisis House. This is done at the program level, for all admissions to the crisis house, based on the assumptions listed below as outlined in the December 21, 2015 Nexus Montgomery proposal. This ROI calculation is a standalone measure and does not get rolled up into the overall SMI ROI or the overall partnership ROI, due to the overlap with the SMI population level measure, as outlined above. Due to the Crisis House cost being a largely up-front cost, the program cost and program savings are calculated cumulatively.

Assumptions:

- 90% of admissions to the Crisis House would have otherwise been an admission to the hospital.
- 67% of those admissions would have been in a Nexus Montgomery Hospital

Prevented Nexus Montgomery Hospital Admissions: (Total admissions*90%)*67%
Gross Savings: Prevented NM Admissions * Average Admission Cost
Variable Savings: Gross Savings * 50%
Net Savings: Variable Savings – Total Program Cost
ROI: Variable Savings/Total Program Cost

Crisis House	FY17-FY19
A. Cumulative Total Admissions (A)	359
B. Avoided Hospitalizations (A*90%)	323
C. Avoided NM Hospitalizations (B*67%)	216
D. Gross Savings (B*$10,140)	$1,399,301
E. Variable Savings (D*50%)	$1,097,538
F. Cumulative Costs	$462,478
G. Net Savings (E-F)	$635,060
H. ROI (E/F)	2.37

SNF Alliance

Return on Investment for this program is done at the program target population level and is based on a reduction in rehospitalizations, using the National Quality Forum endorsed, PointRight Pro30

Methodology[16].The baseline year for this program is FY18. Savings are calculated on an NMRP hospital average rehospitalization cost of $10,000.

Reduction in rehospitalizations: Baseline period rehospitalizations - Measurement period rehospitalizations
Gross Savings: Reduction in rehospitalizations x $10,000
Variable Savings: Gross Savings * 50%
Net Savings: Variable Savings – Program Cost
ROI: Variable Savings/Program Cost

SNF Alliance	FY19-FY18
Program Cost FY19	$242,704
Risk Adjusted Reduction in Rehospitalizations	331
Gross Savings	$3,310,000
Variable Savings	$1,655,000
Net Savings	$1,412,296
ROI	6.82

For the SNF Alliance we are also working with our regional Quality Improvement Organization to obtain Medicare Part A & B payment data to be able to base our ROI calculation on total cost of care, in closer alignment with the proposed CTI ROI methodology.

Conclusion

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

In a region representing 22% of Maryland residents, Nexus Montgomery has emerged as a vehicle for hospitals to collectively act in their shared community to support the goals of the Maryland Total Cost of Care model. The Nexus targeted community is growing, aging and diversifying faster than Maryland as a whole, putting the area at risk for increasing disparities and health care utilization. Over the first three years of the Regional Partnership program, Nexus Montgomery has demonstrated the capacity to

16 https://www.qualityforum.org/QPS/QPSTool.aspx#qpsPageState=%7B%22TabType%22%3A1,%22TabContentType%22%3A2,%22SearchCriteriaForStandard%22%3A%7B%22TaxonomyIDs%22%3A%5B%5D,%22SelectedTypeAheadFilterOption%22%3A%7B%22ID%22%3A49589,%22FilterOptionLabel%22%3A%22pointright%22,%22TypeOfTypeAheadFilterOption%22%3A1,%22TaxonomyId%22%3A0%7D,%22Keyword%22%3A%22pointright%22,%22PageSize%22%3A%2225%22,%22OrderType%22%3A3,%22OrderBy%22%3A%22ASC%22,%22PageNo%22%3A1,%22IsExactMatch%22%3Afalse,%22QueryStringType%22%3A%22%22,%22ProjectActivityId%22%3A%220%22,%22FederalProgramYear%22%3A%220%22,%22FederalFiscalYear%22%3A%220%22,%22FilterTypes%22%3A0,%22EndorsementStatus%22%3A%22%22%7D,%22SearchCriteriaForForPortfolio%22%3A%7B%22Tags%22%3A%5B%5D,%22FilterTypes%22%3A0,%22PageStartIndex%22%3A1,%22PageEndIndex%22%3A25,%22PageNumber%22%3Anull,%22PageSize%22%3A%2225%22,%22SortBy%22%3A%22Title%22,%22SortOrder%22%3A%22ASC%22,%22SearchTerm%22%3A%22%22%7D,%22ItemsToCompare%22%3A%5B%5D,%22SelectedStandardIdList%22%3A%5B%5D,%22StandardID%22%3A2375,%22EntityTypeID%22%3A1%7D

design, execute and adjust programming to address community-level challenges, counteract these demographic forces, reduce hospital and total cost of care, and improve health.

With overlapping patients and communities, the Regional Partnership is important to addressing total cost of care and population health as programs are less duplicative and more effective when pursued collectively. For example, if each hospital operated a community-based program like WISH, a resident in a targeted building could be offered similar services from multiple hospitals. Multiple teams would also involve redundant program infrastructure and management resources. By offering a single program, managed through Nexus Montgomery, WISH has been able to meaningfully engage with building residents and staff to become engrained in the culture of buildings. Another example of a program being more efficient through hospital partnership is the SNF Alliance. Before Nexus Montgomery, several hospitals had made attempts to engage their most frequently utilized SNFs with limited success. Most SNFs receive referrals from multiple hospitals and hospitals struggled to exert influence on SNFs. With all the hospitals now acting collectively, SNFs are highly incentivize the engage and respond to process improvement efforts to ensure continuing referrals. These are two examples; however, all of the Nexus Montgomery programming would be less efficient or not possible without the Regional Partnership approach.

As Nexus programming has evolved, we maintain focus on the four high-risk target populations that were selected because of the potential to drive community population-level improvements. New programming, such as investments in additional Crisis House beds, Hospital to SNF and SNF to Home transition support, and advanced care planning, are consistent with the goals described in the original RFP response. As State goals have shifted to Total Cost of Care, Nexus Montgomery has adapted by reframing existing programs, such as WISH and the SNF Alliance, to consider the impact on health care spending overall.

Appendix A

Andrew Kim House
Arcola Towers
Asbury Methodist Village
Avondale Park
Bauer Park Apartments
Bedford Court
Bethany House
Brooke Grove
Charter House
Chelsea Tower (until March 2018)
Churchill Senior Living
Covenant Village
Elizabeth House
Five Star Premier Residences
Forest Oak Towers
Franklin Apartments
Friends House
Hampshire Village
Holly Hall
Homecrest House
Inwood House
Kensington Park Senior Living
Lakeview House
Manor Apartments
Oaks at Olde Towne
Randolph Village
Revitz House
Riderwood (until September 2018)
Ring House
Rolling Crest Commons
The Bonifant
The Oaks at Four Corners
The Villages at Rockville
Town Center Apartments
Victory Court
Victory Crest
Victory Crossing
Victory Forest
Victory House of Palmer Park
Victory Oaks
Victory Terrace
Victory Tower
Waverly House
Willow Manor at Cloppers Mill
Willow Manor at Coleville
Willow Manor at Fair Hill Farm

Appendix B: Pre-Post Report - WISH

Pre/Post Analysis - Summary

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

Program Name
20190830_wish_all_program (5887)

Chronic Conditions
All Patients

Most Recent Payer
All

Visit Type
All

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

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	487	487	487	272

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	94	36	19.3%	7.4%	-11.9%
3 Months	122	88	25.1%	18.1%	-7.0%
6 Months	169	136	34.7%	27.9%	-6.8%
12 Months	137	125	50.4%	46.0%	-4.4%

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	123	45	2.5	0.9	-1.6
3 Months	206	162	4.2	3.3	-0.9
6 Months	340	313	7.0	6.4	-0.6
12 Months	352	363	12.9	13.3	0.4

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	115	$793,640	$217,498	$8,443	$6,042	($2,401)
3 Months	167	$1,138,198	$835,207	$9,329	$9,491	$162
6 Months	224	$1,735,498	$1,921,527	$10,269	$14,129	$3,860
12 Months	172	$1,458,754	$2,255,487	$10,648	$18,044	$7,396

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	123	45	$793,640	$217,498	$6,452	$4,833	($1,619)
3 Months	206	162	$1,138,198	$835,207	$5,525	$5,156	($370)
6 Months	340	313	$1,735,498	$1,921,527	$5,104	$6,139	$1,036
12 Months	352	363	$1,458,754	$2,255,487	$4,144	$6,213	$2,069

Casemix Data Through:
06/30/2019

ENS Panels Last Updated:
08/18/2019

- 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 12 Months of Visits Before and After the Enrollment Date

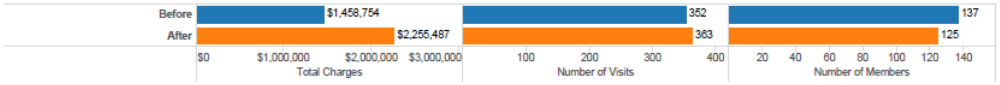
The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they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

Total Number of Members in the Panel
487

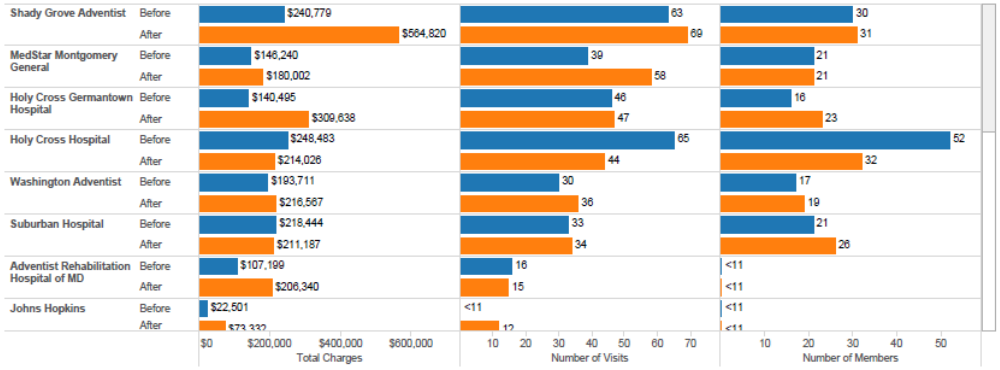
Number of Members with Data for Analysis
272

Number of Members with Visits during Analysis Period
172

All Hospitals



Hospital Details



Before or After Enrollment
Before
After

Most Recent Payer
All

Time Period
12 Months

Visit Type
All

Sorting Option
Total Visits - After Enrollment

Hospital Name
All

Program Name
20190830_wish_all_program (5887)

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

Casemix Data Through:
06/30/2019

ENS Panels Last Updated:
08/18/2019

- 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 12 Months of Visits Before and After the Enrollment Date

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

Most Recent Payer
All

Time Period
12 Months

Trend Metric
Visits

Visit Type
All

Hospital Name
All

Program Name
20190830_wish_all_program (5887)

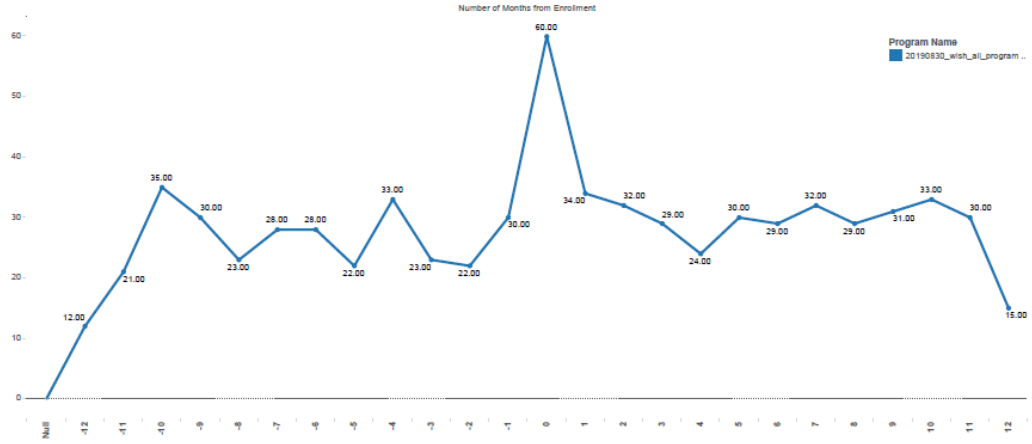
Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

Relative Trend



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 - 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.
06/30/2019	
ENS Panels Last Updated:	
08/18/2019	

Pre/Post Analysis

Analysis of 12 Months of Visits Before and After the Enrollment Date

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

Most Recent Payer
All

Visit Type
All

Hospital Name
All

Time Period
12 Months

Program Name
20190830_wish_all_program (5887)

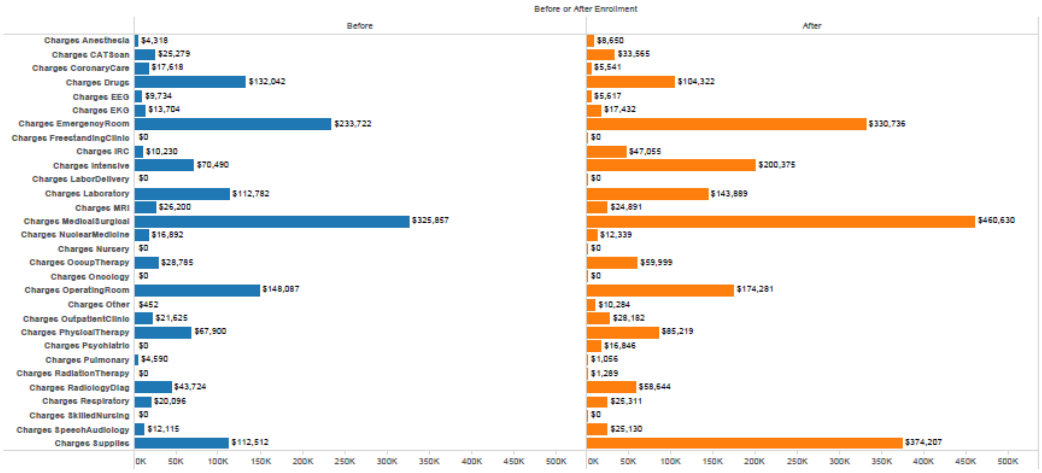
Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

Breakdown of Charges Sheet



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 - 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.
06/30/2019	
ENS Panels Last Updated:	
08/18/2019	

Appendix C: Pre-Post Report – ACT Team

Pre/Post Analysis - Summary

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

Program Name
20190826_act (9546)

Chronic Conditions
All Patients

Most Recent Payer
All

Visit Type
All

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

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	70	70	70	63

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	29	19	41.4%	27.1%	-14.3%
3 Months	48	30	68.6%	42.9%	-25.7%
6 Months	59	44	84.3%	62.9%	-21.4%
12 Months	60	49	95.2%	77.8%	-17.5%

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	63	32	9.0	4.6	-4.4
3 Months	178	88	25.4	12.6	-12.9
6 Months	363	165	51.9	23.6	-28.3
12 Months	489	244	77.6	38.7	-38.9

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	37	$310,611	$51,452	$10,711	$2,708	($8,003)
3 Months	56	$647,408	$175,819	$13,488	$5,861	($7,627)
6 Months	64	$1,036,455	$481,546	$17,567	$10,944	($6,623)
12 Months	61	$1,436,989	$877,791	$23,950	$17,914	($6,036)

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	63	32	$310,611	$51,452	$4,930	$1,608	($3,322)
3 Months	178	88	$647,408	$175,819	$3,637	$1,998	($1,639)
6 Months	363	165	$1,036,455	$481,546	$2,855	$2,918	$63
12 Months	489	244	$1,436,989	$877,791	$2,939	$3,598	$659

Casemix Data Through:
06/30/2019

ENS Panels Last Updated:
08/05/2019

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

Pre/Post Analysis

Analysis of 12 Months of Visits Before and After the Enrollment Date

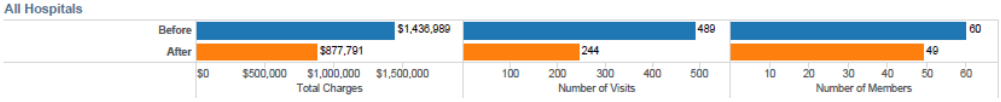
The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they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

Total Number of Members in the Panel
70

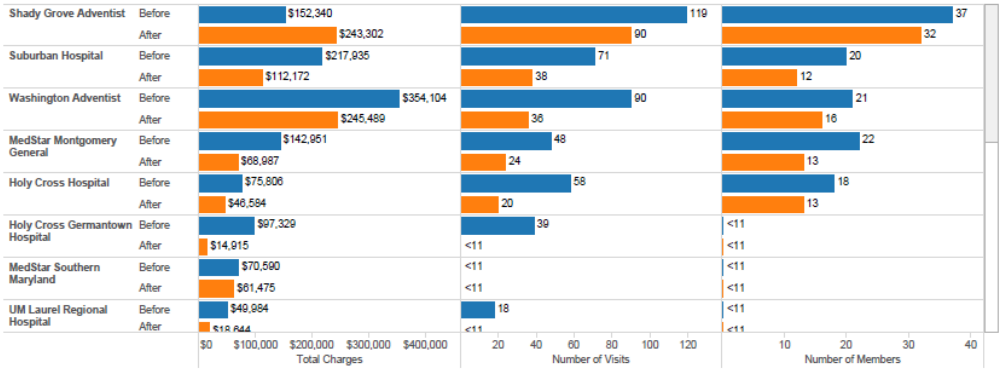
Number of Members with Data for Analysis
63

Number of Members with Visits during Analysis Period
61

All Hospitals



Hospital Details



Before or After Enrollment
Before After

Most Recent Payer
All

Time Period
12 Months

Visit Type
All

Sorting Option
Total Visits - After Enrollment

Hospital Name
All

Program Name
20190826_act (9546)

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

Casemix Data Through:
06/30/2019

ENS Panels Last Updated:
08/05/2019

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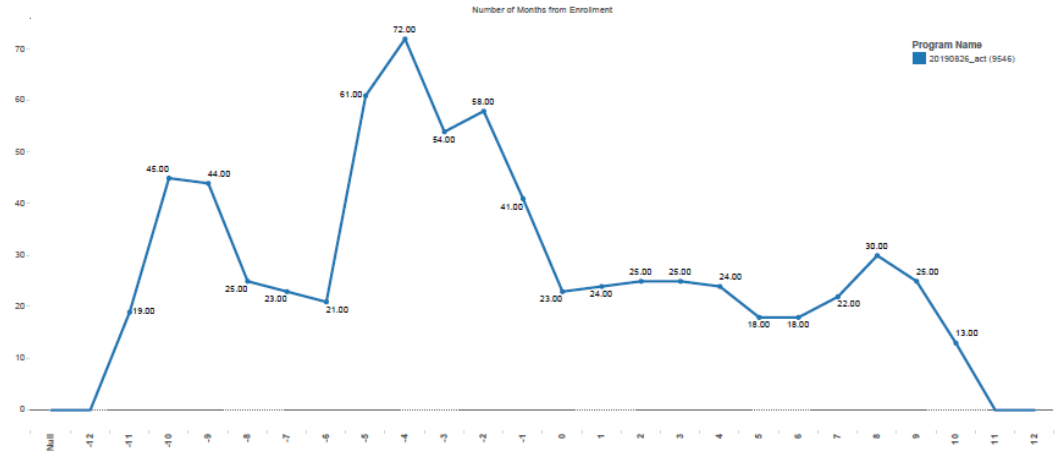
Relative Trend



Most Recent Payer: All

Time Period: 12 Months

Trend Metric: Visits

Visit Type: All

Hospital Name: All

Program Name: 20190826_act (9546)

Chronic Conditions: All Patients

N/A

N/A

Chronic Condition Operator: (•) AND ( ) OR

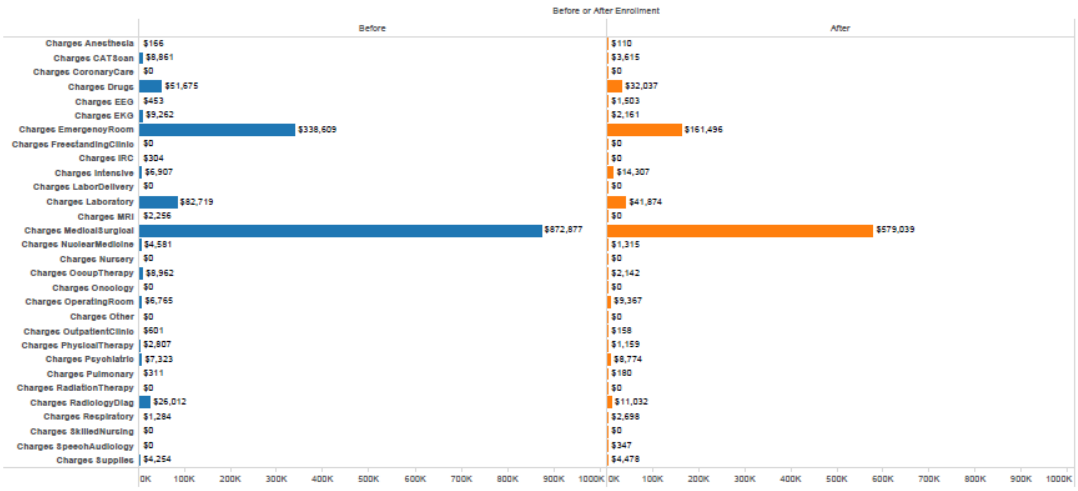
Casemix Data Through:	- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP. - Data source: - Panel information provided to CRISP by ENS - HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals - Individual patients identified using CRISP EID - CRISP suppressed cells with counts of 10 and under - 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.
06/30/2019	
ENS Panels Last Updated:	
08/05/2019	

Pre/Post Analysis

Analysis of 12 Months of Visits Before and After the Enrollment Date

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

Breakdown of Charges Sheet



Most Recent Payer: All

Visit Type: All

Hospital Name: All

Time Period: 12 Months

Program Name: 20190826_act (9546)

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 - 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.
06/30/2019	
ENS Panels Last Updated:	
08/05/2019	

Appendix D

Althea Woodland Nursing and Rehabilitation Center
Arcola Health and Rehabitiliation
Asbury Methodist Village (Wilson Health Care Center)
Bedford Court
Bel Pre Nursing and Rehabilitation
Bethesda Health and Rehabilitation
Brighton Gardens of Tuckerman Lane
Brooke Grove
Cadia Hyattsville
Cadia Springbrook
Cadia Wheaton
Carriage Hill
Collingswood
Crescent Cities
Fairland Center
Fox Chase
Friends Nursing Home
Hebrew Home of Greater Washington
Hillhaven
Kensington
Layhill
Manor Care Adelphi
Manor Care Bethesda
Manor Care Chevy Chase
Manor Care Hyattsville
Manor Care Potomac
Manor Care Silver Spring
Manor Care Wheaton
Montgomery Village
Oak Manor
Oakview
Potomac Valley
Regency Care of Silver Spring
Riderwood
Shady Grove Center
Sligo Creek Center
The Village at Rockville