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	Totally Linking Care, MD (TLC-MD/TLC)
RP Hospital(s)	Doctors Community Hospital, UM Capital Region Health (Laurel and Prince George's Hospital Centers), MedStar Southern Maryland Hospital, MedStar St. Mary's Hospital, Calvert Memorial Hospital and Ft. Washington Hospital
RP POC	David Chernov, Executive Director, David.chernov@tlc-md.org
RP Interventions in FY 2019	1) Care Coordination (clinical) 2) Community Health Workers 3) Medication Therapy Management (UM School of Pharm) 4) Faith-based Community Engagement (Maryland Citizens' Health Initiative Education Fund) 5) Blue Bag (HQI)
Total Budget in FY 2019 *This should equate to total FY 2017 award*	FY 2019 Award: $1,200,000
Total FTEs in FY 2019	Employed: 0

	Contracted: 20 (for Executive Director, Analytical Group, Policy Manual, Trainer, Grant writer, RNs, CHWs, and RX Medical partners and staff at Member Hospitals)
Program Partners in FY 2019 *Please list any community-based organizations or provider groups, contractors, and/or public partners*	1. eQHealth (software and services) 2. Prince George's Healthcare Alliance (CHWs) 3. Univ of MD School of Pharmacy (Medication Therapy Mgmt.) 4. Maryland Citizens' Health Initiative Education Fund (Faith-based) 5. HQI (Medication mgmt.) 6. Prince George's Dept of Health

Overall Summary of Regional Partnership Activities in FY 2019

(Free Response: 1-3 Paragraphs):

TLC completed the rollout of all initiatives and updated the population health application platform (eQHealth) infrastructure to track all patient activity and tracking required to monitor outcomes across all hospitals in the partnership across southern Maryland. This infrastructure was mature enough to attract the attention of the CDC ("we can contract with one organization to study population health, i.e. diabetes and other chronic diseases, across the entire southern part of the state, rather than with multiple hospitals") and provided funding to expand into other areas to assist our patient population across our catchment area.

In addition, TLC contracted with an evaluator (KPMG) this FY to review our outcomes utilizing data collected from CRISP, eQHealth and our member hospitals' information systems. The data indicated a tremendous reduction in hospitalizations, readmissions, and PQIs for our patients that reached goals (page 42 below).

Our efforts moving forward will be to build on these results to optimize current programs (by expanding our training programs for our hospitals via our formalized and documented "boots on the ground" training guide) and to focus on insuring our enrolled patients (all patients in TLC are enrolled in the eQHealth population health software platform) reach goals as indicated on discharge and care plans created by care coordinators assigned to each patient. The bottom line for TLC is that now have in place a fully mature infrastructure to accomplish the following:

1) Identify our target population(s) for each intervention

2) Ability to enroll qualified patients into a population health software application that provides an overlay for each hospital information system
3) Share provider notes within the system for all programs (from multiple partners in our community including community health workers, faith-based supports, medication therapy management and any new initiatives/programs in the future) to update and communicate with all care providers focused around the patient
4) Developed a methodology to study and evaluate the efficacy of all programs and validation via a trusted, respected third party
5) **Achieved a 662% ROI (page 25)**

Intervention Program

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

Intervention or Program Name #1	Care Coordination to include RNs for patients with 2+ Chronic Conditions and Medicare FFS
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*	All patients meeting our criterial are assigned a care coordinator (RN) to be the "quarterback" for all interactions with the patient. This includes coordinating/adding additional programs (outlined here) as well as implementing the discharge plan and helping to schedule follow-up appointments with PCP/specialists. (our training manual is attached for more clarity).
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	1. Hospital Staff: Case Managers, RNs, 2. EQHealth –software, RNs services) 3. Prince George's Healthcare Alliance -CHWs 4. Univ of MD School of Pharmacy (Medication Therapy Mgmt.) – Pharmacists
Patients Served *Please estimate using the Population category that best applies to the Intervention,*	# of Patients Served as of June 30, 2019: 1,363 [source: KPMG report to the TLC Board of total active 398 plus inactive 965 = 1,363]

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.*	TOTAL ENROLLEES REFERRED IN CY18 (COUNT) Denominator of Eligible Patients: CRISP Analytical File CY 2018:
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	See Addendum I
Intervention-Specific Outcome or Process Measures	KPMG report from FY 2017 thru May 2019 to show that those patients who complete the program are more apt to not get readmitted.

Intervention Program	Active at 5/31/19	Inactive (Beginning TLC-MD to Current)			
		Goals Met	Expired	Other	Total Inactive
Care Coordination (CC)	247	86	67	551	704
Community Health Worker Program (CHWP)	71	5	12	53	70
Blue Bag Initiative (BB)	45	16	4	62	82
ASA Medication Adherence (AMA)	0	1	1	5	7
Others	35	0	14	88	102
Total for TLC-MD	398	108	98	759	965

Total Unique Enrollees (Count)	Active	Inactive (Beginning TLC-MD to Current)		
		Goals Met	Expired	Other
No. of unique enrollees	334	99	79	611
No. of enrollees in 2 or more programs	64	9	19	148
% of enrollees in 2 or more programs	19%	9%	24%	24%

POP Category	Year	Population	Patients	Regional Partnership
2+ Chronic Conditions and Medicare FFS	2018	121,142	18,672	Totally Linking Care Southern MD

(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.*	Additional information: • Total number of Patients in care coordination who were referred to each TLC-MD program, by hospital system • Total number of Patients who denied services, by hospital system, by reason for denial as stated by patient • Total number of Problems/Barriers for enrollees, captured by program, hospital system • Total number of Goals established for enrollees, by goal type, by program • Total number of Interventions for enrollees, by intervention type, by program (defines the clinical, behavioral and social determinants of health facing enrollees and can be used for grant research and budgeting) • % gender • Avg. age • Total number of contacts by type of contact, by program, by hospital system • Average number of interventions for all enrollees, by program, by hospital system
Successes of the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	As evidenced from the attached CRISP pre/post report, there was a 43% reduction in total charges and 32% reduction in hospital visits for June 2019. Further, there was a 53% reduction in total charges specifically for Med/Surge and 39% for ER respectively. In addition, by mapping the eQ panel submitted to CRISP to actual hospital members' information systems data, it was also determined that there was a ***reduction in hospitalization use rate of 40%, readmission use rate of 85% and PQI use rate of 91% respectively for patients where "discharge plan goals were met."*** About the CHW: • Comparison of Pre/Post hospital visits by type – ED, inpatient, observations, by hospital system • Comparison of Pre/Post hospital costs by type – ED, inpatient,

	observations, by hospital system
Lessons Learned from the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	TLC must focus on working with patients that are most open to intervention/behavioral change to help reach "goals met." Intuitively, this means addressing non-clinical, SDOH issues that may not be addressed solely by clinical interventions upon discharge from the hospital. This will allow patients to focus on what really matters most to them – housing, nutrition, childcare, etc. first. Then and only then, TLC might find the opportunity to address the issues/tasks as presented on the hospital discharge summary. More data on patient enrollments in each program, and pre/post comparisons by hospital system to assess workflow and intervention effectiveness.
Next Steps for the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	Focus on understanding why goals are not met. What can TLC do to better understand the "real issues" high-utilization patients are facing? How can TLC be presented prior to patient discharge in a manner that allows the case manager to really understand the unique problems the patient is experiencing, and why the patient continues to "over-use" the healthcare system, **based on their unique situation**? What can TLC do to break the cycle to change the behavior that caused the problems to begin with? How can TLC determine if the patient actually wants to make a change vs. agreeing to participate just to "get out of the hospital and end the discussion……?" Use FY2019 data to analyze outcomes by program, by hospital system to compare outcomes by hospital system. i.e. compare pre/post outcomes for hospital based CHW Programs (internal) vs. non-hospital based CHW programs (external – Healthcare Alliance). This data can be used for program improvement.
Additional Free Response (Optional)	See Addendum IV for number of readmissions vs admissions from KPMG annual report to TLC Board.

Intervention or Program Name #2	Community Health Workers (CHW)
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*	This program connects the patient with a formally trained health worker from their community who understands their challenges, lives in their neighborhood and can relate to their needs/issues and barriers. CHWs work very closely with the assigned care manager (RN) to report findings, additional needs and reasons for continued use of the healthcare system for services best provided outside the hospital environment.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	Prince George's Healthcare Alliance (PGCHCA) and member hospitals. Hospitals have the option of using their own CHWs or can contract with TLC's provider (PGHCA).
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*	# of Patients Served as of June 30, 2019: 526 [source: eQHealth panel]

<table>
<tr><td>intervention's targeted population.
Feel free to also include your partnership's denominator.</td><td></td></tr>
<tr><td></td><td>Denominator of Eligible Patients: same as Care Coordination Program

<table><tr><th>POP Category</th><th>Year</th><th>Population</th><th>Patients</th><th>Regional Partnership</th></tr><tr><td>2+ Chronic Conditions and Medicare FFS</td><td>2018</td><td>121,142</td><td>18,672</td><td>Totally Linking Care Southern MD</td></tr></table></td></tr>
<tr><td>Pre-Post Analysis for Intervention (optional)
If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.</td><td>See Addendum II</td></tr>
<tr><td>Intervention-Specific Outcome or Process Measures
(optional)
These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership maintains and uses to analyze performance. Examples may include: Patient satisfaction; % of</td><td>• Total number of Patients in care coordination who were referred to each TLC-MD program, by hospital system
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• Total number of Goals established for enrollees, by goal type, by program
• Total number of Interventions for enrollees, by intervention type, by program (defines the clinical, behavioral and social determinants of health facing enrollees and can be used for grant research and</td></tr>
</table>

referred patients who received Intervention; operationalized care teams; etc.	budgeting) • % gender • Avg. age • Total number of contacts by type of contact, by program, by hospital system • Average number of interventions for all enrollees, by program, by hospital system
Successes of the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	• Comparison of Pre/Post hospital visits by type – ED, inpatient, observations, by hospital system • Comparison of Pre/Post hospital costs by type – ED, inpatient, observations, by hospital system
Lessons Learned from the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	More data on patient enrollments in each program, and pre/post comparisons by hospital system to assess workflow and intervention effectiveness.
Next Steps for the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	Use FY2019 data to analyze outcomes by program, by hospital system to compare outcomes by hospital system. i.e. compare pre/post outcomes for hospital based CHW Programs (internal) vs. non-hospital based CHW programs (external – Healthcare Alliance). This data can be used for program improvement.
Additional Free Response (Optional)	TLC's fully mature infrastructure and data analysis capabilities can now study the effects of combinations of interventions. For example, "Did our outcomes improve with patients that were assigned community health workers?" If yes, this will guide TLC to optimization of said interventions and provide information of best use of investments.

Intervention or Program Name #3	Medication Therapy Management (MTM, P3)
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	Pilot with Ft. Washington Medical Center & MedStar St. Mary's Hospital
Brief description of the Intervention *2-3 sentences*	In partnership with the University of Maryland School of Pharmacy (P3 program), medication therapy management is provided for patients with multiple medications exhibiting signs of confusion, trouble with medication adherence and any other issues related to their medication regiment.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	University of Maryland School of Pharmacy (P3 program)
Patients Served *Please estimate using the Population category that best applies to the Intervention, from the CY 2018 RP Analytic Files.* *HSCRC acknowledges that the High Utilizer/Rising Risk or Payer designations may over-state the population, or may not entirely represent this intervention's targeted population.*	# of Patients Served as of June 30, 2019: 48
	Denominator of Eligible Patients: All patients do not get this program, so there is little data in CRISP currently. Intervention is being rolled out now, so more data should be available in the next Q.

*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.*	
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.*	• Development of various process maps/workflows for P3 MTM services based on hospital's use of internal or external care team/resources. • Operationalized P3 MTM coordination and communication with other care team members in a patient centered manner • Began program pilot to test various workflows and models in 2 hospitals out of 6 hospitals • Both hospitals were able to successfully refer patients into the P3 MTM program • Total of 6 patients referred to P3 MTM program • Of the 6 patients referred, 2 were served by P3 MTM program, 3 patients were unable to reach after 3 attempts, while 1 patient was discharged to hospice.
Successes of the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	The P3 MTM program was just implemented and has been able to serve 2 patients so far during their transitioning from the hospital to their home. Of note is one patient on 17 medications who had several questions and concerns around her medications. The P3 MTM program was able to work with the patient via a Community Health Worker facilitated telephone call. Issues relating to non-adherence due to medication side effects were addressed with patient counseling provided. In addition, need for follow up lab/bloodwork was identified. P3 MTM was able to work collaboratively with

	the patient's cardiologist and endocrinologist in a patient centered manner to ensure continuity of the discharge care plan by communicating items on the care plan that required providers to follow up on in addition to informing each provider of medication related problems relating to their field of practice. Utilizing eQ-Suite as the central documentation and care coordination solution prevented any potential gaps in communication between various team members working around the same patient. Overall, great care team communication and handoff was attained during this patient's transitioning confirming that the developed workflow and model of care works and is scalable.
Lessons Learned from the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	Patient engagement continues to be the number one barrier within the P3 MTM program and the TLC-MD program offerings overall. Despite patients agreeing and providing their signature as consent to program enrollment, only about 40% of patients engage after hospital discharge with a lower percentage actually following through with interventions and meeting program goals. Patient continued engagement after discharge has become the "rate limiting step" in the overall effectiveness of the program. In addition, one model where all team members are within the same hospital which allows the community health workers to build relationships with patients in a face to face manner has demonstrated better success with continued patient engagement post discharge from the hospital.
Next Steps for the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	Create a "Patient Engagement" committee to develop steps and processes that will foster patient engagement that transcends care setting, whether inpatient or outpatient. Some points being considered include; warm hand offs with care team members in the outpatient setting meeting up with patients while they are still in the hospital, providing motivational interviewing training to hospital staff enrolling patients, switch from a provider centered approach to a patient centered approach in prioritizing post discharge action/care plan.

Additional Free Response (Optional)	This program is in partnership with the University of Maryland School of Pharmacy and provides both telephonic and telehealth patient consults in the patient's home. In addition, TLC is experimenting with using community health workers to facilitate telehealth in patient's homes, solving for the lack of computer expertise of many of TLC's patients. Again, TLC's mature infrastructure can now study the effects of combining interventions (medication therapy management and CHWs) via a trusted third party to help maximize and optimize patient outcomes.

Intervention or Program Name #4	Faith-based Community Engagement
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	Pilot with Ft. Washington and MedStar St. Mary's Hospital
Brief description of the Intervention *2-3 sentences*	Upon enrollment in TLC via a TLC member hospital, patients have the opportunity to share their preferred faith-based congregation to be notified of their admission/re-admission to any MD hospital. TLC works with CRISP to create ENS messages that are routed to a trained hospital liaison who then contacts a trained congregation leader who initiates their specific process/team to visit their congregant in a MD hospital.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	Maryland Citizens' Health Initiative Education Fund, Inc.
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*	# of Patients Served as of June 30, 2019: Pilot stage – not applicable at this time
	Denominator of Eligible Patients: All patients do not get this program, so there is little data in CRISP currently. Intervention is being rolled out now, so more data should be available in the next Q.

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.*	Pilot stage – not applicable at this time
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 Maryland Faith Health Network (MFHN) model is designed to improve communication among the people caring for a person at their hospital and the people caring for the person within their faith community. Professional literature on faith and health partnerships indicates that this model can reduce potentially avoidable utilization and strengthen relationships between hospitals and community leaders, thereby building regional cross-sector capacity for collaboration to promote population health. To date, the MFHN has met with all hospitals in TLC to discuss the model and consider the opportunities and challenges associated with implementation. Process outcome measures in the future will include the number of hospitals proceeding with implementation of the MFHN model as indicated by the number of hospitals signing the Memorandum of Understanding and establishing functioning interdisciplinary implementation teams at their facilities.
Successes of the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	TLC-MD partners have expressed great interest in working with congregations.
Lessons Learned from the	Patient engagement is a top priority for TLC-MD, although members have

Intervention in FY 2019 *Free Response, up to 1 Paragraph*	voiced concern about overburdening case management staff in this effort. It makes sense therefore to build strong partnerships with local faith leaders who are already contacting and meeting with people who have been discharged from the hospital.
Next Steps for the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	• Provide expert consulting to facilitate systems development and testing at each hospital and congregation with a signed MOU and functioning team. • Maintain CRISP patient portal, oversee outreach and enrollment and maintain up to date liaison database of trained congregational representatives. • Assist participating hospitals in developing strategies to promote Network internally to staff and enroll additional patients. • Secure commitment of at least three congregation in each participating hospitals' service area and train at least two congregational liaisons to assist in systems refinement, data collection and congregant support. • Host one media event with TLC-MD to broadly promote the Network throughout the region • Validate system function and improvements through monthly CRISP reports, available hospital metrics and information on congregational activities • Present report and recommendations to TLC-MD and HSCRC
Additional Free Response (Optional)	This intervention is based on a very successful model deployed by LifeBridge Health and TLC's selected partner for this program. TLC has learned that we need to "meet the patient where they are…" to increase the chance of patient engagement. If patient engagement cannot be accomplished while the patient is in the hospital (which is often the case, hence our "problem"), TLC has another chance via the patient's trusted advisors (faith-based support members). This initiative also leverages CRISP's ENS service to notify specifically trained faith-based congregation leads (via the hospital ENS

	contact) of their member's recent hospital admission/discharge. TLC categorized this initiative as an extension of the CHW intervention and is exploring further expansion into other areas that TLC patients have "trusted" advisors.

Intervention or Program Name #5	Blue Bag
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*	Upon discharge patients with multiple medications (dispensed in the hospital or indicating that multiple medications are also at home from previous visits) are provided with a "blue bag." Patients are then instructed to go home and collect all medications, supplements and herbs and place them in the blue bag and bring to the next scheduled provider appointment for medication review. The blue bag is also used for facilitation of a medication therapy management telehealth call (from the UM P3 program listed above) facilitated by a CHW.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	Health Quality Indicators (HQI)
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*	# of Patients Served as of June 30, 2019: 279
	Denominator of Eligible Patients: All patients do not get this program, so there is little data in CRISP currently. Intervention is being rolled out now, so more data should be available in the next Q.

Payer designations may over-state the population, or may not entirely represent this intervention's targeted population. *Feel free to **also** include your partnership's denominator.*	
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	See Addendum III
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.*	• 6 and 12-month pre and post hospital utilization and costs for patients in each panel • Reporting outcomes that are relative to the interventions, such as: one hospital reported that their experience with an inpatient pharmacist conducting BBI reviews over the past year resulted in the hospital leadership creating a full-time care transitions pharmacist position since the program has been so well received by patients/staff and impacted readmissions. • # of patients entered per panel compared to the number of patients completed per panel
Successes of the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	• See bullet #2 above • Successful BB intervention at 1 hospital demonstrated a preventive ADE cost savings range of $12,615 to $18,479 for the 58 patients screened between 1/18 thru 6/19

Lessons Learned from the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	Lack of clear communication and data sharing created barriers to full cost analysis for all of TLC BB participants.
Next Steps for the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	HQI will continue to engage with clinical committee to offer technical assistance and support.
Additional Free Response (Optional)	TLC is leveraging the tremendous capabilities of Maryland's QIO, Health Quality Innovators at no expense to the organization. This initiative also leverages the medication therapy management initiative and will be studied to better understand how combinations of interventions improve patient outcomes (or not). Lastly, this information will help direct TLC on where to increase (or decrease) investment in various initiatives.

Core Measures

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

Utilization Measures

Measure in RFP *(Table 1, Appendix A of the RFP)*	**Measure for FY 2019 Reporting**	**Outcomes(s)**
Total Hospital Cost per capita	**Partnership IP Charges per capita** Executive Dashboard: 'Regional Partnership per Capita Utilization' – Hospital Charges per Capita, reported as average 12 months of CY 2018 -or- Analytic File: 'Charges' over 'Population' (Column E / Column C)	Analytic File: 'Charges' over 'Population' (Column E / Column C) $4109.61
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	Analytic File: 'IPObs24Visits' over 'Population' (Column G / Column C) 20%

	-or- Analytic File: 'IPObs24Visits' over 'Population' (Column G / Column C)	
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)	Analytic File 'ED Visits' over 'Population' (Column H / Column C) 18%

Quality Indicator Measures

<table>
<tr><th>Measure in RFP
(Table 1 in Appendix A of the RFP)</th><th>Measure for FY 2019 Reporting</th><th>Outcomes(s)</th></tr>
<tr><td>Readmissions</td><td>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)</td><td>Analytic File:
‘IP Readmit’ over ‘EligibleforReadmit’
(Column J / Column I)

12% for TLC

<table><tr><th>Regional Partnership</th><th>Unadjusted Readmission rate by Hospital</th></tr><tr><td>Calvert Hospital</td><td>8%</td></tr><tr><td>Dimensions</td><td>15%</td></tr><tr><td>Doctors Hospital</td><td>15%</td></tr><tr><td>Fort Washington</td><td>9%</td></tr><tr><td>MedStar Medicare FFS</td><td>17%</td></tr><tr><td>Totally Linking Care Southern MD</td><td>12%</td></tr></table></td></tr>
<tr><td>PAU</td><td>Potentially Avoidable Utilization

Executive Dashboard:
‘[Partnership] Quality Indicators’ – Potentially Avoidable Utilization, reported as sum of 12 months of FY 2019

-or-</td><td>CY 2018
Analytic File:
‘TotalPAUCharges’
(Column K)

$ 99,640,293.44</td></tr>
</table>

	Analytic File: 'TotalPAUCharges' (Column K)	

CRISP Key Indicators (Optional)

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

Measure in RFP *(Table 1 in Appendix A of the RFP)*	**Measure for FY 2019 Reporting**	**Outcomes(s)**
Portion of Target Population with Contact from Assigned Care Manager	**Potentially Avoidable Utilization** Executive Dashboard: 'High Needs Patients – CRISP Key Indicators' – % of patients with Case Manager (CM) recorded at CRISP, reported as average monthly % for most recent six months of data *May also include Rising Needs Patients, if applicable in Partnership.*	28.7 June 2019 High Needs 16.5 June 2019 Rising Needs

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.

See Appendix IV: EQHealth Reports for additional process results from EQHealth surveys developed by the TLC Clinical Committee for types of chronic conditions that we track for success.

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)

Total TLC Costs was $1,200,000 including in-kind

The TLC CRISP Pre-Post Report for Care Coordination shows a reduction of charges per patient of $4,103 for those who remained in the program in the AFTER section of the CRISP Pre-Post Report.

This is a 662% ROI.

NOTE: we did not utilize any figure for patients who are not included in the AFTER section (920 patients) (back up in excel report file)

Pre Post Care Coordination

	Charges	Visits	Members	
Before	$ 73,531,298	8741	2857	
per captial		$ 8,412	$ 25,737	
After	$ 41,905,984	5973	1937	[1,363 per EQHealth]
per captial		$ 7,016	$ 21,634	
Variance	$ (31,625,314)	$ (2,768)	$ (920)	
per capital		(1,396)	(4,103)	

reduce real charges and each per capital categories

FY 2019	HSCRC Grant	Patients in Program costs less	ROI
Total TLC Grant	$ 960,000		
Total TLC expenditure	$ 240,000		
Total	$ 1,200,000	$ 7,947,052	662%

Patients in Program costs less	1937	$ (4,103)	$ (7,947,052.13)
Patients not experiencing charges (deceased, moved to an	$ (920)	$ 25,737	$ (23,678,261.87)
			$ (31,625,314.00)

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.

As outlined in TLC's initially proposed (December 6, 2015) RFP:

Primary Goal: Reduce the frequency and severity of high utilization of hospital-based services.

Strategy #1 – **Screen all admissions to our hospitals and implement layered care coordination.**

As outlined on page 2 above, upon discharge all patients are evaluated (are they on the "high utilizer" list and/or do they meet TLC enrollment criteria?) upon clearly documented evaluation criteria. A comprehensive training manual (79 pages) was created and used to conduct (5) training sessions for all hospitals in TLC. The training manual was designed as a "self-guided" understanding of what TLC is, why TLC was created, how to determine patient eligibility, examples of patient discussions about TLC and lastly, a step-by-step guide on how to enroll a patient into TLC's population health platform, eQHealth. Of note, all patients are assigned a care coordinator and additional care coordination programs as applicable.

Strategy #2 – **Reinforce the care coordination with special focus on medication management. For patients who are at risk of medication problems, each hospital will provide the enrolled patient with a 30-day supply of medications at discharge**.

TLC made a tremendous investment in medication therapy management (in partnership with the UM School of Pharmacy, page 11 above) in combination with care coordination (all TLC patients are assigned a care coordinator (RN). Patients are screened for ability to afford medications, and if a need is determined are assigned a CHW to help provide funding for medications, transportation and assistance in enrollment for health insurance. Financial support is provided to supplement what the hospital provides post-discharge. This strategy highlights the ability for TLC to combine and multiply the possibility of improving patient outcomes by combining many initiatives (care coordination with CHWs with medication therapy management).

Strategy #3 **– Support physician practices that deal with these high-needs patients.**

TLC's Clinical Committee is co-chaired by a VP of Medical Affairs (who is also a TLC Board Member) from a TLC member hospital. Physician update and engagement efforts are led by a TLC member hospital physician via physician-physician communication. Physician engagement is supported by periodic meetings at member hospital physician meetings. Physicians that work with high-needs patients are actively engaged at referenced meetings led by TLC's co-chair of the Clinical Committee.

Strategy #4 – **Cultivate a highly reliable learning organization.**

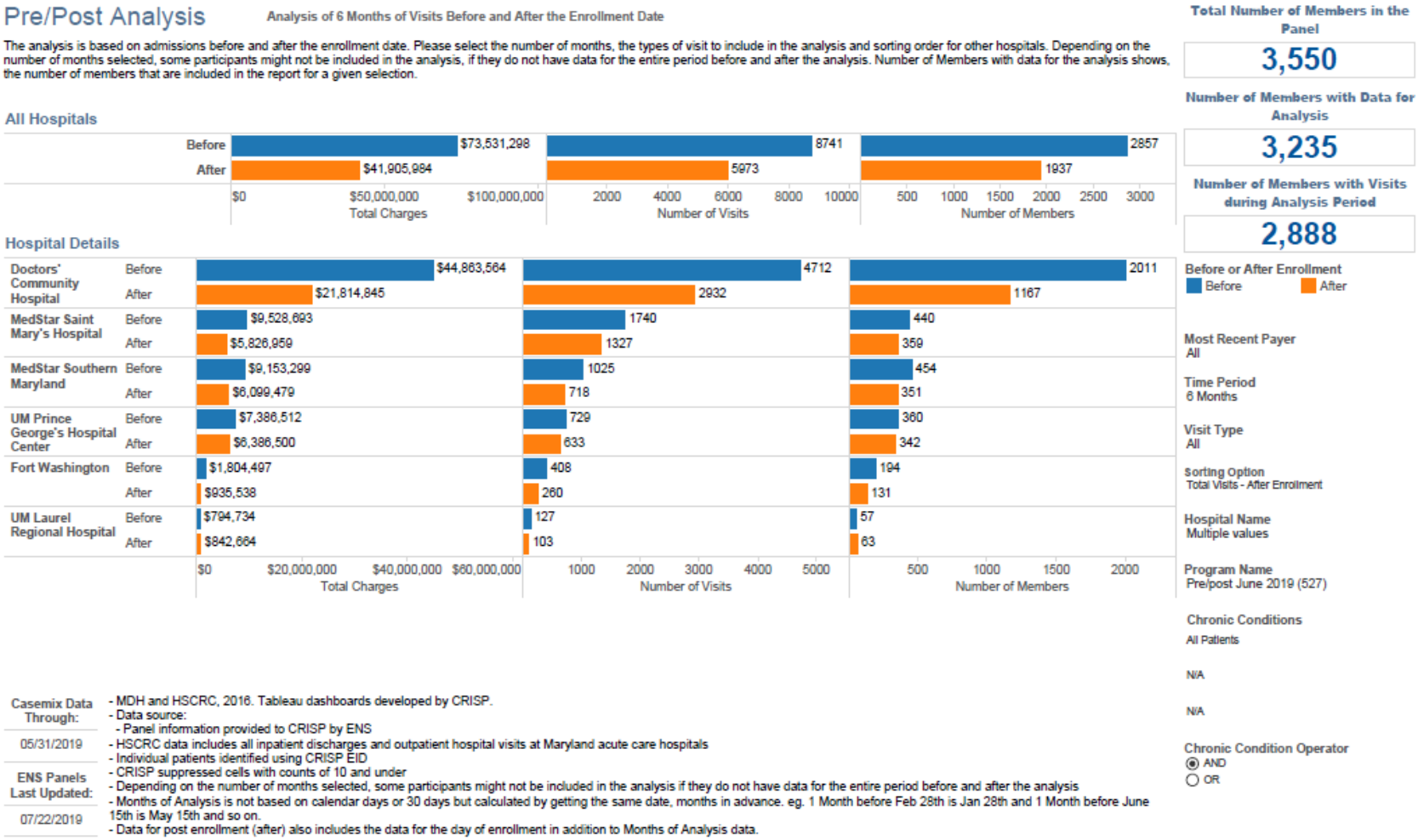
In order to "learn" TLC believes that we need to understand the scope of the problem (who are our patients and why?) and must utilize a database to enroll, track and report on all activities related to addressing the problem utilizing data to substantiate assumed "solutions."

As such and as outlined in this report, TLC has built the infrastructure to "learn" as we deploy:

1) TLC has Identified targeted population – who are the high-utilizers?
2) TLC enrolls and tracks each patient in a population health platform (database) to centralize communication and outcomes measurement
3) TLC analyzes results via all data sources available (CRISP, eQHealth and hospital information systems)
4) TLC contracts with a trusted third-party expert in data analysis (and the "Maryland Model") and works with the TLC Clinical Committee to analyze all interventions to determine where/how TLC can improve patient outcomes. And most importantly, TLC can determine what is not working and reduce investment in these areas to supplement areas that are showing improved outcomes

TLC created the infrastructure as outlined in this report from "ground 0." That is communication, partnership and strategic investment across the counties TLC serves was non-existent prior to TLC's formation. TLC believes (and proves in this report) that in order to really achieve "population health" a cohesive coordinated investment that avoids duplicative services must be applied across a "population" that is not constrained to any one hospital or hospital system. TLC has "learned" that our patients often move from hospital to hospital, often seeking treatment for the same condition (especially in the case of chronic conditions). Hence, a solution that is **not hospital centric**, but is in fact **patient centric** is required to address population health. TLC believes that Regional Partnerships are the way to address the staggering costs associated with chronic conditions, and the only way to effectively reduce the Total Cost of Care for this unique patient population.

Addendum I: Care Coordination Pre/Post CY 2018

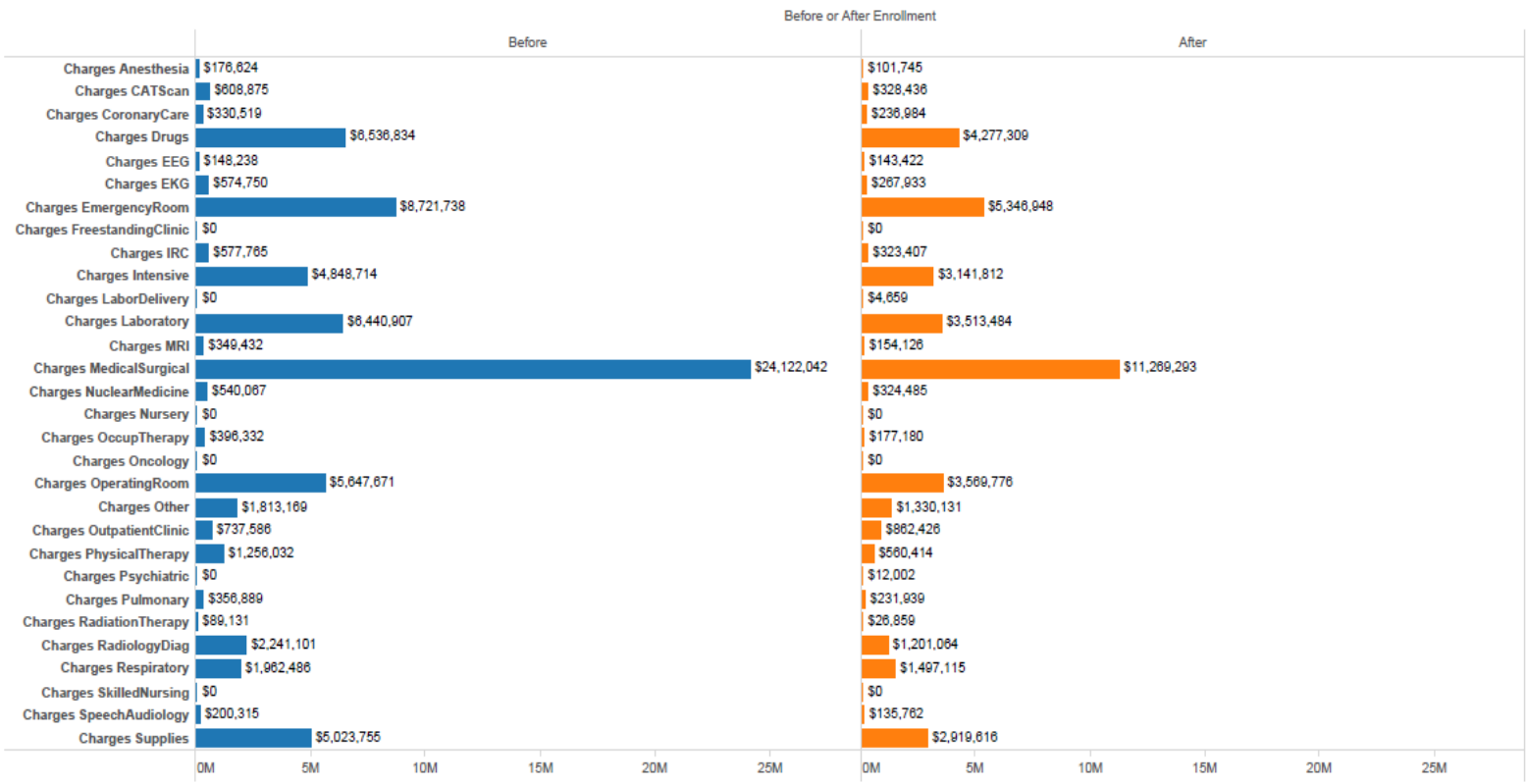


Pre/Post Analysis

Analysis of 6 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
Multiple values

Time Period
6 Months

Program Name
Pre/post June 2019 (527)

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
05/31/2019	- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals - Individual patients identified using CRISP EID
ENS Panels Last Updated:	- CRISP suppressed cells with counts of 10 and under - Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis - Months of Analysis is not based on calendar days or 30 days but calculated by getting the same date, months in advance. eg. 1 Month before Feb 28th is Jan 28th and 1 Month before June 15th is May 15th and so on. - Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.
07/22/2019	

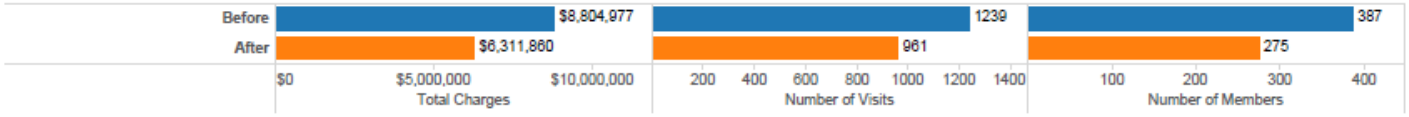
Addendum II: Community Health Workers (CHW) Pre/Post CY 2018

Pre/Post Analysis

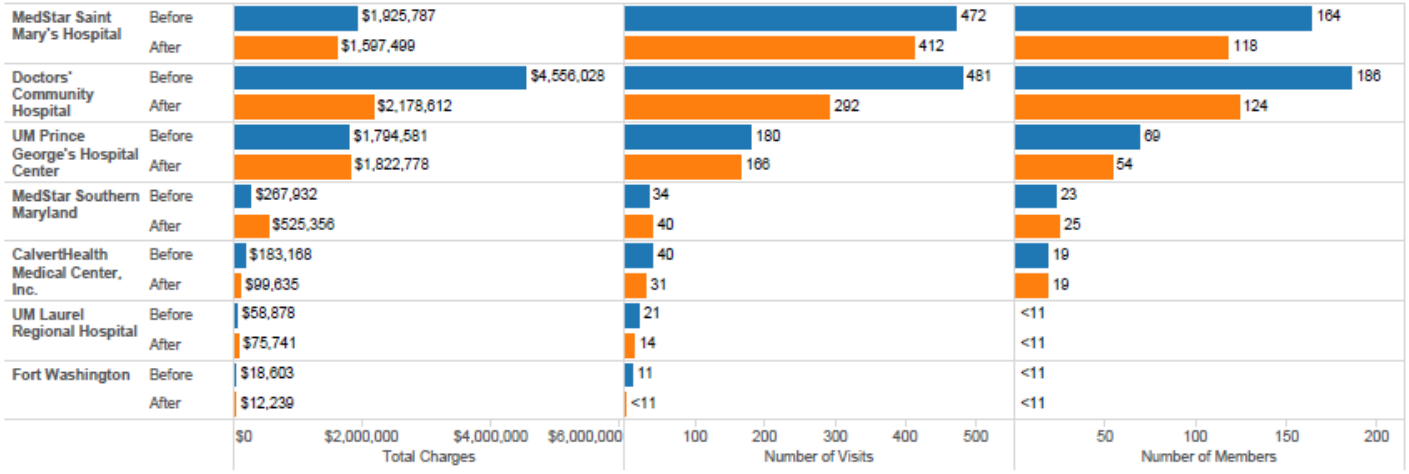
Analysis of 6 Months of Visits Before and After the Enrollment Date

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.

All Hospitals



Hospital Details



Total Number of Members in the Panel
490

Number of Members with Data for Analysis
405

Number of Members with Visits during Analysis Period
393

Before or After Enrollment
Before After

Most Recent Payer
All

Time Period
6 Months

Visit Type
All

Sorting Option
Total Visits - After Enrollment

Hospital Name
Multiple values

Program Name
CHW June 2019 (527)

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

Casemix Data Through:
07/31/2019

ENS Panels Last Updated:
09/01/2019

- 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
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- 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 6 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
Multiple values

Time Period
6 Months

Program Name
CHW June 2019 (527)

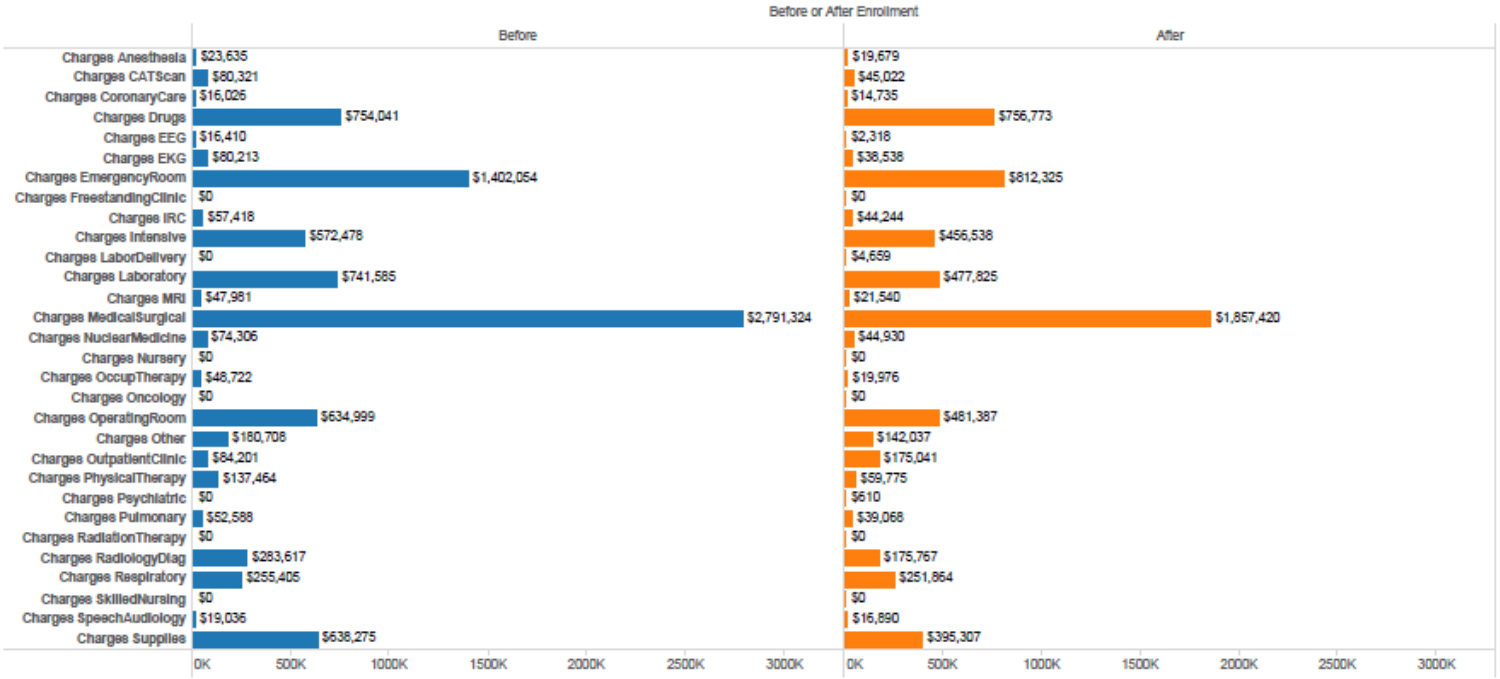
Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

Breakdown of Charges Sheet



Casemix Data Through:
07/31/2019

ENS Panels Last Updated:
09/01/2019

- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
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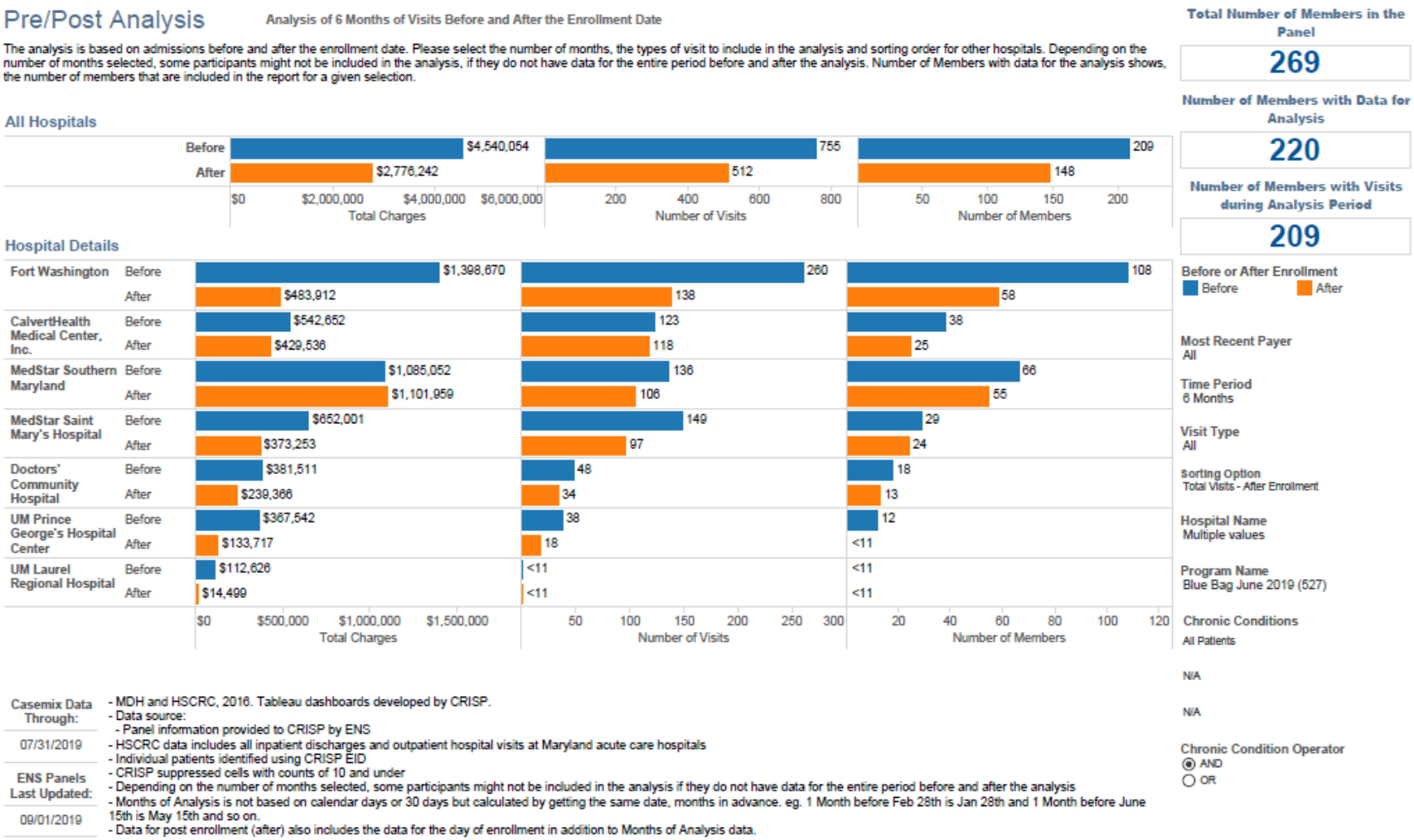
Addendum III: Blue Bag Program Pre/Post CY 2018



Pre/Post Analysis

Analysis of 6 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
Multiple values

Time Period
6 Months

Program Name
Blue Bag June 2019 (527)

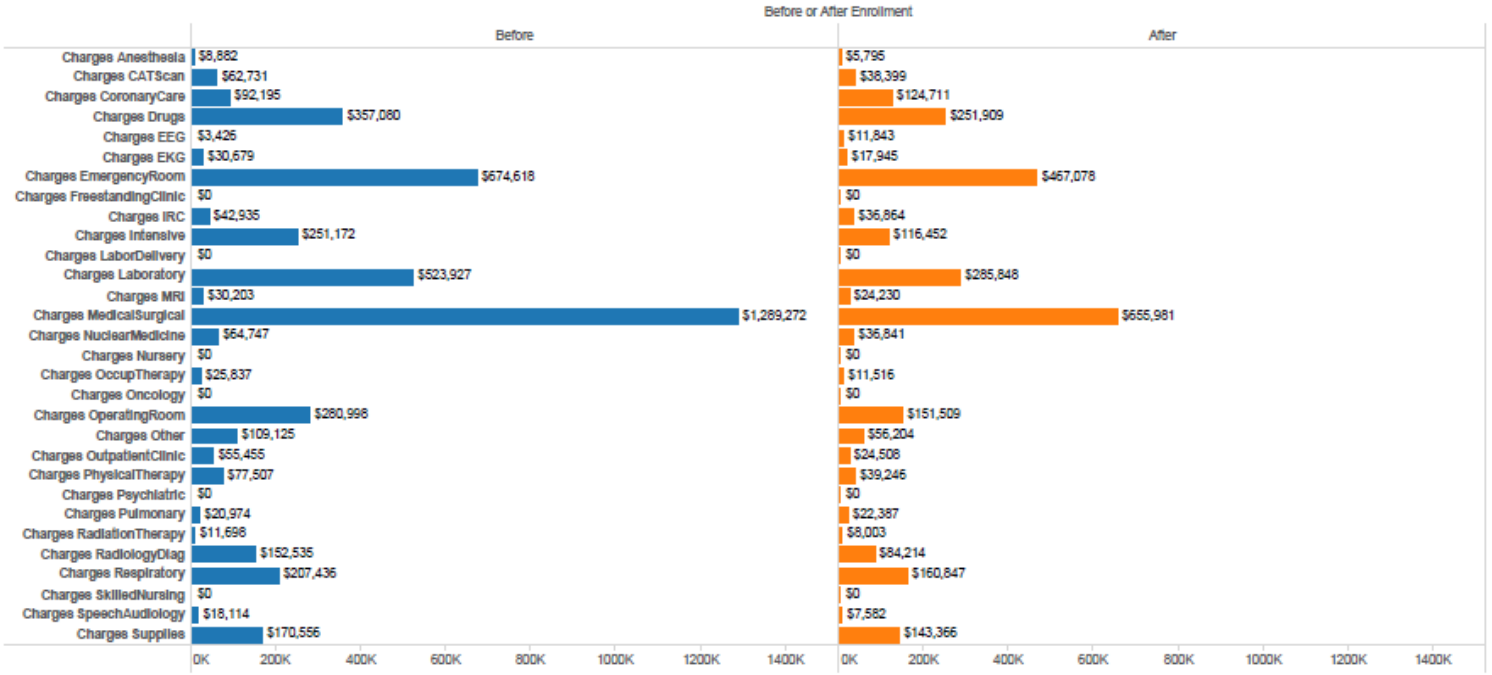
Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

Breakdown of Charges Sheet



Casemix Data Through:
07/31/2019

ENS Panels Last Updated:
09/01/2019

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

Addendum IV: EQHealth Reports

Section/Questions	# of Responses
1. Introduction	**291**
3. Have you provided all your prescription medication containers, over-the-counter medications and supplements?	**73**
No	24
Yes	49
4. Has anyone discussed your medications with you in the last 6 months, not including today's discussion?	**74**
No	40
Yes	34
5. Can you tell me what each of your medications are used for?	**72**
No	42
Yes	30
6. Can you tell me how and when you should take each medication?	**72**
No	37
Yes	35
2. Modified Morisky Scale	**74**
5. Do you know the long-term benefits of taking your medicine as told to you by your doctor or pharmacist?	**74**
No	37
Yes	37
3. Closing	**476**
1. Based on today's review, could you help me understand why you are not able to take your medications as your doctor has prescribed (check all that apply)?	**152**
"I didn't know I wasn't taking them correctly"	1
"I don't like the side effects"	1
"I forget to take my medicine"	1
"I was feeling better"	1
Cost	25

I didn't know I wasn't taking them correctly	22
I don't like the side effects	24
I forget to refill my medicine	16
I forget to take my medication	1
I forget to take my medicine	20
I was feeling better	17
Other	16
Transportation Issues	7
3. The following issues were identified on medication reconciliation (check all that may apply but a minimum of one):	**9**
Expired medications were identified by label	2
Medication was correct, dose was not	1
No issues identified	1
Participant failed to get medication(s) refilled	1
Participant had contraindication for one or more medications	1
Participant stopped taking prescription medications altogether without telling a clinician	2
Participant taking a new over-the-counter medication or supplement without informing their PCP	1
3. The following issues were identified on medication reconciliation (check all that may apply but a minimum of one):	**277**
Drug to drug interactions possible	36
Duplicate medications	32
Expired medications were identified by label	19
Medication was correct, dose was not	6
No issues identified	53
Participant changed to cheaper medication without telling their PCP (ex. Generic substitution or another medication in same drug class)	5
Participant failed to get medication(s) refilled	22
Participant had contraindication for one or more medications	6
Participant stopped taking an over-the-counter medication or supplement without telling a clinician	1
Participant stopped taking medication as prescribed	2
Participant stopped taking medication as prescribed	21
Participant stopped taking prescription medications altogether without telling a clinician	14
Participant taking a new over-the-counter medication or supplement without informing their PCP	4
Participant taking new prescription medication (prescribed by another doctor) without informing their PCP	5

Pill bottles brought in by participant did not match the medication list in the participant's record	6
Pill bottles brought in by participant did not match the medication list in the participant's record	2
Possible risk to participant safety	6
Possible risk to participant safety	37
4. What is the number of expired medications/OTC the participant should NOT be taking?	**19**
0	17
1	1
3	1
5. What is the number of narcotic medications the participant should NOT be taking?	**19**
0	18
2	1
(blank)	
(blank)	
(blank)	
Grand Total	**841**

	# of Responses
1. Medication Management	**193**
1. Did you receive a Blue Bag for your medications?	**14**
No	1
Yes	13
2. Have you sorted your medications using the Blue Bag?	**12**
No	3
Yes	9
23. Has anyone reviewed your medications with you in the last 6 months?	**12**
No	10
Yes	2
24. Can you tell me what OTC Medications (Vitamins/Herbal/Supplements) you currently take (What, how, when, indication)?	**10**
0	1
No	6
Non	1
None	1
Vitamin D 5000 IU ; Melatonin	1
25. How many supplements do you take?	**12**
0	1
1	2
2	2
3	1
4	1
5	2
15	1
None	2
26. How many OTC medications/supplements is the patient on?	**19**
0	3
1	1
2	3
3	7

4	3
5	1
None	1
27. Are there OTC Medications (Vitamins/Herbal/Supplements) you take and you are currently out of?	**12**
No	6
Yes	6
28. Did patient start or stop any OTC medication(s) without knowledge of prescriber?	**11**
No	6
Yes	5
29. Did patient know what each medication was for?	**11**
No	11
30. Did patient know how and when to take each medication?	**11**
No	11
31. Did patient start or stop any prescription medication(s) without knowledge of prescriber?	**12**
No	6
Yes	6
32. Is patient currently taking any medication that was discontinued or not on current list of meds?	**11**
No	6
Yes	5
4. Can you tell me what prescription medications you currently take (What, how, when, indication)?	**11**
ASA 81 mg - 1 tablet daily; clopidogrel 75 mg 1 tablet daily; hydralazine 10 mg 1 tablet TID; lisinopril 20 mg 1 tablet daily; metformin XR 500 mg 1 tablet daily; metoprolol tartrate 25 mg 1 tablet BID; nifedipine ER 60 mg 1 tablet BID; oxycodone 10 mg 1 tablet every 8 hours as needed	1
No	8
Not at home	1
Phenytoin 200 twice a day	1
5. How many prescription medications is the patient on?	**22**
0	1
2	1
5	3
7	2
9	1

10	3
14	1
15	4
16	1
20	1
23 per discharged summary. Patient thinks over 15.	1
8 (eight)	1
8? what about the Vosevi?	1
Don't know	1
7. How many medications do you take?	**13**
4	1
5	1
6	2
10	2
13	1
14	1
15	1
16	1
8 (eight)	1
Don't know	1
not at home at time of call	1
2. Wellness	**58**
6. Have you used illegal substances or abused legal drugs?	**20**
Have never used illegal substances or abused legal drugs	18
Yes - have been using for 1-3 years	1
Yes - have been using for more than 3 years	1
7. In the past 4 weeks, which of these substances have you used (Select all that apply)?	**20**
Marijuana (cannabis)	1
None	19
8. Over the past 5 years, how many times have you been treated in a substance abuse program?	**18**
0	14
N/A	1

No	1
None	1
Zero	1
3. Issues/Goals	**230**
1. (Pharmacist) The following medication adherence issues have been identified during this interaction (Select all that apply):	**40**
Inappropriate use	16
Other	1
Overuse	2
Polypharmacy	11
Polyprescriber	6
Underuse	4
10. How many of these interventions were identified?	**4**
3	1
Diphenhydramine - Is this indication for sleep?	1
Hydralazine - Not in tablet form, prescribed a s an injectable. Was this intentional?	1
(blank)	1
12. Did patient have drug with DOSE TOO LOW?	**13**
No	11
Yes	2
13. What was the root cause/reason for the DOSE TOO LOW (Select all that apply)?	**2**
Subtherapeutic dose	2
14. How many of these interventions were identified?	**1**
1 - metformin, may need to be increased based on most recent A1c.	1
16. Did patient have drug with LACK OF MONITORING?	**13**
No	7
Yes	6
18. How many of these interventions were identified?	**5**
1	2
2	1
diabetes testing	1
(blank)	1

20. Did patient need ADDITIONAL DRUG THERAPY?	**13**
No	8
Yes	5
22. How many of these interventions were identified?	**3**
1	2
Cough not treated	1
24. Did patient have ADVERSE DRUG REACTION?	**14**
No	11
Yes	3
25. What was the root cause/reason for the ADVERSE DRUG REACTION (Select all that apply)?	**5**
Contraindicated	1
Drug/Food interaction	1
Incorrect administration	1
Lack of monitoring	1
Undesireable effect	1
26. How many of these interventions were identified?	**3**
1	1
5	1
(blank)	1
28. Did Patient have DOSE TO HIGH?	**12**
No	12
32. Did patient have issues with COMPLIANCE?	**15**
No	4
Yes	11
34. How many of these interventions were identified?	**7**
1	1
2	4
3	1
(blank)	1
38. How many of these interventions were identified?	**2**
2	1
3	1

4. Did patient have drug with UNNECESSARY DRUG THERAPY?	**15**
No	9
Yes	6
40. Did the patient have any Gaps In Care/Social Determinants of Health Issues affecting Optimal Med Management?	**13**
No	11
Yes	2
41. Which SDH were identified (Select all that apply)?	**3**
Lack of social support	1
Low health literacy	2
42. Did patient have risks of Med issues (Polypharmacy and/or Multiple Prescribers)?	**13**
No	9
Yes	4
43. If yes, select all that apply:	**4**
Multiple Prescribers	1
Polypharmacy	3
5. What was the root cause/reason for the UNNECESARY DRUG THERAPY (Select all that apply)?	**10**
Duplicate therapy	2
Indicated but de-prescribing recommended	1
No Indication	6
Non-drug therapy more appropriate	1
6. How many of these interventions were identified?	**5**
1	1
3	1
4	1
Duplicate therapy - Eliquis and Plavix; how long has patient been on this therapy? Was it prescribed by the same provider? --- No indication: Ferrous fumarate 324 mg - Iron level not identified at this time ---	1
Lovenox and ondansetron - these medications are not necessary for the patient at this time and there is no indication for this at this time.	1
8. Was the patient on WRONG DRUG/WRONG DRUG CHOICE?	**15**
No	11
Yes	4

4. Interventions	**204**
1. (Pharmacist) The following activities have been completed during this interaction (Select all that apply):	**204**
Assessed med management	18
Assessed non-adherence	17
Assessed OTC and herbs	16
Assisted with pillbox (electronic)	2
Discussed beliefs/motives	17
Discussed eye and foot care	5
Educated member on benefits of medication adherence	15
Educated member on importance of taking medications as prescribed	12
Educated member on medication management	15
Educated member on medication safety	19
Educated member on other	5
Educated member on type, dose and side effects of prescribed medications	14
Educated member to carry a list of current medications at all times	16
Other	1
Provided medication voucher(s)	1
Provided pill organizer	4
Reviewed immunizations	14
Reviewed new discharge medications	13
Grand Total	**685**

Unique Patients: 497	Responses		
Survey Question	**No**	**Yes**	**Grand Total**
Is the patient adherent with their diagnostic plan (lab work/imaging)?	154	367	521
Is the patient adherent with their medication plan?	131	394	525
Is the patient adherent with their nutrition plan?	190	331	521
Is the patient adherent with their PCP appointments?	182	343	525
Grand Total	**657**	**1435**	**2092**

Unique Patients: 497	Responses		
Survey Question	**No**	**Yes**	**Grand Total**
Calvert Memorial Hospital	**485**	**357**	**842**
Is the patient adherent with their diagnostic plan (lab work/imaging)?	122	87	209
Is the patient adherent with their medication plan?	94	117	211
Is the patient adherent with their nutrition plan?	127	83	210
Is the patient adherent with their PCP appointments?	142	70	212
Doctor's Hospital	**54**	**516**	**570**
Is the patient adherent with their diagnostic plan (lab work/imaging)?	9	134	143
Is the patient adherent with their medication plan?	11	132	143
Is the patient adherent with their nutrition plan?	21	121	142
Is the patient adherent with their PCP appointments?	13	129	142
Fort Washington Hospital	**7**	**56**	**63**
Is the patient adherent with their diagnostic plan (lab work/imaging)?	2	14	16
Is the patient adherent with their medication plan?	1	15	16
Is the patient adherent with their nutrition plan?	2	13	15
Is the patient adherent with their PCP appointments?	2	14	16
Prince Georges Hospital	**25**	**179**	**204**
Is the patient adherent with their diagnostic plan (lab work/imaging)?	4	47	51
Is the patient adherent with their medication plan?	6	45	51
Is the patient adherent with their nutrition plan?	11	40	51
Is the patient adherent with their PCP appointments?	4	47	51
Southern Maryland Hospital	**32**	**191**	**223**

Is the patient adherent with their diagnostic plan (lab work/imaging)?	7	48	55
Is the patient adherent with their medication plan?	6	50	56
Is the patient adherent with their nutrition plan?	13	43	56
Is the patient adherent with their PCP appointments?	6	50	56
St. Mary's Hospital	**54**	**136**	**190**
Is the patient adherent with their diagnostic plan (lab work/imaging)?	10	37	47
Is the patient adherent with their medication plan?	13	35	48
Is the patient adherent with their nutrition plan?	16	31	47
Is the patient adherent with their PCP appointments?	15	33	48
Grand Total	**657**	**1435**	**2092**

Have you ever had your Vitamin D level checked?	197	246	443
Grand Total	**197**	**246**	**443**

Question 2, If responded "Yes" to Question 1			
	No	**Yes**	**Grand Total**
Do you know what the result was?	235	10	245
Grand Total	**235**	**10**	**245**

Question 3, If responded "Yes" to Question 2	**Responses**
Enter Vitamin D level	**12**
8	1
13	1
22.3	1
24.1	1
33.8	1
low	2
Pt. could not remember the actual number but he was told that "it was good" and he did not need to take a supplement. Pt. stated that he consumes a very nutritionally balanced diet.	1
Pt. said that he is given vitamin D at dialysis but he does not know the dose.	1
Unable to state however pt confirmed receipt of PO Vit D	1
Vit D3, x1 cap daily	1
vitamin d3 2000 units daily by mouth	1
Grand Total	**12**

Question 4			
	No	**Yes**	**Grand Total**
Are you currently taking Vitamin D?	311	129	440

Grand Total	**311**	**129**	**440**

Question 5, If responded "Yes" to Question 4	**Responses**
How much Vitamin D are you taking and how often?	**119**
100,000 units MWF	1
1 capsule weekly	1
1000 IU Daily	1
1000 IU daily	1
1000 units daily	2
1000 units daily.	1
1000U daily	1
2,000 UNITS/DAILY	1
2,000units every morning	1
200 mg	3
2000 units	1
2000 units daily	2
2500 IU Daily	1
3000 IU Daily	1
50 000 IU	1
50 000 IU weekly	3
50,000 u weekly	1
50,000 units every Monday.	1
50,000 units every two weeks	1
50,000 units po weekly	1
50,000 units q7 days	1
50,000 units weekly	1
5000 IU Daily	1
5000IU	1
5000U	1
600 mg daily	1

600mg BID	1
Calcitriol 0.125 mcg per day Ergocalciferol 50,000 u per week	1
Calcitrol one daily	1
Calcium 600mg and Vit D 400mg daily	1
calcium carb citrate Vit D3 ER unknown units.	1
cholecalciferol (Vitamin D3 (Cholecalciferol) tab) 4,000 iu Oral every day	1
cholecalciferol (Vitamin D3 (Cholecalciferol) tab) 5,000 International_Unit(s) Oral every day.	1
Cholecalciferol 5,000 units daily	1
Cholecalciferol weekly	1
Citracel + D250mg	1
D2 50,000Ui weekly	1
D3 1.25 weekly	1
D3 5000iU	1
D3, 50,000 x1 weekly	1
Daily OTC calcium with Vit. D. Unable to determine the dosage.	1
Ergocalciferol 1.25 every three days.	1
Ergocalciferol 50,000u	1
ergocalciferol Vit D2 50k weekly	1
In multivitamin.	1
Mbr's son reports that she receives it at the dialysis center; uncertain per strength.	1
member cannot recall dosage	1
Member not taking Vit D supplements at this time.	1
Member unable to confirm correct dose. States it may be 2k units daily.	1
Men's vitamin.	1
multivitamin	1
multivitamin daily	1
multivitamin for women	1
Multivitamin tablet daily.	1
multivitamin with D	1

New order, needs to pick it up from the pharmacy.	1
One-a-day multivitamin daily	1
One-a-Day multivitamin daily.	1
Ongoing daily intake of Vit D dietary supplements.	1
Per mbr, Vit D treatment is ongong and administered at Dialysis	1
Pt. said that he is given vitamin D at dialysis but he does not know the dose.	1
Recently stopped vitamin D supplements pre-op.	1
Renal dosage	1
Se med list	1
Takes D3 50,00 units per week when her PCP advises her that her levels are low, is not currently needing it.	1
Takes it daily. Unsure of dosage. Reports her calcium pills have vitamin D.	1
Taking OTC 1,000u daily. Was prescribed Vit D2 50,000u weekly but did not have it filled.	1
Two tablets twice day of OTC, does not know the dose	1
unknown	1
unknown by member	1
unknown daily	1
unknown dose	1
Unsure of the dose, given to her weekly at dialysis	1
Vit D 1,000 units daily	1
Vit D 2,000units daily	1
Vit D 5,000 units weekly	1
Vit D 50,000 per week	1
Vit D 50,000u per week	1
Vit D 50,000u weekly	2
Vit D2 1.25 per week	1
Vit D2 50,000 units 2xweek	1
Vit D2 50,000 units weekly	1
Vit D2 50,000Ui x1 capsule weekly	1
Vit D3 1000 units po daily	1

Vit D3 1000ui daily	1
Vit D3 2,000 daily	1
Vit D3 2,000u daily	1
Vit D3 2,000U x1 softgel daily	1
Vit D3 2,000ui	1
Vit D3 2000 iu/day	1
Vit D3 2000 units every day	1
Vit D3 2000 units/daily	1
Vit D3 2000iu	1
Vit D3 5,000 Units daily	1
Vit D3 50mcg daily	1
Vit D3, 2000ui daily	1
Vit D3, x1 cap daily	1
Vitamin D OTC daily	1
Vitamin D2 (1 tab/day)	1
Vitamin D2 50,000 intl units (1.25 mg) oral capsule, 50000 Intl_Unit= 1 cap, PO, q7day, 3 refills Vitamin D3 2000 intl units oral tablet, 2000 Intl_Unit= 1 tab, PO, Daily, 6 refills	1
Vitamin D2 50,000 Weekly	1
vitamin D2 50000 units weekly	1
Vitamin D2 ergocalciferol 50,000 units weekly	1
Vitamin D2-1.25mg. One capsule weekly	1
vitamin d3 1,000 units	1
Vitamin D3 1000 intl units oral tablet, 1000 Intl_Unit= 1 tab, PO, Daily	1
Vitamin D3 1000 units po daily	1
Vitamin D3 1000 units twice a day	1
vitamin d3 2000 units daily by mouth	1
Vitamin D3 5,000iU x1 capsule weekly	1
x1 5000U weekly	1
x1 capsule; 2000U weekly.	1
Grand Total	**119**

Assessment of the benefit of TLC-MD's interventions