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	Northeast Region
RP Hospital(s)	University of Maryland Upper Chesapeake Medical Center University of Maryland Harford Memorial Hospital Union Hospital of Cecil County
RP POC	Colin Ward, VP Population Health and Clinical Integration - UM UCH
RP Interventions in FY 2019	• Post Discharge Clinics • Community-based Care Management • Information Technology & Data Analytics
Total Budget in FY 2019 *This should equate to total FY 2017 award*	FY 2019 Award: $2,153,980
Total FTEs in FY 2019	Employed: 25
	Contracted: -No Contracted FTEs
Program Partners in FY 2019 *Please list any community-based organizations or provider groups, contractors, and/or public partners*	• Healthy Harford/Healthy Cecil • CRISP • Cecil County Government – Department of Community Services/Office on Aging • Cecil County Health Department • Harford County Health Department • Harford County EMS • Harford County Office on Aging • Harford County Multidisciplinary Committee • Meals on Wheels • United Way of Central Maryland

	• Skilled Nursing Facilities (Citizens Care, Sterling Senior Care, Forest Hill Health and Rehab, Bel Air Health and Rehab, Calvert Manor, Elkton Transitional Care) • Amedisys Home Health • Bayada Home Health • Primary and Specialty Care Providers • UM UCH Care Transformation Organization

Overall Summary of Regional Partnership Activities in FY 2019

(Free Response: 1-3 Paragraphs):

The University of Maryland Upper Chesapeake Health (UMUCH) and Union Hospital of Cecil County (UHCC) Regional Partnership (RP) work to address the medical and social needs of high utilizer patients and those with multiple chronic conditions. The RP has deployed people, processes and technology that help identify and support patients in the pursuit of optimal health. The partnership leverages post-discharge clinics and community-based care teams while implementing telehealth programs and a shared (CRISP-hosted) care management documentation system. Patients are engaged at a Post Discharge Clinic (UHCC or UM UCH Comprehensive Care Center) and/or the Community-based Care Teams (WATCH Program).

The RP interventions target Medicare and dual-eligible patients with multiple visits to the hospital and/or two or more chronic conditions. These patients are likely to have non-medical issues that are hampering the ability to maintain good health. The partnership works with multidisciplinary teams in both counties to identify and addresses barriers to care with evidence-based techniques such as motivational interviewing. The barriers may include, transportation, insurance eligibility, co-pay or pharmaceutical issues, legal/guardianship and nutrition. Solving these issues is work that is most frequently not reimbursable by Medicare.

The RP is also leveraging technology to help extend limited human resources by deploying remote patient monitoring systems, video conferencing for evaluation or education, and data systems in conjunction with CRISP that allow for daily prioritization and tracking of patient utilization to guide strategic program evaluation.

Intervention Program

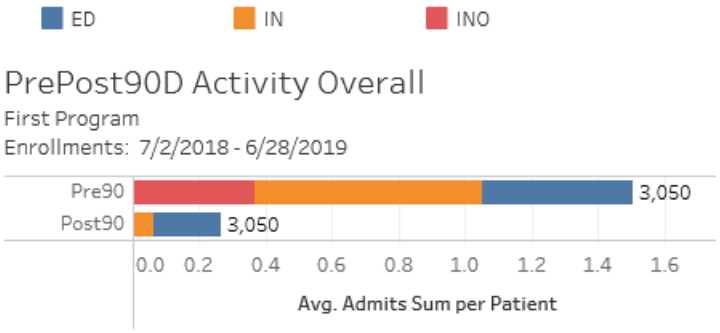
Please copy/paste this section for each Intervention/Program that your Partnership maintains, if more than one.

Intervention or Program Name	Post Discharge Clinics
RP Hospitals Participating in Intervention	UHCC UM UCH

Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.	
Brief description of the Intervention *2-3 sentences*	The Post Discharge Clinics (at UM UCH and UHCC) monitor the patient's immediate needs after discharge from the emergency department or inpatient units, develops a comprehensive medical and social support treatment plan, and provides follow-up for 30 days. Teams of nurses, a social worker, community health worker and pharmacist support patients in the comprehensive care center clinic in person, via telephone, or in the patient's home through telehealth/video calls. The patient may or may not need to be seen by a provider depended on his connectivity to primary care in the community.

Participating Program Partners
Please list the relevant community-based organizations or provider groups, contractors, and/or public partners
	• Primary and Specialty Care Providers
	• Meals on Wheels
	• Cecil County Government – Department of Community Services/Office on Aging
	• Cecil County Health Department
	• Harford County Office on Aging
	• Lyft
	• Behavioral Health
	  ○ Upper Bay Counseling
	  ○ Key Point
	  ○ Klein Family Crisis Center
	• Community Action Agency
	• Habitat for Humanity
	• Shoprite Grocery (Healthy Eating & Shopping Education)

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: 3,050
	Denominator of Eligible Patients: 41,413

Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	 Using the RP Data Warehouse, the RP calculates a significant 90-day utilization reduction for the patients receiving the intervention. This analysis for Program Year 3 shows: • 55% Reduction in ED utilization in the 90 Days post intervention • 94% Reduction in Bedded Stays (Inpatient + Observation) in the 90 Days post intervention
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.*	Using data from the RP Data Warehouse, the RP identified an opportunity to contact eligible sub-populations (CHF, COPD) within 48 hours of hospital discharge. This was an opportunity for the Transitional Nurse Navigator to provide additional disease-specific education, confirm that the patient received their medications and coordinate any additional required care. The TNNs were able to connect with 60% of eligible patients with 48 hours (weekends included) in Program Year 3.
Successes of the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	There was an observable change in the kind of acute care utilization in the 90 Days post intervention for this population. • Pre 90 Days = 30% ED visits/ 70% Bedded Stays • Post 90 Days = 76% ED Visit/ 24% Bedded Stays This shows that the patients who received this intervention had less overall hospital utilization after the intervention, but also that the type of hospital utilization was typically ED visits only with less of a need for the more expensive bedded stays.
Lessons Learned from the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	Based on risk stratification, certain patients are not scheduled for in-person visits but are engaged using electronic means. For patients that received a Zoom video call, approximately 40% result in the identification of an issue

	that requires intervention by a prescriber, even after seeing the Primary Care Provider post discharge.
Next Steps for the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	As the new MD PCP model has been introduced into the community, the RP seeks to integrate these program offerings in a coordinated way with the Primary Care offices. This includes methods for sharing information about patients with practice-based care coordinators using CRISP, Doc Halo and in-person meetings.
Additional Free Response (Optional)	The RP used operating funding (not RP Grant) to make a significant investment in the Comprehensive Care Center. The RP added two FTEs in Program Year 3 and will add another three FTEs in Program Year 4. In addition, the CCC moved into a larger, state-of-the-art location that doubled the size from approximately 3,000 square feet to more than 6,000 which allows for a greater number of patients and greater depth of service for high need and rising risk patients.

Intervention or Program Name	Community-Based Care Management- Wellness Action Teams of Cecil & Harford (WATCH)
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	UHCC UM UCH
Brief description of the Intervention *2-3 sentences*	The Regional Partnership specifically funds the Community-Based Care Management Program (CBCM) called Wellness Action Teams of Cecil & Harford counties (WATCH). The CBCM serve as the bridge between the post-discharge clinic, primary care physicians and community providers. The goal is to develop and work longitudinal care plans, with the goal of reducing avoidable utilization. WATCH is comprised of four teams of nurses, social workers, pharmacist, and community health workers which engage clients into services across Cecil & Harford counties. WATCH provides ongoing care management, care coordination, medication reconciliation, health coaching and assistance to remove barriers to health (food insecurity, transportation, housing, medications, etc.).

<table>
<tr><td>Participating Program Partners
Please list the relevant community-based organizations or provider groups, contractors, and/or public partners</td><td>

Geriatric Assistance Network (GAIN)
Primary and Specialty Care Providers
Meals on Wheels
Cecil County Government – Department of Community Services/Office on Aging
Cecil County Health Department
Harford County Office on Aging
Harford County Health Department
Lyft
Behavioral Health

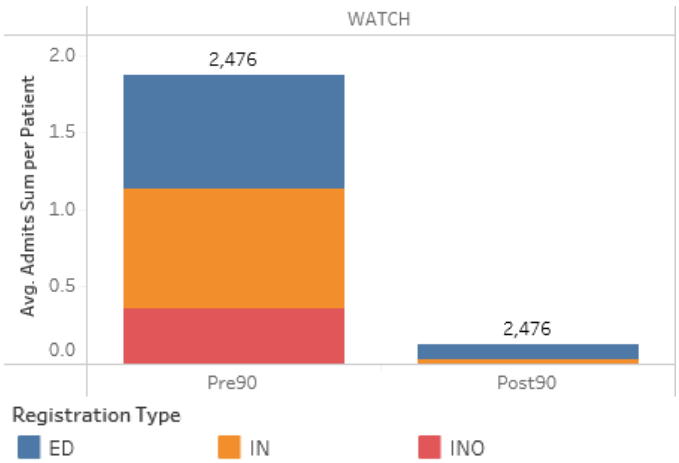
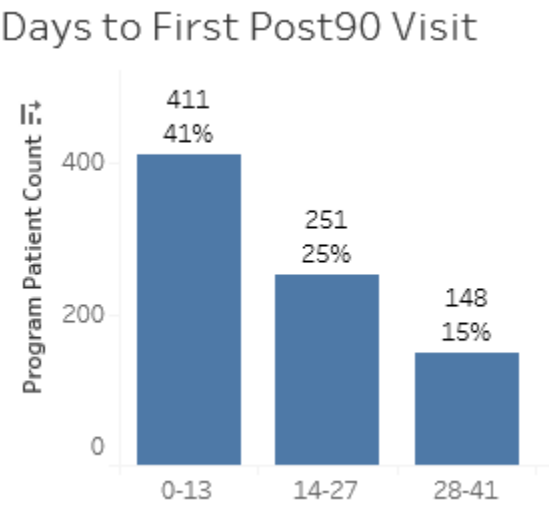
Upper Bay Counseling
Key Point
Klein Family Crisis Center

Community Action Agency
Habitat for Humanity
Shoprite Grocery (Healthy Eating & Shopping Education)
Skilled Nursing Facilities

Citizens Care
Sterling Senior Care
Forest Hill Health and Rehab
Bel Air Health and Rehab
Calvert Manor
Elkton Transitional Care

Amedisys Home Health Agency
Bayada Home Health Agency

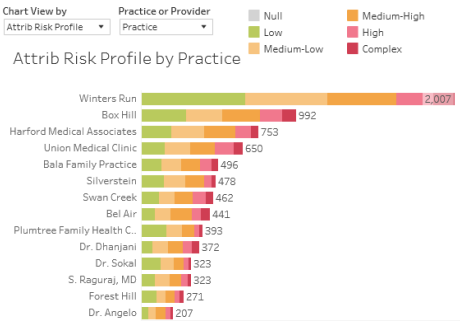
</td></tr>
<tr><td rowspan="2">Patients Served
Please estimate using the Population category that best applies to the Intervention, from the CY 2018 RP Analytic Files.
HSCRC acknowledges that the High Utilizer/Rising Risk or Payer designations may over-state the population, or may not entirely represent this intervention’s targeted population.
Feel free to also include your partnership’s denominator.</td><td># of Patients Served as of June 30, 2019:
2,476</td></tr>
<tr><td>Denominator of Eligible Patients:
41,413</td></tr>
</table>

Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	 Using the RP data Warehouse (Feed by CRISP Data), the WATCH program shows a significant reduction in the hospital utilization after program engagement. In addition, more than 90% of the patients engaged in the WATCH program had zero hospital utilization in the 90 days post enrollment date.
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 WATCH program is a community-based program that attempts to assist patients with their medical and social barriers in the home. This can be challenging as some patients can be wary of allowing people into the home when they are feeling unwell or embarrassed. The WATCH program aims to complete an in-home visit within 30 days for more than 50% of the eligible patients. In Program Year 3, the WATCH team was successful more than 66% of the time.

Successes of the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	The RP Data Warehouse has shown that nearly 20% of patients discharged from Skilled Nursing Facilities in the service area are readmitted to an Acute Care facility within 30 Days of the SNF discharge. As a result, the WATCH team partnered with local SNFs to identify and connect with these patients immediately after discharge. In Program Year 3, the WATCH team was able to help reduce the post-SNF discharge readmission rate from 19.9% to 17.8%, good for an improvement of 10.5%.
Lessons Learned from the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	Motivational Interviewing techniques are vital to helping sustain engagement with patients. It is common that the Post Discharge Clinics identify urgent or emergent needs, but the WATCH team is most likely uncover and address deeper issues that drive the patient's health status. The WATCH team has used this training to help prioritize issues by "meeting the patient where they are" and resolving items on the patient's schedule. This means that smoking cessation or counseling on alcohol intake occur deeper into the engagement while assistance with co-pays or applications for supplemental income are addressed. By prioritizing based on patient ability and mindset, a greater number of barriers can be addressed over the long-term, leading to better health and less expensive healthcare utilization.
Next Steps for the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	The WATCH teams are working collaboratively with the hospital community health programs to identify and refer patients to chronic disease management programs. These programs include Diabetes Prevention, "Living With…Chronic Diseases" and the Care Fit program for the elderly.
Additional Free Response (Optional)	The WATCH teams will also attempt to leverage the new Klein Family Harford Crisis Center to address the Behavioral Health issues that may also be impacting health status, before the need to come to the acute care setting. This is an unique partnership among Upper Chesapeake Health, Harford County Government, the State of Maryland, and Harford County Health Department that makes emergent behavioral health services available to patients 24 hours per day, seven days per week.

Intervention or Program Name	Information Technology & Data Analytics
RP Hospitals Participating in Intervention	UHCC UM UCH

Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.	
Brief description of the Intervention *2-3 sentences*	The Regional Partnership has developed and piloted a number of technologies to improve the health of the target population. This includes a data analytics system that incorporates CRISP feeds, a CRISP-hosted care management documentation system called GSI Health, Zoom video calls and the Vivify Remote Patient Monitoring system. In addition, the RP has deployed several communications systems with partners in the community, including Doc Halo secure texting, local EMS referral systems (via the EMS Electronic Medical Record) and CRISP Care Alerts.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	• CRISP • Primary and Specialty Care Providers • Harford County Health Department • Harford County EMS • Applied Data Group/SecureNet MD
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: • Data Warehouse = 3,050 (CCC/WATCH) + 8,168 (MDPCP) • GSI Health Care Plans = 1,670 • Zoom video calls= 374 • Vivify RPM= 63
	Denominator of Eligible Patients: 41,413 (Note: One component of the IT interventions, the Data Warehouse, provide information at the strategic and operational level and has also been organized to support Harford County MDPCP participants)
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	Not Applicable
Intervention-Specific Outcome or Process Measures (optional) *These are measures that may not have generic definitions across Partnerships*	The CCC and WATCH teams complete daily Zoom video calls to help evaluate patients and provide education. Approximately 10 video calls per month are completed by the Pharmacist to complete medication reconciliation, provide medication

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.*	adherence support and make recommendations about lower cost alternatives. In addition the RP Data Warehouse has been expanded to allow functionality to stratifies patients by risk within primary care practices and allows the CCC and WATCH teams to prioritize and coordinate care with physicians in the community. Utilization & Risk Analysis Utilization - Overall September 2019 | | Patient Count | % of Total | |---|---|---| | High | 233 | 2.85% | | Non HU | 1,777 | 21.76% | | Unknown | 6,158 | 75.39% | | Grand Total | 8,168 | 100.00% | Attributed Risk Profile | | Patient Count | % of Total | |---|---|---| | Complex | 642 | 7.86% | | High | 1,103 | 13.50% | | Medium-High | 1,956 | 23.95% | | Medium-Low | 2,072 | 25.37% | | Low | 2,394 | 29.31% | | Null | 1 | 0.01% | | Grand Total | 8,168 | 100.00% | 
Successes of the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	The CCC and WATCH teams have changed workflow in Program Year 3 to increase the probability that eligible Congestive Heart Failure patients will participate with Remote Patient Monitoring. This year, the team leverages a community health worker to meet with the patient while in the hospital to enroll the patient before he or she returns home. This allows for the RPM kit to be delivered to the home within the same day as discharge and helps bridge a crucial 48 hour period identified by the RP Data Warehouse as having higher probability of readmission for CHF patients.
Lessons Learned from the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	The CCC and WATCH team members also report changes in this cardiac sub-population's understanding of their disease state. The RPM system helps expand the reach of the care managers by providing automated reminders and education about medications. This has helped to create a more compliant patient panel and allows the team to work through other medical or social barriers.
Next Steps for the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	The WATCH team has worked closely with Harford county EMS to create a referral process that is directly incorporated in the Harford County EMS documentation system such that patients may be connected with services prior to actually having an acute care visit. In Program Year 4, the RP intends to increase the patients that are connected with these vital interventions before hospitalization.

Additional Free Response (Optional)	

Core Measures

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

Utilization Measures

Measure in RFP *(Table 1, Appendix A of the RFP)*	**Measure for FY 2019 Reporting**	**Outcomes(s)**
Total Hospital Cost per capita	**Partnership IP Charges per capita** Executive Dashboard: 'Regional Partnership per Capita Utilization' – Hospital Charges per Capita, reported as average 12 months of CY 2018 -or- Analytic File: 'Charges' over 'Population' (Column E / Column C)	The RP Charges per Capita • Calendar 17: $255 • Calendar 18: $261 Increase of 2.6%
Total Hospital Discharges per capita	**Total Discharges per 1,000** Executive Dashboard: 'Regional Partnership per Capita Utilization' – Hospital Discharges per 1,000, reported as average 12 months of FY 2019 -or- Analytic File: 'IPObs24Visits' over 'Population' (Column G / Column C)	The RP Total D/C per 1,000 • Fiscal 18: 7.9 • Fiscal 19: 7.8 Decrease of 1.1%
ED Visits per capita	**Ambulatory ED Visits per 1,000**	The RP Total 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)	• Fiscal 18: 31.6 • Fiscal 19: 30.3 Decrease of 4.0%

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)	The RP Average Unadjusted Readmission Rate • Fiscal 18: 10.8% • Fiscal 19: 10.9% Increase of 0.8%
PAU	**Potentially Avoidable Utilization** Executive Dashboard: '[Partnership] Quality Indicators' – Potentially Avoidable Utilization, reported as **sum** of 12 months of FY 2019 -or- Analytic File:	The RP PAU Charges • Fiscal 18: $104,912,484 • Fiscal 19: $103,228,650 Decrease of 1.6%

	'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.*	The RP % High Needs with Care Manager • Fiscal 18 (Jan-June): 19.9% • Fiscal 18 (Jan-June): 19.4% Decrease of 2.8% (Note: RP Has identified linkage issue between GSI Care Management System and CRISP that is believed to understate the patients with Care Managers that are documenting in GSI.

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.

1. Longitudinal Care Plans – The RP documents in a care management system that is hosted by CRISP and available for providers across the continuum to view (GSI Health). In Program Year 3, the RP developed 1,670 care plans in GSI that addressed both medical and social barriers.

2. Care Alerts – The RP has created 1,084 Care Alerts in CRISP for these high need patients. The Care Alerts commonly indicate status related to Palliative Care or have been drafted with critical information to avoid a readmission and connect the patient with the CCC/WATCH programs.

3. PHQ-2 and PHQ-9 – The RP screens all referred patients for depression. More than 3,000 patients (3,620) received the two question screening questionnaire and the result of that screening can trigger a re-screening with the longer PHQ-9. Patients with mild or moderate depression may receive counseling from the program social workers, or may be referred to behavioral health programs in the community. Those with severe depression are automatically referred to behavioral health programs, including Upper Bay, Key Point or UM UCH services.

Return on Investment – (Optional)

The RP calculates a reduction in Medicare Bedded Stays (Inpatient + Observation) to determine variable cost savings associated with the program.

Medicare Bedded Stay Reductions	
Avoided Stays	3,020
ALOS (Blended)	2.85
Days Saved	8,605
Variable Costs Savings per Day	500
Total Cost Savings	$ 4,302,500
FY 19 RP Grant	$ 2,153,980
ROI	2.00

Annual Cost per Patient as calculated by:

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

The RP served 3,620 unique patients in FY 19 and incurred total expenses of $2,321,461. This created an investment per patient served of $641.

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.

The UMUCH/UHCC Regional Partnership is a person-centered, multi-disciplinary model of care that leverages technology to extend the care and support of patients outside of the hospital. The services provided by the RP are often not reimbursable by Medicare but are vital components of helping patients maintain optimal health. In the three years since the awarding of the grant, the RP has honed its skill in identifying social barriers that are driving medical issues and become expert at determining the optimal time to tackle each issue, as the sequencing of these interventions is often as important as the intervention itself.

The WATCH Program is particularly effective at building trust with the clients to access the patient home and visualize an accurate living situation that is impacting health. Once in the home, the nurse and community health worker ask to view the patient medications. It is common at this point that the patient first conveys that they cannot afford their medications and have not, in truth, been taking them for weeks or months. This is more difficult to observe in the hospital or physician office. Once the

WATCH team assists the client with finding cheaper medications, or connects them with supplemental insurance or income, the patient begins to adhere to the regime with relative ease. With a certain trust established, the patient is much more likely to begin to change health behaviors such as smoking cessation, adherence to diet and exercise plans and attending physician follow-up appointments.

The Regional Partnership was planned and developed prior to FY 17 during a time in which many Accountable Care Organizations (ACOs) were operating- none however, in Northeastern Maryland. The RP has successfully organized services that support the patient, via longitudinal care planning, education and coordination as well as the physicians responsible for this population by addressing gaps in care that are difficult for providers to identify and address. Despite the waning enthusiasm for ACOs in the state, the RP remains perfectly suited to support providers and align with state goals via the Maryland Primary Care Program (MDPCP) and the Medicare Performance Adjustment (MPA).