HSCRC Regional Partnership Transformation Grant

West Baltimore Collaborative

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	West Baltimore Collaborative (WBC)
RP Hospital(s)	University of Maryland Medical Center (UMMC) UMMC Midtown Campus Saint Agnes HealthCare Bon Secours Baltimore Hospital
RP POC	Meredith Truss meredith.truss@umm.edu 410-328-9708
RP Interventions in FY 2019	Community-based care coordination for Medicare patients whose chronic illnesses have led to frequent utilization of services at two or more hospitals.
Total Budget in FY 2019 *This should equate to total FY 2017 award*	FY 2019 Award: $1,584,444 FY 2019 Budget: $1,980,555
Total FTEs in FY 2019	Employed: 2.0 • 1.0 Population Health Manager • 1.0 Senior Population Health Analyst
	Contracted: 6.6 • 2x 1.0 Nurse Case Manager • 4x 1.0 Care Coordinators • 0.6 Program Director
Program Partners in FY 2019 *Please list any community-based organizations or provider groups, contractors, and/or public partners*	HealthCare Access Maryland (HCAM): HCAM was contracted by the WBC during FY19 to outreach, enroll, and provide home-based care coordination and supportive services to clients at all four hospital sites.

	Chesapeake Regional Information System for our Patients (CRISP): Patients who meet WBC criteria based on case mix data are uploaded into ENS PROMPT, which triggers an alert to the hospital sites and HCAM when an eligible patient visits one of the WBC hospitals. This allows hospital staff and HCAM to identify and outreach patients in close to real-time. CRISP has also developed a "WBC enrolled" panel for HCAM to monitor utilization. The WBC director regularly works with CRISP to monitor utilization of enrolled clients, including use of the pre/post utilization report tool based on the enrolled ENS panel. Lyft: The WBC has contracted with Lyft to provide transportation to enrolled clients for medical and related appointments until they are connected to sustainable, permanent sources of transportation. Meals on Wheels of Central Maryland: The WBC has contracted with Meals on Wheels (MOW) to deliver meals to clients in need. The WBC pays for meals during client enrollment in the program, during which time MOW secures other sources of sustainable funding for clients who will need continued meal delivery beyond WBC enrollment.

Overall Summary of Regional Partnership Activities in FY 2019

(Free Response: 1-3 Paragraphs):

During FY19 the WBC enrolled 142 unique Medicare clients into its home- and community-based care coordination program. Patients in the program benefited from medical care management as well as navigation to resources to address social determinants of health; please see Attachment 1 "West Baltimore Collaborative Infographic" for an overview of the program to-date, and Attachment 3 for detailed pre-post utilization results. The WBC continued to build upon its momentum and progress this year by focusing on enrollment, performance improvement, service enhancement, and professional development.

In September 2018 the WBC hired a full time Senior Population Health Analyst to support the partnership. The analyst has been instrumental in developing new performance dashboards and conducting analyses that have informed the implementation of new supportive services for WBC clients, including analyses of readmissions using the CRISP visit-level pre/post report, social determinants of health, quality of life, and diagnoses, among others. See Attachment 1 "West Baltimore Collaborative Infographic" and Attachment 2 "April – WBC Snapshot" as examples – patient information redacted. In late FY19 the WBC Governance Committee implemented some changes to the partnership's leadership structure and contracted with the Berkeley Research Group to analyze operations and provide recommendations to enhance program efficiency, which will be a focus during FY20.

The WBC worked during FY19 to extend support for social determinants of health since housing, food insecurity, and transportation are prevalent needs among enrolled clients. The WBC uses Lyft as a transportation vendor while clients are being linked with sustainable transportation. To address food insecurity, the WBC partnered with Meals on Wheels to deliver meals for the WBC as described above under the Program Partners section. HCAM also began to use InstaCart to order groceries for clients in urgent need, and purchased a supply of Save-A-Lot grocery store and Walmart gift cards to provide to clients as an incentive for keeping certain medical appointments and/or achieving health goals. To address housing and other patient needs, the WBC established a Client Assistance Fund for HCAM. Care coordinators had discretion to access the fund to meet various needs as long as those needs would enable the client to maintain their health at home, meet care plan goals, and/or follow through with discharge instructions. The following list includes examples of items and services that HCAM purchased with the fund during FY19:

- Over-the-counter medications and prescription co-pays
- Clothing
- Utility bills
- Security deposits
- Housing application fees

To enhance coordination and professional skills, in January 2019 the WBC hosted a retreat for hospital and HCAM staff working on the program. Sessions during the first part of the day focused on enhancing skills, and an afternoon working session gave attendees the opportunity to work in teams to identify priorities for the WBC during 2019. Priorities that were identified and implemented between January and June 2019 included the creation of a summary report of goals, metrics, and outcomes (see Attachment 2 "April – WBC Snapshot"), enhanced communication between hospital and HCAM staff at each site (accomplished via ongoing team meetings), development of standard operating procedures at each site (completed for 3 of 4 hospitals), and enhanced methods to identify WBC-eligible patients.

Intervention Program

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

Intervention or Program Name	HCAM Care Coordination
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*	Member hospitals refer eligible patients to HCAM via ENS PROMPT for outreach. Once enrolled, HCAM conducts a post-discharge home visit to review the client's needs and to create a care plan and home visit schedule. HCAM staff provide home-based care coordination and care management for 90 days, including health education,

<table>
<tr><td></td><td>assessment of barriers to health, medication reconciliation, transportation, assistance with medical appointments, and navigation to social/support services and community resources. The ultimate goal is the successful transition to primary or specialty care medical homes with sufficient behavioral health and other support to address social determinants and barriers to health.</td></tr>
<tr><td>Participating Program Partners
Please list the relevant community-based organizations or provider groups, contractors, and/or public partners</td><td>All: HCAM, CRISP, Lyft, MOW</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:
FY19: 142 unique clients with 146 cases
Total: 314 unique clients with 354 cases</td></tr>
<tr><td>Denominator per Regional Partnership Analytic File:
Population = 18,832
Distinct Patients = 2,781
Source: 2018 Regional Partnership Analytic File, Population Category "2+ IP or Obs>=24 or ED Visits Medicare FFS"

Denominator per ENS PROMPT notifications for WBC-eligible patients:
Distinct Patients = 737
Source: FY19 CRISP ENS PROMPT WBC Data</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>The WBC analyzes pre-post utilization over a 6 month time period to determine lasting impact of the program beyond the 90 day intervention window. Please see the attached 6 month pre-post utilization report (Attachment 3) and below summary for all patients ever enrolled in the WBC, which was generated in July 2019.

<u>WBC 6 Month Pre/Post Enrollment Utilization Analysis</u>

<table>
<tr><td></td><td colspan="4"><u>7/12/2019</u> - 257 patients*</td></tr>
<tr><td></td><td>Pre</td><td>Post</td><td>Reduction</td><td>% Change</td></tr>
<tr><td>Total</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Charges</td><td>$13,870,581</td><td>$10,086,661</td><td>$3,783,920</td><td>-27.3%</td></tr>
<tr><td>Visits</td><td>2415</td><td>2,190</td><td>225</td><td>-9.3%</td></tr>
<tr><td>Inpatient</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Charges</td><td>$10,765,599</td><td>$7,107,946</td><td>$3,657,653</td><td>-34.0%</td></tr>
<tr><td>Visits</td><td>476</td><td>364</td><td>112</td><td>-23.5%</td></tr>
<tr><td>ED</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Charges</td><td>$1,260,131</td><td>$1,092,561</td><td>$167,570</td><td>-13.3%</td></tr>
<tr><td>Visits</td><td>925</td><td>711</td><td>214</td><td>-23.1%</td></tr>
<tr><td>Outpatient</td><td></td><td></td><td></td><td></td></tr>
</table></td></tr>
</table>

Charges	$1,124,804	$1,182,663	-$57,859	5.1%
Visits	916	1,039	-123	13.4%

*Out of 7/12/19 panel of 354 cases

Highlights include:

- Decrease in total, inpatient, and ED visits
- Decrease in total, inpatient, and ED charges
- Increase in outpatient visits and charges

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.

Please see Attachment 2 "April – WBC Snapshot" for intervention-specific outcome metrics that are captured and utilized for operational improvements. This report tracks the number of referrals per week and month, cumulative enrollment, top 5 diagnoses driving inpatient and emergency department utilization over the past 3 months, comparison of utilization by hospital, and names (redacted) of frequent utilizers.

Process measures reported by HCAM for FY19 include:

- # of referrals sent to HCAM: 1,611
- # of referrals not eligible: 657
- # of referrals who declined services: 382 (64.9% indicated no interest)
- # of referrals who enrolled: 146
- % of eligible referrals who enrolled in WBC (i.e. clients): 15.3% (146/954)
- % of home visits successfully completed: 83% (413/495)

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

As summarized in the Pre-Post Analysis section above, cumulative utilization outcomes for all WBC clients are very positive with a decrease in total charges, fewer inpatient, observation, and ED visits and charges, and an increase in hospital outpatient visits. In addition, 3 month pre-post analysis of only those WBC clients who enrolled during FY19 shows that these patients had $1,318,092 fewer charges in the 3 months following enrollment (Attachment 4). The WBC was also very successful in implementing new supports for social determinants of health during FY19. The new MOW partnership resulted in delivery of 4,300 meals to 41 enrolled clients living with food insecurity. There were also more than 18 clients* who received a service or item through the Client Assistance Fund, including items such as over-the-counter and prescription medications, season-appropriate clothing for an elderly patient, and security deposits for four patients with insecure or unsafe housing.

	*HCAM used the fund to purchase a small supply of inexpensive over-the-counter medical supplies to give to clients as needed (Ensure, shower benches, personal hygiene products, etc.), in addition to the 18 clients with specific needs that were met through the fund.
Lessons Learned from the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	The WBC relies heavily on the CRISP ENS system to identify eligible patients, and through continual process evaluation the WBC identified two opportunities related to ENS use: • Staff need to be available to review ENS and outreach referrals throughout the day, as opposed to HCAM's original staffing model which focused on identification and outreach in the morning and patient home visits in the afternoon. This is a change that hospitals began to implement during late FY19, and will be fully implemented as the hospitals assume responsibility for operations during FY20. • Due to some ENS limitations, the system is only able to alert hospitals about WBC-eligible patients during their third encounter as opposed to their second, WBC-qualifying encounter. As a result, each WBC hospital developed processes to review and identify eligible patients during their second encounter. In addition, WBC leadership recognized mid-way through the reporting year that enrollment was not optimal and worked with HCAM to implement several changes: enhanced communication between hospital and HCAM staff at each site; development of standard operating procedures around referral and patient hand-off at each site; and, enhanced methods to identify WBC-eligible patients. Although these initially improved enrollment, numbers began to taper off during Q4. Leadership worked with external subject matter experts (Berkeley Research Group) to make several changes to the operational structure of the WBC including ending the contract with HCAM on 7/31/19. In August 2019 enrollment significantly increased and the WBC is confident that its new structure will allow hospital staff to maximize referrals and enrollment.
Next Steps for the Intervention in FY 2020 *Free Response, up to 1 Paragraph*	The WBC ended its contract with HCAM on July 31, 2019. Since the current regional partnership program will be changing after FY20, the WBC plans for its four member hospitals to assume program operations during FY20 to minimize disruption to patient enrollment and service provision. During July and August, WBC management developed standard guidance on WBC operations, services offered, and data collection for patients and expenses. All

	four hospitals were trained on guidance and data collection tools, and most began active enrollment in August 2019 with a goal for all to be actively enrolling WBC patients by the end of the FY20 Q1. Management will collect data monthly to review hospital performance. The WBC is also actively working with other hospitals in Baltimore City to conceptualize a city-wide approach to community-based care coordination for the next phase of the regional partnership program beginning in FY21.
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)	IP Charges per Capita = $4,482.55 Source: 2018 Regional Partnership Analytic File, Population Category "2+ IP or Obs>=24 or ED Visits Medicare FFS", calculated as IP Charges / Population
Total Hospital Discharges per capita	**Total Discharges per 1,000** Executive Dashboard: 'Regional Partnership per Capita Utilization' –	Total Discharges = 0.22/1,000 Source: 2018 Regional Partnership Analytic File, Population Category "2+ IP or Obs>=24 or ED Visits Medicare FFS"

	Hospital Discharges per 1,000, reported as average 12 months of FY 2019 -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)	Ambulatory ED Visits = 0.32/1,000 Source: 2018 Regional Partnership Analytic File, Population Category "2+ IP or Obs>=24 or ED Visits Medicare FFS"

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)	Unadjusted Readmission Rate per Regional Partnership Analytic File = 21.7% Source: 2018 Regional Partnership Analytic File, Population Category "2+ IP or Obs>=24 or ED Visits Medicare FFS" Average Unadjusted Readmission Rate per ENS PROMPT = 32% Source: FY19 CRISP ENS PROMPT WBC Data (October 2018 – June 2019 data on clients enrolled in FY 19 with IP discharges during or after enrollment, population = 101 patients)

PAU	**Potentially Avoidable Utilization** Executive Dashboard: '[Partnership] Quality Indicators' – Potentially Avoidable Utilization, reported as **sum** of 12 months of FY 2019 -or- Analytic File: 'TotalPAUCharges' (Column K)	Total FY19 PAU Charges per Regional Partnership Analytic File = $24,227,904 Source: 2018 Regional Partnership Analytic File, Population Category "2+ IP or Obs>=24 or ED Visits Medicare FFS" Total FY19 PAU Charges per Executive Dashboard = $68,404,839 Source: WBC Executive Dashboard, Population Category "Medicare" Reduction in PAU Charges During WBC Enrollment = $362,648 (26% reduction) Source: CRISP 3 month Pre-Post report on patients enrolled during FY19, PAU charges through June 2019 (IP or OBS>23). Population = 92 clients enrolled in FY19 with 3 months pre and post data.

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.*	June 2019: 32.5% May 2019: 33.6% April 2019: 35.4% March 2019: 34.4% February 2019: 35.8% January 2019: 33.0% Average = 34.1% Source: WBC Executive Dashboard

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.

None to report, all reported as intervention-specific measures above.

Return on Investment – (Optional)

The WBC managed 146 cases during FY19 and spent $971,451. The calculated annual cost per patient is $6,654 per patient, or $2,218 per patient per month.

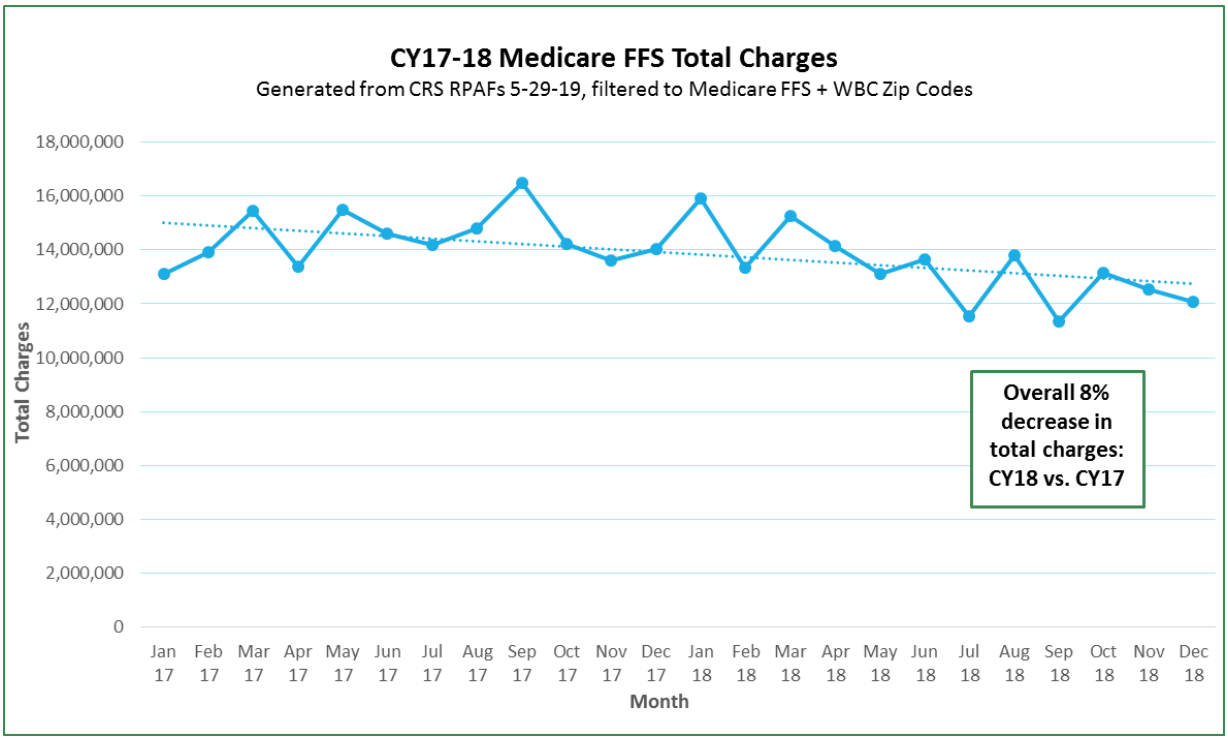
$971,451 / 142 patients = $6,841 per patient per enrollment period (approx. 3 months)

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 WBC made significant enhancements throughout FY19 to both program processes and services offered to clients. Pre-post analysis indicates that the efforts of the WBC are having a positive impact by reducing costs and shifting health care utilization from the inpatient and ED settings to the outpatient setting for clients. In addition, total charges for the Medicare population at-large in WBC zip codes is steadily decreasing, with an 8% decrease observed in CY18 vs. CY17. The WBC is one of several initiatives targeting Medicare patients residing in the West Baltimore community, however given that the partnership has served 314 of the most complex and highest cost patients, leadership believes that our efforts have significantly contributed to this overall reduction.

Figure 1. CY17-18 Medicare FFS Total Charges



In addition, the WBC has been able to address multiple social determinants of health for enrolled clients through partnerships with MOW and Lyft, and through the Client Assistance Fund. Although the partnership encountered challenges related to ENS best practice implementation and vendor

performance, management and front-line operations staff have worked to address these challenges and are implementing plans in FY20 to ensure continued success.