HSCRC Transformation Grant

FY 2020 Report

The Health Services Cost Review Commission (HSCRC) requires the following information for FY 2020 Regional Partnership Transformation Grant Program participants: this Report, the Budget Report, and the Budget Narrative. Whereas the Budget Report distinguishes efforts between each hospital, this Summary Report should consolidate information and 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 (MTC) Saint Agnes HealthCare Grace Medical Center
RP Point of Contact	Meredith Truss meredith.truss@umm.edu
RP Interventions in FY 2020	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 2020 *This should equate to total FY 2017 award*	FY17 Award: $1,980,555 FY20 Expenses: $1,044,478

Total FTEs in FY 2020	Budgeted FTEs - Employed: 9.1
	• WBC Cross-Hospital Support:
	  ○ 0.8 Population Health Manager
	  ○ 0.5 Senior Population Health Analyst
	  ○ 0.3 Director/Clinical Oversight
	• UMMC: 5.08
	• MTC: 1.42
	• St. Agnes: 0.5
	• Grace: 0.5

	Budgeted FTEs - Contracted: None in FY20
Program Partners in FY 2020 *Please list any community-based organizations or provider groups, contractors, and/or public partners*	Chesapeake Regional Information System for our Patients (CRISP): Patients who meet WBC criteria (Medicare, zip code residence, chronic condition, and 2+ encounters at 2+ WBC hospitals) based on case mix data are uploaded into ENS PROMPT, which triggers an alert when an eligible patient visits

	one of the WBC hospitals. This allows hospital staff to identify and outreach patients in close to real-time. The WBC also maintains a "WBC Enrolled" ENS panel to track utilization of enrolled patients and update pre/post reports. Lyft: The WBC has contracted with Lyft to provide transportation to enrolled patients 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 patients in need. The WBC pays for meals during enrollment in the program, during which time MOW secures other sources of sustainable funding for patients who will need continued meal delivery beyond WBC enrollment.

Overall Summary of Regional Partnership Activities in FY 2020

(Freeform Narrative Response: 1-3 Paragraphs):

During FY20 the WBC enrolled 278 unique Medicare patients into its home- and community-based care coordination program. The WBC changed its implementation model during FY20, with hospitals taking on outreach, enrollment, and care coordination of eligible patients instead of contracting with a vendor. This change proved to be highly successful and the program experienced an increase in the enrollment rate of eligible patients (34% in FY20 vs. 15% in FY19), and an increase in the total number of patients enrolled (278 unique patients in FY20 vs. 142 in FY19).

Each WBC member hospital operated the program through existing transitional care coordination departments with some variation in staffing models. At UMMC and MTC, the WBC program included nursing, community health worker, social work, and pharmacy support. At St. Agnes the program was primarily delivered by social workers and community health workers with medical care management by patients' health care providers, and at Grace Medical Center the program was primarily delivered by a lead nurse. However WBC leadership created guidance and standards for the hospitals (see Attachment 1 "Hospital Guidance") to ensure that all patients received the same minimum service elements and approximately 90 days of community-based care coordination.

The WBC continued to monitor enrollment and utilization data throughout the year, and changed the monthly dashboard for FY20 to reflect hospital performance vs. vendor performance (see Attachment 2 "FY20 Monthly Referral and Enrollment Review"). Also see Attachment 3 "West Baltimore Collaborative Infographic" for an overview of the program through the end of FY20 including details on Meals on Wheels and Lyft, and Attachment 4 for detailed 6-month pre-post utilization results.

Intervention Program

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

Intervention or Program Name	WBC 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 utilize ENS PROMPT to identify eligible patients and outreach for WBC enrollment. Once enrolled, patients receive 90 days of care coordination including home visits and telephonic care coordination. Services include health education, 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.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	All: CRISP, Lyft, MOW
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, 2020: FY20: 278 unique patients with 292 cases Total: 533 unique patients with 646 cases
	Denominator per Regional Partnership Analytic File: Population = 18,832 Distinct Patients = 2,589 Source: 2019 Regional Partnership Analytic File, Population Category "2+ IP or Obs>=24 or ED Visits Medicare FFS"
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	The 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 4) and below summary for all patients ever enrolled in the WBC, which was generated in September 2020.

WBC 6 Month Pre/Post Enrollment Utilization Analysis

	9/2/20 - 499 patients*			
	Pre	**Post**	**Reduction**	**% Change**
Total				
Charges	$21,677,488	$16,117,345	$5,560,143	-25.6%
Visits	3775	3,354	421	-11.2%
Inpatient				
Charges	$16,398,158	$11,662,671	$4,735,487	-28.9%
Visits	710	534	176	-24.8%
Inpatient + Obs				
Charges	$17,833,218	$12,662,085	$5,171,133	-29.0%
Visits	886	645	241	-27.2%
ED				
Charges	$2,012,277	$1,591,184	$421,093	-20.9%
Visits	1,413	1,101	312	-22.1%
Outpatient				
Charges	$1,831,993	$1,864,076	-$32,083	1.8%
Visits	1,476	1,608	-132	8.9%
	*Out of 8/1/20 panel of 533 unique patients 9/17 – 5/20			

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 "Monthly Referral and Enrollment Review" for intervention-specific process measures including the number of referrals and enrollments by hospital and month.

Other outcome measures in addition to pre/post utilization outcomes include:

- **Decrease in readmission rate**: among all patients who enrolled in the WBC +/- 7 days of an inpatient discharge (n=168 enrolled between 2017-2020), the readmission rate was **26% during 30 days pre-enrollment vs. 15% during 30 days post- enrollment**
- **Decrease in PAU charges**: among all patients who enrolled in the WBC during FY20, PAU charges were $2,398,376 during 3 months pre-enrollment vs. $1,578,174 during 3 months post-enrollment (**35% decrease = $820,202 less**)
- **Decrease in PQI visits**: among all patients who enrolled in the WBC during FY20, the number of Inpatient + Obs>23 PQI visits was 45 during 3 months pre-enrollment vs. 18 during 3 months post-enrollment (**60% decrease = 27 fewer visits**)

Successes of the Intervention in FY 2020
Freeform Narrative Response, up to 1 Paragraph

During FY20 the WBC more than doubled the enrollment rate of eligible patients and reached a significantly higher number of patients than in previous years, with sustained decreases in utilization 6 months after enrollment. When looking at pre/post utilization only among FY20 enrollments, one metric that stands out is reduced ED utilization (see Attachment 5). The decrease in the

	rate of ED visits post vs. pre actually becomes more pronounced over time. The WBC continued its work to address social determinants of health during FY20 with Meals on Wheels and Lyft, with 7,700 meals delivered to 87 patients in need. The WBC also provided each new patient with a grocery store gift to address food access in the community. In addition, welcome bags were distributed to new patients this year that included a variety of health promotion items such as portion control plates, salt substitute, and digital scales for heart failure patients. Hospital staff relayed that patient feedback to this new support was very positive.
Additional Freeform Narrative 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 2019 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 2020 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 2019 -or- Analytic File: 'Charges' over 'Population' (Column E / Column C)	IP Charges per Capita = $4,697.36 Source: 2019 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' – Hospital Discharges per 1,000, reported as average 12 months of FY 2020 -or- Analytic File: 'IPObs24Visits' over 'Population' (Column G / Column C)	Total Discharges = 0.21/1,000 Source: 2019 Regional Partnership Analytic File, Population Category "2+ IP or Obs>=24 or ED Visits Medicare FFS"
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 2020 -or- Analytic File 'ED Visits' over 'Population' (Column H / Column C)	Ambulatory ED Visits = 0.31/1,000 Source: 2019 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 2020 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 2020 -or-	Unadjusted Readmission Rate per Regional Partnership Analytic File = 19.6% Source: 2019 Regional Partnership Analytic File, Population Category "2+ IP or Obs>=24 or ED Visits Medicare FFS"

	Analytic File: 'IP Readmit' over 'EligibleforReadmit' (Column J / Column I)	
PAU	**Potentially Avoidable Utilization** Executive Dashboard: '[Partnership] Quality Indicators' – Potentially Avoidable Utilization, reported as **sum** of 12 months of FY 2020 -or- Analytic File: 'TotalPAUCharges' (Column K)	Total PAU Charges per Regional Partnership Analytic File = $26,685,704.40 Source: 2019 Regional Partnership Analytic File, Population Category "2+ IP or Obs>=24 or ED Visits Medicare FFS" Reduction in PAU Charges During WBC Enrollment = $820,202 (35% reduction) Source: CRISP 3 month Visit-Level Pre-Post report on patients enrolled during FY20, all PAU charges through June 2020. Population = 89 patients enrolled in FY20 with 3 months pre and post data and PAU charges.

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 2020 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 2020: 18.6% May 2020: 17.0% April 2020: 23.0% March 2020: 22.9% February 2020: 22.4% January 2020: 22.6% Average = 21% Source: WBC Executive Dashboard

Self-Reported Process Measures

Please describe any partnership-level 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)

Annual Cost per Patient as calculated by:

Total Patients Served (all interventions) / Total FY 2020 Expenditures (from FY 2020 budget report)

The WBC managed 278 unique patients during FY20 and spent $1,044,478. The calculated annual cost per patient is $3,757.11 per patient, or $1,252.37 per patient per month.

$1,044,478 / 278 patients = $3,757.11 per patient per enrollment period (approx. 3 months)

Impact of COVID-19 on Interventions – (Optional)

Please include information on the impact of COVID-19 on your interventions, if any. Freeform Narrative response, 1-3 paragraphs.

The WBC hospitals made significant adjustments due to the challenges brought on by the COVID-19 pandemic. Some of these challenges and adjustments included:

- Hospital patient volumes dropped at WBC sites, which led to fewer referrals during the spring months
- Conservation of PPE meant that staff were unable to meet patients face-to-face in the community for home visits, so this mode of intervention and support was sacrificed; however staff maintained telephone contact with patients
- Staff were not able to provide welcome bags during some of the spring months
- Some community physician offices would not schedule new patients during the height of the pandemic, which created a barrier to linking patients with care
- Among patients with established providers, fewer patients at high risk for COVID-19 attended their appointments during the spring months to avoid potential exposure; however some patients and providers began to utilize telehealth as an alternative
- Many agencies and community resources were closed or operating remotely, which led to some difficulty accessing services for patients

Intervention Continuation Summary

Please include a brief summary of the successful interventions that have been supported by this grant program that will be continuing after the conclusion of the grant. Freeform Narrative Response, 1-3 paragraphs.

The West Baltimore Collaborative has connected some of the most underserved Medicare patients in the target zip codes with medical care and social support resources. The WBC interventions continue to show sustained decreases in utilization among patients served, and the WBC is pleased with its progress after implementing many operational changes during FY20. Although the WBC ended its formal partnership at the close of FY20, the hospitals will continue to work with at-risk patients through their existing transitional care programs. In addition, many of the hospital transitional care staff continue to reach out to counterparts at other hospitals as a result of the relationships that were built through the WBC.

Opportunities to Improve – (Optional)

If there is any additional information you wish to share to help the HSCRC enhance future grant programs, please include the information here. Freeform Narrative Response, 1-3 paragraphs.