HSCRC Regional Partnership Transformation Grant Narrative

Year 4 - FY 2020

Bay Area Transformation Partnership (BATP)

Anne Arundel Medical Center

and

University of Maryland Baltimore Washington Medical Center

Submitted on: 9/30/20

Submitted by Cynthia Gingrich, BATP Program Management Consultant

Contents

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	Bay Area Transformation Partnership
RP Hospital(s)	Anne Arundel Medical Center University of Maryland Baltimore Washington Medical Center
RP POC	Report prepared by Cynthia Gingrich, Project Management Consultant, Gingrich Consulting Services, LLC, on behalf of partnership hospitals. **Please direct FY20 report inquiries to:** **Finance Contacts for Budget/Expense/Audit inquiries:** AAMC: Urvashi Sagar, Finance usagar@aahs.org UMBWMC: Vernon Webb, Finance Vernon.Webb@umm.edu Please do not send budget/expense/audit questions to anyone other than the Finance contacts listed above. **Business Contacts for Narrative Report inquiries:** AAMC: Renee Kilroy, rkilroy@aahs.org UMBWMC: Elizabeth Tingo, Elizabeth.Tingo@umm.edu
RP Interventions in FY 2020	Total Interventions in FY20: **8,581** AAMC: 5,590 UM BWMC: 2,672
Total Budget in FY 2020	**$3,850,532 = FY20 actual expenses** **$3,831,141 = FY17 Original Grant Award for the Bay Area Transformation Partnership hospitals**

Total FTEs in FY 2020	**Employed FTE's:** 20.4 Direct, 3.8 Indirect = 24.2 AAMC: 11.4 Direct, 2.9 Indirect = 14.3 UM BWMC: 9 Direct, 0.9 Indirect = 9.9
	Contracted FTE's: 14.0 The Coordinating Center (AAMC): 4.25 The Coordinating Center (UM BWMC): 4.5 Anne Arundel County Dept of Aging Senior Triage Team (UM BWMC): 4.0 BATP Project Manager (.5 for AAMC, .5 for UMBWMC): 1.0
Program Partners in FY 2020 *Please list any community-based organizations or provider groups, contractors, and/or public partners*	**Participating Community Based Organizations *for whom grant funding is used:*** Anne Arundel County Department of Aging and Disabilities Senior Triage Team The Coordinating Center Fire/EMS Mobile Integrated Community Health Programs: Queen Anne's County (contribution) Anne Arundel County (contribution) **Additional Participating Community Based Organizations (*not grant funded*):** Anne Arundel County Department of Health Department of Aging and Disabilities Programs Department of Mental Health Adfinitas Health (skilled nursing facility providers and hospitalist groups) Amedisys Home Health Arundel Lodge Bayada Home Health CareFirst Chesapeake Palliative Medicine CRISP Fire/EMS Mobile Integrated Community Health Programs Prince Georges County Hospice Organizations Hospice of the Chesapeake Season's Hospice Heartland Hospice Prince George's Hospice Primary Care (19 offices) and Specialist (69) Practices, Collaborative Care Network Primary Care and Specialist Practices, UM BWMC, UM Medical Group (16 practices)

Program Partners in FY 2020 (continued)	Skilled Nursing Facilities (SNF Collaborative) Medical Directors, Administrators, Directors of Nursing and Corporate representation for: Cadia Healthcare of Annapolis Caroline Nursing and Rehab CommuniCare Marley Neck CommuniCare South River Crofton Care and Rehab Fairfield Nursing Center Futurecare Capital Region Futurecare Chesapeake Futurecare Irving Genesis Corsica Hills Genesis Severna Park Genesis Spa Creek Genesis Waugh Chapel Ginger Cove SAVA Glen Burnie SAVA Heritage Harbor SAVA North Arundel Signature Health Chesapeake Shores Signature Health Mallard Bay Hospice, Community Care Management, and Adfinitas Health are also active members of the SNF Collaborative.

Overall Summary of Regional Partnership Activities in FY 2020

The Bay Area Transformation Partnership between Anne Arundel Medical Center, the University of Maryland Baltimore Washington Medical Center and over forty (40) program partners joined forces over the past four years to improve patient care through improved cross-organizational care coordination. The primary focus was to concentrate on assisting our most vulnerable, higher utilizer[1], all-payer population as well as rising risk[2] patients with medical and non-medical assistance, keeping them in the least-restrictive home environment with strong community service/support, to avoid unnecessary emergency and hospital care.

The HSCRC asked and we designed our programs to reduce total cost of care (TCOC), reduce potentially avoidable utilization (PAU) and show yearly, positive return on investment per program and overall. Our TCOC reduction strategy, as outlined in our proposal, is based on finding the higher utilizers and rising risk patients for whom long-term impact can be made by assisting with: ***chronic condition management through alignment with PCPs and Specialists, assistance with non-medical services and timely alignment with behavioral health resources.***

The strength of the partnership was in the identification and resolution of cross-organizational communication and information gaps, analysis of current and future state workflows, and workflow redesign. The partnership has studied communication gaps and developed solutions using industry standards, EHR and CRISP tools to bring care team knowledge of each other's capabilities, needs and activities to strengthen the patient-centric approach to care. We have built relationships across the state and with community partners, have taught one another about what is most important for *each* care team member to know and when, and designed and adapted charting and communication practices to meet those needs. This streamlines care, bridges gaps in knowledge around patient medical, behavioral health, non-medical needs and factors related to home life that contribute to unnecessary utilization**.** ***Our over-arching goal has been to improve patient care and reduce PAU and associated costs through improved care coordination with direct communication, and provide relevant, actionable data at the point of care for each care team member, with a 'no walls' approach across the continuum of care.***

In FY20, BATP assisted 5,500+ unique patients with over 8,800 interventions (Figure 1), including Shared Care Alerts, One Call Care Management (non-medical assistance), Community Care Management from three programs (The Coordinating Center, Anne Arundel County Senior Triage Team and AAMC Community Care Management) and Behavioral Health programs (Navigators for AAMC, Integrated in Primary Care for UMBWMC). In addition, we worked closely with Fire/EMS mobile integrated community health (MICH) programs and integrated more pharmacy support into the post-discharge space in FY20.

Although FY20 was unusually challenging, our teams and interventions continued to adapt, reaching many of our target patient populations. Appendix A shows the number of target patients (high utilizers >=65 years old, rising risk >=65 years old) who were discharged from each hospital this year, by month (non-unique across months). To assist with showing total impact for those interventions focusing on target populations, we have a BATP Combined Panel which includes all patients who received any of our core interventions (other than behavioral health navigation and integrated behavioral health as prior utilization is not a factor). The combined panels (one for each hospital) consider that patients receive one or more of our interventions, and look at outcome metrics for the unique set of patients, rather than at the per-intervention level.

[1] >=3 all-hospital inpatient or observation >23 hour (bedded) visits in previous 12 months (from date of measurement)
[2] 2 or more all-hospital inpatient, ED or observation>23 hour visits in previous 12 months (from date of measurement)

Major Accomplishments

- 110+[3] different departments and organizations, both within the hospital (ED, Mental Health Consultants, discharge planners, care managers, transitional nurse navigators) and in the community (PCPs, specialists, hospice, palliative care, skilled nursing providers and staff, behavioral health, etc.) use CRISP Halo secure texting under the BATP umbrella. 1,496 providers and 1,360 staff members from these organizations sent 299,583 secure messages to one another this fiscal year, an average of 820 secure messages per day being sent within and across organizations to improve patient care.

- Our four (4) community care management programs, combined, assisted 1,366 patients, showed an average reduction in potentially avoidable utilization of 35%, 3-months pre/post for patients enrolled in services between July 1, 2019 and March 30, 2020. 813 (60%) of patients were Medicare FFS. Return on investment for these programs ranged from 3.5 to 8.5 in FY20.

- Completed our 5th year of highly successful SNF Collaborative quarterly meetings, averaging 80 attendees consisting of leadership from 18 Skilled Nursing Facilities including Administrators, Medical Directors and Directors of Nursing as well as corporate representation and other community partners.
    - In FY19, the skilled nursing facilities and hospitals agreed that patients often readmit because they do not expect the SNF to be so different from the hospital setting in terms of resources and support. To assist in solving this problem, the hospitals developed matching brochures to explain the differences and manage expectations of patients and families. SNF leadership was most appreciative of this common vocabulary and message across care settings.

  Formed workgroups based on SNF-Collaborative priorities of:

    - Improving Sepsis Prevention, Detection and Treatment as one of the top reasons for readmission. Produced a draft toolkit for nurse training on gathering data and provider communication.

    - SNF-to-Community Care Transition Improvements, focusing on bringing the SNF social workers and other staff into the care coordination conversation (encouraging the use of CRISP Unified Landing Page to see Care Alerts, Care Teams, Programs and be able to reach out directly via secure text).

  Held a COVID-19-focused SNF Collaborative based on SNF and community partner interest, the result of which informed priorities to streamline patient transitions, improvements in testing hand-offs and sharing of best practices.

- Three (3) behavioral health programs (inpatient/ED and community navigators at AAMC and a psychiatrist, two psychotherapists and Admin at UMG), assisted a total of 1,631 patients across the partnership. These programs reached 29% more patients in FY20 than they did in FY19, attributable to continual process improvement in outreach and engagement (navigators), and the impact of telehealth on increased service acceptance and show-rates (integrated behavioral health in primary care).

[3] Adfinitas Health, AAMC 21 departments, Arundel Lodge, Bayada Home Health, Chesapeake Palliative Medicine, AAMC and UMBWMC ED Provider on call, 19 Skilled Nursing Facilities, 24 Primary Care offices, 30 Specialist offices, Queen Anne's County Mobile Integrated Care unit, Hospice of the Chesapeake, Prince George's County Fire/EMS, Arundel Lodge Behavioral Health Home, Anne Arundel County Dept of Aging. UMBWMC has their own instance of Halo secure texting, which is above and beyond the usage noted here.

- Partnered with hospital IT and CRISP to developed innovative, advanced use of CRISP Encounter Notification Service (ENS) for providers and community partners, based on workflow redesign and integration that delivers patient movement within provider, staff and care management workflows (Epic inbaskets, Halo secure texting and/or using PROMPT user interface to see ENS alerts on any patient panel).

- Primary care providers and staff receive real-time CRISP ENS notifications in Epic inbaskets when their attributed patients are discharged from any hospital or skilled nursing facility. This workflow allows them to contact patients quickly to schedule follow-up appointments and document their actions for reporting to the state. (AAMC live, UMBWMC analysis phase)

- When Community Care Managers or Transitional Nurse Navigators add their program and themselves to the Care Team in Epic via outreach encounters, CRISP creates an auto-subscription panel that is used to send ENS alerts via Halo secure texting to the team if their patients readmit.

- Cross-organizational use of Halo secure texting – Per above statistics, there are many cross-organizational use cases for secure texting, which are dependent upon the current CRISP-hosted statewide Halo secure texting implementation. These workflows took years to plan and implement and are saving time and lives.

Summary of Unique Patients and Non-Unique Interventions Provided to Patients in FY20

The list of interventions and numbers of patients who received each one (Figure 1) has two sections. The first section lists *unique patients* for non-behavioral health interventions and separately for all behavioral health interventions (mutually exclusive categories). The combined non-behavioral health intervention panel includes a combined panel for patients who received any **core** BATP intervention (Shared Care Alerts, Community Care Management or One Call Care Management assistance). It does not include patients from the Fire/EMS programs or from the AAMC Pharmacy MTM or Practice Panel Coordinator programs.

The total number of *unique patients* assisted by core BATP interventions was 5,579 in FY20, with *non-unique interventions* totaling 8,821 across the partnership hospital and community partner programs.

BATP Intervention Totals	**FY20 All Payer**	
	AAMC	**UM BWMC**
Unique Patients		
All Non Behavioral Health Interventions (Combined panel of unique patients who received one or more BATP intervention (Care Alert, Community Care Management, One Call Care Management)	2246	1705
All Behavioral Health Interventions (Combined)	1248	380
Total # of unique patients	**3494**	**2085**
Non-Unique Interventions	**AAMC**	**UM BWMC**
Shared Care Alerts (New or updated)	2128	1138
The Coordinating Center	226	524
AAMC Community Care Mgt	424	N/A
Senior Triage Team	N/A	209
One Call Care Management	542	376
Behavioral Health in Primary Care	N/A	380
Behavioral Health Navigator ED	559	N/A
Behavioral Health Navigator Community	699	N/A
AA County Fire/EMS*		45
QA County Fire/EMS*	99	
Pharmacy MTM Program*	559	N/A
Patient Panel Coordinators*	913	N/A
Total # of non-unique interventions :	**6149**	**2672**
*Not included in 'All Non Behavioral Health Interventions' Panel		
Cost:		
FY20 Total Expenditures	**$ 2,222,885**	**$ 1,632,108**
Annual Cost Per Intervention	**$ 361.50**	**$ 610.82**
Annual Cost Per Unique Patient	**$ 636.20**	**$ 782.79**
Return:		
Non-Behavioral Health Interventions (Combined Panel) Results		
Average Change in Total Charges	$ (11,529,781)	$ (11,151,381)
Average Cost/Patient Reduction	$ (6,174)	$ (7,275)
Average Cost/Visit Reduction	$ (1,822)	$ (1,618)
Average Reduction in IP/ED/Obs/OP Visits per 10 Members	-6.7	-10.6
Overall Return on Investment	**2.46**	**3.56**

Figure 1 BATP Intervention Summary FY20

Return on Investment Formula = ((Total Change in Charges x .5) - Cost of Interventions)) / (Cost of Interventions)

BATP Combined Panels

Intervention or Program Name	All BATP Core Interventions (Combined Panels of our non-behavioral health interventions)
RP Hospitals	All
Brief description of the Intervention	Combined panels are used to remove the factor of a single patient receiving multiple interventions. These per-hospital panels contain all patients who received any core BATP intervention in FY20 including: Shared Care Alerts, Community Care Management from vendor or internal services and/or One Call Care Management assistance.
Participating Program Partners	Please see individual intervention sections for a list of partners specific to each.
Patients Served	# of Patients Served as of June 30, 2020: **3,951** AAMC: 2,246 UM BWMC: 1,705
	Denominator of Eligible Population: **550,445** RP Analytic File Denominator of Eligible Patients: **44,930** CY2019 RP Analytic File, 2+ IP, ED or Obs>23 Visits All Payer BATP Denominator of Eligible Patients: **10,412** CRISP Public Health Dashboard, Total High Utilizer and Rising Risk patients discharged from AAMC or UM BWMC in FY20
Pre-Post Analysis for Intervention	**AAMC Pre/Post Combined Panel Results** 2,246 Patients in FY20 Panel 1,246 patients who had a visit within 3 months pre or post, showed Reduction in Total Charges of (-$11,529,781) Average Charges/Pt (-$6,173) Average Charge/Visit (-$1,822) IP/ED/Obs/OP Visit Rate per 10 Members (-6.7) **UM BWMC Pre/Post Combined Panel Results** 1,705 Patients in FY20 Panel 926 patients who had a visit within 3 months pre or post, showed Reduction in Total Charges of (-$11,151,381) Average Charges/Pt (-$7,275) Average Charge/Visit (-$1,618) IP/ED/Obs/OP Visit Rate per 10 Members (-10.5)

All Hospital PAU Reduction in Charges and Visits – Combined Panels

AAMC 3-month Pre/Post Reduction in PAU, Readmissions, PQI Visits

All Hospital	Reduced Charges	% Reduction in Visits Post vs Pre	Visits Post vs Pre
PAU Visits	$ (3,650,702)	-43%	-324
Readmissions	$ (3,412,266)	-56%	-202
PQI Visits	$ (1,868,657)	-61%	-185
PAU Readmissions (IP and Obs)	$ (1,782,045)	-31%	-139

UM BWMC 3-month Pre/Post Reduction in PAU, Readmissions, PQI Visits

All Hospital	Reduced Charges	% Reduction in Visits Post vs Pre	Visits Post vs Pre
PAU Visits	$ (4,494,055)	-38%	-359
Readmissions	$ (4,191,138)	-56%	-254
PQI Visits	$ (2,413,898)	-52%	-206
PAU Readmissions (IP and Obs)	$ (2,080,157)	-28%	-153

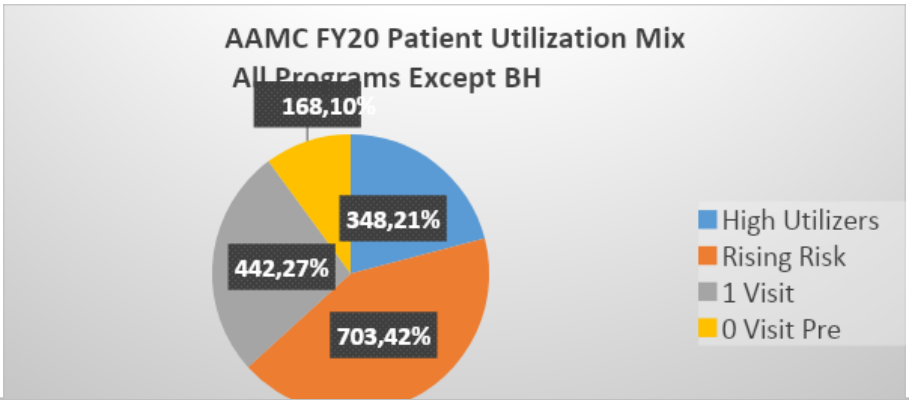
Intervention-Specific Outcome or Process Measures

Patient All-Hospital Utilization Mix (HU/RR) 12 months PRIOR to Start of Interventions

Patients who received the BATP core interventions had the following utilization 12 months PRIOR to receiving intervention assistance (utilization at time of intervention start).

AAMC: 21% of patients assisted by AAMC core BATP interventions were high utilizers, 42% were rising risk, 27% had a single visit of any type (IP, ED, Obs>23) and 10% had no visits 12 months prior to receiving a core intervention.

Total high utilizers assisted in FY20 = 348
Total rising risk patients assisted in FY20 = 703
Total Pts with a single IP, ED, Obs visit = 442
Total Pts assisted with no hospital or ED/Obs visits 12 months pre = 168

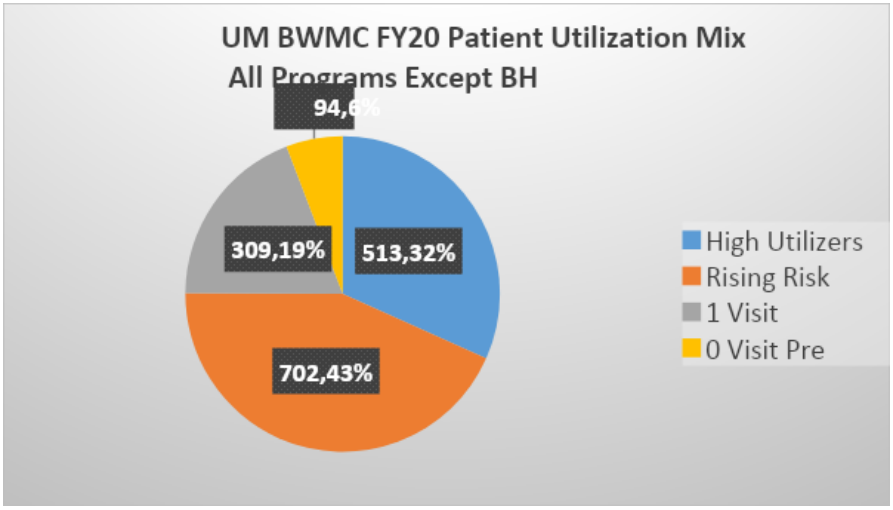


AAMC
1161 Unique Patients

	High Utilizers	Rising Risk	1 Visit	0 Visit Pre
Patients	348	703	442	168
Visits	1642	2911	442	0
Charges	$23,632,298	$12,678,366	$3,509,809	$0.00
Avg Chg/Pt	$67,909	$18,035	$7,941	$0.00
Avg Chg/Visit	$14,392	$4,355	$7,941	$0.00
Avg Visits/Pt	4.7	4.1	1.0	0.0
Percent of Total Unique Pts	21%	42%	27%	10%

UM BWMC: 32% of patients assisted by UM BWMC core BATP interventions were high utilizers, 43% were rising risk, 19% had a single visit of any type (IP, ED, Obs>23) and 6% had no visits 12 months prior to receiving a core intervention.

Total High Utilizers assisted in FY20 = 513
Total Rising Risk assisted in FY20 = 702
Total Pts with a single IP, ED, Obs visit = 309
Total Pts assisted with no hospital or ED/Obs visits 12 months pre = 94



UM BWMC

1,618 Unique Patients

	High Utilizers	Rising Risk	1 Visit	0 Visits Pre
Patients	513	702	309	94
Visits	2276	2974	309	0
Charges	$ 33,819,204	$ 16,183,039	$ 191,556	0
Avg Chg/Pt	$ 65,924	$ 23,053	$ 620	0
Avg Chg/Visit	$ 14,859	$ 5,442	$ 620	0
Avg Visits/Pt	4.4	4.2	1.0	
Percent of Total Unique Pts	**32%**	**43%**	**19%**	**6%**

Successes of the Intervention in FY 2020

AAMC ROI for Combined Panel: **2.46**
UM BWMC ROI for Combined Panel: **3.56**

When combined, our programs are reaching higher utilizer and rising risk patients, as well as assisting patients who have not yet become rising risk and preventing some patients from initial hospital or ED utilization.

Our average cost per unique patient was approximately $700, with an average reduction in all-hospital cost per patient of (-$6,700), 3-months post-interventions.

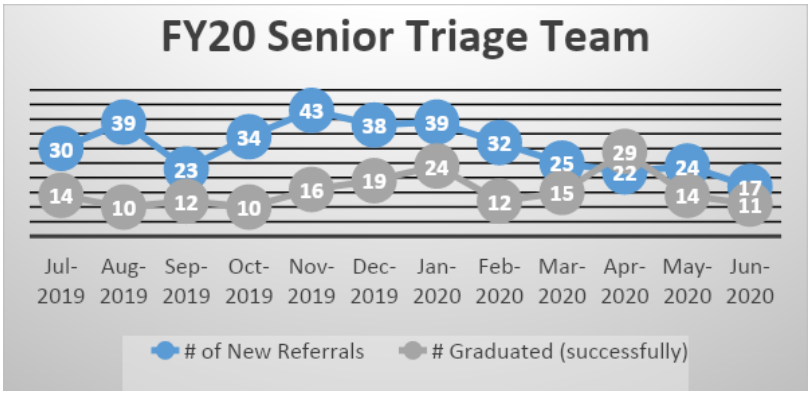
Total reduction in cost using CRISP casemix data for patients receiving BATP interventions was a decrease of -$11.5M for AAMC and -$11.2M UM BWMC. These outcome metrics far exceeded planned goals and are consistently strong year-over-year.

Community Care Management Services

Senior Triage Team (Anne Arundel County Department of Aging)

Intervention or Program Name	Senior Triage Team - Community Care Management Anne Arundel County Department of Aging & Disabilities
RP Hospitals	UM Baltimore Washington Medical Center
Brief description of the Intervention	An intensive 60-day community care management program for UMBWMC most complex, high utilizer Medicare FFS patients. Resourced by 2 RN's, 2 social workers, a team lead and an administrator. The team was designed around Medicare FFS high utilizers and has been working with BATP since 6/1/16. They have advanced knowledge of all services and supports in Anne Arundel County, and how to streamline requests for and access to services, including financial analysis and housing assistance. FTE = 4.0
Participating Program Partners	The Senior Triage Team model has a built-in support system called the Silver CRICT Team, an aging/senior population Community Resource Initiative Care Team, comprised of the Department of Social Services, the Housing Commission, Department of Mental Health, Core Service Agency, Crisis Response and others. The team develops a multi-agency action plan to assist with long-term support connections, in addition to immediate assessment and care management.
Patients Served	# of Patients Served as of June 30, 2020: **202 (**out of 366 referred) Capacity of service = 60 active patients, 2-month program = 360 patients/year However, considering unable to contact, patients who expire, and those who decline the service after hospital discharge, the capacity of the program is closer to 300.
	Denominator of Eligible Population: **66,961** RP Analytic File Denominator of Eligible Patients: **1,511** CY2019 RP Analytic File, 3+ IP or Obs>=24 Visits Medicare FFS BATP Denominator of Eligible Patients: **770** CRISP PaTH report UM BWMC eligible target patients are Inpatient/Observation high utilizers (3+ bedded stays in the last 12 months), 2 to 6 chronic conditions, **Medicare FFS**, 65+ years old.
Pre-Post Analysis for Intervention	**ROI: 4.57** (up from ROI of 2.41 in FY19) Pre/Post 3-month for July – March patients (9 months): Change in Total Charges (-$2.5M) Change in Average Charge/Pt (-$10,407) Change in Rate of Visits per 10 Members (-14.4) 81% (163) Medicare FFS Reductions in utilization continue to increase at 6 and 12 months per Pre/Post analysis.

Intervention-Specific Outcome or Process Measures



Total Pts	Percent	% Change from FY19	
366		12% ↓	Total Referrals
110	30%	4% ↑	of referrals never became active (declined, unable to contact, etc.)
256	70%	-4% ↓	patients were actively in the program at some point during the year
196	77%	17% ↑	of patients who were active, graduated successfully from the program
11	3%	-2% ↓	of referrals disengaged during the year
8	2%	-1% ↓	of referrals died during service
6	2%	0%	of referrals were enrolled in hospice
32	9%	0%	referrals had no notable prior utilization (not in pre/post)

COVID - Avg referrals 35/mo (July-Feb), 22/mo (Mar-June)
37% decreased referrals pre vs post COVID

Reduction in Potentially Avoidable Utilization (All Hospital and UMBWMC Only)

To measure our goal to reduce PAU, we used CRISP/HSCRC guidance provided in Pre/Post instructions to examine 3-month pre and post reduction in PAU (IP readmissions, PQI visits, IP and Obs readmissions and overall PAU). The results for this service are:

All Hospital	Reduced Charges	% Reduction in Visits Post vs Pre	Visits Post vs Pre
PAU Visits	$ (676,932)	-29%	-58
Readmissions		-55%	-51
PQI Visits	$ (294,123)	-44%	-33
PAU Readmissions (IP and Obs)	$ (382,810)	-20%	-25

UMBWMC Only	Reduced Charges	% Reduction in Visits Post vs Pre	Visits Post vs Pre
PAU Visits	$ (682,359)	-43%	-67
Readmissions		-54%	-40
PQI Visits	$ (374,127)	-32%	-39
PAU Readmissions (IP and Obs)	$ (308,232)	-32%	-28

	The 'COVID impact': (June 2019 thru Feb 2020 pre-COVID versus March 2020 through June 2020) showed a 55% decrease in patients graduating successfully (per month), a 37% decrease in number of referrals to the program and an 11% decrease in the number of active clients.
Successes of the Intervention in FY 2020	This service consistently shows the highest long-term decrease in pre/post visits per 10 members of community care management interventions, -14.4 in FY20. 81% of patients who had IP/ED/Obs visits within 3 months of enrollment into the program are Medicare FFS (the highest Medicare FFS percentage of all partnership interventions). Reduced all-hospital PAU by 29% in the first 9 months of FY20, a change in charges of (-$676,932) 3 months pre/post. Patients had 51% less readmissions after receipt of this service (-43 visits). This team receives ENS notifications via Halo secure texting based on Care Team charting in Epic (auto-subscription panel at CRISP), which enables fast outreach and schedule adjustments, as well as cross-organizational care team coordination. Through the BATP relationship, the Anne Arundel County Department of Aging and Disabilities provided intensive, half-day training and written material on their 25+ programs to 65 hospital and community social workers and care managers, the 3rd such training since the partnership began, gratis.
Additional Free-Form Narrative Response	Assisting patients with undiagnosed behavioral health issues is particularly challenging for community care managers, as many services require a diagnosis to qualify for assistance. UM BMWC and the Senior Triage Team employ continual process improvement to study and resolve gaps in communication and delayed or missing data across care teams.

The Coordinating Center

Intervention or Program Name	The Coordinating Center – Community Care Management
RP Hospitals	All
Brief description of the Intervention	The Coordinating Center provides 30-day LOS community care management with a focus on health coaching to hospital-referred high-utilizer and rising risk patients. Health coaches perform in-home visits and follow-up to facilitate chronic condition management, alignment with PCPs and Specialists, patient-approved goal setting and assistance with non-medical services. AAMC – 4.25 FTE's (3.0 Health Coaches, 1.0 Intake Coordinator, .25 Director). July – Oct (4 months in FY20). UMBWMC – 4.5 FTE's (3.0 Health Coaches, 1.0 Intake Coordinator, .5 RN Program Lead). Full 12 months FY20.
Participating Program Partners	The Coordinating Center aligns higher-utilizer and rising risk patients with medical and non-medical services. They also refer patients to other appropriate levels of care including: Hospice of the Chesapeake, Palliative Care, Anne Arundel County Department of Aging & Disabilities Programs, home health agencies, the Senior Triage Team (for UMBWMC), and various other county and state programs. They work closely with Skilled Nursing Facilities as patients transition from hospital to SNF to home.
Patients Served	# of Patients Served as of June 30, 2020: **750** AAMC: **226** (July 2019 – Oct 2019, 4 months) UM BWMC: **524** (July 2019 – June 2020, 12 months)
	Denominator of Eligible Population: **550,445** RP Analytic File, >=3 bedded stays 12 months prior, All Payer Denominator of Eligible Patients: **44,930** RP Analytic File, >=2 IP/ED/Obs>23 Visits 12 months prior, All Payer

Pre-Post Analysis for Intervention

AAMC / The Coordinating Center Community Care Mgt

ROI = **4.63** (4 months)

Pre/Post Results, 3-month, All Hospital, All Payer:
Change in Total Charges (-$1,958,601)

Average Charge/Pt Pre $18,461
Average Charge/Pt Post $14,040
Change in Average Charge/Pt (-$4,421)
Change in Average Charge/Visit (-$719)
Change in Rate of Visits per 10 Members (-13.3)

UM BWMC / The Coordinating Center Community Care Mgt

ROI **= 8.55**

Pre/Post Results, 3-month, All Hospital, All Payer:
Change in Total Charges (-$4,934,065)

Average Charge/Pt Pre $24,555
Average Charge/Visit Pre $16,833
Change in Average Charge/Pt (-$7,722)
Change in Average Charge/Visit (-$1,965)
Change in Rate of Visits per 10 Members (-11.9)

Intervention-Specific Outcome or Process Measures

AAMC / The Coordinating Center

756 patients were referred to the service.
226 graduated successfully from the program, 95% of which had a visit within 3 months of referral (pre or post).
57% (129) of patients who graduated from the service were Medicare FFS.

Change in PAU/Readmissions/PQI – All Hospital

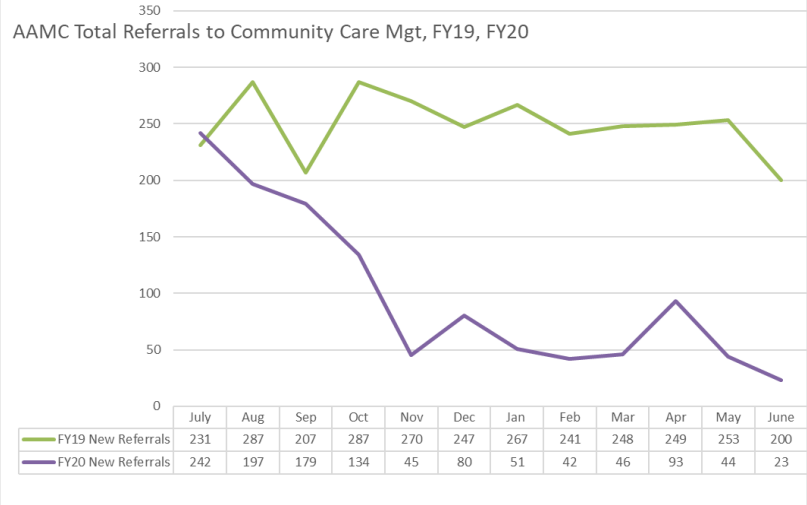
All Hospital	Reduced Charges	Reduction in Visits Post vs Pre	Visits Post vs Pre
PAU Visits	$ (600,154)	-36%	-53
Readmissions		20%	2
PQI Visits	$ (479,276)	-63%	-47
PAU Readmissions (IP and Obs)	$ (120,878)	-8%	-6

Change in PAU/Readmissions/PQI – AAMC Only

AAMC Only	Reduced Charges	Reduction in Visits Post vs Pre	Visits Post vs Pre
PAU Visits	$ (563,014)	-40%	-54
Readmissions		33%	3
PQI Visits	$ (529,833)	-69%	-48
PAU Readmissions (IP and Obs)	$ (33,181)	-9%	-6

Referral Analysis

Average referrals/month for The Coordinating Center = 188
AAMC new internal CCM program started Nov 2019 with
Average referrals/month = 46
Average # Pts graduating/month 51 (The Coordinating Center)
Average # Pts enrolling/month 56 (AAMC CCM)



UM BWMC / The Coordinating Center Community Care Mgt

1,923 patients were referred to the service
524 (27%) graduated successfully from the program,
73% of which had a visit within 3 months of referral (pre or post).
50% (257) of those who graduated were Medicare FFS

Change in PAU/Readmissions/PQI – All Hospital

All Hospital	Reduced Charges	Reduction in Visits Post vs Pre	Visits Post vs Pre
PAU Visits	$ (956,362)	-34%	-125
Readmissions		-56%	-100
PQI Visits	$ (786,404)	-50%	-81
PAU Readmissions (IP and Obs)	$ (169,958)	-21%	-44

Change in PAU/Readmissions/PQI – UM BWMC Only

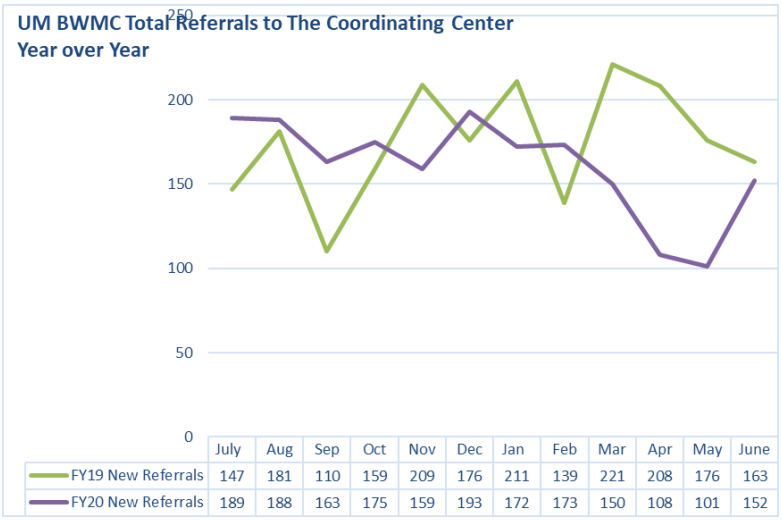
UMBWMC Only	Reduced Charges	Reduction in Visits Post vs Pre	Visits Post vs Pre
PAU Visits	$ (1,271,372)	-43%	-128
Readmissions		-60%	-84
PQI Visits	$ (717,153)	-32%	-76
PAU Readmissions (IP and Obs)	$ (554,219)	-32%	-52

% of High Utilizers, Rising Risk, 1 Visit and 0 Visits 12 months Prior to Service

	High Utilizers	Rising Risk	1 Visit	0 Visits Pre
Patients	227	235	42	9
Visits	962	1031	42	0
Charges	$ 12,522,482	$ 5,911,423	$ 440,253	0
Avg Chg/Pt	$ 55,165	$ 25,155	$ 10,482	0
Avg Chg/Visit	$ 13,017	$ 5,734	$ 10,482	0
Avg Visits/Pt	4.2	4.4	1.0	
Percent of Total Unique Pts	44%	46%	8%	2%

44% of patients referred to this service were high utilizers at service start, costing $55K in the 12 months prior to enrollment in The Coordinating Center services.
46% were Rising Risk, average cost of $25K
8% had a single IP, ED or Obs visit, average cost $10K 12 months pre.
2% had no prior IP, ED or Obs visits

Referral Analysis



COVID impacted UM BWMC census and referrals to The Coordinating Center with a 32% decrease during Mar-May, with recovery in June.

Patient acceptance of care management service increased by 16% (44-63% pre-covid, 63%-74% acceptance post-covid) during the pandemic as The Coordinating Center used telephonic outreach rather than in-home visits. Patients appreciated the contact

	and outreach to home without the risk of a home visit. Adjusted the model so that liaison contacted referrals while they were still in the hospital to introduce the program, then immediately after discharge reached out to schedule the support call. Phone-based support expedites collaborating with patient, home health, PCP, etc. Care coordination is expedited.
Successes of the Intervention in FY 2020	Patients in this program showed reduced Potentially Avoidable Utilization by approximately 126 Visits (-$1M) for <u>each</u> hospital in FY20 (3-month pre/post). Patients in this program had a decrease of 80 to 100 readmissions 3 months after receipt of service in FY20. Community Care Management teams are vital Care Team members: - They are one of few resources who have the privilege and responsibility to enter homes, meet patients where they are, understand home, family and support considerations and share what is appropriate via Care Alerts and other care collaboration charting. - They are experts at listening and working with patients to develop patient-approved goals. They share them in the medical record to inform other Care Team members. - Community Care Managers receive admission and discharge encounter notifications via Halo secure texting (based on panels or Care Team charting in Epic) for their own patients, so they can reach out, rearrange schedules, touch base with PCP's, Specialists, hospital, ED, SNF, Home Health, patients and staff as needed. - Return on Investment for The Coordinating Center program is consistently high year-over-year. - Challenge: The number of patients who graduate successfully from The Coordinating Center service is approximately 27% of all patients referred to the service.

AAMC Community Care Management

Intervention or Program Name	AAMC Community Care Management
RP Hospitals Participating in Intervention	AAMC
Brief description of the Intervention	AAMC Community Care Management is a team of RN's, Social Worker and Community Health Workers who receive referrals from inpatient care management and PCPs with a goal to assess medical and non-medical resource needs and alignment with services/support. The team works with higher utilizer, rising risk, 2 or more chronic conditions, patients with high readmission risk with focus on Medicare FFS but including all payer patients. In-home visits are provided as appropriate. FTE's = 2.78
Participating Program Partners	This team is educated on all community and hospital-based programs and how to assist patients with obtaining services, including caregiver assistance, home health, transportation, insurance, any of the Anne Arundel County Department of Aging 25+programs, etc.
Patients Served	# of Patients Served as of June 30, 2020: **423** Nov 1, 2019 start of program (8 months)
	Denominator of Eligible Patients: **44,930** RP Analytic File, 2+ IP/Obs/ED Visits 12 months prior
Pre-Post Analysis for Intervention	**ROI = 3.46** Of the 423 patients served, 194 (46%) had a visit within 3 months prior to or after start of service (3-month pre/post). Change in Total All Hospital Charges: (-$1,941,763) Change in Charges per Patient: (-$5,461) Change in Charges per Visit: (-$1,837) Reduction in # of Visits per 10 members: (-6.7) 62% of patients (264) were Medicare FFS, with Change in Total All Hospital Charges: (-$981,827) Change in Charges per Patient: (-$4,774) Reduction in # of Visits per 10 members: (-7.3)
Intervention-Specific Outcome or Process Measures	An average of 53 new, unique patients per month were enrolled in the program.

High Utilizer / Rising Risk Breakdown (12 months prior to Enrollment in Service):

	High Utilizers	Rising Risk	1 Visit	0 Visits Pre
Unique Patients	93	139	86	29
# Visits	518	503	86	0
Charges (IP,ED,Obs)	$ 7,141,921	$ 1,567,283	$ 495,707	0
Avg Chg/Pt	$ 76,795	$ 11,275	$ 5,764	0
Avg Chg/Visit	$ 13,787	$ 3,116	$ 5,764	0
Avg Visits/Pt	5.6	3.6	1.0	
	27%	40%	25%	8%

The AAMC Community Care Management service assisted 27% (93) high utilizers, 40% (139) Rising Risk (2 or more IP/ED/Obs visits in 12 months prior), 25% of patients had a single IP/ED/Obs visit 12 months prior, and 8% had zero IP/ED/Obs visits 12 months prior.

PAU Reduction (Nov 2019 – March 2020 Patients, 3-month Pre/Post)
All Hospital and AAMC Only:

Unique Patients: 194

All Hospital	Reduced Charges	% Reduction in Visits Post vs Pre	Visits Post vs Pre
PAU Visits	$ (1,059,632)	-37%	-82
Readmissions	$ (929,313)	-59%	-60
PQI Visits	$ (356,305)	-36%	-39
PAU Readmissions (IP and Obs)	$ (703,327)	-37%	-43

AAMC Only	Reduced Charges	Reduction in Visits Post vs Pre	Visits Post vs Pre
PAU Visits	$ (974,181)	-40%	-72
Readmissions	$ (710,021)	-59%	-60
PQI Visits	$ (423,878)	-42%	-39
PAU Readmissions (IP and Obs)	$ (550,303)	-38%	-33

Successes of the Intervention in FY 2020

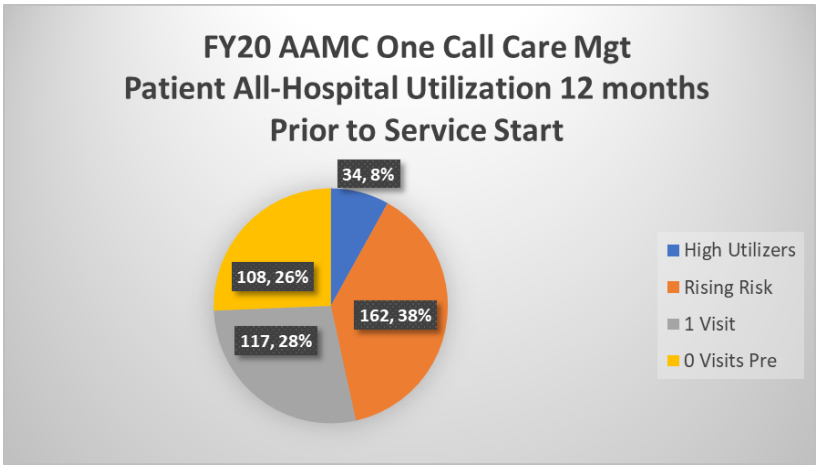
AAMC transitioned to an internal Community Care Management team in November 2019 with an impressive 53 patients per month average enrolled and a reduction in PAU of over $1M consisting of 82 less PAU visits 3-months post service.

Readmissions for patients receiving service decreased by 60 visits totaling (-$929,313).

In-home visits were curtailed due to COVID-19, but patient acceptance of the program was strong, with patients accepting phone-based assistance without risking in-home contact.

One Call Care Management

Intervention or Program Name	One Call Care Management
RP Hospitals	All
Brief description of the Intervention	The One Call Care Management service is a single phone number at both AAMC and UMBWMC for Primary Care Providers to call to refer patients in need of non-medical assistance, such as transportation, care-giver support, housing, financial concerns, insurance, etc. The AAMC service also includes a Behavioral Health Navigator - Community resource which is measured separately herein. FTE's = 1.01 (BH community measured separately)
Participating Program Partners	Referral sources: Primary Care Providers and specialist groups from both hospitals (Anne Arundel Medical Group, University of Maryland Medical Group). Referrals to: Anne Arundel County Department of Health (Healthy Start, REACH, Dental Program), house call providers, Hospice of the Chesapeake, Palliative Care, Queen Anne's, Prince George's County and Anne Arundel County Mobile Integrated Care Units (MICH), Food Bank, Partners in Care, The Coordinating Center, Behavioral Health Navigators, Pharmacists, Psychotherapists, Johns Hopkins Home Care, Chronic Condition support programs, etc.
Patients Served	# of Patients Served as of June 30, 2020: **918** AAMC: **542** (1.01 FTE) UM BWMC: **376** (1.0 FTE)
	Denominator of Eligible Population: **550,445** RP Analytic File, All Payer, All Population associated with the Partnership
Pre-Post Analysis for Intervention	**AAMC** **ROI = 2.43 all patients** **ROI with Rising Risk Only = 1.99** The One Call Care Management service aids all patients referred by their providers for non-medical needs. Since prior hospital/ED utilization is not a factor in referring to the service, we look deeper into the Pre/Post results, breaking them down by high and rising risk, patients who had a single visit and those who had zero visits 12 months prior to assistance. AAMC Pre/Post for all OCCM patients showed a reduction in total charges of (-$528,003) and an average charge per patient decrease of (-$1,605).



AAMC One Call Care Mgt Utilization Mix (HU, RR, 1 IP, ED or Obs Visit, 0 Visits) 12 months Prior to Intervention Start Date

	High Utilizers	Rising Risk	1 Visit	0 Visits Pre
Patients	34	162	117	108
Visits	147	622	117	0
Charges	$ 1,908,677	$ 2,158,680	$ 514,195	0
Avg Chg/Pt	$ 56,138	$ 13,325	$ 4,395	0
Avg Chg/Visit	$ 12,984	$ 3,471	$ 4,395	0
Avg Visits/Pt	4.3	3.8	1.0	
	8%	38%	28%	26%

AAMC OCCM Outcome Metrics by Utilization Type

34 High Utilizer patients showed a change in all hospital total charges of (-$369,369), a reduction in average charges per patient of (-$14,614), a reduction of average charge per visit of (-$1084), and a reduction of -2.4 visits per 10 members in 3-month pre/post.

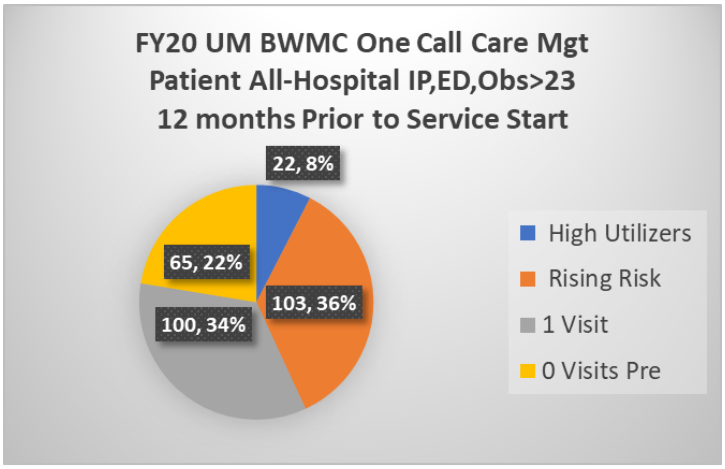
162 Rising Risk patients showed a change in all hospital total charges of (-$460,584), a reduction in average charges per patient of (-$3,704) and -1.3 visits per 10 members.

Rising Risk	Pre	Post	Change Pre to Post
Pts	107	77	-30
Visits	$ 304	$ 186	-118
Charges	$ 1,106,667	$ 646,083	$ (460,584)
Avg Charge/Pt	$ 10,343	$ 6,638	$ (3,704)
Avg Charge/Visit	$ 3,640	$ 4,426	$ 785
Avg Visits/Pt	2.8	1.5	$ (1.3)

High Utilizers	Pre	Post	Change Pre to Post
Pts	28	34	
Visits	108	51	-57
Total Charges	$ 595,075	$ 225,706	$ (369,369)
Avg Charge/Pt	$ 21,253	$ 6,638	$ (14,614)
Avg Charge/Visit	$ 5,510	$ 4,426	$ (1,084)
Avg # Visits/Pt	3.9	1.5	$ (2.4)

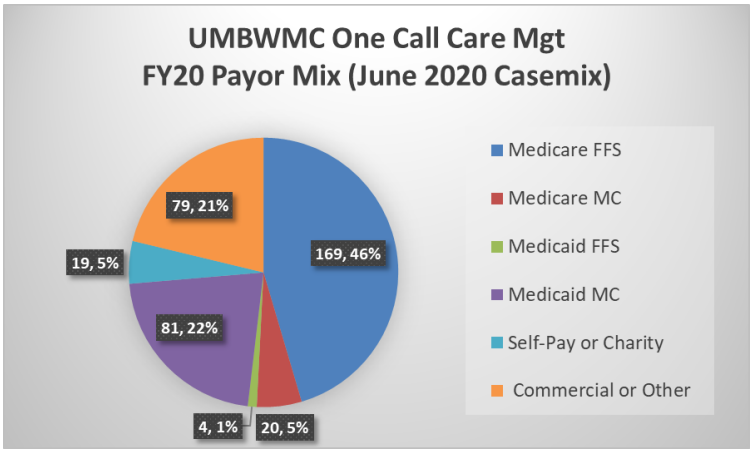
UMBWMC One Call Care Management
ROI = 1.94 using all patients
ROI = 5.26 using Rising Risk patients only
Knowing the patient utilization mix informs the potential for showing a difference 'pre' to 'post', and is a consideration for program referral criteria adjustment, if desired.

UM BWMC One Call Care Mgt Utilization Mix (HU, RR, 1 Visit, 0 Visits) 12 months Prior to Intervention Start Date



	High Utilizers	Rising Risk	1 Visit	0 Visits Pre
Patients	22	103	100	65
Visits	96	355	$ 259	0
Charges	$ 2,333,577	$ 1,940,383	$ 486,407	0
Avg Charge/Pt	$ 106,071.67	$ 18,838.67	$ 4,864.07	0
Avg Charge/Visit	$ 24,308.09	$ 5,465.87	$ 1,878.02	0
Avg # Visits/Pt	4.4	3.4	2.6	0
	8%	36%	34%	22%
*95 patients had 1 ED visit (any hospital) prior to referral to OCCM				

Payor Mix:



UM BWMC OCCM Outcome Metrics by Utilization Type

81 Rising Risk patients showed a change in all hospital total charges of (-$507,537) within 3 months of receiving this intervention. A reduction in average charges per patient of (-$5,468) and -1.3 visits per 10 members.

The change in total charges for 22 High Utilizer patients was (-$7,172), and a reduction of -1.3 visits per 10 members.

Rising Risk	Pre	Post	Change Pre to Post
Pts	65	40	-25
Visits	185	90	-95
Total Charges	$ 786,885	$ 279,349	$ (507,537)
Avg Charge/Pt	$ 12,106	$ 6,638	$ (5,468)
Avg Charge/Visit	$ 4,253	$ 4,426	$ 172
Avg # Visits/Pt	2.8	1.5	-1.3

High Utilizers	Pre	Post	Change Pre to Post
Pts	16	12	-4
Visits	44	31	-13
Total Charges	$ 139,940	$ 132,768	$ (7,172)
Avg Charge/Pt	$ 8,746	$ 6,638	$ (2,108)
Avg Charge/Visit	$ 3,180	$ 4,426	$ 1,245
Avg # Visits/Pt	2.8	1.5	-1.3

Intervention-Specific Outcome or Process Measures (optional)	The One Call Care Management Services chart discrete 'reasons for referral' to understand the types of assistance being requested and provided. These process metrics also capture additional patient needs uncovered through the assistance process. Below is the table for AAMC FY20, and UMBMWC top reasons for calls mirror these results.

Reason for Referral	FY 2020 Totals	% of Service
Transportation	138	17.8%
Provider Referral	116	15.0%
Other	82	10.6%
Insurance Coverage	76	9.8%
Medication Assistance	60	7.7%
Basic Needs	41	5.3%
Care Management Enrollment	40	5.2%
Housing	40	5.2%
Personal care	37	4.8%
Financial Concerns	27	3.5%
Home Health/Home Safety	27	3.5%
Care Giver Support	25	3.2%
Hospice & Palliative Care	13	1.7%
DME	11	1.4%
The Coordinating Center	10	1.3%
Dental Health	8	1.0%
Family Lifestyle Concerns	5	0.6%
Social Security	5	0.6%
Physician Housecall	4	0.5%
Community Partner	2	0.3%
Support Group	2	0.3%
Insurance Care Coordination	2	0.3%
Cognitive Defects	1	0.1%
Home Safety	1	0.1%
Meal Assistance	1	0.1%
Medical Equipment	1	0.1%
Total OCCM Assistance (Non BH)	**775**	**100.0%**

Additional process metrics include # of unique providers referring per month and # of unique practices referring/month.

The AAMC Behavioral Health Navigator – Community service is now part of the One Call Care Management umbrella at AAMC, and a full 53% (868) of patients referred to the service are for behavioral health assistance. The BH Navigator-Community service is reported as a separate program in this report.

Successes of the Intervention in FY 2020

Patients and families continually express gratitude for assistance and follow-up with obtaining valuable resources through this service. It is very satisfying for the providers, patients, families, and One Call Care Managers.

This service identifies gaps and challenges in non-medical services, communicates to leadership and community partners, and works to resolve them. For example, in FY20 the One Call Care Managers identified a lack of affordable dental services as a major challenge. By recognizing this need and reaching out to community partners, they discovered a new Anne Arundel County Dental Health Program which now has a dedicated dental coordinator (as of Sept 2019) who can assist patients and families.

	Alignment of One Call Care Managers with a Pharmacy resource has been effective in assisting patients with medication reconciliation and in finding more affordable medications, in particular insulin and inhalers. These affordable options are then communicated to providers to close the loop and improve future prescribing patterns.
Additional Freeform Narrative Response	Transportation services are still limited or highly restrictive. - AA County Senior Van and Taxicab Vouchers application process has a prohibitive lead-time and application process. There are long wait times, and patient ID must match their residence in order to obtain service. We need a faster way to get patients to/from appointments with 2-day notice. - The Lyft program is helpful, but patients still need to get to the curb on their own. - Medicaid transportation will only transport patients to appointments covered by Medicaid (i.e. patients cannot get to University of MD Dental School appointments or other medical appointments not covered by Medicaid). - Partners in Care is helpful but there is still an age limit, patient ID has to match their residence (which is frequently reason for exclusion), limited to 1 ride per week and van service is expensive (approximately $20/hour). - Medical Assistance transportation can only be used for MA-covered visits. In-home aid - Patients who need in-home aid often cannot afford it or do not qualify for assistance.

Shared Care Alerts

Intervention or Program Name	Shared Care Alerts
RP Hospitals Participating in Intervention	All
Brief description of the Intervention	A Care Alert is special cross-encounter, multidisciplinary note designed to provide a single location in the medical record for the most important, actionable information about a patient's medical and non-medical needs, for and by the entire Care Team. Shared Care Alerts are a **foundational component** to cross-organizational, multi-disciplinary care coordination, as they consolidate 'need-to-know now' information in a single location for hospital and community partners. Care Teams include clinicians and social workers both within the hospital and in the community, who have a treatment or working relationship with the patient. Care Alerts are shared in real-time from Epic to and via CRISP and are sent and received to/from over 100 organizations / offices statewide, regardless of EHR vendor. FTE's = UMBWMC 2.0 FTE's (Medical and Behavioral Health) AAMC .5 FTE
Participating Program Partners	Anne Arundel Medical Center and UM Baltimore Washington Medical Center; Emergency Department Physicians and staff, Primary Care Providers, Specialists, Hospitalists, Nursing, Social Workers. ● The Coordinating Center (community care mgt) ● Anne Arundel County Department of Aging & Disabilities – Senior Triage Team (community care mgt) ● Arundel Lodge ● Hospice of the Chesapeake ● End State Renal Disease Seamless Care Organization (ESCO) ● Prince George's and Queen Anne's County Mobile Integrated Health Unit ● Primary Care Providers (AAMG and UMG)
Patients Served	# of Patients Served as of June 30, 2020: **3,266** AAMC: **2,128** UMBWMC: **1,138**
	Denominator of Eligible ***Population***: 550,445 Denominator of Eligible ***Patients***: 3,855 From CY2019 RP Analytic File: 3+ IP or Obs>23, All Payer

Pre-Post Analysis for Intervention

ROI = 47.4 AAMC
ROI = 48.6 UMBWMC

Shared Care Alerts when measured as a program, show the highest return on investment of all interventions, with heavy overlap with community care management. Patients with a community care manager should have a care alert that includes at least their program enrollment timeframe, how they can assist and how to reach them.

Pre/Post 3-month summary for July 2019 – March 2020 (9 months) of patients TCOC reduction (June 2020 casemix data):

AAMC: Of 2,128 patients, 1,113 (52%) had an IP, ED, Obs or OP regulated space visit within 3 months pre or post.
(-$9,829,822) reduction in all hospital costs
(-$6,157) average cost per patient
(-$1,888) average cost per visit
(-6.2) visits per 10 members
32% of patients who received a Care Alert in FY20 were Medicare FFS

UM BWMC: Of 1,138 patients, 692 (61%) had an IP, ED, Obs or OP regulated space visit within 3 months pre or post.
(-$11,328,849) reduction in all hospital costs
(-$10,185) average cost per patient
(-$2,415) average cost per visit
(-13.4) visits per 10 members
55% of patients who received a Care Alert in FY20 were Medicare FFS

Intervention-Specific Outcome or Process Measures

Both hospitals and community partners achieved our goal of reducing Potentially Avoidable Utilization for patients who received this intervention. *

AAMC All-Hospital and Per-Hospital Results for PAU/Readmission/PQI Reduction
Unique Patients = 1,074 (IP, ED, Obs)

AAMC - All Hospital Change in PAU, Readmissions and PQI Visits			
All Hospital	Reduced Charges	% Reduction in Visits Post vs Pre	Visits Post vs Pre
PAU Visits	$ (3,567,037)	-45%	-313
Readmissions		-38%	-18
PQI Visits	$ (1,740,835)	-63%	-174
PAU Readmissions (IP and Obs)	$ (1,826,203)	-33%	-139

AAMC Only	Reduced Charges	% Reduction in Visits Post vs Pre	Visits Post vs Pre
PAU Visits	$ (3,701,884)	-54%	-303
Readmissions		-49%	-19
PQI Visits	$ (1,755,729)	-69%	-163
PAU Readmissions (IP and Obs)	$ (1,946,155)	-43%	-140

UM BWMC - All-Hospital and Per-Hospital Results for PAU/Readmission/PQI Reduction

Unique Patients = 917

UM BWMC - All Hospital Change in PAU, Readmissions and PQI Visits

All Hospital	Reduced Charges	% Reduction in Visits Post vs Pre	Visits Post vs Pre
PAU Visits	$ (4,231,137)	-45%	-309
Readmissions		-61%	-204
PQI Visits	$ (1,914,800)	-54%	-152
PAU Readmissions (IP and Obs)	$ (2,316,337)	-39%	-157

UM BWMC - Intrahospital Change in PAU, Readmissions and PQI Visits

UMBWMC Only	Reduced Charges	% Reduction in Visits Post vs Pre	Visits Post vs Pre
PAU Visits	$ (3,569,939)	-53%	-266
Readmissions		-61%	-145
PQI Visits	$ (1,662,042)	-47%	-136
PAU Readmissions (IP and Obs)	$ (1,907,897)	-47%	-130

*Data source: Pre/Post Export, limiting encounter date to July – March patients only, to ensure 3-month pre/post for all patients.

Successes of the Intervention in FY 2020

Awards Received in FY20 - The Shared Care Alerts intervention received recognition for new, innovative approaches to improve care coordination and cross-organizational outcomes using team-based care with measurable results. The awards and recognition included:

MD Patient Safety Center Circle of Honor Award, 2019 (8 selected out of 70 submissions)

Institute for Healthcare Improvement (IHI) conference in December 2019, presented poster session, Orlando, FL

	American Case Management Association (ACMA) 2020 Poster Session selected to present in 2021.

Behavioral Health Interventions

Integrated Behavioral Health in Primary Care (UM BWMC)

Intervention or Program Name	Integrated Behavioral Health in Primary Care
RP Hospitals Participating in Intervention	UM BWMC
Brief description of the Intervention	UMBWMC, through UM Medical Group, has integrated behavioral health resources across six (6) primary care clinics. Two (2) psychotherapists, a psychiatrist and an administrative assistant provide therapy and medication management services to patients in need. FTE's = 4.0
Participating Program Partners	The behavioral health specialists are aware of and refer patients to other medical and non-medical services as needed, both within the health system and to community services. Connection and collaboration across disciplines, including care management, is very helpful for both staff and patients.
Patients Served	# of Patients Served as of June 30, 2020: **380 new pts** Psychotherapists saw 249 new patients, 1,568 visits Psychiatrist saw 131 new patients, 256 follow-up visits
	Denominator of Eligible Patients: **550,445** RP Analytic File, All Population
Pre-Post Analysis for Intervention	Pre/Post is not helpful for this intervention as there is little 'pre' utilization, other than to use the pre/post export to study the patient utilization mix (see below).
Intervention-Specific Outcome or Process Measures	**Patient Utilization Mix 12 Months *Prior* to Start of Service (patients seen by two (2) psychotherapists)**

	High Utilizers	Rising Risk	1 Visit	0 Visits Pre
Patients	9	125	124	106
Visits	31	456	124	0
Charges	$ 504,684	$ 1,060,939	$ 324,891	0
Avg Chg/Pt	$ 56,076	$ 8,488	$ 2,620	0
Avg Chg/Visit	$ 16,280	$ 2,327	$ 2,620	0
Avg Visits/Pt	3.4	3.6	1.0	
Percent of Total Unique Pts	2%	34%	34%	29%

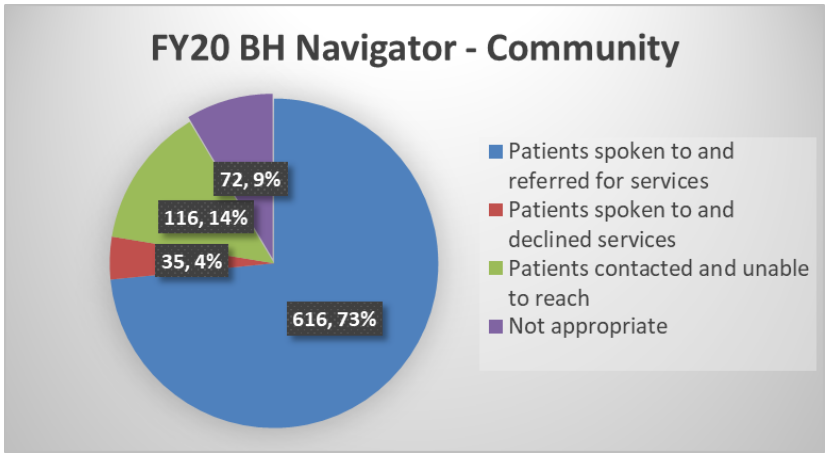
Successes of the Intervention in FY 2020	Integrating behavioral health services into primary care has improved access to care, streamlined patient holistic care, and is highly valued by PCPs and patients alike. Patient engagement increased throughout the year (an already low no-show rate decreased even further), in particular during COVID-19 (March and later). Patients value the safety and convenience of the telehealth visits and most have integrated smoothly. Due to the above factors of increased show-rate and patient satisfaction, this intervention, which is a cost minus revenue line item, had its lowest net cost, as revenue increased. Psychiatrist produced training material for PCPs detailing guidance on referrals and distinguishing between referrals to psychotherapists versus psychiatrist services.
Additional Freeform Narrative Response	Per team feedback, it may be worth implementing a model in which there is an ability for patients to be seen from their homes via telehealth, periodically, to improve access and continuity of care. The psychiatrist prepared training material for PCP's to distinguish between psychotherapy versus psychiatry referrals (what is appropriate for each). If PCPs brief patients about the nature and type of behavioral health service they are referring to, it helps to set expectations, clarify need, and reduce no-show rates for those who are not actually interested in therapy. It would be helpful for PCPs to include a note referencing why the patients are being referred in the visit note or on the referral, as sometimes the clinical concern is not readily clear in the chart or to the patient.

Behavioral Health Navigator – Community (AAMC)

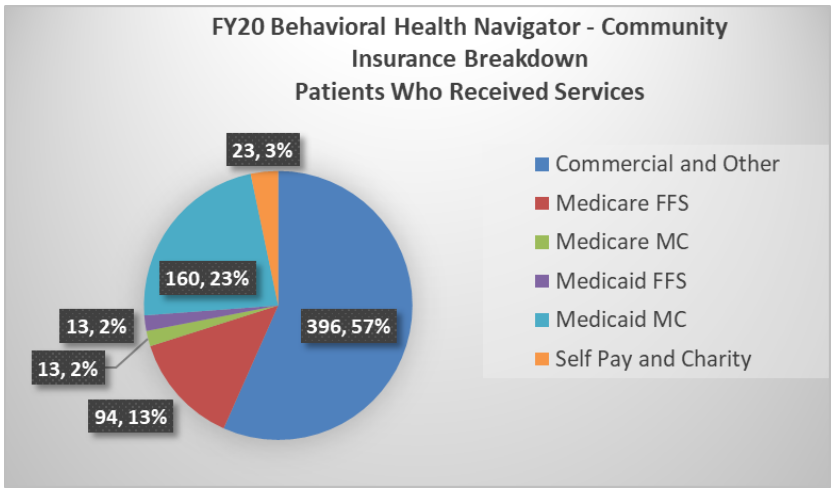
Intervention or Program Name	Behavioral Health Navigator – Community
RP Hospitals Participating	AAMC
Brief description of the Intervention	AAMC Community Behavioral Health Navigator receives referrals from PCPs for patients who have agreed to assistance. The behavioral health navigators establish relationships, workflows and referral processes with community partners. They create training material for PCPs, including patient-facing brochures with insurance and referral sources. Their primary role is to speak with patients, evaluate their need and align them with services that match their insurance, timeline, therapy and medication needs. They follow-up 30, 60 and 90 days after referral as needed. FTE = .8
Participating Program Partners	This service refers to 15 behavioral health organizations, including AAMC Outpatient Behavioral Health Services, BWMC Counseling Center, Anne Arundel County YWCA, Omnihouse Outpatient Mental Health, Arundel Lodge, Family & Children's Services of MD, Bowie Counseling Services, and several others.
Patients Served	# of Patients Served as of June 30, 2020: **699**
	Denominator of Eligible Population: **550,445** RP Analytic File, All Payer Population for BATP Denominator of Eligible Patients: **175,624** RP Analytic File, All Payer Patients CY2019 BATP Denominator: **140,000** AAMC Collaborative Care Network attributed patients
Pre-Post Analysis for Intervention	Patients are offered BH Navigation services as needed, regardless of prior utilization patterns. The utilization mix of patients served in FY20: **Patient Utilization Mix 12 months *Prior* to Service**

	High Utilizers	Rising Risk	1 Visit	0 Visits Pre
Patients	9	125	124	106
Visits	31	456	124	0
Charges	$ 504,684	$ 1,060,939	$ 324,891	0
Avg Chg/Pt	$ 56,076	$ 8,488	$ 2,620	0
Avg Chg/Visit	$ 16,280	$ 2,327	$ 2,620	0
Avg Visits/Pt	3.4	3.6	1.0	
	2%	34%	34%	29%

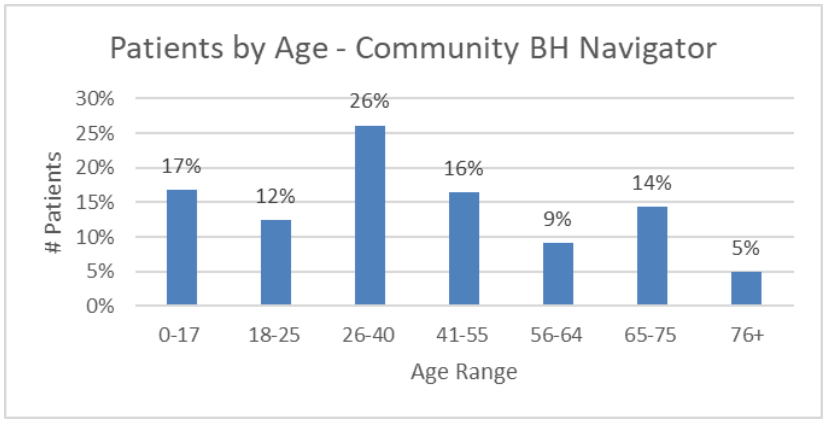
Intervention-Specific Outcome or Process Measures	Process Metrics: Number of patients referred to BH Navigator, # patients spoken to and referred for behavioral health services, # spoken to and declined, patients contacted and unable to reach, and referrals that were not appropriate (patient not interested in assistance and/or not discussed prior to referral).



Insurance breakdown: 57% of patients have Commercial/Other insurance, followed by Medicaid MC (23%), Medicare FFS (13%), etc.



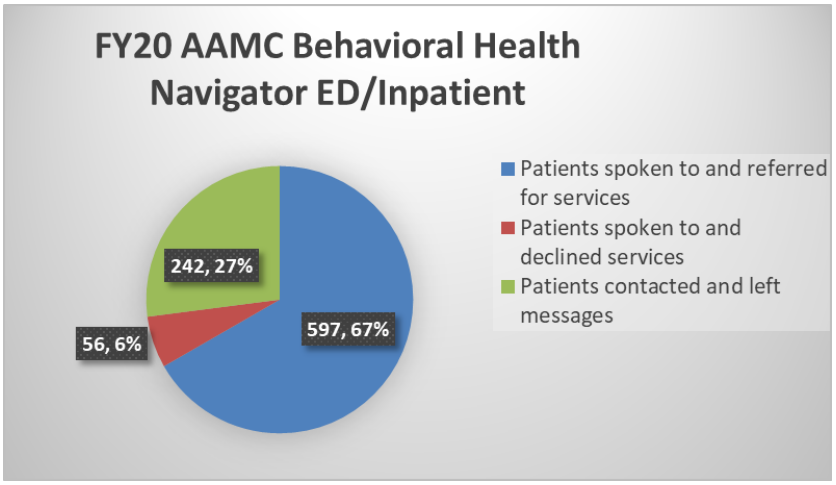
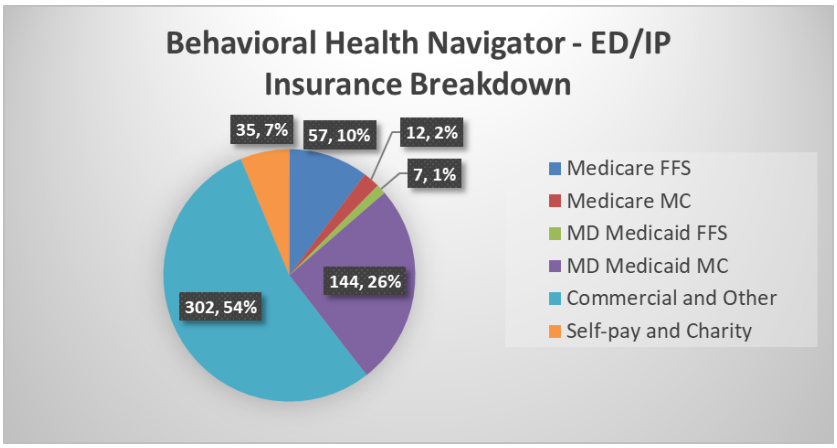
Average Age = 40

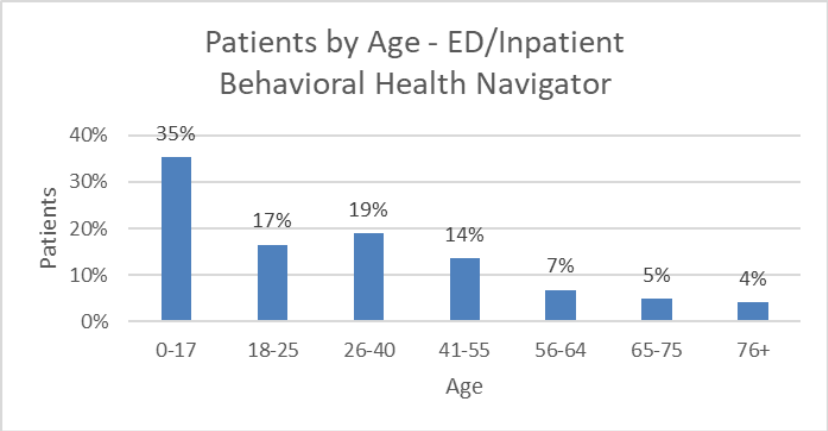


Successes of the Intervention in FY 2020	The FY20 Community BH Navigator has done an outstanding job reaching and assisting referred patients. Even with a 33% decline in referrals in the last four months of the fiscal year likely due to COVID-19, she assisted a total of 76% *more* patients than in the previous fiscal year (different resource). She attributes this success to calling multiple phone numbers and reaching out at least twice per patient for initial contact. The percentage of patients who were 'unable to reach' decreased from 43% in FY19 to 14% in FY20. The BH Navigator attributes this success to calling the patient twice, trying different phone numbers, and using a hospital phone rather than a cell phone (the patient knew it was a call from the hospital). Patients consistently express sincere gratitude for the assistance and follow-up in finding timely access to community resources for therapy and medication management based on their insurance and personal needs. Continual process improvement including communication with and education of PCPs to discuss and explain this service to patients prior to referral, has resulted in a service that has a reduced number of patients who are unable to contact or who decline service after referral.

Behavioral Health Navigator – Emergency Department / Inpatient (AAMC)

Intervention or Program Name	Behavioral Health Navigator – Emergency Department / Inpatient
RP Hospitals Participating in Intervention	AAMC
Brief description of the Intervention	The ED Behavioral Health Navigator receives referrals from both the emergency department mental health consultants and inpatient providers and clinical staff. The behavioral health navigators establish relationships, workflows and referral processes with community partners. They create training material for PCPs, including patient-facing brochures with insurance and referral sources. Their primary role is to speak with patients, evaluate their need and align them with services that match their insurance, timeline, therapy and medication needs. They follow-up 30, 60 and 90 days after referral. FTE = 1.0
Participating Program Partners	This service refers to 15 behavioral health organizations, including AAMC Outpatient Behavioral Health Services, BWMC Counseling Center, Anne Arundel County YWCA, Omnihouse Outpatient Mental Health, Arundel Lodge, Family & Children's Services of MD, Bowie Counseling Services, and several others.
Patients Served	# of Patients Served as of June 30, 2020: **559**
	Denominator of Eligible Population: **550,445**

	CY2019 RP Analytic File, All Payer Population Hospital Denominator: **74,251** CRISP Patient Total Hospitalizations (PaTH) report, filtering on AAMC, all patients, All payer, patients who had an ED or Inpatient visit in FY20.
Pre-Post Analysis for Intervention	**ROI = 13.08** Patients who receive this service have a *decrease of -9.0 visits per 10 members* 3-months pre/post, which is consistent (sustained) over the 1, 3 and 6-month pre/post time periods. The vast majority of the change in visits is attributable to all-hospital ED visits**.** FY20 Change in all hospital total charges = (-$1,349,959)
Intervention-Specific Outcome or Process Measures	 

	Average age = 31 
Successes of the Intervention in FY 2020	On average, there were 80 patients referred by the ED Mental Health Consultants or inpatient teams to the BH Navigator each month of FY20. An average of 57 per month (70%) were spoken to and referred to services. This represents a *28% increase* in the percent of referred patients who receive services over FY19 (which was 43%).
Additional Freeform Narrative Response (Optional)	This is an outstanding service as it finds and assists patients in need *as they present* to the ED and hospital settings or shortly thereafter. Having a behavioral health intervention with these types of referrals coupled with high patient acceptance has resulted in strong return on investment, which is unique within our portfolio for behavioral health services.

Pharmacy Medication Therapy Management Program - AAMC

Intervention or Program Name	Pharmacy Medication Therapy Management Program
RP Hospitals Participating in Intervention	AAMC
Brief description of the Intervention	The AAMC Pharmacy MTM program is designed to reduce 30-day all-cause readmissions for high-utilizing patients, including in-hospital, post-discharge medication reconciliation and collaboration with patients and primary care providers. Patients who have Epic readmission risk scores that meet threshold, receive medication review and counseling by the pharmacist prior to discharge, complete medication review 3 to 5 days post-discharge and PCP follow-up. The MTM team includes clinical pharmacists, pharmacist residents, pharmacy technicians, and programmatic support (IT, office, and administration), in collaboration with patients' primary care providers. The focus is on patients discharged from Anne Arundel Medical Center with a >10% risk of readmission.
Participating Program Partners	Primary Care Provider offices Community Pharmacists

	Specialists
Patients Served	# of Patients Served as of June 30, 2020: **559**
	Denominator of Eligible Patients: **66,961** RP Analytic File, 2+ IP/Obs/ED Visits 12 months prior BATP Denominator: **66,185** AAMC Total Discharges FY20, Data Source: Public Health Dashboard, CRISP
Pre-Post Analysis for Intervention (optional)	This program uses three (3) different pre/post panels: 1. Full Program: Patients who received the full service, including patient counseling, MTM with patient and follow-up with PCP and post-discharge follow-up. 2. Partial Program: Pharmacist was able to follow-up with patient or PCP but not both (i.e. patient did not have a PCP, or patient was unable to reach so pharmacist worked with PCP). 3. Full and Partial Program: All patients who received either the full program or the partial program assistance. Pre/Post results below are based on the 319 patients assisted from Jan 1, 2020 thru April 30, 2020.

Intervention		Members in the Panel	% Medicare FFS	Pre/Post Timeframe	# of patients with at least 1 visit 3-months pre or post	% of patients with at least 1 visit 3-months pre or post	Change in Total Charges (Casemix)	Average Charge/Pt Pre	Average Charge/Pt Post	Total Charge/Pt Change	Total Charge/ Visit Change	Change in Rate of Visits per 10 members	Time period	ROI (.5*Change in Charges) minus Cost/ (Cost)
Pharmacy MTM and Community Follow-up (Full Program) AAMC	All Payer	181		3 mo	181	100%	$ (2,616,352)	$ 21,886	$ 13,450	$ (8,436)	$ (2,205)	-16.1	4 mo	**12.60**
	Medicare FFS	119	66%	3 mo	119	100%	$ (1,602,880)	$ 20,766	$ 14,005	$ (6,761)	$ 1,872	-15.0		
Pharmacy MTM and Community Follow-up (Partial Program) AAMC	All Payer	145		3 mo	143	99%	$ (1,578,335)	$ 23,547	$ 22,085	$ (1,462)	$ (1,428)	-10.6	4 mo	**7.20**
	Medicare FFS	89	61%	3 mo	88	99%	$ (1,173,385)	$ 22,458	$ 16,058	$ (6,400)	$ (2,443)	-11.5		
Pharmacy MTM and Community Follow-up (Full or Partial Program) AAMC	All Payer	319		3 mo	317	99%	$ (3,999,691)	$ 22,376	$ 17,281	$ (5,095)	$ (1,755)	-13.2	4 mo	**19.79**
	Medicare FFS	202	63%	3 mo	201	100%	$ (2,591,351)	$ 21,005	$ 14,825	$ (6,180)	$ (2,092)	-12.8		

Intervention-Specific Outcome or Process Measures	

Average Readmission score	17%
Medication Therapy Problems (MTP) identified	408
MTP immediately resolved	52
Category of Medication Therapy Problems	
Indication	137
Effectiveness	81
Safety	132
Compliance	84

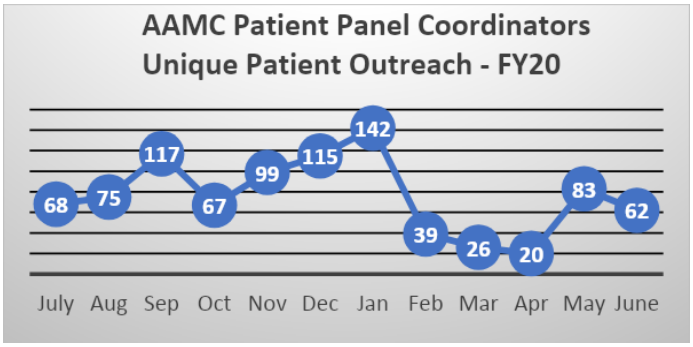
Successes of the Intervention in FY 2020	**ROI=12.60 (Full Program)** Per above outcome metrics, patients who received full program services (pharmacists worked with the patient on medication review, education and reconciliation, followed-up with PCP) overall had a change in total charges of (-$2.6M) and a reduction of visits of -16.1 per ten members. (Jan – Apr patients, July 2020 casemix). Although patients who received partial assistance (pharmacist worked with the patient directly, or worked with the PCP, but not both), showed a significant reduction in all-hospital costs and visits, and an ROI of 7.2, this is a much lower return and change in charges and visits than when patients received full program assistance. All patients (full or partial program) cumulative reduction in costs (-$3.9M), per patient change in charges of (-$5,095) and -13.2 visits per 10 members was also significant.

Practice Panel Coordinators - AAMC

Intervention or Program Name	Practice Panel Coordinators
RP Hospitals Participating in Intervention	AAMC
Brief description of the Intervention	Patient Panel Coordinators 1.46 FTE's assisted 12 primary care offices and over 900 patients by using dashboards to identify gaps in care or opportunities to improve key health maintenance factors, including controlling Diabetes A1C, Hypertension, colorectal screening and tobacco use and cessation screening.
Participating Program Partners	Primary Care Provider offices associated with the AAMC Collaborative Care Network (CCN), a clinically integrated network.

<table>
<tr><td>Patients Served</td><td># of Patients Served as of June 30, 2020: 913</td></tr>
<tr><td></td><td>Denominator of Eligible Population: 550,445
All Payer Population, RP Analytic File

Denominator of Eligible Patients: 174,624

BATP Denominator of Eligible Patients: 140,000
Approximate patients attributable to the Collaborative Care Network (CCN) Primary Care offices.</td></tr>
<tr><td>Pre-Post Analysis for Intervention</td><td>Not applicable.</td></tr>
<tr><td>Intervention-Specific Outcome or Process Measures</td><td>Process Metrics: Monthly Patient Outreach
 

The panel coordination work transitioned to a single resource in February 2020, with the work transitioning to other roles within the primary care practices as part of the overall strategy and restructuring for MDPCP.

<table>
<tr><td>FY20 Goal: For All Offices to Reach Goal in Each Measure</td><td></td></tr>
<tr><td></td><td>Jun-20</td></tr>
<tr><td>Diabetes A1C Poor Control</td><td>1 of 12 offices achieved goal</td></tr>
<tr><td>Controlling Hypertension</td><td>0 of 12 offices achieved goal</td></tr>
<tr><td>Colorectal Screening</td><td>0 of 10 offices achieved goal</td></tr>
<tr><td>Screening for Tobacco Use and Cessation</td><td>1 of 2 offices achieved goal</td></tr>
</table>
Outcome Metrics:
COVID-19 had a significant impact on AAMG Primary Care offices reaching goals for chronic condition management in FY20. Starting in February, Patients were very reluctant to seek care. Offices closed and had to navigate becoming proficient in telemedicine. The community care management team supported the effort by guiding patients who had access to MyChart to schedule appointments and coordinated with primary care offices to accept patients. Many chronic conditions worsened during this time period as patients struggled with access to medications, medications adjustments and affordability. PPC leadership is expecting to see a</td></tr>
</table>

	recovery period with regard to chronic condition management and goals as PCP office use of telemedicine increases and becomes more part of the norm, and patient engagement improves.
Successes of the Intervention in FY 2020	The PCP offices, Practice Panel Coordinators and Community Care Management Teams have worked closely together to succeed in the transition from office-based care to adjusting outreach, scheduling, patient visits and follow-up using telehealth capabilities. Along with the new workflows, documentation and procedures, the teams have worked with IT to refine CCN Dashboards to track and report metrics, so they can effectively communicate performance to providers and staff, find opportunities for improvement and efficiencies and share them across care providers and teams.

Fire/EMS Programs

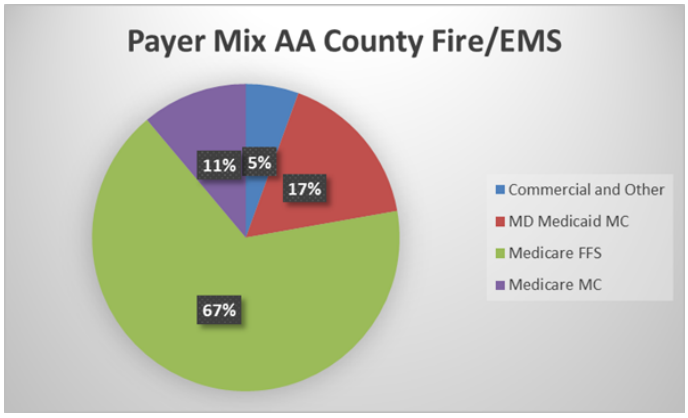
Queen Anne's County Fire/EMS Mobile Integrated Community Health Program

Intervention or Program Name	QA County Fire/EMS Mobile Integrated Community Health Program
RP Hospitals Participating in Intervention	AAMC
Brief description of the Intervention	The Queen Anne's Mobile Integrated Community Health program is a highly successful program which provides home-based visits by community health nurses and paramedics to assess patient needs for medical and non-medical support. The team includes an addictions counselor, pharmacist support and peer specialist as well as programmatic support (IT, Office, administration). The focus is on high utilizers of emergency services and emergency departments. AAMC contributes 15% of the funds for this service. The goal of this program is to reduce 30-day readmissions for high utilizing patients. QA MICH program goal is to keep patients out of the hospitals and ED's for at least 30 days, noting that the results show a reduction in visits 90-days post intervention.
Participating Program Partners	QA MICH assists patients and also refers them as needed to various community services/support.
Patients Served	# of Patients Served as of June 30, 2020: **99**
	Denominator of Eligible Population: **50,381** Queen Anne's County population 2019 Denominator of Eligible Patients: **11,034** Queen Anne's County Patient Population (CRISP Pub Health Dashboard, FY20) High Utilizers Queen Anne's County FY20: **179** CRISP Population Health Dashboard, FY20

Pre-Post Analysis for Intervention	**Pre/Post Results**, 3-month, All Hospital, All Payer: Change in Total Charges (-$821,266) Average Charge/Pt Pre $21,626 Average Charge/Visit Pre $20,570 Change in Average Charge/Pt (-$1,055) Average Charge/Visit (-$4,090) Change in Rate of Visits per 10 Members (-4.0) ED Visits: When limited to all-hospital ED Visits, the change in visits per 10 members is -8.3 using 3-month pre/post, and -7.3 at 6-months pre/post.
Intervention-Specific Outcome or Process Measures	Fire/EMS tracks 911 call frequency, which is primary referral criteria in appropriate referrals for the service.
Successes of the Intervention in FY 2020	The QA MICH program continues to use data analytics to study and improve their program. By performing analysis based on the pre/post trends, they studied patient utilization patterns and saw an increase in patient ED/hospital utilization at 12 months 'post' intervention in FY19. In FY20, they changed their program to have additional outreach, including four (4) touchpoints; An initial in-person visit, a 3-month follow-up call, a 6-month in-person visit and a 12-month follow-up call. Patient utilization patterns post-intervention improved following this adjustment to the model.

Anne Arundel County Fire/EMS Mobile Integrated Community Health Program

Intervention or Program Name	Anne Arundel County Fire/EMS Mobile Integrated Community Health Program
RP Hospitals Participating in Intervention	All
Brief description of the Intervention	AA County Fire/EMS in FY20 began exploring foundational work for a future mobile integrated community health program, starting with assisting frequent 911 callers with assistance from two (2) social workers from the AA County Department of Aging, who assess and align patients with medical and non-medical resources. The BATP hospitals, Fire/EMS and the Department of Aging team members met regularly with and assisted in developing the program, scope, operational processes and measurement plans.
Participating Program Partners	Anne Arundel County Fire/EMS Anne Arundel County Department of Aging & Disabilities Anne Arundel Medical System UM Baltimore Washington Medical System

Patients Served	# of Patients Served as of June 30, 2020: **49**
	Denominator of Eligible Patients: **550,445** RP Analytic File, All Population Program-specific denominator: approx. **400** Frequent 911 callers, Fire/EMS database
Pre-Post Analysis for Intervention (Optional)	55% (27) of patients served by this program had an MRN for **both** AAMC and UMBWMC (*shared* patients), 18% (9) had AAMC MRN's only, and 27% (13) had UMBWMC MRN's only. Since CRISP pre/post restricts panels to a single MRN source and 'n' is small, we combined UMBWMC and shared patients into a single panel for overall program results, noting results are 'all hospital' visits and charges. Results 3-month Pre/Post: 25 patients had data for the 3-month pre/post report. Those 25 patients had a decrease in average charges per patient of (-$8,708), an average decrease of (-$1,168) per visit, and -2.3 visits per 10 members. Change in All Hospital Charges: (-$108,384)
Intervention-Specific Outcome or Process Measures	
Successes of the Intervention in FY 2020	Assisted 49 frequent 911 callers, and reduced unnecessary use of 911 and hospital/ED services by helping with DME, alignment with medical care, caregiver services, and other support. Fire/EMS studied and met with successful programs from other counties, and applied lessons learned to this program, such as frequency of contact and follow-up. The partnership Program Manager trained the Fire/EMS program and quality resources on program measurement techniques using CRISP tools and options for future measurement. Contracts signed for use of Halo secure texting, with implementation and use of CRISP services pending.

	The program is phasing in to receiving hospital referrals of high needs/high utilizer patients.

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	**Measure for FY 2020 Reporting**	**Outcomes(s)**
Total Hospital Cost per capita	**Partnership IP Charges per capita** RP Analytic File: 'Charges' over 'Population' (Column E / Column C)	Charges: $1,543,366,677.45 Population: 550,445 **= $2,803.85**
Total Hospital Discharges per capita	**Total Discharges per 1,000** RP Analytic File: 'IPObs24Visits' over 'Population'*1000 (Column G / Column C) *1000	IPObs24Visits = 59,884 Population = 550,445 **= 10.9%** **109**
ED Visits per capita	**Ambulatory ED Visits per 1,000** RP Analytic File 'ED Visits' over 'Population' (Column H / Column C) *1000	ED Visits: 174,993 Population: 550,445 **= 31.8%** **318**

Quality Indicator Measures

Measure in 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) Analytic File:	IP Readmit (J) = 4,642 Eligible for Readmit (I) = 39,152 Unadjusted Readmission Rate for Partnership: **11.9%**

	'IP Readmit' over 'EligibleforReadmit' (Column J / Column I)	Source: RP Analytic File, CY2020 (Using Exec Dashboard Average = 11.8%)
PAU	**Potentially Avoidable Utilization** Executive Dashboard: '[Partnership] Quality Indicators' – Potentially Avoidable Utilization, reported as **sum** of 11 months of FY 2020 Analytic File: 'TotalPAUCharges' (Column K)	**PAU = $94,226,844** Sum of 11 months, July 2019 – May 2020, June casemix data, Executive Dashboard

CRISP Key Indicators

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	**Measure for FY 2020 Reporting**	**Outcomes(s)**
Portion of Target Population with Contact from Assigned Care Manager	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.*	AAMC = 12.36% average monthly % of HU's with Community Care Manager in last 6 months of FY20 UMBWMC = 13.49% average monthly % of HU's with Community Care Manager in last 6 months of FY20 Source: Executive Dashboard 'High Needs' section

Self-Reported Process Measures

All process measures are included in intervention sections.

Return on Investment

Annual Cost per Patient as calculated by:

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

AAMC: $636.20

UM BWMC: $782.79

Note: Annual Cost per unique patient does not include patients assisted by Fire/EMS programs (AA and QA County), Practice Panel Coordinator outreach (AAMC) or Pharmacy Program (AAMC).

Impact of COVID-19 on Interventions

As described in the individual program sections, COVID-19 impacted hospital/ED census and thus impacted the numbers of patients being assessed and referred out to community programs from March through June 2020, anywhere from 25% to 37% decrease. In the first 8 months of the fiscal year prior to COVID-19 impact, the hospitals each had an average of 550 high utilizers (*no age restriction*) being discharged each month (non-unique across months). During the COVID time period of March 2020 through June 2020, there were an average of 415+ high utilizer discharges, a 24% decrease. Rising risk patients decreased to 2,000 for BWMC and 2,430 for AAMC during COVID, a 23% decrease for BWMC and a 29% decrease for AAMC as compared to normal monthly discharge rates of 2,600 for BWMC and 3,427 for AAMC.

Although referrals were down, our community care management and integrated behavioral health programs demonstrated a higher number of referred patients who accepted service as they welcomed hospital and community program outreach during the pandemic and appreciated the communication and assistance without the risk of in-home visits.

Intervention Continuation Summary

All BATP programs are continuing beyond grant funding.

Opportunities to Improve Future Grant Programs

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.

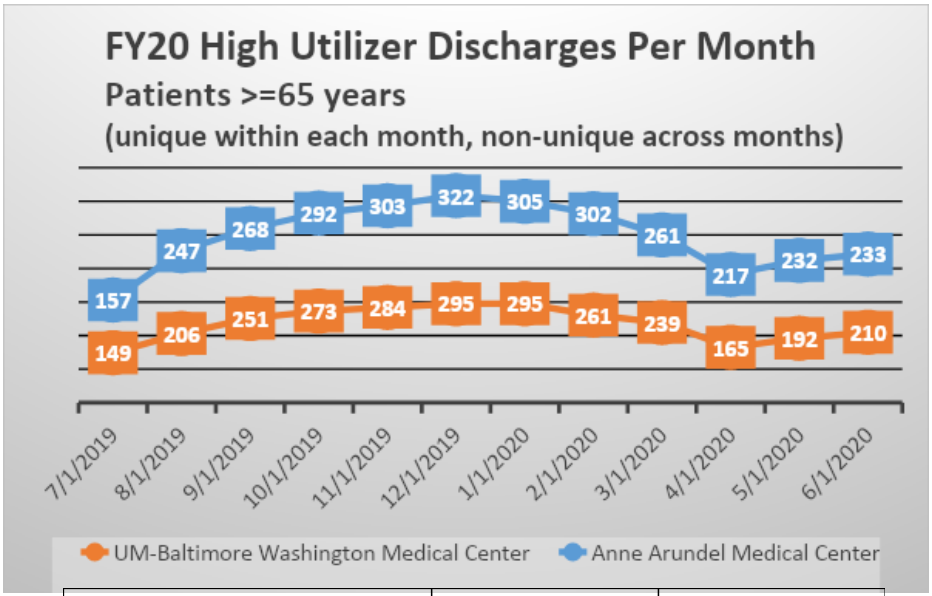
It would be helpful for HSCRC to:

1. Use reports, data analytics and lessons learned from previous program qualitative and quantitative reporting to understand the workforce effort, cost and timelines required to positively impact populations, including what percent of a population can be assisted. This would help to inform and manage expectations for future programs and to aid in setting aggressive but realistic goals.

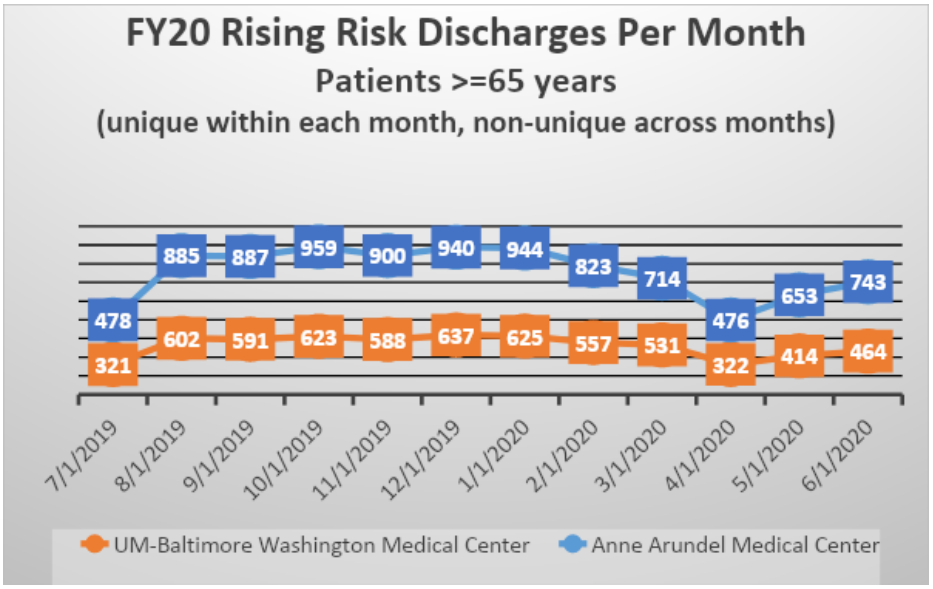
2. Build upon the information gathered in # 1 by having state-wide discussion and learn together so as not to repeat mistakes and to take advantage of efficiencies to address recurring gaps that require new or improved services.

3. Examine the outcome of items # 1 and # 2 above and assist in policy changes at the state, local and federal levels as needed.

Appendix A - BATP High Utilizer and Rising Risk Discharges, FY20[4]



High Utilizers >=65 years	UM BWMC	AAMC
FY20 Monthly Average	235	262
Average Pre COVID	252	275
Average Post COVID	202	236
% Decrease during COVID	-20%	-14%



Rising Risk >=65 years	UM BWMC	AAMC
FY20 Monthly Average	523	784
Average Pre COVID	568	852
Average Post COVID	433	647
% Decrease during COVID	24%	24%

[4] Data Source: CRISP Public Health Dashboard, Trend tab filtered by 'hospital' and 'patient' and Need Types (high need and rising risk), Age Restricted to >=65 years, timeframe FY20