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	
RP Hospital(s)	CalvertHealth Medical Center
RP Point of Contact	Melissa Carnes, Grant Development Coordinator
RP Interventions in FY 2020	1
Total Budget in FY 2020 *This should equate to total FY 2017 award*	FY 2020 Award: $252,000
Total FTEs in FY 2020	Employed: 6.29
	Contracted: 0.15
Program Partners in FY 2020 *Please list any community-based organizations or provider groups, contractors, and/or public partners*	Calvert County Office on Aging Southern Pines Senior Center Calvert Pines Senior Center North Beach Senior Center CalvertHealth Medical Group Asbury Solomons Results Fitness Community Life Center of Southern Calvert County Calvert County Health Department Calvert County Health Ministry Network Team Weis Pharmacy - Lusby Walmart Prince Frederick-Pharmacy Giant Pharmacy – Dunkirk Project Echo Homeless Shelter Calvert County Library – Prince Frederick and Solomons Safe Nights Program On Our Own, Homeless shelter

	Southern Pines Senior Apartments St. John Vianney Food Pantry SMILE Food Pantry Chesapeake Cares Food Pantry Ladies of Charity Food Pantry SEEDCO

Overall Summary of Regional Partnership Activities in FY 2020

(Freeform Narrative Response: 1-3 Paragraphs):

Through the It Takes A Village (Villages) program, CalvertHealth continues to reach the local Medicare, Medicaid and uninsured eligible target population to bring health and wellness services to the vulnerable population of Calvert County. The main principles of our program are:

- Take the care where it is needed most
- Address locally identified needs
- Utilize available resources
- Expand a long-standing relationship with the local Office on Aging
- Build upon successful programs using engaged staff and volunteers
- Create a platform for growth of the program.

Services continue to be delivered at the three Calvert County Office on Aging Senior Centers located in north, central and southern Calvert County. Partnerships continue with churches, food pantries, underserved neighborhoods and town centers. Program staff includes: social workers, registered nurses, dieticians, personal trainers, weight loss/diabetes counselors, physicians, physician assistants, nurse practitioners, and a health care concierge who provides health risk assessments, screenings, and referrals for care coordination. We also partner with a social worker from SEEDCO that screens people for, and assists with enrollment in the state health insurance exchange. In FY 2020, a total of 527 people were seen through the Villages program at the senior centers; an additional 396 people, age 50 and over, were served on the CalvertHealth Mobile Health Unit via 90 visits to various locations throughout Calvert.

Intervention Program

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

Intervention or Program Name	CalvertHealth Transformations Grant – It Takes a Village
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	CalvertHealth Medical Center

Brief description of the Intervention *2-3 sentences*	The It Takes a Village program continues to provide a diverse range of health services to each of the three Calvert County Senior Centers, as well as to local town centers and faith-based partnering organizations to bring needed health services to our targeted population aligned with our HSCRC grant. Program participants are referred to appropriate program partners, including providers and services available at CalvertHealth. The dietitian and personal trainer teamed up to offer an additional service in FY 2020: Wellness Fridays at the senior centers.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	Calvert County Office on Aging Southern Pines Senior Center Calvert Pines Senior Center North Beach Senior Center CalvertHealth Medical Group Asbury Solomons Results Fitness Community Life Center of Southern Calvert County Calvert County Health Department Calvert County Health Ministry Network Team Weis Pharmacy - Lusby Walmart Prince Frederick-Pharmacy Giant Pharmacy – Dunkirk Project Echo Homeless Shelter Calvert County Library – Prince Frederick and Solomons Safe Nights Program On Our Own, Homeless shelter Southern Pines Senior Apartments St. John Vianney Food Pantry SMILE Food Pantry Chesapeake Cares Food Pantry Ladies of Charity Food Pantry SEEDCO
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: 1977 Denominator of Eligible Patients: **91,399**

Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	
Intervention-Specific Outcome or Process Measures (optional) *These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership maintains and uses to analyze performance.* *Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.*	**IT TAKES A VILLAGE PROGRAM STATISTICS (Senior Centers)** July 2019 – June 2020 Total number of people seen: 527 Number of locations served: 3 <u>Southern Pines Senior Center:</u> 181 Nurse – 141 Wellness Fridays – 19 Social worker – 21 <u>Calvert Pines Senior Center: 81</u> Nurse – 43 Wellness Fridays - 33 Social worker - 5 <u>North Beach Senior Center:</u> 265 Nurse – 253 Wellness Fridays - 8 Social worker – 4 As if March 12, 2020 all community outreach activities were cancelled due to the Pandemic. Additionally, members of the target populations were seen on the CalvertHealth Mobile Health Unit throughout Calvert County at partnering organizations, churches and businesses in an effort to avoid ED utilization, and connect people needing care to physicians, specialists and local health resources. **<u>COMMUNITY MOBILE HEALTH CENTER STATISTICS</u>** July 2019 – June 2020 Number of locations served: 90 Number of community members served : 772 Male: 278 (over age 50 = 126) Female: 494 (over age 50 = 270) Total # of referrals issued: 41 PCP Office: 9 Office on Aging: 1 Dental Clinic : 1 CCHD: 1

	Smoking cessation: 2 Resource Info.: 6 Urgent Care/ER: 2 SEEDCO (Insurance): 17 Breast Center: 2 <u>Services Provided</u> Blood pressure screenings: 312 Flu Clinics: 9 # of Flu Shots given: 80 Glucometers: 4 Dental Screening Events: 7 # of children seen: 247 Free Medical Clinics: 9 # of participants: 47 Dietary Presentations: 3 # of participants: 25 Manual Breast Exams: 5 COVID-19 Screenings: 1 event, 9 participants, 1 tested As of March 12 all community outreach events were cancelled due to the COVID-19 Pandemic.
Successes of the Intervention in FY 2020 *Freeform Narrative Response, up to 1 Paragraph*	We continued with the community coordination care team and the continuum of care for Diabetes, in collaboration with Calvert County Health Department, Office on Aging, CalvertHealth Medical Center, Ask The Experts, and Faith based organizations. Evidenced based self- management programs, as well as hospital based programs were offered while navigating participants to programs based upon their needs and readiness to learn. A low cost, no commitment fitness membership through Results Fitness was available to participants for access to physical activity to help with weight loss and reduce complications of diabetes. Rock Steady Boxing continued and grew, adding additional classes to people living with Parkinson's Disease to improve their fitness, and improve overall Parkinson's symptoms.
Additional Freeform Narrative Response (Optional)	For FY 2020, our goals are: (1) to get the cholestech and glucometer up and running on the mobile health unit (achieved), (2) to partner with all food pantries for the flu vaccination program for those with no insurance coverage and (Achieved), (3) to complete IT installation on the mobile unit. (Achieved) Still working to get a documentation platform built in the Medical Center's EHR for seamless use for patients receiving care on the mobile unit. We added a pharmacist to the Ask the Expert program. This was due to begin in mid-March, 2020. Due to the COVID-19 Pandemic the senior centers were closed, and all of our community outreach services were cancelled as of March 12, 2020.

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)	Charges: $224,477,283 Population: 91,399 Charges per capita: $2,456 Source: CY 2019 RP Analytic File
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)	Inpatient/OBS Visits: 8,822 Population: 91,399 Inpatient/OBS Visits over population: 0.096 Source: CY 2019 RP Analytic File
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)	ED Visits: 33,953 Population: 91,399 ED visits over population: 0.37 Source: CY 2019 RP Analytic File

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- Analytic File: 'IP Readmit' over 'EligibleforReadmit' (Column J / Column I)	Inpatient Readmits: 658 Eligible for readmit: 5,833 Readmission Rate: 11.3% Source: CY 2019 RP Analytic File
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: $21,741,527

		Source: CY 2019 RP Analytic File

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.*	January 2020 – 21.8% February 2020 – 22.2% March 2020 – 23.8% April 2020 – 20.7% May 2020 – 18.7% June 2020 – 9.9% Average: 19.5% Source: Executive Dashboard for Regional Partnerships

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.

Within each geographic areas (northern, central and southern) exist a community coordination care team which includes health care professionals such as a Registered Nurse, Registered Dietitian, Social Worker, Community Health Workers, Personal Trainers, and newly added Pharmacist. Community based resources are also included, provided by non-profits, to meet the needs of that community, handle program tracking, referrals, and getting insurance coverage for eligible participants. For many of the outreach events, a representative from SEEDCO is present to assist participants in determining their eligibility for the Maryland Health Insurance Exchange, and in enrolling them in a plan if they are eligible.

We have built capacity within each geographic area to assist with expanding the network of support to assist with caring for the target population. The unifying factors for each geographic location are the healthcare professionals and Mobile Health Center contained in this grant. We are still working on

implementation of a centralized data collection tool that may help to support unified care plans and additional outcome measures can be collected.

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)

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.

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.

Reaching the target population at the senior centers, a key element of the Villages grant program since inception, has been an instrumental factor in our program's success to date. We do not "only" serve the target population at the local senior centers: we have expanded our reach to other areas in need in our county, and will continue to do so in the coming years.

Specific enhancements include:

- Ask-the-Pharmacist and medication reconciliation program
- Free mobile clinics staffed by a physician, nurse practitioner, and/or physician assistant
- COVID testing

One of our many success stories includes:

- We had our first Free COVID screening, and testing in June, at one of the food pantries targeting those without insurance and without a PCP. We set it up to be drive thru which worked out good since the pantry was drive thru also. The mobile unit was manned with a Physician Assistant and Registered Nurse. We had a representative from the MD Health Exchange who was set up to enroll individuals that qualified, on the spot, with eligibility effective June 1st. The brief screenings were done by the social worker, and med. tech., and a canopy was set up with a Registered Nurse to do the test. Over 20 individuals wanted to get tested, but did not meet criteria. The pantry had 46 patrons. 3 people were able to get insurance, and another needed

follow up in another county. 2 accepted the PA as their new Primary Care Provider and 1 was referred to our nurse for drive thru COVID test.

- Due to the success, 4 more clinics were planned for the first month of FY 2021. We expect to continue to do more of these clinics, and will now model the Flu Shot Clinics scheduled for Fall 2020 after the drive thru format, due to the COVID-19 Pandemic.

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.

- Some of the delay in implementing services and programs was due to competing priorities of certain program stakeholders. Earlier involvement and buy in of program stakeholders to increase scheduling of programs, and to make sure the infrastructure and technology exist to support the planned work of the programs may have helped avoid some of the delay, and allowed earlier deployment of some programs.