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.

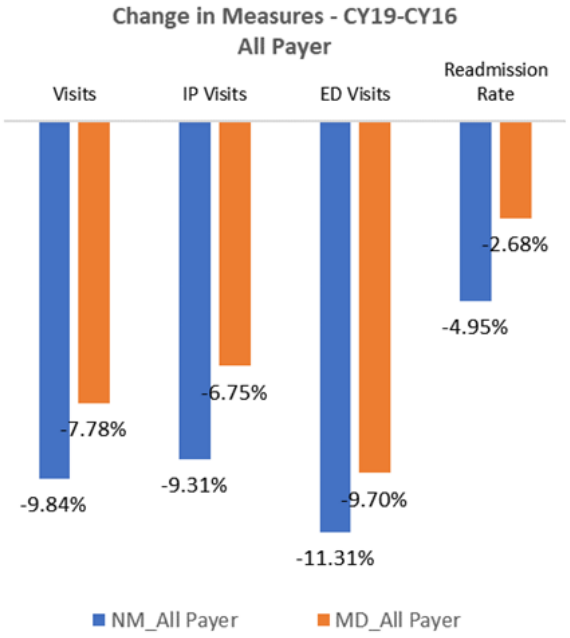
Regional Partnership Information

Regional Partnership (RP) Name	Nexus Montgomery
RP Hospital(s)	Adventist HealthCare Shady Grove Medical Center, Adventist HealthCare White Oak Medical Center, Holy Cross Germantown Hospital, Holy Cross Hospital, MedStar Montgomery Medical Center, and Suburban Hospital, a member of Johns Hopkins Medicine
RP Point of Contact	Susan Donovan, Managing Director, Nexus Montgomery
RP Interventions in FY 2020	1. Wellness for Seniors at Home (WISH) 2. Hospital Care Transitions (HCT) 3. Severely Mentally Ill (SMI) 4. Specialty Care for the Uninsured (Project Access) 5. Skilled Nursing Facility (SNF) Alliance 6. Voice Your Choice (formerly Community Advance Directives Program)
Total Budget in FY 2020 *This should equate to total FY 2017 award*	FY 2020 Award: $ 7,663,683
Total FTEs in FY 2020	Employed: 22.36
	Contracted: 17.53
Program Partners in FY 2020 *Please list any community-based organizations or*	Primary Care Coalition (PCC) Cornerstone Montgomery Jewish Social Service Agency (JSSA) Sheppard Pratt Health System SNF Alliance Members (36 Skilled Nursing Facilities) The Coordinating Center (TCC)

provider groups, contractors, and/or public partners	Montgomery County Department of Health and Human Services There are many additional community partners involved with Nexus Montgomery, including other local nonprofits and public health departments. In addition, Nexus Montgomery partners with CRISP, PointRight and our QIO to provide data support.

Overall Summary of Regional Partnership Activities in FY 2020

(Freeform Narrative Response: 1-3 Paragraphs): In its fourth and final year of operating under the HSCRC Transformational Grant program, Nexus Montgomery impacted over 100,000 community members through its six programs. Since Nexus Montgomery began, these programs have contributed nearly $30M of gross savings in support of the Maryland Total Cost of Care model, resulting in a strong return on investment for key programs. These savings have contributed to declining utilization at Nexus Montgomery hospitals, which often started off lower and has decreased at rates faster than Maryland overall for both the All Payer and Medicare populations (below).



Data Source: Case-mix Data, CRISP Public Health Dashboard

FY20 was a year of sustainability and adaptability for Nexus Montgomery. When COVID-19 struck, Nexus Montgomery quickly adapted to support hospitals and clients in new ways: converting from in-person to virtual support, preserving patients' access to services, and supporting Skilled Nursing Facilities in establishing COVID-19 safe practices. Four of six programs, including Hospital Care Transitions, Severe Mental Illness/Behavioral Health, Skilled Nursing Facility Alliance, and Voice Your Choice (formerly Community Advance Care Planning), were successfully sustained in some capacity beyond the conclusion of the Transformation Grants. The Nexus Montgomery partnership infrastructure was also sustained and continues to serve as the vehicle for hospitals to collectively improve health, prevent utilization and impact total cost of care in ways no single hospital could on its own.

Intervention Program

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

Intervention or Program Name	Wellness and Independence for Seniors at Home (WISH)
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	All Nexus Hospitals
Brief description of the Intervention *2-3 sentences*	Wellness and Independence for Seniors at Home (WISH) helps eligible seniors optimize health, remain independent at home, and reduce avoidable hospital use by connecting them to the services they need before their health declines. Eligible seniors were those living in the targeted Independent Living Facilities (ILFs). Working through lay health coaches that are backed by Registered Nurses, seniors at risk of declining health receive an assessment of their health and social risks. Those at high risk for hospitalization receive ongoing individualized health coaching based around mutually agreed upon self-management goals and are connected with community-based support to help keep them out of the hospital.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	1. The Coordinating Center (TCC) 2. Participating Independent Living Facilities (See Appendix A)
Patients Served	# of Patients Served as of June 30, 2020: FY20: 1,615

*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.*	Cumulative: 5,080[1] Denominator of Eligible Patients: **Program Denominator:** 5,208 (Total Unique Beneficiaries in the ILF Buildings, from HQI, resident in 46 Independent Living Facilities) RP Analytic File: 31,621 patients[2] (2+ Chronic Conditions & Medicare FFS)
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	A Pre-Post analysis of actively enrolled clients shows a decrease in 1-, 3-, And 6-month hospital utilization after initial enrollment in the WISH program. The full Pre-Post report is included in Appendix B. Data limitation: The structural design of the Pre-Post reporting portal combined with the nature of engagement in the WISH program, make it challenging to view the cumulative Pre-Post impact of the WISH program. Once enrolled, participants remain engaged in the WISH program, cycling through active and passive episodes based on their current need. The Pre-Post report triggers off a client's original enrollment date, when the largest impact of the program is expected. However, the Pre-Post portal is not designed to monitor clients for longer than 12 months post enrollment and participants roll off the report 12 months from their enrollment regardless of their current status. Due to this, only 278 participants are currently captured in the Pre-Post reporting for the WISH program.

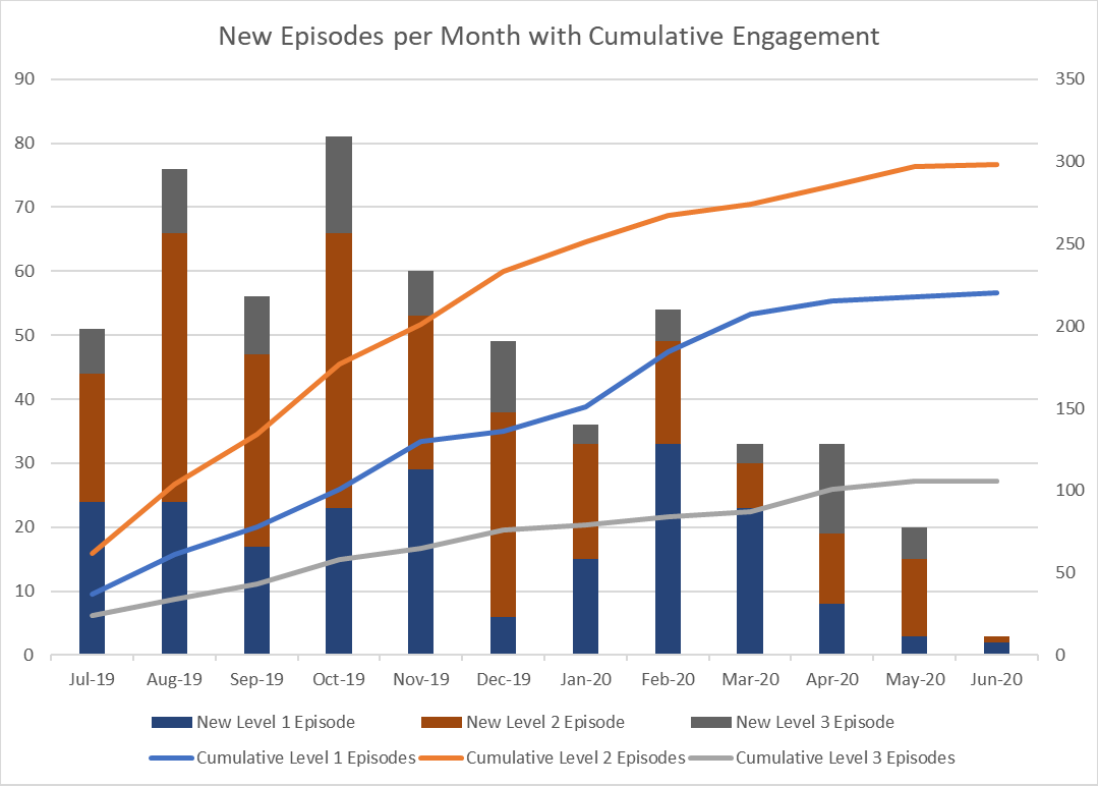
[1] Ever Engaged participants are individuals who have consented to participate in the program since October 2016. WISH has been focusing exclusively on the Independent Living Facilities since FY18.

[2] The RP Analytic File population significantly overstates the population for this program, as it is not restricted to residents of the target ILFs. Additionally, participants do not specifically require 2 chronic diseases to be eligible to become engaged. Enrollment is based on a risk assessment completed by health coaches.

WISH Pre-Post Reporting															
FY20															
All Hospital Pre-Post	n	Total Charges			Total Number of Visits			Average Charges per Visit			Average Charges per Member			% decrease in visits
		Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	
All Hospital 1 Month	278	$388,694	$257,434	$ (131,260)	75	29	-46	$5,183	$8,877	$ 3,694	$7,933	$11,702	$ 3,769	-61%
All Hospital 3 Month	243	$718,377	$387,707	$ (330,670)	150	80	-70	$4,789	$4,846	$ 57	$9,330	$7,754	$ (1,576)	-47%
All Hospital 6 Month	166	$911,934	$539,533	$ (372,401)	169	116	-53	$5,396	$4,651	$ (745)	$16,285	$10,791	$ (5,494)	-31%
FY20															
In Patient Pre-Post	n	Total Charges			Total Number of Visits			Average Charges per Visit			Average Charges per Member			% decrease in visits
		Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	
In Patient 1 Month	278	$243,602	$213,952	$ (29,650)	17	12	-5	$14,330	$17,829	$ 3,499	$17,400	$23,772	$ 6,372	-29%
In Patient 3 Month	243	$430,781	$238,964	$ (191,817)	32	19	-13	$13,462	$12,577	$ (885)	$15,385	$14,057	$ (1,328)	-41%
In Patient 6 Month	165	$623,369	$400,770	$ (222,599)	34	31	-3	$18,334	$12,928	$ (5,406)	$31,168	$16,699	$ (14,469)	-9%
FY20															
ED Pre-Post	n	Total Charges			Total Number of Visits			Average Charges per Visit			Average Charges per Member			% decrease in visits
		Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	
ED 1 Month	27	$36,236	$11,135	$ (25,101)	28	11	-17	$1,294	$1,012	$ (282)	$1,812	$1,237	$ (575)	-61%
ED 3 Month	47	$65,070	$46,025	$ (19,045)	53	35	-18	$1,228	$1,315	$ 87	$1,914	$2,092	$ 178	-34%
ED 6 Month	42	$70,979	$58,418	$ (12,561)	58	52	-6	$1,224	$1,123	$ (101)	$2,535	$2,655	$ 120	-10%
FY20															
Obs Pre-Post	n	Total Charges			Total Number of Visits			Average Charges per Visit			Average Charges per Member			% decrease in visits
		Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	
Obs 1 Month	258	$108,856	$32,347	$ (76,509)	30	6	-24	$3,629	$5,391	$ 1,762	$4,536	$5,391	$ 855	-80%
Obs 3 Month	217	$222,526	$102,718	$ (119,808)	65	26	-39	$3,423	$3,951	$ 528	$5,856	$6,420	$ 564	-60%
Obs 6 Month	146	$217,586	$80,346	$ (137,240)	77	33	-44	$2,826	$2,435	$ (391)	$6,217	$4,726	$ (1,491)	-57%

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.

Until the program began to ramp down in May 2020, new WISH client episodes remained consistent for most of FY20. A single client may have multiple episodes during the year, at both an active status (level 1: intensive 60-day intervention) and in passive status (levels 2 and 3: level 3 is a passive monitoring state with level 2 being a short-term intervention around a specific health need). As the program began to ramp down, coaches continued to maintain a high amount of new level 2 episodes. By June 2020, all new clients had been resolved or handed off to community resources to continue working with the clients and provide services.



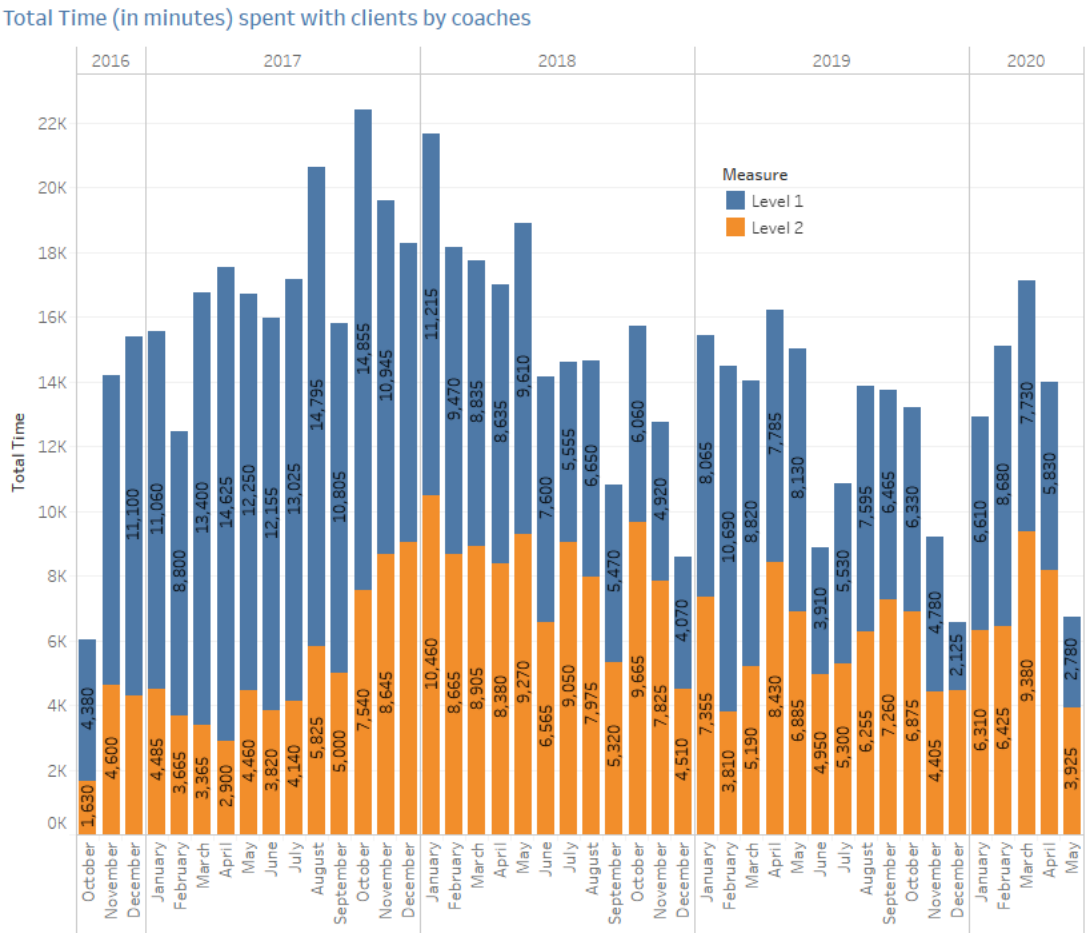
In FY20, WISH coaches redoubled partnership efforts with building staff and referral sources, resulting in a continue stream of new referrals into the program, even in its fourth year of operation. This resulted in 22 buildings having more than 75% of their residents ever referred to the WISH program (up from 12 in FY19).

Number of Buildings by Referral Cohort				
	FY17	FY18	FY19	FY20
High Engagement (>75%)	0	2	12	22
Medium Engagement (51-75%)	0	10	21	12
Low Engagement (26-50%)	0	20	7	6

However, as the cumulative number and percent of residents engaged grew over the first three years of the program, staff began to report increasing difficulty in converting referrals to new clients and a decline in perceived opportunity to engage new clients from the limited population within targeted buildings. In FY20, this resulted in the plateauing of the number of buildings in the High Engagement and Medium Engagement cohorts, shown below.

Number of Buildings by Engagement Cohort				
	FY17	FY18	FY19	FY20
High Engagement (>50%)	0	2	15	15
Medium Engagement (26-50%)	1	15	19	19
Low Engagement (0-25%)	42	30	10	6

Over the course of the program, coaches have spent many thousands of hours providing services either face to face or on the phone to clients. In FY20, 2,146 hours of direct client

	services were provided. Direct client service hours did not decline in response to the COVID-19 pandemic, even after coaches could no longer access buildings due to the lockdown and shifted to providing remote client support only.  WISH client surveys show high levels of satisfaction with the program, with 91% of clients reporting to be satisfied with the services they receive and 84% likely to recommend WISH to others. The coaches score particularly strongly around communication with clients.
Successes of the Intervention in FY 2020 *Freeform Narrative Response, up to 1 Paragraph*	In the program's third year of focusing exclusively on independent living and senior housing facilities, the WISH program maintained consistent levels of engagement with building residents. Relationships and engagement with building staff remained strong throughout FY20. Regular meetings and strategy discussions were established with several large housing groups that oversee multiple WISH buildings. The second annual ILF Resident Managers breakfast helped to increase engagement and program education. Nexus Montgomery evaluated WISH for sustainability through the Care Transformation Initiative program but preliminary analysis did not justify the ongoing investment needed to support the full program. Individual Nexus hospitals continue to evaluate the possibility of relaunching a program similar to WISH as a CTI.

	WISH had a positive impact on its clients, as demonstrated through Pre-Post analysis, client satisfaction survey results, as well as consistent anecdotal feedback from building staff and residents. As one client shared: "My health coach gave me the support I needed to get well and taught me what I needed to stay well". While the WISH program was completed at the end of FY20, the impact of the program continues through the partners and clients it supported. As described by one partner: "What WISH has done to better the lives of thousands of people has been a marvel to experience. For it is not just the clients themselves who benefited from WISH, but the family members, friends, neighbors, other healthcare and community members that interacted with these seniors. The ripples of WISH and what personnel have accomplished will not go away."
Additional Freeform Narrative Response (Optional)	For the two years of operations in which savings are measurable, the WISH program generated a cost savings of $6.4 M for a cost of $4.7 M resulting in a cumulative program ROI of 1.36.

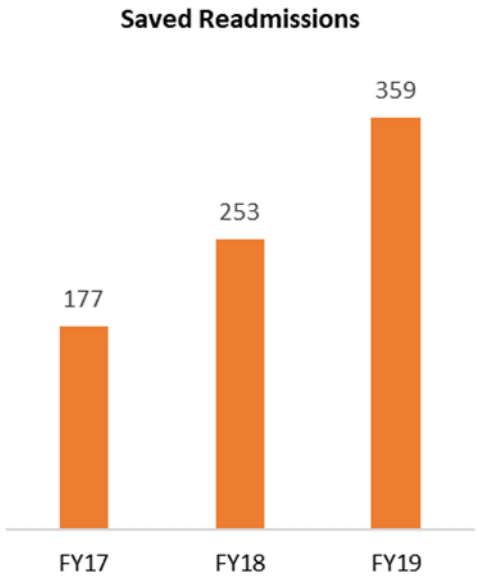
Intervention or Program Name	Hospital Care Transition (HCT) Program
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	All Nexus Hospitals
Brief description of the Intervention *2-3 sentences*	Each Nexus hospital operates a Hospital Care Transition (HCT) program to support patients transitioning from the hospital to another care setting – be it home or another facility, such as a Skilled Nursing Facility. Through Nexus, each hospital has been able to expand their existing HCT programs to serve more patients at high risk of re-hospitalization. In addition, Nexus established a learning collaborative which brings together hospital care transition staff to share data and best practices, as well as to identify additional areas for collaboration.
Participating Program Partners *Please list the relevant community-*	Each hospital has a long-established list of community partners that support its Care Transitions Program. This list is extensive, covers the vast majority of services in the community, and is constantly being updated.

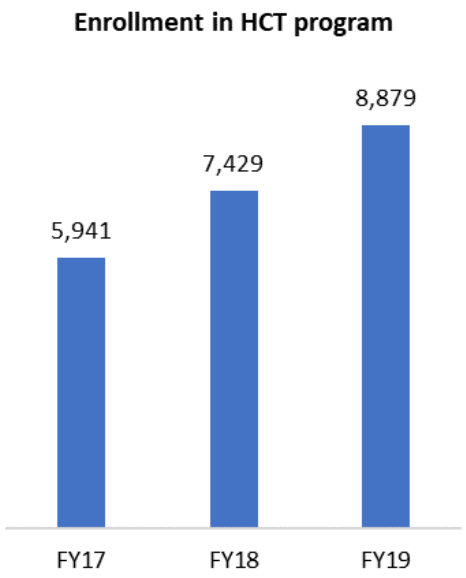
based organizations or provider groups, contractors, and/or public partners	
Patients Served *Please estimate using the Population category that best applies to the Intervention, from the CY 2018 RP Analytic Files. HSCRC acknowledges that the High Utilizer/Rising Risk or Payer designations may over-state 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[3]: FY19: 8,879 Cumulative: 22,249
	Denominator of Eligible Patients: [4] Program Denominator: 53,715 RP Analytic File: 153,371[5] (2+ IP or Obs >=24 or ED visits)
Pre-Post Analysis for	This is not a population that is paneled at the Partnership level in CRISP. The program is specifically designed to impact at the population level the Risk Adjusted 30-day readmission rate, rather than a broader total cost of care (though it should ultimately impact this as well).

[3] Total discharges enrolled in HCT program, there may be duplication by patient.

[4] Total discharges not patients, there may be duplication by patient

[5] The program denominator is made up of patients with an eligible discharge from one of the six Nexus Hospitals, they are predominantly made up of patients from the Med/Surg departments and they are patients who screen at higher risk of a re-admission and who are being discharged home. The closest match to this population in the RP Analytic File was the 2+IP, Obs 24+ or ED population, but this pool significantly over-estimates the denominator as they are not necessarily all at higher risk for re-admission, or even readmission eligible, nor does someone specifically need 2+ utilizations to be in the HCT Program.

Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	Enrollment is triggered by a hospital stay, skewing the data by having a high cost event in the immediate pre-enrollment timeframe. As a result, Nexus Montgomery, believes this would not be a useful measure in this instance.
Intervention-Specific Outcome or Process Measures (optional) *These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership maintains and uses to analyze performance. Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.*	The HCT Program Metrics are: 1. Return on Investment (ROI) – this is detailed in the final section 2. Change in the O/E Ratio (Observed/Expected Readmissions), which when multiplied by the expected number of readmissions estimates saved readmissions. The Observed versus Expected readmission rate for eligible patients discharged from the 6 Nexus Montgomery hospitals improved over the course of the program. In FY17 there was an improvement of 0.2 over baseline (FY16), in FY18 0.22 improvement and in FY19 and improvement of 0.27 over baseline. The absolute improvement between baseline and FY19 in O:E ratio was from 1.03 to 0.92. This translates to an estimated 359 saved readmissions in FY19 and 789 from the start of the grant through the end of FY19.  Current analysis was completed using Rate Year 20 risk adjustment for the O/E Ratio and applied to each year of the analysis. This update showed improvement in prior years performance over that which was reported last year. 3. Total Enrollment

	 Over the course of Nexus Montgomery, the hospital HCT programs enrolled an increasing number of patients.
Successes of the Intervention in FY 2020 *Freeform Narrative Response, up to 1 Paragraph*	One of the key features of this program is the work being done by the Learning Collaborative. Each month, the Learning Collaborative brings together the leads of each of the 6 hospitals Care Transition programs with the goal of shared learning about successes and challenges, as well as collective problem solving around shared pain points. During the year there was a focus on difficult to place patients at SNFs due to challenging behaviors, which led to the creation of a workgroup made up of the individual hospitals and a small group of SNFs who wanted to partner with the hospitals to better cater to these patients. The Learning Collaborative also had joint learning sessions with Adult Protective Services and the County Homeless programs to improve strategies to transition these patients. The Learning Collaborative also identified the need for greater cross-hospital collaboration between client-facing staff. As a result, they planned a Learning Forum that would meet quarterly with client-facing care transition staff for shared education, best practice sharing and collaboration. This forum was put on hold due to COVID-19 but is now planned to start remotely in Fall of 2020 and will transition to in person as soon as is practical.
Additional Freeform Narrative Response (Optional)	Through FY19, the HCT program generated a cost savings of $5.7 M for a cost of $4.5 M resulting in a cumulative program ROI of 1.28.

Intervention or Program Name	Severely Mentally Ill (SMI)
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	All Nexus Hospitals
Brief description of the Intervention *2-3 sentences*	There are three original components to the SMI program. The first component increased the availability of Residential Crisis beds, which serve patients experiencing a mental health crisis that traditionally would have been treated in the hospital due to a lack of a safe alternative. Prior to Nexus Montgomery's investment, there were 16 crisis beds operated by Cornerstone Montgomery available in the county. An eight bed Crisis House, which also is managed by Cornerstone Montgomery, opened in FY18. A new 16 bed Crisis House, to be managed by Shepherd Pratt Health System, is in development. The second component added a third Assertive Community Treatment (ACT) team in Montgomery County. Cornerstone Montgomery also manages the third ACT team. ACT teams provide ongoing care and support for up to 100 patients in the community who are at risk of hospitalization. The team coordinates services for a broad range of needs, including housing and employment. Finally, the third SMI component, the Nexus Montgomery Behavioral Health Integration Manager, was hired to bring together a behavioral health workgroup to facilitate interagency coordination to reduce hospital use by patients with severe mental illness who are high utilizers of the hospitals. In FY20, Nexus Montgomery contracted with Montgomery County Department of Health and Human Services to provide voluntary medical respite services to homeless patients being discharged from a partner hospital with a need for home health services, and who do not have a home in which to receive them. This 15-bed location will contract with a Federally Qualified Health Center and a case management vendor to provide common medical and behavioral health services that reduce the risk of readmission or complication, while facilitating placements into permanent housing for those who seek it.
Participating Program Partners	Cornerstone Montgomery Sheppard Pratt Health System Montgomery County Department of Health and Human Services

Please list the relevant community-based organizations or provider groups, contractors, and/or public partners	We also collaborate with: Montgomery County EMS Mindoula Health Urban Behavioral Associates Vesta, Inc MTM Services
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: <u>ACT</u> FY20: 116 Cumulative: 149 <u>Crisis House</u>[6] FY20: 180 (Layhill) 524 (Total Cornerstone) Cumulative: 549 (Layhill) 1,201 (Total Cornerstone) <u>Total SMI Program</u> FY20: 3,393[7] Cumulative: 13,260[8]
	Denominator of Eligible Patients: **Program Denominator:** 3,393 (NM residents with a NM hospital visit with a primary SMI diagnosis) RP Analytic File: 22,210 (3+ IP or Obs>=24 or ED Visits)[9]

[6] This is a sum of admissions across years, it is not possible to obtain an unduplicated count of patients
[7] This is a sum across all SMI programs, it is not possible to obtain an unduplicated count of patients
[8] This is a sum across all SMI programs, summed across the financial years, it is not possible to obtain an unduplicated count of patients
[9] The program denominator is significantly smaller than the RP Analytic File denominator – which is a high utilizer population, but not limited to patients with a diagnosis of Severe Mental Illness. Additionally, although the SMI population has a tendency to be a high utilizing population, with the exception of the Behavioral Health Workgroup, they do not require 3 or more utilizations to be eligible for the ACT Team or Crisis House.

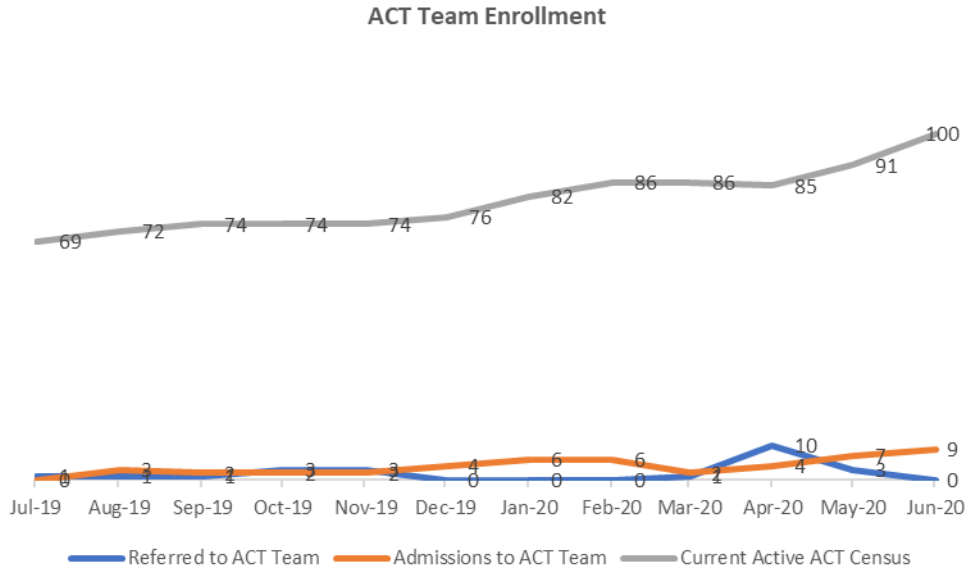
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	The Pre-Post report is limited to members of the ACT team. Consistent with previous years, there are decreases in utilization in all time frames and for all services with the most pronounced decreases in the period immediately after enrollment but remaining robust through 12 months. These reductions range from an 83% reduction in Inpatient utilization in the month after enrollment, to an 11% reduction in Observation utilization 12 months out from enrollment. The trends are consistent with each of the prior years of the program. The full Pre-Post analysis for the ACT Team is included in Appendix C.

ACT Pre-Post Reporting															
FY20															
All Hospital Pre-Post	n	Total Charges			Total Number of Visit			Average Charges per Visit			Average Charges per Member			% decrease in visits
		Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	
All Hospital 1 Month	85	$729,126	$94,063	$ (635,063)	92	38	-54	$7,925	$2,475	$ (5,450)	$17,784	$4,090	$ (13,694)	-59%
All Hospital 3 Month	81	$1,072,034	$323,702	$ (748,332)	234	111	-123	$4,581	$2,916	$ (1,665)	$18,170	$8,749	$ (9,421)	-53%
All Hospital 6 Month	67	$1,024,035	$458,661	$ (565,374)	367	164	-203	$2,790	$2,797	$ 7	$17,966	$10,921	$ (7,045)	-55%
All Hospital 12 Month	59	$1,305,673	$787,678	$ (517,995)	466	234	-232	$2,802	$3,366	$ 564	$24,179	$17,504	$ (6,675)	-50%
FY20															
In Patient Pre-Post	n	Total Charges			Total Number of Visit			Average Charges per Visit			Average Charges per Member			% decrease in visits
		Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	
In Patient 1 Month	85	$663,794	$75,350	$ (588,444)	35	6	-29	$18,966	$12,558	$ (6,408)	$24,585	$15,070	$ (9,515)	-83%
In Patient 3 Month	80	$893,249	$237,705	$ (655,544)	61	17	-44	$14,643	$13,983	$ (660)	$24,142	$21,610	$ (2,532)	-72%
In Patient 6 Month	66	$762,538	$337,360	$ (425,178)	76	32	-44	$10,033	$10,543	$ 510	$20,609	$10,065	$ (10,544)	-58%
In Patient 12 Month	59	$949,915	$614,144	$ (335,771)	100	52	-48	$9,499	$11,810	$ 2,311	$29,685	$21,934	$ (7,751)	-48%
FY20															
ED Pre-Post	n	Total Charges			Total Number of Visit			Average Charges per Visit			Average Charges per Member			% decrease in visits
		Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	
ED 1 Month	35	$54,280	$18,713	$ (35,567)	53	32	-21	$1,024	$585	$ (439)	$2,360	$936	$ (1,424)	-40%
ED 3 Month	63	$153,294	$59,818	$ (93,476)	165	88	-77	$929	$680	$ (249)	$2,948	$1,930	$ (1,018)	-47%
ED 6 Month	57	$227,038	$93,596	$ (133,442)	280	124	-156	$811	$755	$ (56)	$4,366	$2,674	$ (1,692)	-56%
ED 12 Month	56	$288,839	$127,384	$ (161,455)	348	166	-182	$830	$767	$ (63)	$5,555	$3,266	$ (2,289)	-52%
FY20															
Obs Pre-Post	n	Total Charges			Total Number of Visit			Average Charges per Visit			Average Charges per Member			% decrease in visits
		Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	Pre	Post	Variance	
Obs 1 Month	53	$11,052	$0	$ (11,052)	4	0	-4	$2,763	$0	$ (2,763)	$2,763	$0	$ (2,763)	-100%
Obs 3 Month	30	$25,491	$26,180	$ 689.00	8	6	-2	$3,186	$4,363	$ 1,177	$3,642	$4,363	$ 721	-25%
Obs 6 Month	23	$34,459	$27,705	$ (6,754.00)	11	8	-3	$3,133	$3,463	$ 330	$4,307	$3,958	$ (349)	-27%
Obs 12 Month	20	$66,918	$46,151	$ (20,767.00)	18	16	-2	$3,718	$2,884	$ (834.00)	$7,435	$4,196	$ (3,239.00)	-11%

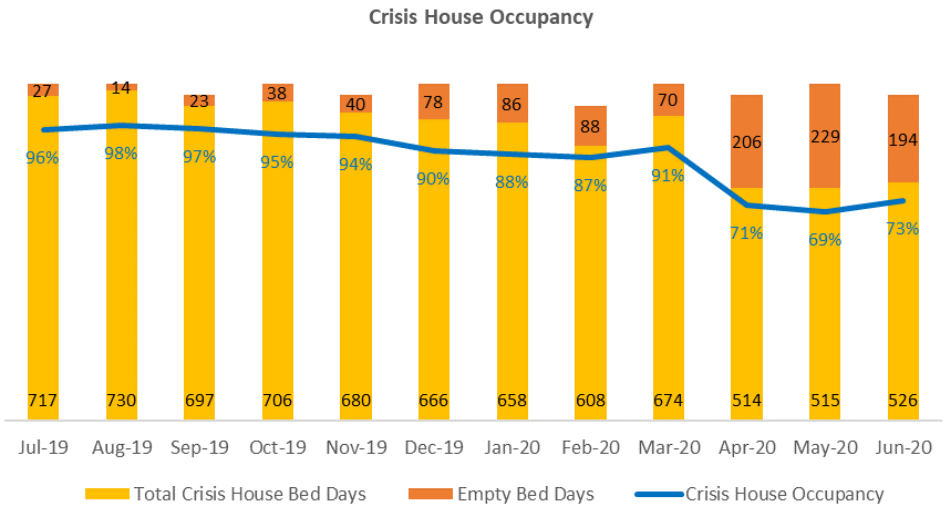
Intervention-Specific Outcome or Process Measures (optional) *These are measures that may not have generic definitions across Partnerships or Interventions*	Active ACT team enrollment increased over the year from 69 to 100 – the maximum capacity for the team. Total number of patients served was 116 in FY20 and 149 over the course of the grant. Although patients are expected to be enrolled in an ACT team over the

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.

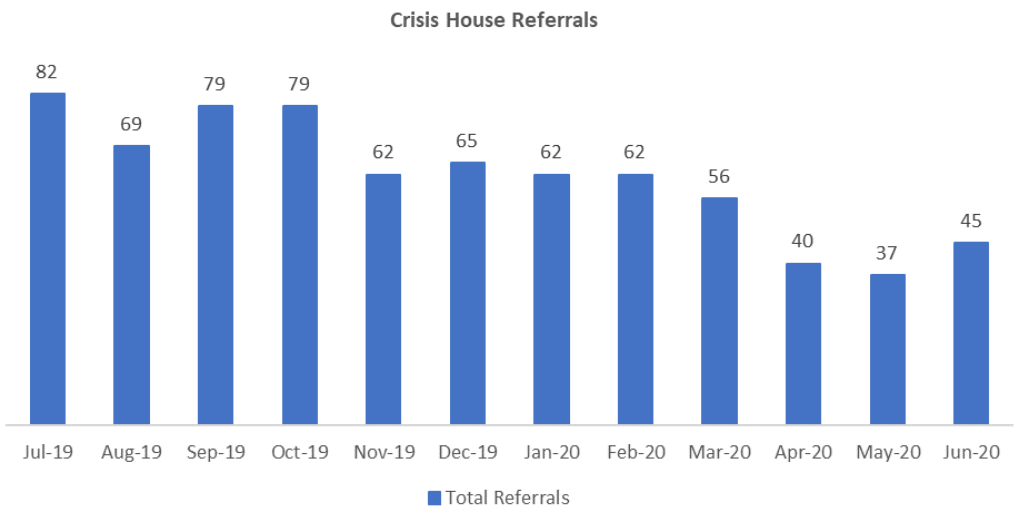
long-term, a small amount of turnover is expected.



In FY20 the Crisis Houses had 524 admissions, 180 of which were to the Layhill Crisis House. Admissions and occupancy rates were strong through the year until they were disrupted by COVID-19. Admissions to the Crisis House were initially suspended due to COVID concerns, while program staff established appropriate guidelines and Cornerstone experienced challenges with finding suitable post-discharge settings for Crisis House clients. Admissions and occupancy began to improve in June, a trend that has continued into FY21.



Referrals to the Crisis House showed greater demand than the number of possible admissions in the months prior to the impact of COVID-19.

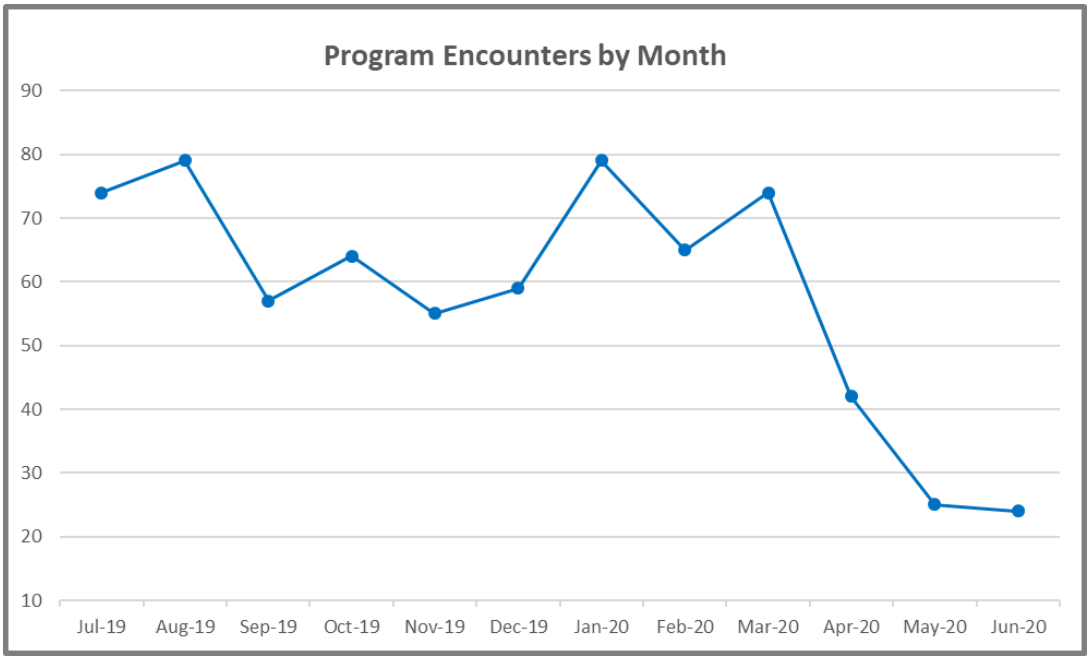
	
Successes of the Intervention in FY 2020 *Freeform Narrative Response, up to 1 Paragraph*	The SMI program has been successful in decreasing hospital utilization – both Inpatient and ED, decreased hospital length of stay and has improved connection of SMI patients to community-based care and resources. The Cornerstone Crisis Houses have prevented hospital admissions (50% of Crisis House admissions came directly from the community in FY20) and reduced Inpatient length of stay by an average of 3.12 days for the step-down admissions (50% of Crisis House admissions in FY20). Engagement with the ACT team has shown significant decreases in hospital utilization at the 1,3,6 and 12-month time frames in the pre-post report, with a higher percentage of utilization in the post time frames being for medical rather than behavioral health concerns. The Behavioral Health Workgroup continued to meet throughout FY20. This work group was facilitated by the Nexus Montgomery Behavioral Health Integration Manager (BHIM) and was made up of staff from the 6 Nexus hospitals, Cornerstone Montgomery, members of Emergency Medical Services (EMS) and other community behavioral health providers. When turnover in the BHIM role occurred in Q3 of FY2020, Nexus leveraged existing staff capacity and procured consulting support to continue to the work of the BHIM through the end of FY20.
Additional Freeform Narrative Response (Optional)	Over the full four years of operation, the Crisis House generated a cost savings of $2.1 M for a cost of $0.5 M resulting in a cumulative program ROI of 4.56.

Intervention or Program Name	Specialty Care for the Uninsured (Project Access)

RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	All Hospitals
Brief description of the Intervention *2-3 sentences*	Project Access is a specialty care referral network that coordinates with primary care clinics, specialty physicians, diagnostic facilities and local hospitals to arrange timely and affordable specialty care for uninsured people who have a household income less than 250% of Federal Poverty Level (FPL). Through Nexus, Project Access expanded the availability of these services for patients who have had hospital contact in the past 60 days and who need follow up specialty care for a related diagnosis. Specialty care is available to patients in Prince George's County ZIP codes in the Nexus target area, regardless of hospital contact. Any patient who is not already connected with primary care is referred to a primary care physician at a local community health center. Patients must maintain a relationship with a primary care provider to remain eligible for ongoing specialty care through Project Access. Patients may be referred directly from the hospital for urgent specialty care needs, or from the primary care clinic.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	PCC Other partners include: Pro bono and contracted (paid) Project Access Network providers
Patients Served *Please estimate using the Population category that best applies to the Intervention, from the CY*	# of Patients Served as of June 30, 2020: FY20: 363 Cumulative: 959
	Denominator of Eligible Patients: **Program Denominator:** 40,486 (Total Uninsured Individuals with NM Hospital Encounter)

*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.*	RP Analytic File: 382,808 (All Payer)[10]
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	There is no Pre-Post Analysis for this program.
Intervention-Specific Outcome or Process Measures (optional) *These are measures that may not have generic definitions across Partnerships or*	In FY20 Project Access served 363 patients with 738 appointments, from 869 referrals. Referrals and appointments were significantly impacted in the last quarter by COVID-19. Due to the COVID-19 public health emergency, most community-based specialists discontinued scheduling appointments for non-urgent issues in Q4 of FY20. Total appointments are understated as pro bono providers may provide follow up care without informing Project Access, counting therefore only their first specialty care appointment arranged by the program. Where clients were appropriate for other programs, Project Access connected them, for example Project Access connected 7 patients to the Maryland Cancer Fund. Overall in FY20, Project Access more than tripled its investment by providing an estimated $646,000 of services for an investment of under $200,000.

[10] The RP Analytic File does not have an appropriate population – as this intervention is limited to patients who have no insurance and who have a hospital utilization in the past 60 days and need follow up specialty care.

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.	
Successes of the Intervention in FY 2020 *Freeform Narrative Response, up to 1 Paragraph*	The program successfully added difficult to recruit specialties to the network, namely nephrology and hematology/oncology and acted as lead to address concerns between PCPs and specialty providers. Additionally, the Project Access staff continued to work diligently with the referral coordinators through quarterly meetings and annual trainings to ensure referral guidelines were appropriately followed.
Additional Freeform Narrative Response (Optional)	Effective FY21, the expanded program criteria facilitated by the Nexus Montgomery investment were ended. Project Access has applied for funding opportunities that would allow some or all of the expanded criteria to be reinstated.

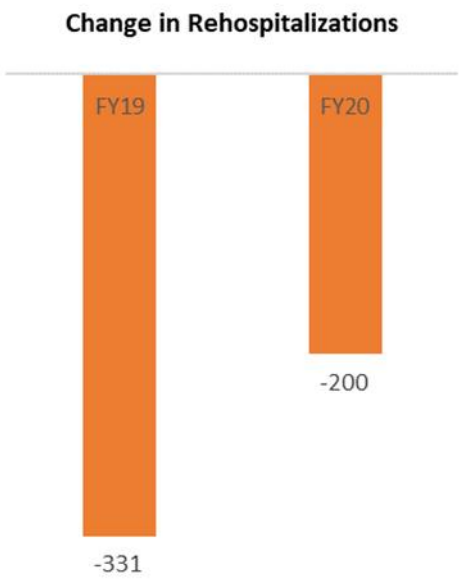
Intervention or Program Name	Skilled Nursing Facility (SNF) Alliance
RP Hospitals Participating in Intervention *Please indicate if All; otherwise,*	All Nexus Hospitals

please indicate which of the RP Hospitals are participating.	
Brief description of the Intervention *2-3 sentences*	The Skilled Nursing Facility (SNF) Alliance brings together 36 SNFs from Montgomery County and Prince George's County who receive the majority of SNF Referrals from the Nexus Hospitals. Through the Alliance, SNFs are provided with and continue to utilize PointRight to track data around 30-day-rehospitalizations and other quality metrics. SNFs are also provided an individualized QI support to reduce readmissions and improve quality of care. The focus for the SNF Alliance is getting SNF staff to incorporate PointRight data in their daily use and for SNFs to identify an area/areas for quality improvement focused on reducing re-hospitalizations. SNFs are also able to send staff to Mental Health First Aid training, responding to the need identified by the facilities for additional education around behavioral health. The Alliance meets collectively on a monthly basis and through FY20 was focused on work around best practices and a program to support SNF to home transitions.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	Skilled Nursing Facilities (See Appendix D)
Patients Served *Please estimate using the Population category that best applies to the Intervention, from the CY 2018 RP Analytic Files.*	# of Patients Served as of June 30, 2020: FY20: 12,506 (Total annual post-acute volume at SNF) Cumulative: 40,491[11]
	Denominator of Eligible Patients: **Program Denominator:** 12,506 (Total annual post-acute volume at SNFs) RP Analytic File: 43,239 (2+IP or Obs>=24 or ED Visits & Medicare FFS)[12]

[11] This is a sum of FY admission data, it is not possible to obtain an unduplicated count of patients, or across years

[12] The RP Analytic File does not have an appropriate population – the 2+IP or Obs>=24 or ED Visits & Medicare FFS is the closest applicable population, but over-estimates by not being limited to those then admitted to a SNF, it also doesn't capture the required 3 day admission to be eligible for a SNF admission. The SNF admission can also occur after only a single hospital utilization, if it results in a qualifying stay.

*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.*	
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	Nexus Montgomery does not believe a Pre-Post analysis is appropriate for this population because enrollment is triggered by a 3 or more-day hospital stay, which would skew the data by having a high cost event in the immediate pre-enrollment timeframe.
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.*	The key intervention-specific metric for this program is the risk adjusted 30-day rehospitalization rate from SNFs using the PointRight Pro30 methodology. The absolute reduction in risk adjusted rehospitalizations from the baseline of FY20 is 597. Due to COVID-19 there have been significant reductions in volume in the last 4 months of the year. Adjusted for this decrease in volume, the reduction in risk adjusted rehospitalization is 200. When combined with the reduction in risk adjusted rehospitalizations for FY19, SNF Alliance members have seen a reduction of 531 risk adjusted rehospitalizations since the start of the program.

Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.	
Successes of the Intervention in FY 2020 *Freeform Narrative Response, up to 1 Paragraph*	The initial intervention in FY20 focused on reducing 30 day readmission, providing best practices and educational opportunities, data driven individualized quality improvement activities, PointRight Data review and support, and a SNF to Home pilot program that provided services to bridge the gap between discharge from SNF and the start of care for home health services with the goal of reducing 30-day readmissions. Since the beginning to the COVID-19 Pandemic, the focus of the SNF Alliance moved to addressing the urgent needs of the SNFs. Nexus Montgomery hosted educational sessions with presenters from the County, State and National Guard. These education sessions focused on information around PPE, staffing, testing, recommendations for re-opening, visitation, and how to handle an outbreak. Nexus Montgomery had weekly meetings with the SNF medical directors, hospitalists, and ER doctors to discuss the MOLST form and how/when to update considering COVID. The goal of these meetings was to ensure that patients were only transferred to the hospital if they desired a hospital level of care. Very early in the pandemic, Nexus developed a daily SNF inventory of data collection. This inventory included information on bed availability, number of cases among residents and staff, SNFs that were closed or open to admission, admission criteria, inventory of PPE and supply. This inventory helped the Nexus Hospital with patient discharge and placement.
Additional Freeform Narrative Response (Optional)	Over the two years the SNF Alliance has been in operation, it has generated a cost savings of $2.7 M for a cost of $0.5 M resulting in a cumulative program ROI of 4.76.

Intervention or Program Name	Voice Your Choice (Community Based Advanced Directive Program)
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	All Nexus Hospitals
Brief description of the Intervention *2-3 sentences*	Nexus is seeking to improve quality of care at the end-of-life and to ensure that providers can respect their patients' wishes with a community-wide campaign that will increase awareness of advanced care planning and remove barriers to completing advanced directives. The community-based implementation partner, Jewish Social Services Agency, has developed a program to promote conversations about end-of-life care options, provide tools to aid in advance care planning and documentation, increase the completion rate of Advanced Directives, and expand the use of hospital accessible electronic storage services so that patients' needs can be met during a healthcare crisis.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	Jewish Social Services Agency (JSSA) In addition, the following organizations participate with Nexus hospital representatives on the Voice Your Choice Steering Committee: Catholic Charities Cedar Lane Unitarian Universalist Church M Jane Markley Consulting, LLC Montgomery County Palliative Care and End of Life Coalition Prince George's Healthcare Alliance, INC
Patients Served *Please estimate using the Population category that best applies to the Intervention, from the CY*	# of Patients Served as of June 30, 2020: FY20: 85,534 (Individuals who received information about advanced care planning) Cumulative: 85,534
	Denominator of Eligible Patients: **Program Denominator:** 1,067,814 (All adult residents of Nexus Montgomery zip codes) RP Analytic File: 382,808 (All Payer)

*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.*	
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	The savings for this program will be realized when an individual experiences a healthcare crisis, not in the immediate 12 months, therefore the Pre-Post analysis is not appropriate for this program.
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*	600 individuals participated in educational sessions about advanced care planning. Robust surveys have been developed to measure effectiveness of educational sessions. Collection of these measures is ongoing. 85,534 individuals received informational materials.

uses to analyze performance. Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.	
Successes of the Intervention in FY 2020 *Freeform Narrative Response, up to 1 Paragraph*	Voice Your Choice, Nexus Montgomery's newest program, was launched in late FY19. FY20 was a year of tremendous growth and development for the program. With input from the community and support of a multi-stakeholder Steering Committee, a solid infrastructure was built and with many workplan tasks completed ahead of schedule. Highlighted deliverables during FY 2020 included: • Developing the program name, tag line, logo, mission, and vision, as well as language for messaging to the diverse communities that make up the Nexus Montgomery service area. • Creating an advance care planning curriculum from scratch to include a presentation, four distinct surveys to track growth in knowledge and action of the participants, and pre- and post-emails to encourage participation. • Determining the program metrics, including proxy measures, to evaluate the effectiveness of the program, as well as the construction of tracking tools for deliverables. • Creating a marketing plan, branding guide, and outreach materials • Developing, designing, testing, and implementing and interactive program website: voiceyourchoice.org • Conceptualizing and operationalizing the provider component which was integrated into the program's deliverables; and • Pivoting from in-person trainings, presentations, and meetings to completely remote education and outreach due to the COVID-19 outbreak.
Additional Freeform Narrative Response (Optional)	The latter half of the fiscal year was overshadowed by the outbreak of the coronavirus. In response to guidance on containment, Voice Your Choice suspended in-person trainings and meetings. Program staff moved to remote locations and the full team continued to work off-site; pivoting to remote learning which involved making changes to the existing community curriculum and learning how to use new technologies. The community presentation was condensed to better hold the attention of a remote audience, and supporting materials and surveys were updated to better match remote learning. Three webinars were ultimately designed: 1) an introduction and overview of advance care planning; 2) a "how to" for uploading an existing advance care plan; and 3) question and answer session for creating an online advance care plan. To date, 25 webinars have been held with a total of 54 participants. As we move forward, at least nine webinars will be offered in each month.

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)	For this reporting, we have opted to use the Regional Partnership Analytic File. Below is each data element for each population that is appropriate for the six core programs. As noted in the Intervention Program section, we do not believe these measures best reflect the populations served by the programs below. This metric is reported for the full period of CY 2019 **Roll Up (All Payer): $1,709 (11.8% increase over baseline CY15)** Project Access: All Payer: as roll up WISH: 2+ Chronic Conditions & Medicare: $2,437 (33.9% **decrease** over CY15) Severely Mentally Ill: 3+IP or Obs>=24: $378 (9.9% **increase** over CY15) Hospital Care Transitions: 2+IP or Obs>=24 or ED visits: $797 (9.2% **decrease** over CY15) SNF Alliance: 2+IP or Obs>=24 or ED Visits & Medicare FFS: $2,884 (8.1% **increase** over CY15) Community Advance Directives: All Payer: as roll up

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)	This metric is reported for the 9 months of FY20 for which we have final data. The comparison is against the first 9 months of FY16 **Roll up (All Payer): 31** (27.9% **decrease** over FY16 baseline)[13] Project Access: All Payer: as roll up WISH: 2+ Chronic Conditions & Medicare: 64 (39.0% **decrease** over FY16) Severely Mentally Ill: 3+IP or Obs>=24: 7 (30.0% **decrease** over FY16) Hospital Care Transitions: 2+IP or Obs>=24 or ED Visits: 19 (26.9% **decrease** over FY16) SNF Alliance: 2+IP or Obs>=24 or ED Visits & Medicare: 55 (32.1% **decrease** over FY16) Community Advance Directives: All Payer: as roll up
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)	This metric is reported for the 9 months of FY20 for which we have final data. The comparison is against the first 9 months of FY16 **Roll up (All Payer): 177 (5.3% decrease over FY16)** Project Access: All Payer: as roll up WISH: 2+ Chronic Conditions & Medicare: 83 (39.0% **decrease** over FY16) Severely Mentally Ill: 3+IP or Obs>=24: 9 (0.0% change over FY16) Hospital Care Transitions: 2+IP or Obs>=24 or ED Visits: 97 (6.7% **decrease** over FY16)

[13] This decrease has been magnified by the impact of COVID January-March 2020 – prior years showed decreases but in single digits. This is seen across all populations. Prior year trends have been amplified in CY20 due to Covid

		SNF Alliance: 2+IP or Obs>=24 or ED Visits & Medicare: 123 (9.8% **increase** over FY16) Community Advance Directives: All Payer: as roll up

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)	For this reporting, we have opted to use the Regional Partnership Analytic File. Below is each data element for each population that is appropriate for the six core programs. As noted in the Intervention Program section, we do not believe these measures best reflect the populations served by the programs below. This metric is reported for the 9 months of FY20 for which we have final data. The comparison is against the first 9 months of FY16 **Roll up (All Payer): 9.6% (8.8% decrease over FY16)** Project Access: All Payer: as roll up WISH: 2+ Chronic Conditions & Medicare: 14.0% (6.8% **decrease** over FY16) Severely Mentally Ill: 3+IP or Obs>=24: 31.5% (6.6% **decrease** over FY16) Hospital Care Transitions: 2+IP or Obs>=24 or ED Visits: 15.8% (8.3% **decrease** over FY16) SNF Alliance: 2+IP or Obs>=24 or ED Visits & Medicare: 18.0% (9.6% **decrease** over FY16)

		Community Advance Directives: All Payer: as roll up
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)	This metric is reported for the 9 months of FY20 for which we have final data. The comparison is against the first 9 months of FY16 **Roll up (All Payer): $179,448,654 (16.0% decrease over FY16)**[14] Project Access: All Payer: as roll up WISH: 2+ Chronic Conditions & Medicare: $56,111,874 (24.8% **decrease** over FY16) Severely Mentally Ill: 3+IP or Obs>=24: $92,506,144 (8.3% **decrease** over FY16) Hospital Care Transitions: 2+IP or Obs>=24 or ED Visits: $132,261,804 (12.6% **decrease** over FY16) SNF Alliance: 2+IP or Obs>=24 or ED Visits & Medicare: $55,199,893 (77.0% **decrease** over FY16) Community Advance Directives: All Payer: as roll up

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	**Potentially Avoidable Utilization** Executive Dashboard:	Not Applicable

[14] The decrease for this measure is likely due to the impact of COVID, prior years saw an increasing trend in PAU for the All Payer, 2+IP or Obs>=24 or ED visits and Medicare FFS and 2+IP or Obs>=24 or ED Visits populations

Assigned Care Manager	'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.*	

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.

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)

In addition to the requested data below, we are also calculating Return on Investment for a number of our programs. The methodology for each is outlined below along with the most recent available data.

Annual Cost per Patient	FY18	FY19	FY20	Cumulative
Annual Cost	$7,928,805	$7,631,758	$7,426,915	$22,987,478
WISH	$1,329	$1,086	$1,073	$1,329
HCT	$336	$301	$224	$265
SMI	$1,487	$1,112	$238	$193
Specialty Care for the Uninsured	$666	$658	$941	$733
SNF Alliance	$0	$19	$25	$14
Community Advance Directives	n.a.	n.a.	$3	$3
Partnership Total	**$340**	**$327**	**$66**	**$137**

WISH

Return on Investment is measured at the program target population level for the WISH population. Savings are calculated as the difference between the target cost and the actual cost. The target cost is calculated as:

(baseline per beneficiary cost * current beneficiaries) * inflation factor.

Gross Savings: Target Medicare Payments – Current Period Medicare Payments
Variable Savings (Part A only): Gross Savings * 50%
Net Savings: Variable Savings – Total Program Cost
ROI: Variable Savings/Total Program Cost

Medicare Savings	CY17	CY18	Cumulative
Program Cost	$2,143,523	$2,555,635	$4,699,158
Part A Variable Savings	$2,166,471	$780,609	$2,947,080
Part B Gross Savings	$510,922	$2,949,785	$3,460,707
Total Savings	$2,677,393	$3,730,394	$6,407,787
Net Savings	$533,870	$1,171,759	$1,705,629
ROI	1.25	1.46	1.36

Through this methodology, the WISH program is showing a strong ROI for total Medicare Part A & B, with the savings being more strongly seen in Part B payments. With the change in QIOs in Maryland, we have been unable to get the claims data by building since the first quarter of calendar year 2019.

HCT Program

Return on Investment for the HCT programs are measured at the enrolled population level. Saved readmissions are calculated by the difference in the observed versus expected readmission (O:E) ratio for the enrolled participants versus the O:E ratio in the baseline period. The number of saved readmissions is then multiplied by the average readmission cost for each hospital to produce a gross savings number.

Difference in O:E Ratio: Baseline O:E ratio – Current O:E ratio
Saved Readmissions: Expected Readmissions * Difference in O:E ratio
Gross Savings: Saved Readmissions * Average Readmission Cost
Variable Savings: Gross Savings * 50%
Net Savings: Variable Savings – Program Cost
ROI: Variable Savings/Program Cost

HCT Program Savings	FY17	FY18	FY19	Cumulative
Eligible Discharges	5,941	7,429	8,879	22,249
Difference in O:E from baseline	0.20	0.22	0.27	
Saved Readmissions	177	253	359	$789
Total Savings	$2,531,448	$3,563,576	$5,293,536	$11,388,560
Variable Savings	$1,265,724	$1,781,788	$2,646,768	$5,694,280
Program Cost	$1,016,091	$1,598,785	$1,836,785	$4,451,661
Net Savings	$1,515,357	$1,964,791	$3,456,751	$6,936,899
ROI	1.25	1.11	1.44	1.28

The HCT programs have seen increased saved readmissions each year of the program as the program size increased and has shown a positive ROI for each year. The ROI for this program is strongly influenced by a larger improvement in the O:E ratio in the behavioral health population.

SMI Program

For the SMI program, we calculate Return on Investment for the Crisis House. This is done at the program level, for all admissions to the Crisis House, based on the assumptions listed below. These were initially outlined in the December 21, 2015 Nexus Montgomery proposal, and have been adjusted to account for the larger than anticipated number of step-down admissions in proportion to community and diversion admissions. Assumptions were based on an analysis of hospital data for the SMI population.

Assumptions:

- 90% of community or diversion admissions to the Crisis House would have otherwise been admissions to the hospital
- Step-down admissions decrease in patient stays by an average of 3.12 days
- 86% of hospitalizations would have been at a Nexus Montgomery Hospital

Crisis House	Cumulative FY17-20
Total Cumulative Admissions	549
Total Community & Diversion Admissions	384
Total Step-Down Admissions	165
Gross Savings	$4,215,838
Variable Savings	$2,107,919
Cumulative Costs	$462,478
Net Savings	$1,645,441
ROI	4.56

SNF Alliance

Return on Investment for this program is done at the target population level and is based on a reduction in rehospitalizations, using the National Quality Forum endorsed, PointRight Pro30 Methodology[15]. The

[15] https://www.qualityforum.org/QPS/QPSTool.aspx#qpsPageState=%7B%22TabType%22%3A1,%22TabContentType%22%3A2,%22SearchCriteriaForStandard%22%3A%7B%22TaxonomyIDs%22%3A%5B%5D,%22SelectedTypeAheadFilterOption%22%3A%7B%22ID%22%3A49589,%22FilterOptionLabel%22%3A%22pointright%22,%22TypeOfTypeAheadFilterOption%22%3A1,%22TaxonomyId%22%3A0%7D,%22Keyword%22%3A%22pointright%22,%22PageSize%22%3A%2225%22,%22OrderType%22%3A3,%22OrderBy%22%3A%22ASC%22,%22PageNo%22%3A1,%22IsExactMatch%22%3Afalse,%22QueryStringType%22%3A%22%22,%22ProjectActivityId%22%3A%220%22,%22FederalProgramYear%22%3A%220%22,%22FederalFiscalYear%22%3A%220%22,%22FilterTypes%22%3A0,%22EndorsementStatus%22%3A%22%22%7D,%22SearchCriteriaForForPortfolio%22%3A%7B%22Tags%22%3A%5B%5D,%22FilterTypes%22%3A0,%22PageStartIndex%22%3A1,%22PageEndIndex%22%3A25,%22PageNumber%22%3Anull,%22PageSize%

baseline year for this program is FY18. Savings are calculated on an NMRP hospital average rehospitalization cost of $10,000.

Target rehospitalizations: Current admissions*baseline rehospitalization rate
Reduction in rehospitalizations: Target rehospitalizations – Current rehospitalizations
Gross Savings: Reduction in rehospitalizations * $10,000
Variable Savings: Gross Savings * 50%
Net Savings: Variable Savings – Program Cost
ROI: Variable Savings/Program Cost

SNF Alliance	Cumulative
Program Cost	$558,121
Saved Rehospitalizations	531
Gross Savings	$5,310,000
Variable Savings	$2,655,000
Net Savings	$2,096,879
ROI	4.76

The SNF Alliance saw 331 saved rehospitalizations in FY19, but only 200 in FY20, this is due to the significant decrease in admissions after COVID-19.

Impact of COVID-19 on Interventions – (Optional)

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

The impact of COVID-19 on individual programs is described in the above intervention sections.

22%3A%2225%22,%22SortBy%22%3A%22Title%22,%22SortOrder%22%3A%22ASC%22,%22SearchTerm%22%3A%22%22%7D,%22ItemsToCompare%22%3A%5B%5D,%22SelectedStandardIdList%22%3A%5B%5D,%22StandardID%22%3A2375,%22EntityTypeID%22%3A1%7D

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.

Program	Sustainability
Skilled Nursing Facility Alliance	Sustained by hospitals as part of the Care Transformation Initiative (CTI) Program
Hospital Care Transitions	• Programs sustained by hospitals with many participating in the CTI program • Continued engagement across HCT program leadership and staff through the ongoing Learning Forum
SMI/Behavioral Health	• Capacity-building investments continue operations and are sustainable through billing and/or implementation partner support. This includes 24 Crisis Beds, the ACT Team, and Medical Respite Care program. • The Behavioral Health Workgroup will be reconvened pending the disposition of the Crisis Now Catalyst Grant proposal.
Voice Your Choice	Funded through the end of the second program year (February 2021)
WISH	Decision to not pursue as a CTI, program ended
Specialty Care for the Uninsured	Expanded Project Access eligibility criteria ended

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.

Appendix A: Participating WISH Independent Living Facilities

Andrew Kim House
Arcola Towers
Asbury Methodist Village
Avondale Park
Bauer Park Apartments
Bedford Court
Bethany House
Brooke Grove
Charter House
Churchill Senior Living
Covenant Village
Elizabeth House
Forest Oak Towers
Friends House
Hampshire Village
Holly Hall
Homecrest House
Inwood House
Lakeview
Manor Apartments
Oaks at Olde Towne
Randolph Village
Revitz House
Ring House
Rolling Crest Commons
The Bonifant
The Oaks at Four Corners
Town Center Apartments
Victory Court
Victory Crest
Victory Crossing
Victory Forest
Victory House of Palmer Park
Victory Oaks
Victory Terrace
Victory Tower
Waverly House
Willow Manor at Cloppers Mill
Willow Manor at Coleville
Willow Manor at Fair Hill Farm

Appendix B: WISH Pre-Post Report

Pre/Post Analysis - Summary

The analysis is based on admissions before and after the enrollment date.

Program Name
202007_WISH_active_last12m (5887)

Chronic Conditions
All Patients

Chronic Condition Operator
(•) AND
( ) OR

Most Recent Payer Group
All

Visit Type
All

N/A

N/A

Total Number of Members on Panel that could contribute to analysis

	1 Month	3 Months	6 Months	12 Months
Total Number of Patients in Panel that could contribute to analysis	156	143	92	10

Percent of Members on the Panel with 1 or more Visits

Time Period	Total Number of Patients with a visit - Pre	Total Number of Patients with a visit - Post	Total Number of Patients with a visit - Pre %	Total Number of Patients with a visit - Post %	Change in Number of Patients
1 Month	30	19	19.2%	12.2%	-7.1%
3 Months	47	39	32.9%	27.3%	-5.6%
6 Months	33	38	35.9%	41.3%	5.4%
12 Months	2	6	20.0%	60.0%	40.0%

Rate of Visits per 10 Members

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Rate of Visits per 10 patients - Pre	Rate of Visits per 10 patients - Post	Visits Rate change
1 Month	52	28	3.3	1.8	-1.5
3 Months	111	71	7.8	5.0	-2.8
6 Months	124	89	13.5	9.7	-3.8
12 Months	19	13	19.0	13.0	-6.0

Average Charge per Member

Time Period	Total Number of Patients with at least 1 visit pre or post	Total charges - Pre	Total charges - Post	Average Charge per patient - Pre	Average Charge per patient - Post	Total Charges per Patients change
1 Month	41	$175,601	$228,033	$5,853	$12,002	$6,148
3 Months	63	$467,327	$456,032	$9,943	$11,693	$1,750
6 Months	47	$645,662	$427,202	$19,566	$11,242	($8,323)
12 Months	6	$85,987	$29,661	$42,994	$4,943	($38,050)

Average Charge per Visit

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Total charges - Pre	Total charges - Post	Average Charge per visit - Pre	Average Charge per visit - Post	Total Charges per Visit change
1 Month	52	28	$175,601	$228,033	$3,377	$8,144	$4,767
3 Months	111	71	$467,327	$456,032	$4,210	$6,423	$2,213
6 Months	124	89	$645,662	$427,202	$5,207	$4,800	($407)
12 Months	19	13	$85,987	$29,661	$4,526	$2,282	($2,244)

Casemix Data Through:
06/30/2020

ENS Panels Last Updated:
07/30/2020

- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
  - Panel information provided to CRISP by ENS
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
- Individual patients identified using CRISP EID
- CRISP suppressed cells with counts of 10 and under
- Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis
- Months of Analysis is not based on calendar days or 30 days but calculated by getting the same date, months in advance. eg. 1 Month before Feb 28th is Jan 28th and 1 Month before June 15th is May 15th and so on.
- Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.

Pre/Post Analysis

Analysis of 12 Months of Visits Before and After the Enrollment Date

The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they do not have data for the entire period before and after the analysis. Number of Members with data for the analysis shows, the number of members that are included in the report for a given selection.

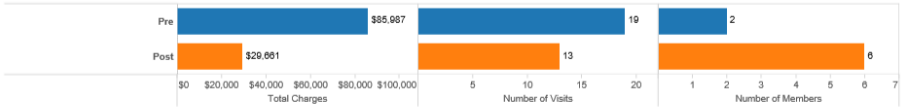
Total Number of Members in the Panel
158

Number of Members with Data for Analysis
10

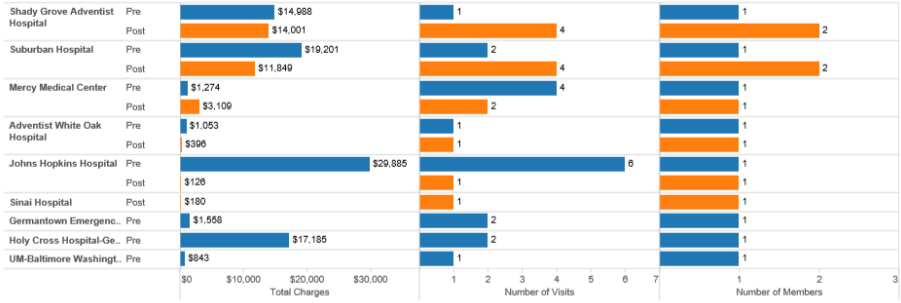
Number of Members with Visits during Analysis Period
6

Before or After Enrollment
Pre Post

All Hospitals



Hospital Details



Most Recent Payer Group
All

Time Period
12 Months

Visit Type
All

Sorting Option
Total Visits - After Enrollment

Hospital Name
All

Program Name
202007_WISH_active_last12m (5887)

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

Casemix Data Through:
06/30/2020

ENS Panels Last Updated:
07/30/2020

- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
  - Panel information provided to CRISP by ENS
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
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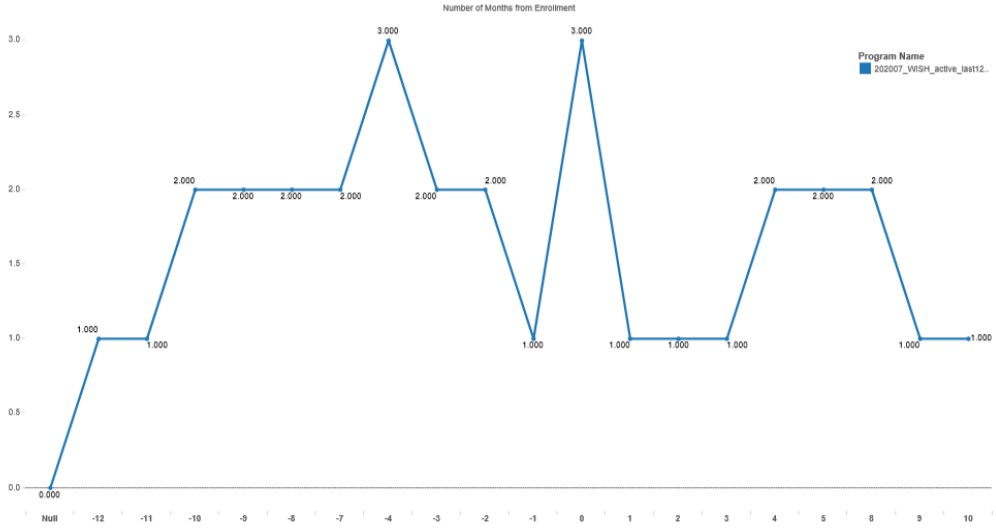
- Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.

Pre/Post Analysis

Analysis of 12 Months of Visits Before and After the Enrollment Date

The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they do not have data for the entire period before and after the analysis. Number of Members with data for the analysis shows, the number of members that are included in the report for a given selection.

Relative Trend



Most Recent Payer Group
All

Time Period
12 Months

Trend Metric
Visits

Visit Type
All

Hospital Name
All

Program Name
202007_WISH_active_last12m (5887)

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

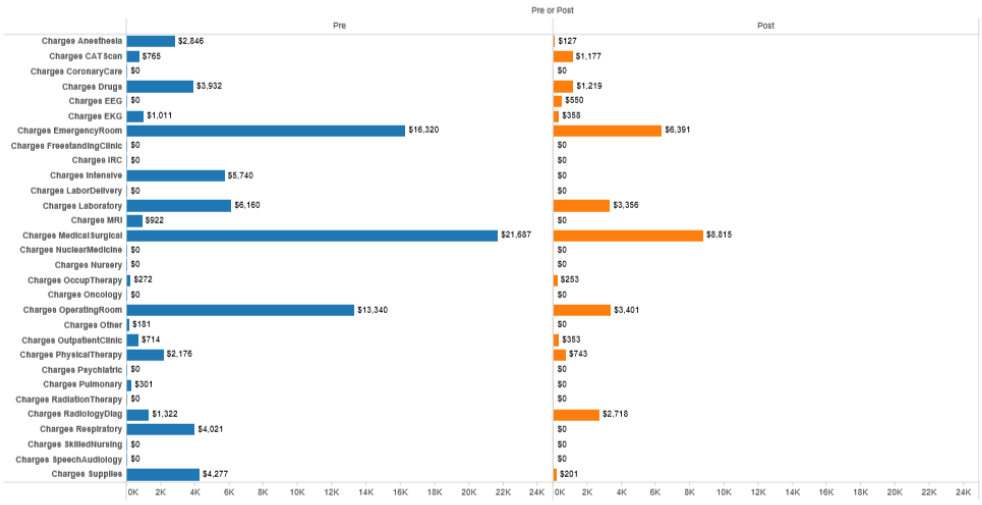
Casemix Data Through:	- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
06/30/2020	- Data source: - Panel information provided to CRISP by ENS - HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals - Individual patients identified using CRISP EID - CRISP suppressed cells with counts of 10 and under - Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis - Months of Analysis is not based on calendar days or 30 days but calculated by getting the same date, months in advance. eg. 1 Month before Feb 28th is Jan 28th and 1 Month before June 15th is May 15th and so on...
ENS Panels Last Updated:	
07/30/2020	

Pre/Post Analysis

Analysis of 12 Months of Visits Before and After the Enrollment Date

The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they do not have data for the entire period before and after the analysis. Number of Members with data for the analysis shows, the number of members that are included in the report for a given selection.

Breakdown of Charges Sheet



Most Recent Payer Group
All

Visit Type
All

Hospital Name
All

Time Period
12 Months

Program Name
202007_WISH_active_last12m (5887)

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

Casemix Data Through:	- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
06/30/2020	- Data source: - Panel information provided to CRISP by ENS - HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals - Individual patients identified using CRISP EID - CRISP suppressed cells with counts of 10 and under - Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis - Months of Analysis is not based on calendar days or 30 days but calculated by getting the same date, months in advance. eg. 1 Month before Feb 28th is Jan 28th and 1 Month before June 15th is May 15th and so on. - Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.
ENS Panels Last Updated:	
07/30/2020	

Pre/Post Analysis - Summary

The analysis is based on admissions before and after the enrollment date.

Program Name
202007_WISH_engaged_last12m (5887)

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

Most Recent Payer Group
All

Visit Type
All

Total Number of Members on Panel that could contribute to analysis

	1 Month	3 Months	6 Months	12 Months
Total Number of Patients in Panel that could contribute to analysis	297	259	196	36

Percent of Members on the Panel with 1 or more Visits

Time Period	Total Number of Patients with a visit - Pre	Total Number of Patients with a visit - Post	Total Number of Patients with a visit - Pre %	Total Number of Patients with a visit - Post %	Change in Number of Patients
1 Month	50	24	16.8%	8.1%	-8.8%
3 Months	80	51	30.9%	19.7%	-11.2%
6 Months	69	54	35.2%	27.6%	-7.7%
12 Months	16	12	44.4%	33.3%	-11.1%

Rate of Visits per 10 Members

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Rate of Visits per 10 patients - Pre	Rate of Visits per 10 patients - Post	Visits Rate change
1 Month	76	33	2.6	1.1	-1.4
3 Months	158	82	6.1	3.2	-2.9
6 Months	192	124	9.8	6.3	-3.5
12 Months	58	42	16.1	11.7	-4.4

Average Charge per Member

Time Period	Total Number of Patients with at least 1 visit pre or post	Total charges - Pre	Total charges - Post	Average Charge per patient - Pre	Average Charge per patient - Post	Total Charges per Patients change
1 Month	67	$388,794	$279,719	$7,776	$11,655	$3,879
3 Months	97	$777,853	$423,840	$9,723	$8,311	($1,413)
6 Months	89	$1,039,439	$566,123	$15,064	$10,484	($4,581)
12 Months	18	$229,016	$194,040	$14,314	$16,170	$1,856

Average Charge per Visit

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Total charges - Pre	Total charges - Post	Average Charge per visit - Pre	Average Charge per visit - Post	Total Charges per Visit change
1 Month	76	33	$388,794	$279,719	$5,116	$8,476	$3,361
3 Months	158	82	$777,853	$423,840	$4,923	$5,169	$246
6 Months	192	124	$1,039,439	$566,123	$5,414	$4,566	($848)
12 Months	58	42	$229,016	$194,040	$3,949	$4,620	$671

Casemix Data Through:
06/30/2020

ENS Panels Last Updated:
07/30/2020

- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
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- Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.

Pre/Post Analysis

Analysis of 12 Months of Visits Before and After the Enrollment Date

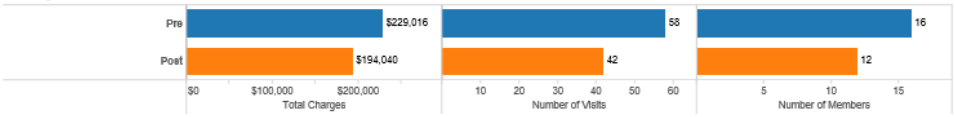
The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they do not have data for the entire period before and after the analysis. Number of Members with data for the analysis shows, the number of members that are included in the report for a given selection.

Total Number of Members in the Panel
301

Number of Members with Data for Analysis
36

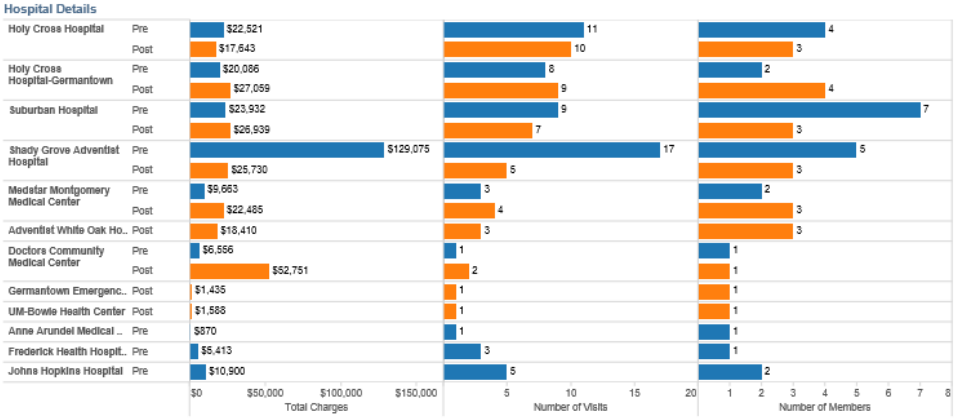
Number of Members with Visits during Analysis Period
18

All Hospitals



Before or After Enrollment
Pre
Post

Hospital Details



Most Recent Payer Group
All

Time Period
12 Months

Visit Type
All

Sorting Option
Total Visits - After Enrollment

Hospital Name
All

Program Name
202007_WISH_engaged_last12m (5887)

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

Casemix Data Through:
06/30/2020

ENS Panels Last Updated:
07/30/2020

- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
  - Panel information provided to CRISP by ENS
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
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- Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis
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- Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.

Pre/Post Analysis

Analysis of 12 Months of Visits Before and After the Enrollment Date

The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they do not have data for the entire period before and after the analysis. Number of Members with data for the analysis shows, the number of members that are included in the report for a given selection.

Most Recent Payer Group
All

Time Period
12 Months

Trend Metric
Visits

Visit Type
All

Hospital Name
All

Program Name
202007_WBH_engaged_last12m (S..

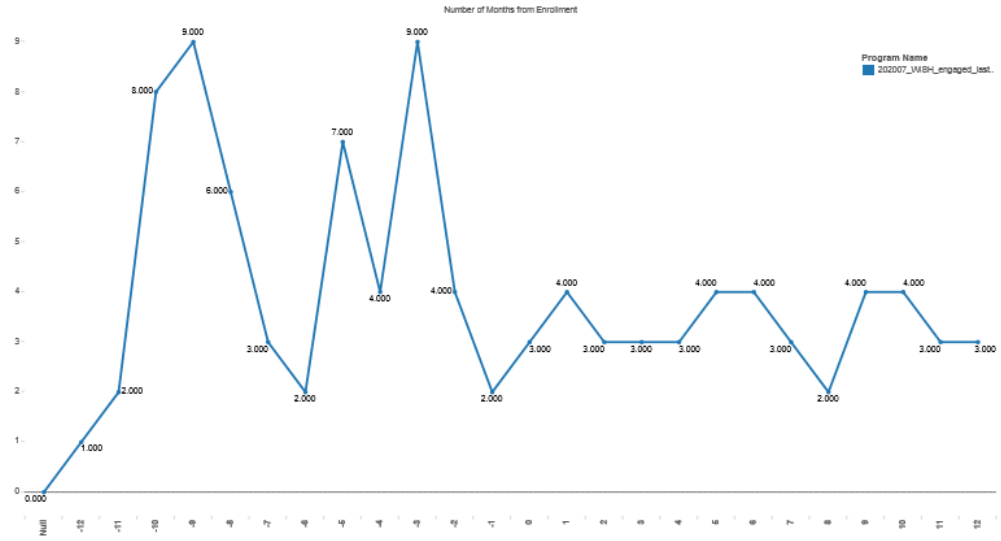
Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

Relative Trend



Casemix Data Through:	- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP. - Data source: - Panel information provided to CRISP by ENS
06/30/2020	- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals - Individual patients identified using CRISP EID
ENS Panels Last Updated:	- CRISP suppressed cells with counts of 10 and under - Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis - Months of Analysis is not based on calendar days or 30 days but calculated by getting the same date, months in advance. eg. 1 Month before Feb 28th is Jan 28th and 1 Month before June 15th is May 15th and so on...
07/30/2020	

Pre/Post Analysis

Analysis of 12 Months of Visits Before and After the Enrollment Date

The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they do not have data for the entire period before and after the analysis. Number of Members with data for the analysis shows, the number of members that are included in the report for a given selection.

Most Recent Payer Group
All

Visit Type
All

Hospital Name
All

Time Period
12 Months

Program Name
202007_WBH_engaged_last12m (

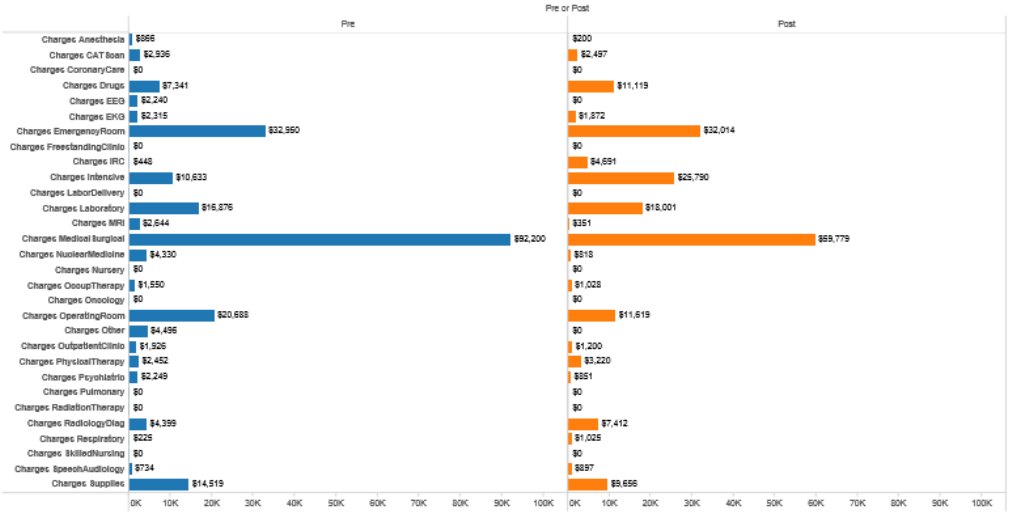
Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

Breakdown of Charges Sheet



Casemix Data Through:	- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP. - Data source: - Panel information provided to CRISP by ENS
06/30/2020	- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals - Individual patients identified using CRISP EID
ENS Panels Last Updated:	- CRISP suppressed cells with counts of 10 and under - Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis - Months of Analysis is not based on calendar days or 30 days but calculated by getting the same date, months in advance. eg. 1 Month before Feb 28th is Jan 28th and 1 Month before June 15th is May 15th and so on. - Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.
07/30/2020	

Appendix C: ACT Team Pre-Post Report

Pre/Post Analysis - Summary

The analysis is based on admissions before and after the enrollment date.

Program Name
202008_act (9546)

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

Most Recent Payer Group
All

Visit Type
All

Total Number of Members on Panel that could contribute to analysis

	1 Month	3 Months	6 Months	12 Months
Total Number of Patients in Panel that could contribute to analysis	85	83	69	59

Percent of Members on the Panel with 1 or more Visits

Time Period	Total Number of Patients with a visit - Pre	Total Number of Patients with a visit - Post	Total Number of Patients with a visit - Pre %	Total Number of Patients with a visit - Post %	Change in Number of Patients
1 Month	41	23	48.2%	27.1%	-21.2%
3 Months	61	38	73.5%	45.8%	-27.7%
6 Months	59	43	85.5%	62.3%	-23.2%
12 Months	54	45	91.5%	76.3%	-15.3%

Rate of Visits per 10 Members

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Rate of Visits per 10 patients - Pre	Rate of Visits per 10 patients - Post	Visits Rate change
1 Month	92	38	10.8	4.5	-6.4
3 Months	247	113	29.8	13.6	-16.1
6 Months	381	166	55.2	24.1	-31.2
12 Months	466	234	79.0	39.7	-39.3

Average Charge per Member

Time Period	Total Number of Patients with at least 1 visit pre or post	Total charges - Pre	Total charges - Post	Average Charge per patient - Pre	Average Charge per patient - Post	Total Charges per Patients change
1 Month	49	$729,126	$94,063	$17,784	$4,090	($13,694)
3 Months	68	$1,198,040	$325,640	$19,640	$8,569	($11,071)
6 Months	62	$1,092,214	$460,338	$18,512	$10,706	($7,807)
12 Months	56	$1,305,673	$787,678	$24,179	$17,504	($6,675)

Average Charge per Visit

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Total charges - Pre	Total charges - Post	Average Charge per visit - Pre	Average Charge per visit - Post	Total Charges per Visit change
1 Month	92	38	$729,126	$94,063	$7,925	$2,475	($5,450)
3 Months	247	113	$1,198,040	$325,640	$4,850	$2,882	($1,969)
6 Months	381	166	$1,092,214	$460,338	$2,867	$2,773	($94)
12 Months	466	234	$1,305,673	$787,678	$2,802	$3,366	$564

Casemix Data Through:
06/30/2020

ENS Panels Last Updated:
07/30/2020

- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
  - Panel information provided to CRISP by ENS
- HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals
- Individual patients identified using CRISP EID
- CRISP suppressed cells with counts of 10 and under
- Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis
- Months of Analysis is not based on calendar days or 30 days but calculated by getting the same date, months in advance. eg. 1 Month before Feb 28th is Jan 28th and 1 Month before June 15th is May 15th and so on.
- Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.

Pre/Post Analysis

Analysis of 12 Months of Visits Before and After the Enrollment Date

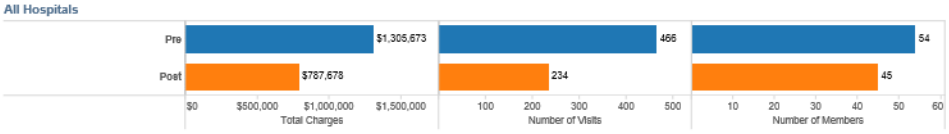
The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they do not have data for the entire period before and after the analysis. Number of Members with data for the analysis shows, the number of members that are included in the report for a given selection.

Total Number of Members in the Panel
85

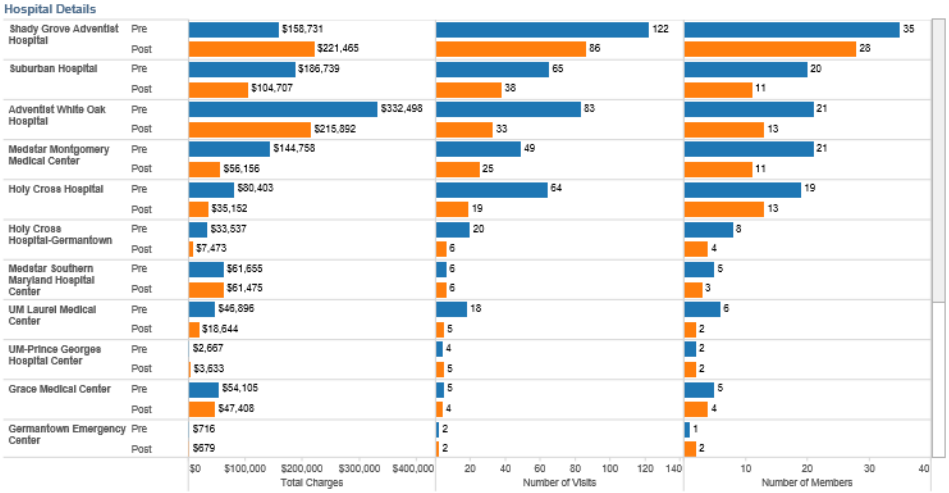
Number of Members with Data for Analysis
59

Number of Members with Visits during Analysis Period
56

All Hospitals



Hospital Details



Most Recent Payer Group
All

Time Period
12 Months

Visit Type
All

Sorting Option
Total Visits - After Enrolment

Hospital Name
All

Program Name
202008_act (9546)

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

Casemix Data Through:
06/30/2020

ENS Panels Last Updated:
07/30/2020

- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
- Data source:
  - Panel information provided to CRISP by ENS
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Pre/Post Analysis

Analysis of 12 Months of Visits Before and After the Enrollment Date

The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they do not have data for the entire period before and after the analysis. Number of Members with data for the analysis shows, the number of members that are included in the report for a given selection.

Most Recent Payer Group
All

Time Period
12 Months

Trend Metric
Visits

Visit Type
All

Hospital Name
All

Program Name
202008_act (9546)

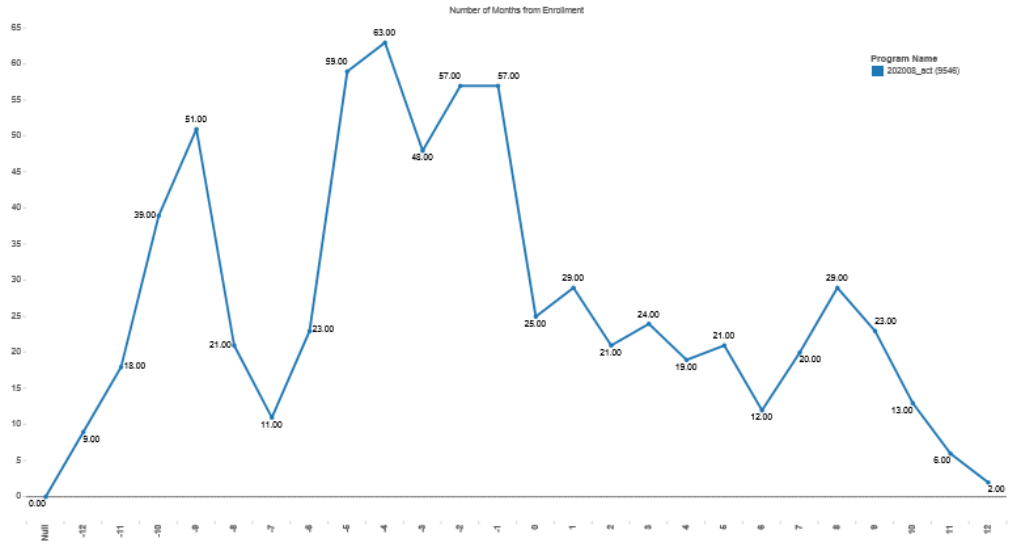
Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

Relative Trend



Casemix Data Through:	- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
06/30/2020	- Data source: - Panel information provided to CRISP by ENS - HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals - Individual patients identified using CRISP EID - CRISP suppressed cells with counts of 10 and under - Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis - Months of Analysis is not based on calendar days or 30 days but calculated by getting the same date, months in advance. eg. 1 Month before Feb 28th is Jan 28th and 1 Month before June 15th is May 15th and so on...
ENS Panels Last Updated:	
07/30/2020	

Pre/Post Analysis

Analysis of 12 Months of Visits Before and After the Enrollment Date

The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they do not have data for the entire period before and after the analysis. Number of Members with data for the analysis shows, the number of members that are included in the report for a given selection.

Most Recent Payer Group
All

Visit Type
All

Hospital Name
All

Time Period
12 Months

Program Name
202008_act (9546)

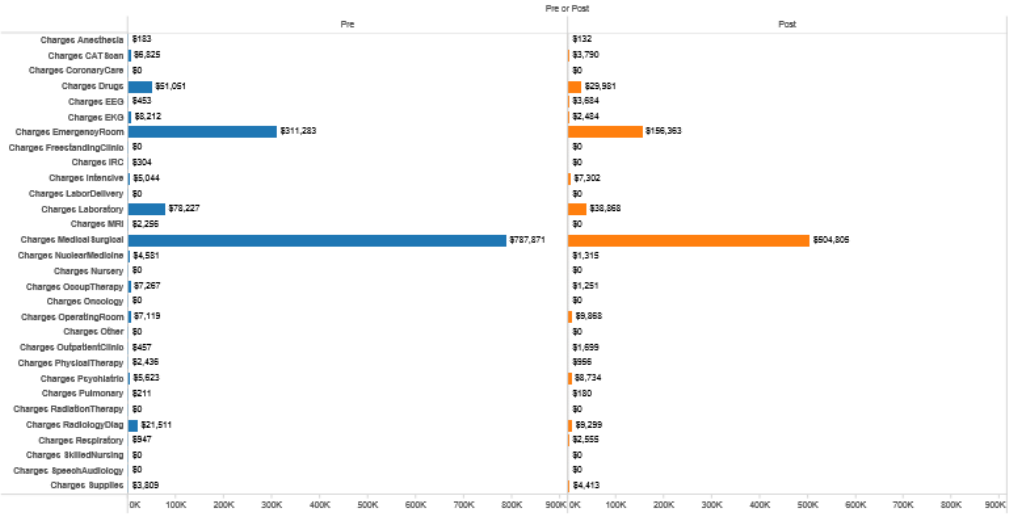
Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(•) AND
( ) OR

Breakdown of Charges Sheet



Casemix Data Through:	- MDH and HSCRC, 2016. Tableau dashboards developed by CRISP.
06/30/2020	- Data source: - Panel information provided to CRISP by ENS - HSCRC data includes all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals - Individual patients identified using CRISP EID - CRISP suppressed cells with counts of 10 and under - Depending on the number of months selected, some participants might not be included in the analysis if they do not have data for the entire period before and after the analysis - Months of Analysis is not based on calendar days or 30 days but calculated by getting the same date, months in advance. eg. 1 Month before Feb 28th is Jan 28th and 1 Month before June 15th is May 15th and so on. - Data for post enrollment (after) also includes the data for the day of enrollment in addition to Months of Analysis data.
ENS Panels Last Updated:	
07/30/2020	

Appendix D: Skilled Nursing Facilities

Althea Woodland Nursing and Rehabilitation Center
Arcola Health and Rehabitiliation
Asbury Methodist Village (Wilson Health Care Center)
Bedford Court
Bel Pre Nursing and Rehabilitation
Bethesda Health and Rehabilitation
Brighton Gardens of Tuckerman Lane
Brooke Grove
Cadia Hyattsville
Cadia Springbrook
Cadia Wheaton
Carriage Hill
Collingswood
Crescent Cities
Fairland Center
Fox Chase
Friends Nursing Home
Hebrew Home of Greater Washington
Hillhaven
Kensington
Layhill
Manor Care Adelphi
Manor Care Bethesda
Manor Care Chevy Chase
Manor Care Hyattsville
Manor Care Potomac
Manor Care Silver Spring
Manor Care Wheaton
Montgomery Village
Oak Manor
Oakview
Potomac Valley
Regency Care of Silver Spring
Shady Grove Center
Sligo Creek Center
The Village at Rockville