HSCRC Transformation Grant

FY 2020 Report

Submitted by Trivergent Health Alliance on behalf of three partner hospital:
Frederick Memorial Hospital,
Meritus Medical Center,
And
UPMC Western Maryland

FY 20 Year-End Report Narrative Template
Performance Year 4

Presented to the
Maryland Health Services Cost Review Commission (HSCRC)

September, 2020

Contents

HSCRC Transformation Grant

FY 2020 Report

The Health Services Cost Review Commission (HSCRC) requires the following information for FY 2020 Regional Partnership Transformation Grant Program participants: this Report, the Budget Report, and the Budget Narrative. Whereas the Budget Report distinguishes efforts between each hospital, this Summary Report should consolidate information and describe all hospitals, if more than one, that are in the Regional Partnership.

Regional Partnership Information

Regional Partnership (RP) Name	Trivergent Health Alliance Regional Partnership (RP)
RP Hospital(s)	Frederick Memorial Hospital (FMH), Meritus Medical Center (MMC), UPMC Western MD (UPMC)
RP Point of Contact(s)	- Jo Wilson (VP- Population Health, UPMC Western MD) - Larry Kaufman (CEO of Trivergent)
RP Interventions in FY 2020	**1. Behavioral Health:** 1.1- Community Based Behavioral Health Case Management. 1.2- Integration of Behavioral Health Professionals in Primary Care. **2. Complex Care Management:** 2.1- Implementation of Community Health Worker Service. 2.2- Expansion of existing outpatient care management platforms to address multidisciplinary clinical and care coordination needs of identified high utilizers, and the under-served, population at-risk to become high utilizers. - **FMH:** Expansion of CARE Clinic Services and Mobile Integrated Health Pilot Program. - **MMC:** Embedded Case Management Services added to Specialty Care. - **UPMC Western MD:** Union Rescue Mission Clinic and Hometown Healthy Program. **3. ED PAU*:** 3.1: Improved care coordination and transitions by increasing integration with CRISP and creation of Care Alerts in alignment with Maryland Hospital Associate/CRISP/HSCRCs state wide goal to improve care coordination. 3.2: Reduction of PAU will inherently be achieved through implementation of the CCM and BH interventions as described above.

	3.3: Implementation of Mobile Integrated Health program as funding sources are identified and in alignment with state and county EMS regulatory compliance. **These interventions are carried out simultaneously in conjunction with the BH and CCM interventions detailed through 1 and 2 above. The BH interventions primarily focus to decrease ED PAU. The primary focus of the CCM intervention work is to decrease preventable inpatient utilization and secondarily focuses to decrease ED PAU. ED PAU measurement is incorporated into the BH and CCM process and outcome measures. Reporting for 3.2 and 3.3 will be inherently embedded within the BH and CCM specific intervention sections.* 4. **Create a Regional Care Management Education Center (RCMEC)**** Implement standardized, evidence based, case management education and training regionally. *** This intervention is carried out within intervention 2.2.*
Total Budget in FY 2020	**Initial Award:** $3,100,000; distributed equally among the three-member hospitals. **FY 2020 Award:** $2,169,999; distributed equally among the three-member hospitals: - FMH: $723,333 - MMC: $723,333 - UPMC: $723,333
Total FTEs in FY 2020= 38.7	**Employed:** 26.2 FTE
	Contracted: 12.5 FTE
Program Partners in FY 2020 *Please list any community-based organizations or provider groups, contractors, and/or public partners*	- Allegany County Department of Social Services (DSS) - Allegany County Health Department - Allegany County Human Resources Development Commission (AHRDC) - Archway Station, Inc. - Asian American Center Frederick County - Associated Charities - CRISP - Emergency Medical Services (EMS): Frederick County and Allegany Counties - Lighthouse, Inc. - Local Management Board - Maryland Area Health Education Center West (AHEC West) - Potomac Case Management Service, Inc. (PCM) - Turning Point/Waystation - Union Rescue Mission - Washington County Commission on Aging

	- Western Maryland Food Bank

Overall Summary of Regional Partnership Activities in FY 2020

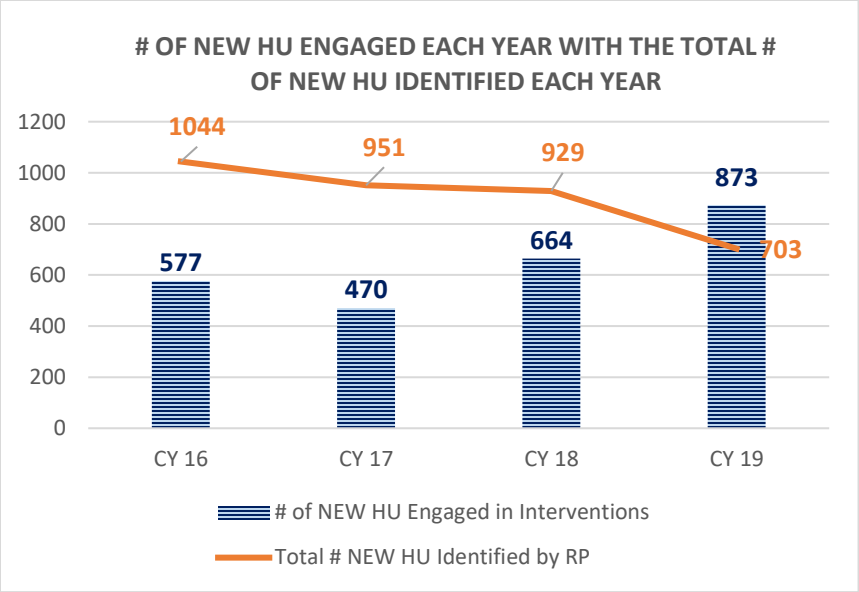
Freeform Narrative Response: 1-3 Paragraphs:

During Fiscal Year (FY) 2020 a total of 17,159 patients were engaged through the Regional Care Transformation grant funded interventions. The table below lists the number of patients engaged by intervention.

Table 1: FY 2020 total number of patients engaged through the Regional Care Transformation (RCT) program by intervention type.

RCT Program Intervention:	FY 18- RP Number of Engaged Patients	FY 19- RP Number of Engaged Patients	FY 20- RP Number of Engaged Patients
Behavioral Health- Strategy 1:			
1.1 Community Based Behavioral Health Case Management	1,868	1,459	2,475
1.2 Integrated Behavioral Health Professional in Primary Care	2,574	3,031	3,655
Complex Care Management- Strategy 2:			
Number of Targeted High Utilizers **Engaged in CCM Services**	470	664	**873**
2.1 Community Health Worker Services:			
Inpatient CHW	923	2,697	2,532
Outpatient CHW	1402	1,477	1,318
2.2 Expansion of Care Management existing infrastructure to include the following services:			
URM Clinic and Hometown Healthy Partnership (new FY 19)	310	750	1,269
Care Clinic	379	1,488	3,253
Embedded Care Management services in specialty care practices	220	633	1,784
Total number of patients engaged in RCT Interventions	**8,146**	**12,199**	**17,159**

Within the graphic below, the number of "new" high utilizers identified each year are displayed via the orange values. (These "new" high utilizers had not met the criteria previously, yet now meet the RP's initial targeted high utilizer definition.) The blue columns serve to communicate the total number of high utilizers the partnership has been able to engage each year. Effective management of the high utilizers is difficult but critically necessary to make lasting change that will ultimately drive the cost curve to decrease overall.



- **Calendar year (CY) 2016:** the RP engaged 577 patients and had 1044 High Utilizers identified from calendar year 2015 data analysis.
- **Calendar Year (CY) 2017:** the RP engaged 470 patients and had 951 new High Utilizers identified from calendar year 2016 data analysis.
- **Calendar Year (CY) 2018:** the RP engaged 664 patients and had 929 new High Utilizers identified from calendar year 2017 data analysis.
- **Calendar year (CY) 2019**: the RP engaged 873 patients and had 703 new High Utilizers identified from calendar year 2018 data analysis.

While our program continues to identify new high utilizers each year, there are some current high utilizers that graduate from specific interventions, and others that continue to require engagement in services (albeit to a lesser degree in most circumstances, yet- not always).

Intervention Programs

Strategy 1- Behavioral Health Program Interventions

Intervention or Program Name	1.1 Community Based Behavioral Health Case Management (BH CM)
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	All RP Hospitals are participating.
Brief description of the Intervention *2-3 sentences*	Implementation of Community Based Behavioral Health Case Management (BH CM) within each hospital system provides therapeutic services to patients in multiple outpatient physician practices. Through these services, patients discharged from the ED with specialized BH CM needs have the

	resources to bridge the gap from discharge to appropriate outpatient services. This program has shown reduced rates of readmissions and ED utilization for program participants. FMH and MMC refer those described as "High-Utilizers" to Potomac Case Management when being discharged from either the ED, Inpatient Psychiatric Units, or Medical Floors for continued services within the community.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	- Archway Station, Inc. - Lighthouse, Inc. - Potomac Case Management Service, Inc. - Turning Point/Waystation - Union Rescue Mission
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>2,475</u>** **Denominator of Eligible Patients: <u>489,799</u>** (Source of denominator # 1, as requested by HSCRC: RP Analytic file for 01Jan2019-31Dec19_yearly downloaded from CRISP on 9/18/20; 3+ IP or Obs>=24 visits; Column C- Population.) **RP Denominator (Intervention Specific): <u>11,664</u>** (Source: Unique number of patients discharge from BH IP units or the ED with primary BH ICD-10 codes F10-F69, F80-F99.)
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	Community based BH CM targets to support behavioral health patients after inpatient or ED discharge to prevent ED revisit and/or readmission. **<u>FMH-</u>** A copy of the calendar year 2018 CRISP Pre/Post report results demonstrated via FMH's BH CM in partnership with Potomac Case Management, Inc. is provided as Figure 1: *Community Based Behavioral Health Case Management: CRISP Pre/Post report for patients engaged in services calendar year (CY) 2018; Frederick Memorial Hospital.* Key impact summarized from this CRIPS Pre/Post report includes: **Change in Pre/Post Total Charges at the 12-month mark:** quantifies that patients engaged in this service generated <u>$379,390</u> less in charges after engagement, than required prior to engagement. **Visits per 10 members reduced at the following rates:** 1-month mark: -9.4 (less visits) 3-month mark: -7.0 (less visits) 6-month mark: -3.5 (less visits) 12 months: 0.1 (more visits)

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.*	Fiscal year 2020 a total of 2,240 patients were engaged in the Behavioral Health Case Management intervention (an increase of 781 from prior year). The Regional Partnership's ED revisit rate of program participants: - FMH- 3.4% revisit rate - MMC-15.7% revisit rate - UPMC- 11.96% revisit rate The Regional Partnership readmission rate of program participants: - FMH- 1.7% readmission rate - MMC- 3.0% readmission rate - UPMC: 12.28% readmission rate
Successes of the Intervention in FY 2020 *Freeform Narrative Response, up to 1 Paragraph*	- Successfully integrated BH Case Management and Peer Recovery Services into community-based settings and primary care (ex- UPMC Western MD Weekly Clinics). - Successful in reduction of high-utilizers returning to the ED and/or needing readmission for psychiatric care. - Continuation of collaborative work with other disciplines. - Ability to engage clients in the program and see impact in their subsequent utilization.
Additional Freeform Narrative Response (Optional)	

Intervention or Program Name	**1.2 Integrated Behavioral Health Professional in Primary Care**
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	All RP Hospitals are participating.
Brief description of the Intervention *2-3 sentences*	Implementation of standardized depression screening tools to screen all adults within RP employed practices. Grant resources have been utilized to create or expand access to Behavioral Health Professionals (BHPs) embedded in Primary Care among regional partnership members. A standardized approach to depression screening leads to early detection and early intervention, allowing BHPs and primary care providers in coordination to develop collaborative treatment plans with the patient. These efforts support early detection and treatment to ward off escalation and crisis, which often lead to avoidable ED and inpatient utilization.

<table>
<tr><td>Participating Program Partners
Please list the relevant community-based organizations or provider groups, contractors, and/or public partners</td><td>- Archway Station, Inc.
- Lighthouse, Inc.
- Union Rescue Mission</td></tr>
<tr><td rowspan="2">Patients Served
Please estimate using the Population category that best applies to the Intervention, from the CY 2018 RP Analytic Files. HSCRC acknowledges that the High Utilizer/Rising Risk or Payer designations may over-state the population, or may not entirely represent this intervention's targeted population.
Feel free to also include your partnership's denominator.</td><td># of Patients Served as of June 30, 2020: <u>3,655</u>
(Value = # of unique patients engaged with Integrated Behavioral Health Professionals during FY 2020.)</td></tr>
<tr><td>Denominator of Eligible Patients: <u>489,799</u>
(Source of denominator # 1, as requested by HSCRC: RP Analytic file for 01Jan2019-31Dec19_yearly downloaded from CRISP on 9/18/20; 3+ IP or Obs>=24 visits; Column C- Population.)

RP Denominator (Intervention Specific): <u>20,854</u>
Value is derived from the following logic:
(# of adult FMH, MMC and UPMC patients of employed PCP practices in calendar year 2019) + (# of eligible adult FMH Care Clinic patients) + (# of eligible adult UPMC Clinical Resource Center patients) times 20%.
Note: MRNs are cross referenced to ensure a unique patient count. Next, a factor of 20% is applied to the account for the incidence of depression in the United States.</td></tr>
<tr><td>Pre-Post Analysis for Intervention (optional)
If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.</td><td>This intervention aims at early detection to provide early intervention to prevent escalation and progression of needs. Provided high utilization is not part of this programs engagement criteria, pre/post analytics yield null results and would not be an effective method to measure impact.</td></tr>
<tr><td>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.</td><td>Table 2: Metric Results for FY 2020 Summarized to include all three hospitals of the Regional Partnership:
<table>
<tr><th>Metric</th><th>Outcome</th></tr>
<tr><td>% of hospital employed PCPs utilizing standard depression screening tool (PHQ 2/9).</td><td>76%</td></tr>
<tr><td>Total #- PHQ 9's administered (adults) within Employed Primary Care Providers</td><td>51,858</td></tr>
<tr><td># of unique adult patients who were screened via PHQ 2 or 9 in the previous 12 months</td><td>219,226</td></tr>
</table></td></tr>
</table>

	# of unique patient visits in the previous 12 months 203,578 **% of unique adult patients within RP screened during FY 2020** 51% **Total # of interventions completed by BHPs in FY 20 (Intervention= telephonic, face-to-face, or home support for FMH, MMC and UPMC)** 39,912
Successes of the Intervention in FY 2020 *Freeform Narrative Response, up to 1 Paragraph*	- Successful in integrating BH Case Management and Peer Recovery Services into community-based settings and in Primary Care (PC). - Successful in reduction of high-utilizers returning to the ED and/or needing readmission for psychiatric care. - Patients are receptive to engaging with the integrated BH specialist embedded in primary care; as receiving care from within their primary care providers office is not seen with the same stigma associated with walking into a branded behavioral health care center. Thus, allowing patients in need of BH counseling to ultimately receive the care needed. After engaging with the Integrated BH specialist, if it is determined longer-term BH services are needed, clients are more willing to engaging (i.e. evidence the stigma that once prevented their engagement is being overcome- as the benefits of such care is experience). - Patient's that screen positive for significant risk of depression are being referred to Integrated BHP in primary care where available. - Awareness of depression continues to increase. - Embedded BH case management continues to facilitate many patients to be managed by their PCP on mental health medications and avoid long waits for mental health services in the community. The communication between the PCP and the mental health medication prescribing provider has increased. - Primary Care practices embrace having access to embedded Behavioral Health Specialists.
Additional Freeform Narrative Response (Optional)	

Strategy 2- Complex Care Management

Intervention or Program Name	2.1 Addition of Community Health Worker Services
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	All RP Hospitals are participating.
Brief description of the Intervention *2-3 sentences*	2.1: Community Health Worker (CHW) service implemented as an extension of existing outpatient care management infrastructure to provide high touch care to increase patient engagement, assess for social determinants of health needs, and connect patients with appropriate community-based resources. The outpatient Community Health Workers are supported by a clinically strong, multidisciplinary team to address clinical patient needs. All RP Hospitals are participating: - **FMH** partnered with Asian American Center to implement a hybrid model through which CHW representatives can make a warm connection with the patient prior to discharge from inpatient status, and then follow up to address need via the outpatient CHW service - **MMC** partnered with the Commission of Aging to implement an outpatient CHW service targeting high utilizers. During the first quarter of fiscal year 2019 MMC executed a plan to increase the quality of the interactions between CHW and patients to ensure that upon graduation from the program, all needed goals were met. The impact of conducting this re-training resulted in more in-depth care and better coordination of care, yet required a decrease in overall caseload per CHW FTE. MMC has confirmed that the investment in a higher quality service yields greater benefit to the patient and is evident in clients post engagement reduction in avoidable utilization. - **UPMC** repurposed FTEs to expand their existing outpatient CHW service to now reach inpatients, with identified high and moderate risk for readmission, prior to discharge. UPMC Western Maryland's inpatient CHW service facilitates scheduling of outpatient follow up appointments and mitigates roadblocks to attending the follow up appointments.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	- Frederick County Asian American Center - Washington County Commission on Aging - UPMC Western MD had an existing CHW program which has been expanded using grant funded resources
Patients Served *Please estimate using the Population category that best*	**# of Patients Served as of June 30, 2020: 783** (Value = Number of targeted high utilizers "engaged" within Care Management Platform.)

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.*

Denominator of Eligible Patients: 489,799
(Source of denominator # 1, as requested by HSCRC: RP Analytic file for 01Jan2019-31Dec19_yearly downloaded from CRISP on 9/18/20; 3+ IP or Obs>=24 visits; Column C- Population.)

RP Denominator (Intervention Specific): 876
(Value = Number of targeted calendar year (CY) 2018 new high utilizers that meet our initial target population inclusion criteria.)

Pre-Post Analysis for Intervention (optional)
If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.

Table 3: Complex Care Management Calendar year 2018 High-Utilizers: CY 2018 to CY 2019 Utilization Comparison Results

CY 18 High Utilizers in CY 19	Engaged Patients- Aggregated	
# of Engaged High Utilizers by RP	721	
	Encounters	Charges
Total Pre	883	$16,881,090
Total Post	575	$11,733,207
Total change in utilization:	(308)	($5,147,883)
	# of Reduced Occurrences	Reduction in Total Charges
Readmissions	336	$6,819,171
PQIs	163	$2,501,710
Total Change in PAU (reductions)	499	$9,320,881

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

Table 4: Outpatient CHW Service (FMH and MMC)

Metric	Outcome
Total # of unique patients cared for through the CHW Service in fiscal year 2020	713
Total # of referrals made by CHW to connect patients to additional services based on need	3,601

Intervention; operationalized care teams; etc.	

Quality of life assessment scores completed pre and post CHW service engagement	MMC- Pre: 2.17, Post: 2.65 FH- Pre: 2.92, Post: 3.90
Total # graduated from the program	366

Table 5: Inpatient CHW Services (UPMC)

Metric	Outcome
# of patients engaged with Inpatient CHW services fiscal year 2020	2,532

Successes of the Intervention in FY 2020 *Freeform Narrative Response, up to 1 Paragraph*	- Patients assessed to have moderate risk, high risk, or very-high risk for readmission that engaged with the inpatient CHW service and attended their follow up appointment within seven days demonstrated significantly lower readmission rates than those patients who did not engage with the service and did not attend their follow up appointment within seven days. - Washington County Commission on Aging (community partner) is now a recognized Trainer for CHW Certification. - MMC Onboarded three new CHWs. - Continued to refine referral criteria, and the articulation of program "graduation" criteria. - Frederick Health continues to successfully utilize a CHW model that utilizes both employed and contracted CHWs. This model affords the CHWs to work more closely with multidisciplinary care coordination team members at both the health system and our community partner. - Number of referrals CHW are able to process and facilitate in order to connect patient to needed community-based services has improved as staff competency increases.
Additional Freeform Narrative Response (Optional)	

Intervention or Program Name	2.2 Expansion of Care Management Outpatient Platforms
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	Each hospital is participating in this initiative via the following complex care management platform expansion programs: - **FMH:** Expansion of FMH's Care Clinic and implementation of a Mobile Integrated Health Pilot in collaboration with Frederick County EMS. - **MMC:** Expansion of embedded Care Management Services into specialty care practices. - **UPMC:** Union Rescue Mission Clinic and implementation of Hometown Healthy Partnership. All RP Hospitals are participating in the intervention but expanding upon existing resources and infrastructure to speed impact of grant resources via shovel ready interventions without duplicating existing programs.
Brief description of the Intervention *2-3 sentences*	**CARE Clinic:** Expansion of access to the existing multidisciplinary outpatient CARE Clinic focused on providing disease based follow up care and care coordination from 2 days a week, to 5 days a week. A Mobile Integrated Health pilot program has been implemented in collaboration with Frederick County EMS to provide proactive home visits for ED and/or EMS high utilizers. A paramedic initially meets with referred client. Subsequent visits are conducted with the paramedic and any additional disciplines (Pharm, RN, SW, Dietitian, etc.) deemed appropriate. Additional community resources are engaged based on identified need (i.e. Behavioral Health Case Management, Hospice, Home Health, Community Health Worker Service, etc.). **Embedded Care Management in Specialty Care:** Expansion of existing Integrated Care Management services in primary care to include two specialty practices (Pulmonary and Cardiology). Integrated Care Management team provides multidisciplinary care coordination, and care transition support from the primary or specialty care outpatient office in collaboration with the provider and their office-based team. **Hometown Healthy Partnership:** Hometown Healthy Partnership (HHP) events started in June 2019 to improve the health and wellbeing of our community. During the pilot of Hometown Healthy Partnership, we registered 1974 unique individuals who participated in 2715 screenings or activities at 38 events (30 additional events since last report). The pilot of the HHP has ended and the next phase was to launch in 2020 but the pandemic halted implementation. To streamline efforts and expand participation in programs, HHP was transitioned to the Wellness Ambassadors. Wellness Ambassadors are members of faith based or community groups who volunteer to promote healthy living in their organization.

<table>
<tr><td></td><td><u>Union Rescue Mission Clinic:</u> The Union Rescue Mission Clinic supports the BH and CCM strategies and increases access to primary care by extending the reach of the existing multidisciplinary outpatient Clinical Care Resources (CCR) clinic. This service provides pro-active engagement with underserved populations to increase access to primary care, screen for health risks that need attention and management, and navigate resources to address needs related to social determinants of health.</td></tr>
<tr><td>Participating Program Partners
Please list the relevant community-based organizations or provider groups, contractors, and/or public partners</td><td>- Allegany County Department of Social Services (DSS)
- Allegany County Human Resources Development Commission (AHRDC)
- Allegany County Health Department
- Associated Charities
- Emergency Medical Services (EMS): Frederick County and Allegany Counties
- Local Management Board
- Maryland Area Health Education Center West (AHEC)
- Union Rescue Mission
- Western Maryland Food Bank</td></tr>
<tr><td rowspan="2">Patients Served
Please estimate using the Population category that best applies to the Intervention, from the CY 2018 RP Analytic Files. HSCRC acknowledges that the High Utilizer/Rising Risk or Payer designations may over-state the population, or may not entirely represent this intervention's targeted population.
Feel free to also include your partnership's denominator.</td><td># of Patients Served as of June 30, 2020: <u>2,583</u></td></tr>
<tr><td>Denominator of Eligible Patients: <u>489,799</u>
(Source of denominator # 1, as requested by HSCRC: RP Analytic file for 01Jan2019-31Dec19_yearly downloaded from CRISP on 9/18/20; 3+ IP or Obs>=24 visits; Column C- Population.)

RP Denominator (intervention specific): <u>14,353</u>
(Value = Sum of FMH + MMC + UPMC Eligible Patients)</td></tr>
<tr><td>Pre-Post Analysis for Intervention (optional)
If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.</td><td><u>Care Clinic:</u> CRISP Pre/Post Analysis report for CARE Clinic patients quantifies significant reduction in visits at the 1 month, 3 months, and 6-month intervals. In alignment with this interventions objective to reduce avoidable utilization, the Pre/Post report quantifies significant decreases in following post engagement with CARE Clinic services: the rate and average charge per member, rate of visits per 10 members, and average charge per visit.

CARE Clinic Pre/Post Report excerpt is presented in Table 6. Care Clinic CRISP Pre/Post Summary of Results to summarize the outcomes quantified.

Table 6: Care Clinic CRISP Pre/Post Summary of Results
<table>
<tr><th>Time Period</th><th>Total # of Visits: Pre</th><th>Total # of Visits: Post</th><th>Total Charges: Pre</th><th>Total Charges: Post</th></tr>
</table>
</td></tr>
</table>

1 Month	1,306	509	$9.6M	$2.3M
3 Months	2,464	1,515	$14.5M	$7.1M
6 Months	3,334	2,535	$18.1M	$11.6M
12 Months	3,253	2,696	$17.9M	$12.7M

Union Rescue Mission Clinic:
Internal Pre/Post Analysis are posted in Table 7. *MCR Pre/Post analysis results* for program participants by comparing calendar year 2018 utilization to that of calendar year 2019. Reduction in utilization is demonstrated for inpatient, ED, OBS visit, and readmissions counts; indicating shift from higher cost, more complex to lower level need.

Table 7: Union Rescue Mission Clinic Pre/Post Analysis Results

Utilization Metric	Calendar Year 2019 Value	Calendar Year 2018 Value	% of Change (Reduction)
Total Charges	$81,088	$186,023	(56.4%)
Total Visit Count	13	79	(83.5%)
Inpatient Visit Count	5	14	(64.3%)
ED Visit Count	8	61	(86.9%)
OBS Visit Count	0	4	(100%)
Readmission Visit Count	1	1	0%

Hometown Healthy Partnership (HHP): Refer to pg.14 for program description.

# of Patients Served as of June 30, 2020: 1,269.

Embedded Care Management in Specialty Practices:
CRISP Pre/Post Analysis Results for patients engaged with Embedded Care Management in two Specialty Practices are summarized in ***Table 8***.

Table 8: Embedded CM in two Specialty Practices: CRISP Pre/Post Summary of Results

Time Period	Total # of Visits: Pre	Total # of Visits: Post	Total Charges: Pre	Total Charges: Post
1 Month	457	183	$5.2M	$953K
3 Months	807	480	$7.9M	$3.0M
6 Months	1200	844	$10.4M	$5.4M
12 Months	1784	1380	$13.5M	$8.5M

	Embedded Care Management CRISP Pre/Post reduced charges summarized from *Table 8*: 1 Month: $4.2M 3 Month: $4.9M 6 Month: $5.0M 12 Month: $5.0M
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.*	**CARE Clinic Process Metrics:** Fiscal year 2020 average number of CARE Clinic scheduled visits per month increased to 387 per month from FY 19 average value of 314 per month. The Readmission Rate was 2% for these patients. **Mobile Integrated Health (MIH) Process Metrics:** - July 2016- July 2017: MIH application written and submitted. - July/Aug. 2017: Application approval notification received and implementation work began. - Nov/Dec. 2017: On boarding/orientation of Paramedic. - Jan/Feb 2018: Began enrolling participants. Slow ramp up, problem solved challenges and determined initial paramedic was not the best fit for the program, new candidate search commenced. - July 2018: New paramedic on boarded. Ramp up of program demonstrated through increased participation and engagement of clients identified by EMS and hospital (high utilizers). EMS embedded a referral mechanism into the EMR enabling all paramedics to refer potential participants into the program. - June 2019- Current paramedic promoted, recruitment of 3rd paramedic is under way. - July 2019- Successful on board of new paramedic. Work continues to stabilize and grow the program through increased participation and engagement of clients identified by EMS and Hospital.
Successes of the Intervention in FY 2020 *Freeform Narrative Response, up to 1 Paragraph*	- Collaborative working relationship between embedded Case managers and specialist, which facilitates providers to refer patients in need of CM services - Reduced utilization achieved through all 3 initiatives: Union Rescue Mission Clinic, CARE Clinic, and embedded case management in specialty care. - Initiation of COVID Discharge Call follow up process, that included WebEx video Visits. - Addition of FT Respiratory Therapy Educator at Pulmonary Consultants. - Expansion of transitions of care program to community-based PCPs to include RN, DE, RT, SW, CN - UPMC Western MD- Aunt Bertha: The online community resource directory and referral system includes 1666 resources serving Allegany county. Merged into one domain for affiliated users and a public facing domain (path2help.com). 300 health related social needs assessments

	have been completed. Worked with partners to increase claimed programs (100) and closed loop referrals (84). Initiated monthly highlights to users with training tips. - Utilization of the CARE clinic continues to play a significant role in decreased hospital utilization. - UPMC Western MD's outpatient Community Health Worker program was successful in increasing self-reported QOL metric to monitor effectiveness of interventions on the QOL of enrolled patients; improving workflows for assessing and addressing patients' physical environment for safety; and adding workflows for assessing and addressing patients' social determinants of health.
Additional Freeform Narrative Response (Optional)	***RP Intervention #4: Regional Care Management Education Center (RCMEC)*** **Objective:** Establish a regional center to offer standardized and responsive care management education programs serving the regional partnership's interdisciplinary care management team working with high utilizing patients, and at-risk patients. - Regional Partnership members contracted with Compass to implement access to evidenced based American Case Management Association training material that are updated yearly to ensure the content is relevant and current. - Access to this educational material is key to ensure our team members across our partnership are current with best practices, have access to relevant continuing education for growth, and are aware of applicable regulatory changes.

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	CY19 RP Analytic File, 3+IP or OBS >24 =visits Total Hospital Charge per Capita= $2,642/12= **$220.17**
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	CY19 RP Analytic File, 3+IP or OBS >24 =visits Total Discharges per 1,000= 293.2/12= **24.43**
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	CY19 RP Analytic File, 3+IP or OBS >24 =visits Total Ambulatory ED Visits per 1,000= 1,052/12= **87.68**

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	CY19 RP Analytic File, 3+IP or OBS >24 =visits Average Unadjusted Readmission Rate by hospital:

	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	FMH- **10.47%** MMC- **10.23%** UPMC- **10.52%** Average for RP- **10.41%**
PAU	**Potentially Avoidable Utilization** Executive Dashboard: '[Partnership] Quality Indicators' – Potentially Avoidable Utilization, reported as **sum** of 12 months of FY 2020	CY19 RP Analytic File, 3+IP or OBS >24 =visits Total Sum of Potentially Avoidable Utilization- **$120,943,857**

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.

- *Most of the RCT process and outcome metrics have been communicated and populated into either the pre/post or process metrics section with the Intervention section of this template.*

Behavioral Health Strategy

As a means to decrease the number of high utilizers to MMC, a small committee from Meritus (Social Worker and Care Management), Potomac Case Management, Integrated Services and Waystation meet bi-weekly to discuss care plans for patients in the services. The noted Care Plans are kept in a notebook in the ED to be reviewed by anyone working with the patient.

Complex Care Management Strategy

Additional self-reported process measures for Complex Care Management Strategy included FMH and MMC Quality of Life Survey scores; which increased by 1.46 over a 12-month average. The total number of referrals made by CHW to community programs (3,601 between FMH and MMC) is another process measure that has been monitored and tracked by the RP.

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)

FMH- Total FY 2020 Expenditures ($1,043,545) / Total Patients Served (2,997) = $348.19

MMC- Total FY 2020 Expenditures ($1,305,834) / Total Patients Served (5,182) = $251.99

UPMC- Total FY 2020 Expenditures **($956,899)** / Total Patients Served **(6,707)** = **$142.67**

Overall RP- Total FY 2020 Expenditures **($3,306,278)** / Total Patients Served **(14,886)** = **$222.10**

	Trivergent Regional Partnership Projected to Annual	FY 17		FY 18		FY 19		FY 20	
		Projected	Actual	Projected	Actual	Projected	Actual	Projected	Actual
a	**Grant Award**	$3.1M		$3.1M		$3.1M		$3.1M	
b	**Reduction in Charges (Pre-post change in utilization for targeted engaged HU)**	$6.2M	$12.8M	$7.8M	$14.9M	$8.64M	$26.6M	$10.2M	$6.3M
c	**Variable savings factor**	30%		40%		40%		40%	
d	**Variable savings (b*c)**	$1.9M	$3.84M	$3.1M	$5.96M	$3.4M	$10.64M	$4.1M	$2.52M
e	**Program Expenses (FY)**	$3.1M	$2.1M	$3.1M	$3.08M	$3.1M	$3.6M	$3.1M	$3.3M
f	**ROI (d/e)**	1.58	1.83	1.61	1.93	1.78	2.94	2.11	0.76
g	**Accrual to Payors- Shared Savings**	-		$310K		$620K		$930k	

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.

Behavioral Health Strategy

Patient's identified with acute mental health and/or addiction issues have suffered greatly from the COVID-19 pandemic. During the earlier months of the pandemic, agencies were not seeing patients for individual therapy nor medication reviews, which in turn affected a patient's mental stability. The fear of COVID-19 also affected the community case workers because of declining utilization of patient services, out of fear of contracting COVID-19. During the course of the pandemic, there has been an increase in the number of patients suffering from acute mental health issues and being admitted to inpatient psychiatric facilities for medication stabilization. The length of stay for these patients increased as patients in the hospital could not be discharged to traditional outpatient services. UPMC Western MD had to shut down their psychiatric emergency department for 90 days to convert it to a COVID-19 medical ED.

Complex Care Management Strategy

During the earlier months of the COVID-19 pandemic, many of the Regional Partnerships employees were utilized in a different capacity than their regular jobs. For instance, all MMC Outpatient Care Management staff were pulled to operate the COVID Nurse Call Line (12 hours a day- 7 days a week), serve as initial COVID drive-through testing site staff, and to create a COVID follow up and Safe

Discharge Team. As of May 1, 2020, the MMC Outpatient Care Management staff are no longer staffing the COVID Drive-through but are still operating the COVID Nurse Call Line (8 hours a day- 7 days a week). UPMC Western MD shifted focus from Community Health Worker home visits and community events, to COVID-19 Wellness Calls. The focus became high-risk patients such as; seniors and patients with multiple co-morbidities ensuring that patients had a good supply of medication, food, diabetic supplies, oxygen supplies and accessible information about COVID-19 signs, symptoms and preventative strategies. The COVID pandemic also disrupted the CHWs ability to connect with their patients. There were no home-visits allowed, there was limited engagement with patients, home safety evaluations and a slowed connection to community-based services. The community-based services that were able to operate had a limited capacity and sources became limited. Internally, there were budget constraints that were felt over the unplanned COVID-19 expenses and loss in revenue. Although there were many services interrupted, Frederick Health had been able to maintain 100% of their CARE Clinic capacity through utilizing telephonic visits and tele-health home visits. UPMC Western MD also used virtual services to screen patients for their access to food and medication, assessing risk factors and educating patients on reducing risk of spread and exposure.

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.

Behavioral Health Strategy

MMC is planning on continuing to utilize Potomac Case Management for Mental Health/Addiction services in the community, which has proven to be an effective strategy in keeping patients from returning to the emergency department. Crisis Counselors and Social workers at Meritus will team up with PCM to meet the patients in the community and provide supportive services (transportation to appointments, services for treatment, assistance in daily living skills, etc). In addition to Community Based Behavioral Care Management, MMC will continue integrating behavioral health into primary care. The integrated services team which works with patients through the primary care practices in the community has been a great success. Those patients identified by the RN or Physician who may be dealing with mental health and/or addictions stressors are referred to the Social Worker for continued care. The Social Worker will briefly work with the patient on his/her issues and make referral to mental health and/or addiction providers for longer term treatment. Ongoing funding for the Behavioral Health initiatives will be applied for as part of the Regional Partnership Catalyst Grant Program.

In addition to behavioral health integration and peer recovery programs, UPMC Western MD was able to build a crisis residential facility, The Center for Hope and Healing. This facility will bridge people stepping down from an inpatient admission and/or prevent a hospitalization all together. It is an 8-bed facility that will provide services to individuals that are in crisis due to a mental health or substance abuse diagnosis. Individuals will be able to stay 10 days, with the possibility of an extension if it is clinically necessary. During their stay, individuals will get connected with their outpatient providers, attend intensive outpatient therapy groups, follow up on any inpatient addiction rehab referrals, and work with our peer recovery support specialists. The Center for Hope and Healing is staffed with 4.6 LPNs and 4.6 behavioral health residential providers 24/7 and all staff are trained in mental health first aid, basic life support (BLS), and motivational interviewing. The Center for Hope and Healing will be the bridge that helps individuals develop a more autonomous lifestyle and develop/enhance skill sets that

will help them be successful in the community. The regional grant helped justify the need and develop support for the Center.

Complex Care Management Strategy

Both the Community Health Worker program as well as the embedded Outpatient Care Management services are going to continue because of the success in patient engagement and outcomes. Both of these strategies have proven to be effective in reducing PAUs, PQIs, Readmissions to the hospital, as well as improving patient's confidence in their ability to successfully self-manage their chronic disease. Meritus will collaborate with the Commission on Aging to support ongoing training for Community Health Workers. The Meritus Outpatient Care Management team will also continue to meet weekly with the Community Health Workers to review care plans and collaborate on challenging cases. The Community Health Workers will continue to provide a minimum of twice weekly touches for the highest risk patients in an effort to reduce unnecessary ED utilization and provide social support connections. The embedded multi-disciplinary Outpatient Care Management team will provide on-the-spot, face-to-face education and support to patients visiting the pulmonary or cardiology practice. In addition, these teams provide telephonic longitudinal care management services to patients with poorly controlled disease. The multidisciplinary team includes an RN, Social Worker, Respiratory Therapist, Community Navigator, and Community Health Worker who work collaboratively to address patient educational and social determinant of health needs.

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.

Behavioral Health Strategy

The increase in tele-conferencing services has allowed patients to be more compliant with meeting with their therapist and/or psychiatrist. Patients are reporting feeling more at ease with their provider in the comfort of their home vs. traveling into an office. This feeling of ease is driven by external factors that the patient may not be able to control if they are traveling to their appointment (seeing someone they recognize- confidentiality, transportation issues, childcare, etc.). The attendance rates for tele-conferencing patients has been steady and with the continued services with Potomac Case Management, the program can maintain working relationships with the clients.

Complex Care Management Strategy

MMC initiated tele-conference visits in response to the COVID pandemic. These video visits provide an opportunity for the embedded care management team to connect with patients from the comfort of their home while still being able to provide visual demonstrations, trouble shoot challenges with equipment, and allows for some limited visual assessment of a patient's condition. Moving forward, MMC is working to integrate a tele-visit platform into EPIC, the EHR. This will make initiating a visit more seamless for both patient and care manager.

Appendix

Figure 1: *Community Based Behavioral Health Case Management: CRISP Pre/Post report for patients engaged in services calendar year (CY) 2018; Frederick Memorial Hospital*

Pre/Post Analysis - Summary

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

Program Name
CM PTMC CY2018 (210005)

Chronic Conditions
All Patients

Chronic Condition Operator
(•) AND
( ) OR

Most Recent Payer
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	213	213	213	213

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	187	62	87.8%	29.1%	-58.7%
3 Months	200	105	93.9%	49.3%	-44.6%
6 Months	206	130	96.7%	61.0%	-35.7%
12 Months	208	160	97.7%	75.1%	-22.5%

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	316	115	14.8	5.4	-9.4
3 Months	489	340	23.0	16.0	-7.0
6 Months	655	581	30.8	27.3	-3.5
12 Months	979	981	46.0	46.1	0.1

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	192	$2,014,043	$297,678	$10,770	$4,801	($5,969)
3 Months	204	$2,503,744	$997,985	$12,519	$9,505	($3,014)
6 Months	208	$2,973,880	$1,742,055	$14,436	$13,400	($1,036)
12 Months	209	$4,193,375	$3,813,985	$20,160	$23,837	$3,677

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	316	115	$2,014,043	$297,678	$6,374	$2,589	($3,785)
3 Months	489	340	$2,503,744	$997,985	$5,120	$2,935	($2,185)
6 Months	655	581	$2,973,880	$1,742,055	$4,540	$2,998	($1,542)
12 Months	979	981	$4,193,375	$3,813,985	$4,283	$3,888	($395)

Casemix Data Through:	- 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.
06/30/2020	
ENS Panels Last Updated:	
08/27/2020	