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	UHCC-UMUCH; Northeast Maryland
RP Hospital(s)	University of Maryland Upper Chesapeake Medical Center University of Maryland Harford Memorial Hospital Christiana Care, Union Hospital (Formerly Union Hospital of Cecil County)
RP Point of Contact	Colin Ward, VP Population Health and Clinical Integration - UM UCH
RP Interventions in FY 2020	• Post Discharge Clinics • Community-based Care Management • Remote Patient Monitoring • Information Technology & Data Analytics
Total Budget in FY 2020 *This should equate to total FY 2017 award*	FY 2020 Award: $1,962,814
Total FTEs in FY 2020	Employed: • Post Discharge Clinics = 21 FTEs • Community-based Care= 25 FTEs
	Contracted: No contracted FTEs
Program Partners in FY 2020 *Please list any community-based organizations or provider groups, contractors, and/or public partners*	• Office on Aging: Karen Winkowski • Harford Co. Health Department: Kim Prout, RN • Harford Co. Department of Social Services • Harford Co. Lions Club

	• Harford Co. Multidisciplinary Team Meetings
	• UM UCMC
	  ○ Inpatient Case Management Teams
	  ○ Comprehensive Care Center
	• CRISP
	• Lyft
	• Harford Community Action Agency
	• United Way of Central MD (Project Homeless Connect): Amy Novack
	• Klein Family Crisis Center: Rod Kornrumpf
	• Adult Protective Services: Chrystal Patton
	• Healthy Harford / Healthy Cecil: Bari Klein
	• Harford Co. EMS: Mary Anna Adams
	• Alzheimer's Association of Maryland: Nicole Gorski
	• Geriatric Assistance Network (GAIN)
	• Meals on Wheels
	• Veteran's Association
	• CAPABLE Program
	• Habitat for Humanity
	• ShopRite Grocery Program
	• Harford Co. Subacute Rehabilitation Facilities
	  ○ Lorien Facilities
	  ○ Sterling Riverside
	  ○ Citizens
	  ○ Sava Care Facilities
	• Cecil Co. Skilled Nursing Facilities
	  ○ Calvert Manor
	  ○ Elkton Transitional Care
	  ○ Laurelwood
	• Home Healthcare Companies
	  ○ Amedisys
	  ○ Bayada
	• Cecil Co. No Wrong Door: Morgan Deweese
	• Cecil Co. Health Department – Lauren Levy
	• Cecil Co. Department of Social Services
	• Spiritual Partnership: Immaculate Conception Church
	• Cecil Co. Lions Club
	• Cecil Co. EMS
	• Cecil Co. Multi-Disciplinary Team Meetings

Overall Summary of Regional Partnership Activities in FY 2020

(Freeform Narrative Response: 1-3 Paragraphs):

The University of Maryland Upper Chesapeake Health (UMUCH) and Christiana Care- Union Hospital (CCUH) Regional Partnership (RP) work to address the medical and social needs of high utilizer patients and those with multiple chronic conditions. The RP has deployed people, processes and technology that help identify and support patients in the pursuit of optimal health. The partnership leverages post-discharge clinics and community-based care teams while implementing telehealth/telemedicine programs as well as a shared (CRISP-hosted) care management documentation system, GSI Health.

The RP interventions target Medicare and dual-eligible patients with multiple visits to the hospital and/or two or more chronic conditions. These patients are likely to have non-medical issues (transportation, medication affordability and environmental concerns) that hamper the ability to maintain good health. The partnership works with multidisciplinary teams in both Cecil and Harford counties to identify and address barriers to care with evidence-based techniques such as motivational interviewing and the Stanford University "Living with Chronic Conditions" education series. The holistic approach to care, though not often reimbursed by Medicare, improves patient health while reducing the need for future hospital-based care.

The RP extends limited human resources by deploying remote patient monitoring systems (Vivify Health), video conferencing for education or treatment, and analytic capabilities in conjunction with CRISP that allow for daily prioritization and tracking of patients to best match RP resources to patient need.

Intervention Program

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

Intervention or Program Name	Post Discharge Clinics
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	CC- Union Hospital UM UCH
Brief description of the Intervention *2-3 sentences*	The Post Discharge Clinics (at UM UCH and CC-Union) monitor the patient's immediate needs after discharge from the emergency department or inpatient units, develops a comprehensive medical and social support treatment plan, and provides follow-up for 30 days. The care plans are documented in the CRISP-hosted platform, GSI Health, so that community providers can participate in the process to a higher degree.

	A multi-disciplinary team of nurses, a social worker, community health worker and pharmacist support patients in the comprehensive care center clinic in person, via telephone, or in the patient's home through virtual visits. The patient may or may not need to be seen by a provider dependent on his connectivity to primary care in the community.

Participating Program Partners
Please list the relevant community-based organizations or provider groups, contractors, and/or public partners
	● Office on Aging: Karen Winkowski
	● Harford Co. Health Department: Kim Prout, RN
	● Harford Co. Department of Social Services
	● Harford Co. Multidisciplinary Team Meetings
	● UM UCMC
	  ○ Inpatient Case Management Teams
	  ○ Comprehensive Care Center
	● CRISP
	● Lyft
	● Harford Community Action Agency
	● Klein Family Crisis Center: Rod Kornrumpf
	● Adult Protective Services: Chrystal Patton
	● Healthy Harford / Healthy Cecil: Bari Klein
	● Meals on Wheels
	● Habitat for Humanity
	● ShopRite Grocery Program
	● Harford Co. Subacute Rehabilitation Facilities
	  ○ Lorien Facilities
	  ○ Sterling Riverside
	  ○ Citizens
	  ○ Sava Care Facilities
	● Home Healthcare Companies
	  ○ Amedisys
	  ○ Bayada
	● Cecil Co. Department of Social Services
	● Union Pulmonology of Elkton

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*	# of Patients Served as of June 30, 2020: 3,141
	Denominator of Eligible Patients: 41,413

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.*	
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.*	
Successes of the Intervention in FY 2020 *Freeform Narrative Response, up to 1 Paragraph*	The RP leveraged Vivify (Remote Monitoring) to reduce the readmission rate for High Risk COPD patients. In FY 20, there were 138 patients enrolled in Vivify, 21 of whom had a 30-day readmission to the hospital (15%). In the final quarter of the year, 45 patients were enrolled, with only 4 readmissions (9%). In addition, a dedicated Community Health Worker was assigned to this population to visit the patient within 48 hours of discharge to assist with medication availability, instruction on proper use of oxygen and nebulizers, and conduct environmental assessments, all of which helped the team refine care plans to better address patient needs.
Additional Freeform Narrative Response (Optional)	The PDCs embedded providers from Infectious Disease, Podiatry and Cardiac specialties to create treatment synergy for complex patients. For complex diabetic patients, as an example, the Podiatrist works with the PDC's Social Worker and RN Care Manager to develop a care plan prior to the patient's foot surgery as well as the Infectious Disease Physician and Pharmacist to select the medication regimen best suited for the patient. Often Home Health agencies were part of weekly patient "grand rounds" to discuss patient's need prior to a scheduled hospital visit with the goal of coordinating post procedure care and eliminating readmissions.

----------INTERVENTION 2----------

Intervention or Program Name	Community-Based Care Management- Wellness Action Teams of Cecil & Harford (WATCH)
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	CC- Union Hospital UM UCH
Brief description of the Intervention *2-3 sentences*	The Regional Partnership specifically funds the Community-Based Care Management Program (CBCM) called Wellness Action Teams of Cecil & Harford counties (WATCH). The CBCM serves as the bridge between the post-discharge clinic, primary care physicians and community providers. The goal is to develop and work longitudinal care plans, with the goal of reducing avoidable utilization. Patients are typically enrolled for 90 days, although the duration of engagement is variable based on how the patient responds to the care plan.

Participating Program Partners
Please list the relevant community-based organizations or provider groups, contractors, and/or public partners
	● Geriatric Assistance Network (GAIN)
	● Primary and Specialty Care Providers
	● Meals on Wheels
	● Cecil County Government – Department of Community Services/Office on Aging
	● Cecil County Health Department
	● Harford County Office on Aging
	● Harford County Health Department
	● Lyft
	● Behavioral Health
	  ○ Upper Bay Counseling
	  ○ Key Point
	  ○ Klein Family Crisis Center
	● Community Action Agency
	● Habitat for Humanity
	● ShopRite Grocery (Healthy Eating & Shopping Education)
	● Skilled Nursing Facilities
	  ○ Citizens Care
	  ○ Sterling Senior Care
	  ○ Forest Hill Health and Rehab
	  ○ Bel Air Health and Rehab
	  ○ Calvert Manor

	○ Elkton Transitional Care ● Amedisys Home Health Agency ● Bayada Home Health Agency
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: 4,546 (includes patients that by-pass the PDC)
	Denominator of Eligible Patients: 41,413
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	
Intervention-Specific Outcome or Process Measures (optional) *These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership maintains and uses to analyze performance.* *Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.*	The WATCH team monitored performance data on Initial Intake Assessments (IIA) completed within seven days for most critical patients (Tier 1 & Tier 2) and Home Visits completed for all patients. The IIA percentage increased from 27% at the end of FY 19 to 100% by March of 2020. The team also conducted at least 3 home visits on nearly 300 more patients in just the first 9 months of FY 2020 which resulted in a 33% increase. The team estimates that this number would have been significantly higher were it not for Covid-19. In FY 19, 850 patients received at least 3 home visits, in FY 20 that volume increased to 1,132.
Successes of the Intervention in FY 2020 *Freeform Narrative Response, up to 1 Paragraph*	The WATCH team emphasized better integration with hospitals and post-acute partners in the region to increase the amount of patients that engaged with community-based care teams. As a result of a streamlined referral process, improved intake program, and embedded resources within the facilities, the WATCH team increased the attempt to contact within 48 hours percent from 45% in FY 19 to 97% by March of 2020.

Additional Freeform Narrative Response (Optional)	

----------INTERVENTION 3----------

Intervention or Program Name	Data and Analytics
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	CC- Union Hospital UM UCH
Brief description of the Intervention *2-3 sentences*	The Regional Partnership has developed and piloted a number of technologies to improve the health of the target population. This includes a data analytics system that incorporates CRISP feeds, a CRISP-hosted care management documentation system called GSI Health which assists with patient prioritization based on many clinical and utilization data points. Secure Zoom video calls and the Vivify Remote Patient Monitoring System have been deployed, with particular acceptance during Covid-19, to help patients remain well outside of the hospital. In addition, the RP has deployed several communication systems with partners in the community, including Doc Halo secure texting, local EMS referral systems (via the EMS Electronic Medical Record) and CRISP Care Alerts.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	• CRISP • Primary and Specialty Care Providers • Harford County Health Department • Harford County EMS • Applied Data Group/SecureNet MD • Vivify
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*	# of Patients Served as of June 30, 2020: 4,546
	Denominator of Eligible Patients: 41,413

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.*	
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 team conducted more than 277 prescriber-driven telemedicine visits with patients during the initial Covid-19 outbreak (March – June). This was a critical feature of the program, as the RP had long been using secure video calls for chronic condition education and addressing social determents of health. Prior to Covid, a CHW focused on the highest risk patients completed 72 home visits within 48 hours to facilitate telehealth visits with the multi-disciplinary team. The RP leveraged the CRISP hosted care management, GSI Health, to create care plans viewable by providers across the continuum. This year, the PDC created 3,140 new care plans while partners, such as the local Departments of Health, established another 615. Sharing the platform for patients in common created a much more efficient process for managing patients with complex medical and social needs.
Successes of the Intervention in FY 2020 *Freeform Narrative Response, up to 1 Paragraph*	The RP Data Warehouse provides insights at the operational and strategic level. In the most recent year, the Data Warehouse enabled frontline team members to be aware of patient discharges from SNFs, create dashboards for patients in the hospital or SNF or home. This minimized a common problem, where patients are "lost in follow-up" – meaning that they leave the SNF but none of the RP programs are notified of the discharge to commence the next phase of care. Additionally, the program overlays risk profiles of patients to conduct more targeted outreach and/or initiate a pre-visit planning process to ensure care and treatment can remain on track for the patient.
Additional Freeform Narrative Response (Optional)	

Core Measures

Please fill in this information with the latest available data from the in the CRS Portal Tools for Regional Partnerships. For each measure, specific data sources are suggested for your use– the Executive Dashboard for Regional Partnerships, or the CY 2019 RP Analytic File (please specify which source you are using for each of the outcome measures).

Utilization Measures

Measure in RFP *(Table 1, Appendix A of the RFP)*	**Measure for FY 2020 Reporting**	**Outcomes(s)**
Total Hospital Cost per capita	**Partnership IP Charges per capita** Executive Dashboard: 'Regional Partnership per Capita Utilization' – Hospital Charges per Capita, reported as average 12 months of CY 2019 -or- Analytic File: 'Charges' over 'Population' (Column E / Column C)	The RP Charges per Capita ● Calendar 18: $261 ● Calendar 19: $272 Increase of 4.5% (lower is better)
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)	The RP Total D/C per 1,000 ● Fiscal 19: 7.9 ● Fiscal 20: 7.3 Decrease of 7.4% (lower is better)
ED Visits per capita	**Ambulatory ED Visits per 1,000** Executive Dashboard: 'Regional Partnership per Capita Utilization' –	The RP Total ED Visits per 1,000 ● Fiscal 19: 30.3

	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)	• Fiscal 20: 26.1 Decrease of 13.7% (lower is better)

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)	The RP Average Unadjusted Readmission Rate • Fiscal 19: 11.5% • Fiscal 20: 11.2% Decrease of 2.8% (lower is better)
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)	The RP Sum of PAU • Fiscal 19: $99,391,835 • Fiscal 20: $97,623,844 Decrease of 1.8% (lower is better)

CRISP Key Indicators (Optional)

These process measures tracked by the CRISP Key Indicators are new, and HSCRC anticipates that these data will become more meaningful in future years.

Measure in RFP *(Table 1 in Appendix A of the RFP)*	**Measure for FY 2020 Reporting**	**Outcomes(s)**
Portion of Target Population with Contact from Assigned Care Manager	**Potentially Avoidable Utilization** Executive Dashboard: 'High Needs Patients – CRISP Key Indicators' – % of patients with Case Manager (CM) recorded at CRISP, reported as average monthly % for most recent six months of data *May also include Rising Needs Patients, if applicable in Partnership.*	The RP Average Percent of *High Risk* Patients with a Care Manager ● January - June 2019: 9.5% ● January – June 2020 : 9.9% Increase of 4.0% (higher is better) The RP Average Percent of *Rising Risk* Patients with a Care Manager ● January - June 2019: 9.0% ● January – June 2020 : 9.3% Increase of 3.1% (higher is better)

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)

4,546 patients served/ $2,427,251 in expenditures in FY 2020 = $533 per patient

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 RP notes a significant impact of Covid-19 on the patients in Cecil and Harford counties. Notably, patients are hesitant to accept placement in Sub-Acute Rehabilitation Facilities (SAR) due to the fear of getting Covid-19. Those who do accept the placement, often leave the SAR before their convalescence is complete. It is expected then, that patients may instead opt for home health services in place of the SAR treatment. This has overwhelmed the home health agencies with new cases and creating delays in the start of care metrics. This change in the flow of patients across the post-acute continuum has placed a new burden on the PDCs and WATCH Teams, as they are receiving referrals for patients far more acute with less ability for self-care at home. The RP is closely monitoring readmissions and collaborating with the hospital discharge planning teams to ensure that referrals are completed when patients decline SAR. The PDC average referral volume per week has increased from 30 to nearly 80 comprised of 25 patients who previously would have been admitted to a SAR.

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.

Many of the interventions funded via the HSCRC Regional Partnership Grants (1.0) will remain in effect in Northeast Maryland. The WATCH program has successfully transitioned to support the Maryland Primary Care Program participants with embedded resources in the practice and will continue to visit patients in their homes (notwithstanding the Covid-19 precautions). This transition has allowed the team to better integrate with primary care and foster more collaboration in the development of care plans. In addition, the WATCH program has developed skills and connections with important non-medical resources that can be initiated from within the Primary Care Practices to potentially impact future hospital utilization.

The Post Discharge Clinic has grown in both physical space and human resources during the four years of the RP. Program expansion within the PDC includes a new, multi-disciplinary Congestive Heart Failure program with a continuum-wide medical pathway and standardized care plan. This program can be integrated with the Vivify (remote patient monitoring) program to remain connected with patients between visits and aggressively titrate treatments to prevent decline.

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.