HSCRC Transformation Grant

FY 2018 Report

The Health Services Cost Review Commission (HSCRC) is reviewing the following for FY 2018: this Report, the Budget Report, and the Budget Narrative. Whereas the Budget Report distinguishes between each hospital, this Summary Report should describe all hospitals, if more than one, that are in the Regional Partnership.

# Regional Partnership Information

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| **Regional Partnership (RP) Name** | Greater Baltimore Medical Center |
| **RP Hospital(s)** | Greater Baltimore Medical Center |
| **RP POC** | Sarah Fogler, Senior Director of Population Health |
| **RP Interventions in FY 2018** | Expansion and Management of Chronic Conditions Through Improved Integration of Mental Health Services, Palliative Care Services, and Care Coordination |
| **Total Budget in FY 2018**  *This should equate to total FY 2017 award* | FY 2018 Award: $1,903,618 |
| **Total FTEs in FY 2018** | Employed: 10 |
| Contracted: 13 |
| **Program Partners in FY 2018**  *Please list any community-based organizations or provider groups, contractors, and/or public partners* | * Allegeant * Baltimore County Health Department * Care Progress, LLC * Catholic Charities * Evergreen Health * Health Care for All Coalition * Keswick Multi-Care Center * Kolmac Clinic * Mosaic community services * MedStar * Sheppard Pratt Health System |

# Overall Summary of Regional Partnership Activities in FY 2018

(Free Response: 1-3 Paragraphs):

**The Behavioral Health Enhanced Patient-Centered Medical Home (BHE-PCMH)** – This initiative builds upon the patient-centered medical home model operating in GBMC’s primary care practices by embedding mental health professionals in the practices. In partnership with Sheppard Pratt, mental health professionals are embedded in the GBMC primary care practices, which provides for ready access to behavioral health consultants and psychiatric consultation services. The initiative also integrates behavioral health resources into the inpatient setting by providing psychiatric consultation and post-discharge mental health and community linkage support.

**Palliative Care and Elder Medical Care (formerly Support Our Elders)** – This initiative is supported by a strong partnership between Gilchrist and MedStar, where patients with advanced and complex chronic disease are provided with clinical and social support in their homes, whether in independent living or in a facility-based environment. This program also provides clinical staff for palliative care efforts in 2 nursing homes within the services area.

**Expansion of Care Coordination and Care Management Services** – The patient-centered medical home (PCMH) model has been embraced in GBMC’s primary care offices with a deliberate focus on preventative health care, care management and coordination, and population health management. Efforts have emphasized helping patients achieve and maintain better health with tactics in place to reduce avoidable hospital admission and unnecessary emergency department use, eliminate gaps in care for routine screenings and improve quality outcomes for patients with chronic conditions.

# Intervention Program

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

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| **Intervention or Program Name** | Expansion and Management of Chronic Conditions Through Improved Integration of Mental Health Services |
| **RP Hospitals Participating in Intervention**  *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.* | Greater Baltimore Medical Center |
| **Brief description of the Intervention**  *2-3 sentences* | Mental health professionals are embedded in GBMC primary care practices to provide screening, short-term intervention, and ongoing counseling/behavioral management. Specialty outpatient psychiatric services and consultation services are provided at GBMC’s medical homes and psychiatrists also provide evaluations on inpatient and ER patients and provide post-discharge mental health support (time-limited services). Finally, patients are referred to community based programs and services for longer-term support. |
| **Participating Program Partners**  *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners* | * Kolmac Clinic * Mosaic community services * Sheppard Pratt Health System |
| **Patients Served**  *Please estimate using the Population category that best applies to the Intervention, from the CY 2017 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, 2018:  Over 5,000 patient visits with behavioral health consultants; more than 500 visits with psychiatry; and nearly 200 patient visits with a substance abuse consultant |
| Denominator of Eligible Patients:  Nearly 54,000 patients screened for depression (measure specification aligned with Medicare Shared Savings Program quality measure PREV-12) |
| **Pre-Post Analysis for Intervention** (optional)  *If available, RPs may submit a screenshot or other file format of the Intervention’s Pre-Post Analysis.* | See Appendix A. |
| **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.* | Outcomes measures (other than the pre-/post-analysis) include:   * More than 88,000 NIDA screens have been administered on more than 50,000 unique patients * Using the Active patient registry, patients have experienced a 29% reduction in anxiety scores and a 32% reduction in depression scores. Given system limitations, inactive patients are not included this outcome calculation, which may underestimate the full impact of the work given that “graduated patients” are categorized as an inactive. |
| **Successes of the Intervention in FY 2018**  *Free Response, up to 1 Paragraph* | Successes in FY 2018 include: an increase in the volume of behavioral health and psychiatry referrals and visits; an increased rate of screening and a reduction in patient depression and anxiety; reduced inpatient, ED, and observation stay cost and utilization; increased awareness and adoption of the program among primary care and specialty providers, patients, and the community; and the successful launch of new behavioral health tracking registry available through the organization’s electronic medical record. |
| **Lessons Learned from the Intervention in FY 2018**  *Free Response, up to 1 Paragraph* | Lessons learned in FY 2018 include: gaining a better understanding of how to obtain primary care and specialty provider buy-in to the program; refining the practice workflows and scheduling to ensure warm hand-offs between providers and the embedded mental health professionals; and the need for improved predictive analytics to proactively identify patients that could benefit from behavioral/mental health referral, consultation, and treatment. |
| **Next Steps for the Intervention in FY 2019**  *Free Response, up to 1 Paragraph* | Next steps in FY 2019 include: continued focus on increasing referrals and completed visits, given there is a no show rate of 12.6 % for behavioral health appointments and no show rate of 8.6 % for psychiatry appointments; continued refinement of practice workflows to ensure that behavioral health embedded staff are truly integrated into the practice locations; and, increased sophistication in behavioral health predictive analytics and developing a patient targeting registry. |
| **Additional Free Response** (Optional) |  |

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| **Intervention or Program Name** | Expansion and Management of Chronic Conditions Through Palliative Care Services |
| **RP Hospitals Participating in Intervention**  *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.* | Greater Baltimore Medical Center |
| **Brief description of the Intervention**  *2-3 sentences* | GBMC’s Gilchrist Services, in partnership with MedStar’s Total Elder Care (TEC) program, has expanded the program Elder Medical Care (formerly Support Our Elders). Medicare patients who are unable to make frequent visits to the primary care physician are currently supported at home by a rounding interdisciplinary team including physicians, nurse practitioners, social workers, and administrative coordinators who can care for complex chronic conditions within the patient’s home. Gilchrist Services has also expanded the palliative care program in partnership with area nursing homes, which provides palliative services by a nurse practitioner to better manage symptoms and discuss patient care plans. |
| **Participating Program Partners**  *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners* | * Allegeant * Baltimore County Health Department * Care Progress, LLC * Catholic Charities * Evergreen Health * Health Care for All Coalition * Keswick Multi-Care Center * MedStar * Notre Dame School of Pharmacy * Lorien at Home * Diamond Lab Services |
| **Patients Served**  *Please estimate using the Population category that best applies to the Intervention, from the CY 2017 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, 2018:  300 patients |
| Denominator of Eligible Patients:  Nearly 12,000 Medicare beneficiaries, using the Medicare Shared Savings Program assigned beneficiary count as an estimate of patients served. |
| **Pre-Post Analysis for Intervention** (optional)  *If available, RPs may submit a screenshot or other file format of the Intervention’s Pre-Post Analysis.* | See Appendix B. |
| **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 2018**  *Free Response, up to 1 Paragraph* | The Elder Medical Care Home Services program continued to experience growth with an overall rate of 25% in our average daily census during FY 2018.  The program also continued to expand the ancillary services available to our patients who worked collaboratively the primary care providers.  These additional services include: lab services, behavioral health professionals, Community Service Coordinators and interventions by pharmacists on a case by case basis which enabled the team to provide even more clinical interventions in the home setting. |
| **Lessons Learned from the Intervention in FY 2018**  *Free Response, up to 1 Paragraph* | One of the ongoing lessons during FY 2018 continues to be highlighting the partnership needed from the primary care providers in the community to assist with transition or co- management of their patients. The existing primary care providers are pivotal in initiating referrals and working with the patients/families to establish rapport with the Elder Medical Care Home Services team. This could also enable referrals to the program to be made earlier in the progression of the disease state as the patients and their caregivers are initially experiencing issues with getting in to see their primary care providers versus once they have been homebound for a significant period of time. |
| **Next Steps for the Intervention in FY 2019**  *Free Response, up to 1 Paragraph* | In FY 2019, the Elder Medical Care Home Services program will continue to work on refinement of the referral process, exploring ways of applying our program to meet the needs and requests of our partners and the communities they live in along with expanding clinical capabilities. |
| **Additional Free Response** (Optional) |  |

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| **Intervention or Program Name** | Expansion and Management of Chronic Conditions Through Care Coordination |
| **RP Hospitals Participating in Intervention**  *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.* | Greater Baltimore Medical Center |
| **Brief description of the Intervention**  *2-3 sentences* | GBMC is working to expand its hospital-based care management function to focus on high-utilizer patients. Additionally, care management/coordination support is fully integrated in all 10 of the employed primary care practices. Through the addition of an inpatient case manager for high-utilizers, as well as additional care coordination staff in each primary care practice, the team will work (or is working) with patients proactively to meet their individual needs, in an effort to avoid unnecessary emergency department, inpatient hospital visits, and/or avoidable readmissions. |
| **Participating Program Partners**  *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners* | * Allegeant * Baltimore County Health Department * Care Progress, LLC * Catholic Charities * Evergreen Health * Health Care for All Coalition * Keswick Multi-Care Center * Kolmac Clinic * Mosaic community services * MedStar * Sheppard Pratt Health System |
| **Patients Served**  *Please estimate using the Population category that best applies to the Intervention, from the CY 2017 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, 2018:  10,633 (as defined by the number of unique ambulatory patient care management touches) |
| Denominator of Eligible Patients:  Nearly 12,000 Medicare beneficiaries, using the Medicare Shared Savings Program assigned beneficiary count as an estimate of patients served. |
| **Pre-Post Analysis for Intervention** (optional)  *If available, RPs may submit a screenshot or other file format of the Intervention’s Pre-Post Analysis.* | Planning to introduce pre-post analysis for care coordination services in FY 2019. |
| **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.* | Process measures include:   * A 29% reduction in gaps in care, per patient, since April 2018 closing a total of nearly 19,000 gaps in care for patients. * More than 10,000 transition of care calls were made by the care management team, which include medication reconciliation, follow-up appointment scheduling, etc. * Successful bi-directional integration with CRISP where panels are submitted and ENS notifications are received daily for care team follow-up. * In the inpatient setting, GBMC has experienced a total of 292 “Great Saves” in the ED due to case management intervention. |
| **Successes of the Intervention in FY 2018**  *Free Response, up to 1 Paragraph* | Successes in FY 2018 include: improved quality of care as evidenced by an overall quality performance score of 94% in Medicare Shared Savings Program for performance year 2017; improved promotion of health and wellness as evidenced by demonstrated reductions in gaps in care; improved patient experience with expanded access to primary care (extended hours, 365 days a year); successful implementation of a telehealth pilot; and, expanded diabetes education. |
| **Lessons Learned from the Intervention in FY 2018**  *Free Response, up to 1 Paragraph* | Lessons learned in FY 2018 include: a need for increased attention of utilization metrics to ensure the total cost of care goals are met through, in part, GBMC’s advanced primary care; difficulty targeting specific sub-populations of patients for varying levels of care management support and tracking their outcomes; need for more sophisticated data analytics; and, continued changes to the electronic medical record to support care management workflow enhancements. |
| **Next Steps for the Intervention in FY 2019**  *Free Response, up to 1 Paragraph* | Next steps in 2019 include: the integration of social determinants of health into patient care management interventions; enhanced predictive analytics and patient targeting through the electronic medical record and corresponding workflow changes; renewed focus on high utilizing patients; and, thoughtful alignment of the care management model with the new federal/state total cost of care programs. |
| **Additional Free 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 2017 RP Analytic File (please specify which source you are using for each of the outcome measures).

## Utilization Measures

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| Measure in RFP  *(Table 1, Appendix A of the RFP)* | **Measure for FY 2018 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 2017  -or-  Analytic File:  ‘Charges’ over ‘Population’  (Column E / Column C) | Using the CRISP Analytic file and instructions, please see below for this metric calculation:   |  |  | | --- | --- | | **GBMC** | **Partnership IP Charges per capita** | | **Metrics** |  | | 2+ Chronic Conditions and Medicare FFS | $ 7,575.01 | | 2+ IP or Obs>=24 or ED Visits | $ 2,393.50 | | 2+ IP or Obs>=24 or ED Visits Medicare FFS | $ 5,365.04 | | 3+ IP or Obs>=24 Visits | $ 1,003.05 | | 3+ IP or Obs>=24 Visits Medicare FFS | $ 2,595.87 | | All Payer | $ 3,950.55 | | Medicare FFS | $ 8,377.07 | |  |  | | **GBMC - Support Our Elders** |  | | **Metrics** |  | | 2+ Chronic Conditions and Medicare FFS | $ 6,411.02 | | 2+ IP or Obs>=24 or ED Visits | $ 1,987.91 | | 2+ IP or Obs>=24 or ED Visits Medicare FFS | $ 4,540.66 | | 3+ IP or Obs>=24 Visits | $ 806.29 | | 3+ IP or Obs>=24 Visits Medicare FFS | $ 2,134.98 | | All Payer | $ 3,482.48 | | Medicare FFS | $ 7,308.19 | |
| 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 2018  -or-  Analytic File:  ‘IPObs24Visits’ over ‘Population’  (Column G / Column C) | Using the CRISP Analytic file and instructions, please see below for this metric calculation:   |  |  | | --- | --- | | **GBMC** | **Total Discharges per 1,000** | | **Metrics** |  | | 2+ Chronic Conditions and Medicare FFS | 284.79 | | 2+ IP or Obs>=24 or ED Visits | 99.55 | | 2+ IP or Obs>=24 or ED Visits Medicare FFS | 230.04 | | 3+ IP or Obs>=24 Visits | 44.54 | | 3+ IP or Obs>=24 Visits Medicare FFS | 116.54 | | All Payer | 146.06 | | Medicare FFS | 306.07 | |  |  | | **GBMC - Support Our Elders** |  | | **Metrics** |  | | 2+ Chronic Conditions and Medicare FFS | 252.52 | | 2+ IP or Obs>=24 or ED Visits | 85.22 | | 2+ IP or Obs>=24 or ED Visits Medicare FFS | 203.65 | | 3+ IP or Obs>=24 Visits | 36.22 | | 3+ IP or Obs>=24 Visits Medicare FFS | 97.28 | | All Payer | 131.30 | | Medicare FFS | 276.72 | |
| Total Health Care Cost per person | **Partnership TCOC per capita – Medicare**  Total Cost of Care (Medicare CCW) Report ‘Regional Partnership Cost of Care’:  ‘Tab 4. PBPY Costs by Service Type’ – sorted for CY 2017 and Total | Using the CRISP Analytic file and instructions, please see below for this metric calculation:   |  |  | | --- | --- | | **GBMC** | **Partnership TCOC per capita – Medicare - CY2017 \* Full Year Per Beneficiary Costs** | | **Metrics** |  | | 2+ Chronic Conditions and Medicare FFS | $ 13,527 | | 2+ IP or Obs>=24 or ED Visits | $ 13,527 | | 2+ IP or Obs>=24 or ED Visits Medicare FFS | $ 13,527 | | 3+ IP or Obs>=24 Visits | $ 13,527 | | 3+ IP or Obs>=24 Visits Medicare FFS | $ 13,527 | | All Payer | $ 13,527 | | Medicare FFS | $ 13,527 | |  |  | | **GBMC - Support Our Elders** |  | | **Metrics** |  | | 2+ Chronic Conditions and Medicare FFS | $ 15,105 | | 2+ IP or Obs>=24 or ED Visits | $ 15,105 | | 2+ IP or Obs>=24 or ED Visits Medicare FFS | $ 15,105 | | 3+ IP or Obs>=24 Visits | $ 15,105 | | 3+ IP or Obs>=24 Visits Medicare FFS | $ 15,105 | | All Payer | $ 15,105 | | Medicare FFS | $ 15,105 | |
| 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 2018  -or-  Analytic File  ‘ED Visits’ over ‘Population’  (Column H / Column C) | Using the CRISP Analytic file and instructions, please see below for this metric calculation:   |  |  | | --- | --- | | **GBMC** | **Ambulatory ED Visits per 1,000** | | **Metrics** |  | | 2+ Chronic Conditions and Medicare FFS | 258.55 | | 2+ IP or Obs>=24 or ED Visits | 252.09 | | 2+ IP or Obs>=24 or ED Visits Medicare FFS | 212.94 | | 3+ IP or Obs>=24 Visits | 31.34 | | 3+ IP or Obs>=24 Visits Medicare FFS | 48.84 | | All Payer | 376.48 | | Medicare FFS | 302.32 | |  |  | | **GBMC - Support Our Elders** |  | | **Metrics** |  | | 2+ Chronic Conditions and Medicare FFS | 215.55 | | 2+ IP or Obs>=24 or ED Visits | 172.75 | | 2+ IP or Obs>=24 or ED Visits Medicare FFS | 179.67 | | 3+ IP or Obs>=24 Visits | 21.28 | | 3+ IP or Obs>=24 Visits Medicare FFS | 36.86 | | All Payer | 277.62 | | Medicare FFS | 261.90 | |

## Quality Indicator Measures

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| Measure in RFP  *(Table 1 in Appendix A of the RFP)* | **Measure for FY 2018 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 2018  -or-  Analytic File:  ‘IP Readmit’ over ‘EligibleforReadmit’  (Column J / Column I) | Using the CRISP Analytic file and instructions, please see below for this metric calculation:   |  |  | | --- | --- | | **GBMC** | **Unadjusted Readmission rate by Hospital** | | **Metrics** |  | | 2+ Chronic Conditions and Medicare FFS | 152.11 | | 2+ IP or Obs>=24 or ED Visits | 189.37 | | 2+ IP or Obs>=24 or ED Visits Medicare FFS | 196.03 | | 3+ IP or Obs>=24 Visits | 331.89 | | 3+ IP or Obs>=24 Visits Medicare FFS | 299.33 | | All Payer | 132.70 | | Medicare FFS | 145.63 | |  |  | | **GBMC - Support Our Elders** |  | | **Metrics** |  | | 2+ Chronic Conditions and Medicare FFS | 143.21 | | 2+ IP or Obs>=24 or ED Visits | 177.74 | | 2+ IP or Obs>=24 or ED Visits Medicare FFS | 186.88 | | 3+ IP or Obs>=24 Visits | 311.88 | | 3+ IP or Obs>=24 Visits Medicare FFS | 288.15 | | All Payer | 117.80 | | Medicare FFS | 135.71 | |
| PAU | **Potentially Avoidable Utilization**  Executive Dashboard:  ‘[Partnership] Quality Indicators’ –  Potentially Avoidable Utilization, reported as **sum** of 12 months of FY 2018  -or-  Analytic File:  ‘TotalPAUCharges’  (Column K) | Using the CRISP Analytic file and instructions, please see below for this metric calculation:   |  |  | | --- | --- | | **GBMC** | **Potentially Avoidable Utilization** | | **Metrics** |  | | 2+ Chronic Conditions and Medicare FFS | $ 108,463,768 | | 2+ IP or Obs>=24 or ED Visits | $ 247,559,772 | | 2+ IP or Obs>=24 or ED Visits Medicare FFS | $ 97,971,227 | | 3+ IP or Obs>=24 Visits | $ 175,649,371 | | 3+ IP or Obs>=24 Visits Medicare FFS | $ 66,265,013 | | All Payer | $ 273,639,552 | | Medicare FFS | $ 111,100,460 | |  |  | | **GBMC - Support Our Elders** |  | | **Metrics** |  | | 2+ Chronic Conditions and Medicare FFS | $ 37,022,739 | | 2+ IP or Obs>=24 or ED Visits | $ 64,338,805 | | 2+ IP or Obs>=24 or ED Visits Medicare FFS | $ 33,757,658 | | 3+ IP or Obs>=24 Visits | $ 43,272,730 | | 3+ IP or Obs>=24 Visits Medicare FFS | $ 21,978,245 | | All Payer | $ 71,819,208 | | Medicare FFS | $ 38,129,428 | |

## 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.

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| Measure in RFP  *(Table 1 in Appendix A of the RFP)* | **Measure for FY 2018 Reporting** | **Outcomes(s)** |
| Established Longitudinal Care Plan | **% of patients with Care Plan recorded at CRISP**  Executive Dashboard:  ‘High Needs Patients – CRISP Key Indicators’ –  % of patients with Care Plan recorded at CRISP, reported as average monthly % for most recent six months of data  *May also include Rising Needs Patients, if applicable in Partnership.* | Using the CRISP Executive Dashboard and Instructions, please see below for this metric calculation:  1.8% |
| 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.* | Using the CRISP Executive Dashboard and Instructions, please see below for this metric calculation:  22.7% |

## Self-Reported Process Measures

Please describe any partnership-level process 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.

In FY 2018, GBMC introduced new Epic functionality that allows for shared care plans across care setting via the longitudinal plan of care. The goal of this enhancement is to continue working towards seamless care where inpatient and outpatient care teams are able to provide continuous, patient-centered care. In FY 2019, GBMC plans to introduce pre-/post-CRISP analyses to track measurable outcomes of the longitudinal plan of care efforts, and care management activities more generally. Additionally, beginning in November 2018, GBMC will be formally assessing social determinants of care through EPIC and following up with comprehensive care planning around social and clinical patient needs.

# Return on Investment

Indicate how the Partnership is working to generate a positive return on investment. Free Response, please include your calculation if applicable.

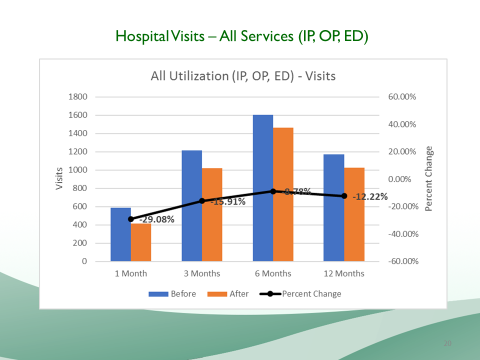
For FY 2018, the return on investment of two of the three initiatives funded by this transformational grant have been measured using pre-/post-CRISP analyses (i.e., Elder Medical Care and Behavioral Health PCMH integration). While GBMC has additional work to do on assessing the return on investment of care management, one indirect indicator of positive gains of the initiative is the high patient experience of care scores in the PCMH practices. Additionally, the “great saves” in the emergency department have deterred avoidable inpatient stay costs.

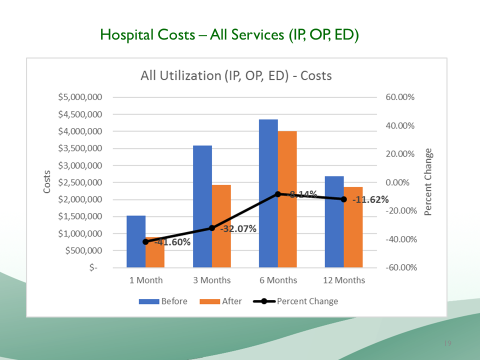
# Conclusion

Please include any additional information you wish to share here. Free Response, 1-3 Paragraphs.

The Transformational grant has afforded GBMC and its partners with a wealth of opportunities to transform patient care and cost and quality outcomes. The organization has learned significant lessons through the implementation of these three initiatives and will continue to work on process improvement and quantifying the return on investment of the grant funding across all three initiatives.

**APPENDIX A. Pre-/Post-CRISP Analysis for the Behavioral Health PCMH Integration**

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**APPENDIX B. Pre-/Post-CRISP Analysis for the Elder Medical Care Services Program**

