HSCRC Planning Grant Final Report
Proposal from The Johns Hopkins Hospital for the
The Community Health Partnership of Baltimore

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Goals, Strategies and Outcomes	1a	**Articulate the goals, strategies and outcomes that will be pursued and measured by the regional partnership.** The goals of the Community Health Partnership of Baltimore align with the State of Maryland, HSCRC and CMS, and that is to transform Maryland's health care system to be highly reliable, highly efficient, and patient-centered. We envision a health care system in which multi-disciplinary teams work with high need/high-resource patients to manage chronic conditions in order to improve outcomes, lower costs, and enhance patient experience. Through aligned collaboration at the regional and state levels, and the execution of evidence-based interventions, the state and regional partnerships can work together to improve the health and well-being of the population. Our strategies include: 1. Rapidly develop criteria and risk-stratification processes that identify and target the high-need Medicare population; 2. Plan and develop care coordination and population health improvement approaches that build and improve upon previous successful strategies and are ready for implementation upon receipt of funding on February 1, 2016; 3. Define a care delivery and financial sustainability model that continuously improves population health and decreases per capita expense for the Baltimore City region; 4. Build on our existing partnership infrastructure and staffing/workforce strategy that supports the care delivery model; 5. Upon approval, immediately implement the governance structure designed to support collaboration in the new care delivery environment and facilitate the sharing of best practices and innovative care delivery strategies; 6. With the West Baltimore Collaborative (led by the University of Maryland Medical Center), develop and implement strategies and a common approach to care management that will, at a minimum, ensure that Baltimore City hospitals use a common algorithm to coordinate the development of patient care plans in ways that are patient-centered and do not result in redundant, overlapping, and potentially conflicting post admission care plans; 7. In coordination with the West Baltimore Collaborative develop a shared set of outcomes metrics and evaluation methodologies; and 8. Building on an existing organizational effectiveness program we have implemented, expand continuous quality improvement processes to enhance the learning health system model and ensure that we benefit from our experience as we have done in the Johns Hopkins Community Health Partnership (J-CHiP). Our desired outcome is to create an innovative, financially sustainable community-based care delivery model for high-risk

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		Medicare beneficiaries that improves health, decreases per capita cost, and improves satisfaction and experience with our health care systems. To measure our success, we will: 1. Evaluate current performance against our goals and strategies and identify areas of opportunity; 2. Evaluate current performance against patient satisfaction metrics and identify areas of opportunity; and 3. Evaluate quality, outcome, and cost metrics associated with high-risk Medicare population and identify areas of opportunity. <u>Building upon Lessons Learned from J-CHiP</u> The Johns Hopkins Community Health Partnership (J-CHiP), developed through a CMS Center for Medicare & Medicaid Innovation (CMMI) Health Care Innovation Award, is a trans-disciplinary care coordination program designed to improve the quality and efficiency of care across the continuum for high-risk adults in 7 zip codes in East Baltimore. The intention of the Community Health Partnership of Baltimore is to leverage and expand the innovative work and lessons learned from J-CHiP and other initiatives across the region to create a comprehensive, "shovel ready" and integrated program to achieve the three part aim of improved population health, improved patient experience, and reduced per capita costs. The lessons learned from these initiatives and data related to the top diagnoses and utilization patterns across Medicare high utilizers in the geographic area, include: the impact of addressing barriers related to social determinants of health, changing behavior of care teams to improve communication and outcomes, engaging patients effectively, building successful partnerships with community-based organizations, and embedding Community Health Workers and Neighborhood Navigators within the community. <u>Evolution of our Efforts during the Planning Grant</u> The Johns Hopkins Hospital (JHH) convened and facilitated a collaborative planning process, bringing together hospital partners in Baltimore City as well as a broad spectrum of other community-based partners, to share programs, experiences, and data with the goal of developing a regional approach for care coordination. The hospital partners changed during the planning process and now include: The Johns Hopkins Hospital (JHH) (lead applicant), Johns Hopkins Bayview Medical Center, Mercy Medical Center, Sinai Hospital and MedStar Health (Franklin Square Hospital and Harbor Hospital). All the hospital partners serve similar patient populations, share many patients, and are all challenged to reduce unnecessary utilization, including readmissions and emergency department visits. <u>Alignment across Baltimore City</u> The Johns Hopkins Hospital was the lead applicant for this planning grant proposal, and the University of Maryland was the lead on another. Since the time of the initial award, and in fact during the development of the proposals, the two

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		partnerships have been committed to working together, knowing that many high-cost high-use patients visit multiple hospitals across the city, and that the goals of the partnership cannot be achieved without improving health and lowering costs for all city residents. One of the goals of the planning process—and a charge to us by the HSCRC/DHMH staff when the grant was awarded—was to identify the areas that most lend themselves to being developed jointly. This was explored during meetings of the Alignment Committee, with participants from both partnerships. The Committee identified Patient Attribution, Care Profiles, and Quality Measures as priority areas for joint development. The results of the work of the subcommittees addressing these areas will be described in detail in the Implementation Program Application.
	1b	**Describe the target population that will be monitored and measured, including the number of people and geographical location.** In alignment with the HSCRC and the West Baltimore Collaborative, the Community Health Partnership of Baltimore (the Partnership) defines high utilizers as those who experienced three or more hospitalizations in the past year. This alignment is ideal as we all work towards the shared goal of improving quality of care by reducing avoidable hospitalizations. Furthermore, in defining our target population, it made sense to build on this definition of high utilizers who received service from at least one of the partner hospitals within the Partnership in 2014. Based on the CRISP reports available to the Partnership, there were 21,223 hospitalizations among Medicare beneficiaries who met the high utilizer definition in the zip codes identified by the hospital partners. At this time, we are unable to quantify how many unique Medicare beneficiaries had 3+ hospitalizations. Geographically, this target population resides in the following 19 zip codes: 21202, 21205, 21206, 21209, 21211, 21213-19, 21222-25, 21230, 21231, and 21237 which represented the combined community benefit service areas (CBSAs) of the partner hospitals. Unfortunately CRISP data is not yet available to narrow down our population to only those who have used a Partnership hospital described above, nor was CRISP data available to identify the unique patients that made up the 21,000+ hospitalizations. Additionally, the combined CBSAs of the partner hospitals create a broad area that is too large for our initial intervention and overlaps significantly with the area designated for the West Side Collaborative for attribution purposes. Recognizing the current limitations of the CRISP data and the deployment delay of the PaTH reports, which are not expected until Q1 calendar year 2016, the Partnership has begun working with the Berkley Research Group (BRG). All hospital partners have consented to sharing their hospital data with BRG, who will identify the number of unique patients served in the identified zip codes, the number of patients touching multiple hospital partners in the Partnership, and help to characterize the population and their appropriate target zip codes. The target population will be further defined and described in the Implementation Proposal.

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Long term, the partnership expects to touch as many individuals in the target population as possible. Shorter term, the target population will need to be stratified in order to deploy meaningful interventions for those with the greatest need. Processes will be created to ensure that any patients from the Johns Hopkins Community Health Partnership (J-CHiP) that met their goals and have lower level needs will receive services through other existing lower level care management programs. These patients will remain engaged with primary care and could be eligible for the Community Health Partnership of Baltimore interventions in the future if their needs change. Participants in the Johns Hopkins Medicine Alliance for Patients (JMAP) ACO will also be excluded. Furthermore, with appropriate permissions in place, the Johns Hopkins Adjusted Clinical Groups (ACG) Case Mix System may also be used to identify those who are the highest risk of health care utilization, and therefore most likely to benefit from additional support.

Table 1: Target Population Inclusion and Exclusion Criteria
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<tr><th>Inclusion Criteria</th><th>Exclusion Criteria</th></tr>
<tr><td>Medicare or Dual Eligible</td><td>Patient does not meet criteria for complex care management programs</td></tr>
<tr><td>Residence in target zip code</td><td>Member of JMAP ACO</td></tr>
<tr><td>3+ hospitalizations in 12 month period</td><td>Has PCP affiliated with West Baltimore Collaborative OR majority of utilization at West Baltimore Collaborative partner hospital</td></tr>
<tr><td>Has PCP at affiliated practice OR has no PCP, majority utilization at a partner hospital</td><td></td></tr>
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In our target population, the top diagnoses by APR-DRG for hospitalizations are heart failure, sepsis and disseminated infections, renal failure, chronic obstructive pulmonary disease, and mental illness, respectively. Within our target population, mental illness also happens to be the second most prevalent and expensive reason for emergency room visits. (The full list is heart failure, mental health, addiction, asthma, and diabetes, respectively.) For the purposes of matching the appropriate patients to needed interventions, we have therefore decided to stratify our target population by subtypes. These subtypes will include the following:
1. High Medical Needs/Low Mental Health and Substance Abuse Needs: patients with complex medical conditions but no major mental health or substance abuse diagnoses.
2. Low Medical/High Mental Health and Substance Abuse Needs: patients without complex medical conditions, who have major mental health or substance abuse diagnoses.
3. High Medical Needs/High Mental Health and Substance Abuse Needs: patients who have complex medical diagnoses in addition to diagnoses of mental illness and or substance abuse.
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		The number of individuals who meet each subtype will be determined as soon as information is available from CRISP.
	1c	**Describe the specific metrics that will be used to measure progress including patient satisfaction, quality, outcomes metrics, process metrics and cost metrics. Describe how the selected metrics draw from or relate to the State of Maryland's requirements under the new model.** Methodology Choosing Medicare beneficiaries as the initial target population comes with many challenges in measurement. First, without claims data provided from the Center for Medicare and Medicaid Services, it is difficult to get a comprehensive view of the health of each individual in our target population. Obtaining Electronic Medical Record (EMR) data is also a challenge, as primary care practices across the city employ different EMR systems, and not all of our target patients have a regular primary care doctor from whom they receive care. However, once the PATH report becomes available from CRISP, we will be able to profile our target population and begin to understand their utilization, cost, and conditions. In designing metrics that will be used to measure progress, we therefore decided to focus on evidence-based measures that we can reliably report on using existing data sources whenever possible. In addition, we recognized the value in aligning performance measures with existing initiatives such as the Maryland State Health Improvement Plan, Meaningful Use, Patient Centered Medical Home, the National Quality Forum, CMS Physician Quality Reporting System, Johns Hopkins Community Health Partnership (J-CHiP), and the Johns Hopkins Medicine Alliance for Patients (JMAP) ACO in order to reduce duplication of data collection and reporting efforts. Under the leadership of our partnership, the measurement plan was shared with the West Baltimore City Collaborative, and the partnerships mutually agreed that alignment across these measures would be beneficial for working towards common city health goals, for simplifying documentation necessary from providers, and for maximizing our mutual understanding of how health outcomes change across Baltimore City as a result of the proposed interventions. Measures As shown in the dashboard in Appendix A, our measures fall into three main domains: process; quality; and utilization and costs. While each of these domains cover measures aimed at monitoring progress for the regional intervention as a whole, the process measures will be reported only for individuals in the target population, and the quality measures will only be gathered for members of the target population who have a PCP site which participates in reporting these measures to the collaborative. The process measures in the dashboard are designed to measure care coordination, patient engagement, and how well the regional interventions described in the next section are achieving their goals for the target population, and these measures will also be used to inform ongoing CQI efforts across partners. These

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		measures include rates of PCP assignment for individuals who did not previously have a PCP, rates of care plan creation among the target population who have an assigned care manager, use of encounter notification alerts by members of the care team, and percent of the target population who are connected to needed interventions. For the full list, please see the dashboard in Appendix A. Quality measures include prevention and screening rates for conditions like cancer, smoking, BMI, tobacco, and depression, as well as chronic disease management specific measures that monitor control of cardiovascular disease, diabetes, COPD, and depression. Measures related to the use of high risk medications and medication reconciliation, fall screenings, and patient satisfaction measures also fall under the Quality section of our dashboard. Each of these quality metrics will be reported only for patients at ambulatory practices participating in the Community Health Partnership of Baltimore that are able to provide quality reports to the analytics team. Short term, the partnership will use the Hospital Consumer Assessment of Healthcare Providers Survey (HCAHPS) measures to assess patient satisfaction at the hospital level, as these surveys are already being conducted. Longer term, the partnership plans to use the Clinician and Group Consumer Assessment of Healthcare Providers Survey (CG CAHPS) to understand satisfaction in ambulatory care settings. Utilization and cost measures include outcomes such as overall admission rates, rates of preventable admissions (using multiple different conditions to understand potentially avoidable utilization), 30 day readmission rate, emergency department utilization rates, and hospital related costs per capita (see Appendix A for more detailed descriptions of each measure). Overall, these measures were designed to align with the HSCRC suggested measures, the other quality and measurement initiatives already in place across the state, alignment with the West Baltimore Collaborative, and to provide the Community Health Partnership of Baltimore with the information needed to monitor and evaluate ongoing interventions. In alignment with the HSCRC requests, data broken down by race and ethnicity will be provided when this information is available. Several measures suggested by the HSCRC are not yet possible to collect. For example, although we would like to monitor the total cost per capita for patients in the interventions, this will not be possible without Medicare claims data. *Note: The initial measures and dashboard proposed here are subject to change with further input from our partners and from further alignment work with the West Baltimore Collaborative as we prepare our Implementation Proposal.*

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<tr><td></td><td>1d</td><td>Describe the regional partnership's current performance (target population) against the stated metrics.
In light of the fact that the Community Health Partnership of Baltimore is in a planning phase and not yet established, there is not yet a data structure in place to capture its current performance on the stated metrics - we are limited to the data points available through CRISP about our proposed target population. Currently, the ability to utilize CRISP reports to narrow down a target population is limited, and therefore only general information regarding utilization and cost are available. Using available CRISP reports, there were 21,223 hospitalizations in CY2014 among Medicare beneficiaries who met the high utilizer definition and reside in the target zip codes, 6,349 readmissions and 34,110 ED visits (see Table 2). The total charges for hospitalizations among this population were $359,776,441 and the ED charges totaled $51,304,667. Currently, patient experience ratings vary by hospital and by measure, and therefore we do not yet have a composite score across the partnership. It should be noted that patient experiences measures are not specific to our target population. Process metrics cannot be collected until after implementation. The Partnership will work closely with BRG to better characterize the target population and identify unique individuals to target for the interventions.

Table 2: Target Population Preliminary Utilization and Cost Data
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<tr><th></th><th>CY 2014 Hospitalizations: 3+ / Medicare</th><th>CY 2014 Hospitalization Charges: 3+ / Medicare</th><th>CY2014 Readmissions: 3+ / Medicare</th><th>CY2014 ED Visits: 3+ / Medicare</th><th>CY2014 ED Charges: 3+ / Medicare</th></tr>
<tr><td>Total in Partnership zip codes[2]</td><td>21,223[1]</td><td>$359,776,441</td><td>6,349</td><td>34,110</td><td>$51,304,667</td></tr>
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Dashboard Notes:
Source data: Chesapeake Regional Information System for our Patients (CRISP)
[1] In CY14, there were 114,690 total hospitalizations in the 19 partnership zip codes, of which 36% (44,302) were a 3+ hospitalization. 21,223 of these were attributed to Medicare beneficiaries who resided within 19 partnership zip codes.
[2]More specific estimates of the number of unique Medicare patients with 3 or more hospitalizations in the target population, as well as other data characterizing this population will be provided by BRG for the Implementation Proposal.</td></tr>
<tr><td></td><td>1e</td><td>Define the data collection and analytic capabilities that will be used to measure goals and outcomes.
Recognizing that the analytic capabilities required for this partnership would require work above and beyond the current analytic resources at each partner organization, we intentionally chose measures that aligned with what was already being collected by partner organizations for the purposes described in the previous section. The metrics chosen are either</td></tr>
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		already available through CRISP or other existing reports, or will be collected through the partnership's care management system. While the specific measures and metrics described here reduce the burden of data collection efforts, analytics capabilities are still needed for ongoing reporting and evaluation purposes. Leveraging the significant population health analytic capabilities that Johns Hopkins Health Care has had the opportunity to develop during the J-CHiP grant, we will work with our hospital partners to use claims data, CRISP reports and other hospital data, and direct referrals to identify the appropriate high-risk patients from the proposed multi-hospital CBSA population. We will target patients with multiple chronic illness, mental health, substance use disorder, and unhealthy behaviors who are at risk for high utilization of health care services, especially the beneficiaries who frequent each of our hospitals. Each of the hospitals have their own teams of analysts that will work jointly with the overall partnership's analytics team through designated representatives to ensure that the data collection and monitoring efforts are coordinated across partners. These representatives will also support the ongoing analytics requirements necessary to produce monthly dashboards monitoring the progress of the partnership.
	1f	**List the major areas of focus for year one. [For the completion of this plan, if various areas of focus require different descriptions, please identify each area under the following sections of the plan.]** Building on lessons learned in J-CHiP and leveraging the current infrastructure, we will redeploy existing staff/managers that already focus on Medicare patients in East Baltimore. Our Year 1 focus areas include: • Staff orientation and training: We will orient existing staff to the goals and strategies of the regional partnership; provide training on measures that will be collected, revised workflows and processes, communication, IT, etc. • Expanding the patient engagement training and maintenance: We will expand the work that we started in J-CHiP and JMAP to include the other participants of our regional partnership. This includes training staff and physicians utilizing a number of formats, continued skill building and maintenance, and learner evaluation. Deployment slated for July 2016 (see Q5e for more details). • Embedding teams in primary care practice sites: We will redeploy staff to appropriate existing and new practice sites, coordination with practice site leaders, etc. • Expanding Community Health Workers (CHW) in the community and in the Emergency Departments (EDs): Continue the partnership with Sisters Together and Reaching to expand the community-based CHW model. We will also deploy CHWs to the EDs in order to help address the patient's social determinants of health barriers and connect them to their patient-centered medical home. The deployment of CHWs in the ED grew out of our experience in J-CHiP. Specific feedback from colleagues working in the ED has suggested that this intervention closely aligns with the existing CHW intervention to ease transitions and take advantage of the knowledge and experience of our community partners.

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		• Continuing the Neighborhood Navigator program with community-based partner: Continue to build capacity of the Men and Families Center and extend the work of the Neighborhood Navigators. • Improving workflows and communication across transition points: Improve handoffs and communication between staff/care teams as the patient transitions across care settings (i.e., hospital to ambulatory site, hospital to SNF or nursing home, SNF or nursing home to ambulatory site, etc.). • Deploying Community Bridge team: A team consisting of Primary Care Provider, Case Manager, Health Behavioral Specialist, Psychiatrist, Physician Addiction Specialist, and Peer Support Specialists will be deployed in a central location in our regional partnership. This team will manage and coordinate the short-term health needs of Medicare high utilizers across the region that are not currently connected to primary care and patients with urgent/prominent behavioral health conditions and substance abuse challenges. Deployment slated for July 2016. • SNF Collaboration: We will continue the J-CHiP subacute interventions and create a multi-hospital SNF collaborative building upon existing work started at each institution. We will focus on implementing evidence-based protocols and processes geared toward reducing preventable utilization (ED visits and readmissions) and improving care transitions from hospital to facility and facility to home. Additionally, we will scale and spread the Skilled Nursing Collaborative initiated by Sinai to Skilled Nursing Facilities utilized by the regional partner hospitals to create a Preferred Provider Network that capitalizes on best-practices for handoffs, reduces variation in care management and fosters care coordination across the continuum of care. • House Calls Program: Will function as a community-based program that provides home-based medical care, care management, caregiver support, counseling, and acute inpatient continuity to high-need, high-cost home-bound individuals on a longitudinal basis. • Remote Patient Monitoring: Will provide daily nurse monitoring and immediate feedback to patients with heart failure, diabetes, or COPD. A simple device placed in the home reminds patients to measure their weight, blood pressure, pulse oximetry, glucose, and to take medications. A nurse monitors all of these metrics via computer, interacts with the patient, and even reaches out to physicians as needed in prompt response to metrics exceeding normal thresholds. We will also expand an existing J-CHiP remote patient monitoring and education pilot aimed initially at reducing CHF admissions of high utilizers through the use of tablet software.
Formal Relationships and Governance	2a	**List the participants of the regional partnership such as hospitals, physicians, nursing homes, post-acute facilities, behavioral health providers, community-based organizations, etc. Specify names and titles where possible.** Partner Hospitals include: 1. Johns Hopkins Hospital a. Dan Brotman, MD, SFHM, FACP, Director, Hospitalist Program b. Amy Deutschendorf, MS, RN ACNS-BC, Vice President, Care Coordination/Clinical Resource Management

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		c. Diane Lepley, RN, MSN, Administrative Director for Grants and Special Projects; Director of Clinical Analytics Care Coordination/Clinical Resource Management d. Steve Mandell, Senior Director, Healthcare Information Systems e. Stephanie Reel, Chief Information Officer, University Administration f. Melissa Richardson, MBA, Director, Care Coordination 2. Johns Hopkins Bayview Medical Center a. Michele Bellantoni, MD, CMD, Medical Director, Specialty Hospital Programs b. Anita Everett, MD, DFAFA, Division Director of Community and General Psychiatry c. Dan Hale, PhD, Special Advisor, Office of the President d. Carol Sylvester, RN, MS, Vice President of Care Management Services 3. MedStar Franklin Square Medical Center - Debi Kuchka-Craig, Vice President of Managed Care, MedStar Health, Inc. *(representing both MedStar hospitals)* - Kathy Talbot, Vice President of Reimbursement, MedStar Health, Inc . *(representing both MedStar hospitals)* 4. MedStar Harbor Hospital (see above) 5. Mercy Medical Center - Michael Mullane, Senior Advisor to the President and CEO - Christopher Thomaskuttty, Chief of Staff and Senior Vice President, Clinical Programs 6. Sinai Hospital - Darleen Won, Director of Population Health, LifeBridge Health <u>Physician Practice Sites</u> We await target population data from CRISP re: patient attribution to primary care practice sites in order to finalize our list but anticipate the following sites will have a large number of Medicare patients who reside in our target geography: 1. Family Health Center of Baltimore 2. Health Care for the Homeless - Kevin Lindamood, President and CEO - Nilesh Kalyanaraman, MD, Chief Medical Officer 3. Johns Hopkins Bayview Beacham Center for Geriatrics Medicine *(a current J-CHiP site)* 4. Johns Hopkins Bayview Comprehensive Care Practice *(a current J-CHiP site)* - Michael Fingerhood, MD 5. Johns Hopkins Bayview General Internal Medicine *(a current J-CHiP site)* 6. Johns Hopkins Community Physicians at Greater Dundalk *(a current J-CHiP site)* 7. Johns Hopkins Community Physicians at East Baltimore Medical Center *(a current J-CHiP site)*

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		8. Johns Hopkins Community Physicians at Wyman Park *(a current J-CHiP site)* 9. Johns Hopkins Outpatient Center *(a current J-CHiP site)* <u>Post-acute Facilities include:</u> 1. Brinton Woods Post-Acute Care Center 2. Future Care – North Point 3. Future Care – Canton Harbor 4. Genesis Heritage Elder Care 5. Riverside Skilled Nursing Facility <u>Community-based Partners:</u> • Health Care for the Homeless - Kevin Lindamood, President and CEO - Nilesh Kalyanaraman, MD, Chief Medical Officer • Sisters Together and Reaching (STAR) - Debra Hickman, President and CEO - Demetrius Frazier, Community Health Worker Supervisor • The Men and Families Center - Leon Purnell, Executive Director - Brian Knight, Program Director • Esperanza Center - Kathryn Kline, MD, Medical Director <u>Other Key Partners in the Planning Process</u> • Advanced Health Collaborative - Robb Cohen, CEO • Johns Hopkins Community Physicians - Jenny Bailey, RN, BS, Senior Director for Quality and Transformation - Scott Feeser, MD, Medical Director, Johns Hopkins Medical Alliance for Patients ACO - Steve Kravet, MD, MBA, FACP, President • Johns Hopkins HealthCare - Linda Dunbar, PhD, RN, Vice President of Population Health and Care Management - Felicia Hill Briggs, PhD, Senior Director of Population Health Research and Development

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		- Victoria Lo, Population Health Research Associate - Sarah Kachur, PharmD, Director, Population Health Research and Development - Karyn Nicholson, MSN, RN, Clinical Informatics Specialist - Tracy Novak, MHS, Manager of Population Health Project Management - Regina Richardson, RN, BSN, MBA, CCM, Senior Director of Population Health and Care Management - Melissa Sherry, MPH, Senior Research Associate for Population Health - Laura Herrera Scott, MD, MPH, Medical Director, Population Health • Johns Hopkins Health System - Ed Beranek, Vice President of Revenue Management and Reimbursement - Scott Berkowitz, MD, MBA, Medical Director, Accountable Care - Anne Langley, JD, MPH, Senior Director, Health Policy Planning and Community Engagement • Johns Hopkins Home Care Group - Katie Blythe, MHA, Administrative Resident - Mary Myers, RN, MS, Vice President/Chief Operating Officer • Matrix Ventures, LLC - Vince Truant, CEO
	2b	**Describe the governance structure or process through which decisions will be made for the regional partnership. List the participants of the structure/process.** The hospital members of the Community Health Partnership of Baltimore (Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Sinai Hospital, Mercy Medical Center, MedStar Franklin Square Hospital and MedStar Harbor Hospital) will jointly form a limited liability company (LLC) to serve as the management entity. The ownership of the LLC will be held by the hospitals in the partnership which will elect the Board directors. • Board officers will be elected by board directors. • Each hospital will appoint its board director at the time the formal governance documents are executed. • An Annual Meeting will be held where the following will take place: o Election, as needed of board director terms o Election of board officers o Review of previous year's performance including finances, quality and strategic direction <u>Board Committees</u> • Committees will meet in-person once per month. • Committees will have no delegated authority, however are to make specific recommendations to the board for approval; any recommendation to the board must include: a cost-benefit analysis, evidence-based practice basis

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		for recommendations whenever applicable, justifications for recommendations, etc. and ensure the board members have the information they need to make an informed decision. • Committees of the Board may include: o Finance Committee. o Partnership Program Intervention Committee.
	2c	**Identify the types of decisions that will be made by the regional partnership.** The Community Health Partnership of Baltimore will be governed by a Board of Directors with membership from each partner hospital. The Committees of the Board will make recommendations to the board for approval. The following are examples of the types of decisions that the Board will make: • *Finance Committee* is to be chaired by the Board Treasurer and will be comprised of one appointee from each hospital o Any recommendation to be brought to the board must be approved a majority of the committee. o Finance Committee responsibilities include monitoring and recommendations to the board related to: ➢ Financial and resource oversight. ➢ Financial investments. ➢ Investments of other types of resources (e.g. clinical staff, administration, equipment, supplies). ➢ Recommends the budget to the board for approval. ➢ Serves as the "audit" committee of the board, if needed. ➢ Determines financial viability of proposed project(s) and sustainability post-implementation. ➢ Evaluates and recommends potential funding opportunities and mechanisms to the board. ➢ Reviews and monitors contracts, insurance needs/policies. • The Community Health Partnership of Baltimore's *Program Interventions Committee* may be chaired by a board director; hospitals will encourage participation on the committee by community partners o Any recommendations to be brought to the board must be approved by a super-majority vote of the committee. o Program Intervention Committee responsibilities include: ➢ Planning, implementation and monitoring of project(s) performance. ➢ Monitor key performance and outcome metrics as approved by the board, including: population health data, access to care, and numbers served. ➢ Monitor any needed continuous quality improvement initiatives. ➢ Evaluating and recommending proposed projects, developing materials for board discussion

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		(includes both new and ongoing projects) based on a cost-benefit analysis, evidence-based practice bases for recommendations whenever applicable, justifications for recommendations, etc. and ensures the board has the info they need to make an informed decision. ➢ Clinical intervention(s): • Design, scope, staffing, resources required, workflows. • Partnership Member roles, responsibilities, performance expectations, reporting, etc. • Definition and eligibility criteria for target patient population. • New processes, workflows and tools of any substance. • Metrics/measures that will be used to monitor performance. • Training plans. • Methods for secure access to care plans across clinical teams and Partnership Member organizations. • Contingency and sustainability plans for the clinical initiative(s). • *Executive Committee* o Voting rights among Partnership Members, Quorum requirements (any changes). o Removal of a Partnership Member (without the partner in question). o Addition of a Member to the Partnership. o Formation of a partnership with a third party (i.e. home health agency, lab).
	2d	**Describe the patient consent process for the purpose of sharing data among regional partnership members.** Where appropriate, Business Associate Agreements will be entered into with the regional partnership members for the purposes of sharing data. Additionally, patients will be individually consented to participate in interventions provided by the Community Health Partnership of Baltimore. As part of that consent process, patients will be advised that their data will be shared with providers and other third parties for the purposes of treatment and care coordination. Additional data sharing will occur between the regional partnership members consistent with each member's Notice of Privacy Practices, which permits each member to use and disclose the data of its patients to third parties for purposes of treatment and care coordination consistent with HIPAA. In addition to data shared directly from hospital members, the regional partnership will also receive inter-facility data from CRISP. Such inter-facility data may be received by regional partnership members without explicit consent from patients, since the sharing of the data falls within the treatment and care coordination exceptions under HIPAA. Since CRISP is an HIE, it has employed an opt-out mechanism to comply with the state HIE regulations. Information on all patients is in CRISP until if and when a patient chooses to exercise his opt-out right. Opt-outs are handled by CRISP.

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		Due to some of the difficulty many facilities have had with adequately educating its patients on CRISP and their opt-out right, some patients may not be fully aware of its existence or its opt-out. Therefore, when consenting patients for care management services, the Community Health Partnership of Baltimore is exploring some type of additional education about CRISP, including the fact that the regional partnership members use CRISP to share and receive information, as well as provide general education about the regional partnership and the sharing of data across facilities.
	2e	**Describe the processes that will be used by the regional partnership improved care and the MOUs or other agreements that will be used to facilitate the legal and appropriate sharing of care plans, alerts and other data as described in the process.** 1. CRISP will help to plan and implement infrastructure for care coordination programs developed within the Health System Transformation program, quality improvement, and cost reduction initiatives. The Community Health Partnership of Baltimore and CRISP will work jointly to meet the objects in each of the core ICN categories listed below and to execute the following deliverables. a. Community Provider Connectivity b. Reporting and Analytics c. CRISP Alerts and Notifications d. CRISP Query Portal. Members of the Regional Partnership will inventory care plans that are actively used within the RP , notify CRISP of their source system and ability to send to the CRISP query portal 2. Community based Organization Partners i. Compensation ii. Service Level Agreements iii. Reporting of performance iv. Operational and financial procedures v. Intellectual Property
	2f	**Attach the list of HIPAA compliance rules that will be implemented by the regional partnership.** See Appendix B.
Data and Analytics	3a	**Define the data collection and analytics capabilities that will be used to measure goals and outcomes, including specific metrics and measures.** The data collection and analytic capabilities were described in section 1e. To generate the specific metrics and measures listed in Appendix A, various analytic capabilities will be employed. A team of CQI experts from the Armstrong Institute for

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		Quality and Patient Safety* will be in charge of ensuring that the quality metrics collected from EMR data are collected and aggregated from as many primary care practices involved with the target population as possible. The population health analytics team supported by the Community Health Partnership of Baltimore will work closely with the intervention teams and the IT infrastructure to ensure all necessary process can be reported regularly, and they will also utilize all available CRISP reports for other related process measures. The utilization and cost measures will be aggregated from CRISP and in partnership with the finance team, as well as gathered from PAU reports from existing hospitals. The population health analytics team will take a central role in aggregating all the data to produce dashboards and ongoing reports for monitoring purposes. *<u>Note:</u> The Armstrong Institute's goal is to eliminate preventable harm to patients and to achieve the best patient outcomes at the lowest possible cost, and then to share knowledge of how to achieve this goal. The Institute also provides an infrastructure that oversees, coordinates and supports patient safety and quality efforts across Johns Hopkins' integrated health care system.*
	3b	**Describe with specificity the regional partnership's plan for use of CRISP data.** As CRISP continues to evolve and create new, useful technologies for managing and tracking population health, CRISP has become the linchpin for the Community Health Partnership of Baltimore to be able to identify patients for targeting and monitoring, connect members of the care team to each other to strengthen care coordination and inform interventions, for future attribution to appropriate primary care teams, and for future evaluation purposes to support our partnership. More specifically, the Community Health Partnership of Baltimore will rely on CRISP data to identify our target population and stratify it by risk score using the PATH report (when available from CRISP). CRISP's cross hospital utilization reports will also be used to understand past utilization as part of the patient attribution algorithm this partnership created along with the West Baltimore Collaboration to ensure patients are not receiving duplicative care management services from the two partnerships (see Appendix C for more information). As part of the interventions proposed here, CRISP will be used to keep care team members informed about ongoing patient care processes and patient updates, and the ENS services will continue to be used to help link primary care and care management to what is happening in the hospitals across the partnership. Once the patient care profile and care plans are available on CRISP, the partnership plans to use these features to their full potential as well. The Community Health Partnership of Baltimore plans to maximize use of CRISP data in all ways possible.
Risk Stratification,	4a	**Describe any plans for use of risk stratification, HRAs, care profiles, or care plans. Describe how these draw from or complement the standardized models being developed.**

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HRAs, Care Profiles, and Care Plans		Patients identified for interventions will be risk stratified utilizing CRISP, EMR data, and the ACG predictive risk model to assign and deploy high/low medical and high/low mental health care management services. If a patient is identified as high medical with low mental health needs, he will be assigned a Case Manager as a primary care team coordinator with support from other interdisciplinary team members as needed. If a patient is identified as high mental health with low medical needs, he will be assigned a Health Behavioral Specialist with others supporting. Once assigned and patient contact is made, risk assessments are completed by a care team member(s) thereby driving the development of a patient specific care plan to be shared with regional partners via EMRs and CRISP. There are no currently accepted standards for risk stratification in post-acute settings. In our previous experience with J-CHiP, the Skilled Nursing Facility (SNF) Collaborative data support admitting diagnosis risk stratification as do other developing models including the INTERACT model developed by CMS and those tested in other CMMI demonstrations to reduce avoidable hospitalizations among nursing home residents.
	4b	**For risk stratification, include the types of patients, risk levels, data sources, accountabilities (who is accountable to do what?)** Once individuals with at least three hospitalizations in the past 12 months are identified, and the partnership's analytics team ensures they meet the inclusion/exclusion criteria outlined in part 1b, these patients will be further stratified using the Johns Hopkins Adjusted Clinical Grouper (ACG) software. This software will allow the partnership to stratify the population by highest utilization, by number of chronic conditions, and by risk score, as well as to determine whether or not individuals have conditions such as cancer or ESRD which may require a different type of intervention. Using risk scores (or other criteria) from the ACG system, the analytics team will be able to develop a distribution of risk scores from which the partnership can prioritize members of the target population of high utilizers for initial enrollment. If possible, the partnership will also stratify the population into the following categories (recognizing the limitations of available substance abuse data): 1. High Medical Needs/Low Mental Health and Substance Abuse Needs 2. Low Medical/High Mental Health and Substance Abuse Needs 3. High Medical Needs/High Mental Health and Substance Abuse Needs 4. Cancer 5. End-stage renal disease (ESRD) The partnership's analytics team will be responsible for identifying the target population, narrowing this population down using inclusion and exclusion criteria, and then stratifying by category and by risk score to create patient lists that can be matched to regional interventions.

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		Once individuals have been stratified into categories, some examples of responsibilities will be as follows: • For high-risk Medicare patients who have an identified primary care physician (PCP), an embedded Case Manager will be the primary assigned care team member for patients with high medical/low mental health needs. The Health Behavioral Specialist will be the primary care team member for patients with low medical/high mental health needs. The Community Health Worker is assigned to patients with high, medium, or low medical with clinical oversight by the primary care team member. • For patients without an identified PCP and/or urgent behavioral/substance abuse needs, care will be provided by a Community Bridge Team at a central location that is made up of a PCP, Case Manager, Health Behavioral Specialist, Psychiatrist, Addiction Specialist, and Peer Support Specialists. This team will manage and coordinate the short-term health needs and connect them to an appropriate ambulatory practice site for their ongoing care. The Community Bridge Team will also facilitate a connection to a Community Health Worker for needed community services. • For the short-stay SNF post-acute patients and patients discharged from acute to nursing home, the proposed risk stratification is by SNF/nursing home admitting diagnoses determined by the admitting medical provider following review of hospital discharge documents.
	4c	**For HRAs, include the types of screenings, who is accountable for completing, and where information is recorded.** Those patients identified for stratified levels of intervention will be outreached to initiate enrollment for care management services. Any member on the care team can initiate the outreach process. The level of intervention will determine who on the care team may have primary responsibility for engaging patients to begin completing a comprehensive Care Management Health Risk Assessment. This comprehensive risk assessment includes psychosocial and clinical domains to identify problems that will drive prioritized interventions. The social, "Barriers to Care", assessment domains helps to identify needs related to transportation, housing, financial, social support etc. The clinical assessment domains assess condition specific Health Status, Medication Adherence, Life Planning, Cultural and Linguistic Needs, Activities of Daily Living, Caregiver Resources, Nutrition, Physical Activity, Pain, Sleep, Alcohol and Substance Use, Emotional/Behavioral, Domestic Neglect and Violence, Cognitive, and engagement using the Patient Activation Measure (PAM). The risk assessments will be stored in the Primary Care Provider's home-based EMR and/or the Care Management documentation platform. Problems are addressed by creating self-management and care management goals. Each goal includes interventions, identified barriers and documents progression of goal. These goals will be shared via the care plan. The care plan developed in the provider's EHR will also be recorded within the CRISP patient clinical portal to encourage collaboration. All patients admitted to SNF and nursing homes undergo a complete standardized health assessment, Minimum Data Set

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		(MDS) that includes diagnoses, treatments, medications, functional status, and cognitive and mood assessment. These data are compiled in electronic format under CMS regulations.
	4d	**For care profiles and/or care plans, include the key elements that will be included, the systems through which they will be accessible, the people who will have access. Standardized care profiles are anticipated to be developed by the state-level integrated are coordination infrastructure.** The Patient information in the Clinical Portal of CRISP is being planned as a second tier. The first tier or landing page will be the Care Profile. Most of the Care Profile data will be pulled from different CRISP sources including Admission, Discharge, and Transfers (ADT) data feeds, patient demographics, Crisp Reporting Services Case Mix Data, the care plan (if available) and the Care Alert (if available). [To assist with care coordination and communication, we plan to submit the Care Plan and the Care Alert field to CRISP.] Proposed key elements that would be included in the CRISP Care Profile view will include the following: • Care alerts – summary of patient current needs and pertinent issues anyone working with the patient should be aware of. • Care plans that identify problems, goals and interventions will be developed by those involved in the patient's care at home, in an ambulatory setting, during an ED visit, and/ or an inpatient stay. These care plans can be initiated in the EMR, Care Management or CBO platforms and uploaded into CRISP to be accessed and shared with all those involved in the care coordination for the patient. We are working with the West Baltimore Collaborative to align specific domains for consideration (see the alignment work referenced in Q1a for details). • Care manager that is working with the patient including name, phone number and email. • Name of the Care management program the patient is enrolled in, the care management organization and start date in the program. • Indicate if the patient has an advanced directive. This care profile including care plans would be available in CRISP and would be accessible using the query function once a provider is recognized as a member of the patient's care team. Telephone numbers for all providers and organizations requesting ENS will also be listed on the Care Profile. One CRISP enhancement scheduled for an imminent release is the ability to identify if the patient is in a case management program. Once a provider is recognized as a member of the patient's care team, that provider can use the query function to assess if there is a care manager involved with the patient and the care manager's contact information. This functionality will help to improve coordination and communication across the continuum of care.

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		For Post-Acute patients, care profiles for high-risk diagnoses of CHF, COPD, delirium, and infections treated with high-risk antibiotics will be taken from the J-CHiP SNF Collaborative Clinical Protocols. These protocols will be made accessible to all SNF and nursing home medical directors, administrators, and directors of nursing. The J-CHiP SNF Collaborative discharge planning protocol will be disseminated to SNF and nursing home leaders as well as case managers and social workers.
	4e	**Identify the training plan for any new tools identified in this section.** CRISP system and workflow integration training is provided by CRISP and Care Management training staff. New hire orientation includes access and workflow training. Any system change or upgrades is updated in procedure manuals and workflow documents, shared with staff and stored in a centralized file for ongoing access. The J-CHiP SNF Collaborative employed a Nurse Coordinator who educated SNF staff on protocol implementation. This model will be replicated in the Community Health Partnership of Baltimore SNF Collaborative.
Care Coordination	5a	**Describe any new care coordination capabilities that will be deployed by the regional partnership.** The Community Health Partnership of Baltimore will capitalize on the existing infrastructure and capabilities of the Care Management Department at Johns Hopkins HealthCare, which has many years of experience with an embedded and regional approach to population health care management strategies. The infrastructure includes Clinical Screeners to help with the patient eligibility process, a centralized referral phone line to assist with direct referrals from providers and other urgent needs, a training division to help with orientation and revised workflows/processes, and several Clinical Informatics Specialists to assist with IT system needs/upgrades/revisions. CRISP will facilitate collaboration and coordination across regional partners with the identification of Care Coordinators by name and contact information at each facility. There will be centralized and shared Care Management referral processes which will support timely patient identification, warm handoffs to appropriate care teams and program enrollment. Identification of regional partners' facility and provider network's care coordination services along with unified regional interventions will support coordination efforts. The Community Bridge team will create a new level of accountability and care coordination for patients with prominent behavioral health conditions that are having repeated difficulty engaging in routine community health and behavioral health services. The Community Health Partnership of Baltimore will also deploy CHWs to the EDs in order to help address the patient's social determinants of health barriers and connect them to their patient-centered medical home. This intervention was

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		not part of J-CHiP, but throughout the execution of the J-CHiP interventions, it became increasingly clear that many patients seen in the ED will need community-based support in order to overcome barriers to care and avoid future visits. Our goal is that this intervention be led by a community-based partner as the other CHW interventions, and we will use our existing partnership and protocols in order to launch this new intervention quickly. New care coordination capabilities in the post-acute setting include: symptom management protocols, home health care coordinators for transition planning at skilled facilities, Outpatient Parenteral Antimicrobial Therapy (OPAT) case managers provided by home care; and case managers provided to supplement primary care practices that do house calls and chronic care. A new collaborative among nursing homes and hospice providers serving the RP is proposed to expand hospice services to SNF patients and nursing home residents for whom a change in care plan from full medical interventions to palliative care is appropriate. The House Calls Program will function as a community-based program that provides home-based medical care, care management, caregiver support, counseling, and acute inpatient continuity to high-need, high-cost home-bound individuals on a longitudinal basis. Through the use of remote patient monitoring, the Community Health Partnership of Baltimore will provide daily nurse monitoring and immediate feedback to patients with heart failure, diabetes, or COPD. We will also expand an existing J-CHiP remote patient monitoring and education pilot aimed initially at reducing CHF admissions of high utilizers through the use of tablet software.
	5b	**Identify the types of patients that will be eligible for care coordination and how they will be identified and by whom.** The target population includes: • Medicare beneficiaries living within 19 zip codes (21202, 21205, 21206, 21209, 21211, 21213-19, 21222, 21223, 21224, 21225, 21230, and 21231) of the regional partners • 3+ Admission in past year • Multiple and Complex Chronic Conditions • Serious Mental Illness (Schizophrenia, Bipolar Depression, Severe Dementia) • Substance Abuse • ESRD on Dialysis • Cancer List of eligible patients will be created and updated regularly by the partnership's analytics team using CRISP historical

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		data and the ACG system to stratify patients by condition prevalence and risk. We will also use direct referral from hospitals and providers as another way to identify patients throughout the implementation period. The eligible patients will be screened by a Clinical Screener and assigned to the appropriate care team member based on high/low medical and high/low mental health and substance abuse need. CRISP daily notifications are integrated into the workflow of all team members. The direct referrals can be received and processed by embedded staff where available or via a centralized population health email address managed by Clinical Screeners.
	5c	**Define accountability of each person in the care coordination process.** Health Care teams are comprised multidisciplinary staff across the care continuum that supports patients and families' care transitions, primary and specialty care access and follow-up and social support services. Key roles are outlined below. **Case Manager (CM)** The CM assesses, plans, implements, coordinates, monitors, and evaluates the options and services available to patients and their families. The CM is responsible for appropriate communications and collaboration of patient's care between various disciplines across the continuum. The CM: • conducts assessments to identify the patient's physical, psychosocial, spiritual, and financial needs; • develops patient-centered goals and identifies appropriate interventions; • provides self-management support to help patients better care for themselves; • acts as a patient liaison when coordinating the patient's healthcare needs with care team members, agencies and facilities; and • works one-on-one with patients to track and review progress. **Health Behavioral Specialist (HBS)** Patients are referred to an HBS if they have emotional and behavioral issues that have a negative impact on their ability to effectively manage their healthcare needs. HBSs are skilled in offering interventions that are based on a Cognitive Behavioral Model (CBT). The LCSW-C: • identifies and guides referred patients through protocols and therapeutic interventions relevant to their needs; • assists in accelerating a referral if the patient's psychiatric condition is beyond the scope of the embedded HBS services available; • evaluates and develops a safety plans for patients who present in the clinic with a mental health crisis; and • provides caregiver support to family and friends of the patient, as needed. **Community Health Worker (CHW)**

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		The CHW addresses the complex social and health problems of patients. The CHW receives clinical oversight from one or more CMs or HBBs, which includes assignment of tasks. The CHW: • is actively engaged in the community and knowledgeable about the cultural landscape; • has a working knowledge of community organizations and resources; • checks in with patients on an ongoing basis to assess their engagement; • assists patients with arranging appointments and coordinating transportation, if needed; • provides patient mentorship; • reinforces treatment plan tasks and goals; and • provides patient education, or refers patients to a Health Educator. **Neighborhood Navigators (NN)** NNs are responsible for regular outreach activities to existing clients on and around the blocks on which they live to build awareness among neighborhood residents of available health care and social service resources. Each navigator is assigned a geographic area consisting of approximately 30 occupied houses. NNs spend, on average, 40 hours per month on such activities. The NN: • works door-to-door to share knowledge of available resources and health and social services; • provides assistance with adherence to and engagement with prescribed care by listening to concerns or difficulties patients may have in managing their illnesses alongside other burdens; • provides appropriate referrals to community resources; and • assists patients with arranging appointments with and getting to resources. **Inpatient teams including the CHW in the ED** Case manager/social work teams in the hospitals that are already responsible for the development of solid discharge plans for high-risk patients. These individuals will collaborate with home care coordinators, transition guides and the appropriate community teams (e.g. case managers, home care nurses, community health workers, etc.) to ensure the continuation of care in the outpatient setting via a solid hand-off and scheduling of timely follow-up appointments. The CM/SW dyad may work with embedded team to address needs of patients with psychiatric/substance use issues and provide longer-term support post-discharge or post-ED visit. They will also work with CHWs embedded in the ED to address the needs of patients with critical social issues such as homelessness, lack of documentation, or lack of insurance. **Post-acute teams** Hospital discharge planners must document risk screening and referrals to appropriate levels of care and services in the

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<tr><th>Section</th><th>#</th><th>Question</th></tr>
<tr><td></td><td></td><td>community. The facility medical provider identifies high-risk diagnoses and orders clinical protocols. The facility nurse implements clinical protocols for high-risk diagnoses. The Social Worker/case manager completes the SNF discharge planning protocol, identifies high-risk diagnoses and medications, and makes appropriate referrals for community-based services. Home Care tracks and reports patients on remote patient monitoring.</td></tr>
<tr><td></td><td>5d</td><td>Describe staffing models, if applicable.
Our J-CHiP experience with interdisciplinary care teams has informed staffing models for the regional partnership strategies. Care teams include embedded Case Managers focusing on care coordination for patients with high medical needs, embedded Health Behavioral Specialist managing patients with high mental health needs and CHWs based in the community to address social determinants impacting care. Thorough consideration of assigned caseloads not only accounts for the care coordination responsibilities of each role, but also the day-to-day access availability of the team to providers to address urgent referrals, management and participation in Interdisciplinary Rounds and other unanticipated demands.

<table>
<tr><th>Care Team Member</th><th>Caseload Ratio</th></tr>
<tr><td>Case Manager</td><td>1:85</td></tr>
<tr><td>Health Behavioral Specialist</td><td>1:65</td></tr>
<tr><td>CHW</td><td>1:100</td></tr>
<tr><td>Outpatient Parenteral Antimicrobial Therapy (OPAT) Case Manager</td><td>1:25-30</td></tr>
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</td></tr>
<tr><td></td><td>5e</td><td>Describe any patient engagement techniques that will be deployed.
As we face new health care challenges and develop new models of delivery, we recognize that many of the health challenges facing our health system and our country are related to chronic health conditions that require health behavior change. Clinicians face pressure of limited time and increasing emphasis on outcomes. In addition, many providers have no formal training on the tactics and skills needed to facilitate patient engagement, effect health behavior change and promote patient satisfaction.

Since patient engagement is critical to success, we developed the Patient Engagement Training (PET) initiative for J-CHiP and JMAP staff and supervisors that leads to the development, maintenance, and utilization of patient engagement skills. We will expand that program to include the Community Health Partnership of Baltimore. The PET program:
• Helps providers and organizations realize the goals of patient centered care by changing the behavior in health care teams so we more fully assist patients in being active partners in their recovery and health care.</td></tr>
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Section	#	Question
		• Uses the evidence-based principles and skills of Motivational Interviewing (MI) to achieve behavior change by providers and patients. • Recognizes that to maintain and develop skills, initial training must be combined with support and maintenance activities. We developed and will expand to the Community Health Partnership of Baltimore an 8-hour curriculum to train staff on basic communication and motivational interviewing principles and skills to help and support patients in making incremental steps in a healthy direction to achieve behavior change. Core principles include a patient-centered approach related to respecting the patients' autonomy, working in partnership, listening more than telling, and recognizing readiness to change. Core skills include use of open-ended questions, affirm the person, active listening, and summarizing. We are piloting a similar 4-hour curriculum for JMAP primary care providers and will also expand that to PCPs in the Community Health Partnership of Baltimore. In addition to the training, we recognize it is important to maintain and practice these skills regularly. We identified Team Champions who help promote patient engagement skills & principles within their teams and develop team plans for continued engagement. We send out monthly "Tip-of-the-Month" emails that include helpful hints and a link to a short video on the monthly topic. Our leaders provide group and individual coaching to the Team Champions and monitor plan implementation; they also developed a menu of PET exercises that can be used within the health care team to highlight, review, and build skills. In response, managers added patient engagement skills as a core competency on job descriptions. The PET program has developed a rating form for staff and supervisors to use to evaluate skills semi-annually. Examples of success include: care team use of PET language and concepts during team rounds; improving patients' self-monitoring and achievement of their health care goals in care plan; and changing behavior of care teams, providers and patients.
Physician Alignment	6a	**Describe the methods by which physician alignment will be created.** *Administrative alignment:* The Community Health Partnership of Baltimore will leverage the success of JMAP's Regional Advisory Council (RAC) to align physicians in the work of the regional partnership. The objective of the RAC is to: "Ensure implementation of JMAP programs while promoting clinical integration amongst all participants and other key partners in the Region. Advise the JMAP Quality and Medical Management Committee of key clinical, quality and strategic priorities for the Region, as they relate to the mission of JMAP and achieving the Triple Aim".

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		The Community Health Partnership of Baltimore will use a similar infrastructure to have meetings with the physicians in the partnership to help ensure consistent communication about the partnership and the important activities impacting sites or when we need the sites to take action in some way. A council for the Community Health Partnership of Baltimore will be used to engage providers (Hopkins and non-Hopkins) to: • Promote clinical integration within the Region. • Promote the development of physician leadership within the Region. • Communicate and collaborate with other non-participant providers within the Region who impact the partnership's members When possible, the Community Health Partnership of Baltimore will leverage JMAP's RAC to also communicate to providers. In addition, the Mid-Atlantic Medical Directors Association (MMDA) will be leveraged to communicate information to SNF providers. Dr. Bellantoni serves as Secretary of the Mid-Atlantic Medical Directors Association (MMDA) and educational program chair of the society. The MMDA Board of Directors has endorsed the Johns Hopkins HSCRC Regional Partnership SNF Collaborative and has established a symposium at the November 6, 2015 annual educational meeting on the topic of transitions in care. Physician speakers from both acute hospital and SNF plan to describe their experiences with J-CHiP SNF Collaborative and engage medical directors and physicians to join the Community Health Partnership of Baltimore. *Fiscal Alignment:* There currently are no authorities for gain sharing or pay for performance under the current legal structure in MD. Once HSCRC receives approval from CMMI for such activities, the Community Health Partnership of Baltimore will work with the provider community to also align financial incentives.
	6b	**Describe any new processes, procedures and accountabilities that will be used to connect community physicians, behavioral health and other providers in the regional partnership and the supporting tools, technologies and data that will assist provides in the activities associated with improved care, cost containment, quality and satisfaction.** Transitioning to payment models that base compensation on outcomes requires physicians and health plans to exchange new kinds of information. In order to do that, there may be new patient consent processes needed as well as Business Associates Agreement to share data across provider types. Once the consents and agreements are in place, CRISP has positioned itself as the developer and facilitator of data transfer. Specifically, providers will subscribe to the encounter notification system so they can get real time alerts when their patients are touching the hospital system. New care alerts will be developed to allow providers across regional

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		partners to get a quick view of the most pertinent issue to effective and efficient care management. Development of a care profile will allow providers to get quick summaries on the patient's inpatient utilization and the development of provider profiles will enable attribution across the regional partners. Appendix C describes how attribution will work across both Baltimore City regional partnerships. The collaborating SNFs have joined CRISP with the goal of sharing important clinical data with community physicians. Johns Hopkins Home Care leaders have extended their use of technology to the SNF to manage CHF during the transition from SNF to community. CMS website provides measures of quality for all SNFs and nursing homes. The Community Health Partnership of Baltimore SNF Collaborative will review these data quarterly. Johns Hopkins uses Epic as its Certified EHR and is able to share patient information via Epic Care Everywhere with other hospitals that use Epic such as Mercy Health System. Care Everywhere provides a framework for interoperability, so that wherever the patient goes, between healthcare systems in the same town or across state and national borders, the clinicians providing care can have the information they need. When an Epic system is on both sides of the exchange, a rich data set is exchanged and additional connectivity options, such as cross-organization referral management, are available. A physician seeing a patient at one hospital can use Care Everywhere to access that same patient's record at another hospital and be able to view patient health information includes any information in the personal electronic health record. Exchanged information may include: allergies, medications, medical history, immunizations, patient visit summaries, test results, diagnoses, and procedures. In addition, Epic Care Everywhere has the capacity to support the same interoperability with other vendor's EHRs. For example, Johns Hopkins All Children's Hospital in St. Petersburg, Florida uses Cerner's EHR and they worked with Epic to establish an interoperable connection with similar capabilities. Sinai and MedStar both use Cerner as its Certified EHR. Over calendar year 2016, Johns Hopkins will work with the Sinai and MedStar IT teams to establish the same connection across EMR's for those patients that are shared. As such, there are profound opportunities among the partners to share patient data in new ways to improve care and safety. Every hospital in the partnership uses a CMS Meaningful Use Certified Electronic Health Record for patient care. At discharge, the hospital produces a mandated Continuity of Care Document (CCD) which is automatically transmitted to referring physicians, other hospitals, and/or CRISP. The CCD is a structured coded document which includes allergies, discharge medications, hospital course, test results, diagnoses, procedures, etc. Due to the structured nature of the document, segments of the document can be extracted and reformatted for other patient care uses.

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<tr><th>Section</th><th>#</th><th>Question</th></tr>
<tr><td></td><td>6c</td><td>Describe any new value-based payment models that will be employed in the regional partnerships.
There are several value-based payment models that are currently deployed in the regional partnership. They include pay for performance and patient centered medical homes with commercial payers and accountable care organizations (ACO's) with Medicare. Medicare's participation in pay for performance and bundled payment (not currently being deployed) requires special permission from CMS. In addition, changes may be needed in Maryland statute and regulations. During the implementation process, the Community Health Partnership of Baltimore will work with HSCRC to assists in the changes necessary for the regional partners to participate in additional Medicare value based payment models.

In addition to ACO's, a Medicare value based payment that is available to the regional partnership is the Medicare physician fee schedule for chronic care management. Providers are eligible for reimbursement for care management for Medicare beneficiaries with multiple (two or more) chronic conditions. Because of the administrative burden to providers and the financial burden (co-pays) to beneficiaries the model has not been well received by providers or beneficiaries. During the implementation of the regional partnership, barriers to participation will be addressed and where possible mitigated, as the CCM is one revenue that will sustain parts of the proposed interventions.</td></tr>
<tr><td rowspan="2">Organizational Effectiveness Tools</td><td>7a</td><td>Attach the implementation plan for each major area of focus (with timelines and task accountabilities).
Below is a timeline for beginning each major focus area. A detailed implementation plan will be submitted with the Implementation Program Application.

<table>
<tr><th rowspan="2">FOCUS AREA</th><th colspan="4">Calendar Year 2016</th></tr>
<tr><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td>Staff orientation and training</td><td>X</td><td></td><td></td><td></td></tr>
<tr><td>Improving communication across transition points</td><td>X</td><td></td><td></td><td></td></tr>
<tr><td>Embedding teams in primary care practice sites</td><td>X</td><td></td><td></td><td></td></tr>
<tr><td>Strengthening SNF Collaborative</td><td>X</td><td></td><td></td><td></td></tr>
<tr><td>Remote Patient Monitoring</td><td>X</td><td></td><td></td><td></td></tr>
<tr><td>Expanding CHWs in the community and in EDs</td><td></td><td>X</td><td></td><td></td></tr>
<tr><td>Continuing Neighborhood Navigator Program</td><td></td><td>X</td><td></td><td></td></tr>
<tr><td>Deploying Community Bridge team</td><td></td><td>X</td><td></td><td></td></tr>
<tr><td>Expanding patient education training and maintenance</td><td></td><td></td><td>X</td><td></td></tr>
<tr><td>House Calls Program</td><td></td><td></td><td>X</td><td></td></tr>
</table></td></tr>
<tr><td>7b</td><td>Describe the continuous improvement methods that will be used by the regional partnership.</td></tr>
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Section	#	Question
		In conjunction with the Armstrong Institute for Quality and Patient Safety, Johns Hopkins Medicine applies nationally recognized quality improvement methods and tools to improve the quality of care, promote efficient and effective use of resources, and to improve health outcomes. The Lean Sigma 'Define, Measure, Analyze, Improve, Control' (DMAIC) model for quality improvement is the primary tool used. The Lean Sigma method is the framework used for local site-specific and broad-scale initiatives to promote effective and sustainable solutions while building high performing care teams. A Quality Improvement (QI) Facilitator will be deployed to sites and will work with the local teams once every two months or more often as needed. Local practice teams should include but are not limited to: the Office Medical Director, Practice Administrator/Manager, providers, RN's, Medical Assistants, front desk/office staff, care managers, community health workers, and health behavioral specialist roles. The local team will identify a clinic-specific quality improvement project using the DMAIC method and integrate QI work with current site processes. The QI facilitator will document the project plans by developing and maintaining A3 charters (documents DMAIC). The QI facilitator will bring and explain data to these meetings to support improvement efforts. The QI facilitator will collaborate with local project teams such as care management, pharmacy, operations, and behavioral health to help facilitate streamlined workflows that improve efficiency and collaboration. Additionally, the QI facilitator will identify and share best practices between local teams, analyze global strengths and opportunities, and provide recommendations for priorities to leadership.
	7c	**Attach a copy of the metrics dashboard that will be used to manage performance over time with an explanation of associated processes that will be used to monitor and improved performance.** See Appendix A. The processes needed to create these dashboards will require joint efforts between the partner organizations, primary care practices, CRISP, and the partnership analytics team as described in section 3a. The Johns Hopkins Medicine Ambulatory Quality and Transformation team will produce dashboards for quality improvement purposes on a routine basis. The team will work with the regional partners to collect data from multiple sources including: available administration claims, practice electronic medical records, patient experience surveys, and CRISP data. The Quality Improvement facilitator will provide metric definitions and report specifications and assure practices' reports meet those definitions. The Quality Improvement Data Analyst will obtain reports with predefined measurement periods from the various sources/practices and collate reports into dashboards with entity, practice, and provider level performance. Additionally, the Quality Improvement Data Analyst will provide graphical and other visualizations of the data, including run charts.

Section	#	Question
		Performance dashboards and visualizations will be shared with key stakeholders and local quality improvement teams to communicate meaningful and timely information on performance indicators. They will also guide the performance and implementation strategies by identifying opportunities for improvement.
	7d	**Describe the work that will be done to affect a patient-centered culture.** With the patient at the center of the team, the goal of sharing information, individualized care planning and returning the patient to their Primary Medical Home to ensure well-coordinated care will be the focus of all team members. Targeted patients will have their Case Manager identified in CRISP with contact information to facilitate coordination and collaboration across the region. A comprehensive longitudinal care plan identifying problems, care management and self-management goals as well as interventions specific to the patient, will be developed in the EMR and/ or Care Management system and uploaded in CRISP to be shared with all others involved in the patient's care. Caregivers will be identified during the initial patient engagement/ assessment phase and document in the EMR, Care Management system and CRISP. Caregiver support services will be made available by exploring resources and providing education that can assist to minimize the psychosocial stressors associated with the demands of being a caregiver. The patient and his/her family/surrogate decision-maker contribute to the patient goals of care established for the clinical protocols implemented by the SNF Collaborative. The patient is actively engaged in the monitoring of the clinical conditions and symptom management. For example, a CHF patient may establish as a goal the ability to walk one block without dyspnea to visit a friend.
New Care Delivery Models	8a	**Describe any new delivery models that will be used to support the care coordination outcomes. (For instance, tele-visits, behavioral health integration or home monitoring.)** We will incorporate several post-acute interventions developed and deployed by the Johns Hopkins Home Care Group (and/or others who may be identified by Sinai or Mercy) to assist patients in their homes. This includes remote patient monitoring geared toward patients with chronic diseases like CHF and COPD, "Home Care Connect" (which provides in-home call buttons linking patients to nurses), and other services under development (e.g. PICC line management, infusion, etc.). Monitoring includes daily (or multiple times a day) with equipment in home, via a web-based wireless technology monitoring of biostatistics and symptomology; intervention with patients/families when problems occur; communication with physicians to coordinate interventions such as medication changes, doctors' visits, etc.; and deployment of nurses to the field for further intervention as deemed necessary. Remote patient monitoring (telehealth) has the potential to reduce avoidable re-hospitalizations, but require resources for the technology and reimbursement for medical providers not currently available.

Section	#	Question
		We will also expand an existing J-CHiP remote patient monitoring and education pilot aimed initially at reducing CHF admissions of high-utilizers through the use of tablet software that promotes medication compliance, dietary compliance, health literacy, and patient engagement. Early feedback indicates improved patient experience, improved health outcomes, and evidence of avoiding admissions that leads to cost savings.
	8b	**Identify how the regional partnership will identify patients, new processes, new technology and sharing of information.** In addition to the new processes outlined in Q6b, new eligible Medicare patients will be identified by direct referrals from providers across the continuum including primary care providers, inpatient teams, ED staff, Transition Guides, etc. The Community Health Partnership of Baltimore will standardize clinical care using best practices to a population of high-utilizers of health care resources who are risk for further debility and morbidity. Adaptation to electronic health records by SNF has lagged behind acute care, in large part due to the exclusion of SNF by CMS to the incentive programs offered to hospitals and community-based medical providers. However, the complexity of the patients and advances in software including more user friendly and web-based secure access. We are working with a vendor on a cloud-based transactional care management system for community-based organizations that can provide bi-directional communication with CRISP. This is a short-term solution until other options are available (e.g. CRISP Care Management platform). We are having discussions with another vendor on their cloud-based system that will implement education, monitoring, and engagement pathways for our partnership to track progress of patients in their health education and engagement. We will include more details in our Implementation proposal. We will also use new functionality in CRISP that includes: 1. Patient Care Profiles: Partner hospitals will work to improve the quality of the data captured in their Continuity Care Documents (CCD), which is mandated by Meaningful Use and sent to CRISP. CRISP will parse the data from these CCDs to create Patient Care Profiles which will supply providers with a concise and relevant synopsis of the patient's last known medical state. 2. Care Plan Alerts: Partner hospitals will modify their certified EHRs to accept and display Care Plan Alerts from CRISP. In this way, providers and care managements will be notified that a Care Plan exists /changes for their patient and provides links to the data. 3. Care Plans: Regional Partners will evaluate their workflows and care management protocols to determine how they can create Care Plans within their EHRs and transmit this data to CRISP so that it may be shared with others to support continuity of care. 4. MOLST and Advanced Directives: Partner hospitals will evaluate their workflows and discharge planning to

Section	#	Question
		determine how they can create MOLST and Advanced Directive documents within their EHRs and transmit this data to CRISP so that it may be shared with others to support continuity of care.
Financial Sustainability Plan	9a	**Describe the financial sustainability plan for implementation of these models.** The Community Health Partnership of Baltimore will attempt to recover revenue by billing payers for appropriate services such as chronic care management, health education, behavioral health, provider services in the House Call program, etc. As additional services become reimbursable from the payer, we will pursue them. We will continue efforts to advance meaningful and appropriate payment reform to create incentives for providing complementary social services to meet patients' needs. As we find sustainable reductions to hospital services under the GBR, a portion of those funds will be reinvested in the programs. Over the longer term, it is unlikely that the funding of these interventions can remain solely the financial responsibility of the hospital. The hospitals and the HSCRC should work with the payer community to help with the continued and expanded funding. It will also be important to assure that the savings achieved do not only benefit the payers but that the savings ultimately flow back to the patients.
	9b	**Describe the specific financial arrangements that will incent provider participation.** Maryland is limited in the financial arrangements it can offer to providers to incent their participation in the regional partnership. Permissions from CMS and the need for possible changes in statutory and regulatory language in MD limit value based payment models. As part of the planning process, there were several discussions on the type of incentives that could be provided to providers. These included gain sharing and pay for performance. Additionally, reimbursing providers for their time in the form of purchased RVU's as well as fixed incentive payments for particular milestones e.g. follow-up visit within 7 days post hospital discharge were explored. These ideas have been shared with the HSCRC.
Population Health Improvement Plan	10a	**Provide detailed description of strategies to improve the health of the entire region over the long term, beyond just the target populations of new care delivery models. Describe how this plan aligns with the state's vision, including how delivery model concepts will contribute and align with the improvement plan, as well as how it aligns with priorities and action plans of the Local Health Improvement Coalitions in the region.** Partnerships across city hospitals to address health at the regional level offer a new perspective on improving community health and create opportunities for addressing social determinants of health that greatly effect individuals across the geographic area. By partnering across hospitals, primary care practices, skilled nursing facilities, and community

<table>
<tr><th>Section</th><th>#</th><th>Question</th></tr>
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organizations, the Community Health Partnership of Baltimore hopes to begin changing the drivers of health in Baltimore City that have led to the high utilization and poor health outcomes seen in this region today

During the planning process, healthcare needs were thought of on a continuum and interventions were designed for each part of the continuum, specifically in the areas of primary care, acute care and post-acute care. These interventions are meant to wrap around the Medicare high utilizer population at each point of interaction with the health system and in the community to address gaps in care as well as create person centered teams which can address individual needs across the spectrum.

See Q1f for a list and description of proposed interventions for the Community Health Partnership of Baltimore.

In J-CHiP, Johns Hopkins partnered with two community-based organizations, bringing their knowledge and expertise in the target community as well as their credibility, as they reached out to and engaged patients and addressed barriers to care and other social determinants of health. At the onset, we will continue these partnerships and interventions, and our hope is to engage additional community partners at various levels as we all pursue the goal of improving health and well-being of our patients and by extension the community. To that end, we include an intervention that will build the capacity of community-based organizations in East Baltimore by partnering with Vince Truant, CEO of Matrix Ventures, a business development and management advisory firm focused on planning and implementation. Mr. Truant has been a member of the Johns Hopkins Hospital’s Patient and Family Advisory Council and the J-CHiP Steering Committee. He is committed to health improvement in Baltimore and to providing education, support, and mentoring to community-based organizations to ensure they have the capacity to engage in these efforts fully.

These interventions align with the State Health Improvement Process framework for progress toward a healthier Maryland. Four of the five focus areas and the following measures will be addressed in the regional partnership:

<table>
<tr><th>Focus Area</th><th>Measure Addressed</th></tr>
<tr><td rowspan="3">Healthy Living</td><td>Adults who have healthy weight</td></tr>
<tr><td>Adults who smoke</td></tr>
<tr><td>Life expectancy</td></tr>
<tr><td>Healthy communities</td><td>Fall related death rate</td></tr>
<tr><td>Access to health care</td><td>Persons with a usual source of health care</td></tr>
<tr><td>Quality preventive care</td><td>ED utilization for chronic diseases</td></tr>
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Section	#	Question
		In addition to clinical outcome measures, State and county level data on critical health measures provided through the SHIP will be tracked for Baltimore City as well as measures available in County Health Rankings. The interventions and their respective measures also align with the following priority areas identified by the Baltimore City Health Department in *Healthy Baltimore 2015*: 1. Promote Access to Quality Health Care for All 2. Promote Heart Health 3. Recognize and Treat Mental Health Needs 4. Reduce Drug Use and Alcohol Abuse 5. Encourage Early Detection of Cancer 6. Create Health Promoting Neighborhoods The local health improvement coalition (LHIC) for Baltimore City, once it is re-activated, will develop current strategies for the improvement of health in Baltimore City. Under the leadership of current health commissioner Dr. Leana Wen, the Baltimore City Local Health Improvement Coalition is undergoing a transformation. The LHIC's "re-invention" will be led by the new Chief of Policy and Engagement, expected to start 12/1. In 2016, the LHIC redevelopment plan will be focused on convening key leaders from the hospitals, FQHCs and the community to identify and support city-wide strategies to improve population health which include improvements in access to behavioral health services, identification of high utilizers and appropriate, effective care management. These principles align with the interventions and goals identified in the regional partnership. Active participation in the Baltimore City LHIC will ensure that our delivery model and interventions align with the priorities and actions of the LHIC. It will also ensure that we keep current on Baltimore City health issues, stay informed regarding efforts in progress across the city to improve health, and identify opportunities for new or enhanced partnerships. The Baltimore City Hospitals Community Benefit Collaborative is another important forum that seeks to improve the health of the residents of Baltimore City. Representatives of the Community Benefits programs of most of the city hospitals meet once a month to discuss how the hospitals can work together to maximize the impact of our collective health improvement efforts. The group prioritizes social determinants of health, and for the coming year has committed to focus on health literacy, and specifically on messages encouraging positive engagement with the health care system by establishing a relationship with a primary care provider. The goal is to help people understand how to use the health care system effectively, which will reduce ED and inpatient utilization. In addition, members of the Collaborative share information about their respective Community Health Needs Assessments and Implementation Plans, seeking

Section	#	Question
		opportunities to work together now and in the future to make the most efficient use of resources and ensure the most comprehensive results.
Appendix A		Metrics Dashboard (see Q7c)
Appendix B		List of HIPAA Compliance Rules (see Q2f)
Appendix C		Attribution Algorithm for Shared Patients with the West Baltimore Collaborative

Appendix A
DRAFT Dashboard for the Community Health Partnership of Baltimore
Monitoring Measures
2016

Categories & Measures	Q1	Q2	Q3	Q4
Process Metrics				
Total number eligible for Regional intervention				
Risk Prediction Model (Newly Identified)				
Referral				
N(%) eligible patients with no known care manager who are assigned a care manager				
N(%) eligible patients who refused ambulatory care management				
N(%) eligible patients with known behavioral health challenge and no known PCP who are referred to the Community Bridge Team				
Of eligible patients without a known PCP, the N(%) assigned to PCP				
N(%) eligible patients referred to Community Bridge Team who are assigned a PCP				
Of those enrolled in ambulatory case management, N(%) with a completed Health Risk Assessment				
Of those enrolled in ambulatory case management, N(%) with a completed Longitudinal Care Plan in CRISP				
% of inpatient discharges that result in an Encounter Notification System alert going to a physician				
All Population for Covered ZIPs				
Target Population				
Training and Education				
Number of staff who complete Patient Engagement Training				
Physicians				
Nurses				
Nurse Practitioners				
Care Managers				
Community Health Workers				
Quality Metrics				
Patient Experience				
N(%) "Top Box" responses to HCAHPS Discharge Information Domain: *"During your hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?"*				
% "Agree or Strongly Agree" on HCAHPS: Care Transitions Domain: "*When I left the hospital, I had good understanding of the things I was responsible for in managing my health?*				
Preventive Care and Chronic Condition Management*				
Hypertension (HTN): Controlling High Blood Pressure				
Diabetes Mellitus: Urine Protein Screening				
Diabetes Mellitus: Hemoglobin A1c Poor Control				
Diabetes Mellitus: Foot exam				
Diabetes Mellitus: Retinal Eye exam screening				
Influenza Immunization				
Pneumococcal Vaccination for Patients 65 Years and Older				
Preventive Care and Screening: Breast Cancer Screening				

Appendix A
DRAFT Dashboard for the Community Health Partnership of Baltimore
Monitoring Measures
2016

Categories & Measures	Q1	Q2	Q3	Q4
Colorectal Cancer Screening				
Body Mass Index (BMI) Screening and Follow-Up				
Screening for Clinical Depression and Follow-Up Plan				
Tobacco Use: Screening and Cessation Intervention				
Screening for Fall Risk				
Medication Management*				
Use of High Risk Medications in the Elderly				
Medication Reconciliation				
Documentation of Current Medications in Medical Record				
Cost and Utilization Metrics				
Utilization				
ED Visits per 1,000				
All Population for Covered ZIPs				
Target Population				
Total Hospital Admits per 1,000				
All Population for Covered ZIPs				
Target Population				
Ambulatory Care Sensitive Conditions				
Composite ACSC Discharge Rates per 1,000				
All Population for Covered ZIPs				
Target Population				
Chronic Obstructive Pulmonary Disease or Asthma Discharge Rate per 1,000				
Congestive Heart Failure: Discharge Rate per 1,000				

Appendix A
DRAFT Dashboard for the Community Health Partnership of Baltimore
Monitoring Measures
2016

Categories & Measures	Q1	Q2	Q3	Q4
All Cause 30-day Readmissions per 1,000				
All Population for Covered ZIPs				
Target Population				
Cost				
Total Hospital Cost per Person				
All Population for Covered ZIPs				
Target Population				
Total Health Care Cost per Person**				
All Population for Covered ZIPs				
Target Population				

Calculated Yearly	
ROI***	
Target Population	
High Cost Top 10%	

KEY
*Measures will only be available for patients at primary care practices which choose to participate in reporting these measures
**Total Health Care Cost per person will not be possible to calculate without Medicare Claims Data
***ROI will not be calculated in year 1

Appendix B

List of HIPAA Compliance Rules to be implemented by The Community Health Partnership of Baltimore

1. All personal health information (PHI) will be stored in a secure location that meets HIPAA Security Rule standards, including the implementation of appropriate administrative, physical, and technical safeguards to protect the integrity of the PHI and prevent unauthorized use, access, or disclosure.
2. Access to any PHI by regional partnership members or workforce members of regional partnership members will be monitored, logged, and audited. Additionally, access will be limited to only those workforce members who have a legitimate business reason to access the data. Access to the data will require appropriate validation of user identity via password, token or some other mechanism.
3. Portable electronic devices that will be used to store or access any PHI will be password protected and encrypted.
4. Appropriate agreements, such as a Business Associate Agreement, will be executed with any third parties that maintain PHI or need access to PHI to perform a service or function on behalf of the regional partnership.
5. Each regional partnership member will be required to comply with HIPAA and its own HIPAA privacy and security policies and procedures, in addition to any more protective policies and procedures agreed to and implemented by the regional partnership.
6. Any sharing of PHI between regional partnership members will be done in a secure manner using encryption when appropriate and utilizing encrypted VPN tunnels or secure FTP when possible.
7. Provided the PHI is properly secured in conformity with the Security Rule and the Privacy Rule, regional partnership PHI will be used and disclosed as permitted by the HIPAA Privacy Rule, each regional partnership member's Notice of Privacy Practice, and any applicable Business Associate Agreements in place, including for treatment, payment and health care operations activities.
8. Any use or disclosure of PHI will be limited to the minimum amount of PHI necessary to perform the applicable activity or service based on the professional judgment of the regional partnership member or workforce member of the regional partnership member.
9. Any unauthorized use or disclosure of PHI will be promptly reported to the Privacy Officer of each relevant regional partnership member. Such regional partnership members will work together, in good faith, to identify which member will be responsible for complying with the requirements of the Breach Notification Rule under HIPAA, including assessing the risk of compromise to the PHI, notifying the affected patient(s), if appropriate, and mitigating any risk associated with the unauthorized use or disclosure.

Baltimore City Regional Partnerships