# NexusMontgomery Regional Partnership
# Six Hospitals, One Coordinated Effort

## Regional Transformation Implementation Program

## Proposal for the
## Health Services Cost Review Commission

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Submitted on Behalf of Nexus Montgomery Regional Partnership


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# NexusMontgomery Regional Partnership: Six Hospitals, One Coordinated Effort

## Introduction

The NexusMontgomery Regional Partnership represents an historic commitment of all six hospitals in Montgomery County to collaborate on efforts that promise greater return on investment and benefit for population health through joint effort than from efforts of hospitals individually. The six hospitals will share infrastructure funds and staff resources, share data (both transactional and evaluative), and collectively coordinate with providers, community-based organizations, and public health entities to develop common interventions and projects.

This proposal is submitted by all six Montgomery County hospitals, all as lead applicants: Holy Cross Hospital, Holy Cross Germantown Hospital, MedStar Montgomery Medical Center, Shady Grove Medical Center, Suburban Hospital, and Washington Adventist Hospital. CEO-designated representatives of the six hospitals developed this proposal through a needs analysis conducted using input from VHQC (Medicare data[i]), physician focus groups, Regional Transformation Design work groups, Montgomery County DHHS, community-based organizations, and Healthy Montgomery (the Local Health Improvement Coalition). All of the hospitals are committed to this regional partnership, with an equal rate increase request and regional partnership contribution relative to size of net revenues plus markup.

The governance structure for this collaboration is called the NexusMontgomery Regional Partnership (NM RP). The NM RP Governance Board holds the decision-making authority for strategic program and budget decisions. The Board is informed by a Physician Advisory Board, Finance Committee, and Partnership Program Intervention Committee (P-PIC). The P-PIC is chaired by a NM RP Board member with participation from both hospital and community partners. Because NM RP will oversee multiple interventions, each with a set of partners, a Performance Management Center (the operational arm of NM RP), also includes intervention-level structures to ensure learning and collaboration among the partners of each intervention. This purposeful focus on shared learning aims for effective implementation and continuous improvement in each intervention across all hospitals and community partners. The network of collaborative partners and governance is described in Section 6 and depicted in Figure 4 on page 20.

This partnership among the six NM RP hospitals developed as an outcome of the HSCRC's investment in the NexusMontgomery Regional Transformation Design grant, which found:

- The NM RP hospitals share a patient population. Among Medicare high utilizers (3+ admissions in a year), 57% were readmitted to a different hospital than the index admission; and among other Medicare patients with two hospital admissions within a year, 35% used more than one hospital.[ii] These different site readmissions largely occur among the NM RP hospitals.

- The NM RP hospitals and other local providers face common challenges:
    - Lack of interoperability in care management systems is a barrier to sharing care plans and communication among patients' care managers.
    - Care management vendors abound, all citing significant impact. However, their evaluative data is typically on small, selective case bases and not in communities of linguistic and cultural diversity like Montgomery County.
    - Transition from nursing facility to home poses a challenge for most skilled nursing homes in this region.[iii]

- Insufficient psychiatric beds and services[iv] lead to boarding of patients in the emergency department or hospital.
- The region's large number of immigrants include many whose visa status make them ineligible for insurance. More than half of unauthorized (undocumented) immigrants lack insurance.[v]

- The region has many small physician groups and numerous community-based organizations (CBO). Stakeholder meetings made clear that aligning each hospital individually to each provider, skilled nursing facility, or CBO is cumbersome, duplicative, and unproductive. In the short term, hospitals seek significant impact on high utilizers of regulated services and the upstream social and economic issues that drive this use. A shared approach to alignment and standardized processes between hospitals and with other providers, CBOs, and public health is crucial to achieving long-term positive health impact for the NM RP's target populations.

- All NM RP partners are united in their deep commitment to this community and the health of its increasingly diverse population. Both Montgomery and Prince George's Counties are majority minority, with 33% of Montgomery residents and 22% of Prince George's residents foreign-born, compared to only 15% statewide; more than 37% of foreign-born residents over five years old speak English less than very well.[vi] Two thirds (65.2%, 152,000 individuals) of Maryland's unauthorized immigrant population live in this service area of the NM RP hospitals,[vii] as do nearly half (46.4%, 214,968 individuals) of Maryland's uninsured.[viii]

- This region is aging much faster than the State as a whole; one in eight Montgomery County residents is currently age 65+; by 2030 one in five will be age 65+. In that same time period, the County's population – the largest and most racially and ethnically diverse of all Maryland jurisdictions – is expected to increase from 1 million to 1.15 million.[ix]

The interventions proposed focus on the populations and disease states that challenge all six hospitals and the communities they serve. The interventions are interconnected, achieving better identification of high-risk and complex-needs individuals; establishing improved long-term and post-acute care integration and coordination; and supporting efficient provision of services through integration of data, protocols, and community resources. Interventions will offer care management to improve transitions from hospital-to-home, reducing readmissions, and will work pre-emptively to stabilize the health of high-risk elderly in their homes, avoiding initial admissions. This proposal focuses on populations at risk for avoidable utilization, and high utilizers, both post discharge and living in the community. The target populations are Medicare and Dually Eligible age 65 and over, the all-payer hospital discharge population, uninsured patients ineligible for ACA programs, and high-utilizing severely mentally ill. Development of further population health programs is included as an infrastructure activity of NM RP.

## 1. Target Population

**1a. Geographic Scope:** The geographic scope of services under this proposal consists of the Maryland ZIP codes that represent the residence of 80% of the combined patient discharges across all six lead hospitals. This encompasses the majority of Montgomery County ZIP codes plus some Prince George's County ZIP codes. See Appendix A for the comprehensive list of the 42 target ZIP codes. These ZIP codes contain the following incorporated cities: Gaithersburg, Rockville, Takoma Park, College Park, Glenarden, Greenbelt, Hyattsville, Laurel, and New Carrolton.

**1b. Target Populations:** Within this geographic area, the NM RP proposes care management interventions and one capacity building intervention. The targeted clients of these interventions are a) current high

utilizers, b) persons at high risk of readmission and/or c) persons with unstable chronic illness at risk of potentially avoidable hospital utilization as shown in Table 1.

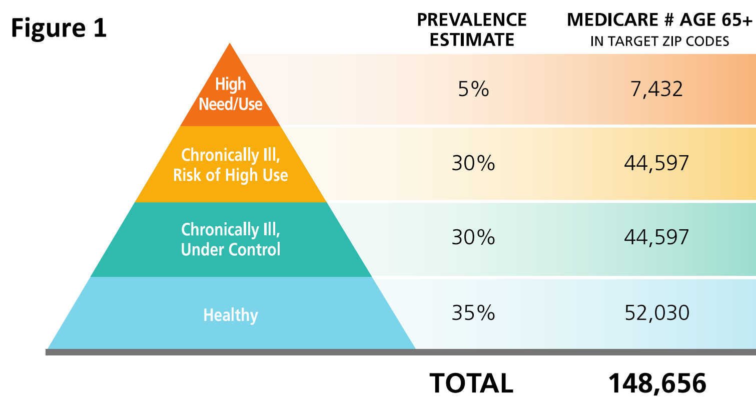
Per the HSCRC Health Status Pyramid in Figure 1 below, high utilizers and those at high risk of readmission fall into Tier 1 (High Need/High Use). Though only estimated at 5% of the population, this is a high cost group and will receive specific NM RP focus. However, fewer than half of high utilizers remain in this top utilization tier by the following year.[x] Therefore, in support of new All Payer Model (NAPM) goals for Medicare savings and controlling per Maryland beneficiary growth, the NM RP will also pre-emptively target a population of Medicare and Dually Eligible seniors age 65 and over who are at risk of near term hospital utilization, whether or not they have had a recent hospitalization. This target population emphasizes pre-emptively identifying and reducing the risk of avoidable use for those in the second tier – chronically ill at risk of high use.

**Table 1: Populations, Payers, and the Subpopulations of Focus**

| Populations and Payers | Intervention Type | Tier 1 | | Tier 2 |
|---|---|---|---|---|
| | | High Utilizers | High Risk of Readmission | Unstable Chronic Illness, Risk of PAU |
| Community-Living (at home) Seniors (Medicare and Dually Eligible Age 65+) | Care Mgmt | | | ✓ |
| SNF-to-Home Discharges (Medicare and Dually Eligible Age 65+) | Care Mgmt | | ✓ | ✓ |
| Hospital-to-Home Discharges (All-Payer) | Care Mgmt | ✓ | ✓ | ✓ |
| Hospital-to-Home Discharges (Uninsured-Ineligible) | Care Mgmt | ✓ | ✓ | ✓ |
| Severely Mentally Ill (Medicaid and Dually Eligible) | Capacity Building | ✓ | ✓ | ✓ |

The total number of Medicare beneficiaries age 65 and greater residing in the target ZIP codes is 148,656.[xi] Using HSCRC estimates, in any given year the health status of Medicare beneficiaries falls into one of the levels shown in the Health Status Pyramid in Figure 1.

**Figure 1**




Community-Living Seniors: Medicare & Dually Eligible, age 65 and over Because seniors are a rapidly growing segment of the target region's population, as discussed above, focus on seniors is vital to the

NM RP programs and to NAPM goals. High-risk patients within this population will be identified by trained referral sources (senior living resident counselors, EMS, PCPs). Criteria for referral include: worsening of a chronic life-limiting condition (e.g. end organ failure, chronic obstructive pulmonary disease, Dementia, Medical Frailty), frequent use of emergency medical services, little family support or a change in family support, and noticeable decline in functioning (e.g. gait, grooming, cognition, activities of daily living). An NM RP intervention (Health Stabilization for Seniors) will provide assessment and care coordination for this population. By focusing initially on residents of senior housing facilities – a defined population – evaluation will allow for more meaningful measurement of impact than is possible at the ZIP code level.

SNF-to-Home Discharges: Medicare & Dually Eligible, age 65 and over. Patients discharged from hospital to Skilled Nursing Facilities (SNFs) and then to home constitute a related target population of Medicare and Dually Eligible seniors. The NexusMontgomery Transformation Design process revealed that (a) these individuals are not followed to home by the NM RP hospitals' care transitions programs and (b) the same-year readmission rate for this population is high, as shown in Table 2. Referrals for care coordination will be made by the hospital discharge planners at the time the patient is discharged to the SNF, with further criteria for inclusion through health risk assessment conducted in the SNF through the NM RP Health Stabilization for Seniors intervention.

**Table 2: Medicare Hospital Admissions, Following Discharge from SNF to Home**

| Medicare Beneficiaries Living in Montgomery County (CY 2014 data) | Number of Claims | As Percent of (A) |
|---|---|---|
| A. Number SNF Claims Discharged to Home | 4,711 | n/a |
| B. Number SNF Claims Discharged to Home, with subsequent admission to hospital | 2,554 | 54% |
| C. Number Claims with SNF Discharged to Home, with subsequent admission to hospital within 30 Days | 1,444 | 31% |

Source: VHQC: H.E.A.L.T.H. Partners zip codes

Hospital-to-Home Discharge Patients: All-Payer. Each NM RP hospital uses risk scoring criteria to target those patients at highest risk for readmission. Risk scoring considers multiple medications, limited functional status, psychosocial needs, and multiple chronic conditions with the highest risk being congestive heart failure, chronic obstructive pulmonary disease, and diabetes. These ambulatory sensitive chronic conditions reflect the cardiovascular and diabetes burden described in the Community Health Needs Assessments of the NM RP hospitals and by Healthy Montgomery.

High utilizers are a shared population among the NM RP hospitals; high-utilizing patients access multiple hospitals. Currently, each hospital uses internally-developed criteria to target the highest risk population of their own discharges. The NM RP creates an opportunity for the hospitals to share criteria and effectiveness data, and together develop even more accurate and predictive risk identification methods. This will ensure that hospital care transitions resources are focused on the population of patients most at risk of future hospital utilization, at any hospital, and for whom hospital care transitions services can reduce potentially avoidable utilization. This joint focus on risk criteria also serves as the basis for the NM RP to prioritize development of upstream population health programs that can impact the causes of these chronic conditions in the longer term. These programs, many of which are already offered by the NM RP hospitals, would be enhanced with savings returned by the expansion of the hospitals' care transition programs, as discussed in *Plans for Using the ROI* in Section 4.

ACA Ineligible-Uninsured: Nearly half (46.4%) of Maryland's uninsured population resides in the NM RP region, placing a disproportionate burden on NM RP hospitals for this care. Over 40% of these uninsured are ineligible for state and federal coverage due to immigration status.[xii] This includes unauthorized (undocumented) immigrants as well as immigrants with certain deferred action statuses such as Deferred Action for Childhood Arrivals (DACA) or "Dreamers". This population is referred to in this proposal as the ineligible-uninsured.

Though hospitals are reimbursed for uncompensated care through the Maryland All-Payer mechanism, the utilization patterns of the ineligible-uninsured population exacerbates the burden of their care. The 30-day same site readmission rate for self-pay patients is roughly 25% higher than the commercially insured; over 2,500 self-pay patients are discharged from NM RP hospitals annually and over 240 are re-admitted within 30 days.[xiii] Research demonstrates that ineligible-uninsured patients are less likely to access post-acute care, contributing to disparities in health outcomes after acute events.[xiv] These disparities between the ineligible-uninsured and patients with insurance coverage include increased hospital readmissions, more hospital days upon readmission, and higher mortality rates.[xv]

Severely Mentally Ill: In Montgomery County, an estimated 32,641 persons have disabling behavioral health disorders.[xvi] Although Montgomery County has Maryland's lowest rate of ED visits for substance abuse and the second lowest for mental health conditions, the rates have increased by 12 percentage points for substance use disorders and 38 percentage points for mental health conditions from 2010 to 2013.[xvii] This troubling trend must be addressed. Already lack of appropriate services in the community frequently results in boarding psychiatric patients in the ED or hospital beds. Not only do hospitals incur considerable expense, but the patients also are unlikely to receive recommended and needed care in this situation. Due to the nature of severe mental illness, this is a Medicaid and Dually Eligible population. The NM RP will support capacity building of community crisis beds and a new Assertive Community Treatment team, as well as the development of longer-term population health strategies in collaboration with the Core Services Agency and the Healthy Montgomery Behavioral Health Task Force.

## 2. Proposed Interventions

NexusMontgomery proposes four distinct, yet complementary interventions that target high-utilizing patients and those at risk of high utilization or potentially avoidable utilization. The interventions will engage hospital discharge patients in need of care transition management and community residents and patients whose health care needs can be met in the community. Intervention One, Health Stabilization for Seniors, is a new intervention to be implemented as a shared resource of the NM RP. Intervention Two, Care Transition Services, will scale up the care transition programs of each of the six NM RP hospitals, increasing the number of high-readmission risk patients who will receive care management on discharge from the hospital to home. Intervention Three collaborates with an existing community specialty care program for the uninsured to reduce readmissions. Intervention Four builds crisis beds and Assertive Community Treatment capacity to reduce hospital utilization by those with severe mental illness. These four interventions complement each other by serving (a) current high utilizers and those at risk of readmission, immediately upon hospital discharge and (b) pre-emptively identifying those at risk of high or potentially avoidable hospital utilization, ideally before an index admission (or readmission if the program client has previously been hospitalized). Figure 2 on page 9 graphically represents Interventions One and Two focusing on maintaining health at home and reducing hospital utilization. The financial model and return on investment for each intervention is described in Section 4.

In addition, the NM RP proposes infrastructure development to support effective care coordination and care management across providers, including expanded use of CRISP services and developing hand-off

protocols with commercial payer/Medicaid care management programs. This will free hospital care management resources to focus further on Medicare patients, who have no other care management options. The NM RP also proposes structures for process improvement to enhance the efficiency and effectiveness of the interventions and transform the health system through root cause analysis, a learning collaborative, and involvement and alignment of stakeholders, patients, and caregivers.

## 2a. Intervention One: Health Stabilization for Seniors

**Population Served in this New Program:** NexusMontgomery will initiate this Health Stabilization for Seniors (HSS) program[xviii] which pre-emptively provides care coordination services for Medicare and Dually Eligible seniors, aged 65 or greater who are at high risk for hospital utilization within the next 120 days. HSS aims to keep these high-risk seniors healthy at home and prevent initial admission or readmission (for those with previous inpatient care). Section 1 describes of the population recruitment mechanisms. The program begins with residents of 22 senior independent living facilities referred by the facility resident counselors and by EMS. Four months later, the program also accepts seniors being discharged from SNF to home who reside in the Geographic Scope. At the end of Year 1, the program opens to additional senior living facilities and accepts referrals from EMS and select PCPs for any at-risk seniors who reside in the Geographic Scope. PCPs will be selected (a) who have existing NM relationships as a result of their participating patients who reside in the senior living facilities or (b) who serve an area determined through NM RP data analysis to be a Medicare high utilization hot spot. At steady state operations, the program will serve approximately 3600 clients per year.

**Delivery Model/Services**: The HSS intervention focuses on stabilizing health conditions for at-risk seniors so that Medicare and Dually Eligible beneficiaries age 65 and over currently at home can maintain their health at home. The program begins with training referral sources (senior living resident counselors, EMS, PCPs, hospital discharge planners/SNFs) on the specific referral criteria. During the NexusMontgomery Regional Transformation design grant, a pilot test of referrals by senior living resident counselors resulted in 78% concurrence between referrals and a score of high or moderate risk for hospital admission on a validated health risk assessment (Care at Hand). The chronic conditions of interest in the referral criteria reflect the top chronic conditions associated with high user Medicare utilization[xix] as shown in Appendix B.

For all seniors referred to HSS, The Coordinating Center (TCC),[1] NM's selected care coordination partner for HSS, will obtain patient/client consent[2] and conduct a health risk assessment (HRA) using a web-based mobile application called Care at Hand.[3] A sample consent form is included as Appendix C.

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[1] NM RP stakeholders selected The Coordinating Center (TCC), a nonprofit organization with extensive experience in Maryland, as the vendor that will perform risk assessment and care coordination. TCC is accredited by URAC, a nationally recognized accreditation organization. TCC has also been continuously certified since 2000 under the Standards for Excellence program of the Maryland Association of Non Profit Organizations that certifies nonprofits according to measures of ethical practices and accountability.

[2] TCC has been obtaining patient consent from and coordinating care for vulnerable individuals for thirty years. TCC has altered existing consent forms consistent with the specific circumstances of the HSS program.

[3] The Care at Hand system was developed as a care coordination tool that aims to reduce hospital readmissions. It has been validated through a process that included review by geriatricians and community nurses, psychometric evaluation among nonmedical workers, and field-testing. Analysis of Care at Hand will be published in 2016 (Ostrovsky A, O'Connor L, et al. Predicting 30-120 day readmission risk among Medicare FFS patients using non-medical workers and mobile technology. PHIM. Jan 2016 *in press.*) http://careathand.com/

The initial HRA survey stratifies clients into risk levels and provides information to the care team about the primary active issues affecting the client's health risk. The Care at Hand algorithm creates a custom survey of up to 15 questions tailored to the client's active health issues. The algorithm continually adjusts and changes the questions in order to predict upcoming risk for hospital use and generates alerts when risk increases. All questions are in lay language and address three categories of concern: issues intrinsic to the patient's disease or condition, extrinsic issues pertaining to care coordination breakdowns, and extrinsic issues pertaining to social and environmental factors affecting health.

Seniors at high risk will participate (upon patient consent) in intensive care coordination to address and resolve the key issues affecting their health and risk status; the expected average intervention is 60 days. This is a patient-centered, facilitative model; assessment and services are individualized to the needs of each patient and their family members. A Community Health Coach equips patients to be fully engaged in and take ownership of their health and health care. Intensive care coordination can include connection to community services (e.g. PCP, behavioral health, social services, wellness programs, occupational therapy), medication reconciliation, benefits application, health education and activation, and accompanying the client to medical appointments to enhance communication and health literacy. Seniors at medium or low risk, including those who successfully completed an episode of HSS intensive care coordination, will receive periodic contact from TCC using Care at Hand evaluation questions to identify any new increased risk level for hospital utilization. A finding of high risk triggers a period of intensive care coordination.

Program clients referred by discharge planners of the NM RP hospitals as high risk for SNF-to-home-to-readmission will participate in the HSS program commensurate with their hospital discharge to SNF. During the patient's SNF stay, TCC will provide "light touch" coordination, conduct the Care at Hand HRA, and plan for the transition to home. If the patient's risk score remains high at discharge from SNF, TCC will provide intensive care coordination and track level of risk using Care at Hand, as described above. HSS is a care coordination program, complementing any home health services the client may receive upon SNF discharge. HSS does not provide direct clinical services.

**Workforce:** A TCC care team consists of one RN, one scheduler (whose duties include processing CRISP ENS alerts), and six community health coaches. Community health coaches are unlicensed lay persons with bachelor degrees and relevant experience. Through Care at Hand, the RN receives real time alerts as health coaches perform health risk assessments. The RN is immediately available by phone or video to the health coach and client to resolve issues or develop a plan for care. Each health coach has a client load of approximately 35 patients per month. Care teams are supported by a Program Manager and a social worker (LCSW-C) who serves as liaison to the HSS referral sources and to community services. The Program Manager and social worker support up to three care teams concurrently, making this the most cost effective configuration, assuming sufficient client referrals. The program is further supported by a Quality Improvement Manager, and communications/training, data analysis, and IT functions.

**Collaborative Partners** include DHHS Aging and Disabilities Services, Housing Opportunities Commission, specific senior living facilities, Medicare beneficiaries, SNFs, LifeSpan, VHQC, and PCPs (as targeted). See Appendix D for a list of community and collaborative partners.

**HSS-related Systems Improvement Projects:** In addition to serving individual seniors, the HSS program will undertake related projects designed to transform systems of care, including:

- Targeted Outreach: Data across all six NM hospitals will be analyzed to locate high utilizer hotspot census tracts. Outreach will target PCPs in those areas for referrals to HSS. The program will undertake assessment of community service gaps contributing to poor health and high utilization, and coordinate with Healthy Montgomery and DHHS to find collaborative solutions across diverse organizations and agencies.

- Hospital-to-SNF-to-Home Process Improvement: Root cause analysis will be used to identify causes of high rates of hospital readmissions for Medicare and Dually Eligible patients discharged from SNF-to-home then readmitted to hospital. Because HSS is a shared program among the NM RP hospitals, all six hospitals will refer their hospital-to-SNF Medicare patients age 65 or over into this program, NM will gather data to compare processes and identify specific areas for improvement. The Model for Improvement using PDSA (plan-do-study-act) cycles will be implemented to effect and monitor systems changes. This effort will complement and coordinate with the existing hospitals/SNF/VHQC workgroup that focuses on direct SNF-to-hospital readmissions.

- CRISP Connectivity: The NM RP recognizes that efficiency, effectiveness, and patient experience of care will improve if all providers use a common health information exchange (HIE) for data sharing. In its work with SNFs, PCPs, and other providers, NM RP will promote connection to CRISP services (e.g. ENS and Alert Notification). Likewise CRISP will work to define and expand its protocols, where possible, to allow community-based care management organizations (including TCC) participating with CRISP to load their patient panels, receive ENS notifications, and access care plans from the Clinical Query Portal/Care Profile. NM will provide input to CRISP on the design of the Clinical Query Portal and Care Profile for sharing care plans between provider organizations, and for using ENS panel subscription as a proxy for designating an organization as a care manager for the patient. CRISP will provide hospital utilization and provider panel reports for NM RP evaluation purposes. NM RP and CRISP have drafted an MOU detailing the expectations and the responsibilities of each party, included as Appendix E.

**Relation to Other Programs:** The NM RP has identified and mitigated these potential areas of overlap:

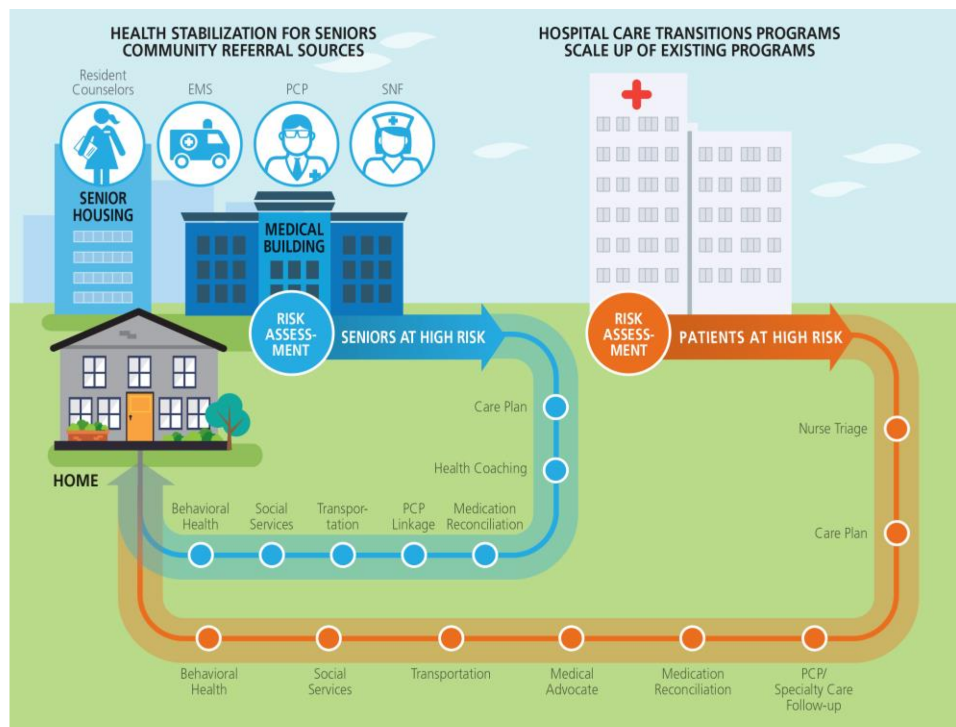
- Residents of the senior living facilities: To ensure no duplication of services and for fidelity of HSS program evaluation, each NM RP hospital will refer discharged patients from the senior facilities who are at risk for readmission to HHS instead of to the hospital's care transition program.
- Primary Care Providers: PCP feedback during HSS design indicated need for clarity in responsibility for their patients. HSS will develop materials and communications for PCPs clarifying that HSS is neither a clinical care nor chronic care management program. (See Section 5 for more on CCM.) HSS will work to link clients to their PCPs and to any care management programs available to them.

## 2b. Intervention Two: Scale Up of Existing Hospital Care Transition Programs

**Population Served in Existing Hospital Care Transition Programs:** Leveraging the infrastructure investments in FY2014 and FY2015, each of the six NM hospitals developed care transition programs that serve an all-payer population of hospital discharges who are high utilizers or at significant risk for readmission/high utilization. See Section 1, Target Population, for the population description, selection, and rationale of the Care Transition Programs. With infrastructure investments to date, the existing care transition programs have been able to serve only 20% to 50% of the patients who score at high risk. These programs are shown to decrease emergency department utilization, reduce 30-day readmissions, and stabilize patients at home for greater patient quality of life and capacity to self-manage. Scale up of

these programs to serve more of the target population presents the most expeditious means to leverage prior investments for immediate return.

**Figure 2**




**Delivery Model/Services:** The care transition programs of each NM RP hospital uses a defined method to select patients and an evidence-based intervention for reducing readmissions after discharge. All six NM RP hospitals employ a Coleman or modified Coleman model[xx] for care transitions programs, though each has a different care team construct. All programs are patient-focused to meet the patient's needs for post-acute recovery. The brief descriptions below detail the services offered and workforce.

**Washington Adventist Hospital and Shady Grove Medical Center Transitional Care Programs** target high utilizers who score 10 or greater on an open-ended risk stratification tool that assesses both medical and social determinants of health. Patients are assessed and enrolled during their hospital stay. Services Offered: Enrolled patients receive a home visit within 72 hours of discharge that focuses on medication reconciliation, discharge instruction review, safety check, preparation for follow-up with PCP, and disease specific education/action plans. Weekly phone calls follow the home visit, with an additional home visit if necessary. The program is a maximum of 90 days in duration. Workforce: RNs.

**Holy Cross Hospital (HCH) and Holy Cross Germantown Hospital (HCGH)** plan to scale up three programs, as follows:

- **Holy Cross Post-Acute Care Liaison:** This program serves a discharge population other than hospital-to-home, instead focusing on all-payer discharges (excluding Kaiser Permanente) to SNFs. In addition to the Coleman Model, this program uses the Hospital Guide to Reducing Medicaid Readmission.[xxi] Services Offered: For patients discharged to SNFs, ensure warm handoff communication by direct Hospital-RN to SNF-RN contact and site visits to SNFs throughout the year. Workforce: RNs.

- **Holy Cross Transitional Care Program (HCH Only):** For patients discharged to home, not qualifying for skilled home care but having multiple conditions or medications and/or assessed for being high risk for readmission. Services Offered: One in-hospital visit, one in-home visit, and at least three coaching phone calls. Workforce: RNs with training in health coaching.

- **Holy Cross Hospital Care Management:** Expand this program to include Medicare patients aged 65-69 and patients identified at admission to have a readmission risk score of greater than 12%. The focus is on Adult Medical-Surgical patients discharged to home**.** Services Offered: Face to face discharge planning services, including appropriate referrals to ensure physician appointments are made and medications obtained. Workforce: Care Managers.

**MedStar Montgomery Medical Center Care Transition Program** serves patients with multiple chronic conditions, limited functional status, psychosocial needs, and high-risk diagnoses. Services Offered: Coordinate education, community resources, and referrals with home visits for complex patients, expand follow-up to 60 days post-discharge. This program modifies the Coleman model with the Transitional Care Model.[xxii] Workforce: Community Health Worker, Transition Care Nurses, Complex Case Manager, and RN home visit nurse (contracted).

**Suburban Hospital's Readmissions Initiative** assesses patients using the "Early Screen for Discharge Planning" tool to determine high risk for readmission. A patient who does not score as high risk may be included in the program based on separate assessment by a social worker or nurse case manager. Services Offered: Patients receive intensive care coordination, including risk screen, interdisciplinary care planning, patient family education, pharmacy teaching on high risk medications, primary provider handover of documents and notes, medication management, telephonic and in-home visits, education work group, and preparation for follow-up with PCP (e.g. appointment, transportation). The program also conducts joint clinical case reviews and process improvement with SNFs. This program combines the Coleman Model and Transitional Care Model. Workforce: Transition Guide Nurses, Community Health Nurse.

**Care Transitions Systems Improvement Projects:** In addition to serving individual patients, the NM RP will undertake related projects to enhance care transition programs and community capacity to further stabilize high utilizing and high-risk populations, including:

- Care Transitions Effectiveness Enhancement: Though the six hospitals run care transition programs based on the Coleman model, each has developed a unique care team and scope of services. Because the return on investment is not uniform across all programs, staffs will share data, and participate in a facilitated learning collaborative to explore best practices and improve all programs.
- Commercial and Medicaid MCO payer Care Management Alignment: NM RP will work with commercial and Medicaid payers to define role and capabilities of their case management programs in post-discharge re-admission reduction. Procedures will be developed for warm patient hand-offs, where appropriate, to meet jointly determined targets. If insured members remain in the hospital care transition programs, NM will explore cost sharing that recognizes the role of hospital programs in improved member health.
- Discharge and Care Plan Sharing: The CRISP Query Portal and Care Profile provide a mechanism for sharing care plans. NM RP will promote the use of this service to provider partners. During the Transformation Design grant, physician discussion panels and SNF representatives reported the

need for hospital discharge plans to define and share core elements in standard ways to increase use and effectiveness in ambulatory and SNF settings. NM RP will facilitate discussions towards normalization, recognizing there are IT and other challenges. Concurrently, NM RP will explore with CRISP using Care Alerts to highlight the core elements.

## 2c. Intervention Three: Post-Acute Specialty Care for Ineligible-Uninsured Patients (PA-SC)

**Population Served in this New Program:** The target of PA-SC is ineligible-uninsured patients discharged with high risk of readmission if immediate (30-day) post-acute, ambulatory specialty care needs are not met. PA-SC is necessary as the out-of-pocket costs to ineligible-uninsured patients for specialty care is a barrier to follow-up. The initial focus of PA-SC is physical therapy, pain management, and specialty office visits for complex chronic condition management. Because, as discussed previously, the NM RP target region is home to such a large portion of the state's uninsured population (46.4%), developing services that address their health care needs – and reduce high cost utilization – is important for both population health and hospital cost containment.

**Delivery Model/Services:** PA-SC builds a new collaboration with an existing program, Project Access that is managed by the Primary Care Coalition. Project Access is a county-funded program serving low-income uninsured patients referred by primary care providers in specific safety-net clinics, currently the only referral source for this program. A network of specialty care providers offer reduced fee services for patients triaged and referred through Project Access.

A Montgomery County program, called Montgomery Cares, subsidizes primary care services for ineligible-uninsured patients at specific safety-net clinics. Unfortunately, not all ineligible-uninsured are aware of the program and, because they are ineligible for health insurance, these individuals often delay seeking health care until their condition is urgent or severe, requiring emergency or hospital care. When discharged from the hospitals, many cannot afford to follow the discharge instructions for ambulatory specialty care. PA-SC will develop referral processes for Project Access to accept ineligible-uninsured patients with specialty care follow-up needs and at high risk of readmission directly from the NM RP hospitals at discharge. NM RP pays the fees for these services that are not billable as there is no other payer. The total cost of this intervention is less than $250,000 per year.

Hospital discharge teams will receive training about Project Access, patient eligibility, and referral processes. For patients meeting criteria, PA-SC will arrange needed specialty care appointment(s), provide navigation, follow-up, and reminders – warm hand-offs – to ensure that patients keep appointments. PA-SC will also navigate the patients for follow-up to a primary care safety-net provider, from which – after 30 days – they may be eligible for additional specialty care services, as needed, through Project Access.

**Workforce**: RN Navigator (0.25 FTE), Program Manager (0.1 FTE) for first 6 months only, to create policies and procedures and establish the referral program with hospitals.

**Relation to Other Programs:** The PA-SC intervention builds upon the Project Access and Montgomery Cares programs in Montgomery County, and links ineligible-uninsured to primary care safety-net providers in both Prince George's and Montgomery Counties, promoting medical homes.

## 2d. Intervention Four: Service Capacity Building for Severely Mentally Ill

**Population Served through Capacity Building Program:** Three complementary sub-interventions aim to reduce hospital utilization by severely mentally ill frequent utilizers.

**Delivery Model/Services:** The three linked sub-interventions are: (a) increased crisis bed capacity (eight beds), (b) an additional Assertive Community Treatment team, and (c) a Behavioral Health Integration Manager to support the cross-organizational efforts to reduce ED and inpatient hospital use. Expand Crisis Bed Capacity: NM RP will provide ~$0.5M in capacity-building funds to Cornerstone Montgomery, a community-based service organization for severely mentally ill,[4] to expand their current 16 crisis beds by an additional eight beds. In preparation for this proposal, this expansion was vetted by the Core Services Agency with DHMH. The additional eight-bed crisis house will serve about 200 unique clients per year who typically stay for 10 to 14 days, during which they are stabilized, connected with a PCP, and receive evaluation and needed services. Upon authorization from ValueOptions, consumers are admitted to crisis beds as an alternative to inpatient hospitalization, at about one quarter the cost. The NM RP will fund facilities development only, and will not fund direct patient care or billable services. Cornerstone will work with the NM RP hospitals on processes for hospital priority for the crisis beds. In future years, Cornerstone and NM RP plan to pilot an RN support model to provide the hospitals with much-needed step down beds for patients with co-occurring psychiatric and somatic episodes.

Assertive Community Treatment (ACT) Team: NM RP will provide capacity-building funds to support startup of another ACT team[xxiii]; the two existing ACT teams are at their capacity of 100 clients each. ACT teams serve the severely mentally ill not suited to traditional treatment formats, and most likely to be high utilizers of hospital inpatient or ED services. Once achieving program fidelity and 100 clients, ACT teams are self-sustaining through billable revenue. NM RP will fund start-up costs only and not direct billed services.

Behavioral Health Integration Manager: The Behavioral Health Integration Manager (BHIM) will facilitate inter-agency efforts to reduce hospital utilization by severely mentally ill patients. Efforts have been piloted but not sustained due to lack of a facilitation resource. One such effort is the Inter-Agency/Client Care Team (the consumer, all hospitals, Core Services Agency, ACT teams). The team brings severely mentally ill patients who are known to be high utilizers and their care management providers from hospitals and community services together to develop a care plan, including care management recommendations for the ED and for ED avoidance. Value Options will identify the top high utilizing behavioral health patients, seen both as in-patients and in hospital EDs, for community care planning. Ensuring that these patients have available and effective care in the community can help to reduce hospital use and improve patient outcomes.

**Workforce**: Behavioral Health Integration Manager.

**Relation to Other Programs:** Capacity building enhances existing programs. The BHIM and inter-agency facilitation supports the recommendations of the Healthy Montgomery (LHIC) Behavioral Health Task Force and pilot efforts initiated by the Core Service Agency and other community providers.

### 2e. Interventions and Hospital Strategic Transformation Plans

Each of the hospitals has submitted a strategic transformation plan that recognizes the work of the regional partnership, while also reflecting efforts designed to improve health and reduce avoidable

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[4] Cornerstone Montgomery began in 2012 with the merger of St. Luke's House, Inc. and Threshold Services, Inc., two organizations with long histories of providing community-based behavioral health services.

utilization that the hospitals are pursuing independently. The increased scale of existing hospital care transitions programs clearly complements the hospitals existing efforts by expanding programs that are already underway and proving successful. The community-focused efforts – Health Stabilization for Seniors, Post-Acute Specialty Care for Ineligible-Uninsured Patients, and Service Capacity Building for Severely Mentally Ill – are jointly funded efforts that will help the NM RP hospitals reach at-risk populations. If successful, the programs will change the use trajectory of those beneficiaries, reducing their overall hospital utilization. These population-based efforts are well-aligned with existing hospital programs serving the broader community such as screenings, education, self-care management, and exercise designed to improve overall community health and well-being.

## 3. Measurement and Outcomes

### 3a. High Level Goals

The NM RP interventions and activities described in this proposal are designed to produce reductions in the following outcomes measures, both for All Payer and for Medicare FFS and Dually Eligible:[xxiv]

- Total Hospital Cost per capita
- Total Hospital Admits per capita
- ED Visits per capita
- Readmissions
- Potentially Avoidable Utilization

The NM RP region generally has a lower utilization rate and readmission rate than Maryland overall. However, the sheer size of the population of the NM RP geographic region (23% of Maryland's population) magnifies even small changes in measured rates when translated to costs. The geographic region is also facing a rapidly growing senior population that is becoming a larger percent of the total population. The 42 ZIP codes of NM RP contain a population of 1,324,643. With projected annual growth of 3.1% between 2015 and 2025, Montgomery County's percent of seniors will increase from 13.9% to 17.6%[xxv]. The NM RP performance on these outcome measures can have significant impact on Maryland's New All Payer Model. As the senior population in the region grows, it is imperative that the NM RP hospitals and their region have strong programs in place to maintain and improve performance on the key NAPM measures.

**Table 3: NM RP Outcome Measures: Baseline and Projections**

| Outcome Measure | All Payer | | | | Medicare FFS | | | |
|---|---|---|---|---|---|---|---|---|
| | Baseline | Projections | | | Baseline | Projections | | |
| | CY2014 | CY2016 | CY2017 | CY2018 | CY2014 | CY2016 | CY2017 | CY2018 |
| Total hospital cost per capita (charges per person) | $1,436 | $1,432 | $1,424 | $1,424 | $4,493 | $4,461 | $4,415 | $4,414 |
| Total hospital admits per capita (admits per thousand) | 84.3 | 83.9 | 83.2 | 83.2 | 235.5 | 232.9 | 228.3 | 228.3 |
| ED visits per capita (ED visits per thousand) | 246.2 | 246.0 | 245.7 | 245.7 | 281.7 | 280.8 | 279.8 | 279.8 |
| Readmission Rate | 11.73% | 11.40% | 10.92% | 10.90% | 16.47% | 15.72% | 15.15% | 15.12% |

The NM RP interventions are designed to complement each other to reduce hospital admissions, readmissions, ED visits, total hospital costs, and potentially avoidable utilization. The Hospital Care

Transitions intervention and the PA-SC intervention target readmission reduction. The Health Stabilization for Seniors and the Capacity Building for the Severely Mentally Ill interventions pre-emptively target avoidable hospital utilization, to reduce initial admissions, ED Visits, and as a consequence, readmissions. These programs work in parallel, sharing resources and learnings and avoiding duplication of effort.

Table 3 on page 13 shows the outcomes measures for All-Payer and Medicare FFS, at baseline (CY2014) and the cumulative predicted reduction from CY2014 baseline for program years CY2016 to CY2018 for the populations in the 42 ZIP Codes.[xxvi] These projections were built at the program level and accumulated, using program assumptions and for HSS, the predictive modeling performed by Discern Health as part of the Regional Transformation Design grant. The outcome projections represent the incremental impact of the NM RP interventions. The baseline for potentially avoidable utilization charges per person is $201.82. Future program year reductions in PAU will occur, but are not yet quantified.

Each year, the programs will achieve greater cumulative impact. Between CY2016 and CY2017, improvement is largely driven by the programs ramping up and serving clients. By CY2017, all programs will be operating at or near full capacity, touching more patients. Between CY2017 and CY2018, additional reductions will come through the NM RP process improvement infrastructure. This includes a learning collaborative for the hospital care transition programs and gains made in use of CRISP. Process improvement will focus on three critical elements that increase return on investment:

- Driving down program per patient cost
- Improving the targeting of patients to those at highest risk of hospital utilization
- Increasing the efficacy of the programs at reducing admissions, readmissions, and/or ED Visits for the patients served

## 3b. Program Specific Measures

**Health Stabilization for Seniors:** A population-based evaluation will be conducted on the cohort of residents in the 22 independent senior living communities, since this population is well-defined and the intervention will reach a substantial proportion of this cohort over time. This will capture the effects of the care coordination program as well as the specificity of the referral and risk assessment criteria. In addition, pre/post outcome measures will be applied to all program participants (the HSS patient panel), including those living in senior living facilities, referred for SNF-to-home coordination, or referred by EMS or community physicians, regardless of the client's residence. CRISP is developing a pre/post report for this purpose for cost and utilization measures. Further evaluation also measures change in client health status and health activation using Insignia Health Patient Activation Measure (PAM) scores. Research indicates that PAM is predictive of future emergency department and hospital use.

Health Stabilization for Seniors has numerous process measures to be tracked. The most crucial is *Referral Conversion to Active Case Management.* This measure reflects percent of referrals into HHS that, on the initial health risk assessment, score as high risk. A lower conversion rate jeopardizes the program's return on investment.

**Hospital Care Transition Programs:** The primary outcome measure to be monitored is relative improvement from the All-Cause Readmission Rate (expected) to the Readmission Rate (observed), for both all-payer and Medicare (age 65+) populations served. Additional outcome and process measures will be defined as part of the hospital care transition programs learning collaborative, including:

- Assessing patient experience with program enrollment and consent, *Percent of Patients Declining to Participate in the Care Transitions Programs* will be used. The NM RP will collect baseline data and work towards a target for voluntary patient participation.
- Determining if additional program scale is needed, *Percent of High Utilizers Placed in a Hospital Care Transition Program* will be used. To start, this data will be collected at the individual hospital level and reported to the NM RP.

**Specialty Care for Ineligible-Uninsured Post-acute Patients:** The 30-day readmissions rate for patients served will be tracked via CRISP ENS notifications to closely monitor the observed readmission rate for this population. Process measures include number of patients connected to outpatient specialty care, days from discharge to appointment, no show rates, and the average cost per patient.

**Services for Severely Mentally Ill:** Measures to be tracked include number of inpatient/observation bed days and average length of stay, and number of ED visits and average LOS (hours) for the severely mentally ill. Initial definitions were developed and data collected as part of the design process. These will be refined with baseline set for CY2016 (crisis beds open February 2017, ACT team in early ramp up second half of CY2016).

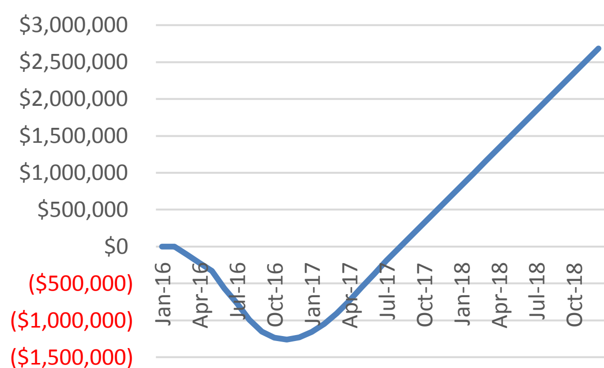
## 4. Return on Investment (ROI)

The planned outcomes of the NM RP activities support the New All-Payer Model (NAPM) directly through reduction in readmissions and potentially avoidable hospital utilization and in an overall focus on the Three Part Aim of better care, better health, and reduced costs. Given the size of the population in the NM RP region, NAPM success is impacted by the performance of NM RP hospitals on the Core Outcome Measures. To date, NM RP hospitals have generally performed well, but the first two years of infrastructure effort have captured the low hanging fruit. The NM RP, through its focus on collaborative learning, shared resources, and process improvement is formed to ensure continued good performance on measures, and to jointly address (and fund through savings) systems changes that improve the population health in this region into the future.

The NM RP recognizes the importance of creating a positive return (greater than 1.0) for the HSCRC investment in Transformation Implementation programs. This section details the return on investment (ROI) calculations for each of the interventions, and timeframe for achieving a cumulative net savings. The NM RP infrastructure contributes to the achievement of the returns. The ROI for each program is shown, as well as the ROI with NM RP costs allocated to that program based on that program's annual intervention cost as a percent of the NM RP whole. The interventions proposed have not been evaluated for their capacity to reduce total cost of care beyond the hospitals.

**Health Stabilization for Seniors:** The program focuses on high need and complex patients (Medicare/Dually Eligible, age 65+), most living with chronic conditions who may or may not have recently had a hospital contact but are at high risk of such within the next 120 days. This intervention creates savings through the avoidance or delay of the index admission or a same year readmission, as well as reduction in ED and EMS use. The ROI is shown in Table 4 on page 16.

**Figure 3**



During the client ramp-up period (January –November 2016) the program will generate losses as it implements patient services and incurs start-up administrative costs. The program will achieve break-even status by the end of 2017, and continue to generate a positive return thereafter with refinement in referral criteria and risk assessment in CY2018.

**Table 4: ROI for Health Stabilization for Seniors**

| NM RP: Health Stabilization for Seniors (HSS) | CY2016 | CY2017 | CY2018 | CY2019 |
|---|---|---|---|---|
| A. Number of Patients | 1544 | 3780 | 3780 | 3780 |
| B. Number of Medicare/Dual Eligible | 1544 | 3780 | 3780 | 3780 |
| C. Annual Intervention Cost/Patient | $1,519 | $962 | $962 | $962 |
| D. Annual Intervention Cost (A x C) | $2,345,996 | $3,637,689 | $3,637,689 | $3,637,689 |
| E. Annual Charges (Baseline) | $7,013,209 | $34,989,435 | $36,017,724 | $36,017,724 |
| F. Annual Gross Savings (32% x E) | $2,270,967 | $11,212,784 | $11,513,496 | $11,513,496 |
| G. Variable Savings (F x 50%) | $1,135,484 | $5,606,392 | $5,756,748 | $5,756,748 |
| H. Annual Net Savings (G-D) | $(1,210,513) | $1,968,703 | $2,119,059 | $2,119,059 |
| ROI: PA-SC | 0.48 | 1.54 | 1.58 | 1.58 |
| ROI: w/ NM RP infrastructure allocated | 0.43 | 1.38 | 1.41 | 1.41 |

**Scale Up Existing Hospital Care Transition Programs:** Expansion of the hospital care transition programs focuses on providing care coordination services to hospital patients (all-payer including Medicare and Dually Eligible) who are already high utilizers or assessed as high risk for readmission. Expanding the hospital care transition programs builds upon the investments made by each of the hospitals over the past two years in developing readmission reduction programs. Table 5, shows the combined ROI for these programs across the NM RP hospitals. All Payer ROI is on the left, and the Medicare subpopulation ROI is on the right of the Table. Expansion of the existing hospital care transition programs – through hiring, training, and caseloads for additional care management staff – can be accomplished in 16 weeks or less, reaching steady state by the fifth month post-award. This ramp up in CY2016 is reflected in the lower ROI for CY16. CY18 and CY19 reflect a 5% improvement in gross savings each year achieved through the learning collaborative. Appendix F details ROI for each individual hospital program. There is sufficient variability to assure opportunities for improvement.

**Table 5: ROI for Scale Up of Existing Hospital Care Transition Programs**

| NM RP: Hospital Care Transition Programs | ALL-PAYER | | | | MEDICARE | | | |
|---|---|---|---|---|---|---|---|---|
| | CY16 | CY17 | CY18 | CY19 | CY16 | CY17 | CY18 | CY19 |
| A. Number of Patients | 9,690 | 19,379 | 19,379 | 19,379 | 9,690 | 19,379 | 19,379 | 19,379 |
| B. # Medicare/Dual Eligible | 4,366 | 8731 | 8731 | 8731 | 4,366 | 8731 | 8731 | 8731 |
| D. Annual Intervention Cost All-Payer: A x C Medicare: B x C | $1,305,051 | $1,974,244 | $1,974,244 | $1,974,244 | $606,330 | $918,682 | $918,682 | $918,682 |
| E. Ann. Charges (Baseline) | $19,486,205 | $38,972,411 | $38,972,411 | $38,972,411 | $9,002,618 | $18,005,237 | $18,005,237 | $18,005,237 |
| F. Ann. Gross Savings (14% x E) | $2,629733 | $5,259,467 | $5,522,440 | $5,798,562 | $1,229,504 | $2,459,009 | $2,581,9594 | $2,711,057 |
| G. Variable Savings (F x 50%) | $1,314,866 | $2,629,733 | $2,761,220 | $2,899,281 | $612,752 | $1,229,504 | $1,290,980 | $1,355,528 |
| H. Annual Net Savings (G-D) | $14,215 | $655,489 | $786,976 | $925,037 | $8,422 | $310,822 | $372,297 | $436,846 |
| ROI: Hospital CT Programs | 1.01 | 1.33 | 1.40 | 1.47 | 1.01 | 1.34 | 1.41 | 1.48 |
| ROI: w/NM RP Infrastructure | 0.90 | 1.19 | 1.25 | 1.31 | 0.91 | 1.20 | 1.26 | 1.32 |

## Post-Acute Specialty Care for Ineligible-Uninsured Patients (PA-SC)

The NM RP region bears a disproportionate burden for care for the uninsured relative to the State as a whole, with two-thirds of Maryland's unauthorized immigrant population and nearly half of the State's uninsured. This readmission reduction program returns value to payers in the form of reduced uncompensated care. PA-SC targets only low-income ineligible-uninsured at high risk of re-admission due to affordability of needed ambulatory specialty care in the immediate 30 days post-discharge. This program only breaks even, but benefits payers and hospitals alike. Table 6 displays the ROI.

**Table 6: ROI for Post-Acute Specialty Care for Ineligible-Uninsured Patients**

| NM RP: Health Stabilization for Seniors (HSS) | CY2016 | CY2017 | CY2018 | CY2019 |
|---|---|---|---|---|
| A. Number of Patients | 156 | 264 | 264 | 264 |
| C. Annual Intervention Cost/Patient | $1,029 | $961 | $961 | $961 |
| D. Annual Intervention Cost (A x C) | $160,499 | $253,667 | $253,667 | $253,667 |
| E. Annual Charges (Baseline) | $624,000 | $1,056,000 | $1,056,000 | $1,056,000 |
| F. Annual Gross Savings (50% x E) | $312,000 | $528,000 | $528,000 | $528,000 |
| G. Variable Savings (F x 50%) | $156,000 | $264,000 | $264,000 | $264,000 |
| H. Annual Net Savings (G-D) | $(4,499) | $10,333 | $10,333 | $10,333 |
| ROI: HSS Program ROI (G/D) | 0.97 | 1.04 | 1.04 | 1.04 |
| ROI: w/ NM RP infrastructure allocated | 0.87 | 0.93 | 0.93 | 0.93 |

## Service Capacity Building for Severely Mentally Ill

This capacity building intervention provides one-time grants to expand crisis beds and ACT team capacity. Capacity grant investments are made in CY16 with less than 50 clients served in the ACT team. February 2017, the Crisis Beds are open and October 2017 the ACT team achieves Fidelity. ROI is predicated on the experience of Cornerstone Montgomery, which operates 16 crisis beds in the region. Average annual admissions to an 8 bed crisis house is 238 patients, of which 90% would otherwise have been hospitalized. With front-loaded investment as shown in Table 7, accumulated savings in future years are significant.

**Table 7: ROI for Service Capacity Building for the Severely Mentally Ill**

| NM RP: Capacity for Severely Mentally Ill | CY2016 | CY2017 | CY2018 | CY2019 |
|---|---|---|---|---|
| A. Number of Patients | 0 | 218 | 238 | 238 |
| D. Annual Intervention Cost | **$841,650** | **$ 483,021** | **$208,374** | **$208,374** |
| E. Annual Charges (Baseline) | $ - | **$1,963,500** | **$2,142,000** | **$2,142,000** |
| F. Annual Gross Savings (60% x E) | $ - | **$1,178,100** | **$1,285,200** | **$1,285,200** |
| G. Variable Savings (F x 50%) | $ - | **$589,050** | **$642,600** | **$642,600** |
| H. Annual Net Savings (G-D) | **$(841,650)** | **$106,028** | **434,226** | **434,226** |
| ROI: Capacity for SMI | **0** | **1.22** | **3.08** | **3.08** |
| ROI: w/ NM RP infrastructure allocated | 0 | 1.09 | 2.75 | 2.74 |

**Plans for Using the ROI:** The NM RP Governance Board holds responsibility for decisions on reinvestment of program ROI. The Board recognizes the need to continue investing strategically in interventions that have near-term positive impact on the NAPM goals and that support financial stability of NM RP hospitals under GBR. Initially, the Board expects to place at least half the expected ROI savings into near-term programs. At the next tier of investment, the Governance Board focuses on population

health programs for which the return on investment may be longer term. The Governance Board will seek a balance between near-term and longer-term ROI programs that empower a healthier population with lower chronic disease burden and more access to needed services in future decades. This, in turn, will reduce the need for further investment in care transition and care coordination programs.

Governance Board decisions on investment of ROI may include further expansion of successful programs as well as the start of new programs. The NM RP infrastructure includes support for literature review and sharing on evidence-based programs from around the country. The Governance Board aims to ensure that NM RP investments are both strategic and based on the latest evidence.

Payers will see a return from the NM RP programs in the form of reduced hospital utilization by their members. In addition, the NM RP Governance Board will consider investment with payers in programs that meet mutually beneficial goals.

## 5. Scalability and Sustainability

The NM RP will begin its system transformation efforts with three care management programs and a capacity building program, each of which can produce return on investment as discussed in the previous section. The Hospital Care Transitions Programs achieve savings earlier than the three community-based programs, but all programs will produce cumulative savings through reduced admissions within two years. These programs are sustainable without additional rate increases beyond the ongoing amounts associated with this award. In fact, these programs will return savings to the NM RP. The NM RP Governance Board determines the use of savings, as described in the previous section. NM RP can use the savings to scale these or other programs, to sustain programs with reinvestment as costs rise over time or new technologies become available, or to build out new programs with evidence-based potential for return.

The NM RP interventions may also enhance the sustainability of the NAPM by reducing SNF, home health, and specialty care utilization.

As long as there is a gap between the number of high utilizing/ high-risk patients and the capacities of the HSS and Hospital Care Transitions programs, there is opportunity for scaling. Broadening scope could also be considered for reinvestment funds. For example:

- As PCPs referring high-risk seniors to the HSS program develop trust in the program, this may create interest in a Chronic Care Management program – built as a shared resource with the physician community – for their chronically ill, but stable, Medicare patients.
- Recent literature suggests that reducing spending and improving outcomes for frequent users is more effective when Hospital Care Transition programs span both inpatient and ED settings. The NM RP infrastructure could focus on piloting and scaling this design.
- Payers may want to collaborate with the NM RP hospitals to expand successful interventions to their beneficiaries.

The NM RP partners are mission-driven organizations that share a strong commitment to the community they serve and to the health of its population. Changes in the health care environment – and the recognition that change will continue – has driven the creation of the NM RP. For the health of our shared community, hospital and community partners must forge, scale, and sustain effective programs, while continuously searching for methods that yield better, longer term, or longer lasting

improvements. The NM RP structure forms a foundation for learning together and for building trusting relationships across hospital entities, across the continuum of care providers, and across sectors.

Already the six NM RP hospitals have come together to share information on their community programs (e.g. diabetes self-management education, exercise, nutrition classes) and are altering community scheduling to reduce overlap and better serve the community. As the NM RP matures, joint efforts expect to target upstream interventions to prevent or control the disease states that most impact hospital utilization (e.g. cardiovascular disease and diabetes).

## 6. Participating Partners and Decision-Making Process

**6a. Governance Structure:** The NexusMontgomery Regional Partnership governance structure is a collaborative partnership to share funds, resources and data, and coordinate jointly with providers, community-based organizations, public health and others on programs, projects, and interventions in support of the New All-Payer Model goals and requirements. An Operating Agreement and a Participation Agreement govern its functioning. The Operating Agreement defines the charter elements and key aspects of governance (committees, board seats, roles of the partners, and voting rights). The Participation Agreement details partner responsibilities and partnership processes (addressing non-performance of an NM RP member, the data management and sharing plan, the patient protection plan, mechanisms for financial accountability and conflict of interest, and reporting requirements).

Health Management Associates (HMA) is facilitating the NM RP Governance Work Group and drafting the NM RP agreements. The Operating Agreement decisions-matrix is included as Appendix G. This matrix is undergoing review by hospitals' legal counsel. The Governance Work Group meets next on January 6, 2016 to address the Participation Agreement. The NexusMontgomery Governance Board will be appointed at the time the Operating Agreement is executed (target: mid-February) and constituted within 20 business days of execution. The NM RP expects to retain the current Governance Work Group members as the founding directors. The NM RP Governance Board begins with six seats, one for each of the six lead hospitals: Holy Cross Hospital, Holy Cross Germantown Hospital, MedStar Montgomery Medical Center, Shady Grove Medical Center, Suburban Hospital and Washington Adventist Hospital. The Board can expand to a maximum of nine seats, to include community entities.

The NM RP Governance Board will have two standing committees, the Partnership Program Intervention Committee and the Finance Committee. The Board takes recommendations from the two standing committees, a Physician Advisory Board, and external partners. The NM RP Governance Board has final decision-making authority on all programmatic and budgetary issues.

NM RP shall operationalize its shared capacity through an existing neutral 501c3 organization, the Primary Care Coalition of Montgomery County, Inc. (PCC). A management agreement between each of the six lead hospitals and the PCC will create a Performance Management Center to manage the shared interventions, facilitate the shared resources from the partners, hire the additional resources needed, and contract with program implementation partners such as The Coordinating Center and Cornerstone Montgomery. The Performance Management Center has formal reporting structures to the NM RP Governance Board. Figure 4 on page 20 provides an illustration of the NM RP governance structure, performance management center, and partners' input.

**6b. Incorporation of Perspectives and Shared Decisions:** For the six NM RP hospitals, the regional partnership is a new era in collaboration. The Operating and Participation Agreements provide formal structure for shared decision-making. However, the NM RP hospitals recognize that their experiential

capacity for shared decision-making will build over time through co-leading the NM RP. These inter-hospital relationships must be fostered, while also including the many non-hospital partners who participate on an in-kind basis with the interventions. To this end, the following formal structures promote incorporation of perspectives from multiple stakeholders.

- A Physician Advisory Board (PAB) will include a range of provider types from the community to foster communication, engage physicians, advise the Board, and inform work of the committees. Montgomery County has many small physician practices and no single 'voice of the physician. The PAB provides for diverse physician input to the NM RP in a way a single Board seat could not.
- The Partnership Program Intervention Committee (P-PIC) is chaired by a Board director. Each collaborating hospital appoints one designated committee member, and community partners will fill up to five committee seats, pending Governance Board approval. The P-PIC is responsible to review programs and develop program ideas for recommendation to the Board, including: (1) monitor key performance and outcome metrics, (2) monitor any needed continuous quality improvement initiatives, and (3) evaluate and recommend proposed projects (both new and ongoing), ensuring the Board has the information needed for informed decisions. Key partners in the interventions, which may include representatives of Medicare beneficiaries, Senior Living Facilities, SNFs, DHHS, and Behavioral Health, will help to shape plans for NM RP programs going forward.

**Figure 4**

Community partners as well as patients, families and caregivers will also contribute perspectives within program operations through process improvement efforts, focus groups, and panel discussions. For example, in the planned improvement activity for SNF-to-home stabilization, the voices of patients, caregivers, SNF staff, DHHS Aging and Disabilities, etc. will be needed to identify and address root causes of hospital readmission after SNF-to-home discharge. Stakeholder communication and engagement in the programmatic activities is essential to the continual learning of the NM RP programs. (Letters of support from community partners are included as Appendix H.)

**6c. Funding:** The collaborating hospitals contribute an equal percentage of net revenue plus markup to the programs and interventions detailed in this proposal. This places each hospital as an equal contributor in relative proportion to its net revenues plus markup.

## 7. Implementation Work Plan (CY16 Output from Project Management Software: **Smartsheet**)

| Task Name | Start Date | End Date |
|---|---|---|
| **Section 1 - Four NM RP Interventions** | **12/01/15** | **12/30/16** |
| 1.A - Health Stabilization for Seniors | 12/01/15 | 12/30/16 |
| 1.A.1 - Progam Operations | 01/02/16 | 12/30/16 |
| 1.A.1.1 - Startup: Finalize Client Participation Consents for HSS Participation | 01/02/16 | 02/15/16 |
| 1.A.1.2 - Startup: Draft Referral Entity Participation Agreements | 01/04/16 | 02/15/16 |
| 1.A.1.3 - Startup: Finalize referral criteria, workflow for referrals from Sr. Living | 01/15/16 | 03/01/16 |
| 1.A.1.4 - Startup: Develop "Go-Live" checklist for sr. living facilities | 01/15/16 | 02/15/16 |
| 1.A.1.5 - Startup:Sign contract with TCC (care coordination); | 03/15/16 | 03/15/16 |
| 1.A.1.6 - Startup: Customize outreach referral materials for resident counselors, EMS | 03/15/16 | 03/31/16 |
| 1.A.1.7 - Startup: Develop SNF outreach materials | 04/01/16 | 04/29/16 |
| 1.A.1.8 - Startup & Develop secure method for sending referrals | 02/01/16 | 04/01/16 |
| 1.A.1.9 - Sr. Living RollOut: Sign Participation Agreements with 22 Sr. Living Facilities | 04/01/16 | 09/30/16 |
| 1.A.1.10 - Sr.Living Roll Out: Hire/Train Hub 1 | 03/01/16 | 04/29/16 |
| 1.A.1.11 - Sr. Living RollOut: Train Resident Counselors in criteria and referral processes | 04/01/16 | 09/30/16 |
| 1.A.1.12 - Sr. Living RollOut: Train EMS in criteria and referral processes | 04/01/16 | 09/30/16 |
| 1.A.1.13 - Sr.Living RollOut: MILESTONE Hub 1 First clients | 05/01/16 | 05/01/16 |
| 1.A.1.14 - Sr. Living: Ongoing referral, client HRA, active care coordination | 05/01/16 | 12/30/16 |
| 1.A.1.15 - SNF RollOut: Sign Participation Agreements with SNFs | 06/01/16 | 09/30/16 |
| 1.A.1. 16 - SNF-RollOut: update referral criteria for Hospital-to-SNF discharges | 06/01/16 | 06/30/16 |
| 1.A.1.17 - SNF Roll Out: Hire/Train Hub 2 | 07/01/16 | 07/29/16 |
| 1.A.1.18 - SNF RollOut: Train Hospital Discharge Planners in criteria and referral processes | 07/01/16 | 09/30/16 |
| 1.A.1.19 - SNF RollOut: MILESTONE Hub 2 First clients | 08/01/16 | 08/01/16 |
| 1.A.1.20 - SNF: Ongoing referral, client HRA, active care coordination | 08/01/16 | 12/30/16 |
| 1.A.1.21 - ScaleUp: Hire/Train Hub 3 | 09/01/16 | 09/30/16 |
| 1.A.1.22 - ScaleUp MILESTONE Hub 3 first clients | 10/01/16 | 10/01/16 |
| 1.A.1.23 - ScaleUp PCPs: Meet with three most active physician offices surrounding each senior living facilities; train in referral criteria and work | 09/01/16 | 12/30/16 |

Implementation Work Plan (continued) — Tasks 1.A.1.24 THRU 1.A.3.5

| Task Name | Start Date | End Date |
|---|---|---|
| **Section 1 - Four NM RP Interventions** | **12/01/15** | **12/30/16** |
| 1.A - Health Stabilization for Seniors (Con't) | 12/01/15 | 12/30/16 |
| 1.A.1 - Progam Operations (Con't) | 02/01/16 | 12/30/16 |
| 1.A.1.24 - ScaleUp PCPs: Accept clients from select PCPs | 10/01/16 | 12/30/16 |
| 1.A.1.25 - ScaleUp PCPs:meet with PCPs in targeted hotspot | 12/01/16 | 12/30/16 |
| 1.A.1.26 - ScaleUp: Patient Activation Measure collection. Utilize tool, as provided under agreement with VHQC. | 07/01/16 | 12/30/16 |
| 1.A.2 - Process Improvement | 03/01/16 | 12/30/16 |
| 1.A.2.1 - Facilitate SNF/Hospital Process Improvement Work Group | 09/01/16 | 12/30/16 |
| 1.A.2.2 - Facilitate Sr. Living resident Counselor, Residents, TCC proces | 07/01/16 | 12/30/16 |
| 1.A.2.3 - Activate resident education program (Quarterly) | 03/31/16 | 12/30/16 |
| 1.A.2.4 - Update community resource directories (ongoing) | 03/01/16 | 12/30/16 |
| 1.A.2.5 - PDSA cycles for process measures improvement (conversion rate from referral to high risk HRA score) | 07/01/16 | 12/30/16 |
| 1.A.2.6: Data analysis to find hotspots of Medicare admissions | 09/01/16 | 12/01/16 |
| 1.A.3 - Reporting & Evaluations | 02/01/16 | 12/30/16 |
| 1.A.3.1 - Set up database with baseline information on each facility | 03/01/16 | 03/30/16 |
| 1.A.3.2 - Via Hospitals, enact CRISP participation for HSS panel upload, receipt of ENS and alerts | 03/01/16 | 03/30/16 |
| 1.A.3.3 - Establish CRISP functionality to include shared care plans and designated care manager | 02/01/16 | 06/30/16 |
| 1.A.3.4 - Conduct paired sample t-test on pre and post activation measures for clients who complete the program in given quarter and all clients served to date | 06/01/16 | 12/30/16 |
| 1.A.3.5 - Review process and outcomes metrics, conduct PDSA cycles to improve | 03/31/16 | 12/30/16 |

Implementation Work Plan (continued) — Tasks 1.B.1 THRU 1.C.2.1

| Task Name | Start Date | End Date |
|---|---|---|
| **Section 1 - Four NM RP Interventions** | **12/01/15** | **12/30/16** |
| 1.B - Scale Up Existing Hospital Care Transition Programs | 12/01/15 | 12/30/16 |
| 1.B.1 - Program Operations | 03/01/16 | 12/30/16 |
| 1.B.1.1 - Recruit new staff | 03/01/16 | 04/29/16 |
| 1.B.1.2 - Onboarding of new staff | 05/02/16 | 06/01/16 |
| 1.B.1.3 - New Staff Hands-on Training | 06/02/16 | 07/01/16 |
| 1.B.1.4 - Steady-state Operations (producing ROI) | 07/01/16 | 12/30/16 |
| 1.B.2 - Process Improvement | 07/01/16 | 12/30/16 |
| 1.B.2.1. - Care Transition Effectiveness Enhancement / Learning Collaborative | 07/01/16 | 12/30/16 |
| 1.B.2.2 - Commercial / Medicare Payer Care Management Hand-Offs | 09/01/16 | 12/30/16 |
| 1.B.2.3 - Conduct PDSA Cycles Based upon Evaluation Reports | 09/01/16 | 12/30/16 |
| 1.B.3 - Reporting & Evaluations | 12/01/15 | 12/30/16 |
| 1.B.3.1 - Ensure Common Definition of Process and Outcome Measures/Data | 12/01/15 | 06/30/16 |
| 1.B.3.2 - Supply Periodic Measures Data (e.g. monthly, quarterly, annually) | 12/01/15 | 12/30/16 |
| 1.B.3.3 - Periodic Review of Evaluation Reports for Accuracy | 04/01/16 | 12/30/16 |
| 1.C - Post-Acute Specialty Care for Ineligible-Uninsured Patients (PA-SC) | 03/01/16 | 12/30/16 |
| **1.C.1 - Program Operations** | **03/01/16** | **12/30/16** |
| 1.C.1.1 - Refine referral criteria to capture highest readmit risks | 03/01/16 | 03/31/16 |
| 1.C.1.2 - Develop Hospital to PASC referral procedures | 03/01/16 | 08/29/16 |
| 1.C.1.3 - Implement patient referral program / train patient discharge planners | 04/01/16 | 12/30/16 |
| 1.C.2 - Process Improvement | **07/01/16** | **12/30/16** |
| 1.C.2.1-Monitor referrals for compliance with risk criteria, alter as needed | 07/01/16 | 12/30/16 |

Implementation Work Plan (continued) — Tasks 1.D.1 THRU 1.D.3.5

| Task Name | Start Date | End Date |
|---|---|---|
| **Section 1 - Care Management Programs (Con't)** | **03/01/16** | **12/30/16** |
| 1.D - Service Capacity Building for Severely Mentally Ill | 03/01/16 | 12/30/16 |
| 1.D.1 - Capacity-building for crisis beds | 03/01/16 | 12/30/16 |
| 1.D.1.1 - Hire Crisis House Manager | 03/01/16 | 03/31/16 |
| 1.D.1.2 - Obtain Crisis Bed Expansion Approval | 03/01/16 | 04/29/16 |
| 1.D.1.3 - Scout Crisis House Locations | 04/01/16 | 08/31/16 |
| 1.D.1.4 - MILESTONE: Procure Crisis House | 09/01/16 | 09/01/16 |
| 1.D.1.5 - Renovate Crisis House | 10/01/16 | 12/30/16 |
| 1.D.1.6 - Hire Crisis House Staff | 12/15/16 | 12/30/16 |
| 1.D.2 - Start-up Assertive Community Treatment (ACT) Team / MTS | 03/01/16 | 12/30/16 |
| 1.D.2.1 - Contract with ACT vendor (PEP or Cornerstone) | 03/01/16 | 03/31/16 |
| 1.D.2.2 - Obtain ACT / MTS Expansion Approval | 03/01/16 | 03/31/16 |
| 1.D.2.3 - Hire ACT / MTS initial staff | 04/01/16 | 04/29/16 |
| 1.D.2.4 - MILESTONE: First Clients for Mobile Treatment Service | 05/01/16 | 05/01/16 |
| 1.D.2.5 - Hire Additional Staff for Fidelity | 12/01/16 | 12/30/16 |
| 1.D.3 - Severely Mentally Ill Process Improvement | 03/01/16 | 12/30/16 |
| 1.D.3.1 - Select/hire Behavioral Health Integration Manager | 03/01/16 | 03/31/16 |
| 1.D.3.2 - Re-Start Client Care Team Pilot (CSA, hospitals, client, ACT) | 04/01/16 | 04/29/16 |
| 1.D.3.3 - MILESTONE: Monthly Client Care Team Meetings | 04/01/16 | 12/30/16 |
| 1.D.3.4 - Address ED to ACT handoff re: legal/HIPAA concerns | 04/01/16 | 10/31/16 |
| 1.D.3.5 - Design MED-PSYCH RN Capacity for Crisis Bed | 10/01/16 | 12/30/16 |

Implementation Work Plan (continued) — Tasks 2.A.1 THRU 2.A.3.2

| Task Name | Start Date | End Date |
|---|---|---|
| **Section 2 - Systems Improvement** | **01/01/16** | **02/28/17** |
| 2.A - Technology Solutions | 01/01/16 | 02/28/17 |
| 2.A.1 - Community Provider Connectivity / Alerts & Notifications | 01/01/16 | 12/30/16 |
| 2.A.1.1 - Obtain technical specifications from CRISP, create provider outreach materials | 01/01/16 | 01/29/16 |
| 2.A.1.2 - Refer SNFs for ADT feeds to CRISP | 07/01/16 | 12/30/16 |
| 2.A.1.3 - Engage PCPs for patient panels, ambulatory data, and ENS subscriptions | 09/01/16 | 12/30/16 |
| 2.A.1.4 - Create Participation Agreements w/CRISP for NMRP vendor partners (TCC Cornerstone, etc.) | 02/01/16 | 04/29/16 |
| 2.A.2 - CRISP Query Portal & Care Profile | 07/01/16 | 12/30/16 |
| 2.A.2.1 - Facilitate regional input to query portal and care profile design | 07/01/16 | 12/30/16 |
| 2.A.2.2 - As feasible incorporate select care plan data elements into Care Profile or Alerts, include data on care manager-to-patient relationships | 07/01/16 | 12/30/16 |
| 2.A.3 - Care Plan Sharing | 06/01/16 | 02/28/17 |
| 2.A.3.1 - Care Plan Core Element Normalization | 06/01/16 | 12/30/16 |
| 2.A.3.1-1: Stakeholder Meetings to Create Care Plan Framework | 07/01/16 | 09/30/16 |
| 2.A.3.1-2: Identify Key Elements of Care Plan Framework | 06/01/16 | 06/30/16 |
| 2.A.3.1-3: Initiate Normalization across Providers | 10/01/16 | 12/30/16 |
| 2.A.3.2 - Share Care Plans via CRISP | 10/01/16 | 02/28/17 |
| 2.A.3.2-1: Identify 1-2 hospitals as a "Pilot" to upload care plans | 10/01/16 | 11/30/16 |
| 2.A.3.2-2: Identify a Care Management org. to use as a "Pilot" | 10/01/16 | 11/30/16 |
| 2.A.3.2-3: Develop a Communication Protocol re: Care Plans | 12/01/16 | 12/30/16 |
| 2.A.3.2-4: Educate healthcare providers on Care Plan Availability | 01/01/17 | 02/28/17 |

Implementation Work Plan (continued) — Tasks 3.A.1 THRU 4.A.4.4

| Task Name | Start Date | End Date |
|---|---|---|
| **Section 3 - Monitoring & Evaluation** | **02/01/16** | **12/30/16** |
| 3.A - Monitoring & Evaluation Planning | 02/01/16 | 12/30/16 |
| 3.A.1 - Finalize Evaluation Plan Consistent with Project Interventions and Metrics | 04/01/16 | 06/30/16 |
| 3.A.2 - Finalize routine reports needed with VHQC and CRISP | 02/01/16 | 03/31/16 |
| 3.A.3 - Establish mechanism for adhoc reporting with CRISP, VHQC | 07/01/16 | 12/30/16 |
| 3.A.4 - Develop data reporting framework and timeline with intervention entities | 04/01/16 | 06/30/16 |
| 3.B - Monitoring & Evaluation Activities | 04/01/16 | 12/30/16 |
| 3.B.1 - Produce Monthly & Quarterly Reports | 04/01/16 | 12/30/16 |
| 3.B.2 - Tableau-based "pre/post" analysis for cohorts of patients (panels) that are relevant to the RP | 04/01/16 | 06/30/16 |
| 3.B.3 - Cross-hospitalization utilization report for the region | 06/30/16 | 06/30/16 |
| 3.B.4 - VHQC provides periodic Medicare Outcomes data | 04/01/16 | 12/30/16 |
| **Section 4 - Regional Partnership Governance & Management** | **11/15/15** | **12/30/16** |
| 4.A - Regional Partnership Governance | 11/15/15 | 12/30/16 |
| 4.A.1 - Finalize Nexus Montgomery Operating Agreement | 11/15/15 | 02/19/16 |
| 4.A.2 - Complete Nexus Montgomery Partnership Agreement | 11/15/15 | 02/26/16 |
| 4.A.3 - MILESTONE: Identify and Appoint Members of RP Board of Directors | 03/11/16 | 12/30/16 |
| 4.A.3.1 - Schedule board meetings (10 meetings per year)" | 03/11/16 | 03/11/16 |
| 4.A.3.2 - Conduct routine board meetings | 03/11/16 | 12/30/16 |
| 4.A.4 - Creation of Partnership Program Intervention Committee (PPIC) | 04/15/16 | 12/30/16 |
| 4.A.4.1 - Develop key performance and outcome metrics to recommend to the Board of Directors | 04/15/16 | 06/30/16 |
| 4.A.4.2 - Monitor key performance and outcome metrics approved by the Board | 07/01/16 | 12/30/16 |
| 4.A.4.3 - Monitor continuous quality and process improvement initiatives | 09/15/16 | 12/30/16 |
| 4.A.4.4 - Recommend improvements and changes to programs | 09/15/16 | 12/30/16 |

Implementation Work Plan (continued) — Tasks 4.A.5 THRU 4.B.8

| Task Name | Start Date | End Date |
|---|---|---|
| **Section 4 - Regional Partnership Governance & Management (Con't)** | **01/15/16** | **12/30/16** |
| 4.A - Regional Partnership Governance (Con't) | 01/15/16 | 12/30/16 |
| 4.A.5 - Creation of the Finance Committee | 03/15/16 | 12/30/16 |
| 4.A.5.1 - Develop Budget for Board Approval, CY16 & FY17 | 03/15/16 | 06/30/16 |
| 4.A.5.2 - Monitor financial viability and sustainability of projects | 03/15/16 | 12/30/16 |
| 4.A.5.3 - Review and monitor contracts, insurance needs / policies | 04/15/16 | 12/30/16 |
| 4.A.5.4 - Conduct financial and resource oversight | 04/15/16 | 12/30/16 |
| 4.A.5.5 - Evaluates and recommends potential funding opportunities and mechanisms to the board | 06/30/16 | 12/30/16 |
| 4.A.6 - Creation of the Physician Advisory Board | 09/30/16 | 09/30/16 |
| 4.A.7 - Establish MOU with VHQC | 01/15/16 | 02/15/16 |
| 4.A.8 - Establish MOU with CRISP | 01/15/16 | 02/15/16 |
| 4.B - RP Performance Management Center | 02/01/16 | 12/30/16 |
| 4.B.1 - Establish Management Agreement between PCC and hospitals | 03/11/16 | 03/31/16 |
| 4.B.2 - Hire NMRP Director, staff | 03/11/16 | 04/29/16 |
| 4.B.3 - Manage NMRP Resources | 03/11/16 | 12/30/16 |
| 4.B.4 - Manage RP Work Plan | 03/11/16 | 12/30/16 |
| 4.B.5 - Provide Contractor Management | 02/01/16 | 12/30/16 |
| 4.B.6 - Provide Fiscal Management | 02/01/16 | 12/30/16 |
| 4.B.7 - Conduct Best practices lit reviews, distribute | 02/01/16 | 12/30/16 |
| 4.B.8 - Engage stakeholders (patients and caregivers, referral sources, providers, CBOs, DHHS) in program specific dialogue | 02/01/16 | 12/30/16 |

## 8. Budget and Expenditures

| Hospitals/Applicants | Six Lead Applicants: Holy Cross Hospital, Holy Cross Germantown Hospital, Shady Grove Medical Center, Washington Adventist Hospital, MedStar Montgomery Medical Center, Suburban Hospital | |
|---|---|---|
| Number of Interventions | **Four** | |
| Total Budget Request ($) | **$7,950,216** | |
| | | |
| **Workforce / Type of Staff** | **Description** | **Amount** |
| **1. Health Stabilization for Seniors** | At full implementation, there will be 3 hubs | |
| HSS Program Operations Manager | 1 for HSS Program | $149,386 |
| RN | 1 per hub | $395,044 |
| Liaison (LCSW) | 1 for HSS program | $124,489 |
| Admin/Scheduler | 1 per hub | $188,116 |
| Health Coaches | 6 per hub | $1,496,793 |
| HSS Program/Improvement Director | 1 for HSS program | $130,047 |
| Communications Manager | .15 FTE for HSS program | $15,400 |
| **Health Stabilization for Seniors** | **Labor total** | **$2,499,276** |
| | | |
| **2. Hospital Care Transitions Expansion** | | |
| **Holy Cross Hospital** | | |
| RN | 5.25 FTE | $552,500 |
| | | |
| **Holy Cross Germantown Hospital** | | |
| RN | .65 FTE | $71,500 |
| | | |
| **Shady Grove Adventist Hospital** | | |
| RN (supported w/telehealth) | 4.5 FTE | $463,500 |
| | | |
| **Washington Adventist Hospital** | | |
| RN (supported w/telehealth) | 3 FTE | $307,500 |
| | | |
| **MedStar Montgomery Medical Center** | | |
| Community Health Worker | .6 FTE | $23,208 |
| Transitional Care RN | .75 FTE | $74,880 |
| Complex Case Manager | .9 FTE | $89,856 |
| RN | Home Visiting, Contracted to Family & Nursing Care | $21,600 |
| | | |
| **Suburban Hospital** | | |
| Transition Guide Nurse | 2 FTE | $242,000 |
| Community Health nurse | 1 FTE | $72,600 |
| | | |
| **Hospital Care Transitions Expansion** | **Labor total** | **$1,919,144** |

| 3. Post-Acute Specialty Care for Ineligible-Uninsured Patients (PA-SC) | | |
|---|---|---|
| RN Sp. Care Coordinator | Triage referrals, navigate pt to specialty care to avoid no shows, ensures pt arrives at specialist with all labs, radiology, etc. needed to optimize visit (.25 FTE) | $27,510 |
| Program Manager | refine referral procedures and risk criteria with hospital discharge planners | $1,757 |
| **PA-SC** | **Labor Total** | **$29,267** |
| | | |
| **4. Service Capacity for the Severely Mentally Ill** | | |
| Behavioral Health Integration Manager | | $100,575 |
| Crisis House Liaison | | $106,361 |
| **Service Capacity for SMI** | **Labor Total** | **$206,937** |
| | | |
| **Infrastructure: NM RP (process improvement, Intervention Management, NM RP financials, etc.)** | | |
| NM RP Director | 1 FTE, direct report to NM Board, P-PIC, Finance Committee | **$210,685** |
| Process Improvement Manager | 1 FTE Leads learning collaborative, PI initiatives, responsible for production, review and achievement of Outcomes measures | **$165,538** |
| NM RP Coordinator | 1 FTE Process improvement initiatives, provider relations, best and evidence based practice reviews | **$90,294** |
| IT/Data Analyst/CRISP interface | 1 FTE Data definition and collection for outcomes and process measures, CRISP & provider liaison for connectivity | **$135,440** |
| Communication Manager | .25 FTE. Engage and inform stakeholders, focus groups, panel discussions | **$26,336** |
| Legal Consultants | Multiple areas (e.g. ED-to-ACT handoff, care plan sharing, unify HIPAA-based PHI sharing protocols of the hospitals, etc.) | **$107,606** |
| Governance Structure Consultants | Support the formative early period on of the NM RP Governance Board and Committees | **$21,660** |
| Evaluation, Dashboard, SME Consultants | Build outcomes measure data collection tool, dashboard for NM RP board and committees | **$153,425** |
| **Infrastructure NM RP** | **Labor Total** | **$910,984** |
| | | |
| **IT/Technologies** | **Description** | **Amount** |
| **1. Health Stabilization for Seniors** | See http://careathand.com/ | |
| Care at Hand (CAH) | Licenses for staff, health risk assessments for clients, evaluation | $252,798 |
| Mobile Technology for CAH | Tablets, cell phones, supplies | $74,129 |
| Health Stabilization for Seniors | IT/Technology total | **$326,927** |

| Other Implementation Activities | Description | Amount |
|---|---|---|
| **1. Health Stabilization for Seniors** | | |
| Interpreter Services (per client/mo) | For non-English or Spanish speaking clients | $101,525 |
| OT/MTM Consults (per client/mo) | Occupational Therapy or Medication Therapy Management, as needed | $204,460 |
| Consumer Supports (per client/mo) | Immediate needs (transport, TracFone, etc.) | $122,676 |
| Meetings/Conferences/Focus Groups | w/residents, SNFs, stakeholders (monthly, qtrly) | $6,498 |
| Travel | To client homes, SNFs, PCPs | $145,534 |
| Materials Translation/Production | | $17,328 |
| **Health Stabilization for Seniors** | **Other Implementation Activities total** | **$598,020** |
| | | |
| **2. Hospital Care Transitions Expansion** | | |
| Patient Prescription Drugs | MedStar MMC patient supports | $1,900 |
| Patient Medical Supplies/DME | MedStar MMC patient supports | $500 |
| Post-discharge Services | MedStar MMC patient supports | $2,700 |
| Patient Supports | Suburban patient supports | $50,000 |
| **Hospital Care Transitions Expansion** | **Other Implementation Activities total** | **55100** |
| | | |
| **3. Post-Acute Specialty Care for Ineligible-Uninsured Patients (PA-SC)** | | |
| Specialist Care | payments for ambulatory specialty for ineligible-uninsured patients, 30 days post-discharge, for patients at high risk of 30-day readmission | $224,400 |
| **PA-SC** | **Other Implementation Activities total** | **$224,400** |
| | | |
| **4. Service Capacity for the Severely Mentally Ill** | | |
| Capacity Building Grant: ACT (MTS) Team | To support start-up costs, prior to ACT team reaching Fidelity and being able to bill for services as an ACT team. | $250,000 |
| Capacity Building grant: Crisis House Downpayment | | $220,000 |
| Capacity Building Grant: Crisis House renovations | | $220,000 |
| **Service Capacity for SMI** | **Other Implementation Activities total** | **$690,000** |
| | | |
| **Infrastructure: NM RP (process improvement, Intervention Mgmt, NM RP financials, etc.)** | | |
| Focus groups, collaborative, Panels | Monthly, quarterly convenings | **$13,287** |
| **Infrastructure NM PR** | **Other Implementation Activities total** | **$13,287** |
| | | |
| **Other Indirect Costs** | **Description** | **Amount** |
| **1. Health Stabilization for Seniors** | | |
| Recruiting | 27 FTE to recruit | $5,372 |
| Office Space | For care teams, Prog Ops Mgr, PI Mgr | $92,921 |
| **Health Stabilization for Seniors** | **Other Indirect TOTAL** | **$98,293** |
| | | |
| **Hospitals Admin Fee** | **5% of each Lead Hospital's rate increase** | **$378,582** |
| **TOTAL Expenses and Investment** | | **$7,950,216** |

## 9. Budget and Expenditures Narrative

### Basis for Requested Amount

The budget presented is a Rate Year 2017 budget. This represents the annualized operational costs for the NexusMontgomery Regional Partnership interventions and infrastructure going forward. The total request is $7,950,216, representing 0.5% of FY15 Approved Net Revenue plus markup for each of the Lead Hospitals as follows:

| Hospital | FY15 Approved Net Revenue plus Markup |
|---|---|
| Holy Cross Hospital | $445,604,045 |
| Holy Cross Germantown Hospital * | $53,446,533 |
| MedStar Montgomery Medical Center | 171,080,788 |
| Shady Grove Adventist | 371,262,310 |
| Suburban Hospital | $302,620,414 |
| Washington Adventist | 246,029,028 |
| **TOTAL** | **$1,590,043,118** |
| **0.50% of Total** | **$7,950,216** |

* Annualized from 9-Month Actuals of $40,084,900

To develop costs, the NM RP created a monthly budget with an expected start date of March 1, 2016. The budget matches the NM RP work plan, accounting for staffing and intervention ramp up months. CY2016 will be a shortened operating year (ten months) and is the year in which all interventions ramp up and achieve steady state, except Crisis Bed and ACT Team with steady state reached in February and October 2017, respectively. The CY2016 budget is $5,639,434. The narrative below describes the budget presented in Section 8. For all intervention and infrastructure budgets:

- Work Force/ Type of Staff: The budget in Section 8 describes each position type for each intervention and for the NM RP infrastructure, with number of FTE. The labor is represented at fully loaded rates*.

- IT/Technologies: All costs are fully loaded. The Care At Hand technology shown in the budget is used for the Health Stabilization for Seniors. Various technologies are also utilized by the existing hospital care transitions programs and the Post-Acute Specialty Care for Ineligible-Uninsured (PA-SC). These are factored into the loaded labor costs.

- Other Implementation Activities: Costs are fully loaded; costs for specialty care under PA-SC, and the capacity grants for Services for the Severely Mentally Ill have no overhead costs from the NM RP; these are pass-through funds.

- Other Indirect Costs: The NM RP Lead Hospitals each retain 5% of their rate increase for a) the administrative expense of managing the NM RP funds and b) indirect labor involved in providing data and staff for the achievement of data analysis, learning collaborative goals, and performance improvement.[5]

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[5] Fringe and overhead rates vary among the multiple organizations involved in NM RP interventions. As an example the PCC, which will manage the NM RP Performance Management Center, has a fringe rate of 26.4% and indirect rate of 8.3%.

### Health Stabilization for Seniors

- Workforce: All labor are employed by The Coordinating Center (TCC), except the Program/Improvement Director and (.15 FTE) Communications Manager which are employed by the NM Performance Management Center (Primary Care Coalition, PCC).

- IT/Technologies: TCC utilizes an innovative predictive analytic and care coordination technology called Care At Hand (CAH). In addition to one-time license costs, there are use costs for the predictive screening tool. The budget also includes consulting funds for CAH to mine the CAH database for QI interventions that can target inefficiencies in the care coordination process.

- Other Implementation Activities: TCC has a multilingual work force, however the NM RP region is highly diverse, presenting challenges to having the specific linguistic capability for every client; interpreter funds are included in the budget. Client supports include minor client transportation costs, small purchases such as a pill box or other small value assistive devices to stabilize or improve the health of the senior client. TCC has found through its years of care coordination services that some clients require medication therapy management (as differentiated from medication reconciliation) or short-term occupational therapy not billable under Medicare to remain stable at home. TCC contracts for these services; estimated costs are reflected in the budget and are calculated on number of clients that will be in intensive care coordination each month.

- Other Indirect Costs: The three Care Coordination teams (employed by TCC) will locate at the Primary Care Coalition (PCC) offices. PCC can expand its office space far more cost effectively than if TCC leased new space and charged this lease cost to NM RP; PCC headquarters are centrally located in the NM RP region. Further, the HSS program's systems improvement projects will benefit from having the entire HSS team co-located with the NM RP Performance Management Center at PCC. Recruiting costs shown are for TCC recruitment of 27 FTE to staff the 3 care coordination hubs.

### Scale Up of Existing Hospital Care Transition Programs

- Workforce: The position types, FTE and costs are shown in the budget, indicating which organization will be hiring or contracting the positions. All labor costs are loaded.

- Other Implementation Activities: Two care transition programs budget for limited patient supports (e.g. initial post-discharge medications, durable medical equipment).

The variations in staffing mix, technology and use of patient supports will be areas the Care Transitions learning collaborative will explore to create improvements in the individual NM RP hospital care transition programs through shared learning.

### Post-Acute Specialty Care for Ineligible-Uninsured Patients (PA-SC)

- Workforce: The .25 RN position will be employed by PCC. This is a fully loaded rate and includes allocated portion (.25) of office space costs ($2730) and travel funds ($552).

- IT/Technology: PA-SC builds upon an existing program infrastructure, which already has electronic referral technology to manage provider referrals. The expanded use of this referral technology for PA-SC is provided in-kind to NM RP.

- Other Implementation Activities: The PA-SC program arranges and pays for ambulatory specialty care services for ineligible-uninsured patients in the first 30 days post-discharge, when there is a high risk of readmission if the patient does not obtain or follow-up with the specialty care service. The costs in this budget are the charges to be reimbursed to the specialists. There will be no markup or indirect costs for the NM RP. Note: these payments to specialty care providers are made under provider contracts negotiated by the existing Project Access program of Montgomery County, MD (administered by PCC). Because the patients are ineligible-uninsured, there is no insurer. These are therefore not billable services; they will not and cannot be billed to another party.

### Service Capacity Building for Severely Mentally Ill

- Workforce: The NM RP supports two positions. The Crisis House liaison is a Cornerstone Montgomery position. Initially this position scouts the crisis house location, and hires/trains the crisis house team while designing with the hospitals the procedures for hospital priority use of the crisis beds. Once the new crisis house (8 beds) opens, the Crisis House liaison ensures hospital referral is occurring, while beginning work on the design of a program in which crisis beds can use an RN to create med-psych step down beds for the hospitals. The Behavioral Health Integration Manager will be employed by PCC and located at the Core Services Agency in Montgomery County. This position facilitates inter-agency efforts to reduce hospital utilization by severely mentally ill patients. This position follows recommendations of the Healthy Montgomery (LHIC) Behavioral Health Task Force.

- Other Implementation Activities: Through grants, the NM RP creates capacity which will reduce admissions and ED visits by the severely mentally ill. Specific capacity is: 1 additional ACT team, and 8 additional Crisis Beds. The NM RP will not own or manage these services, as there are existing providers. NM RP provides grants in FY17 in the amounts of $250,000 for ACT (Mobile Treatment Service) team startup, $220,000 to support purchase of a Crisis House, and $220,000 to support renovation of a purchased crisis house (installation of sprinklers, other code related requirements). In future years, NM RP will review use this grant budget line item for additional capacity building such as grants to provide ADA-compliant crisis beds and licensed medical support to create med-psych step down beds.

### NexusMontgomery Regional Partnership Infrastructure

The NM RP is an historic collaboration among the six hospitals with all six hospitals in Montgomery County participating. The NM RP has purposefully designed an infrastructure that shares resources, avoids duplication of services, and adopts structured learning opportunities, all to support the new All Payer Model and achieve the outcomes proposed in Section 3. The returns on investment described in Section 4 are predicated upon process improvement of the interventions, which come about through the facilitation and structure of the NM RP.

- Workforce: All positions in the budget not labelled 'consultant' will be employed by the NM RP Performance Management Center (managed by the PCC). The Consultants will be contracted entities. The labor costs represent fully loaded rates, and are inclusive of travel, office space and minor supplies costs for these positions

- Other Implementation Activities: The collaborative nature of the NM RP requires regular stakeholder meetings; convening of patients, families and care givers; collaborative learning sessions and other venues for sharing. The budget includes costs for these activities.

## 10. Proposal Summary

| Hospitals/Applicants | **Six Lead Applicants:**<br>**Holy Cross Hospital, Holy Cross Germantown Hospital, Shady Grove Medical Center, Washington Adventist Hospital, MedStar Montgomery Medical Center, Suburban Hospital** |
|---|---|
| Date of Submission: | **December 21, 2015** |
| Health System | <u>Hospital</u> — <u>Health System Affiliation</u><br>Holy Cross Hospital ........ Holy Cross Health<br>Holy Cross Germantown Hospital ........ Holy Cross Health<br>Shady Grove Medical Center ........ Adventist HealthCare<br>Washington Adventist Hospital ........ Adventist HealthCare<br>MedStar Montgomery Medical Center ........ MedStar Health<br>Suburban Hospital ........ Johns Hopkins Medicine |
| Number of Interventions | **Four** |
| Total Budget Request ($) | **$7,950,216** |

**1. Target Patient Population**

The geographic scope of services consists of the Maryland ZIP codes that represent the residence of 80% of the combined patient discharges across all six lead hospitals. These ZIP codes contain the incorporated cities: Gaithersburg, Rockville, Takoma Park, College Park, Glenarden, Greenbelt, Hyattsville, Laurel, and New Carrolton.

| Health Stabilization for Seniors | Hospital Care Transition Programs | Post-Acute Specialty Care Ineligible-Uninsured | Service Capacity Building for Severely Mentally Ill |
|---|---|---|---|
| Medicare and Dually Eligible, Age 65+<br>• Seniors in community, unstable health, chronic illness, at risk of PAU<br>• Seniors discharged from hospital-to-SNF-to-home, at high risk of readmission | All Payer<br>Patients discharged from hospital-to-home<br>• High utilizers<br>• High risk of re-admit<br>Each hospital uses risk assessment criteria to select patients. | Uninsured patients ineligible for ACA plans or Medicaid<br>Discharged with specialty care needs<br>• High utilizers<br>• High risk of re-admit or PAU | Medicaid and Dually Eligible, all ages<br>Patients with severe behavioral health diagnoses<br>• High utilizers<br>• High risk of re-admit or PAU |

**2. Program Interventions**

| Health Stabilization for Seniors | Hospital Care Transition Programs | Post-Acute Specialty Care Ineligible-Uninsured | Service Capacity Building for Severely Mentally Ill |
|---|---|---|---|
| Referral by senior housing resident counselors, EMS, PCPs, or at time of discharge to SNF<br>Risk assessment using Care at Hand (mobile technology) and intensive care coordination with follow-up risk monitoring<br><u>Start</u>: May 2016 | Care transitions services and warm hand-offs using Coleman method with modifications per each hospital<br><u>Start</u>: July 2016<br><u>Workforce</u>: RNs, Case Managers, Community Health Workers | Ineligible-uninsured patients at high risk of readmission for up to 30 days post-acute ambulatory specialty care needs referred to Project Access.<br><u>Start</u>: April 2016<br><u>Workforce</u>: RN Navigator | Start up funds to expand crisis beds (8 beds) and add Assertive Community Treatment (ACT) team<br>Behavioral Health Integration Manager (BHIM) to support care team meetings and cross-organizational services. |

| | | | |
|---|---|---|---|
| Workforce: Care team: Nurse, scheduler, six community health coaches. Program manager and social worker oversee three teams.<br>Infrastructure: Care At Hand mobile software. SNF-to-home root cause analysis and process improvement. | Infrastructure:<br>• Learning collaborative for cross-hospital program improvement.<br>• Care plan sharing.<br>• Coordination with payer case management. | Infrastructure: Existing Project Access program. Existing electronic referral system. | Start:<br>Crisis Beds: Feb 2017<br>ACT team: May 2016<br>BHIM: April 2016<br>Workforce: BHIM<br>Infrastructure: Existing ACT and crisis bed providers. |

**3. Measurement and Outcomes Goals**

The NM RP region (42 target ZIP codes) generally has lower utilization and readmission rates than Maryland overall. However, the sheer size of the region's population – 23% of the Maryland population and 21% of Medicare FFS beneficiaries) magnifies even small changes in measured rates when translated to costs. Therefore, also faces a rapidly growing senior population that is becoming a larger percent of the total population. Therefore, the NM RP hospitals performance on outcome measures can have significant impact on NAPM. As the senior population grows, the NM RP hospitals and the region must have strong programs in place to maintain and improve performance on the key NAPM measures.

The NM RP interventions are designed to produce reductions in the following outcome measures, both for All Payer and for Medicare FFS and Dually Eligible, as follows:

| Outcome Measure | All Payer | | | | Medicare FFS | | | |
|---|---|---|---|---|---|---|---|---|
| | Baseline | Projections | | | Baseline | Projections | | |
| | CY2014 | CY2016 | CY2017 | CY2018 | CY2014 | CY2016 | CY2017 | CY2018 |
| Total hospital cost per capita (charges per person) | $1,436 | $1,432 | $1,424 | $1,424 | $4,493 | $4,461 | $4,415 | $4,414 |
| Total hospital admits per capita (admits per 1000) | 84.3 | 83.9 | 83.2 | 83.2 | 235.5 | 232.9 | 228.3 | 228.3 |
| ED visits per capita (ED visits per 1000) | 246.2 | 246.0 | 245.7 | 245.7 | 281.7 | 280.8 | 279.8 | 279.8 |
| Readmission Rate | 11.73% | 11.40% | 10.92% | 10.90% | 16.47% | 15.72% | 15.15% | 15.12% |

Initially, beginning to serve clients drives improvement. Later reductions come through the NM RP process improvement infrastructure, including a learning collaborative for the hospitals care transition programs and gains made in use of CRISP. Process improvement will focus on critical elements that improve return on investment: driving down program per patient cost; improving the targeting of patients to those at highest risk of hospital utilization; and increasing the efficacy of the programs at reducing admissions, readmissions and/or ED Visits for the patients served.

**4. Return on Investment / Total Cost of Care Savings**

The Governance Board intends a tiered framework for reinvestment into programs that support shared populations or shared challenges of the NM RP hospitals. This tiered framework focuses first on programs supporting immediate NAPM goals, second on programs creating longer-term gains in population health status, and third on developing programs mutually benefiting payers and NM RP hospitals. Payers will realize a return from the NM RP programs in the form of reduced hospital utilization by their members. Net savings and ROI for each intervention is shown below. The interventions proposed have not been evaluated for their capacity to reduce total cost of care beyond the hospitals.

| Health Stabilization for Seniors (HSS) | CY2016 | CY2017 | CY2018 | CY2019 |
|---|---|---|---|---|
| Annual Net Savings (Medicare) | -$1,210,513 | $1,968,703 | $2,119,059 | $2,119,059 |
| ROI: HSS Program ROI | 0.48 | 1.54 | 1.58 | 1.58 |
| **Hospital Care Transitions Expansion** | **CY2016** | **CY2017** | **CY2018** | **CY2019** |
| Annual Net Savings (All Payer) | $14,215 | $ 655,489 | $ 786,976 | $ 925,037 |
| Annual Net Savings (Medicare) | $ 8,422 | $ 310,822 | $ 372,297 | $436,846 |
| ROI: Hospital Care Transitions | 1.01 | 1.33 | 1.40 | 1.47 |
| **Post-Acute Sp. Care (Ineligible Uninsured)** | **CY2016** | **CY2017** | **CY2018** | **CY2019** |
| Annual Net Savings (Uncomp. Care) | $ (4,499) | $ 10,333 | $ 10,333 | $ 10,333 |
| ROI: PA-SC | 0.97 | 1.04 | 1.04 | 1.04 |
| **Capacity Building for the SMI** | **CY2016** | **CY2017** | **CY2018** | **CY2019** |
| Annual Net Savings (Medicaid) | $(841,649.5) | $ 106,028 | $434,226 | $ 434,226 |
| ROI: Capacity Building for the SMI | 0 | 1.22 | 3.08 | 3.08 |

## 5. Scalability and Sustainability Plan

The NM RP programs are sustainable without additional rate increases. Each program creates a positive return on investment, though each has a different cumulative net savings curve and date at which the program passes the breakeven mark. All programs produce cumulative savings through reduced admissions within two years. NM RP will use the savings to scale these or other programs, to sustain programs with reinvestment as costs rise over time or new technologies become available, or to build out new programs with evidence-based potential for return. Each of the programs is designed for further scaling as long there remain more high risk/ high utilizing patients than capacity of a program. NM RP recognizes that program return on investment is predicated on serving only those patients that meet high-risk criteria, so programs will not be scaled beyond that need.

Broadening scope will also be considered for reinvestment funds. For example, as PCPs referring high-risk seniors to the HSS program develop trust in the program, this may create interest in a Chronic Care Management program for their chronically ill, but stable, Medicare patients, which could be built as a shared resource with the physician community.

As the NM RP matures, joint efforts for upstream interventions to prevent or control the disease states that most impact hospital utilization (e.g. cardiovascular disease, diabetes) is expected.

## 6. Participating Partners and Decision-Making Process

All six Montgomery County hospitals are lead applicants and full collaborative partners in NM RP, each contributing an equal percentage of net revenue plus markup to the programs and interventions, making each an equal participant relative to its revenues. The rate increase total of $7,950,216 is allocated to partners, as follows: Holy Cross Hospital ($2,228,020), Holy Cross Germantown Hospital ($267,233), Shady Grove Medical Center ($1,856,312), Washington Adventist Hospital ($1,230,145), MedStar Montgomery Medical Center ($855,404), and Suburban Hospital ($1,513,102).

The NM RP Governing Board will have a representative from each hospital and set policy and direction for NM RP under the guidance of an Operating Agreement (key aspects of governance: committees, board seats, partners roles, voting rights) and a Participation Agreement (partnership processes: e.g. non-performance of an NM RP member, data management and sharing plan, patient protection plan, financial accountability and conflict of interest, and reporting requirements). The Governing Board can expand to up to nine seats to incorporate community partners and representatives with particular expertise. A Physician Advisory Board, comprised of a range of providers from the community, will advise the Board. The Board has two standing committees – a Partnership Program Intervention Committee (P-PIC) and a Finance Committee. The P-PIC is comprised of board and community representatives. In addition, interventions will work with specific networks of community stakeholders, including patients, families, and care-givers.

## 7. Implementation Plan

The workplan details:

- Implementation: four interventions
- Technology improvements (CRISP use and care plan sharing)
- Monitoring and evaluation (data collection and analysis/evaluation)
- Governance and management

All four interventions are ready for implementation immediately post-award.

- Health Stabilization for Seniors: NM RP selected a care coordination vendor (The Coordinating Center, TCC). TCC, PCC, senior living facilities, residents/, and stakeholders continue meeting to accomplish preliminary activities in expectation of funding. With March award, TCC can begin seeing clients on May 1, 2016. Expansion to SNF-to-home clients occurs in August 2016, and reaches scale in December 2016.
- Scale Up of Existing Hospital Care Transitions Programs: Each hospital needs only to add staff to scale existing operations. Staff recruitment and training is planned for 16 weeks post-award, with an estimate of July 1, 2016 as the date the programs are scaled. As 30-day readmission programs, new staff will manage full caseloads by late July 2016.
- Post-Acute Specialty Care Ineligible-Uninsured: An existing program, Project Access, has the needed infrastructure (e-referrals, network of specialists, RNs and bilingual client support workers). In the first month, the initial high readmission risk criteria will be refined, and hospital discharge planner/care transitions teams will be trained in referral processes. Months 3, 4, and 5 will pilot the program at reduced patients, with full patient load reached July 1, 2016.
- Capacity Building for Severely Mentally Ill: Cornerstone Montgomery started their second 8 bed crisis house in 2014 and will follow the same work plan. Milestones: procure Crisis House by September 2016, renovate and open by February 2017. ACT team start-up is a well-documented process. NM RP is meeting with potential vendors (PEP, Cornerstone); with selection targeted pre-award. Pending DHMH approval for ACT team expansion, clients are seen in month 3, with full client load by month 20 (estimate October 2016).

## 8. Budget and Expenditures

The budget presented is a Rate Year 2017 budget. This represents the annualized operational costs for the NexusMontgomery Regional Partnership interventions and infrastructure going forward. The total request, representing 0.5% of FY15 Approved Net Revenue plus markup for each of the Lead Hospitals, is **$7,950,216.**

| Budget Category | 1. Health Stabilization for Seniors | 2. Hospital Care Transitions | 3. PA-SC for Ineligible-uninsured | 4. Capacity Building for SMI | NM RP Infrastructure |
|---|---|---|---|---|---|
| **Labor** | $ 2,499,276 | $ 1,919,144 | $ 29,267 | $ 206,937 | $ 910,984 |
| **IT/Technologies** | $ 326,927 | n/a | n/a | n/a | n/a |
| **Other Impl. Act.** | $ 598,020 | 55100 | $ 224,400 | $ 690,000 | $ 13,287 |
| **ODC** | $ 98,293 | 0 | 0 | 0 | $ 378,582 |
| **TOTALS** | $ 3,522,515 | $ 1,974,244 | $ 253,667 | $ 896,936 | $ 1,302,853 |

CY2016 will be a shortened operating year (ten months) and is the year in which all interventions ramp up and achieve steady state, except Crisis Bed and ACT Team expansions. The CY2016 budget is $5,639,434.

## End Notes

[i] VHQC data is for the H.E.A.L.T.H. Partners Care Transitions Community, defined by CMS QIN-QIO as Montgomery County ZIP codes excluding three small population ZIPs and three ZIPs shared with Prince George's County (20777, 20838, 20839, 20842, 21771, and 21797).

[ii] VHQC data for the H.E.A.L.T.H. Partners Care Transitions Community.

[iii] Montgomery County Commission on Aging Summer Study 2015: *Long Term Care Services and Supports: Nursing Home Quality*, http://www.montgomerycountymd.gov/HHS-Program/Resources/Files/2015LTCSummerStudyreport.pdf. Accessed December 15, 2015.

[iv] Carrisoza and Richards. Behavioral Health in Montgomery County. Office of Legislative Oversight: Report Number 2015-13, July 28, 2015, pp. 106-107.

[v] Migration Policy Institute analysis of U.S. Census Bureau data from the 2013 American Community Survey and the 2008 Survey of Income and Program Participation by Bachmeier of Temple University and Van Hook of The Pennsylvania State University, Population Research Institute.

[vi] 2014 American Community Survey 1-Year Estimates, Selected Characteristics of Native and Foreign-Born Populations. The percentage of foreign-born who speak English less than very well counts residents older than 5 years of age only.

[vii] Migration Policy Institute, as above.

[viii] 2014 American Community Survey, 1-Year Estimates, Health Insurance Coverage Status.

[ix] Maryland Department of Planning State Data Center.

[x] Steven B. Cohen and William Yu, The Concentration and Persistence in the Level of Health Expenditures over Time: Estimates for the U.S. Population, 2008-2009, Statistical Brief (Rockville, MD: Agency for Healthcare Research and Quality, January 2012).

[xi] US Census Data, 2010: Medicare beneficiaries for the NM RP ZIP codes described in section 1a, geographic scope.

[xii] Primary Care Coalition of Montgomery County, Inc. serving as Performance Manager for the National Capital Area Connector Entity maintains statistics about uninsured and ineligible populations.

[xiii] "Self-pay" is used here as a proxy for ineligible-uninsured. The ineligible-uninsured population makes up a substantial portion of the self-pay group seen in Montgomery County hospitals.

[xiv] Effects of insurance status on post-acute care among working age stroke survivors. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3348849/

[xv] Disparities in Outcome Among Patients with Stroke Associated with Insurance Status. http://stroke.ahajournals.org/content/38/3/1010.full.pdf

[xvi] Carrisoza and Richards, as above. p i.

[xvii] Carrisoza and Richards, as above. pp. 106-107.

[xviii] This intervention is detailed in the Regional Transformation Design Final Report submitted December 7, 2015 by Holy Cross Hospital on behalf of the Nexus Montgomery Regional Partnership.

[xix] VHQC data for the H.E.A.L.T.H. Partners Care Transitions Community.

[xx] Eric Coleman, MD, MPH, http://caretransitions.org/

[xxi] Published by the Agency for Healthcare Research and Quality.

[xxii] Mary D. Naylor, PhD, RN, http://www.transitionalcare.info/

[xxiii] http://maryland.valueoptions.com/provider/handbook/MTS_Assertive_Community_Treatment.pdf

[xxiv] For these measures, NM RP uses definitions and sources described in the RFP Appendix A, Table 1.

[xxv] 2014 Total Population Projections for Non-Hispanic White and All Other by Age, Sex and Race (7/8/14) Prepared by Maryland Department of Planning

[xxvi] Data from report provided by CRISP via Repliweb, updated December 16, 2015.

## Appendix A: NM RP Target ZIP Codes for 80% of Combined Inpatient Discharges (All-Payer from All NM RP Hospitals)

| ZIP Codes | Number of Discharges | Percent of Discharges | Cumulative Percent of Discharges | County |
|---|---|---|---|---|
| 20906 | 6,574 | 7.1% | **7.1%** | Montgomery |
| 20904 | 4,358 | 4.7% | **11.8%** | Montgomery |
| 20874 | 4,098 | 4.4% | **16.2%** | Montgomery |
| 20902 | 3,708 | 4.0% | **20.2%** | Montgomery |
| 20878 | 3,433 | 3.7% | **23.9%** | Montgomery |
| 20877 | 3,206 | 3.5% | **27.3%** | Montgomery |
| 20850 | 3,165 | 3.4% | **30.7%** | Montgomery |
| 20783 | 2,872 | 3.1% | **33.8%** | Prince George's |
| 20852 | 2,651 | 2.9% | **36.7%** | Montgomery |
| 20901 | 2,534 | 2.7% | **39.4%** | Montgomery |
| 20886 | 2,482 | 2.7% | **42.1%** | Montgomery |
| 20910 | 2,395 | 2.6% | **44.7%** | Montgomery |
| 20853 | 2,080 | 2.2% | **46.9%** | Montgomery |
| 20854 | 2,069 | 2.2% | **49.1%** | Montgomery |
| 20903 | 1,749 | 1.9% | **51.0%** | Montgomery |
| 20912 | 1,740 | 1.9% | **52.9%** | Montgomery |
| 20879 | 1,643 | 1.8% | **54.7%** | Montgomery |
| 20876 | 1,613 | 1.7% | **56.4%** | Montgomery |
| 20782 | 1,515 | 1.6% | **58.0%** | Prince George's |
| 20817 | 1,482 | 1.6% | **59.6%** | Montgomery |
| 20814 | 1,417 | 1.5% | **61.1%** | Montgomery |
| 20832 | 1,402 | 1.5% | **62.7%** | Montgomery |
| 20895 | 1,212 | 1.3% | **64.0%** | Montgomery |
| 20705 | 1,151 | 1.2% | **65.2%** | Prince George's |
| 20871 | 1,082 | 1.2% | **66.4%** | Montgomery |
| 20905 | 1,076 | 1.2% | **67.5%** | Montgomery |
| 20815 | 1,038 | 1.1% | **68.6%** | Montgomery |
| 20851 | 975 | 1.0% | **69.7%** | Montgomery |
| 20706 | 903 | 1.0% | **70.7%** | Prince George's |
| 20855 | 892 | 1.0% | **71.6%** | Montgomery |
| 20882 | 803 | 0.9% | **72.5%** | Montgomery |
| 20872 | 802 | 0.9% | **73.4%** | Montgomery |
| 20740 | 792 | 0.9% | **74.2%** | Prince George's |
| 20784 | 723 | 0.8% | **75.0%** | Prince George's |
| 20774 | 713 | 0.8% | **75.8%** | Prince George's |
| 20785 | 699 | 0.8% | **76.5%** | Prince George's |

| 20770 | 689 | 0.7% | **77.2%** | Prince George's |
|---|---|---|---|---|
| 20707 | 683 | 0.7% | **78.0%** | Prince George's |
| 20737 | 644 | 0.7% | **78.7%** | Prince George's |
| 20708 | 608 | 0.7% | **79.3%** | Prince George's |
| 20866 | 594 | 0.6% | **79.97%** | Montgomery |
| 20816 | 261 | 0.3% | **80.25%** | Montgomery |

**Note:** These ZIP codes contain the following incorporated cities: Gaithersburg, Rockville, Takoma Park, College Park, Glenarden, Greenbelt, Hyattsville, Laurel, and New Carrolton.

## Appendix B: Active Issues In Nexus Montgomery Resident Pilot

The Active Issues list represents health issues of concern issue and frequency within the 46 Medicare and Dually Eligible beneficiaries age 65+ surveyed by The Coordinating Center for a NexusMontgomery pilot test of referrals from senior living resident counselors.

Active issues are not mutually exclusive. One resident can have hypertension and COPD and be counted in each. Hypertension, diabetes, and arthritis were the most common active issues identified.

| | |
|---|---|
| Hypertension | 15 |
| Diabetes | 14 |
| Arthritis | 11 |
| Fall Risk | 9 |
| Atrial Fibrillation/Arrythmia | 5 |
| COPD | 5 |
| Dementia | 5 |
| Coronary Artery Disease | 4 |
| Peripheral Vascular Disease | 4 |
| Vertigo | 3 |
| Gout | 3 |
| Peripheral Neuropathy | 2 |
| Depression | 1 |
| Hypotension | 1 |
| Medication Side Effects | 1 |
| Urinary Tract Infection | 1 |
| Parkinson's | 1 |
| Wound | 1 |
| CHF | 1 |
| Blindness | 1 |
| Pain in legs (occasional Tylenol use) | 1 |

## Appendix C:  NM RP

THE COORDINATING CENTER
INSPIRED SOLUTIONS

# SAMPLE CONSENT TO RELEASE INFORMATION

I hereby give consent to release the following type of information regarding ___________________________to The Coordinating Center to locate, coordinate and monitor healthcare and community based services.
Please check all that apply.

☐ Medical records ☐ Psychosocial ☐ Educational ☐ Developmental

☐ Financial ☐ Mental Health ☐ Nutritional ☐ Therapy (OT/PT/Speech)

☐ Vocational ☐ Housing ☐ Provider records ☐ Hospital providers

☒ Other (specify) - _________________________________________________

I also authorize The Coordinating Center to release the information obtained regarding the client to relevant health care providers, local, state and federal agencies or their representative, and/or insurance companies, in order to obtain medical and community based services. I understand that The Coordinating Center will not release the name of the person or any identifying information other than for the purpose listed above, without my expressed written consent. I may withdraw my consent at any time, by written notice of such withdrawal, delivered either personally by phone or by mail to The Coordinating Center. Following the withdrawal of my consent, no further disclosure of information will be made effective on the date of receipt of said request.

I understand that this authorization is voluntary and that my access to services will not be altered if I do not sign this form. I also understand that referrals for external services may be dependent upon the ability to transfer information to other providers of service on a need to know basis. I further understand that if the organization authorized to receive information is not a health plan or health care provider and if such information is re-disclosed by the recipient, the released information may no longer be protected by federal privacy regulations, but may be protected under state law.

I give consent to discuss my care with the following individuals who are personally involved with my needs:

1) ______________________________ 2)______________________________

(Name/relationship) (Name/relationship)

Signed this____________________ day of_______________________2________

This consent will expire one year from the date signed above.

________________________________ ________________________________

Signature of Participant Signature of Witness

________________________________ ________________________________

Print Name of Signor Print Name of Witness

## Appendix D: NM RP Community and Collaborative Partners

| Health Stabilization for Seniors Partners | |
|---|---|
| **Senior Living Facility Partners** | |
| **Housing Facility** | **Managing Entity** |
| Andrew Kim | Victory Housing |
| Arcola Towers | Housing Opportunities Commission |
| Asbury Methodist Village | Asbury Communities |
| Bauer Park Apartments | Housing Opportunities Commission |
| Brooke Grove | Brooke Grove Foundation |
| Charter House | Charter House |
| Elizabeth House | Housing Opportunities Commission |
| Forest Oak Towers | Housing Opportunities Commission |
| Friends House Retirement | Friends House |
| Homecrest | B'nai Brith |
| Holly Hall | Housing Opportunities Commission |
| Revitz House | Charles E. Smith Life Communities |
| Ring House | Charles E. Smith Life Communities |
| The Oaks at Four Corners | Housing Opportunities Commission |
| The Village at Rockville | National Lutheran Communities and Services |
| Town Center Apartments | Housing Opportunities Commission |
| Victory Court | Victory Housing |
| Victory Forest | Victory Housing |
| Victory Oaks | Victory Housing |
| Victory Terrace | Victory Housing |
| Victory Tower | Victory Housing |
| Waverly House | Housing Opportunities Commission |
| **Care Management Vendor Partners** | |
| The Coordinating Center | |
| ALFA Pharmacy (Medication Therapy Management) | |

| Local Government Partners | |
| --- | --- |
| Montgomery County Department of Health and Human Services | |
| Montgomery County Fire and Rescue | |
| Montgomery County Area Agency on Aging | |
| **Association Partners** | |
| Montgomery County Medical Society/MedChi | |
| LifeSpan | |
| **Data Partners** | |
| VHQC | |
| CRISP | |
| **Post-Acute Specialty Care for Ineligible-Uninsured Patients** | |
| Project Access | Primary Care Coalition of Montgomery County, Inc. |
| Montgomery Cares | Department of Health and Human Services |
| **Service Capacity Building for Severely Mentally Ill** | |
| Cornerstone Montgomery | |
| People Encouraging People | Department of Health and Human Services |
| Core Services Agency | Department of Health and Human Services |

| NM RP Hospital Partners | |
| --- | --- |
| **Montgomery County Hospital Partners** | |
| Holy Cross Hospital | Holy Cross Health |
| Holy Cross Germantown Hospital | Holy Cross Health |
| Shady Grove Medical Center | Adventist HealthCare |
| Washington Adventist Hospital | Adventist HealthCare |
| MedStar Montgomery Medical Center | MedStar Health |
| Suburban Hospital | Johns Hopkins Medicine |
| **Program Implementation and Facilitation Partner** | |
| Primary Care Coalition of Montgomery County, MD, Inc. | |

# ICN Infrastructure Support Memorandum of Understanding

This Memorandum of Understanding (MOU) between Chesapeake Regional Information System for our Patients (CRISP) and the NexusMontgomery Regional Partnership ("NexusMontgomery" or "RP") sets forth the terms and understanding to enhance coordination services provided through the state-designed health information exchange (HIE) Integrated Care Network (ICN) infrastructure with the goal of facilitating care, reducing costs, and improving health outcomes.

This MOU is subject to the legal, regulatory and policy framework governing CRISP's role and services as the state-designated health information exchange as expressed in CRISP's Participation Agreements, approved use cases, and HIE Policies and Procedures (all found at https://crisphealth.org/ABOUT/Policies-Agreements).

## Purpose

**CRISP goals** are to support the care transformation, quality improvement and cost reduction initiatives of the Health Services Cost Review Commission's System Transformation Implementation initiative and achievement of the New All Payer Model metrics. CRISP overall goals, not specific to the NM RP, include the following;

### *Clinical Query Portal Enhancements*

CRISP is improving the functionality of the existing Clinical Query Portal to include elements that are relevant to improve coordinated care services. Examples of this improved functionality include:

- A listing of current notification subscribers
- A dedicated section that lists care plans that have been provided to CRISP
- A dedicated "Care Profile" section that provides a care summary for each patient
- A risk score derived from risk-stratified case mix data

### *Community Provider Connectivity*

CRISP is connecting ambulatory practices, long-term care/post-acute facilities, local health departments, and other relevant community health providers in order to:

- Easily understand where a patient has received care or has a treatment relationship with a non-hospital provider.
- Achieve clinical document transfer from the non-hospital provider to the CRISP clinical query portal for treatment decisions at the point of care.

*Alerts and Notifications Enhancements*

Alerts and notifications might take a variety of forms leveraging CRISP tools such as ENS and other integration capabilities. CRISP and RP will review potential use cases for in-context alerts with the intention of piloting those applicable to RP provider sites. Examples of potential use cases for further support via alerts and notifications:

- Notification that a care plan is available on the Clinical Query Portal
- Notification that a patient has a provider or entity newly subscribing to ENS
- Alerts that a patient's risk score has changed.

*Reporting and Analytics*

CRISP Reporting Services provides information to hospitals and provider organizations to facilitate outcome measurement, strategic planning, and care coordination including reporting and mapping such as:

- Cross-hospital utilization reports by geographic region, and by patient panels. This includes pre-post intervention reports for evaluation purposes.
- Risk scoring reports that assist in identifying patients most appropriate for care management

*Consent Management*

CRISP operates its basic health information exchange services based on an "opt-out" patient consent model—meaning that patient data by default flows through CRISP to providers with an established patient-provider relationship unless the patient actively opts out of participating in the CRISP exchange. Patients are notified of their opportunity to opt out of the HIE program as part of participating providers' "Notice of Privacy Practices" acknowledgement process.

Based on recommendations of CRISP's Board of Directors and the Clinical Advisory Board, CRISP will require active, affirmative ("opt-in") patient consent for patients enrolled in care management. The rationale for this higher level of consent includes the following:

- Care management/coordination, by definition, requires the active engagement and involvement of patients and their proxies/caregivers. Consent should be an integral part of the engagement process.
- Reimbursement for Chronic Care Management (CCM) under Medicare requires active consent for both participation in care management and data sharing related to care management.
- Our "opt-out" framework for consent limits the use of certain data (such as mental health data) and data sharing with entities that are not covered entities or their business associates. Active patient consent allows for the appropriate sharing of data to social service entities and others who may not be governed by CRISP's standard participation agreement.

The capture of patient consent will need to happen at the provider level – through the care coordinator or other means. As providers submit their patient panels to CRISP in order to exchange patient data via CRISP, they will need to attest to the capture of consent for data sharing. CRISP will provide the necessary language as a template for inclusion in the provider's care management consent process.

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## Scope of Work for the NM RP & CRISP under this MOU

The RP recognizes that increasing the number and type of entities sharing ADT, ambulatory, post-acute and other provider data and care plans via CRISP enhances the value of CRISP to all providers. A tipping point of participating providers sharing data must be reached after which all providers will see and gain benefit from CRISP participation for ENS and Alert notifications for their patient panels.

- The RP will conduct outreach, education and referral to CRISP with providers engaged with the NM RP to promote CRISP connectivity: a) ADT and care plans to CRISP, and b) patient panel upload and subscription for ENS and Alert notification. Focus will start with the 6 hospitals of the NM RP and Skilled Nursing Facilities (SNFs) in the region. Further efforts will encompass the region's **inpatient and large community behavioral health providers**, DHHS, and select PCPs involved in the RP shared Care Coordination interventions. When making a referral to CRISP, the RP will provide a contact name, email and the system that would interface with CRISP.
- CRISP will
    i. Educate RP communication and provider relations staff on provider technical criteria for CRISP connectivity; assist with development of talking points and materials for RP staff to use with providers.
    ii. Engage with entities referred by the RP, creating participation agreements and connectivity for ADT and care plan feeds to CRISP when technically feasible.

The RP recognizes that patients seek and receive care across the region and throughout the State. Accordingly, operational efficiencies, cost effectiveness and the overall patient experience of care will be improved if all providers utilize a common HIE for data sharing. To the extent CRISP can provide the data, care plan and care manager-to-patient relationship sharing infrastructure needed by the RP, the RP will not need to develop and implement separate technology solutions for these functions. This allows the RP to benefit from the legal and technical efforts CRISP has undertaken to date and CRISP's funding and technical skills to build the framework to facilitate such sharing efforts. Therefore, CRISP's responsibilities under this MOU with the NexusMontgomery RP include the following:

- Within a definition to be informed by the RP, community-based care management and care coordination entities which may not be business associates of a 'covered entity', will be able to enter into participation agreements with CRISP. Such participation agreements would detail access for loading patient panels for ENS, sharing their care plans via the Query Portal, receiving ENS notification and alerts, and viewing care plans and ENS/Care Manager panels via the Query Portal.

Hospital and ambulatory providers have requested the RP facilitate standardization in care plans to improve ease of use across providers and to facilitate sharing of care manager-to-patient relationships, for both somatic and behavioral health providers. In support, the RP and CRISP shall undertake the following.

- The RP will facilitate regional provider meetings by provider type and across provider types to:
    i. Define care plan, care manager and care management program information that would be most useful for inclusion on the CRISP Query Portal or Care Profile (through extract from Care Plans or upload with ENS panels).
    ii. Gather input for CRISP on Care Profile design.
- CRISP will:

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i. Take recommendations on Care Profile to CRISP's Clinical Committee for consideration; incorporate changes that are approved.
ii. CRISP will make data (to be determined) on care manager-to-patient relationships that are included in ENS panels available for view in the Query Portal.
iii. If feasible, work with 1-2 pilot organizations to incorporate select care plan data elements into Care Profile or Alerts, possibly including data on care manager-to-patient relationships.

CRISP Reporting Services provides information to hospitals and provider organizations to facilitate outcome measurement, strategic planning, and care coordination. CRISP recognizes its role in facilitating program evaluation in support of Health System Transformation and achievement of New All Payer Model goals. CRISP will enhance available reports based on RP feedback and provide custom reports based on RP specifications.

- By Q2 2016 CRISP will provide RP with a Tableau-based "pre/post" analysis for cohorts of patients (panels) that are relevant to the RP. Panels may be specific to care management programs, skilled nursing facilities, or other relevant groups. CRISP will provide retrospective data (hospital cost and utilization including admissions/observation stays over 24 hours, 30 day all cause readmissions, and ED encounters) for individual clients enrolled in an intervention. Data will be provided for up to one year prior to the patient's involvement with the intervention and one year after their involvement. The RP and CRISP will work together to test and refine the report to meet RP evaluation needs.
- By end of Q2 2016, CRISP will provide access to a cross-hospital utilization report for the region.
- By Q4 2016 the RP will provide specifications to CRISP for custom reports; CRISP and the RP will work together to design reports feasible for ongoing production.

As the CRISP ICN infrastructure matures, CRISP will provide information to the RP for further education and engagement of RP participating providers and care coordination entities with CRISP services.

## Deliverables/Milestones

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| NM RP | CRISP | By End of Quarter , 2016 |
|---|---|---|
| **Community Provider Connectivity, Care Plans Sharing, ENS Notifications** | | |
| **Provider outreach materials developed based on CRISP criteria/process**<br><br>**Provider relations staff trained on engaging providers re: ADT/C-CDA connectivity, ENS panel uploads, addition of care managers to ENS panel uploads, upload of care plans** | **Technical criteria/process for Provider Connectivity provided to RP**<br><br>**Ensure CRISP protocols permit community-based care management organizations to sign participation agreements with CRISP, upload their patient panels to CRISP, access the Clinical Query Portal's Care Profile to view care plans and subscribe to ENS notifications for their patient panel. By subscribing to ENS notifications for their panel, community-based care management organizations will be listed on the care profile as an ENS subscriber.**<br><br>**Care coordination vendors under contract to the hospitals or RP have participation agreements with CRISP, uploading patient panels with Care Manager, access to Query portal and receive ENS notification on their managed panels.**<br>• **The Coordinating Center (Care at Hand/CARMA)**<br>• **Family Services Inc/CareLink (BestCareConnect)** | **Q1** |
| **Educate/Engage provider interest in CRISP connectivity**<br>• **Refer up to 5 SNFs technologically ready for ADT connectivity**<br>• Refer 1 inpatient behavioral health provider | Outreach plan for notifying providers who upload ENS panels, how to upload care manager information in conjunction<br><br>Pilot inpatient behavioral health (Adventist) for CRISP connectivity | **Q2** |
| **Continue to Educate/Engage provider interest in CRISP connectivity (ADT, C-CDA, Care Plans, ENS/Panel)**<br>• **Refer additional SNFs for ADT** | Establish an ADT interface with at least three of the five SNFs and make available for ENS notifications. In process with other referred providers | **Q3** |

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| **connectivity**<br>• Refer additional behavioral health providers<br>• Engage with PCPs | | |
|---|---|---|
| **Engage for CRISP connectivity:**<br>• **PCPs (target: 5) for ambulatory data, panel upload and ENS/Alert subscription**<br>• **DHHS for ambulatory clinics, and care plans/ care manager from Core Service Agency (BH)** | Establish an interface with at least three PCPs. In process with DHHS and other referred providers<br><br>Ongoing: In process with referred organizations for ADT, Care Plan and ENS connectivity | **Q4** |
| **Clinical Query Portal, Care Plan Sharing and Care Profile** | | |
| 1st Care Plan Standards Meeting (hospitals and PCPs): discuss care plan, care manager, care management and consent management program information for common definition | Functionality of Clinical Query Portal includes shared care plans, listing of ENS subscribers and, when uploaded with panel, care manager designated.<br>CRISP provides data sharing consent language for inclusion in care management consent process. | **Q1** |
| 1 RP hospital completes Care Plan upload (Adventist) with adherence to the associated consent management process<br>2nd and 3rd Care Plan Standards Meeting (PCPs, hospitals, Care Coordination providers/CBOs):<br>• Select key elements of care plans, common definitions. | **Pilot hospital (Adventist) uploads care plans; available for view on Clinical Query Portal.**<br><br>**Care managers that are included in ENS panels are available to view in the CRISP query portal.**<br><br>All 6 Hospitals uploading care plans | **Q2** |
| 4th Care Plan Standards Meeting (PCPs, hospitals, Care Coordination providers/CBOs):<br>• Obtain feedback on benefits and challenges of using the Care Profile, to the extent providers are using.<br>• Recommend care plan, care manager and care management program information most useful for inclusion in Query Portal/Care Profile. | Using recommendation from RP Care Plan Standards Committee, develop specifications for additional information about care managers/care management programs with data elements that are technically feasible for either sharing via Care Profile or via Alerts. Seek approval by CRISP's Clinical committee. | Q3 |

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| | | |
|---|---|---|
| **Continue to provide input to CRISP on Care Profile design and Alerts.**<br><br>Develop feedback loops with CRISP for ongoing input to CRISP functions and services | As feasible, work with 1-2 pilot organizations to incorporate select care plan data elements into Care Profile or Alerts, possibly including data on care manager-to-patient relationships<br><br>Develop feedback loops with NM RP for ongoing input to CRISP functions and services | Q4 |
| **Reporting and Analytics** | | |
| **Provide specifications for CRISP custom reports, including Pre/Post evaluation report** | **Develop CRISP custom reports per specs, for ongoing production.** | **Q1** |
| **Test the Tableau-based pre/post analysis report.** | Tableau-based "pre/post" analysis report available for cohorts of patients (panels) for program evaluation purposes.<br><br>PaTH Cross-hospital utilization report available for the region | **Q2** |
| **Provide input to CRISP risk scoring reports, as related to needs of the RP interventions**<br><br>Provide feedback on PaTH report | **Pre-Post evaluation report available: retrospective hospital cost and utilization for one year prior to the patient's panel enrollment and one year after their panel enrollment.** | **Q3** |
| **Finalize any revisions needed to pre-post report and other custom reports**<br>Develop feedback loops with CRISP for ongoing reporting | **Complete revisions to pre-post and other custom reports.**<br>Develop feedback loops with NM RP for ongoing reporting | **Q4** |

**In future years, NM RP will continue to engage and refer PCPs, SNFs, community care management providers, behavioral health providers, and others in connectivity to CRISP. CRISP will work to establish connectivity with these referred entities. CRISP and NM RP will develop feedback loops, so NM RP can follow-up with provider on progress or status as needed.**
CRISP will continue to seek NM RP input to the Care Profile design, and its effectiveness in RP partners sharing care plans and knowing current care manager-to-patient relationships across the region.

## Commitment of Resources

The RP and CRISP will work jointly and in good faith to meet the objectives listed in this MOU. The RP and CRISP are each responsible for obtaining the resources needed to meet the objectives. This MOU does not include reimbursement between the two parties for MOU activities.

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## Duration

The duration of the MOU shall be until the sooner of either the completion of all of the deliverables within this document or December 31, 2016. CRISP and RP will work in good faith to meet the timelines for each deliverable. The MOU can be revised and/or amended anytime through written consent of both parties.

Communications regarding changes in the MOU and other correspondence related to this documents shall be coordinated by the following individuals:

| Primary CRISP Contact | | Primary RP Contact | |
|---|---|---|---|
| Name: | David Horrocks, President | Name: | Leslie Graham |
| Phone: | 877-952-7477 | Phone: | 301 628-3410 |
| Email: | David.horrocks@crisphealth.org | Email: | Leslie_Graham@primarycarecoalition.org |

## Acknowledgement

**CRISP**

__________________________________

By:

Date:

**On behalf of NexusMontgomery RP**

**(Primary Care Coalition, as the appointed Management Entity for the NM RP)**

__________________________________

By:

Date:

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## Appendix F: Individual Hospital Care Transition Program Expansion ROI Tables

The following return-on-investment (ROI) calculations represent the incremental impact of the hospital care transition program expansions as proposed under the HSCRC Transformation Implementation rate increase. Rows A and B represent the incremental number of patients to be served in the relevant categories. The number of patients and the savings shown here is in addition to the patients already being served and savings created through the existing programs prior to the proposed scale up. The return on investment for CY16 and CY17 is calculated for each NM RP hospital's care transitions program and shown below, for All Payer and for the subset Medicare population. Note: CY16 ROI is lower than CY17 due to startup costs of hiring and training in this shortened (10-month) year. CY17 ROI represents steady state. The projected CY16, CY17, CY18, and CY19 ROI for the NM RP hospitals' care transition programs in total are described in the proposal narrative section 4: Return on Investment. Improvement in the out-years will occur through the impact of a joint learning collaborative and are not projected at the individual hospital level. As shown below, there is sufficient variability in effectiveness of existing individual hospital programs for confidence that shared learning will produce or exceed the projected 5% annual improvement in CY18 and CY19 described in Section 4 of the proposal narrative.

### All-Payer ROI Projections

| NM RP: Holy Cross Germantown Hospital Hospital Care Management | CY16 | CY17 |
|---|---|---|
| A. Number of Patients | 749 | 1497 |
| B. Number of Medicare and Dual Eligible | 292 | 584 |
| C. Annual Intervention Cost/Patient | $ 39 | $ 29 |
| D. Annual Intervention Cost (A x C) | $ 29,040 | $ 44,000 |
| E. Annual Charges (Baseline) | $ 1,319,192 | $ 2,638,385 |
| F. Annual Gross Savings (5.1% x E) | $ 67,078 | $ 134,155 |
| G. Variable Savings (F x 50%) | $ 33,539 | $ 67,078 |
| H. Annual Net Savings (G-D) | $ 4,499 | $ 23,078 |
| ROI (G/D) | 1.15 | 1.52 |

| NM RP: Holy Cross Germantown Hospital Post-Acute Care Liaison | CY16 | CY17 |
|---|---|---|
| A. Number of Patients | 370 | 739 |
| B. Number of Medicare and Dual Eligible | 229 | 458 |
| C. Annual Intervention Cost/Patient | $ 49 | $ 37 |
| D. Annual Intervention Cost (A x C) | $ 18,150 | $ 27,500 |
| E. Annual Charges (Baseline) | $ 1,070,657 | $ 2,141,315 |
| F. Annual Gross Savings (3.6% x E) | $ 38,632 | $ 77,264 |
| G. Variable Savings (F x 50%) | $ 19,316 | $ 38,632 |
| H. Annual Net Savings (G-D) | $ 5,566 | $ 11,132 |
| ROI (G/D) | 1.06 | 1.40 |

### Medicare ROI Projections

| NM RP: Holy Cross Germantown Hospital Hospital Care Management | CY16 | CY17 |
|---|---|---|
| A. Number of Patients | 749 | 1497 |
| B. Number of Medicare and Dual Eligible | 292 | 584 |
| C. Annual Intervention Cost/Patient | $ 15 | $ 29 |
| D. Annual Intervention Cost (B x C) | $ 11,329 | $ 17,165 |
| E. Annual Charges (Baseline) | $ 514,635 | $1,029,270 |
| F. Annual Gross Savings (5.1% x E) | $ 26,168 | $ 52,336 |
| G. Variable Savings (F x 50%) | $ 13,084 | $ 26,168 |
| H. Annual Net Savings (G-D) | $ 1,755 | $ 9,003 |
| ROI (G/D) | 1.15 | 1.52 |

| NM RP: Holy Cross Germantown Hospital Post-Acute Care Liaison | CY16 | CY17 |
|---|---|---|
| A. Number of Patients | 370 | 739 |
| B. Number of Medicare and Dual Eligible | 229 | 458 |
| C. Annual Intervention Cost/Patient | $ 49 | $ 37 |
| D. Annual Intervention Cost (B x C) | $ 11,249 | $ 17,043 |
| E. Annual Charges (Baseline) | $ 663,547 | $1,327,093 |
| F. Annual Gross Savings (3.6% x E) | $ 23,942 | $ 47,885 |
| G. Variable Savings (F x 50%) | $ 11,971 | $ 23,942 |
| H. Annual Net Savings (G-D) | $ 723 | $ 6,899 |
| ROI (G/D) | 1.06 | 1.40 |

| NM RP: Holy Cross Hospital<br>Care Transitions Program | CY16 | CY17 |
|---|---|---|
| A. Number of Patients | 356 | 712 |
| B. Number of Medicare and Dual Eligible | 111 | 221 |
| C. Annual Intervention Cost/Patient | $ 463 | $ 351 |
| D. Annual Intervention Cost (A x C) | $ 165,000 | $ 250,000 |
| E. Annual Charges (Baseline) | $ 898,610 | $ 1,797,219 |
| F. Annual Gross Savings (32.8% x E) | $ 295,105 | $ 590,211 |
| G. Variable Savings (F x 50%) | $ 147,553 | $ 295,105 |
| H. Annual Net Savings (G-D) | $ (17,447) | $ 45,105 |
| ROI (G/D) | 0.89 | 1.18 |

| NM RP: Holy Cross Hospital<br>Care Transitions Program | CY16 | CY17 |
|---|---|---|
| A. Number of Patients | 356 | 712 |
| B. Number of Medicare and Dual Eligible | 111 | 221 |
| C. Annual Intervention Cost/Patient | $ 463 | $ 351 |
| D. Annual Intervention Cost (B x C) | $ 51,215 | $ 77,598 |
| E. Annual Charges (Baseline) | $ 278,922 | $ 557,845 |
| F. Annual Gross Savings (32.8% x E) | $ 91,599 | $ 183,198 |
| G. Variable Savings (F x 50%) | $ 45,799 | $ 91,599 |
| H. Annual Net Savings (G-D) | $ 7,000 | $ 14,000 |
| ROI (G/D) | 0.89 | 1.18 |

| NM RP: Holy Cross Hospital<br>Hospital Care Management | CY16 | CY17 |
|---|---|---|
| A. Number of Patients | 3554 | 7108 |
| B. Number of Medicare and Dual Eligible | 1315 | 2630 |
| C. Annual Intervention Cost/Patient | $ 41 | $ 31 |
| D. Annual Intervention Cost (A x C) | $ 145,200 | $ 220,000 |
| E. Annual Charges (Baseline) | $ 6,263,740 | $12,527,480 |
| F. Annual Gross Savings (5.1% x E) | $ 318,495 | $ 636,991 |
| G. Variable Savings (F x 50%) | $ 159,248 | $ 318,495 |
| H. Annual Net Savings (G-D) | $ 14,048 | $ 98,495 |
| ROI (G/D) | 1.10 | 1.45 |

| NM RP: Holy Cross Hospital<br>Hospital Care Management | CY16 | CY17 |
|---|---|---|
| A. Number of Patients | 3554 | 7108 |
| B. Number of Medicare and Dual Eligible | 1315 | 2630 |
| C. Annual Intervention Cost/Patient | $ 41 | $ 31 |
| D. Annual Intervention Cost (B x C) | $ 53,725 | $ 81,401 |
| E. Annual Charges (Baseline) | $2,317,619 | $4,635,238 |
| F. Annual Gross Savings (5.1% x E) | $ 117,845 | $ 235,690 |
| G. Variable Savings (F x 50%) | $ 58,923 | $ 117,845 |
| H. Annual Net Savings (G-D) | $ 5,198 | $ 36,444 |
| ROI (G/D) | 1.10 | 1.45 |

| NM RP: Holy Cross Hospital<br>Post-Acute Care Liaison | CY16 | CY17 |
|---|---|---|
| A. Number of Patients | 1324 | 2648 |
| B. Number of Medicare and Dual Eligible | 715 | 1430 |
| C. Annual Intervention Cost/Patient | $ 41 | $ 31 |
| D. Annual Intervention Cost (A x C) | $ 54,450 | $ 82,500 |
| E. Annual Charges (Baseline) | $ 3,836,401 | $ 7,672,802 |
| F. Annual Gross Savings (3.6% x E) | $ 138,427 | $ 276,854 |
| G. Variable Savings (F x 50%) | $ 69,213 | $ 138,427 |
| H. Annual Net Savings (G-D) | $ 14,763 | $ 55,927 |
| ROI (G/D) | 1.27 | 1.68 |

| NM RP: Holy Cross Hospital<br>Post-Acute Care Liaison | CY16 | CY17 |
|---|---|---|
| A. Number of Patients | 1324 | 2648 |
| B. Number of Medicare and Dual Eligible | 715 | 1430 |
| C. Annual Intervention Cost/Patient | $ 41 | $ 31 |
| D. Annual Intervention Cost (B x C) | $ 29,405 | $ 44,552 |
| E. Annual Charges (Baseline) | $2,071,773 | $4,143,545 |
| F. Annual Gross Savings (3.6% x E) | $ 74,755 | $ 149,509 |
| G. Variable Savings (F x 50%) | $ 37,377 | $ 74,755 |
| H. Annual Net Savings (G-D) | $ 7,973 | $ 30,202 |
| ROI (G/D) | 1.27 | 1.68 |

| NM RP: MedStar Montgomery Medical Center Care Transitions Program | CY16 | CY17 |
|---|---|---|
| A. Number of Patients | 390 | 780 |
| B. Number of Medicare and Dual Eligible | 258 | 515 |
| C. Annual Intervention Cost/Patient | $ 363 | $ 275 |
| D. Annual Intervention Cost (A x C) | $ 141,665 | $ 214,644 |
| E. Annual Charges (Baseline) | $ 478,620 | $ 957,239 |
| F. Annual Gross Savings (39.5% x E) | $ 189,007 | $ 378,013 |
| G. Variable Savings (F x 50%) | $ 94,503 | $ 189,007 |
| H. Annual Net Savings (G-D) | $ (47,162) | $ (25,637) |
| ROI (G/D) | 0.67 | 0.88 |

| NM RP: MedStar Montgomery Medical Center Care Transitions Program | CY16 | CY17 |
|---|---|---|
| A. Number of Patients | 390 | 780 |
| B. Number of Medicare and Dual Eligible | 258 | 515 |
| C. Annual Intervention Cost/Patient | $ 240 | $ 275 |
| D. Annual Intervention Cost (B x C) | $ 93,535 | $ 141,720 |
| E. Annual Charges (Baseline) | $ 402,245 | $ 804,490 |
| F. Annual Gross Savings (39.5% x E) | $ 158,846 | $ 317,693 |
| G. Variable Savings (F x 50%) | $ 79,423 | $ 158,846 |
| H. Annual Net Savings (G-D) | $ 8,563 | $ 17,126 |
| ROI (G/D) | 0.85 | 1.12 |

| NM RP: Shady Grove Adventist Hospital Care Transitions Program | CY16 | CY17 |
|---|---|---|
| A. Number of Patients | 942 | 1884 |
| B. Number of Medicare and Dual Eligible | 480 | 960 |
| C. Annual Intervention Cost/Patient | $ 325 | $ 246 |
| D. Annual Intervention Cost (A x C) | $ 305,910 | $ 463,500 |
| E. Annual Charges (Baseline) | $ 1,815,573 | $ 3,631,146 |
| F. Annual Gross Savings (39.9% x E) | $ 724,511 | $ 1,449,022 |
| G. Variable Savings (F x 50%) | $ 362,256 | $ 724,511 |
| H. Annual Net Savings (G-D) | $ 56,346 | $ 261,011 |
| ROI (G/D) | 1.18 | 1.56 |

| NM RP: Shady Grove Adventist Hospital Care Transitions Program | CY16 | CY17 |
|---|---|---|
| A. Number of Patients | 942 | 1884 |
| B. Number of Medicare and Dual Eligible | 480 | 960 |
| C. Annual Intervention Cost/Patient | $ 325 | $ 246 |
| D. Annual Intervention Cost (B x C) | $ 155,878 | $ 236,178 |
| E. Annual Charges (Baseline) | $ 925,133 | $1,850,266 |
| F. Annual Gross Savings (39.9% x E) | $ 369,178 | $ 738,355 |
| G. Variable Savings (F x 50%) | $ 184,589 | $ 369,178 |
| H. Annual Net Savings (G-D) | $ 28,711 | $ 132,999 |
| ROI (G/D) | 1.18 | 1.56 |

| NM RP: Suburban Hospital Care Transitions Program | CY16 | CY17 |
|---|---|---|
| A. Number of Patients | 1376 | 2751 |
| B. Number of Medicare and Dual Eligible | 757 | 1513 |
| C. Annual Intervention Cost/Patient | $ 175 | $ 133 |
| D. Annual Intervention Cost (A x C) | $ 240,636 | $ 364,600 |
| E. Annual Charges (Baseline) | $ 2,589,176 | $ 5,178,351 |
| F. Annual Gross Savings (14.4% x E) | $ 373,933 | $ 747,866 |
| G. Variable Savings (F x 50%) | $ 186,966 | $ 373,933 |
| H. Annual Net Savings (G-D) | $ (53,670) | $ 9,333 |
| ROI (G/D) | 0.78 | 1.03 |

| NM RP: Suburban Hospital Care Transitions Program | CY16 | CY17 |
|---|---|---|
| A. Number of Patients | 1376 | 2751 |
| B. Number of Medicare and Dual Eligible | 757 | 1513 |
| C. Annual Intervention Cost/Patient | $ 175 | $ 133 |
| D. Annual Intervention Cost (B x C) | $ 132,345 | $ 200,523 |
| E. Annual Charges (Baseline) | $1,424,000 | $2,847,999 |
| F. Annual Gross Savings (14.4% x E) | $ 205,656 | $ 411,313 |
| G. Variable Savings (F x 50%) | $ 102,828 | $ 205,656 |
| H. Annual Net Savings (G-D) | $ (29,517) | $ 5,133 |
| ROI (G/D) | 0.78 | 1.03 |

| NM RP: Washington Adventist Hospital Care Transitions Program | CY16 | CY17 |
|---|---|---|
| A. Number of Patients | 630 | 1260 |
| B. Number of Medicare and Dual Eligible | 210 | 420 |
| C. Annual Intervention Cost/Patient | $ 325 | $ 244 |
| D. Annual Intervention Cost (A x C) | $ 205,000 | $ 307,500 |
| E. Annual Charges (Baseline) | $ 1,214,236 | $ 2,428,474 |
| F. Annual Gross Savings (39.9% x E) | $ 484,545 | $ 969,091 |
| G. Variable Savings (F x 50%) | $ 242,272 | $ 484,546 |
| H. Annual Net Savings (G-D) | $ 37,272 | $ 177,046 |
| ROI (G/D) | 1.18 | 1.58 |

| NM RP: Washington Adventist Hospital Care Transitions Program | CY16 | CY17 |
|---|---|---|
| A. Number of Patients | 630 | 1260 |
| B. Number of Medicare and Dual Eligible | 210 | 420 |
| C. Annual Intervention Cost/Patient | $ 322 | $ 244 |
| D. Annual Intervention Cost (B x C) | $ 67,650 | $ 102,500 |
| E. Annual Charges (Baseline) | $ 404,745 | $ 809,491 |
| F. Annual Gross Savings (39.9% x E) | $ 161,515 | $ 323,030 |
| G. Variable Savings (F x 50%) | $ 80,757 | $ 161,515 |
| H. Annual Net Savings (G-D) | $ 13,107 | $ 59,015 |
| ROI (G/D) | 1.19 | 1.58 |

## Appendix G

**Decision Point Matrix for Nexus Montgomery Regional Partnership Operating Agreement [Working Draft as of 12/15/15]**

| Section Reference | Topic | Provision | HMA Comments | Hospital Comments/Feedback |
|---|---|---|---|---|
| I.A.1 | Independent Contractors | The Parties to this Operating Agreement are independent legal entities. Except as described herein, nothing in this Operating Agreement shall be construed or deemed to create between them any relationship of employer to employee, principle and agent, partnership, joint venture, or any relationship other than that of independent parties. No Party to this Operating Agreement shall be required to assume or bear any responsibility for the acts and omissions, or any consequences thereof of any other Party, and shall not be liable to other persons for any act or omission of another Party in performance of their respective responsibilities under this Operating Agreement. | *This affirms each Party is a separate legal entity and as such, are not liable for the actions of another Party* | |
| I.A.2 | Independent Contractors | The Parties maintain the right to enter into agreements and arrangements with other providers. | | |
| I.A.3 | Independent Contractors | None of the Parties are obligated to refer patients to other Nexus Montgomery Regional Partnership (NM RP) Parties. | | |
| I.A.3.a | Independent Contractors | NM RP Party patients retain the freedom to obtain healthcare treatment from any other providers, including those that are not participating in the NM RP. | | |
| I.B.1 | Independent Compliance with Laws and Licensing | It is the responsibility of each of the Parties to independently comply with applicable federal, state and local laws, rules and regulations regarding the provision and delivery of health care services under this Operating Agreement. | | |

| Section Reference | Topic | Provision | HMA Comments | Hospital Comments/Feedback |
|---|---|---|---|---|
| I.B.2 | Independent Compliance with Laws and Licensing | Each Party shall be responsible for the licensing and credentialing of its providers and other staff involved in the implementation, ongoing performance and maintenance of the Clinical Initiatives | *The Clinical Initiatives are the clinical programs, interventions, etc. the NM RP unanimously approved* | |
| I.B.2.a | Independent Compliance with Laws and Licensing | The Parties represent and agree that each Party is in full compliance with all applicable laws, including licensing laws. | | |
| I.B.2.b | Independent Compliance with Laws and Licensing | Subject to legal privileges, a Party will provide the other Parties with immediate notification of any material violation of applicable laws and any action to suspend, revoke or restrict its license(s). | | |
| **I.C.1** | Maintenance of Professional Liability Insurance | The Parties agree to at all times maintain professional liability insurance in the amount of [determine $ amount] U.S. $____ per occurrence; $____ in aggregate. | *To be agreed upon by the parties* | |
| I.C.2 | Maintenance of Professional Liability Insurance | No Party to this Operating Agreement shall be liable for any negligent or wrongful acts, either of commission or omission, chargeable to the other, unless such liability is imposed by law. This Operating Agreement shall not be construed as seeking either to enlarge or diminish any obligation or duty owed by one Party to the other or to a third Party. | *Reiterates the Operating Agreement confers no legal duties or obligations on the Parties* | |

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| Section Reference | Topic | Provision | HMA Comments | Hospital Comments/Feedback |
|---|---|---|---|---|
| I.D.1 | NM RP Governing Board: General Powers | The Board is responsible for the oversight and governance of the NM RP and the related Clinical Initiatives, and any other initiatives the Board may approve. | *Governing body decides direction of the organization, establishes priorities, sets policies, selects and oversees management, and evaluates the performance of the organization as a whole. Management is accountable to the governing body for the operation and performance of the organization.* | |
| I.D.2 | Board Formation and Composition | The initial Board (first year) will be comprised of six Board seats, with up to nine seats thereafter and each NM RP Hospital shall hold one Board seat. Board Directors will be appointed within twenty (20) business days of execution of the Operating Agreement. The Board will elect a Chairperson. | *NM RP could select Chair unanimously or have a system in place (Chair is rotated among the Parties)* | |
| I.D.2.a | Election of Board Officers | Board will have four officers (Chair, Vice Chair, Treasurer and Secretary) elected by the directors<br>• One officer from each system<br>• One year term each, elected annually up to three terms | | |

| Section Reference | Topic | Provision | HMA Comments | Hospital Comments/Feedback |
|---|---|---|---|---|
| **I.D.2.b** | Board Formation and Composition | Representatives appointed to serve on the Board shall be [describe basic requirements for Board Directors] and will serve without compensation, unless the Board determines otherwise. | *Recommend that Directors are administrative and/or clinical leaders* | |
| I.D.2.c | Board Directors' Responsibilities | Board Directors responsibilities include:<br>• Be active participants in meetings and work to build good will and trust among colleague members based on current partnership<br>• Participate in and evaluate governance actions based on the benefit to the partnership and the community, not only your hospital<br>• Be purposeful in soliciting and providing input<br>• Work towards defined shared goals<br>• Representatives involved in governance and committees are decision makers and empowered to act on behalf of the organizations they represent<br>• Respect time commitments by starting and ending meetings on time<br>• Respect deadlines agreed upon and communicate clearly barriers to meeting deadline<br>• Educate colleagues about priorities and new programs<br>• Identify opportunities and be open to redesign or repurpose of existing resources<br>• Look for opportunities to include all-payers in potential financing of the partnership<br>• Set clear and realistic expectations for each partner<br>• Explore the potential consequences of any payment reform on each partner | | |

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| Section Reference | Topic | Provision | HMA Comments | Hospital Comments/Feedback |
|---|---|---|---|---|
| I.D.2.d | Conflict of Interest | In order to ensure transparent communication and foster the partnership, Board Directors agree to<br>Declare any personal or professional conflicts related to employment, business interests or financial gains as related to NM RP | | |
| I.E.1 | Resignation of Board Director | A Board Director may resign at any time. Notice must be given to the other Board Directors by the organization represented by the former Board Director prior to the effective date of the Director's resignation if possible or as soon as possible.<br><br>The organization represented by the resigning Board Director must appoint a new Board Director. An interim Director may be appointed until a new Board Director is designated. | *I would suggest we include a time for replacement named (i.e. 14 days) - Karen* | |
| I.F.1 | Appointment of a Proxy | A Party may appoint a proxy to attend a regular or special meeting of the Board if that Party's Board representative is unable to attend due to an unavoidable conflict or other reasonable circumstance. Each Party will select a proxy in advance of the first meeting of the Board. | | |
| I.F.2 | Proxy Voting Rights | If a Director is unable to attend a Board Meeting at which a decision(s) requires a vote of the Board, the designated proxy may vote on behalf of the Director and the organization he/she represents. | | |
| I.F.3 | Obligation to Keep Proxy Informed | Board Directors agree to keep their proxy sufficiently apprised of Board meetings, agendas, minutes, decisions and other actions as needed to optimize the proxy's ability to meaningfully participate in Board meetings when required. | | |
| I.F.4 | Proxy Attendance at Board Meetings | A proxy may not attend a Board meeting unless his/her participation is required or he/she are invited by the Board. | | |

| Section Reference | Topic | Provision | HMA Comments | Hospital Comments/Feedback |
|---|---|---|---|---|
| II.A.1 | Voting Rights | Each Board Director will be entitled to cast one vote upon each matter submitted to vote at a meeting of the Board. | | |
| II.A.2 | Voting & Decision-making Requirements | *Unanimous* Votes are required for the following:<br>• Administrative/Governance<br>  ○ Management Agreement<br>  ○ Participation Agreement<br>  ○ Voting rights among RP Parties, Quorum requirements (any changes)<br>  ○ Removal of an RP Party (without the partner in question)<br>  ○ Addition of a Party to the RP<br>  ○ Formation of a joint venture with a third Party<br>  ○ Evolution of the NM RP to a legal entity<br>• Project Approval (intervention and infrastructure)<br>  ○ To include scope, resources, scale and geography (who, how, what and where), RP Party roles, responsibilities, performance expectations, reporting, etc. | | |

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| Section Reference | Topic | Provision | HMA Comments | Hospital Comments/Feedback |
|---|---|---|---|---|
| II.A.3 | Voting & Decision-making Requirements | *Super-Majority Votes* (based on a six Director Board requires five votes) for the following:<br>• Administrative/Governance<br>  ○ Termination of the Nexus Montgomery Operating Agreement<br>  ○ Amendments to Operating, Management or Participation agreements<br>  ○ Termination of Operating, Management or Participation agreements<br>  ○ Vendor contracts<br>  ○ Marketing/Communications activities, materials and branding specific to the NM RP<br>• Financial<br>  ○ Budget<br>  ○ Budget revisions<br>• Clinical Integration Programs/Implementation<br>  ○ Definition and eligibility criteria for target patient population<br>  ○ New processes, workflows and tools of any substance<br>  ○ Metrics/measures that will be used to monitor performance<br>  ○ Contingency and sustainability plans for the clinical initiative(s) | | |

| Section Reference | Topic | Provision | HMA Comments | Hospital Comments/Feedback |
|---|---|---|---|---|
| III.A.1 | Board Meetings | During the first year, Board meetings will be conducted in person and the Board will meet ten times per year<br>• Board Directors are expected to attend a minimum of 75% of the in-person meetings<br>• Proxies may attend up to 25% of the Board meetings (in place of a Director)<br>The time and place for the Board meetings will be established by a consensus of the Board. | *We recommend time and place be determined by consensus* | |
| III.A.1.a | Annual Board Meeting | An Annual Meeting will be held (one of the ten regularly scheduled Board meetings) where the following will take place:<br>• Election of Board Directors<br>• Review of previous year's performance including finances, quality and strategic direction | | |
| III.A.1.b | Special Board Meetings & Notice | In the event a special meeting must be called in between one of the regularly scheduled Board meetings, the chair may convene a meeting with at minimum 5 business days' notice; the meeting may be held via teleconference or web based | | |
| III.A.1.c | Board Meetings and Quorum | Quorum for the Board will be comprised of attendance of five of the six directors | | |
| III.A.1.d | Board Meetings Invitees to Board Meetings | Any guests will be approved by the chair and named in the meeting agenda | | |
| III.A.1.e | Board Meetings and Quorum – Meeting Minutes | Minutes will be taken at each meeting of the Board, including regular and special meetings of the Board. | | |

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| Section Reference | Topic | Provision | HMA Comments | Hospital Comments/Feedback |
|---|---|---|---|---|
| IV.A.1 | Board Committees and Advisory and Work Groups- Structure | Three committees will be formed to support the Board and inform Board decision-making: *Partnership Program Intervention Committee* (P-PIC), a *Finance Committee, and a Physician Advisory Board*<br>• Require at minimum one Board Director and preferably two, participate in each committee<br>• The committees will not have the authority to make decisions binding the Regional Partnership. The Committees will make recommendations to the Board, which will be the ultimate decision-maker for the Regional Partnership.<br>Advisory and Work Groups may be formed as needed to support the RP and Board decision-making with approval by the Board | *Within three months of execution of the Operating Agreement, a Physician Advisory Board comprised of a scope of provider types to foster communication venues, engage physicians, advise the Board and inform work of the committees will be formed* | |
| IV.A.1.a | Board Committees – Meetings & Attendance | Committees will meet in-person ten times per year<br>• Committee members are expected to attend at minimum 75% of the in-person meetings<br>• Proxies may not participate in more than 25% of committee meetings | | |
| IV.A.1.b | Board Committees – Special Meetings | With the approval of the Chair and with at minimum 5 business days' notice, if a special meeting must be called in between one of the regularly scheduled committee meetings, it may be held via teleconference or web based | | |
| IV.A.1.c | Board Committees – Authority | Committees will have no delegated authority, however are to make specific recommendations to the Board for approval; any recommendation to the Board must include information needed to make an informed decision | | |

| Section Reference | Topic | Provision | HMA Comments | Hospital Comments/Feedback |
|---|---|---|---|---|
| IV.A.1.d | Appointment of a Proxy to Attend a Meeting of the Committee | Each committee member will select in advance, one proxy who will attend the in-person meeting in the event the member is not able to participate; it is the member's responsibility to keep his or her designated proxy up to date on activities of the committee | | |
| IV.B.1 | Finance Committee – Structure | The *Finance Committee* is to be chaired by the Board Treasurer and will be comprised of one appointee from each hospital | | |
| IV.B.1.a | Finance Committee – Recommendations to the Board | Any recommendation to be brought to the Board must be approved a super-majority (at least five votes) of the committee | | |
| IV.B.1.b | Finance Committee – Responsibilities | Finance Committee responsibilities include monitoring and recommendations to the Board related to:<br>• Financial and resource oversight<br>• Recommends the budget to the Board for approval<br>• Serves as the "audit" committee of the Board, if needed<br>• Determines financial viability of proposed project(s) and sustainability post-implementation<br>• Evaluates and recommends potential funding opportunities and mechanisms to the Board<br>• Reviews and monitors contracts, insurance needs/policies | | |
| IV.C.1 | P-PIC Committee – Structure | The *Partnership Program Interventions Committee (P-PIC)* is to be chaired by a Board Director; hospitals will encourage participation on the committee by community partners | | |

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| Section Reference | Topic | Provision | HMA Comments | Hospital Comments/Feedback |
|---|---|---|---|---|
| IV.C.1.a | P-PIC Committee – Structure | Each hospital will appoint one designated committee member and community partners will be offered up to 5 committee seats, pending Board approval | | |
| IV.C.1.b | P-PIC Committee - Recommendations to the Board | Any recommendations to be brought to the Board must be approved by a super-majority (two-thirds) vote of the committee | | |
| IV.C.1.c | P-PIC Committee - Responsibilities | *Partnership Program Intervention Committee* responsibilities include:<br>• Developing key performance and outcome metrics to be recommended to the Board<br>• Monitor key performance and outcome metrics as approved by the Board, including: population health data, access to care, and numbers served<br>• Monitor any needed continuous quality improvement initiatives<br>• Evaluating and recommending proposed projects, developing materials for Board discussion (includes both new and ongoing projects) and ensures the Board has the information needed to make an informed decision | | |
| **TBD** | Management Entity – Support Governing Body & Manage Clinical Initiatives | The Parties have agreed to retain the services of a Management Entity to manage the day-to-day operations of the NM RP and to each contribute [$___] to fund the start-up of the NM RP upon execution of this Operating Agreement. The method and process will be determined. | | |

| Section Reference | Topic | Provision | HMA Comments | Hospital Comments/Feedback |
|---|---|---|---|---|
| **TBD** | Management Entity – Evaluation & Best Practices | • Support NM RP Governance Board and Partnership Program Interventions Committee in their assessment of progress on program ROI targets; draft plans for program changes; alert on special populations or challenges to address through shared RP programs<br>• Evaluation: common data collection and evaluation of ROI for all programs in RP, including the independent hospital Care Transition programs funded under RP<br>• Best practices: literature review and interviews of similar programs; distribute condensed updates on promising and best practices<br>• Support Partnership Program Interventions Committee: engage consultants and/or provide analysis for new and existing program planning | | |

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| Section Reference | Topic | Provision | HMA Comments | Hospital Comments/Feedback |
|---|---|---|---|---|
| **TBD** | Management Entity – Implementation & Operations of Shared Programs, Projects and RP Infrastructure | • Employ staff for shared program and project functions, as well as RP infrastructure (fiscal and administrative, evaluation and best practices)<br>• Contractor Management: on behalf of the RP, issue RFPs and make recommendations to the RP Governance Board for care management and other program vendors. Manage contracting, invoicing, payment. Performance monitoring of vendors. Develop shared risk contracting terms with vendors in later years, if possible<br>• Stakeholder Engagement: Specific to shared RP programs and projects, engage stakeholders and partners (EMS, Sr. Living, PCPs, DHHS, patients & families)<br>• Coordinate with in-kind hospital resources. E.g. data collection, IT, care plans | | |

| Section Reference | Topic | Provision | HMA Comments | Hospital Comments/Feedback |
|---|---|---|---|---|
| **TBD** | Management Entity – Implementation & Operations of Shared Programs, Projects and RP Infrastructure | • Employ staff for shared program and project functions, as well as RP infrastructure (fiscal and administrative, evaluation and best practices)<br>• Contractor Management: on behalf of the RP, issue RFPs and make recommendations to the RP Governance Board for care management and other program vendors. Manage contracting, invoicing, payment. Performance monitoring of vendors. Develop shared risk contracting terms with vendors in later years, if possible<br>• Stakeholder Engagement: Specific to shared RP programs and projects, engage stakeholders and partners (EMS, Sr. Living, PCPs, DHHS, patients & families)<br>Coordinate with in-kind hospital resources. E.g. data collection, IT, care plans | | |
| **VI.A.1** | Records & Confidential Information – Confidential Information | The Parties agree to protect against the unauthorized disclosure of Confidential Information that may be shared by and among the Parties. The term "Confidential Information" refers to proprietary business information of any Party, including information pertaining to costs, charges, and otherwise deemed confidential by the Board with respect to the Nexus Montgomery Regional Partnership parties and activities. Nothing in this provision shall be construed as prohibiting the Parties from sharing information with each other and a patient regarding healthcare or other services, to the extent allowable under applicable law. Notwithstanding the above, a Party may be compelled to disclose information by law, as prescribed by the Freedom of Information Act. | | |

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| Section Reference | Topic | Provision | HMA Comments | Hospital Comments/Feedback |
|---|---|---|---|---|
| VI.A.1.a | Records & Confidential Information – Exchange, Use and Disclosure of Patient Health Records and Privacy of Protected Health Information | It is the intention of the Parties that the use and disclosure of protected health information ("PHI") by and among the Parties be consistent with the Health Insurance Portability and Accountability Act of 1996, as amended, and it's implementing regulations (collectively "HIPAA"). | | |
| VI.A.1.b | Records & Confidential Information – Exchange, Use and Disclosure of Patient Health Records and Privacy of Protected Health Information | The Parties agree to enter into a Business Associate Agreement ("BAA") and take actions required to comply applicable privacy laws, including but not limited to HIPAA.<br>• If any of the Parties performs any Business Associate functions, as defined by HIPAA, then any such Parties agree to enter into a Business Associate Agreement. The Parties will each enter into a BAA with a non-covered entity with which it is sharing PHI, if required to maintain compliance with HIPAA and other laws. | | |

| Section Reference | Topic | Provision | HMA Comments | Hospital Comments/Feedback |
|---|---|---|---|---|
| VI.A.1.c | Records & Confidential Information – Exchange, Use and Disclosure of Patient Health Records and Privacy of Protected Health Information | It is the intention of the Parties to comply with applicable federal and state confidentiality laws and regulations governing records for the treatment of substance use disorders (SUDs), including but not limited to the exchange, use and disclosure of patients' SUD records among the Parties. This provision will be revised to include processes for ensuring compliance with applicable confidentiality laws and regulations, including 42 CFR Part 2, as the Clinical Initiatives are implemented. The Parties agree to enter into any agreements that may be required by law to protect the exchange, use and disclosure of patients' SUD medical records among the Parties and to utilize such processes, policies, forms, and authorizations as may be required under applicable law to carry out such exchange.<br>• The Parties may be required to enter into Qualified Service Organization ("QSO") Agreements for the disclosure of SUD records.<br>• Under a QSO Agreement, the Parties agree:<br>    ○ In receiving, storing, processing or otherwise dealing with any SUD information it shall be fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2;<br>    ○ If necessary, the Parties will resist in judicial proceedings any efforts to obtain access to SUD information unless access is expressly permitted under 42 C.F.R. Part 2; and<br>    ○ Acknowledge that any unauthorized disclosure of SUD information under this section is a federal criminal offense. | | |

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| Section Reference | Topic | Provision | HMA Comments | Hospital Comments/Feedback |
|---|---|---|---|---|
| **VI.A.1.d** | Records & Confidential Information – Exchange, Use and Disclosure of Patient Health Records and Privacy of Protected Health Information | It is the intention of the Parties to comply with applicable federal and state confidentiality laws and regulations governing records for the treatment of mental health conditions, including but not limited to developmental disabilities. The Parties agree to enter into any agreements that may be required by law to protect the exchange, use and disclosure of patients' mental records among the Parties. | | |
| VII.A.1 | Term & Termination | This Operating Agreement is effective as of upon full execution and shall continue in effect until terminated by the Parties. | | |
| VII.A.1.a | Term & Termination – Termination of this Operating Agreement | The Parties may unanimously agree to terminate this Operating Agreement at any time and cease adherence to the terms herein and participation in the Clinical Initiatives. The process(es) for terminating the Project will be determined by and mutually agreed upon by the Parties. | | |

| Section Reference | Topic | Provision | HMA Comments | Hospital Comments/Feedback |
|---|---|---|---|---|
| VII.A.1.b | Term & Termination – Contractually Binding Obligations Should A Party Terminate Participation in the Operating Agreement | A Party may terminate its participation in the NM RP and adherence to the terms of this Operating Agreement. Parties agree if a Party decides to terminate its participation in the NM RP, the Party will give the other Parties ninety (90) days written prior to the beginning of the budget year on July 1. Once a Party is committed to the NM RP at the start of a budget year (July 1), a Party will be committed to the NM RP for the entire budget year (through and including June 30 of the following year). During the ninety-day (90) notice period, the Party terminating its participation in the NM RP agrees to continue to participate in existing NM RP programs, but the Party will not be permitted to participate in Board meetings, voting and any other decision-making processes. | | |
| VII.A.1.c | Term & Termination – Contractually Binding Obligations Should A Party Terminate Participation in the Operating Agreement | The Board will abide by the terms of the Operating Agreement and votes of the Board made prior to the notice of termination during the notice period and refrain from making decisions that require additional commitments from the withdrawing NM RP Party organization. | | |

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| Section Reference | Topic | Provision | HMA Comments | Hospital Comments/Feedback |
|---|---|---|---|---|
| VII.A.1.d | Term & Termination – Contractually Binding Obligations Should A Party Terminate Participation in the Operating Agreement | The Parties agree that in the event a Party terminates its participation in the NM RP and adherence to the terms of this Operating Agreement, the terminating Party shall continue to fulfill the role(s) and perform activities assigned to the Party as set forth in the NM RP Clinical Initiatives for the notice period of 90 days unless otherwise determined by the Board. | | |
| **VIII.A.1** | Amendments | This Operating Agreement may be amended at any time to add and/or revise the terms, provided the amendment is voted upon and approved by a supermajority vote of the Board. | | |
| **VIII.A.2** | Amendments | This Operating Agreement may be superseded through mutual agreement by the Parties, documented in writing. This would include, but not be limited to, any contractual arrangement subsequently agreed upon jointly between the Parties. | | |

# Appendix H: NM RP Letters of Support from Partners

Senior Living Communities

- Housing Opportunities Commission of Montgomery County
- AHC, Inc. (Charter House)
- Asbury Methodist Village
- Brooke Grove Foundation
- Charles E. Smith Life Communities
- Homecrest House
- National Lutheran Communities and Services (The Village at Rockville)
- Victory Housing

County Government

- Montgomery County Department of Health and Human Services (two letters)
- Montgomery County Fire and Rescue

Other Partners

- LifeSpan Network
- Montgomery County Medical Society
- VHQC

10400 Detrick Avenue
Kensington, MD 20895-2484
(240) 627-9400

November 5, 2015

Steve Ports
Deputy Director
HSCRC
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Ports:

The Housing Opportunities Commission (HOC) of Montgomery County enthusiastically supports the proposal being submitted by the *Nexus* Montgomery Regional Partnership to implement a Community-Based Care Management Program for seniors. This program will be provided to Medicare beneficiaries aged 65 and older who live in independent living facilities. We have participated in the program design and believe the program can help to improve the health status of frail seniors.

The project has brought together a wide range of community stakeholders who are working collaboratively to help develop and implement a care coordination and health improvement model for individuals at risk of hospitalization. We understand the care management vendor, The Coordinating Center, provides evidence based care management aimed at coordinating services that can help to improve resident's health status and reduce unnecessary health service utilization, including emergency room, observation, and inpatient.

Our organization provides affordable housing and programs to low- and moderate-income families and individuals throughout Montgomery County, impacting the lives of over 2,000 seniors. Approximately half of those seniors reside in subsidized independent living communities with on-site Resident Counselors who provide information and referral, crisis intervention and service coordination, as well creating an environment that promotes socialization, health and wellness for residents with the assistance of third party organizations and businesses.

We are committed to working with the *Nexus*Montgomery Regional Partnership, the Primary Care Coalition and The Coordinating Center to make the program available to residents at HOC's seven elderly sites around the county. This will include sending Resident Counselors to a training session and referring frail seniors for risk assessment. We look forward to the implementation of this Community Based Care Management Program that has a tremendous opportunity to improve cost effective care for seniors in our community.

Sincerely yours,

Fred Swan
Resident Services Division Director

An Affordable
Housing Corporation

November 11, 2015

Steve Ports
Deputy Director
HSCRC
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Ports:

We enthusiastically support the proposal being submitted by the *Nexus* Montgomery Regional Partnership to implement a Community-Based Care Management Program for Seniors. This program will be provided to Medicare beneficiaries aged 65 and older who live in independent living facilities. We have participated in the program design and believe the program can help to improve the health status of frail seniors.

The project has brought together a wide range of community stakeholders who are working collaboratively to help develop and implement a care coordination and health improvement model for individuals at risk of hospitalization. We understand the care management vendor, The Coordinating Center, provides evidence based care management aimed at coordinating services that can help improve residents' health status and reduce unnecessary health service utilization, including emergency room, observation, and inpatient visits.

AHC Inc. provides affordable housing and care to over 200 seniors living at The Charter House. Charter House is an age-restricted (55+), community in downtown Silver Spring. The property includes a mix of incomes with three quarters of the apartments reserved for income qualified residents. The remaining 25% of the apartments are market rate. On-site Resident Services staff provide programs and activities for residents including case management for seniors needing services to age in place.

We are committed to working with the *Nexus*Montgomery Regional Partnership, the Primary Care Coalition and The Coordinating Center to make the program available to residents at Charter House. This will include sending resident counselors to a training session and referring frail seniors for risk assessment. We look forward to the implementation of this Community Based Care Management Program that has a tremendous opportunity to improve cost effective care for seniors in our community.

Very truly yours,

Jennifer Endo
Director, Resident Services

2230 North Fairfax Drive Suite 100 Arlington, Virginia 22201
Phone 703.486.0626 Fax 703.486.0653 www.ahcinc.org

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ASBURY Methodist Village
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December 2, 2015

Steve Ports
Deputy Director
HSCRC
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Ports:

We enthusiastically support the proposal being submitted by the *Nexus* Montgomery Regional Partnership to implement a Community-Based Care Management Program for Seniors. This program will be provided to Medicare beneficiaries aged 65 and older who live in independent living facilities. We continue to participate in the program design and believe the program will help to improve the health status of frail seniors.

The project has brought together a wide range of community stakeholders who are working collaboratively to help develop and implement a care coordination and health improvement model for individuals at risk of hospitalization. We are anxious to finalize the details of the program oversight. The expertise Asbury Methodist Village has in serving seniors would be beneficial to the planning and management of the program. We see ourselves as stakeholders in Nexus Montgomery and are committed to the program's success and ultimately the benefits these services will bring to those we collectively serve in Montgomery County. We understand the care management vendor, The Coordinating Center, provides evidence based care management aimed at coordinating services that can help to improve resident's health status and reduce unnecessary health service utilization, including emergency room, observation, and inpatient.

Our organization provides care and housing to over 1,000 seniors in independent living. As the 14th largest not-for-profit Continuing Care Retirement Community in the country, we provide a wide array of services to the 1400 residents that live across the campus. We also offer on-site physician services through Holy Cross Health Partners, outpatient rehabilitation services through Rehab 1st, on campus pharmacy through CVS, and in-house Home Health and Home Care services.

We stand committed to working with the *Nexus*Montgomery Regional Partnership, the Primary Care Coalition and The Coordinating Center to make the program available to residents in our community. This will include sending resident counselors to a training session and referring frail seniors for risk assessment.

We look forward to the collaborative implementation of this Community Based Care Management Program that has a tremendous opportunity to improve cost effective care for seniors in our community.

Sincerely,

Henry R. Moehring, MBA, LNHA
Executive Director

**BROOKE GROVE FOUNDATION, INC.**
18100 Slade School Road
Sandy Spring, MD 20860
Phone: 301-924-2811
Fax: 301-924-1200
E-mail: bgrv@bgf.org

**Brooke Grove Retirement Village**

*The Cottages Independent Living*
301-260-2300

*The Meadows Assisted Living*
301-924-1228

*The Woods Assisted Living*
301-924-3877

*Brooke Grove Rehabilitation and Nursing Center*
301-924-5176

**Other Campuses**

*Williamsport Retirement Village*
154 North Artizan Street
Williamsport, MD 21795
301-223-7971

*Rest Assured Living Center*
1137 Shirley's Hollow Road
Meyersdale, PA 15552
814-634-0567

December 2, 2015

Steve Ports
Deputy Director
HSCRC
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Ports:

The Brooke Grove Foundation enthusiastically supports the proposal being submitted by the *Nexus* Montgomery Regional Partnership to implement a Community-Based Care Management Program for Seniors. This program will be provided to Medicare beneficiaries aged 65 and older who live in independent living facilities. We have participated in the program design and believe the program can help to improve the health status of frail seniors.

The project has brought together a wide range of community stakeholders who are working collaboratively to help develop and implement a care coordination and health improvement model for individuals at risk of hospitalization. We understand the care management vendor, The Coordinating Center, provides evidence based care management aimed at coordinating services that can help to improve resident's health status and reduce unnecessary health service utilization, including emergency room, observation, and inpatient.

The Brooke Grove Foundation provides care and housing to over 250 plus seniors, with our Independent Living housing some 50 plus residents. It is our goal to promote the health and well-being of our independent living residents and we feel that utilizing the services of the *Nexus*Montgomery Regional Partnership, the Primary Care Coalition, and The Coordinating Center would help us in that aim.

We are committed to working with the *Nexus*Montgomery Regional Partnership, the Primary Care Coalition, and The Coordinating Center to make the program available to residents in our facility. This will include sending resident counselors to a training session and referring frail seniors for risk assessment. We look forward to the implementation of this Community Based Care Management Program that has a tremendous opportunity to improve cost effective care for seniors in our community.

Sincerely,

Larry Willett
Director
Independent Living

# Charles E. Smith Life Communities

HEBREW HOME OF GREATER WASHINGTON • WASSERMAN & SMITH-KOGOD RESIDENCES
COHEN-ROSEN HOUSE • ELDERSAFE CENTER • HIRSH HEALTH CENTER
LANDOW HOUSE • REVITZ HOUSE • RING HOUSE


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**President, Cohen-Rosen House/ Landow House Revitz House Ring House**
Aaron M. Rulnick

**Chair, Charles E. Smith Life Communities Trustees Funds, Inc.**
Eric G. Meyers

*Beneficiary Agency*
United Way/CFC

November 9, 2015

Steve Ports
Deputy Director
HSCRC
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Ports:

We enthusiastically support the proposal being submitted by the *Nexus* Montgomery Regional Partnership to implement a Community-Based Care Management Program for Seniors. This program will be provided to Medicare beneficiaries aged 65 and older who live in independent living facilities. We have participated in the program design and believe the program can help to improve the health status of frail seniors.

The project has brought together a wide range of community stakeholders who are working collaboratively to help develop and implement a care coordination and health improvement model for individuals at risk of hospitalization. We understand the care management vendor, The Coordinating Center, provides evidence based care management aimed at coordinating services that can help to improve resident's health status and reduce unnecessary health service utilization, including emergency room, observation, and inpatient.

Charles E. Smith Life Communities provides care and housing to over 1,100 seniors on our campus in Rockville, Maryland. We are pleased that our two two-hundred and fifty unit independent living residences, Ring House and Revitz House, participate in this program. The over five hundred residents will benefit from advanced care coordination.

We are committed to working with the *Nexus*Montgomery Regional Partnership, the Primary Care Coalition and The Coordinating Center to make the program available to residents in our facility. This will include sending resident counselors to a training session and referring frail seniors for risk assessment. We look forward to the implementation of this Community Based Care Management Program that has a tremendous opportunity to improve cost effective care for seniors in our community.

Sincerely,

Beth DeLucenay
Vice President, Planning


*6121 Montrose Road • Rockville, MD 20852*
*Tel 301.770.8448 • Fax 301.770.8309 • www.smithlifecommunities.org*
*www.facebook.com/CESLC* *www.twitter.com/ceslchhgw*

*B'nai B'rith*
Homecrest House *Caring and Supportive Residential Communities for Older Adults*

14508 HOMECREST ROAD
SILVER SPRING, MARYLAND 20906-1801
Website: www.homecresthouse.org

301-598-4000 / TTY 711
301-598-6485 FAX
Email: office@homecresthouse.org

November 8, 2015

Steve Ports
Deputy Director
HSCRC
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Ports:

I and our very low-income residents and their families of Homecrest House enthusiastically support the proposal being submitted by the *Nexus* Montgomery Regional Partnership to implement a Community-Based Care Management Program for Seniors. This program will be provided to Medicare beneficiaries aged 65 and older who live in independent living facilities. We have participated in the program design and believe the program can help to improve the health status of frail seniors.

The project has brought together a wide range of community stakeholders who are working collaboratively to help develop and implement a care coordination and health improvement model for individuals at risk of hospitalization. We understand the care management vendor, The Coordinating Center, provides evidence based care management aimed at coordinating services that can help to improve resident's health status and reduce unnecessary health service utilization, including emergency room, observation, and inpatient.

**Homecrest House is a not-for-profit, non-denominational community dedicated to providing affordable housing and quality services to extremely low-income seniors in Montgomery County, Maryland. The campus is comprised of three buildings on 10 acres with 277 subsidized apartments.**

**The first two buildings, Stein and Moskowitz (built in 1979 and 1985) provide "independent" affordable housing; they do not provide any health care related supportive services. We do have a Resident Services Manager to help in minimal coordination of a variety of services and advocacy. As these residents were aging and needing assistance, without an affordable housing community that could also provide affordable services, they tragically had to move to skilled nursing home settings. The result was usually debilitating to their mental and physical health. Consequently, the Homecrest House Board of Directors entered into agreements with several State and County agencies to construct a building that would provide minimal care support to the residents for personal care services with affordable housing.**

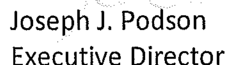
**Thus our third building, The Edwards, opened in 1990 for seniors who no longer were able to live independently, but did not need a nursing home with LIMITED personal care subsidized. Over 25% of our total population is at Federal Poverty levels) personal care.**

**Our mission is to provide seniors of extremely limited income with supportive, affordable housing in order to maintain their independence and a distinctive quality of life. We do NOT have the adequate staff to do more than try to oversee the roller-coaster of transportation to the hospital to rehab and hen back to the hospital and then sooner than later to a nursing home.**

We are committed to working with the *Nexus*Montgomery Regional Partnership, the Primary Care Coalition and The Coordinating Center to make the program available to residents in our facility. This will include sending resident counselors to a training session and referring frail seniors for risk assessment. We look forward to the implementation of this Community Based Care Management Program that has a tremendous opportunity to improve cost effective care for seniors in our community.

**Help us to help the frail – independent elders who have no funds to have more care to keep them out of pre-mature institutionalization (nursing homes).**

Best regards,



Joseph J. Podson
Executive Director

A National Lutheran Community

November 10, 2015

Steve Ports, Deputy Director
HSCRC
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Ports:

We enthusiastically support the proposal being submitted by the *Nexus* Montgomery Regional Partnership to implement a Community-Based Care Management Program for Seniors. This program will be provided to Medicare beneficiaries aged 65 and older who live in independent living facilities. We have participated in the program design and believe the program can help to improve the health status of frail seniors.

The project has brought together a wide range of community stakeholders who are working collaboratively to help develop and implement a care coordination and health improvement model for individuals at risk of hospitalization. We understand the care management vendor, The Coordinating Center, provides evidence based care management aimed at coordinating services that can help to improve resident's health status and reduce unnecessary health service utilization, including emergency room, observation, and inpatient.

The Village at Rockville (TVAR) provides care and housing to over 300 seniors. We are a CCRC (continuing care retirement community) that offers independent living, myPotential short-term rehabilitation, respite, long-term nursing care, hospice, assisted living and memory support. TVAR has provided seniors with a variety of lifestyle, residential and health care options for over 125 years.

We are committed to working with the *Nexus*Montgomery Regional Partnership, the Primary Care Coalition and The Coordinating Center to make the program available to residents in our facility. This will include sending resident counselors to a training session and referring frail seniors for risk assessment. We look forward to the implementation of this Community Based Care Management Program that has a tremendous opportunity to improve cost effective care for seniors in our community.

Sincerely,

Jason Gottschalk
Executive Director

Celebrating 125 years of service, The Village at Rockville is sponsored by National Lutheran Communities & Services,
a faith-based, not-for-profit ministry of the Evangelical Lutheran Church in America serving people of all beliefs.

Address: 9701 Veirs Drive • Rockville, MD 20850 • Phone: 301.424.9560 • Fax: 301.424.9574 • Web: www.thevillageatrockville.org

November 10, 2015

Mr. Steve Ports
Deputy Director
HSCRC
4160 Patterson Avenue
Baltimore, MD 21215

**RE: COMMUNITY-BASED CARE MANAGEMENT PROGRAM FOR SENIORS (CbCS) – LETTER OF SUPPORT**

Dear Mr. Ports:

We enthusiastically support the proposal being submitted by the *Nexus* Montgomery Regional Partnership to implement a Community-Based Care Management Program for Seniors ("CbCS"). This program will be provided to Medicare beneficiaries aged 65 and older who live in independent living facilities. We have participated in the program design and believe the CbCS program can help to improve the health status of seniors who age in place in our apartment communities.

*Nexus* Montgomery Regional Partnership has brought together a wide range of community stakeholders who are working collaboratively to help develop and implement a care coordination and health improvement model for individuals at risk of hospitalization. We are informed by *Nexus* Montgomery that the proposed care management vendor, The Coordinating Center, provides evidence-based care management aimed at coordinating services that can help to improve resident health status and reduce unnecessary health service utilization, including emergency room, observation, and inpatient.

Victory Housing provides affordable housing and related social services to over 1,700 seniors annually, including approximately 1,200 seniors in eight independent living communities (850 apartments) and five assisted living residences (170 rooms) in Montgomery County. Over the past several years in our apartment communities, particularly for very-low-income seniors, we have been trying to tier on free or low-cost health services to allow our residents to maintain their health and age in place, as those residents have limited affordable housing options once they can no longer live independently and must leave our communities. As such, we see the CbCS program as an important new tool in helping us provide care services to our seniors.

We are committed to working with the *Nexus*Montgomery Regional Partnership, the Primary Care Coalition and The Coordinating Center to make the CbCS program available to the residents of our independent living communities and, with the support of HSCRC, we look forward to the implementation of the CbCS program in the near future. Thank you for your time and consideration.

Very truly yours,

James A. Brown, Jr.
President

11400 Rockville Pike, Suite 505 • Rockville, Maryland 20852
(301) 493-6000 • fax (301) 493-9788 • victoryhousing.org

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Isiah Leggett
*County Executive*

Uma S. Ahluwalia
*Director*

December 9, 2015

Mr. Steve Ports, Deputy Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Ports:

The Montgomery County Department of Health and Human Services (DHHS) is pleased to support the NexusMontgomery Regional Partnership (NMRP) proposal to Health Services Cost Review Commission for a regional transformation implementation grant. The NMRP program will improve health for seniors in our community and reduce their hospital costs, contributing to the aims of Maryland's new All-Payer Model.

All six hospitals in Montgomery County, senior housing facilities, DHHS, and many community organizations have come together to create this NMRP program with a health care coordination intervention that promises to stabilize and improve health for seniors. Seniors with high risk of hospital use will receive assessment and services they need to maintain their health and remain active in their homes as long as possible. Services will include assistance with the social determinants of health, activities, and needs that influence health. The initial work will take place in senior housing facilities and, when established, will spread to senior residents in the wider community. The program will also serve seniors discharged from the hospital to skilled nursing facilities to home.

Members of DHHS have contributed to the planning process, including the County Health Officer and the Chief of Aging and Disability Services. Collaboration among organizations is characteristic in Montgomery County and a significant area of strength within our health care delivery system and continuum of care. We have strong and sustainable ongoing relationships with all of the hospitals and other partners in this project. The Department will contribute knowledge and effort in support of the project.

The number of seniors in Montgomery County is expected to increase in coming years, and we are committed to collaborating with the proposed project to ensure better health and fuller lives for these residents.

Sincerely,

Uma S. Ahluwalia

Uma S. Ahluwalia
Director

USA:es

**Office of the Director**

401 Hungerford Drive • Rockville, Maryland 20850 • 240-777-1275 • FAX 240-777-1494 • MD Relay 711
www.montgomerycountymd.gov/hhs

**montgomerycountymd.gov/311** MC311 ANSWERING TO YOU **240-773-3556 TTY**

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Isiah Leggett
*County Executive*

Uma S. Ahluwalia
*Director*

December 9, 2015

Mr. Steve Ports, Deputy Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Ports:

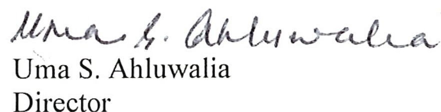
The Montgomery County Department of Health and Human Services (DHHS) is pleased to support this application for one of the two NexusMontgomery Regional Partnership (NMRP) proposals to the Health Services Cost Review Commission for a regional transformation implementation grant. The proposed project will work to improve health care services for county residents who are uninsured or who are afflicted with severe mental illness. By improving services for these populations in an appropriate venue, the program will reduce hospital costs and help to achieve goals of the All-Payer Model.

The DHHS is directly concerned with services for the uninsured and the mentally ill. The Core Service Agency is located within our Department that oversees all safety-net behavioral health programming. The Montgomery Cares safety net healthcare continuum is funded through DHHS and has served over 34,000 uninsured adults. The DHHS will collaborate with the proposed project to help ensure its success.

As I understand, all six county hospitals are working together with community partners to develop the interventions that will ensure our residents get the health care they need. The DHHS works closely with the Primary Care Coalition and a network of safety-net clinics to provide care for uninsured residents. The proposed project will build clinic capacity so that uninsured residents can receive outpatient care in a clinic rather than an emergency department. The project proposes to increase care options for severely mental ill patients outside an expensive hospital setting. These programs will provide needed care in the appropriate venue, leading to better health and less cost for Montgomery County residents and public payers.

The opportunity for this collaborative effort of health care and other providers across Montgomery County promises substantial benefit for our residents.

Sincerely,



Uma S. Ahluwalia
Director

USA:es

**Office of the Director**

401 Hungerford Drive • Rockville, Maryland 20850 • 240-777-1275 • FAX 240-777-1494 • MD Relay 711
www.montgomerycountymd.gov/hhs

**montgomerycountymd.gov/311** MC311 ANSWERING TO YOU **240-773-3556 TTY**

MONTGOMERY COUNTY FIRE AND RESCUE SERVICE

Isiah Leggett
*County Executive*

Scott E. Goldstein
*Fire Chief*

December 10, 2015

Mr. Steve Ports, Deputy Director
HSCRC
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Ports:

On behalf of the Montgomery County Fire and Rescue Service (MCFRS), I enthusiastically support the proposal for a Health Stabilization for Seniors program which is being submitted by the NexusMontgomery Regional Partnership (NM RP) to the Health Services Cost Review Commission. NM RP represents all six hospitals in Montgomery County as well as other community partners and collaborators. This community-wide effort promises to improve health for seniors and reduce hospital costs. Further, it will advance the goals of Maryland's new All-Payer Model.

The MCFRS frequently responds to 911 calls from residents of senior housing facilities. We will participate in the NM RP program by supplying reports and data about these emergency calls. Our emergency response teams will also identify seniors who are at risk for emergency or hospital care and refer them to the health stabilization program for risk assessment and care coordination. We look forward to helping seniors receive the support they need that may help to lessen the need for EMS.

The MCFRS and Montgomery County Department of Health and Human Services are also submitting a grant proposal which will target EMS Super Users. We see the NM RP proposal as complimentary to our Super User program and will work closely with NM RP to ensure that there is no duplication of efforts and that there is coordinated care.

The MCFRS anticipates that the proposed NM RP program will contribute to health and safety in our community, as well as to the state's goal to reduce health care cost. We urge you to support this worthy program.

Sincerely,

Scott E. Goldstein
Fire Chief

SEG/ld

**Office of the Fire Chief**

100 Edison Park Drive, 2nd Floor • Gaithersburg, Maryland 20878 • 240-777-2486 • 240-777-2443 FAX
www.montgomerycountymd.gov/mcfrs

**montgomerycountymd.gov/311** MC311 ANSWERING TO YOU **301-251-4850 TTY**

December 8, 2015

Mr. Steve Ports, Deputy Director
Maryland Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Commitment for Community-based Care Management for Seniors by *Nexus*Montgomery

Dear Mr. Ports:

On behalf of LifeSpan Network, I am writing to endorse the application from the NexusMontgomery Regional Partnership (NM RP) to the Health Services Cost Review Commission. The program is designed to improve community health and reduce overall hospital costs. These aims support the goals of Maryland's new All-Payer Model.

We understand that the NM RP, including all six hospitals in Montgomery County as well as community partners, will implement care coordination and health stabilization programs to improve health for seniors. It will serve residents of senior housing facilities as well as those discharged from the hospital to a skilled nursing facility. Not only will vulnerable seniors receive support to maintain their health, but the program promises to reduce hospital use and costs by seniors who are participants. We are particularly pleased that the program will be working in senior housing communities to meet needs of underserved and frail elderly.

LifeSpan is the largest and most diverse senior care provider association in Maryland, serving nearly 250 organizations, including continuing care retirement communities, skilled nursing facilities, assisted living providers, senior housing and community based senior care organizations. LifeSpan has been involved in the design phase of NM RP over this past year. For this project we administered a survey of participating Montgomery County senior care providers, informed and promoted this project to the field, and worked on planning committees throughout 2015. For this next phase, LifeSpan will be available to continue to support the development and implementation for senior care organizations.

Again, LifeSpan enthusiastically supports the NM RP proposal and look forward to its success.

Sincerely,

Isabella Firth, President

MCMS
MONTGOMERY COUNTY, MD
MEDICAL SOCIETY

December 9, 2015

Mr. Steve Ports
Deputy Director
HSCRC
4160 Patterson Avenue
Baltimore, MD 21215

Re: Commitment for Community-based Care Management for Seniors by *Nexus*Montgomery

Dear Mr. Ports:

On behalf of the Montgomery County Medical Society, I am pleased to offer wholehearted endorsement for the proposal being submitted by the NexusMontgomery Regional Partnership (NM RP) to the Health Services Cost Review Commission.

The NM RP represents all six hospitals in the County as well as community providers, partners, and collaborators. This community-wide effort promises to reduce hospital costs by improving health for seniors who live in senior housing facilities or are discharged from the hospitals. Importantly, it will also help to meet the goals of Maryland's new All-Payer Model.

Montgomery County Medical Society is a professional association representing more than 1,600 physicians who live and/or work Montgomery County, Maryland. We are committed to improving access to health care for the citizens of Montgomery County and to enhancing the success of physician practices.

The MCMS has contributed to the development of the proposed model and physicians will be key partners in its success. Its goals are well-aligned with our Society's interests. We will promote the NM RP program among our members, especially those who serve seniors in their practices. We look forward to supporting health risk assessment and care coordination efforts that improve health for vulnerable senior patients.

Again, I enthusiastically support the NM RP proposal and look forward to its success.

Sincerely,

Susan G. D'Antoni
Executive Director

Working for Physicians and Their Patients in Montgomery County
15855 Crabbs Branch Way | Rockville, MD 20855 | t.301.921.4300 | f.301.921.4368 | montgomerymedicine.org | info@montgomerymedicine.org

December 10, 2015

Steve Ports, Deputy Director
HSCRC
4160 Patterson Avenue
Baltimore, MD 21215

Re: Commitment for Community-based Care Management for Seniors
by *Nexus*Montgomery

Dear Mr. Ports:

With pleasure, I am writing to offer VHQC's support for the application to the Health Services Cost Review Commission from the *Nexus*Montgomery Regional Partnership (NMRP).

The NMRP has engaged in a six-month planning process to design interventions that will improve health for seniors in the community and reduce hospital costs. All six hospitals in Montgomery County with numerous community partners have come together to design this collaborative proposal with goals that will help to meet requirements of Maryland's new All-Payer Model. The planned program will provide services to residents of senior housing facilities and those discharged from hospitals to skilled nursing facilities.

Since the fall of 2014, VHQC has been working with the county hospitals and community partners within the VHQC Care Transitions Project, a CMS Quality Innovation Network - Quality Improvement Organization (QIN-QIO) initiative. VHQC provided extensive analytic support through data reports and Medicare claims analysis for the local zip code area that was critical to the NMRP design process. As this program is implemented, we will continue to supply data and reports that can be used for the ongoing program design and evaluation.

VHQC supports this program unreservedly and looks forward to its success. As the QIN-QIO for Maryland and Virginia, VHQC convenes patients, providers and stakeholders to rapidly improve health quality and achieve better health, better care and lower costs. We do this work through CMS' QIO Program, the cornerstone of Medicare's efforts to improve the quality and value of healthcare.

Sincerely,

Thelma M. Baker

Thelma M. Baker, RHIA, MSHA, CPHQ
Chief Operating Officer

Maryland & Virginia Quality Innovation Network

9830 Mayland Drive, Suite J • Richmond, Virginia 23233 • Tel: 804.289.5320 • Fax: 804.289.5324 • www.vhqc.org