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.

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:

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

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 **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** **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.** **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.** • **The Coordinating Center (Care at Hand/CARMA)** • **Family Services Inc/CareLink (BestCareConnect)**	**Q1**
Educate/Engage provider interest in CRISP connectivity • **Refer up to 5 SNFs technologically ready for ADT connectivity** • Refer 1 inpatient behavioral health provider	Outreach plan for notifying providers who upload ENS panels, how to upload care manager information in conjunction 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) • **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**

connectivity • Refer additional behavioral health providers • Engage with PCPs		
Engage for CRISP connectivity: • **PCPs (target: 5) for ambulatory data, panel upload and ENS/Alert subscription** • **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 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. 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 2nd and 3rd Care Plan Standards Meeting (PCPs, hospitals, Care Coordination providers/CBOs): • Select key elements of care plans, common definitions.	**Pilot hospital (Adventist) uploads care plans; available for view on Clinical Query Portal.** **Care managers that are included in ENS panels are available to view in the CRISP query portal.** All 6 Hospitals uploading care plans	**Q2**
4th Care Plan Standards Meeting (PCPs, hospitals, Care Coordination providers/CBOs): • Obtain feedback on benefits and challenges of using the Care Profile, to the extent providers are using. • 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

Continue to provide input to CRISP on Care Profile design and Alerts. 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 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. 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 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 Develop feedback loops with CRISP for ongoing reporting	**Complete revisions to pre-post and other custom reports.** 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.

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
Name: David Horrocks, President
Phone: 877-952-7477
Email: David.horrocks@crisphealth.org

Primary RP Contact
Name: Leslie Graham
Phone: 301 628-3410
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:

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 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 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 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 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 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 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*	

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 • One officer from each system • 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: • Be active participants in meetings and work to build good will and trust among colleague members based on current partnership • Participate in and evaluate governance actions based on the benefit to the partnership and the community, not only your hospital • Be purposeful in soliciting and providing input • Work towards defined shared goals • Representatives involved in governance and committees are decision makers and empowered to act on behalf of the organizations they represent • Respect time commitments by starting and ending meetings on time • Respect deadlines agreed upon and communicate clearly barriers to meeting deadline • Educate colleagues about priorities and new programs • Identify opportunities and be open to redesign or repurpose of existing resources • Look for opportunities to include all-payers in potential financing of the partnership • Set clear and realistic expectations for each partner • Explore the potential consequences of any payment reform on each partner		

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 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. 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:
		• Administrative/Governance
		  ○ Management Agreement
		  ○ Participation Agreement
		  ○ Voting rights among RP Parties, Quorum requirements (any changes)
		  ○ Removal of an RP Party (without the partner in question)
		  ○ Addition of a Party to the RP
		  ○ Formation of a joint venture with a third Party
		  ○ Evolution of the NM RP to a legal entity
		• Project Approval (intervention and infrastructure)
		  ○ To include scope, resources, scale and geography (who, how, what and where), RP Party roles, responsibilities, performance expectations, reporting, etc.		

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:
		• Administrative/Governance
		  ○ Termination of the Nexus Montgomery Operating Agreement
		  ○ Amendments to Operating, Management or Participation agreements
		  ○ Termination of Operating, Management or Participation agreements
		  ○ Vendor contracts
		  ○ Marketing/Communications activities, materials and branding specific to the NM RP
		• Financial
		  ○ Budget
		  ○ Budget revisions
		• Clinical Integration Programs/Implementation
		  ○ Definition and eligibility criteria for target patient population
		  ○ New processes, workflows and tools of any substance
		  ○ Metrics/measures that will be used to monitor performance
		  ○ 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 • Board Directors are expected to attend a minimum of 75% of the in-person meetings • Proxies may attend up to 25% of the Board meetings (in place of a Director) 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: • Election of Board Directors • 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.		

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* • Require at minimum one Board Director and preferably two, participate in each committee • 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. 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 • Committee members are expected to attend at minimum 75% of the in-person meetings • 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: • Financial and resource oversight • Recommends the budget to the Board for approval • Serves as the "audit" committee of the Board, if needed • Determines financial viability of proposed project(s) and sustainability post-implementation • Evaluates and recommends potential funding opportunities and mechanisms to the Board • Reviews and monitors contracts, insurance needs/policies		
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		

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: • Developing key performance and outcome metrics to be recommended to the Board • Monitor key performance and outcome metrics as approved by the Board, including: population health data, access to care, and numbers served • Monitor any needed continuous quality improvement initiatives • Evaluating and recommending proposed projects, developing materials for Board discussion (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 • Evaluation: common data collection and evaluation of ROI for all programs in RP, including the independent hospital Care Transition programs funded under RP • Best practices: literature review and interviews of similar programs; distribute condensed updates on promising and best practices • Support Partnership Program Interventions Committee: engage consultants and/or provide analysis for new and existing program planning		

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) • 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 • Stakeholder Engagement: Specific to shared RP programs and projects, engage stakeholders and partners (EMS, Sr. Living, PCPs, DHHS, patients & families) • 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) • 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 • Stakeholder Engagement: Specific to shared RP programs and projects, engage stakeholders and partners (EMS, Sr. Living, PCPs, DHHS, patients & families) 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.		

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. • 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. • The Parties may be required to enter into Qualified Service Organization ("QSO") Agreements for the disclosure of SUD records. • Under a QSO Agreement, the Parties agree: ○ 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; ○ 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 ○ Acknowledge that any unauthorized disclosure of SUD information under this section is a federal criminal offense.		

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.		

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

Housing Opportunities Commission
OF MONTGOMERY COUNTY

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

AHC INC.

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

ASBURY Methodist Village
Anticipate More

201 Russell Ave., Gaithersburg, MD 20877 | 301.216.4001 | 800.327.2879 | AsburyMethodistVillage.org

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

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

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

The Village at Rockville

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

Victory Housing

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

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

Uma S. Ahluwalia
Director

USA:es

MONTGOMERY COUNTY FIRE AND RESCUE SERVICE

Isiah Leggett
County Executive

December 10, 2015

Scott E. Goldstein
Fire Chief

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

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

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