Howard County Regional Partnership

Regional Transformation Plan – Final Report
Submitted December 7, 2015

1. Goals, Strategies and Outcomes

A. Articulate the goals, strategies and outcomes that will be pursued and measured by the regional partnership.

The Maryland All-Payer Model provides a glide-path for change to realize health system transformation. The Howard County Regional Partnership (HCRP)[1] will serve as the primary vehicle to coordinate and deploy specific strategies to drive this transformation, where the result is a health care delivery system that is not only highly reliable, efficient, and patient-centered, but also equipped to achieve health care's triple aim of improved outcomes, lower costs and an excellent patient experience. While initial efforts will focus on a segment of the population, HCRP is designed to work collaboratively with community partners, in particular our Local Health Improvement Coalition (LHIC), to ultimately improve the overall health and well-being of our entire Howard County population.

The following strategies will be pursued by the Regional Partnership.

1) Establish a governance structure through the creation of a committee of Howard County General Hospital's Board of Trustees, with a hard-wired connection to the Local Health Improvement Coalition. Build on the successful planning grant decision making structure to develop subcommittees to oversee planning, implementation and monitor Regional Partnership performance.
2) Expand the capacity of an existing community-based care coordination intervention – the Community Care Team (CCT) – operated by Healthy Howard, Inc., a local non-profit organization. Strengthen current referral pathways from the acute care setting and formalize new referrals pathways from the primary care and post-acute care settings for patients in our target population.
3) Utilize Lean process improvement methodology to refine current or develop new standard processes and then implement within the acute, post-acute and primary care settings that support care coordination across the continuum, with initial emphasis on Medicare beneficiaries with high utilization and complex needs.
4) Work initially with existing tools and data sources for risk stratification, information sharing and communication practices to support interventions ready for implementation. On a parallel track, work with CRISP and members of the Regional Partnership to identify and deploy new tools to enable improved identification and tracking of high risk patients across the continuum and activate in-context data sharing, real-time decision support and flexible communication methodologies.
5) Work with community partners to continue with the implementation of a pilot program – Howard County Rapid Access Program (RAP) – to address a critical gap in the continuum of behavioral health services and utilize program evaluation findings to determine potential for longer term investments.
6) Develop evidence-based metrics and reporting tools that inform HCRP leaders and partners of performance and progress towards goals as well as support the development of an evaluation plan.
7) Leverage existing collaborations in the primary care (Advanced Primary Care Collaborative) and post-acute care settings (Lorien Health Systems and Gilchrist Services) to advance provider engagement and alignment strategies.

[1] The Howard County Regional Partnership will be referred to as either HCRP or the Regional Partnership in this final report.

HCRP will submit an application for implementation funding in response to the HSCRC RFP on December 21. Implementation funding is needed in order to fully operationalize these strategies.

The Regional Partnership's desired outcome is to deliver an effective, community-based and financially sustainable model of care initially for high-risk Medicare beneficiaries that improves health, achieves cost savings and offers an enhanced patient experience. Given the strength and level of engagement of the LHIC's member organizations, and the long and productive history of collaboration among Howard County General Hospital (HCGH), Howard County Health Department (HCHD), and the Horizon Foundation to advance the health of the community, HCRP wants its model to be robust enough to manage the health of the population regardless of where individuals fall along the risk continuum. 1C details the outcome, process and cost metrics to be used to measure performance.

B. Describe the target population that will be monitored and measured, including the number of people and geographical location.

In alignment with the goals of Maryland's All-Payer Model, HCRP will initially focus its efforts on Medicare high utilizers living in Howard County. The Regional Partnership decided to define a Medicare "high utilizer" in Howard County as someone with at least two hospital encounters in the past 365 days.[2] As outlined in our interim report, HCRP reviewed a broad range of data from diverse sources during the planning process. Ultimately, we are using CRISP data to help define our overall target population. Based on an analysis provided by CRISP, there were 2,338 unique Medicare FFS beneficiaries who reside in Howard County and had at least two hospital encounters between September 2014 and August 2015, where at least one of those encounters took place at HCGH. Sepsis and disseminated infections, heart failure, rehabilitation, pneumonia and chronic obstructive pulmonary disease were the most common diagnoses. Geographically, this target population clusters in five zip codes - 21044, 21043, 21784, 21045 and 21042.

Overall, there were 9,570 Howard County residents (all payer) with at least two hospital encounters between September 2014 and August 2015, with at least one of those encounters occurring at HCGH. The total charges were $87,390,202. Our target Medicare beneficiaries represent 24% of the patients but account for 48% ($42,291,713) of the total charges.

HCRP's selected care coordination intervention – the Community Care Team (CCT) – currently applies an additional set of eligibility criteria regarding chronic conditions and excludes individuals with a terminal illness. Table 1 below outlines the inclusion and exclusion criteria that will be used to identify patients from the target population for CCT intervention.

[2] A hospital encounter is defined as an admission, observation stay, or emergency department visit.

Table 1 : Inclusion/Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Howard County Resident	Member of Johns Hopkins Alliance for Patients (JMAP) Accountable Care Organization (ACO)*
Medicare or Dual Eligible	Patient's primary care provider (PCP) not part of Advanced Primary Care Collaborative OR not located in Howard County**
At least 2 hospital encounters in 12 month period w/ at least 1 occurring at HCGH	Terminal illness – defined as hospice eligible***
2 or more chronic conditions	

*If identified as a candidate for CCT during inpatient admission, patient will be offered a version of the CCT program and then transition to JMAP care management.

**Not an automatic exclusion. It will be handled on a case-by-case basis due to the fact that the intervention involves close communication and coordination with the PCP and CCT will need to assess its capacity to build new practice relationships.

***HCRP is working with Gilchrist Services to set up a referral pathway for patients to either their Transitions Program or the new Medicare Care Choices initiative.

The target population for the Howard County Rapid Access Program (RAP) is not limited to Medicare beneficiaries. This pilot program is designed to provide access to urgent, outpatient, crisis stabilization services within 24-48 hours of referral for Howard County adults in need of immediate access to short term, psychiatric, problem-focused intervention, regardless of ability to pay. This service is intended to prevent further emotional distress and decompensation which otherwise would result in accessing more acute levels of care. The program has the capacity to serve a total of 780 unique patients during the pilot year (September 1, 2015 – August 31, 2016); it is payer agnostic and referrals are made from the HCGH Emergency Department (ED) or inpatient units.

C. Describe the specific metrics that will be used to measure progress including patient satisfaction, quality, outcomes metrics, process metrics and cost metrics. Describe how the selected metrics draw from or relate to the State of Maryland's requirements under the new model.

HCRP will report on all core metrics required by the HSCRC. In addition, we will collect, monitor and report on intervention-specific measures (some metrics will be used for internal analysis and program evaluation). The Regional Partnership feels that alignment of measures across population health improvement initiatives, including across regional partnerships, is essential when working towards common health goals, simplifying documentation needed from providers, and maximizing our mutual understanding of how health outcomes change as a result of our interventions. Therefore, wherever possible, we selected measures that are already being collected through initiatives such as the State Health Improvement Plan, Meaningful Use, Patient Centered Medical Home, the National Quality Forum, CMS PQRS, and the JMAP Medicare ACO.

The metrics dashboard appears in Appendix A. It is a draft list and will be revised as we continue to work with our partners. For example, HCRP needs to finalize measures specific to the interventions in the post-acute setting. Also, while we will use HCAHPS measures to assess patient satisfaction at the hospital level, the Regional Partnership is looking into using CG CAHPS for patient satisfaction in ambulatory care settings.

The RAP program to provide urgent mental health care services also has a set of metrics, detailed in Table 2 below.

Table 2: RAP Metrics

Diagnostic Presentation
- Diagnosis upon RAP referral
- Diagnosis upon RAP discharge or termination

Continuity of Care / Transition
- # of RAP clients transitioned back to previous provider at termination
- # of RAP clients transitioned to new provider at termination
- # of RAP clients terminated with no follow up provider
- # of RAP clients enrolled with WSI at termination

Access to Care Challenges
- Average # of providers client actually contacted for service prior to enrolling in RAP
- # of providers contacted for service as part of RAP transition planning
- By insurer / payer: Average wait (days / weeks) for prescriber appointment as part of the RAP transition process

Payer Mix
- # of RAP clients by payer (Medicare, Medicaid, commercial, self-pay, uninsured)
- # of RAP uninsured clients enrolled who obtained insurance during the episode of care

Clinical Parameters
- Avg. # of prescriber appointments per RAP client (month, quarter, year)
- Avg. # of therapist appointments per RAP client (month, quarter, year)
- Total # of sessions completed per client

Program Parameters
- Total # of unique individuals served
- Total # of cancellations and no shows during week, month, quarter, year
- Average # days from hospital discharge/referral to first appointment
- # of RAP clients who left prior to completion of episode of care
- # of RAP clients terminated prior to 9th visit by reason code

D. Describe the regional partnership's current performance (target population) against the stated metrics.

We have been in a planning phase to develop the Regional Partnership and therefore do not yet have a data infrastructure in place to capture current performance except for those that can be determined for our potential high risk population through CRISP, HCGH electronic medical record (EMR) data or information from CCT's care management database.

Based on information provided by CRISP, there were 2,338 unique Medicare FFS beneficiaries who reside in Howard County and had at least two hospital encounters between September 2014 and August 2015, where at least one of those encounters took place at HCGH. These patients had a total of 6,950 hospital encounters. The encounters correlated to $42,291,713 in Medicare charges. Of the 6,950 total hospital encounters that this population experienced, only 1,161 occurred outside of HCGH, indicating minimal cross-hospital utilization between HCGH and other hospitals in Maryland.

Looking at HCGH EMR data, we know that the un-risk adjusted inpatient readmission rate was 11.34% (all payer) and for Medicare only was 18.37% for calendar year 2014. The risk adjusted readmission rate was 12.42% (all payer) and 14.53% for Medicare only during that same time period.

E. Define the data collection and analytics capabilities that will be used to measure goals and outcomes.

As outlined in the hospital strategic transformation plan (STP), HCGH has committed to developing a population health analytics team. This team will have the capability to turn data into information to be used to provide real-time decision support internal to the hospital as well as support the ongoing reporting functions to monitor HCRP performance. As other members of the Johns Hopkins Health System have expertise in the area, including Johns Hopkins Bayview, Johns Hopkins Hospital and Johns Hopkins HealthCare, HCGH will seek their input and guidance in building out this functionality at the local level. The team will work closely with members of the Regional Partnership to ensure that data collection and monitoring efforts are coordinated.

F. List the major areas of focus for year one. (For the completion of this plan, if various areas of focus require different descriptions, please identify each area under the following sections of the plan.)

In general, HCRP is focused on care coordination – to take the existing CCT program to scale to meet the needs of our target population of Medicare high utilizers. In order to support care coordination across the continuum, critical work must be done to refine existing or develop new standard processes not only within care settings, but also across care settings by improving communication and transitions.

Our major areas of focus for year one include the following:

Acute Care Setting

- Deploy on-site home care coordinators from Johns Hopkins Home Care Group to identify patients eligible for CCT and drive referrals so that a warm handoff to CCT and enrollment in the program occurs prior to discharge.
- Utilize HCGH's Innovation and Continuous Improvement facilitators (also referred to as the Lean team) to build standard processes and protocols for hospital staff to manage patients from admission to discharge specifically for those in our target population as well as for individuals who are at risk for a complex discharge and/or readmission.
- Design and implement a process within the Emergency Department for early identification of patients in our target population and provide immediate connection to CCT. This work would also identify patients outside of the initial target population with significant social determinants and provide a way for seamless connections to community-based resources and services.
- Continue to refer eligible patients to the Rapid Access Program and evaluate performance of this pilot program.

Post-Acute Care Setting

- In October 2015, HCGH entered into a collaboration with Lorien Health Systems and Gilchrist Services[3] to better manage patients discharged from the hospital to Lorien's skilled nursing facilities (SNFs). This group has committed to standardizing the discharge process from HCGH to Lorien and will be developing and implementing care pathways for the top three causes of readmissions from Lorien properties (sepsis, congestive heart failure, and respiratory failure/pulmonary edema). In addition, one of HCGH's hospitalist physicians, who is also a geriatrician, will lead a monthly case review of patients with unplanned and planned transfers between acute and post-acute settings to identify new areas for improvement, communication and collaboration. This is a model that has worked well for Lorien in other parts of the state and we are eager to implement it here in Howard County. Also, based on the early success of Lorien's telemedicine project in Harford County, we will explore the feasibility of using telemedicine to reduce emergency room visits, inpatient admissions and readmissions.
- Support patients transitioning from SNF-to-home with a standardized referral process to home health services and CCT.

Primary Care Setting

- Leverage the Howard County Advanced Primary Care Collaborative (APPC) as the vehicle to develop active provider referral pathway to CCT. APPC is comprised of nine practices and their patients represent more than one-third of the county's adult population. It is a learning collaborative that also offers technical assistance to groups working on practice transformation. We will kick off formal referral efforts with three pilot practices in January 2016 and then plan to onboard the remaining practices over the course of the year.

[3] Gilchrist Services provides medical directorship and attending services to Lorien properties in Howard County.

2. Formal Relationships and Governance

A. List the participants of the regional partnership such as hospitals, physicians, nursing homes, post-acute facilities, behavioral health providers, community-based organizations, etc. Specify names and titles where possible.

Please refer to Appendix B for the list of current HCRP participants. The Regional Partnership is made up of representatives from the hospital, primary care and specialty care providers, skilled nursing facilities, home care services, behavior health providers and community-based organizations. Several key community-based organizations include HCHD, the Department of Citizen Services and its Office on Aging, as well as member organizations of the Local Health Improvement Coalition (LHIC). During the planning grant process, we actively engaged with patients, family and caregivers and will continue to keep the voice of the patient and family at the center of HCRP efforts moving forward.

B. Describe the governance structure or process through which decisions will be made for the regional partnership. List the participants of the structure/process.

In October 2015, the hospital's Board of Trustees approved the creation of a new board committee to provide general governance for the HCRP. Appendix C includes a list of members who will serve on this committee (referred to as the HCRP Steering Committee). The Steering Committee will, in turn, establish subcommittees to perform critical planning and monitoring functions and appoint members to these working groups. The subcommittees will also offer programmatic recommendations for consideration by the HCRP Steering Committee.

Although the HCRP Steering Committee has not yet met to formalize the subcommittees, we expect the following domains to be addressed:

- Partnership Performance
- Finance and Sustainability
- Provider Alignment and Network Development
- Consumer and Family/Caregiver Engagement
- Community Health Integration and Social Determinants

The last domain – Community Health Integration and Social Determinants – is an explicit link to the LHIC. Advancing overall population health requires HCRP and LHIC to be coordinated and truly connected regarding priorities, strategies and action plans.

The HCRP Steering Committee will have quarterly in-person meetings and communicate offline as needed via email or through a secure information sharing and group management platform such as Basecamp. Once the subcommittees are defined and members identified, charters will be developed and decisions will be made regarding meeting frequency. Depending on the subject matter, certain subcommittees may need to come together more often than others.

C. Identify the types of decisions that will be made by the regional partnership.

The types of decisions to be made by the HCRP Steering Committee include the following:

- Sets strategic direction and priorities
- Identifies participants for subcommittees
- Makes decisions regarding target population
- Approves changes to interventions
- Solicits and reviews proposals and recommendations from the subcommittees
- Monitors and manages performance to achieve goals and priorities
- Determines changes to the governing structure (e.g. if a more formal governing body is needed)

Although the specific subcommittees are not yet finalized, we expect the following types of decisions to be made:

- *Partnership Performance*
  - Oversees all HCRP interventions
  - Monitors key performance and outcome metrics
  - Oversees quality metrics and continuous quality improvement activities
  - Evaluates current programs and proposes new interventions using evidence-based models and best practices as well as recommendations from other subcommittees
- *Finance and Sustainability*
  - Develops and proposes an annual budget to Steering Committee
  - Oversees financial operations and investments
  - Evaluates and recommends opportunities and mechanisms of funding HCRP infrastructure and interventions
  - Reviews legal contracts and agreements as needed
  - Guides and monitors allocation of non-financial resources, such as staff and equipment
  - Evaluates financial sustainability of existing and proposed programs
- *Provider Alignment and Network Development*[4]
  - Plans, implements and oversees provider training and education efforts
  - Evaluates value-based payment models and physician alignment strategies
  - Develops key elements of service level agreements to link primary care with specialty care providers
- *Consumer and Family/Caregiver Engagement*
  - Identifies opportunities for patient and family engagement strategies

[4] The work of this subcommittee is linked to other efforts to harmonize the activities of hospital and community-based committees focused on primary care issues. Please see 6A for additional information.

- Reviews intervention models, protocols and processes and provider/staff trainings to ensure that patient and family preferences are kept front of mind
- Makes recommendations regarding caregiver support
- Recommends, and in some cases, helps to develop patient education information and materials

- *Community Health Integration and Social Determinants*
  - Work to ensure integration with the Local Health Improvement coalition
  - Assess patterns and trends in social needs identified through HCRP interventions to recommend programmatic and policy action

D. Describe the patient consent process for the purpose of sharing data among regional partnership members.

Business Associate Agreements will be established between HCGH and other provider organizations in order to allow the sharing of data among the Regional Partnership participants for the purposes of care coordination and program development, including reporting, continuous quality improvement and program evaluation. The current governance structure of the Regional Partnership legally falls under HCGH. Therefore, to the extent possible, the hospital will seek to modify existing agreements and contracts with community partners and update consent forms and processes accordingly in order to fulfill the legal requirements of the Regional Partnership.

HCRP also supports intervention-specific patient consent processes, meaning that patients consent to participate in and allow personal health information to be shared from any program in which they enroll. The Community Care Team (CCT) has a process for obtaining patient consent for participation in care coordination and data sharing when patients enroll in the program. Patients who are eligible and interested in participating must complete and sign a CCT enrollment form and an authorization form allowing Healthy Howard, Inc. to use and disclose protected health information to other members of the patient's care team. The CCT team member also provides the patient with a copy of Healthy Howard Inc.'s Notice of Privacy Practices. The enrollment and authorization forms are uploaded to TrackVia, CCT's care management and documentation system, within 24 hours of the client signature. Similarly, as part of enrolling in the Rapid Access Program, patients sign a form consenting to participate as well as a release of information to grant the service provider, Way Station, Inc., access the patient's record through EpicCare Link. EpicCare Link offers credentialed community affiliates and providers secure, read-only access to select information from a patient record. HCGH faxes signed copies of both forms to Way Station.

We are aware that CRISP is working on a new patient consent model that would offer patients additional choices regarding the types of information to be shared or not shared with members of his or her care team. Once the model is finalized, we will work to incorporate it into all relevant components of HCRP's consent process. We expect that it will be necessary to provide education and "refresher" training to providers and care coordinators regarding the services available through CRISP and the terms and conditions required for patient consent, and will ensure that it is provided at the appropriate time. We want providers and care coordinators to be equipped to answer questions that patients might have about CRISP and the sharing of health information and support having these conversations within the bounds of a trusted patient-provider relationship as well as during the initial enrollment process for care coordination.

E. Describe the processes that will be used by the regional partnership to improve care and the MOUs or other agreements that will be used to facilitate the legal and appropriate sharing of care plans, alerts and other data as described in the process.

HCGH will update, amend or develop new legal agreements with the main service providers for the HCRP. All agreements will outline roles and responsibilities of participating groups as well as the expectations of the HCRP. Supplemental education materials and even trainings will be provided if necessary to ensure that all HCRP providers understand data sharing rules.

An MOU between HCGH and CRISP is currently in development and we expect for it to be completed by the end of December. This agreement outlines HCRP's prioritized needs and the roles, responsibilities and deliverables of both parties in the following areas: reporting and analytics, community provider connectivity, alerts and notifications, query portal, and a secure texting solution.

F. Attach the list of HIPAA compliance rules that will be implemented by the regional partnership.

Please refer to Appendix D for the list of HIPPA compliance rules.

3. Data and Analytics

A. Define the data collection and analytics capabilities that will be used to measure goals and outcomes, including specific metrics and measures.

Appendix A lists the specific metrics and measures.

As mentioned in section 1E, HCGH has committed to developing a population health analytics team that will perform the various analytic capabilities needed for HCRP. This team will create the necessary infrastructure to aggregate data from different sources, including accessing available CRISP reports and CCT's care management system, TrackVia, to produce the dashboards and any ongoing reports that the Steering Committee and subcommittees need to monitor, evaluate and report out on Regional Partnership performance. Another early project for this group will be to work with Lorien and Gilchrist to develop the measure set specific to HCRP's SNF collaborative work.

A separate team of continuous quality improvement (CQI) experts from the Ambulatory Quality and Transformation team of Johns Hopkins Community Physicians will oversee the collection and aggregation of quality metrics from primary care providers' EMR data.

B. Describe with specificity the regional partnership's plan for use of CRISP data.

We are eager for CRISP to "go live" with the various components of the Integrated Care Network (ICN) infrastructure, especially the Patient Total Hospitalization (PaTH) report, care profile and enhancements to the query portal and notification services that directly support care coordination. HCRP sees CRISP as the primary source of data and information to support the work of the partnership. CRISP data will be used to define our target population, identify patients for selected interventions, share critical information across settings to support care coordination and person-centered care, and monitor and evaluate partnership performance.

4. Risk Stratification, Health Risk Assessments, Care Profiles and Care Plans

A. Describe any plans for use of risk stratification, HRAs, care profiles, or care plans. Describe how these draw from or complement the standardized models being developed.

The HCRP selected care coordination intervention, the Community Care Team, is based on the Camden Coalition model developed by Dr. Jeffrey Brenner. Healthy Howard received technical assistance from Dr. Brenner in establishing CCT. The assessment and risk stratification tools as well as care plan documents are adapted from Camden's materials. Once a person is identified as eligible for CCT, an assessment is performed to determine medical complexity as well as the extent of social barriers (e.g. usual source of care, housing, mobility, self-rating of health and social support). This assessment helps to stratify patients in the sense that it estimates length of intervention needed and therefore helps to balance caseload acuity for CCT staff. CCT is an up-to-90-day intervention. Continuation is assessed every 30 days based on care plan goals. Experience to date suggests that greater social resource needs (e.g. transportation, housing) directly impacts time spent in the program.

Upon enrollment, clients complete an HRA. The CCT community health worker (CHN) utilizes motivational interviewing techniques to develop a care plan with the patient. This care plan is shared with the patient's primary care provider. As features of CRISP's ICN are enabled, providers should be able to see that the patient is engaged in care management with CCT and that a care plan exists. If it is possible for either an abstract or the full care plan to be viewed via CRISP, we will look to share that information.

B. For risk stratification, include the types of patients, risk levels, data sources, accountabilities (who is accountable to do what?)

At this point in time, CCT referrals are driven from the care setting based on different data sources instead of pushed by the results of a population level assessment of utilization and application of risk stratification tool. HCRP is eager to move in that direction and will work with CRISP toward that end.

Detailed below are the current processes for identifying patients for CCT, including data sources used and accountable parties.

Acute Care Setting:
Inpatient – The home care coordinator will receive a daily readmissions report from the hospital's EMR. The report is reviewed to identify potential CCT referrals. In addition, the Early Screening for Discharge Planning (ESDP) tool is administered to all patients upon admission. ESDP is a validated assessment that generates a score from 0 to 24 based on the patient's age, prior living status, disability score, and self-rated walking limitation. Patients who score a 10 or higher are considered to be high risk for a complex discharge and, when combined with other information regarding chronic conditions and prior hospital utilization, it can indicate individuals who might be at risk for readmission. The screen is administered by nursing staff in the inpatient units and the score is recorded in the EMR. A score of 10 or great is noted when patients are discussed during daily multi-disciplinary rounds. The ESDP score, readmission report, review of patient record and qualitative data shared during multidisciplinary rounds are used to identify patients that are eligible for CCT. The home care coordinator is responsible for determining that the patient meets all CCT criteria, introducing the CCT program to the patient and then providing a warm handoff to CCT.

Emergency Department – Starting in the first quarter of 2016, the hospital's Lean team will work with the ED to design and implement a process for early identification of patients at risk for readmission. This process will likely pull from EMR and CRISP data and potentially involve a short assessment. ED leadership will then need to determine what type of staff member will be responsible for making the referral of eligible patients to CCT as well as those outside of our target population who will be supported in connecting to community-based resources and services.

Primary Care setting:
CCT is working with primary care practices to establish referral pathways that fit within existing operations and workflows. To support this work, CCT will embed a care coordinator in practices. They will review CRISP data and information from the practices' EMRs to identify patients eligible for CCT. A care coordinator is already beginning to work with the first 3 practices from the Advanced Primary Care Collaborative. If CRISP runs the Johns Hopkins Adjusted Clinical Grouper (ACG) software or another similar tool on CRISP data to generate a risk score, the primary care providers in the Regional Partnership are interested in figuring out how to utilize that information in managing patient panels and prioritizing care coordination referrals.

Post-Acute Care Setting (SNF):
For patients discharged to a Lorien SNF from HCGH, the home care coordinator will have flagged CCT eligibility prior to transferring the patient. The goal is that CCT makes contact prior to the patient leaving HCGH, checks in with the patient during the SNF stay and is notified prior to discharge from the SNF to reengage with the patient and support the transition to home. SNF staff should also be able to identify patients likely to benefit from CCT upon discharge and the process for doing so is currently under development.

Rapid Access Program:
This program is intended to prevent further emotional distress or decompensation which otherwise would result in accessing more acute levels of care. The target population for RAP is Howard County residents in need of access to urgent care mental health services that meet certain criteria regarding safe discharge, diagnosis treatable by medication and therapy in outpatient setting and the patient has been previously unsuccessful in obtaining access to a community provider. Social workers conduct the screening in the ED and on inpatient units in order to assess eligibility and then coordinate the referral.

C. For HRAs, include the types of screenings, who is accountable for completing, and where information is recorded.

CCT administers an HRA as a part of the initial enrollment that is completed for all patients. Together, the CHN and CHW engage the patient in completing the form during the first home visit. Everything is documented and securely stored in TrackVia. The HRA was developed by the Camden Coalition and the questions originate from a number of evidence-based tools, including the PHQ-4 and the Centers for Disease Control and Prevention's HRQOL Healthy Days measure.

D. For care profiles and/or care plans, include the key elements that will be included, the systems through which they will be accessible, the people who will have access. Standardized care profiles are anticipated to be developed by the state-level integrated are coordination infrastructure.

A care plan is developed for every patient within the first week of the CCT intervention. The CHN and CHW work with the patient during the first home visit to develop a patient-centered care plan that includes both medical and social goals and objectives. Please refer to Appendix E for a template of CCT's care plan, which was recently updated based on PCP preferences discussed during the planning process. CCT's care plan has also been shared with CRISP in an effort to inform the development of a standardized care profile. Depending on the ultimate functionality of the ICN, the Regional Partnership will either push data elements to CRISP to populate key fields for care alerts, care profiles and care plans, or it will utilize a standardized profile and plan developed for use across all regional partnerships.

E. Identify the training plan for any new tool identified in this section.

Training for CCT staff includes education and training on the TrackVia system and all of its components, including the care plan, HRA and other questionnaires. Furthermore, a TrackVia user guide with training information and standards of use was developed for staff to reference at any time.

As new CRISP tools become ready for implementation and more of our ambulatory providers are connected, we plan to work with CRISP to roll out training sessions and resource guides or handbooks for end users.

5. Care Coordination

A. Describe any new care coordination capabilities that will be deployed by the regional partnership.

HCRP is leveraging care coordination capabilities that have proven successful and working to expand those for which there is opportunity for growth in other areas. First, we are partnering to expand the size and scope of CCT in order to address the needs of our target population, especially the social determinants that limit residents' ability to realize health goals.

In the post-acute setting with Lorien's skilled nursing facilities, we are developing care pathways for the top causes of readmissions that will allow patients to be managed at the SNF instead of automatically being transferred to the hospital. The new standardized discharge process from HCGH to Lorien addresses gaps in transitions between facilities and will improve the patient experience. While the Regional Partnership is still in the process of examining the feasibility of telemedicine, we expect that a decision will be made to pursue this new capability to better coordinate the care of patients in the post-acute setting.

Although the Rapid Access Program is not technically a care coordination capability, it is a new approach to coordinating care for an at-risk population where access to services is quite limited. Services are provided through Way Station's Outpatient Community Mental Health Clinic (OMHC) in Columbia. Once connected, the patient takes part in an "episode of care" that includes: one psychiatric evaluation with a Nurse Practitioner with two follow up medication management sessions and an initial clinical evaluation with a therapist with up to six follow up therapy sessions. Way Station then works to transition the patient, if needed, to a permanent community provider after the episode of care. Through the use of a novel online scheduling system, HCGH is able to make the initial appointment with Way Station prior to when the patient is discharged. This means that the patient leaves with an appointment in hand and all the necessary paperwork is received by Way Station in advance of the visit. If a patient fails to show for the first appointment, HCGH is notified and we work with Way Station to contact the client and reschedule.

HCRP recognizes the important role of the caregiver and understands that an increasing number of Howard County residents are assuming caregiving roles either for relatives or friends. The Regional Partnership will work closely with the County's Office on Aging as it implements a new evidence-based caregiver program, Power Tools for Caregivers, and will seek to identify new opportunities to enhance programming and support services for caregivers.

In addition to the new CRISP functions and tools that will support care coordination efforts, the Health Department will soon release an RFP to purchase a web-based management tool that can be used by community partners, including the Regional Partnership, to uniformly assess clients for social support needs, recommend local community resources, track referrals and provide data analytics regarding the success of community referrals. Such a tool will provide the capability to more accurately assess the community's need for services, determine whether existing community resources are sufficient, identify gaps, better inform funding decisions and determine whether vulnerable individuals are

in fact receiving the necessary resources. The totality of this will not only enhance care coordination capabilities but also contribute to improved population health.

B. Identify the types of patients that will be eligible for care coordination and how they will be identified and by whom.

In order to be eligible for HCRP's care coordination intervention, the patient must be a Howard County resident and either a Medicare beneficiary or dual eligible and have two or more chronic conditions. In addition, the patient needs to have had at least two hospital encounters in the past year and at least one of those encounters must have occurred at HCGH. An encounter is defined as either an ED visit, observation stay or inpatient admission.

Eligible patients will be identified in the acute, post-acute and primary care settings. Please see section 4B for a description of the process and accountable parties in each care setting both for CCT as well as for the Rapid Access Program that addresses urgent mental health services.

C. Define accountability of each person in the care coordination process.

Effective care coordination involves a multidisciplinary team that includes both clinical and non-clinical providers across care settings and places the patient and his or her wishes and preferences at the center of all activity. The following describes the accountability of each person in the CCT care coordination intervention.

<u>Program Manager (PM)</u>
The PM is a registered nurse who provides direct supervision to the community-based frontline staff, which includes community health nurses (CHNs), community health workers (CHWs), community social worker (CSW) and care coordinator (CC). The PM holds regular meetings with program staff to assess and promote team functioning and client success. This position ensures adequate training and development of staff and is responsible for developing and monitoring evidence-based program standards and staff compliance.

<u>Community Health Nurse (CHN)</u>
The hospital-based CHN works closely with the JHHCG home health coordinators (HCCs) to identify, screen and engage eligible clients during a hospital encounter and facilitate coordination of services pre- and post-discharge. The community-based CHN is largely responsible for meeting patients in their homes to provide health education and disease-specific management, motivational interviewing and goal setting, and regular follow-up with patients. The CHNs do not administer medications or treatments but work closely with medical providers to help ensure that patients have comprehensive and coordinated care. CHNs are also responsible for directly supervising and providing clinical recommendations to the community health workers.

Community Health Worker (CHW)
CHWs provide the bulk of patient-facing services for patients. Similar to the community-based CHN, the CHWs largely meet patients in their homes. CHWs perform outreach, community education, informal counseling, social support and advocacy to help patients increase health knowledge and self-efficacy. They conduct interviews and assessments with patients to understand and meet their needs. They maintain extensive knowledge of community resources and are able to arrange services in a timely fashion, including transportation, home care, home modifications and social supports. The CHWs report to the CHN and provide regular updates on the client's health status, barriers to good health and progress towards goals.

Community Social Worker (CSW)
The CSW assists CHWs with triaging and understanding patients' psychosocial needs and determining appropriate levels of emergent care services. In addition to connecting patients with behavioral health treatment, this position provides patient education, advocacy, counseling and support.

Care Coordinator (CC)
The care coordinator is responsible for working with partner primary care practices in order to support the screening process and other steps needed to identify patients eligible for CCT. The CC is an embedded position, who will have direct access to the referring physicians and the practices' EMR to help support overall coordination.

Administrative Coordinator (AC)
The AC provides administrative and logistic support to the team. This position is responsible for contacting graduated patients to complete the post-graduation follow-up questionnaire, scheduling appointments for home visits for patients as needed, sending weekly patient updates and caseload lists to PCPs, and documenting all interactions with patients and their providers promptly and accurately.

D. Describe staffing models, if applicable.

HCRP is utilizing the Community Care Team to provide care coordination services to our target population in Howard County. CCT staff roles are described in response to section 5C.

We are working with CCT to finalize a staffing model and caseload to meet the needs of the target population. The team is not currently at capacity, so the initial goal is to drive referrals to get closer to estimated capacity. It will be important to assess whether caseload assumptions hold or if there is opportunity for additional capacity.

E. Describe any patient engagement techniques that will be deployed.

Patient engagement techniques should be part of any health care worker's toolkit. CCT staff is trained in motivational interviewing techniques and employ them regularly to engage patients in the development of their care plans and progress towards their health goals. HCRP plans to utilize the patient engagement training for providers and front line staff developed by Johns Hopkins Health Care for the Johns Hopkins Community Partnership (J-CHiP) and the Johns Hopkins Medicine Alliance for Patients (JMAP) Medicare ACO.

The training helps providers and organizations realize the goals of patient-centered care by changing the behavior of health care teams to enable patients to become active partners their care. It uses evidence-based principles and tools of motivational interviewing to offers training in combination with support and maintenance activities. The program consists of a structured curriculum that is co-led by a PET expert and physician or staff champion. We plan to kick off the program in July 2016. Some of the primary care providers in the community have already had exposure to this training due to their practices' involvement in JMAP.

The Regional Partnership intends to leverage a "Consumer and Family/Caregiver Engagement" subcommittee to understand the patient and caregiver perspective and ensure that we are deploying the right components in training. As Howard County is also a very diverse community - 18% of the population are foreign born and 22% of residents report speaking a language other than English in the home – we must also ensure that our engagement techniques are culturally competent.

6. Physician Alignment

A. Describe the methods by which physician alignment will be created.

HCGH participates in the Howard County Advanced Primary Care Collaborative (APPC) – a convening started almost two years ago by HCHD and the Horizon Foundation. The APPC is comprised of nine practices and together, their patients represent more than one-third of the county's adult population. It is a learning collaborative that also offers technical assistance to groups working on practice transformation. HCRP will use the existing collaborative as the vehicle to implement the care coordination intervention with primary care practices.

The APPC also offers a starting point for future provider alignment. In addition to, yet currently separate from the APPC, HCGH operates two other groups involving primary care practices – the Primary Care Operations Council and the Physician Advisory Council. All three groups work on similar issues and member rosters overlap. With provider alignment as one of the goals of the hospital's strategic transformation plan, during the first six months of 2016, the hospital will work with representatives from each of these three groups to create one committee tied to the Regional Partnership (i.e. Provider Alignment and Network Development subcommittee), and develop a strategic plan to guide its work

for fiscal year 2017. For example, a priority project identified separately by all three groups was the development of an urgent care strategy for the county, which would include patient education around appropriate emergency department use, engagement with specialty groups to begin to build informal networks and service level expectations, and a plan for patients without a usual source to care to be connected with medical homes.

B. Describe any new processes, procedures and accountabilities that will be used to connect community physicians, behavioral health and other providers in the regional partnership and the supporting tools, technologies and data that will assist provides in the activities associated with improved care, cost containment, quality and satisfaction.

CRISP is critical to HCRP's efforts to connect providers and support efforts aimed at achieving the Triple Aim. Community provider connectivity, encounter notifications, care profiles, and sharing of care plans and other important data all serve to better inform and connect providers to one another and to patient information to support care coordination across care settings.

As part of the planning grant process, we dedicated significant time to solicit patient and provider input on provider-to-provider communication standards and strategies, which resulted in decisions to revise certain standard documents such as the hospital's after visit summary, share care plans, implement PCP and CCT developed care alerts through CRISP, and optimize work flows to support both asynchronous and direct methods of communication. Several providers across care settings mentioned the need for a communications support tool. Based on our conversations with CRISP, other regional partnerships expressed interest in a HIPAA compliant secure texting solution for care teams. If CRISP decides to offer a solution, HCRP will utilize it for Howard County. Otherwise, the Regional Partnership will work to implement a local solution.

Although "hi-tech" solutions are often the focus of efforts to improve connectivity and practice patterns, certain "low tech" tools have proven to be quite successful in this space. Regular face-to-face meetings are critical to building relationships, encouraging communication and providing a space for learning and collaboration. In the post-acute setting, one of HCGH's hospitalist physicians, who is also a geriatrician, will lead a monthly case review of patients (unplanned and planned transfers between acute and post-acute settings) to identify new areas for improvement, communication and collaboration. This is a model that has worked well for Lorien in other parts of the state and we are eager to implement it here in Howard County. For the Rapid Access Program, HCGH and Way Station hold monthly case conferences to share clinical information and coordinate care of referred clients, review logistics and workflow of the referral process, and examine program results in order to make adjustments as necessary to ensure clients receive the most efficient and effective care possible.

C. Describe any new value-based payment models that will be employed in the regional partnerships

HCRP is committed to exploring new value-based payment models as permitted by the Centers for Medicare and Medicaid Services (CMS) and the State of Maryland, and we are eager to work with the HSCRC to build a regional approach to value-based payment that supports and enhances care delivery.

7. Organizational Effectiveness Tools

A. Attach the implementation plan for each major area of focus (with timelines and task accountabilities)

As noted in 1F, HCRP is focused on taking the existing CCT program to scale to meet the needs of our target population of Medicare high utilizers. In order to support care coordination across the continuum, we are honing in on work within three care settings as well as efforts to improve communication and transitions between those settings.

Table 3 provides a high level timeline for implementing the work in each major focus area. A detailed implementation plan will be included in the Regional Partnership's application for implementation funding.

Table 3: Focus Area Implementation Plan

Care Setting	Focus Area	Calendar Year 2016			
		Q1	Q2	Q3	Q4
Acute	Home Care coordinators to drive referral and warm handoff to CCT	X			
	Standardized inpatient processes for managing high risk patients	X			
	Standardized process for early identification of high risk patients in emergency department and connection to services upon discharge		X		
Post-Acute	SNF care pathways		X		
	Standardized discharge process from HCGH to SNF	X			
	Active referral pathway from SNF to CCT		X		
Primary Care	Active referral pathway from PCPs to CCT (APPC practices to be phased in throughout 2016)	X	X	X	X

The Rapid Access Program is already being implemented. We will continue to refer eligible patients and evaluate performance of this pilot initiative.

B. Describe the continuous improvement methods that will be used by the regional partnership.

Continuous Quality Improvement (CQI) efforts will be split between the Johns Hopkins Medicine Ambulatory Quality and Transformation Team and HCGH staff.

As described in 1E and 3A, the Ambulatory Quality and Transformation Team is based at Johns Hopkins Community Physicians and will provide analytic support and lead HCRP's CQI initiatives in the primary care setting. A nurse Quality Improvement Analyst will develop and maintain process improvement plans for each practice, attend practice and HCRP meetings as needed, meet with each practice regularly to assess progress and next steps for CQI using Lean methodologies, and assist with performance improvement processes. In addition, a Performance Improvement Data Analyst will perform data analysis and other tasks as needed to support the CQI and process improvement efforts. Both team members have extensive experience providing quality analytics and continuous improvement to ambulatory groups within other innovative partnerships such as JMAP. The team already works with two APPC practices – Johns Hopkins Community Physicians and Columbia Medical Practice.

The hospital's population health analytics team and Lean team will lead HCRP's CQI initiatives in the acute and post-acute settings.

Performance dashboards will be shared with subcommittees and HCRP partners to communicate meaningful and timely information on performance indicators. They will also guide the performance and implementation strategies by identifying opportunities for improvement, a major part of the CQI process conducted by the two teams. HCRP's "Partnership Performance" subcommittee will monitor the CQI process as well as specific improvement initiatives and will include CQI updates in any reports to the Steering Committee.

C. Attach a copy of the metrics dashboard that will be used to manage performance over time with an explanation of associated processes that will be used to monitor and improved performance.

Please see Appendix A for the metrics dashboard. Processes related to monitor and improve the measures presented in the dashboard are still in development but the approach and framework are outlined in 1E, 3A, and 7B.

D. Describe the work that will be done to affect a patient-centered culture.

Patient-centered care and culture are top priorities for HCRP. Patient and caregiver representatives have been extensively involved throughout planning grant process to ensure that this perspective is reflected in all aspects of the Regional Partnership. Patient representation will continue during the implementation process and will be formalized in the creation of the "Consumer and Family/Caregiver Engagement" subcommittee.

Patient-centered culture will be cultivated with trainings and evidence-based programs. As outlined in 5E, HRCP will deploy patient engagement training primary care and post-acute care settings as well as with CCT. HCGH recently deployed the Language of Caring, which is an evidence-based strategy to help staff use a common language for caring communication and empower them to engage and communicate with patients in a more caring and effective way. Without using scripted language, the initiative improves provider-patient communication and enhances patient-centered care.

CCT uses motivational interviewing and other techniques to have the patient drive the development of his or her own care plan. Understanding the goals and feeling ownership of the plan supports patient activation and engagement.

Another aspect of a patient centered culture relates to patient's caregivers since they are often an active player on the patient's health care team. HCRP is working with CRISP to make the designated caregiver's name and contact information visible to providers across care settings. The Regional Partnership is also working with the county's Office on Aging to identify and provide support services and resources to caregivers.

8. New Care Delivery Models

A. Describe any new delivery models that will be used to support the care coordination outcomes. (For instance, tele-visits, behavioral health integration or home monitoring.)

The HCRP is interested in several new delivery models to support care coordination models and outcomes as described in 5A. We plan to work with the Johns Hopkins Home Care Group (JHHCG) to deploy remote patient monitoring, which includes nurse monitoring and triage, to high risk patients with specific chronic conditions such as congestive heart failure being discharged from HCGH to home. JHHCG has been operating this telemedicine program at other hospitals and they have reported initial success in avoiding unnecessary readmission and improving outcomes.

Based on the early success of Lorien Health System's telemedicine project in Harford County, HCRP will also explore the feasibility of using telemedicine to support HCGH provider consultation with Lorien patients without having to transfer the patient to HCGH. This type of care delivery support is intended to reduce emergency room visits, inpatient admissions and readmissions between Lorien's skilled nursing facilities and HCGH. Using telemedicine, Lorien has experienced reductions in all of those utilization measures, as well as positive patient and family satisfaction and feedback.

B. Identify how the regional partnership will identify patients, new processes, new technology and sharing of information.

The Maryland All-Payer Model provides a glide-path for change to transform the health care system and HCRP will guide this transformation to benefit the health and well-being of Howard County residents. Such significant change in a short period of time presents challenges as well as opportunities. When presented with a limited timeframe in which to realize systemic change, organizations that are structured to be flexible and focused on real time continuous improvement have the capability to quickly vet new ideas and engage partners/stakeholders tend to achieve their goals. The Regional Partnership is structured in just this way.

9. Financial Sustainability Plan

A. Describe the financial sustainability plan for implementation of these models.

HCGH will submit an application for implementation funding to the HSCRC on December 21. The hospital is also utilizing infrastructure dollars to support components of the Regional Partnership.

The Regional Partnership is exploring opportunities to use a portion of Medicare reimbursement for transitional care management (TCM) and/or complex care management (CCM) to support HCRP care coordination. We are working with one of our partner primary care practices to develop a model where CCT would be paid by the provider for certain coordination and appointment preparation activities that enable a TCM visit to occur within seven days post discharge. The payment would come from a portion of the provider's reimbursement. In the case of CCM, providers have not taken advantage of these payments because of the administrative burden on the practice and the financial burden of a co-pay for the patient. HCRP will work with practices to reduce barriers to practice adoption and continue to explore opportunities to address patient cost sharing.

B. Describe the specific financial arrangements that will incent provider participation.

HCRP is eager to work with the HSCRC and other regional partnerships across the state to design new arrangements to incentivize provider participation. In the interim, we are exploring the feasibility of expanding on existing contracts that the hospital has with credentialed community physicians to pay a certain hourly rate to cover administrative time needed to serve as the lead physician for the Regional Partnership within a practice and provide oversight and direction at the practice level for care coordination efforts. Covering administrative time will incentivize physician leaders to engage in HCRP work.

10. Population Health Improvement Plan

A. Provide detailed description of strategies to improve the health of the entire region over the long term, beyond just the target populations of new care delivery models. Describe how this plan aligns with the state's vision, including how delivery model concepts will contribute and align with the improvement plan, as well as how it aligns with priorities and action plans of the Local Health Improvement Coalitions in the region.

Over the years, Howard County has prioritized the health of its residents and invested in programs to improve the health and wellness of those who live, work, learn, and worship here. It is important to note that none of the initiatives or programs – from the Healthy Howard Health Plan and the Door to Heath Care to telemedicine in schools and mental health crisis beds – would have been possible without the

strong partnerships and collaborative nature of the county's public health, health care, and social services organizations. Across the risk continuum from prevention activities to complex case management for high needs patients, our efforts to improve population health have been the result of public-private funding partnerships and interagency collaboration with community stakeholders. For example, the Health Department, Horizon Foundation, Columbia Association and hospital came together to fund the biennial Howard County Health Assessment Survey. This survey, combined with the State Health Improvement Process framework, serves as the foundation for prioritization of community needs and shared goal setting.

Moving from data to action, the prioritization and goal setting work and action plan development happens with our Local Health Improvement Coalition. The LHIC is the nucleus of the community health strategy for the entire Howard County region. Its work is focused on the following four priority areas:

1. Increase access to health care
2. Enable people of all ages to achieve and maintain a healthy weight
3. Expand access to behavioral health services and reduce behavioral health emergencies
4. Enable healthy aging in the community

Just as our planning grant steering committee reported up to the LHIC, so too will the Regional Partnership be hardwired to the LHIC. While HCRP is initially focused on care coordination for a small segment of the population with complex health and social needs, over time it will work with the LHIC to address other priority areas for the health of the community.

HCRP's Community Health Integration and Social Determinants subcommittee is one example of the explicit link to the LHIC. This group will work to ensure integration and will assess patterns and trends in social needs identified through HCRP interventions to recommend programmatic and policy action. Another area ripe for collaboration is the connection of data across sectors to improve health outcomes.

Appendices

Appendix A: Metrics Dashboard

Appendix B: Howard County Regional Partnership Participants

Appendix C: HCRP Steering Committee Membership

Appendix D: HIPPA Compliance Rules

Appendix E: The Community Care Team's Care Plan Template

Appendix A: Metrics Dashboard

Howard County Regional Partnership Metrics Dashboard (CY 2016)

Categories & Measures	Q1	Q2	Q3	Q4
Process Metrics				
CCT Intervention				
Number who meet criteria for CCT				
N (%) Eligible population referred to CCT				
From Primary Care				
From Acute Setting				
From Post-Acute Setting				
From "Other"				
N (%) Graduated from CCT				
N (%) Discharged from CCT				
N (%) Patients offered CCT who refused to participate				
N (%) Patient enrolled in CCT from Acute Setting who had in-home visit w/in 3 days post discharge				
N (%) CCT Enrollees with Completed Health Risk Assessment				
N (%) CCT Enrollees with Completed Care Plan				
N (%) CCT Enrollees with a Shared Care Profile in CRISP*				
N (%) Population with at least 1 care team subscriber receiving Encounter Notification Alerts				
All Population for Covered ZIPs				
Target Population				
Training and Education				
Number of staff who complete Patient Engagement Training				
N (%) staff (clinical and non-clinical) identified by practice/ partner organization to receive training				
N (%) CCT staff (CHW, CHN) identified to receive training				
Quality Metrics				

Patient Experience				
N (%) "Top Box" responses to HCAHPS Discharge Information Domain: *"During your hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?"*				
% Agree or Strongly Agree on HCAHPS: Care Transitions Domain: "*When I left the hospital, I had good understanding of the things I was responsible for in managing my health?*				
% Graduated CCT Enrollees who report "Very Satisfied" when asked, "How satisfied were you with the CCT services"(From CCT Survey)				
Preventive Care and Chronic Condition Management*				
Hypertension (HTN): Controlling High Blood Pressure				
Diabetes Mellitus: Urine Protein Screening				
Diabetes Mellitus: Hemoglobin A1c Poor Control				
Diabetes Mellitus: Foot exam				
Diabetes Mellitus: Retinal Eye exam screening				
Influenza Immunization				
Pneumococcal Vaccination for Patients 65 Years and Older				
Preventive Care and Screening: Breast Cancer Screening				
Colorectal Cancer Screening				
Body Mass Index (BMI) Screening and Follow-Up				
Screening for Clinical Depression and Follow-Up Plan				
Tobacco Use: Screening and Cessation Intervention				
Screening for Fall Risk				
Utilization and Cost Metrics				
Utilization				
ED Visits per 1,000				
All Population for Covered ZIPs				
Target Population				
Total Hospital Admits per 1,000				
All Population for Covered ZIPs				

Target Population				
Ambulatory Care Sensitive Conditions				
Composite ACSC Discharge Rates per 1,000				
All Population for Covered ZIPs				
Target Population				
Chronic Obstructive Pulmonary Disease or Asthma Discharge Rate per 1,000				
Congestive Heart Failure: Discharge Rate per 1,000				
All Cause 30-day Readmissions per 1,000				
All Population for Covered ZIPs				
Target Population				
Cost				
Total Hospital Cost per Person				
All Population for Covered ZIPs				
Target Population				
Total Health Care Cost per Person**				
All Population for Covered ZIPs				
Target Population				

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

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

Appendix B: Howard County Regional Partnership Participants

HOWARD COUNTY GENERAL HOSPITAL	
Steve Snelgrove	President
Ed Heise	Director, Emergency Services
Eric Aldrich, MD	VP, Medical Affairs
Karen Davis, PhD	VP, Nursing & Chief Nursing Officer
Elizabeth Edsall Kromm, PhD, MSc	Senior Director, Population Health & Community Relations
Nancy Smith	Senior Director, Patient Care Services
Leslie Rodgers	Director, Patient Support Services
TBD	Director, Case Management (vacant)
Christina Younger	Director, Physician Relations
Eric Hamrock	Innovation and Continuous Improvement Facilitator
Andy Angelino, MD	Medical Director, Behavioral Health Services
James Young	CFO
Ryan Brown	VP, Operations
Robert Linton, II, MD	Chair, Department of Emergency Medicine
Mindy Kantsiper, MD	Associate Medical Director, CIMS
Reza Alavi, MD	Hospitalist
Anirudh Sridharan, MD	Hospitalist & Physician Liaison for Lorien/Gilchrist collaborative
LORIEN HEALTH SYSTEMS	
Lou Grimmel	CEO
Wayne Brannock	COO
Norman Snowberger	CFO
Susan Carroll	VP, Clinical Services
Elizabeth Canarte	Customer Service Transition Specialist
GILCHRIST SERVICES	
Catherine Hamel	VP, Post-Acute Services & Executive Director
Jason Black, MD	Medical Director
Anthony Riley, MD	Medical Director

PRIMARY CARE	
DeWayne Oberlander	CEO, Columbia Medical Practice
William Saway, MD	Columbia Medical Practice
Melissa Blakeman, MD	Regional Medical Director, Maryland Suburbs, Johns Hopkins Community Physicians (JHCP)
Jennifer Bailey	Senior Director, Quality and Transformation, JHCP
Rajiv Dua, MD	Centennial Medical Group
Harry Oken, MD	Community Physician
JOHNS HOPKINS HEALTH SYSTEM	
Linda Dunbar, PhD	VP, Population Health & Care Management, Johns Hopkins Health Care
Scott Berkowitz, MD	Executive Director, JMAP
JOHNS HOPKINS HOME CARE GROUP	
Mary Myers	COO
Dawn Hohl, PhD	Director, Customer Service
Laura Syron	Nurse Manager, Transitions Program
CRISP	
Brandon Neiswender	VP, Operations
COUNTY AND STATE GOVERNMENT	
Maura Rossman, MD	Health Officer
Phyllis Madachy	Director, Department of Citizen Services
Starr Sowers	Administrator, Office on Aging
Wendy Farthing	Health and Wellness Coordinator, Office on Aging
Karen Butler	Director, Department of Social Services
Barbara Albert	SHIP Coordinator, Office on Aging
HEALTHY HOWARD, INC.	
Liddy Garcia Bunuel	Executive Director
Kate Harton	Program Manager, Community Care Team
Jeananne Sciabarra	Director, Healthcare Transformation
THE HORIZON FOUNDATION	
Nikki Highsmith Vernick	President & CEO
Glenn Schneider	Chief Program Officer

WAY STATION, INC.	
Scott Rose	President & CEO
Jean Moise, PhD	Executive VP, Operations
Community and Patient/Family Representatives	
Hector Garcia	Executive Director, FIRN
Pastor Robert Turner	Chair, PATH and Pastor with St. Johns Baptist Church
Jim Greco	Ex-Officio Chair, Outpatient Patient and Family Advisory Council
Carlessia Hussein, PhD	Patient Advisor

Appendix C: HCRP Steering Committee Membership

Name	Affiliation
Maura Rossman, MD	Health Officer, Howard County Health Department
Lou Grimmel	CEO, Lorien Health Systems
Nikki Highsmith Vernick	President and CEO, The Horizon Foundation
Linda Dunbar, PhD	VP, Population Health and Care Management, Johns Hopkins HealthCare LLC
Steven Snelgrove	President Howard County General Hospital
Jim Greco	Patient Advisor
Brandon Neiswender	VP, Operations, CRISP
DeWayne Oberlander	CEO, Columbia Medical Practice
Mary Pieprzak, MD	President, HCGH Professional Staff Mid-Atlantic Nephrology Associates
Pastor Robert Turner	Chair, People Acting Together in Howard (PATH)
Harry Oken, MD	Community Physician
Scott Berkowitz, MD	Executive Director, JMAP Johns Hopkins Medicine
Catherine Hamel	VP, Post-Acute Services, Greater Baltimore Medical Center
Hector Garcia	Executive Director, FIRN
Karen Butler	HCGH Board of Trustees and Director, Howard County Department of Social Services
Kathleen White, PhD	Member, HCGH Board of Trustees
Phyllis Madachy	Director, Department of Citizen Services

Appendix D: HIPPA Compliance Rules

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

Appendix E: Community Care Team's Care Plan Template

Community Care Team—Care Plan

Patient Name: _____ DOB: _____ Enrollment Date: _____

Program Status: _____ Driving Diagnoses: _____ Graduation Date: _____

Reason for Referral: _____

Care Team

PCP: _____ Specialists: _____ (name, specialty)

CHW: _____ CHN: _____ CSW: _____

Goals

Clinical Goal(s): _____

Social Goal(s): _____

Action Items

Action Item	Date Assigned	Date Completed	Resource Used	Resource Used	Resource Used
☐					
☐					
☐					

Progress toward Goals

Completed Action Items: _____

Accomplishments: _____

Barriers and Ongoing Needs: _____

Comments for Primary Care/Specialist Provider:

Rev. 10/2015