

## Regional Partnership Program Summary

August 2019 Update

The following information is being collected to ensure public reporting about the Regional Partnerships is accurate. The information provided will be posted on the HSCRC website and included in periodic reports about the status of the Regional Partnership Grant Program.

Please complete and email the form to [hscrc.rfp-implement@maryland.gov](mailto:hscrc.rfp-implement@maryland.gov) by Friday, September 6<sup>th</sup>.

Please ensure only one form per partnership is submitted.

Regional Partnership Information
<b>Regional Partnership Name:</b> Greater Baltimore Medical Center
<b>Participating Hospitals:</b> Greater Baltimore Medical Center
<b>Participating Community Based Organizations:</b> Greater Baltimore Medical Center
<b>Geographic Service Area Covered by Regional Partnership (e.g., counties or zip codes):</b>  21030, 21093, 21117, 21204, 21212, 21234, 21236, 21252, & 21286
<b>Primary Point of Contact (Name, address, telephone, email):</b>  Sarah Fogler, Senior Director of Population Health 6545 N. Charles Street S. Chapman Bldg. Ground Floor Baltimore, MD 21204 443-849-3833 sfogler@gbmc.org

Program #1
<p><b>Intervention Program Name:</b> Expansion and Management of Chronic Conditions Through Improved Integration of Mental Health Services</p>
<p><b>Category of Intervention:</b></p> <ul style="list-style-type: none"> <li>• <b><u>Behavioral Health Integration</u></b></li> <li>• Care Transition</li> <li>• Home-Based Care</li> <li>• Mobile Health</li> <li>• Patient Engagement &amp; Community Education</li> <li>• Other (Please describe)</li> </ul>
<p><b>Short description of intervention:</b> Mental health professionals are embedded in GBMC primary care practices to provide screening, short-term intervention, and ongoing counseling/behavioral management. Specialty outpatient psychiatric services and consultation services are provided at GBMC’s medical homes and psychiatrists also provide evaluations on inpatient and ER patients and provide post-discharge mental health support (time-limited services). Finally, patients are referred to community based programs and services for longer-term support.</p>

Program #2 (if applicable)
<p><b>Intervention Program Name:</b> Expansion and Management of Chronic Conditions Through Palliative Care Services</p>
<p><b>Category of Intervention:</b></p> <ul style="list-style-type: none"> <li>• Behavioral Health Integration</li> <li>• Care Transition</li> <li>• <b><u>Home-Based Care</u></b></li> <li>• Mobile Health</li> <li>• Patient Engagement &amp; Community Education</li> <li>• Other (Please describe)</li> </ul>
<p><b>Short description of intervention:</b> GBMC’s Gilchrist Services, in partnership with MedStar’s Total Elder Care (TEC) program, has expanded the program Elder Medical Care (formerly Support Our Elders). Medicare patients who are unable to make frequent visits to the primary care physician are currently supported at home by a rounding interdisciplinary team including physicians, nurse practitioners, social workers, and administrative coordinators who can care for complex chronic conditions within the patient’s home. Gilchrist Services has also expanded the palliative care program in partnership with area nursing homes, which provides palliative services by a nurse practitioner to better manage symptoms and discuss patient care plans.</p>

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Program #3 (if applicable)
<b>Intervention Program Name:</b> Expansion and Management of Chronic Conditions Through Care Coordination
<b>Category of Intervention:</b> <ul style="list-style-type: none"><li>• Behavioral Health Integration</li><li>• <b>Care Transition</b></li><li>• Home-Based Care</li><li>• Mobile Health</li><li>• Patient Engagement &amp; Community Education</li><li>• Other (Please describe)</li></ul>
<b>Short description of intervention:</b> GBMC is working to expand its hospital-based care management function to focus on high-utilizer patients. Additionally, care management/coordination support is fully integrated in all 10 of the employed primary care practices. Through the addition of an inpatient case manager for high-utilizers, as well as additional care coordination staff in each primary care practice, the team will work (or is working) with patients proactively to meet their individual needs, in an effort to avoid unnecessary emergency department, inpatient hospital visits, and/or avoidable readmissions.

If more than 3 programs have been funded, please copy and paste additional "Program sections" on additional pages.