HSCRC
Health Services Cost Review Commission

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 by Friday, September 6th.

Please ensure only one form per partnership is submitted.

Regional Partnership Information
Regional Partnership Name: Nexus Montgomery
Participating Hospitals: 1. Adventist HealthCare Shady Grove Medical Center 2. Adventist HealthCare White Oak Medical Center (Formerly Washington Adventist Hospital) 3. Holy Cross Germantown Hospital 4. Holy Cross Hospital 5. MedStar Montgomery Medical Center 6. Suburban Hospital, a member of Johns Hopkins Medicine
Participating Community Based Organizations: 1. Primary Care Coalition 2. The Coordinating Center (TCC) 3. Cornerstone Montgomery 4. Sheppard Pratt Health System 5. SNF Alliance Members (37 Skilled Nursing Facilities) 6. Jewish Social Service Agency (JSSA) There are many additional community partners involved in Nexus Montgomery, including other local non-profits and public health departments and resources. In addition, CRISP and Health Quality Innovators (MD QIO) are working with Nexus to provide data support.
Geographic Service Area Covered by Regional Partnership (e.g., counties or zip codes): Counties Covered by the Regional Partnership: 1. Montgomery County 2. Prince George's County Zip Codes Covered by the Regional Partnership: • Please refer to attachment

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Program #1
Intervention Program Name: Wellness and Independence for Seniors at Home (WISH)
Category of Intervention: • Patient Engagement & Community Education
Short description of intervention: WISH helps seniors, living in targeted independent living facilities, optimize their health, remain independent at home, and reduce avoidable hospital use. Seniors at risk of declining health receive an assessment of their health/social risks from lay health coaches who are backed by Registered Nurses. Clients found at high risk for hospitalization receive ongoing individualized health coaching based around mutually agreed upon self-management goals. Seniors are also connected with community-based support to help keep them healthy and out of the hospital.

Program #2
Intervention Program Name: Hospital Care Transitions
Category of Intervention: • Care Transition
Short description of intervention: Hospital Care Transitions (HCT) programs support enrolled patients as they transition from hospital to home, with the goal of reducing readmission rates within 30 days of discharge. Prior to the formation of Nexus Montgomery, HCT programs were already in operation. Through Nexus funding, additional staffing/contracted resources have allowed HCT programs to expand their reach and serve more patients at high risk of re-hospitalization. During monthly Learning Collaborative meetings, HCT leaders from all Nexus Montgomery hospitals discuss best practices and identify areas for collective process and outcomes improvement.

Program #3
Intervention Program Name: Capacity Building for the Severely Mentally Ill (SMI)

Category of Intervention:

- Behavioral Health Integration

Short description of intervention:

The SMI program has three main components with a goal to provide behavioral health integration and capacity expansion in the community. The first component increased the availability of Residential Crisis beds, which serve patients experiencing a mental health crisis that traditionally would have been treated in the hospital due to a lack of a safe alternative. An eight bed Crisis House, which is managed by Cornerstone Montgomery, opened in FY18. A new 16 bed Crisis house, to be managed by Sheppard Pratt Health System, is in development.

The second SMI component added a third Assertive Community Treatment (ACT) team in Montgomery County. The new ACT team provides ongoing care and support for up to 100 patients in the community who are at risk of hospitalization through coordinating services for a broad range of needs, including housing and employment.

The third SMI component, Behavioral Health Integration, brings together a behavioral health workgroup to facilitate interagency coordination to reduce hospital use by patients with severe mental illness who are high utilizers of the hospitals. This work group is facilitated by the Nexus Montgomery Behavioral Health Integration Manager and is made up of staff from the 6 Nexus hospitals, Cornerstone Montgomery, members of Emergency Medical Services (EMS) and other community behavioral health providers. Its goal is to better coordinate care plans for patients with severe mental illness who are high utilizers of the Nexus partner hospitals.

Program #4

Intervention Program Name:

Specialty Care for the Uninsured (Project Access)

Category of Intervention:

- Other (Please describe):
  - Access to Healthcare Services

Short description of intervention:

Project Access (PA) is a specialty care referral network that coordinates with primary care clinics, specialty physicians, diagnostic facilities and local hospitals to arrange timely and affordable specialty care for uninsured people who have a household income <250% FPL. Through Nexus Montgomery, PA expanded the availability of these services for patients who have had hospital contact in the past 60 days and who need follow up specialty care for a related diagnosis. Patients not connected with primary care are referred to a primary care physician at a local primary care clinic. To remain eligible for Project Access patients must maintain a relationship with a primary care provider.

Program #5

Intervention Program Name:

Skilled Nursing Facility (SNF) Alliance

Category of Intervention:

- Care Transition

Short description of intervention:
The Skilled Nursing Facility (SNF) Alliance is a learning collaborative convened and facilitated by Nexus Montgomery. The Alliance brings together 37 SNFs and the six Nexus partner hospitals to reduce readmissions and improve patient outcomes through implementing best practices to optimize patient care. Through the Alliance, participating SNFs are provided with data management, analysis, and quality improvement support to track/improve upon 30-day readmissions and other quality metrics.

Program #6
Intervention Program Name: Community Advance Directives Program
Category of Intervention: • Patient Engagement & Community Education
Short description of intervention: The Community Advanced Directives program ensures that a person's values, wishes and preferences are honored during a healthcare crisis. Focusing on vulnerable populations, including seniors, the program provides patient centered care and shared decision making. This intervention promotes advanced care planning through training, education and public awareness with the goal to increase the number of individuals with advanced care plans, who have identified a healthcare proxy and uploaded their plans to a secure website for facilitated provider access.