

## 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   |
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| <p><b>Regional Partnership Name:</b></p> <p>Peninsula Regional Medical Center</p>  |
| <p><b>Participating Hospitals:</b></p> <p>Peninsula Regional Medical Center<br/>Atlantic General<br/>McCready Health</p>   |
| <p><b>Participating Community Based Organizations:</b></p> <p>MAC, several area shelters, several community faith-based organizations, City of Salisbury, three Health Departments (Wicomico, Worcester, Somerset), Maryland Food Bank, YMCA, National Kidney Foundation, etc.</p> |
| <p><b>Geographic Service Area Covered by Regional Partnership (e.g., counties or zip codes):</b></p> <p>Wicomico, Worcester, Somerset Counties</p>   |
| <p><b>Primary Point of Contact (Name, address, telephone, email):</b></p> <p>Kathryn Fiddler<br/>100 East Carroll Street<br/>Salisbury MD 21801<br/>410-219-4923<br/>Kathryn.fiddler@peninsula.org</p>   |

| Program #1   |
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| <p><b>Intervention Program Name:</b></p> <p>Wagner Wellness Van Mobile Outreach &amp; SWIFT (Mobile Integrated Health)</p> |
| <p><b>Category of Intervention:</b></p> <p>Mobile Health</p>   |

**Short description of intervention:**

The Wagner Wellness Van is a mobile clinic that is on the road five days per week visiting the tri-county area of Wicomico, Worcester, and Somerset counties. This service collaborates with other community programs and services, including shelters, faith-based organizations, the Maryland Food Bank, local health departments, MAC Center (local Area Agency on Aging), National Kidney Foundation, and others. Services include screenings for hypertension, diabetes, renal disease, cardiac-related illnesses, obesity, cancer, and behavioral health, as well as medical care for those who are uninsured or otherwise cannot afford to see a provider or those who do not have a provider. A key function of the van staff is to connect people with the resources they need, whether it be insurance, PCP, or a more basic need such as food, clothing, and shelter. The van can be found in some of the most impoverished and under-served areas of the Shore as we strive to serve those who are not being served. This past year the van also provided more comprehensive health outreach events for several under-served areas and populations around the Shore, including Wicomico’s west side, Somerset’s most remote areas, the Haitian community, the Migrant Camp, and an all-Hispanic church.

Our Mobile Integrated Health initiative, a collaboration with our Wagner Wellness Van mobile outreach clinic, is a partnership with PRMC, the City of Salisbury, and the Wicomico County Health Department. Program aims to reduce unnecessary use of the 911 EMS system and Emergency Department by addressing their physical and social needs. Program uses a Paramedic, a Nurse Practitioner, an RN, Social Worker, and Community Health Workers to address those needs and reduce unnecessary utilization by making home-based visits to individuals utilizing 911 at least five (5) times over a six (6) month time period for non-life threatening medical reasons. During these home-based visits, the mobile integrated health team provides physical, mental and safety assessments, and screen for social determinates of health. Based on their assessments, the team refers patients to appropriate care interventions such as primary care providers, medical specialists, in home providers, financial and social resources, as well as other community resources necessary.

| Program #2 (if applicable)  |
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| <p><b>Intervention Program Name:</b></p> <p>Smith Island Telemedicine</p>   |
| <p><b>Category of Intervention:</b></p> <ul style="list-style-type: none"> <li>• Care Transition</li> <li>• Patient Engagement &amp; Community Education</li> <li>• Other (Please describe): Telemedicine</li> </ul>  |
| <p><b>Short description of intervention:</b></p> <p>Smith Island, a small island in the Chesapeake Bay, part of Somerset County, Maryland has no direct access to medical care. When any level of care is needed, a 40 (or more) minute boat ride or a Maryland State Police helicopter required. PRMC employs Medical Assistants who lives on the Island and serve a dual role as the telemedicine liaison as well as a Community Health Worker for the residents, following up with patients who have been recently hospitalized and spear-heading community wellness programs. Patients are seen remotely via telemedicine by a PRMC Nurse</p> |

Practitioner, typically the same day. Annually, health fairs are hosted on the island for the residents. Partnering with the Somerset County Health Department, McCready Health, and the National Kidney Foundation, screenings offered, included Blood Pressure, Diabetes Risk Assessment, A1C & cholesterol testing, renal risk assessment, lung cancer risk assessment, Hepatitis C testing, Medication Review with a Pharmacist, and other community programs and resources.

| Program #3 (if applicable)  |
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| <p><b>Intervention Program Name:</b></p> <p>Care Management and Disease Management Program for Chronic Conditions</p>   |
| <p><b>Category of Intervention:</b></p> <ul style="list-style-type: none"> <li>• Care Transition</li> <li>• Patient Engagement &amp; Community Education</li> </ul>   |
| <p><b>Short description of intervention:</b></p> <p>Deploy embedded care managers in Primary Care Practices to proactively enroll evolving and high-risk Medicare beneficiaries into structured chronic care management, as well as episodic, transitional care coordination programs, based on comprehensive bio-psychosocial assessments, longitudinal care planning, consistent communication, and disease management protocols.</p> <p>Other interventions include:</p> <ul style="list-style-type: none"> <li>• Care (Nurse &amp; Social Work) management in Emergency Departments at least 12 hours a day, 7 days a week</li> <li>• Referrals to community-based chronic disease self-management classes</li> <li>• Community-based social workers</li> <li>• Utilization of Maryland Access Point to connect patients to needed resources</li> <li>• Falls reductions classes</li> <li>• Utilize CRISP to use ENS alerts for care coordination and patient identification</li> </ul> |

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