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: UHCC – UMUCH
Participating Hospitals: Union Hospital of Cecil County University of Maryland – Harford Memorial Hospital University of Maryland – Upper Chesapeake Medical Center
Participating Community Based Organizations: • Healthy Harford/Healthy Cecil • CRISP • Cecil County Government- Dept. of Community Services-Office on Aging • Cecil County Health Dept. • Harford County Emergency Services- Department of Public Safety • Susquehanna Hose • Embedded Community Health Worker in Cecil and Harford County Skilled Nursing Facilities • Cecil County Pulmonary Medicine Practice- • Harford County Health Dept. • Primary Care and Specialty Physician Practices • United Way of Central Maryland, Meals on Wheels • Lorien Health • Calvert Manor • Elkton Transitional Care • Amedysis Home Health
Geographic Service Area Covered by Regional Partnership (e.g., counties or zip codes): -Cecil County

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-Harford County
Primary Point of Contact (Name, address, telephone, email): Colin Ward, VP – Population Health UM – Upper Chesapeake Health cward@uchs.org 443-643-3330

Program #1
Intervention Program Name: Comprehensive Care Center
Category of Intervention: • Care Transition/ Post Discharge Clinic • Virtual/Mobile Health • Multidisciplinary Team
Short description of intervention: The Post Discharge Clinics at UMUCH and UHCC (called Comprehensive Care Center) monitors the patient's immediate needs after discharge from the emergency department or inpatient units, develops a comprehensive medical and social support treatment plan, and provides follow-up for 30 days. The Care Centers leverage the expertise of nurses, social workers, community health worker and a pharmacist to help identify and eliminate barriers via in person clinic visits, via telephone, or in the patient's home through telehealth/video calls. Patients newly diagnosed with Congestive Heart Failure may also receive remote monitoring services that wirelessly track weight, blood pressure and pulse oximetry.

Program #2 (if applicable)
Intervention Program Name: WATCH Program (Wellness Action Teams of Cecil and Harford)
Category of Intervention: • Community Care Teams • Patient Engagement & Coaching
Short description of intervention:

The Regional Partnership funds the Community-Based Care Management Program (CBCM) called Wellness Action Teams of Cecil & Harford counties (WATCH). The WATCH program serves as the bridge between the post-discharge clinic, primary care physicians and community providers. The goal is to extend the total length of time that patients receive care management and coordination with the goal of reducing readmissions and optimizing health status.

WATCH is comprised of four teams of that include nurses, social workers, pharmacist, and community health workers which engage clients into services across Cecil & Harford counties. WATCH provides ongoing care management, care coordination, medication reconciliation, health coaching and assistance to remove barriers to health (food insecurity, transportation, housing, medications, etc.). In addition, the WATCH team may engage with patients after Skilled Nursing discharge or in concert with a local EMS service, Susquehanna Hose.

Program #3 (if applicable)
Intervention Program Name: Population Health Informatics
Category of Intervention: • Other – Information Technology/ Data to guide strategic and operational efforts for managing populations
Short description of intervention: A Data Warehouse has been developed in conjunction with CRISP and is operational for UMUCH, UHCC and community partners. The integration of health care and community provider organizations through the Data Warehouse, allows for real-time monitoring of high risk/high utilizer patients. This dynamic system mimics the HSCRC readmission calculation and allows for hospital and community partners to rapidly address patients in the hospitals and community. Further, this system can be used by providers participating in the Maryland Primary Care Program to help manage ED and Inpatient Admission rates.

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