HSCRC
Health Services Cost Review Commission

Revised 9/6/2019

Regional Partnership Program Summary
September 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: Howard Health Partnership (HHP)
Participating Hospitals: Howard County General Hospital
Participating Community Based Organizations: CRISP; Centennial Medical Group; Columbia Medical Practice; Ellicott City Healthcare; 16 Faith communities; Foreign-Born Information and Referral Network (FIRN); Gilchrist Services; Horizon Foundation; Howard County Health Department; Howard County Local Health Improvement Coalition (LHIC); Howard County Office on Aging and Independence; Lorien Health Systems; Maryland Primary Care Physicians; Dr. Scott Maurer's practice; Way Station Inc. **Other program partners:** Berkeley Research Group, LLC; Johns Hopkins Armstrong Institute; Johns Hopkins Community Physicians; Johns Hopkins Home Care Group; Johns Hopkins Medicine; Johns Hopkins University.
Geographic Service Area Covered by Regional Partnership (e.g., counties or zip codes): The geographic scope comprises one county – Howard County, MD. Zip codes in Howard County include: 20701; 20723; 20759; 20763; 20777; 20794; 20833; 21029; 21036; 21042; 21043; 21044; 21045; 21046; 21075; 21076; 21104; 21163; 21723; 21737; 21738; 21771; 21784; 21794; 21797. This is also the community benefit service area (CBSA) for Howard County General Hospital (HCGH).
Primary Point of Contact (Name, address, telephone, email): Tracy Novak, MHS Director, Population Health at Howard County General Hospital 5755 Cedar Lane, Columbia, Maryland 21044 Phone: 410-720-8762 Email: tnovak2@jhmi.edu

Program #1
Intervention Program Name: Community Care Team
Category of Intervention: • Behavioral Health Integration • **Care Transition** • **Home-Based Care** • Mobile Health • Patient Engagement & Community Education • Other (Please describe)
Short description of intervention: The Howard County Community Care Team (CCT) serves adult Howard County residents who have Medicare or are dually eligible with Medicaid who have had two or more encounters (inpatient, emergency or observation) at HCGH within the past year. Patients and their caregivers receive program benefits for 30-90 days by a multi-disciplinary team that provides home-based care coordination services. Community health workers, nurses and a social worker deliver services including health education, disease-specific management, medication reconciliation, behavioral support, connection to and coordination with health care providers, and extensive social support and advocacy with linkages to appropriate community resources. Patients are engaged while at the hospital. An inpatient nurse identifies and screens eligible patients. An inpatient community health worker goes to the bedside to enroll patients and schedules a home visit that occurs 1-2 days after discharge to begin the intervention.

Program #2
Intervention Program Name: Journey to Better Health (J2BH)
Category of Intervention: • Behavioral Health Integration • Care Transition • Home-Based Care • Mobile Health • **Patient Engagement & Community Education** • Other (Please describe)
Short description of intervention: The Journey to Better Health (J2BH) program works with Howard County faith-based organizations and congregations to support the health of their members and other Howard County residents. J2BH offers chronic disease prevention and management strategies to their members tailored to their needs. Program strategies include: ● Chronic Disease Screenings and Education: Conduct screenings for hypertension, obesity and pre-diabetes and classes on chronic disease self-management within congregations. Class offerings include Living Well with Chronic Disease, Living Healthy with Hypertension, Living Well with Diabetes, Cancer Self-Management, and Mental Health First Aid Training. ● Volunteer Support for significant health events: Offer access to the Member Care Support Network (MCSN) which aims to pair members with trained volunteer Community Companions. Free volunteer-driven support system and an innovative approach to addressing health concerns in the community. Volunteers provide a variety of non-medical support services that help patients heal at home. Volunteers work with members for a limited time, and supportive services include social support, spiritual care, home management, transportation and information sharing.

Program #3
Intervention Program Name: Home-Based Primary Care
Category of Intervention: • Behavioral Health Integration • Care Transition • **Home-Based Care** • Mobile Health • Patient Engagement & Community Education • Other (Please describe)
Short description of intervention: Primary care and urgent care for older, homebound individuals. Participants receive an initial in-home assessment including full history and physical exam and a social, behavioral, and home safety evaluation. Participants are assigned a nurse practitioner (NP) and receive monthly or bimonthly NP house calls and intermittent physician house calls. A transitional care team (RN, LCSW, CHW) supports the patient by addressing needs related to advanced care planning, behavioral health, caregiver burden, grief counseling, connection to resources, etc.

Program #4
Intervention Program Name: Remote Patient Monitoring (RPM)
Category of Intervention: • Behavioral Health Integration • Care Transition • **Home-Based Care** • Mobile Health • Patient Engagement & Community Education • Other (Please describe)
Short description of intervention: Home-based program for patients with heart failure, diabetes or COPD with daily monitoring of biometric & symptom data by a registered nurse. This allows for immediate feedback to patient, physician and care team and provides an opportunity for disease education. The nurse monitors data and interacts with patient, physician and care team with the goal of improving patient outcomes, moving care into the most efficient care setting and assisting the patient/family to become more independent by recognizing signs & symptoms of disease progression.

Program #5
Intervention Program Name: Emergency Department Behavioral Health Navigators
Category of Intervention: • **Behavioral Health Integration** • Care Transition • Home-Based Care • Mobile Health • Patient Engagement & Community Education • Other (Please describe)
Short description of intervention: As patients with behavioral health issues (diagnosed mental illness and/or substance use disorder) enter the Howard County General Hospital Emergency Department, Behavioral Health Navigators (BHNs) assist by providing information and make connections to

community resources with the goal of successfully engaging them in treatment. This includes referrals and linkages to mental health treatment, substance use treatment, support groups and housing programs. BHN services consist of a screening that identifies non-medical needs, completing referrals, assistance with scheduling post discharge mental health or drug treatment appointments, and follow up phone calls within 48 hours of discharge from the ED to ensure linkages successfully occurred.

Program #6
Intervention Program Name: Patient Access Line
Category of Intervention: • Behavioral Health Integration • **Care Transition** • Home-Based Care • Mobile Health • Patient Engagement & Community Education • Other (Please describe)
Short description of intervention: Within 24 hours from being discharged, a nurse calls the patient to assist with managing his/her transition from hospital to home. Following a scripted survey tool and using the After Visit Summary as a guide, the nurse reviews how the patient is doing, the medication regimen, instructions for self-care management, red flags, signs and symptoms and who to call with concerns. The nurses also inquires about follow up appointments and the patient's ability to attend.

Program #7
Intervention Program Name: Advanced Care Planning
Category of Intervention: • Behavioral Health Integration • Care Transition • Home-Based Care • Mobile Health • **Patient Engagement & Community Education** • Other (Please describe)
Short description of intervention: Howard County General Hospital is focused on ensuring patients have an Advance Directive (AD) that has a designated Health Care Agent and expresses their end-of-life wishes because these are important components for providing patient-centered care. The Advance Care Planning (ACP) Coordinator meets patients at the bedside to educate and collect ADs post-discharge. The ACP coordinator uploads completed ADs to the hospital's EMR to ensure that providers can easily access the patient's wishes.

Program #8
Intervention Program Name: Palliative Care
Category of Intervention: • Behavioral Health Integration • **Care Transition** • Home-Based Care • Mobile Health • Patient Engagement & Community Education • Other (Please describe)
Short description of intervention: Improving the quality of life for those with chronic, debilitating and life-limiting illnesses. Services include medical care, emotional and social support, advanced care planning and education for individuals with serious illness in HCGH and long-term care facilities. Nurse identifies patients who may benefit from palliative consult and sends an order to hospitalist or palliative specialist. Specialist follows evidence-based protocols in EMR.

Program #9
Intervention Program Name: Behavioral Health Rapid Access Program (RAP)
Category of Intervention: • **Behavioral Health Integration** • Care Transition • Home-Based Care • Mobile Health • Patient Engagement & Community Education • Other (Please describe)
Short description of intervention: RAP is designed to provide access to urgent, outpatient, crisis stabilization services within two business days of referral for adults (18 years and older) who present in the Emergency department, on the inpatient psychiatric unit or on a medical unit and are in need of immediate access to varying levels of psychiatric treatment. The service links patients to the level and type of care needed to prevent further emotional distress and decompensation that would otherwise result in accessing more acute levels of care. Services are provided through Way Station, a subsidiary of Sheppard Pratt at the Columbia, Maryland site. Patients are able to receive up to 9 treatment sessions that include prescriber and therapy, regardless of their ability to pay. Way Station assists patients who need a higher level of outpatient care or treatment beyond the 9 sessions.

Program #10
Intervention Program Name: Peer Recovery Support Specialists (PRSS)
Category of Intervention: • **Behavioral Health Integration** • Care Transition • Home-Based Care • Mobile Health • Patient Engagement & Community Education • Other (Please describe)
Short description of intervention: PRSS are former addicts who have a minimum of 2 years of sustained recovery, and have completed specialized training in the area of addictions and behavioral

health. They are employed by the Howard County Health Department and meet with patients in the hospital or community to assist with enrolling and participating in treatment or support services that address the patient's substance abuse condition. PRSS can also assist in addressing social determinants such as homelessness, unemployment, lack of health insurance, etc.

Program #11
Intervention Program Name: HHP Educational Resources, classes and tools 1. Patient Engagement Program (PEP) 2. Powerful Tools for Caregivers (PTC) 3. Living Well 4. Mental Health First Aid (MHFA) 5. Community Access to Resources through Enhanced technology Applications for Providers and Public (CAREAPP)
Category of Intervention: • Behavioral Health Integration • Care Transition • Home-Based Care • Mobile Health • **Patient Engagement & Community Education** • **Other: Health Promotion**
Short description of intervention: The HHP offers classes to providers, patients and family caregivers to support engaging patients in their health care. The Johns Hopkins Medicine Patient Engagement Program (PEP) is a comprehensive, skills-based program that teaches health care providers how to change their team's culture, engage their patients as partners in health care and communicate in a way that motivates patients to engage in healthier behaviors. Powerful Tools for Caregivers (PTC) is an evidence-based class for family caregivers that offers tools and strategies to better handle the unique challenges caregivers face. Living Well courses teach patients with chronic disease about their disease and coaches them on healthy behaviors. Mental Health First Aid (MHFA) is an 8-hour education program that introduces participants to risk factors and warning signs of mental illnesses, builds understanding of their impact, and overviews common supports. CAREAPP is a web-based tool that offers a risk assessment screening and a database of applicable community programs to which individuals can be referred to electronically using a bi-directional referral tracking system.

The Howard Health Partnership (HHP) has a very active governance structure that helps to oversee this work, see summary below.

1. Steering Committee: objective is to ensure successful performance of the HHP by providing guidance, support and oversight on progress toward goals.
2. Consumer and Family/Caregiver Engagement Workgroup: objective is to ensure HHP interventions and initiatives are patient- and family-centered.
3. Provider Alignment and Network Development Workgroup: objective is to ensure provider alignment by engaging community providers and identifying/reducing barriers to engagement. Strengthen medical home model and coordination between primary & specialty care.
4. Skilled Nursing Facility Collaborative: objective is to improve patient health outcomes of HCGH patients transferred to participating SNFs. Participants include representatives from the 4 SNFs where most patients go.