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.

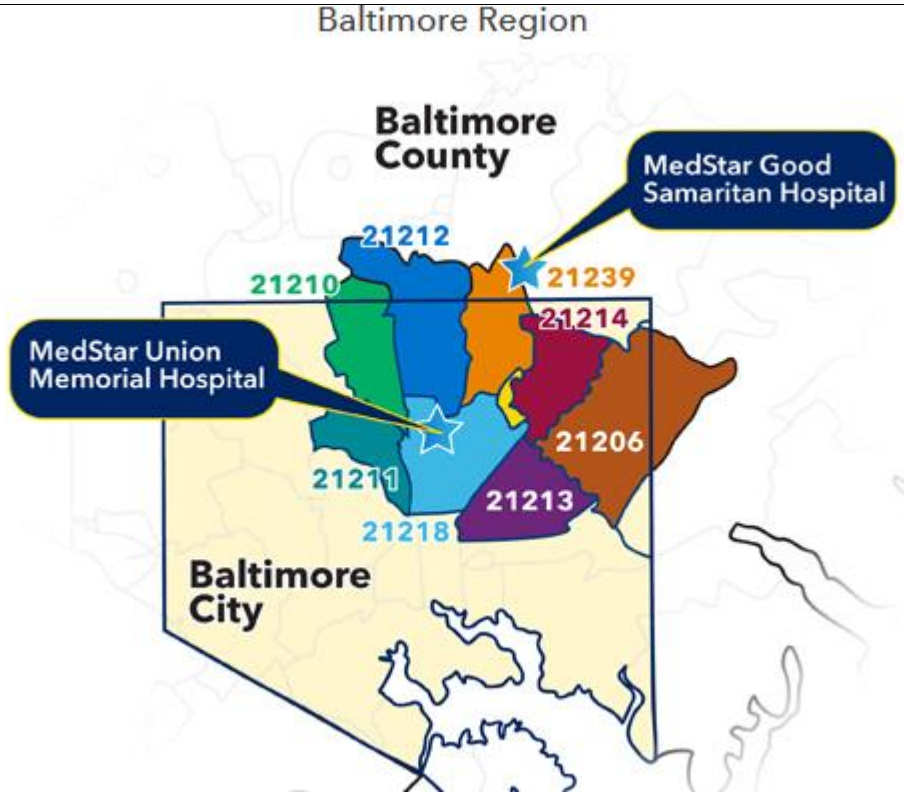
Regional Partnership Information
Regional Partnership Name: **MedStar Total Elder Care Collaborative (TEC-C)**
Participating Hospitals: **MedStar Good Samaritan Hospital, MedStar Union Memorial Hospital** (all other hospitals where our patients may have utilization events—tracked through CRISP-HIE)
Participating Community Based Organizations: • **Transportation**: Action in Maturity, MedStar Transport • **Home PT/OT, Skilled Nursing & Hospice**: MedStar VNA, Hopkins Home Care, Gilchrist Hospice, VITA Hospice • **Sub specialists & inpatient rehabs**: all the local sub-acute facilities • **Hospital & ER care**: all local hospitals where our patients might land. Notified via CRISP alerts. Our teams closely monitor when admitted and attempt to follow-up within 48 hrs of a hospital event. • **Labs & Radiology**: Providers draw labs-in home and use MedStar Good Samaritan lab to process. Initially the team tried LabCorp, but results weren't easily available to clinicians. Mobile radiology services through Mobile Medical • **Delivery of Medication and Equipment**: through local Medicare agencies. MedStar Pharmacy at Good Samaritan hospital provides home delivery and customized blister packaging for patients who opt for that service. Otherwise, any local pharmacy partners with our clinicians and receives electronic prescriptions. • **Social Services & Legal**: triaged through MedStar House Call social worker to various community agencies. Guardianship attorney (on contract by MedStar) engaged when appropriate for patient/family situation. • **Housing:** Over 100 group homes and senior assisted living facilities were identified in our catchment. Our staff has cultivated relationships with many of them to foster awareness and referrals. They routinely offer

ice cream socials, participate in health fairs, and community events. Stadium Place, St. Mary's Roland View, Walker Mews, & Kirkwood House are a few of the senior residence facilities that are strong partners.

Geographic Service Area Covered by Regional Partnership (e.g., counties or zip codes):

Zip codes: 21206, 21210, 21211, 21212, 21213, 21214, 21218, 212239 (within ~ 25 minute driving radius of administrative offices on MedStar Good Samaritan Hospital campus).
See visual below:

We're exploring expansion to other neighborhoods based on need and HSCRC attribution.



Primary Point of Contact (Name, address, telephone, email):

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Program #1
Intervention Program Name:
Category of Intervention: • Behavioral Health Integration • Care Transition • **Home-Based Care** • Mobile Health • Patient Engagement & Community Education • Other (Please describe)
Short description of intervention: MedStar House Call Program (previously known as TEC-C) consists of modular and geographically-targeted teams who serve the most ill subgroup of elders in a catchment area, usually within a 25-minute driving radius. Each team module consists of 5 staff, including geriatricians, nurse practitioners, care coordinators, triage nurses, and social workers. The core element of success is ability to offer ***a single, comprehensive source of home-based medical and social services for patients and their families.*** Core services include home-based primary care, 24/7 on-call medical staff, continuity to the hospital, intensive social services, and coordination of all specialty and ancillary services. As of 2019, MHCP has served over 3,700 elders in Washington D.C. and Baltimore service areas. Since the program began in the Baltimore region, we have helped more than 245 frail seniors receive high quality primary care in the comfort of their own homes and currently have an active census of 125 patients in Baltimore. Each team can serve a total of 300-350 frail elders. The goal of the MedStar House Call Program is to demonstrate the scalability of this model to Maryland, beginning with eight targeted ZIP codes in the county of Baltimore City. The target population for this care model is elders with severe and disabling chronic illness. These ill elders have difficulty getting to a doctor's office and have high annual Medicare costs, usually over $25,000 per year, and even higher in Maryland. According to an internal analysis conducted by JEN Associates, Inc in 2012, such patients represent about 5% of Medicare beneficiaries, many of whom are also eligible for the Medicare shared savings demonstration project, Independence at Home (IAH). This analysis found that IAH-eligible patients had a significantly high rate of 30 day readmissions among all Medicare FFS beneficiaries, including 29% of all Medicare FFS hospitalizations even though IAH-eligibles were just 4% of the Medicare FFS beneficiary population. This population, while small in number, represents a substantial proportion of Medicare expenditures (Congress of the United States Congressional Budget Office, 2005). The target patients are defined as any individual who: 1) Resides in one of the eight targeted ZIP codes; 2) Is age 65 or older; 3) Has two or more serious chronic illnesses; 4) Has functional impairment (in activities of daily living (ADLs) or instrumental activities of daily living (IADLs)) that limit their ability to get to doctor's office; and 5) Is willing to transfer primary care to the MedStar House Call Program.

In addition to these five criteria, we target elders who also have a history of hospitalization in the past year and a history of a post-acute Medicare episode (home health or inpatient rehab), who represent an even higher cost subgroup.

MedStar House Call Program is working with health economist group (JEN/Westat) on a matched-cohort study of the impact of the MHCP care on utilization and total costs of care to present later to HSCRC.