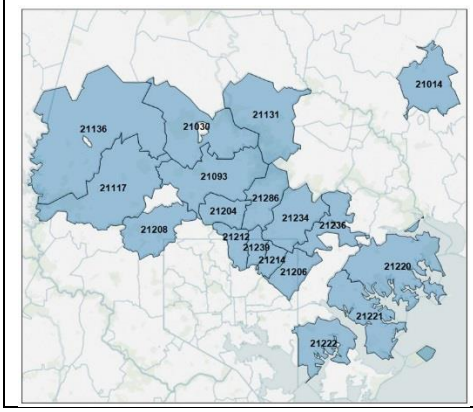
HSCRC
Health Services Cost Review Commission

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: *UM SJMG Transitional Care Center*
Participating Hospitals: *UM St. Joseph Medical Center*
Participating Community Based Organizations: *Maxim CBCM, SJMG Primary Care Providers, VNA Home Health and The Center for Eating Disorders, Baltimore County Department of Health, CRISP, Transformation Grant Regional Partnership Collaborative*
Geographic Service Area Covered by Regional Partnership (e.g., counties or zip codes): The Primary Service Areas of UM SJMC by zip code are concentrated within the Baltimore Metropolitan area. UM SJMC is located in Towson, Maryland, 21204:   

HSCRC
Health Services Cost Review Commission

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

Alice Siawlin Chan, Director of Population Health
7601 Osler Drive, Jordan 2nd Floor
Towson, MD 21204
410-337-4508
alicechan@umm.edu

HSCRC
Health Services Cost Review Commission

Program #1
Intervention Program Name: Transitional Care Center – High Risk Post Discharge and Behavioral Health
Category of Intervention: • Behavioral Health Integration -***Yes*** • Care Transition - ***Yes*** • Home-Based Care • Mobile Health • Patient Engagement & Community Education • Other (Please describe)
Short description of intervention: - At the Transitional Care Center, we focused on medically high risk post discharged patients by providing a comprehensive 1.5 hour consultation with a physician, pharmacist and care manager. In addition, the care manager manages the patient's safe transition and hand off back to the community. An extension of this center is the behavioral health line, where the psychiatrist and psychiatric nurse practitioner perform a full diagnostic workup on each patient. A transitional treatment plan is developed with an emphasis on intensive relapse prevention and reintegration to community, with comprehensive case management. Each patient is assigned to a licensed clinical social worker who conducts individual psychotherapy, and patients are assigned to selected group therapies including cognitive behavioral therapy, dialectical behavior therapy, substance abuse therapies if indicated, and family counselling. Patients are seen for pharmacological visits by the psychiatrist or psychiatric nurse practitioner. The goal is to provide a high intensity treatment for up to 90 days which will prevent the need for re-hospitalization or repeating emergency room visits.

Program #2 (if applicable)
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:

HSCRC
Health Services Cost Review Commission

Program #3 (if applicable)
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:

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