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: Totally Linking Care in Maryland (TLC-MD)
Participating Hospitals: 1. Doctors Community Hospital 2. UM Prince George's Hospital Center 3. UM Laurel Regional Medical Center 4. MedStar St. Mary's Hospital 5. MedStar Southern Maryland Hospital 6. Ft. Washington Medical Center 7. Calvert Memorial Hospital (left 7/1/2019)
Participating Community Based Organizations: 1. Prince George's County Dept of Health 2. St. Mary's County Dept of Health 3. Prince George's County Healthcare Alliance 4. AccessHealth 5. Maryland Citizens' Health Initiative Education Fund, Inc. 6. UM School of Pharmacy 7. Health Quality Indicators (MD's Medicare QIO)
Geographic Service Area Covered by Regional Partnership (e.g., counties or zip codes): 1. Prince George's County 2. St. Mary's County

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Program #1
Intervention Program Name: Care Coordination for patients with 2+ Chronic Conditions and Medicare FFS
Category of Intervention: • Behavioral Health Integration • Care Transition • Home-Based Care • Mobile Health • Patient Engagement & Community Education • Other (Please describe)
Short description of intervention: All patients meeting criterial are assigned a care coordinator (RN) to be the "quarterback" for all interactions with the patient. This includes coordinating/adding additional programs (outlined here) as well as implementing the discharge plan and helping to schedule follow-up appointments with PCP/specialists. This program also connects the patient with a formally trained health worker from their community who understands their challenges, lives in their neighborhood and can relate to their needs/issues and barriers. CHWs work very closely with the assigned care manager (RN) to report findings, additional needs and reasons for continued use of the healthcare system for services best provided outside the hospital environment.

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Program #2
Intervention Program Name: Medication Therapy Management (MTM, P3)
Category of Intervention: • Behavioral Health Integration • Care Transition • Home-Based Care • Mobile Health • Patient Engagement & Community Education • Other (Please describe)
Short description of intervention: Full medication therapy mgmt. consult, including a home visit (via a CHW) to ensure patient is following the latest hospital discharge (or PCP plan) for medications prescribed. Pharmacist home visits are conducted via teleconference or telehealth with the community health worker facilitating the technical aspects of the consult (if needed). Pharmacist confirms patient is taking the correct meds and that there are no contraindications of any meds the patient is currently taken (from previous hospital admissions or prescribed by other physicians).

Program #3
Intervention Program Name: Faith-based Community Engagement
Category of Intervention: • Behavioral Health Integration • Care Transition • Home-Based Care • Mobile Health • Patient Engagement & Community Education • Other (Please describe)
Short description of intervention: Partnering with the Maryland Citizens' Health Initiative Education Fund to train local faith-based congregations to assist with patients just discharged from a Maryland hospital (leveraging CRISP's ENS tools) and to ensure patient is supported to follow discharge plans and overall support with social determinants of health. TLC works with CRISP to create ENS messages that are routed to a trained hospital liaison who then contacts a trained congregation

leader who initiates their specific process/team to visit their congregant in a MD hospital. This initiative is an extension of TLC's Community Health Worker Program below.

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

Program #4
Intervention Program Name: Community Health Worker
Category of Intervention: • Behavioral Health Integration • Care Transition • Home-Based Care • Mobile Health • Patient Engagement & Community Education • Other (Please describe)
Short description of intervention: Partnering with the Prince George's County Healthcare Alliance, provides community health workers (from the county the patient is located in) to assist with home-based visits for care coordination, medication mgmt. (facilitates telehealth visits with pharmacists) and overall support with social determinants of health.

Program #5
Intervention Program Name: Blue Bag
Category of Intervention: • Behavioral Health Integration • Care Transition • Home-Based Care • Mobile Health • Patient Engagement & Community Education • Other (Please describe)
Short description of intervention: Partnering with Maryland's QIO, HQI, and upon discharge, patients with multiple medications (dispensed in the hospital or indicating that multiple medications are also at home from previous visits) are provided with a "blue

bag." Patients are then instructed to go home and collect all medications, supplements and herbs and place them in the blue bag and bring to the next scheduled provider appointment for medication review. The blue bag is also used for facilitation of a medication therapy management telehealth call (from the UM P3 program listed above) facilitated by a CHW.