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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: Trivergent Health Alliance Regional Partnership
Participating Hospitals: Frederick Memorial Hospital, Meritus Medical Center, and Western Maryland Regional Medical Center
Participating Community Based Organizations: Potomac Case Management Service, Inc. Lighthouse, Inc. Archway Station, Inc. Institute for Public Health Innovation Washington County Commission on Aging Asian American Center Frederick County Emergency Medical Services (EMS): Frederick County and Allegany Counties; Union Rescue Mission Allegany County Health Department; Allegany County Department of Social Services (DSS); Maryland Area Health Education Center West (AHEC); Allegany County Human Resources Development Commission (AHRDC); Western Maryland Food Bank; Associated Charities; Local Management Board; CRISP
Geographic Service Area Covered by Regional Partnership (e.g., counties or zip codes):

21501	**21529**	**21556**	**21709**	**21759**	**21780**	**21720**	**21748**
21502	**21530**	**21557**	**21710**	**21762**	**21788**	**21721**	**21749**
21503	**21532**	**21560**	**21714**	**21769**	**21790**	**21722**	**21750**
21504	**21536**	**21562**	**21716**	**21770**	**21792**	**21733**	**21756**

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21505	**21539**	**21766**	**21717**	**21771**	**21793**	**21734**	**21767**
21521	**21540**	**21701**	**21718**	**21773**	**21798**	**21740**	**21779**
21522	**21542**	**21702**	**21727**	**21774**	**21711**	**21741**	**21781**
21523	**21543**	**21703**	**21754**	**21775**	**21713**	**21742**	**21782**
21524	**21545**	**21704**	**21755**	**21777**	**21715**	**21746**	**21783**
21528	**21555**	**21705**	**21758**	**21778**	**21719**	**21747**	**21795**

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Program #1
Intervention Program Name: 1.1 Community Based Behavioral Health Case Management
Category of Intervention: • **Behavioral Health Care Transition- Primary category** This intervention also directly supports the following categories: • Other (Please describe): ○ Improve access to Behavioral Health resources ○ Care Coordination ○ Patient Engagement & Community Education ○ Home-Based Care
Short description of intervention: Implementation of Community based Behavioral Health Case Management (BH CM) leverages the best practice model at WMHS, as it provides patients upon discharge from the emergency department or inpatient behavioral health unit with specialized behavioral health case management resources to bridge the gap from discharge until connected with appropriate community based services. This service has reduced readmissions and ED revisit rates for program participants.

Program #2
Intervention Program Name: 1.2 Integration of Behavioral Health Professionals in Primary Care
Category of Intervention: • **Behavioral Health Integration- Primary category**

- Patient Engagement & Community Education- Intervention also directly supports this category.

Short description of intervention:

Implementation of standardized depression screening tool to screen all adults within health system employed practices for depression. Grant resources have been utilized to create or expand access to Behavioral Health Professionals (BHPs) embedded in Primary Care among regional partnership members. A standardized approach to depression screening leads to early detection and early intervention, allowing BHPs and primary care providers in coordination to develop collaborative treatment plans with the patient. These efforts support early detection and treatment to ward off escalation and crisis, which often lead to avoidable ED and inpatient utilization.

Program #3
Intervention Program Name: 2.1 Addition of Community Health Worker Service Program

Category of Intervention:

- **Patient Engagement** & Community Education- **Primary category** for this intervention
  Other (Please describe):
  This intervention directly supports the following categories as well:
  - Social Determinants of Health
  - Care Coordination
  - Care Transition
  - Home-Based Care

Short description of intervention:

2.1: Community Health Worker (CHW) service implemented as an extension of existing outpatient care management infrastructure to provide high touch care to increase patient engagement, assess for social determinants of health needs, and connect patients with appropriate community based resources. The outpatient Community Health Workers are supported by a clinically strong, multidisciplinary team to address clinical patient needs. Inpatient CHW services facilitate the scheduling of outpatient follow up appointments and ensuring roadblocks to attending the follow up appointments are mitigated- thus supporting efforts to reduce the incidence of readmissions.

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Program #4
Intervention Program Name: 2.2 Expansion of existing outpatient care management platforms to extend the reach of these programs within the identified high utilizer population.
Category of Intervention: Other (Please describe): • Care Coordination- Primary Category Intervention also directly supports the following categories: • Care Transition • Patient Engagement & Community Education • Mobile Health
Short description of intervention: This intervention building on existing outpatient care management infrastructure to address multidisciplinary clinical and care coordination needs of identified high utilizers, and the under-served population at-risk to become high utilizers. o FMH: Expansion of Care Clinic Services and Mobile Integrated Health Pilot Program o MMC: Embedded Case Management Services added to Specialty Care o WMHS: Union Rescue Mission Clinic and Hometown Healthy Program **FMH, Care Clinic:** Expansion of access to the existing multidisciplinary outpatient Care Clinic focused on providing disease based follow up care and care coordination from 2 days a week, to 5 days a week. Implementation of new Mobile Integrated Health pilot in collaboration with Frederick County EMS to provide initial proactive home visits for ED and/or EMS high utilizers. **WMHS, URM and Healthy Hometown Partnership:** Deployment of Clinical Resources within the Union Rescue Mission (URM) to support both the BH and CCM strategy while increasing access to primary care (a challenge found specific to Allegany County during the data analysis in the planning phase). Theses clinical resources are an extension of WMHS's existing multidisciplinary outpatient Clinical Care Resources (CCR) clinic which provides care coordination, and care transition support to patients with complex chronic care needs. Implementation of the Hometown Healthy Partnership is a collaboration between local health and social service providers in Allegany County and community leaders to help improve the health and well-being of our community. The goal of this program is to encourage community members to engage with WMHS and our Partners to learn more about how to live a healthier life and how to properly use the services available in our community **MMC, Embedded Care Management in Specialty Care:** Expansion of existing Integrated Care Management services in primary care to include two specialty practices (Pulmonary and Cardiology). Integrated Care Management team provides multidisciplinary care coordination, and care transition support from the primary or specialty care outpatient office in collaboration with the provider and their office based team.

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Program #5
Intervention Program Name: 3. Reduce Potentially Avoidable Utilization
Category of Intervention: • Other (Please describe)   ○ Appropriate Utilization of Care/ Care Coordination
Short description of intervention: 3.1 Improved care coordination and transitions by increasing integration with CRISP and creation of Care Alerts in alignment with Maryland Hospital Associate/CRISP/HSCRCs state wide goal to improve care coordination. 3.2: Reduction of PAU will inherently be achieved through implementation of the CCM and BH interventions as described above 3.3: Implementation of Mobile Integrated Health program as funding sources are identified and in alignment with state and county EMS regulatory compliance. **These interventions are carried out simultaneously in conjunction with the CCM and BH interventions detailed through 1 and 2 above. The primary focus of the CCM intervention work is to decrease preventable inpatient utilization and secondarily focuses to decrease ED PAU. The BH interventions primarily focus to decrease ED PAU. ED PAU measurement is incorporated into the BH and CCM process and outcome measures. Reporting for 3.2 and 3.3 will be inherently embedded within the BH and CCM specific intervention sections. Reporting associated with 3.1 will be addressed within the CRISP Key Indicators section of this narrative template.*

Program #6
Intervention Program Name: 4. Create a Regional Care Management Education Center (RCMEC)
Category of Intervention: • Other (Please describe)   ○ Appropriate utilization of care/ Care Coordination
Short description of intervention: Implement standardized, evidence based, case management practice and policy education and regionally to ensure consistent, strong, knowledge base of care team members.