

Regional Partnerships – Application Summary

Applicant/ Hospitals	<i>The Johns Hopkins Hospital (lead applicant), Johns Hopkins Bayview Medical Center, Mercy Medical Center, University of Maryland Medical Center, University of Maryland Medical Center Midtown Campus, Greater Baltimore Medical Center (GBMC), and Anne Arundel Medical Center</i>						
Scope and Target Population							
Region	<i>The combined Community Benefits Service Area (CBSA) for JHH and JHBMC covers approximately 27.9 square miles within East Baltimore, with an estimated 303,874 residents. The CBSA for MMC includes 18 combined statistical areas (CSAs) that represent downtown Baltimore and the communities east, west, and south of the city center. The combined CBSA for UMMC and Midtown consists of 12 zip codes within West Baltimore, with an estimated 438,356 people residing in the CBSA. Eight of the 18 CSAs for MMC and 3 of the 12 zip codes for UMMC/Midtown overlap with the JHH/JHBMC CBSA. All of MMC CSAs overlap with either JHH/JHBMC or UMMC/Midtown. (See Appendix 1 and 2.)</i>						250,000 populatio n? Y or N
Health Needs	<i>Hypertension, hyperlipidemia, diabetes, ischemic heart disease, asthma, mental health issues, substance use disorder, multiple chronic conditions</i>						Reference s CHNA? Y or N
Target Population	<i>More than 50 percent of residents living in these CBSA's are recipients of Medicare, Medicaid, dual eligible, lack health insurance and experience the following major barriers to health: poor health literacy, unaffordable/unstable housing, hunger, unemployment, and mental illness.</i>						Initial focus on Medicare or duals? Y or N
Model Concept							
Services/ Intervention	<p><i>Types of services proposed include identifying high-risk patients from a selected geographical area who are being admitted or at risk of being admitted to any of the five Baltimore City hospitals, connect them to care management in a primary care clinic or a community setting, actively engage them in care, and identify and address challenges they experience as barriers to optimal care.</i></p> <p><i>Types of interventions include: community mobilization for health partnerships, transitional care, outreach and engagement services, health education, health and social system navigation services, health coaching and self-management, clinical case management, and pharmacist led medication management. See pages 3-10 for details.</i></p>						
Role of partners	<p><i>See pages 16-18 for list of partners.</i></p> <p><i>The Baltimore City Health Department is grounded in the public health outcome goals of Healthy Baltimore 2015. It plans to continue to lead a collaboration of community members and organizations to achieve collective benefit impact on public health, deploy resources to align with public health priorities and needs of the community, collect and analyze health data for use in community engagement, planning, monitoring, policy making, and legislative advocacy. Sisters Together and Reaching (STAR) will continue to build upon its community based Community Health Worker Case Manager model for this Regional Partnership. The Esperanza Center, with its long-standing history of serving the immigrant population of Baltimore, will contribute lessons learned related to health needs and barriers to care among the growing Latino population in Baltimore City. Based on the experiences serving a patient population challenged by high disease burden and homelessness, Health Care for the Homeless will bring to the table its expertise in providing comprehensive medical services for people experiencing homelessness. All of the partners will participate in regular planning meetings.</i></p>						
	PCPs: Y or N	Long term care: Y or N	Behavioral health: Y or N	Public health? Y or N	Community orgs? Y or N	Others: <i>Esperanza Center, Health Care for the Homeless</i>	
Infrastr./ workforce	<i>Staffing needed for model includes: Medical Director for Population Health and Community Health Programs, Project Manager, Population Health Associate, Senior Data Analyst Project Lead, Analysts, IT/Data Consultant, Clinical Informatics Specialist, Administrative Assistant, Community Program Manager.</i>					Utilizes CRISP? Y or N	Address care plan sharing ? Y or N

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Alignment w/ All Payer Model	<p><i>The proposal addresses how it fits under the All Payer Model and furthers its work in at least two important ways: it creates a forum where hospitals can come together collaboratively rather than competitively to share new knowledge and evidence, particularly around mutual challenges such as case-finding, eligibility criteria, and evaluation methods; and it sets a foundation for leveraging additional common resources, such as IT infrastructure, in the future.</i></p> <p><i>Care coordination is referenced.</i></p>		
Population Health Strategy			
	<p><i>(1) population health assessment, (2) interpretation and prioritization of health needs, (3) risk stratification and segmentation of population according to health needs, (4) development of evidence based interventions tailored to meet the needs of the population, (5) implementation of evidence-based interventions to improve health, (6) ongoing monitoring and continuous QI, (7) evaluation and dissemination</i></p>	<p>Focus on risk factors? Y or N</p>	<p>Align with LHIC? Y or N</p>
Potential for Sustainability			
Value-based payment structures	<p><i>Savings from avoidable utilization with reductions in inpatient admissions and readmissions, savings from patients that receive care across multiple organizations</i></p>		
Population health funding	<p><i>Potential revenue that may be derived from current and proposed CPT codes that permit providers and other entities to bill public and private payers for delivering services such as care management, care coordination, and pharmacist-led Medication Management.</i></p>		
Proposed Process and List of Partners			
Proposed process	<p><i>A Steering Committee will be formed, comprised of at least one senior executive leader from MMC, University of Maryland Medical System (UMMS), STAR, Esperanza Center, Health Care for the Homeless, the Baltimore City Health Department, JHM, JHH, JHBMC, JHHC, Johns Hopkins Community Physicians (JHCP), Johns Hopkins Home Care Group (JHHCG), and Johns Hopkins University (JHU). Leaders from the workgroups listed below will also participate. This Committee will meet monthly for 90 minutes to oversee strategies, make key decisions, review timelines, monitor progress toward milestones, and resolve barriers that affect the Regional Partnership. The Steering Committee is responsible for the Interim Report due on Sept. 1st and the Regional Transformation Plan due on Dec. 1, 2015. Workgroups will be established to focus on key planning areas including: Analytics and Evaluation, Transitional Care and Interventions, and Finance and Sustainability. Each workgroup will have a designated leader who will participate on the Steering Committee and work closely with the Project Manager on timelines, planning deliverables, and meeting materials. Most workgroups will meet twice a month for a 1-2 hour meeting. (see pages 14-15 for details)</i></p>		<p>Includes list of partners? Y or N</p>
Budget			
	<p>Includes line item budget? Y or N</p>	<p>Includes narrative justifying costs? Y or N</p>	<p>Funds are for planning (not implementation)? Y or N</p>

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Applicant/ Hospitals	<i>Baltimore Health System Transformation Partnership (BHSTP): University of Maryland Medical Center (lead);</i>	
Scope and Target Population		
Region	<i>All 19 Baltimore City zip codes representing the Community Benefit Service Area (21201, 21202, 21205, 21206, 21210, 21211, 21213...21229, 21230, and 21231).</i>	250,000 population? Y or N
Health Needs	<i>Highest utilizers of healthcare who have chronic illnesses including mental illness.</i>	References CHNA? Y or N
Target Population	<i>Baltimore City high-utilizers found in 19 zip codes who are either Medicare beneficiaries with 3+ hospital utilizations in one year or dual-eligibles with 3+ hospital utilizations in one year. Includes those with chronic illnesses, including mental health.</i> <i>Population health target population determined while planning and informed using census-tract level data and HSCRC Area Deprivation Index, focused on those who are statistically at risk of high-utilization.</i>	Initial focus on Medicare or duals? Y or N
Model Concept		
Services/ Intervention	<p><i>Creation of the Primary Care Support Center (PCSC), a regionalized, cross-system, integrated solution. The PCSC delivery model serves as a bridge between hospital and primary care providers and provides patients with community-based health and social services in order to create a city-wide continuum of care. The PCSC develops an individualized plan for vulnerable patients immediately after discharge that addresses the social and clinical needs and provides comprehensive wrap-around services synonymous with the patient-centered medical home. The PCSC operates as an extension to primary care practices, allowing them to provide complete patient-centered medical care at no cost to the patient or the primary care provider.</i></p> <p><i>High-utilizers are referred to the PCSC by the discharging hospital for care coordination, including individual continuum-wide care plan creation and connection to a PCP. Patients who are referred to the PCSC without a medical home will be connected to a primary care provider through the PCSC network. In addition to primary care patients receive wrap-around services. PCSC care teams are composed of a mid-level primary care provider, care coordinator, social worker, behavioral health specialist, pharmacist, health educator, medical assistant, nutritionist, community health worker, and health and life coach.</i></p>	
Role of partners	<p><i>Seven acute care hospitals, four federally-qualified health centers, one skilled nursing facility, one local health department/local health improvement coalition, and four community-based health services business.</i></p> <p><i>Partner resources used to develop patient individualized plans. Some examples are: Comprehensive Housing Assistance Inc. (CHAI) to provide senior housing; Healthcare for the Homeless as a partner in addressing specific population and their associated needs; and, Keswick Multi-Care or other BHSTP partner will provide housing insecurity support. High-acuity patients referred to AbsoluteCARE for ambulatory ICU services and advanced primary care practice and Coordinating Center and Mosaic Community Service will provide the design of the cornerstones of care coordination and behavioral health. This partnership's Intention is that it exist beyond the planning stage, specifically via the creation of an IT infrastructure even if not able to mobilize all elements planned.</i></p>	

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	PCPs: Y or N <i>Appendix E)</i>	Long term care: Y or N <i>(See Appendix E)</i>	Behavioral health: Y or N	Public health? Y or N	Community orgs? Y or N <i>(Appendix F)</i>	Others: <i>Healthcare for the Homeless, Mosaic Community Service, Coordinating Center</i>	
Infrastr./ workforce	<p><i>Staffing needed for model:</i></p> <ul style="list-style-type: none"> > PCSC care teams are composed of mid-level primary care provider, care coordinator, social worker, behavioral health specialist, pharmacist, health educator, medical assistant, nutritionist, community health worker, and health and life coach. > PCSC center run by CEO (experience managing clinical operations at the community level), Chief Medical Officer (CMO), Chief Quality Officer/Data Analyst, and Chief Medical Officer (CFO) > Data exchange among partners, including use of CRISP and sharing of patient care plans/profiles. > Technical assistance for accessing/interpreting census-tract and neighborhood-level data needed from HSCRC. > IT consultant to conduct assessment of CRISP and partner's IT infrastructure in order to (1) identify disparate IT infrastructure, (2) evaluate opportunities for data exchange and interoperability, and (3) review hardware, software, and technological clinical tools for use in clinical and administrative operations. 					Utilizes CRISP? Y or N	Address care plan sharing? Y or N
Alignment w/ All Payer Model	<p><i>Design addresses triple aim of Maryland's all payer model and the target population found within the Community Benefit Service Area (CBSA) of the partnering hospitals. Further, the design of care coordination and behavioral health will incorporate evidence-based practices and recommendations from the HSCRC Care Coordination Workgroup.</i></p>						
Population Health Strategy							
	<p><i>Informed by continual process that reviews utilization data, community-level diseases data, and inventories existing community programs and services, researches evidence-based practice and innovation, and ensures community participation in the process.</i></p> <p><i>This strategy includes a PCSC staff member and an advisory council. The inter-disciplinary advisory council (LHIC, community members, community leaders, hospital reps, community healthcare providers, other stakeholders) will develop a strategy that the Population Health Management Director will implement. The advisory council will additionally set population health priorities, assess progress, identify gaps, and select programs for funding.</i></p>					Focus on risk factors? Y or N	Align with LHIC? Y or N
Potential for Sustainability							
Value-based payment structures	<p><i>Suggest that the PCSC model bolsters primary care resources and produces efficiencies in care and IT that make the model scalable and economical. Further savings is suggested via examples of similar models in Kentucky's University Hospital Population Health Management Complex Case Program and Washington's High Utilizer Case Management Program. It is anticipated that cost savings will be demonstrated through financial modeling done during the planning process. This model will be used to motivate payers and hospitals to commit to care management payments that will cover the operating costs and produce a surplus to be invested in the population health strategy. Additionally, exploring a Pay for Success strategy where social service providers are compensated in lieu of reimbursing medical providers for health outcomes will provide opportunity for a different financial model.</i></p>						

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	<p><i>Annual budget surplus from model concepts financing design will be applied toward regions population health strategy. Focus of the funding will be on building local capacity by investing in new and already existing programs.</i></p> <p><i>PCSC rely on care management payments, part of the planning process will determine the feasibility of the model by examining a return on investment allowing hospitals to reduce overhead costs. Suggests that BHSTP may seek a shared savings arrangement in order to generate more revenue. Goal is to examine a financial model that covers PCSC activities and allows for surplus to be invested into population health strategy.</i></p>		
Population health funding	<p><i>Annual budget surplus from model concepts financing design will be applied toward regions population health strategy. Focus of the funding will be on building local capacity by investing in new and already existing programs.</i></p>		
Proposed Process and List of Partners			
Proposed process	<p><i>Utilize 5 workgroups in order to complete planning process:</i></p> <ul style="list-style-type: none"> <i>➤ Infrastructure and Population Health Strategy workgroup</i> <i>➤ IT Infrastructure and Technology Workgroup</i> <i>➤ Care Coordination, Chronic Disease Management, and Care Transitions Workgroup</i> <i>➤ Financing, Data, and Quality Workgroup</i> <i>➤ Provider and Community Engagement Workgroup</i> <p><i>First will completed planning infrastructure, next asset mapping, then define health system transformation through two retreats attended by core representatives from all partner organizations and key stakeholders in order to identify areas of system to target for transformation. Next, the workgroups will meet monthly and report progress at full committee meetings on a monthly basis. Next, qualitative research of the target population, community leaders and partners, and providers will be done to understand the perspective on the health system. Finally there will be a report.</i></p> <p><i>> Explore additional programs and processed while planning the PCSC such as Care at Hand (mobile application for assessing readmission and admission risk), “12-12 C-TAT” (universal hospital screening where with 12 hours of admission all patients are assessed for readmission, those at risk are assigned to a team that develops a prevention strategy to begin implementation prior to discharge), transportation (exploring having the PCSC providing this service), and pay for success (compensates social service providers in lieu of reimbursing medical professionals for improved health outcomes).</i></p> <p><i>>IT consultant to conduct assessment of CRISP and partner’s IT infrastructure in order to (1) identify disparate IT infrastructure, (2) evaluate opportunities for data exchange and interoperability, and (3) review hardware, software, and technological clinical tools for use in clinical and administrative operations.</i></p> <p><i>>Cites Collective Impact, the idea that sustainable improvements are achieved through stakeholders abandoning their agendas in favor of a collective approach.</i></p> <p><i>> Population Health Advisory Council can operate without funding</i></p>		Includes list of partners? Y
Budget			
	Includes line item budget? Y or N	Includes narrative justifying costs? Y or N	Funds are for planning (not implementation)? Y or N

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Applicant/ Hospitals	<i>Trivergent Health Alliance (Frederick Regional Health System, Meritus Medical Center, and Western Maryland Health System). Garrett County Memorial Hospital is also a “partner.”</i>						
Scope and Target Population							
Region	<i>Allegany, Frederick, Washington Counties (80 total zipcodes)</i>					250,000 populatio n? Y or N	
	<i>Population: 455,000+</i>						
Health Needs	<i>Chronic conditions among total population: Hypertension, lipid disease, diabetes, “other” mental health conditions (not cognitive or mood disorders), cardiac arrhythmia, and COPD.</i>					Reference s CHNA? Y or N	
	<i>Chronic conditions among Medicare population: hypertension, lipid disease, arthritis, ischemic heart disease, COPD, and diabetes.</i>						
	<i>Chronic conditions among high utilizers: hypertension, lipid disease, mood disorder, diabetes, COPD, and cardiac arrhythmias</i>						
Target Population	<i>Focus on two specific Medicare populations: (1) high utilizers and (2) those who have multiple chronic conditions (five or more)</i>					Initial focus on Medicare or duals? Y or N	
Model Concept							
Services/ Intervention	<i>Transitions of care; care coordination; prevention and wellness programs; behavioral health integration and behavioral health crisis intervention; virtual care team and community care teams; and long term care (care management and transitions); standardizing clinical resources and tools; leveraging training and workforce development; technologies and evidence-based best practice models; and community services</i>						
Role of partners	<i>Partners will serve on the Executive Committee, Task Forces and work groups, as appropriate. Partner roles and responsibilities include: providing input on structure and process, helping with identification and engagement of patients needing services, workforce strategy and development, and planning, implementation and sustainability. See pages 19-21 for list of partners.</i>						
	<i>In general, community partner staffing will be responsible for transitions of care, care coordination, prevention & wellness programs, behavioral health integration & behavioral health crisis intervention, virtual care team & community care teams, and long term care.</i>						
	<i>Key Alliance partners would govern and oversee the planning, implementation, and accountability for progress throughout Regional Transformation; build bridges to overcome any gaps or barriers during the planning phase; connect critical community partners and other care delivery partners to the specific teams and work processes; and develop infrastructure and systems that cut across organizations and improvement efforts to create sustainable and efficient use of workforce, technology, and standardized evidence-based tools.</i>						
	PCPs: Y or N	Long term care: Y or N	Behavioral health: Y or N	Public health? Y or N	Community orgs? Y or N	Others: <i>See proposed process/partners list section below or pages 17, 19-21</i>	
Infrastr./ workforce	<i>Specific staffing needs for model include hiring a new, local project manager to manage tasks and facilitate workgroups. Also to act as key staff for Alliance leadership.</i>					Utilizes CRISP? Y or N	
	<i>Reporting and data sharing through CRISP and shared regional framework of evidence-based tools, workforce strategies, best practice model deployment, community service approach, and ongoing system learning).</i>					Address care plan sharing ? Y or N	
Alignment w/ All Payer	<i>Yes. The Alliance’s potential savings, community benefits, and other financial strategies to pursue, including payment transformation will all be defined and aligned with the All-Payer mode. The</i>						

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Model	<i>application references care coordination but not HSCRC workgroups.</i>		
Population Health Strategy			
	<i>Focus on aging populations, frail elders and patients with chronic medical conditions and serious mental illness. There will also be emphasis on primary care, prevention, and reduction of risk factors, by reaching patients where they are, whether inside of outside of traditional health care settings.</i>	Focus on risk factors? Y or N	Align with LHIC? Y or N
Potential for Sustainability			
Value-based payment structures	<p><i>The Alliance proposes to fund the model with ongoing cost savings that are expected to be recouped early on by reducing unnecessary, excessive use of the ED, as well as avoidable inpatient admissions and readmissions. They are considering various value-based payment structures such as pay-for-performance, physician gain-sharing, and shared savings. See table on pages 13-14.</i></p> <p><i>The long-term sustainability plan includes the shift to increased reliance on value-based payments and managed care contracts that reward efficiency, value, managing across the care continuum, and will not depend on grant funding from the state or other sources. The Alliance plans to find opportunities to share resources and address alignment of key services and resources (IT, community dollars, staffing, equipment, EHR, inter-operability), share best practices, and identify collective payment strategies. See pages 12-15 for details.</i></p>		
Population health funding	<i>The Alliance is considering financial mechanisms for regional health improvement strategy such as regional health trusts (see table on pages 13-14) and directed community benefit dollars.</i>		
Proposed Process and List of Partners			
Proposed process	<p><i>Planning process will begin with a kick-off retreat with key hospital and community leaders. At this retreat, the team will define a high level multi-year regional transformation plan or horizon map, which will guide their short and long term planning efforts. In May 2015, the general Executive Committee will be formed and conduct its initial meeting. The committee will meet monthly during the planning phase. Three task forces will be formed (Funding and Sustainability, Population Health Strategies, and Clinical Models, Workforce, and Supports). Ad hoc workgroups designed to tackle specific strategies and work will also be formed. More widespread input will be gained through structured focus groups, town hall meetings, and committee structures within various partner organizations. See pages 16-17 for details.</i></p>		Includes list of partners? Y or N
Budget			
	Includes line item budget? Y or N	Includes narrative justifying costs? Y or N	Funds are for planning (not implementation)? Y or N

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Applicant/ Hospitals	<i>Bay Area Transformation Partnership: Anne Arundel Medical Center (lead applicant); University of Maryland Baltimore Washington Medical Center; Healthy Anne Arundel Coalition (LHIC); and, MedChi, the Maryland State Medical Society</i>						
Scope and Target Population							
Region	<i>Includes counties of Anne Arundel, Queen Anne’s, and Talbot (Appendix A) and zip codes in this region.</i>					250,000 populatio n? Y or N	
Health Needs	<i>Need per CHNA identified chronic diseases such as diabetes, hypertension, and chronic obstructive pulmonary disease (COPD), adult obesity, tobacco use, and behavioral health as areas necessary of intervention.</i>					Reference s CHNA? Y or N	
Target Population	<i>Focuses on three distinct segments of the population with priority given to Medicare and dual-eligible population: (1) vulnerable high utilizer population that are chronically ill; (2) the rising-risk population who are in the beginning/early stages of chronic diseases; and (3) the healthy population.</i>					Initial focus on Medicare or duals? Y or N	
Model Concept							
Services/ Intervention	<i>The model created through the planning process will focus on two critical elements of community-wide coordination: identifying the essential partners and designing how they will best interact with each other. Develop a standardized Universal Care Plan template that can be generated from common data elements and accessed within a variety of workflows and provider settings. Develop a registry of vulnerable, chronically ill patients so that providers are notified in real time as patients enter practices or facilities. Notifications provided by the registry will include clinical and social, cogent “need to know right now” information provided in a standardized electronic format. Further identifying the rising-risk patients who receive routine care for chronic illness in EDs and facilitating their entry into patient-centered medical homes and community clinics equipped to provide culturally competent, high-quality medical care through chronic care management services. Finally for the health population a partnership model is proposed as an integrated approach to primary care, public health, and community-based resources in order to pool resources and skills to promote and sustain healthy habits in this population. Additionally, in order to support the Universal Care Plan, the implementation of a text messaging system for providers will be developed.</i>						
Role of partners	<i>Developing this model will require design and testing by subject-matter experts, ACO physicians to provide insight into All Payer Model, long-term and post-acute care providers, behavioral health providers, and the Local Health Improvement Coalition – the Healthy Anne Arundel Coalition will provide patient feedback to the model design. CRISP will provide technological expertise in registry design and development of the notification feature.</i>						
	PCPs: Y or N	Long term care: Y or N	Behavioral health: Y or N	Public health? Y or N	Community orgs? Y or N	Others:	
Infrastr./ workforce	<i>Additional support for data exchange among partners, including use of CRISP and sharing of patient care plans/profiles, will be required in order to create Universal Health Plan platform.</i>					Utilizes CRISP? Y or N	Address care plan sharing? Y or N
Alignment w/ All Payer Model	<i>The Universal Care Plan – once designed, tested, and refined – will have the potential to be propagated statewide by CRISP to support the goals and requirements of the All-Payer Model.</i>						
Population Health Strategy							
	<i>CHNA and LHIC strategic plans identify health disparities, high burdens of chronic disease, tobacco use, and adult obesity as key areas of need for adolescents and adults. While full implementation of the model concept will result in community-wide adoption of the Universal Care Plan, coupled by secure and rapid messaging among providers, in order to continue these efforts at the population level the planning process will include review of</i>					Focus on risk factors? Y or N	Align with LHIC? Y or N

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	<p><i>community resources, evidence-based care pathways, and payment methodologies so patients are given adequate support in the most appropriate setting. Focus on identifying strategies to reduce ED utilization for behavioral health-related conditions, diabetes-related conditions, and addressing tobacco use in adolescents will focus the population health strategy. Activities will include a conference reflecting on care coordination strategies from interdisciplinary teams, sharing of best practices, and collaboration between local behavioral health resources.</i></p>		
Potential for Sustainability			
Value-based payment structures	<p><i>The Bay Area Transformation Partnership will determine how global budgets, accountable care arrangements, gain sharing, and other quality-based reimbursement programs will provide incentives/funding to sustain and expand these efforts across diverse providers of care in value-based systems. One opportunity is with CCM and TCM codes which have become reimbursable for services rendered by clinicians coordinating the care of high-risk individuals. These incentives create an environment that promotes adoption of care-coordination features and services and pairs with the alignment of quality incentives that reduce complications and preventable utilization of medical resources.</i></p>		
Population health funding	<p><i>Explore innovative uses of community-benefit dollars and the best means in which hospitals can support community based providers consistent with legal limitations and focused on effective risk management. Once established, the infrastructure created by this partnership is designed to support providers in better managing high-risk patients should be a relatively low cost means to manage risk. Thus, it will be marketable to providers that seek to undertake shared savings models, managed care payers, and the eventual evolution of gain sharing and bundling initiatives that are likely to be created in Maryland.</i></p>		
Proposed Process and List of Partners			
Proposed process	<p><i>Upon award a separate legal entity will be established to govern the proposal. The entity will establish a steering committee to engage the broader community. CRISP will provide technical support for the registry development and Universal Care Plan notification features. Work in both population area and Universal Care Plan will occur simultaneously and stakeholders and partners will be asked to share insight through meetings that are pertinent to the population served and area of expertise. List of Steering Committee members found on Page 13-14.</i></p>		<p>Includes list of partners? Y or N</p>
Budget			
	Includes line item budget? Y or N	Includes narrative justifying costs? Y or N	Funds are for planning (not implementation)? Y or N

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Applicant/ Hospitals	NexusMontgomery: Holy Cross Health (lead entity), Suburban Hospital, & Primary Care Coordination of Montgomery County					
Scope and Target Population						
Region	Montgomery County, 16 zip codes including Rockville and Gaithersburg.				250,000 population? Y or N	
Health Needs	Focus on seniors 65+, there are approximately 86,080 in the catchment area. Approximately 5,600 of them live in assisted living communities. This will include addressing those who are chronically ill and at high risk as well as those who have chronic disease but are under control. Per HSCRC Chronic Conditions-High Utilizer Report for Montgomery County key disease are cardiovascular disease and diabetes as well as mental health and mood disorder patients.				References CHNA? Y or N	
Target Population	Focus on Medicare beneficiaries and dual eligible individuals. The first priority population will be Medicare and dual eligible individuals residing in senior housing and senior care facilities within the target geographic region. Once modeled appropriately, scaling the program to low-income and other housing communities will be next followed by applying the model to all payers. Focus on seniors because 65+ are set to make up 15% of Montgomery County population by 2020.				Initial focus on Medicare or duals? Y or N	
Model Concept						
Services/ Intervention	<p>The model concept creates a centralized, collaborative function that we refer to as a “switching station” will identify and triage individuals to the appropriate medical and social interventions to improve disease management for the chronically ill (including self-management), and ultimately to reduce inappropriate use of hospital services. Payer engagement during the planning process will facilitate easier potential integration of the model into existing systems.</p> <p>Model embeds a nurse/community health worker team (“the team”) within senior living communities to serve multiple roles and be responsive to each communities needs based on data. Role of the team is to determine community needs, conduct health risk assessments with individual patients, offer nursing interventions, connect to primary care and payer care management agencies, and connect to appropriate services and service providers. This stage will design a common health risk assessment tool, predictive modeling tool, and strategies for individualized engagement and care planning. Additional development of a shared inventory of programs, interventions, and resources identified specifically by and for the senior community in order to improve information sharing and technology capacity to share care plans between providers and insurers and identify gaps in services. Design of IT infrastructure utilizing CRISP to secure patient data via opt-in care management panels, including ENS notification, site-specific reporting on particular characteristics (admissions, diagnosis, falls, readmission, etc.), and the ability to query the system. Finally the model will examine method for measuring health and functional status, cost, and patient experience.</p>					
Role of partners	During the planning period, the project partners will focus on two major areas. They will define the governance, learning, and execution infrastructure needed to achieve NexusMontgomery goals. In addition, they will create processes to manage and measure progress (and adapt) for a portfolio of system-level projects (interventions. See Page 16-18.					
	PCPs: Y or N	Long term care: Y or N	Behavioral health: Y or N	Public health? Y or N	Community orgs? Y or N	Others: list
Infrastr./ workforce	Expertise consultancy needed in areas of financial models, Medicare data analytics, and community-based infrastructure. High touch nurse/community health worker team to link seniors to resources and service and provide “switching station” capacity. Governance will include one entity as a convener.				Utilizes CRISP? Y or N	Address care plan sharing? Y or N

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Alignment w/ All Payer Model	<i>Intention of the planning process is to align with the All Payer Model and determine a fiscally sustainable model that returns savings to the overall health system in order to meet All Payer Model goals. Model focuses is on reducing total cost of care for Medicare patients, scalable for all-payers and could be utilized in other Maryland jurisdictions, and the partnership of NexusMontgomery is committed to planning and implementation as a learning process to be conducted in partnership with HSCRC and other regional partnerships.</i>		
Population Health Strategy			
	<i>Aim is to maintain health status for beneficiaries who are healthy and have chronic conditions that are already under control and maintain attrition for those moving out of critical care into coordinated care by identifying and linking primary (food, transport, etc.), secondary (screening), and tertiary (health coaching) prevention strategies (See page 11 for detail). Partnership will address social determinates of health through Minority Community Empowerment Project and deployment of CHWs and already existing programs will be enhances, expanded, and amended to better promote protective factors and reduce risk factors for the target population. Population health services are embedded into the “switching stations.”</i>	Focus on risk factors? Y or N	Align with LHIC? Y or N
Potential for Sustainability			
Value-based payment structures	<p><i>Financial modeling, intervention design and retooling intended to prioritize fiscally sustainable models that return savings to the overall health system. The modeling process will develop a payment model in collaboration with all partners (hospital, clinic, community service agencies, and local health department) by exploring potential payment mechanisms to reduce overall total cost of care for the target population, achieve measurable health outcomes, be functional for delivery entities (hospital, senior living, etc.), and be adaptable to other target populations.</i></p> <p><i>Build in pay for performance for service providers to ensure quality of care. Intend to integrate new revenue streams, such as Medicare’s billing codes for care management, into financial model and align the financial model with global cost reduction incentives within Maryland’s hospital budget model. Expect to recover initial investments over a 3 year time horizon.</i></p>		
Population health funding	<i>Payment model intended to compensate each part of delivery care team (hospitals, senior living facilities, primary care, community-based services, and local health department) to be compensated for efforts in patient-centered coordination approach. First priority of payment model ensures quality care for patients, next design a system that requires minimum “new money” entering system, and hold financial model accountable via performance measures for fiscal and clinical outcome (see Page 15).</i>		
Proposed Process and List of Partners			
Proposed process	<i>Primary Care Coalition (PCC) will facilitate planning process by convening the core team and Reactor Panels, providing support, producing an interim report for September 1st, and finalizing a final Regional Plan. The Core team will meet once per month to determine the model design. Between meetings subject matter experts, advice from Reactor Panels and participating health system and core team members will conduct analytical and planning work. Partner hospitals will produce the final model decisions. Rector Panels will provide input on senior living communities, service providers, senior engagement, and physician perspectives and needs to be considered in the model. Finally, individual meetings with community partners will provide design and service delivery insight. See Table 3 for the Work Plan.</i>		Includes list of partners? Y or N
Budget			
	Includes line item budget? Y or N	Includes narrative justifying costs? Y or N	Funds are for planning (not implementation)? Y or N

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Applicant/ Hospitals	Howard County/Howard County General Hospital						
Scope and Target Population							
Region	25 zipcodes in Howard County Population: 309,284					250,000 population? Y or N	
Health Needs	Heart disease, stroke, cancer, COPD, diabetes, cancer, diabetes, angina, heart attack, stroke, high blood pressure, overweight, obese, requirement of home care					References CHNA? Y or N	
Target Population	Medicare population, high-utilizers, individuals with multiple chronic conditions,					Initial focus on Medicare or duals? Y or N	
Model Concept							
Services/ Intervention	(1) link residents in the community who may not be accessing the health system appropriately to primary care and other needed resources; (2) improve ease of transitions from various care settings; (3) address social needs; (4) improve access to behavioral and mental health services; (5) identify areas to improve medication education and reconciliation, pharmacy access, and medication compliance across points of care; (6) improve communication and transfers between primary and specialty care. See pages 8-10 for details.						
Role of partners	Howard County LHIC will most likely serve as the “integrator,” who will be the central entity responsible for bringing together stakeholders from all involved organizations to address gaps in care, improve efficiency, and reduce duplication. Partners will provide representatives to participate in Core discussion and process improvement exercises or subcommittees and to collaborate to find sustainable solutions for financing these efforts and creating a potential model that is portable and could be replicated statewide. See pages 17-19 for detailed roles of partners. See page 19 for list of partners.						
	PCPs: Y or N	Long term care: Y or N	Behavioral health: Y or N	Public health? Y or N	Community orgs? Y or N	Others: Howard County Dept of Citizen Services/Office on Aging	
Infrastr./ workforce	Anticipated incremental staff is needed to manage, guide, and further this effort including a Program Manager, Project Manager, Process Improvement Facilitator, Data Analyst, and an Administrative Coordinator/Assistant. See budget narrative for detailed roles and responsibilities for these positions. Data exchange among partners will include use of CRISP, sharing of patient care plans/profiles, readmission analysis reports, high utilization reports, vital statistics, predictive modeling and intervention implementation. See pages 10-11 for details.				Utilizes CRISP? Y or N	Address care plan sharing? Y or N	
Alignment w/ All Payer Model	The proposal addresses how it fits under the All Payer Model. The proposed model will initially target Medicare high utilizer population by providing community-based care coordination, and each of the stakeholders will play an important role in improving health outcomes for these individuals. This approach is aligned with both county goals and the All Payer Model, which also targets utilizers enrolled in Medicare.						
Population Health Strategy							
	The benefit of the proposed model is that it sets the stage for much larger, more permanent changes in the way health care is delivered across a region. Creating a system where information, incentives, and decision making are shared for the good of the overall population reduces duplication of efforts, decreases wasteful spending, improves patient outcomes, and improves patient satisfaction with care. Further, bringing leadership from many separate organizations to a common table provides an open communication				Focus on risk factors? Y or N	Align with LHIC? Y or N	

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	<p><i>stream where all parties can voice barriers to care and concerns about specific areas of health, and divide responsibility for dealing with issues as they arise. Shared responsibility for health outcomes, in particular when shared financing models are in place, means less duplication, less wasteful spending, and improved accountability for patient outcomes.</i></p> <p><i>The model will allow for much broader collaborations to take place around other areas identified for improvement by the LHIC, such as obesity, access to care, and behavioral/mental health for the community. Having a centralized platform to bring together leadership and a data infrastructure in place to support these collaborations will facilitate discussions around other community priority issues. Creating a system like this ensures that the health needs of all residents, whether they fall into a low risk or high risk category, are being met, and helps to ensure that population level movements across risk levels trend in a positive direction</i></p>		
Potential for Sustainability			
Value-based payment structures	Proposed value-based payment structures such as ACO metrics, patient engagement, waiver goals, shared savings, etc.		
Population health funding	Funding structures for regional health improvement strategy such as community benefit dollars, community health trusts, a per member per month (PMPM) participant fee for payers or employers)		
Proposed Process and List of Partners			
Proposed process	<p><i>With the LHIC serving as the central integrator for the delivery model, the decision-making and planning process will also be located centrally within the LHIC. Six 'Cores' will be created targeting specific points of the health care experience or risk areas of the health system: 1) Community Link to Care, 2) Facility Transitions, 3) Social Needs, 4) Mental & Behavioral Health, 5) Pharmacy, and 6) Primary to Specialty Care. Each Core will consist of subject matter experts from the various stakeholders involved in each stage/area fostering collaboration across organizations, aligning goals and efforts, and creating more patient/family centric approaches to care delivery. See pages 16-20 for details about the decision-making model, description of 'cores', meeting schedules, and planning process.</i></p>	Includes list of partners? Y or N	
Budget			
	Includes line item budget? Y or N	Includes narrative justifying costs? Y or N	Funds are for planning (not implementation)? Y or N

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Applicant/ Hospitals	University of Maryland Upper Chesapeake Health & Union Hospital of Cecil County						
Scope and Target Population							
Region	All zipcodes in Harford and Cecil as well as 21087 and 21156 in Baltimore County. Population: 348,000+					250,000 populatio n? Y or N	
Health Needs	Coronary artery disease, hypertension, mood disorders and other mental health issues, substance abuse					Reference s CHNA? Y or N	
Target Population	Medicare and Medicaid patients that are high utilizers of hospital services with chronic conditions, including cardiac, endocrine, and behavioral health issues.					Initial focus on Medicare or duals? Y or N	
Model Concept							
Services/ Intervention	In-home evaluation, care coordination, telehealth monitoring, multidisciplinary clinics , care plan sharing across the continuum to aid in decision making. Pre-intervention, intervention, and post- intervention coordination (see pages. 3-6 for details). Emphasis will shift overtime to seek out patients before they reach the high utilizer threshold, including referrals from ambulatory practices, EMS, and government agencies.						
Role of partners	<p>See page 13 for list of partners.</p> <p>Physicians will identify patients by examining chronic condition information and hospital utilization metrics. Partners will use develop new or utilize existing tools to help create a common understanding of the patient needs and target the appropriate intervention. Administrative staff will manage enrollment in the program and ensure that stakeholders across the continuum are aware of the patient’s participation status in CRISP (patients have the ability to opt out). Emergency Medical Service teams, Private Ambulance companies, CHWs, or visiting nurses will conduct in-home visits for those high-risk patients who demonstrate a willingness to participate but lack the basic resources or support to get to multiple provider locations.</p> <p>Data on the needs of high utilizers referred to the program will be captured and used as an important reference tool for the care team to track additional referrals and understand where the patient has already received care. This allows the Care Center team to work in a supportive manner with the other programs instead of in silos or even in competition.</p>						
	PCPs: Y or N	Long term care: Y or N	Behavioral health: Y or N	Public health? Y or N	Community orgs? Y or N	Other: Heart to Hart Ambulance, home health care, emergency medical services, and CRISP	
Infrastr./ workforce	Staffing needed for model includes: project manager to serve as the administrative lead for the planning program, financial consultant, primary and specialty care providers such as cardiologists and endocrinologists for development of treatment algorithms and framework of multidisciplinary rounds, administrative personnel, Data exchange among partners will be in the form of analysis and heat mapping that allow for interventions to be tailored based on highest impact. A regional patient registry for care coordination will also be developed. The team will require assistance from an IT vendor to develop options for consolidating this data. Among the factors for consideration are connectivity to CRISP.					Utilizes CRISP? Y or N	Address care plan sharing ? Y or N
Alignment w/ All Payer Model	The proposal addresses how it fits under the All Payer Model and supports the patient-centered goals and metrics of reducing avoidable re-admissions and unnecessary ED utilization (see page 6). Care coordination is referenced.						

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Population Health Strategy			
	<i>Tools and interventions for existing or potential high utilizers and those with chronic conditions will be developed. An important secondary function will be to address the overall health needs of the region.</i>	Focus on risk factors? <i>Y or N</i>	Align with LHIC? <i>Y or N</i>
Potential for Sustainability			
Value-based payment structures	<i>Funding through hospital avoidance (reduction in ED visits), Chronic Care Management Funding (alters the current provider incentive model that favors highly specialized procedural volume over the time-consuming, ongoing management of chronic conditions).</i>		
Population health funding	<i>Future establishment of an ACO</i>		
Proposed Process and List of Partners			
Proposed process	<p><i>The group will make decisions about the IT infrastructure needed to support a new delivery model and will also work on a communication and education plan for providers and community members. The first meeting will include a review of the project scope and charter documents. Education on the new Maryland All-Payer Model and the new Medicare Chronic Care Management Code will be provided.</i></p> <p><i>The team will be organized into subcommittees that will work on the pre-intervention tools, the intervention workflow, and the financial model. Teams will meet twice per month, once as a workgroup and once as the entire team, to enable information sharing. Meetings will be recorded via web conferencing and an online forum for exchanging project information will be created.</i></p>		Includes list of partners? <i>Y or N</i>
Budget			
	Includes line item budget? <i>Y or N</i>	Includes narrative justifying costs? <i>Y or N</i>	Funds are for planning (not implementation)? <i>Y or N</i>

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Applicant/ Hospitals	<i>Southern Maryland Regional Coalition (Doctors Community Hospital, Ft. Washington Medical Center, Laurel Regional Hospital, Prince George’s Hospital Center, Bowie Medical Center, and Calvert Memorial Hospital)</i>						
Scope and Target Population							
Region	<i>Prince George’s and Calvert counties (78 zipcodes)</i>						250,000 populatio n? Y or N
Health Needs	<i>Obesity, diabetes, poor nutrition, physical inactivity, smoking, hypertension, cardiovascular disease, asthma, respiratory disorders, stroke, and selected cancers.</i>						Reference s CHNA? Y or N
Target Population	<i>High utilizers, Medicare patients, patients with multiple chronic conditions, frail elders, dual-eligible citizens with high resource needs.</i>						Initial focus on Medicare or duals? Y or N
Model Concept							
Services/ Intervention	<i>Chronic care management, diabetes self-management program, direct to patient efforts to improve HbA1c, continued evaluation of insurance coverage under ACA to ensure patients have chosen he right plans for their disease state, identification of social service programs not fully utilized by residents, identification of ways to pay the hospitals reduction in ED utilization, redesign of physician practices to improve care coordination, medical home model expansion</i>						
Role of partners	<i>See Appendix L for list of partners and Appendix I for role of partners.</i>						
	PCPs: Y or N	Long term care: Y or N (not current partner but nursing homes and hospices are on list of future invitees. See pages 92-95)	Behavioral health: Y or N	Public health? Y or N	Community orgs? Y or N	Others: <i>post-acute providers (Genesis, DaVita, Radiology group, Cancer Treatment), faith-based organizations</i>	
Infrastr./ workforce	<i>Staffing needed for model includes a facilitator/project leader, CHWs, and consultants.</i> <i>For infrastructure, see Appendix I.</i> <i>Data exchange among partners, including use of CRISP and sharing of patient care plans/profiles for the purpose of reducing costs and increasing the quality of services provided in PG and Calvert counties.</i>					Utilizes CRISP? Y or N	Address care plan sharing ? Y or N
Alignment w/ All Payer Model	<i>The proposal addresses how the Transition Care Coordination model supports and fits under the All Payer Model (see page 12). Care coordination is referenced but HSCRC workgroups are not.</i>						
Population Health Strategy							
	<i>During the first year, the Coalition will focus on Medicare and dually eligible patients with multiple chronic conditions demanding high resource expenditures. The intent of the model is to codify what works and then replicate its design elements to identify interventions and best practices for</i>					Focus on risk factors? Y or N	Align with LHIC? Y or N

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	<p><i>other disease states, counties, and insurers with the goal to continue to meet the Triple Aim.</i></p> <p><i>Through the planning process, the Coalition will design, study, and be ready to implement a regional Transitional Care Coordination model that will prevent additional utilization from high-risk patients and avoid future utilization from risking-risk patients.</i></p>		
Potential for Sustainability			
Value-based payment structures	<p><i>Not explicitly stated.</i></p> <p><i>Anticipated flow of funds – see diagram on page 20. “The use of chronic care management model fees and community benefits will continue to be a source of revenue for the Coalition; however, when readmissions and PQIs are reduced, this source opportunity sharing may not exist, so the Coalition will have to continue to evaluate sources of revenue for the long-term.”</i></p> <p><i>The Coalition requests that HSCRC/DHMH devote funding for additional data and technical support during and after the Design Phase to ensure continued engagement.</i></p>		
Population health funding	<p><i>Community benefit dollars from hospitals’ programs</i></p>		
Proposed Process and List of Partners			
Proposed process	<p><i>The Coalition will start with clear objectives for the Pilot program, discuss their plan with physicians and post-acute service providers, take those results and develop the interventions and best practices for short-term and long-term goals, and identify the realistic revenue sources.</i></p> <p><i>During the Design Phase, the Coalition expects to meet monthly from May to July 2015, and bi-weekly from August to November 2015. A detailed, monthly Gantt chart is on page 23.</i></p>		<p>Includes list of partners? Y or N</p>
Budget			
	Includes line item budget? Y or N	Includes narrative justifying costs? Y or N	Funds are for planning (not implementation)? Y or N