HSCRC
Health Services Cost Review Commission

Regional Partnership Program Summaries
Updated September 2019

The current Regional Partnership Program began in FY 2016 and is scheduled to end at the close of FY 2020. There are 14 regional partnerships that are geographically dispersed across Maryland. The Regional Partnerships serve both rural and urban areas of the State and have been predominately focused on improving care coordination for high-utilizer and high-risk Medicare patients.

Common Interventions
The most common interventions across all Regional Partnerships are:

- Care transitions and coordination
- Behavioral health integration
- Patient engagement and community education
- Home-based care

Care transitions focus heavily on supporting high-utilizer patients after a hospital discharge. Interventions designed by Regional Partnerships typically engage patients for 30-90 days after a hospitalization to reduce readmission rates and ensure patients successfully transition back into the community and the care of a primary care provider. Regional Partnerships in rural areas have provided care transition interventions through the use of telehealth services.

Behavioral health integration interventions include the provision of case management to patients with complex psychiatric needs and substance abuse disorders and developing transitional treatment plans to ensure patients are transitioned back into the community with appropriate provider referrals. Regional partnerships have also supported embedding behavioral health providers in primary care practices.

Common patient education and community education interventions include both direct patient education and community-based education. Some Regional Partnerships have worked with faith-based organizations to support chronic disease prevention and management strategies. Other Regional Partnerships have focused on educating patients on advanced directives

Regional Partnerships have approached home-based care interventions in a variety of ways. For example, one Regional Partnership has developed interdisciplinary teams to provide a comprehensive source of medical and social services for patients and families, including directly providing primary care services. Other Regional Partnerships have used home-based care to provide care coordination services, disease management, patient health education, assistance with medical appointments, and transportation.

Common Community Partners

- Local Health Departments
- Local Departments on Aging
- Local Health Improvement Coalitions
- Skilled Nursing Facilities
- Primary Care Physician Practices
- Care Management Organizations
- Behavioral Health Providers
- Faith-based Organizations
- Food Banks