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Health Services Cost Review Commission
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

Donna Kinzer
Executive Director

Stephen Ports, Director
Engagement
and Alignment

Sule Gerovich, PhD, Director
Population Based
Methodologies

Chris L. Peterson, Director
Clinical and Financial
Information

Gerard J. Schmith, Director
Revenue and Regulation
Compliance

The Honorable Edward J. Kasemeyer
Chair
Senate Budget and Taxation Committee
3 West Miller Senate Office Building
Annapolis, MD 21401-1991

The Honorable Maggie McIntosh
Chair
House Appropriations Committee
121 House Office Building
Annapolis, MD 21401-1991

RE: 2016 Joint Chairmen's Report (Page 80) – Status of Hospital Partnerships with Community Behavioral Health Providers

Dear Chair Kasemeyer and Chair McIntosh:

Pursuant to page 80 of the 2016 Joint Chairmen's Report, the Health Services Cost Review Commission (HSCRC) respectfully submits this report on the status of partnerships that support community-based behavioral health care coordination activities funded through HSCRC implementation grants. Specifically, the report provides an overview of the behavioral health landscape in hospitals and the partnerships that have been formed between hospitals and community-based organizations to reduce potentially avoidable utilization. Finally, the report details funds dedicated from the transformation grants as well as other HSCRC financial incentives to support this work.

Thank you for your consideration of this information. If you have any questions regarding this report, please contact Katie Wunderlich at 410-764-2591.

Sincerely,
Donna Kinzer
Donna Kinzer
Executive Director

Enclosure

cc: Steve Ports, HSCRC
Katie Wunderlich, HSCRC
Jordan More, DLS

Status of Hospital Partnerships with Community Behavioral Health Providers

Introduction

This report is submitted to comply with the 2016 Joint Chairmen's Report (JCR), Page 80, requiring the Health Services Cost Review Commission (HSCRC, or Commission) to report on the status of hospital partnerships with non-hospital owned community behavioral health organizations funded through HSCRC implementation grants and the total amount of implementation grant funding used for behavioral health care coordination activities.

The HSCRC is committed to improving health care for all Marylanders through the implementation of our All-Payer Model with the Centers for Medicare & Medicaid Services (CMS). Currently the HSCRC is focused on the delivery of better care and better health outcomes while reducing costs. In order to be successful under the current All-Payer Model, it is essential that Maryland hospitals improve care coordination with community-based behavioral health care providers to reduce potentially avoidable utilization and keep Marylanders healthy in the community.

This document contains information on both the current utilization of behavioral health services in hospitals, as well as the status of the partnerships between hospitals and community-based behavioral health providers funded through HSCRC implementation grants. Additionally, this report will highlight the other ways that the HSCRC provides financial incentives to hospitals to foster community-based care coordination activities that help the State meet the goals of the All-Payer Demonstration Model.

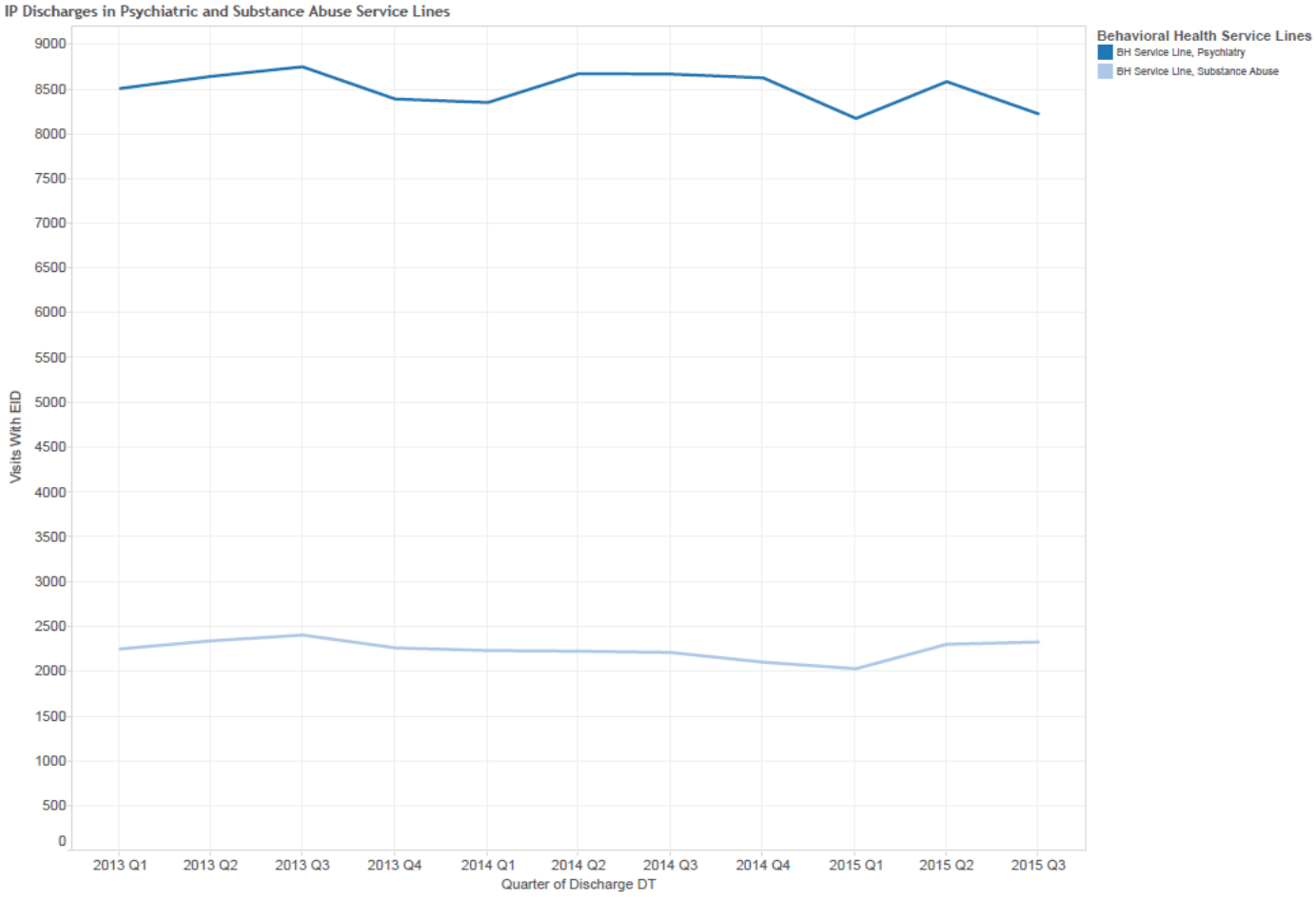
The HSCRC does not intend for hospitals' efforts to supersede the work of community-based providers, particularly in behavioral health. Rather, the HSCRC encourages hospitals to work *with* community providers to address some of the most challenging and costly health issues to avoid unnecessary hospitalizations.

Behavioral Health in Maryland Hospitals

In order to reduce potentially avoidable utilization and to improve health outcomes for patients with chronic conditions, the HSCRC is particularly focused on the delivery of behavioral health services within Maryland hospitals. While inpatient volume for psychiatric and substance abuse services has remained relatively stable over the last three years, the payer mix for those services has changed dramatically. Figure 1 shows inpatient discharges in psychiatric and substance abuse service lines and shows relatively little change over the last three years.

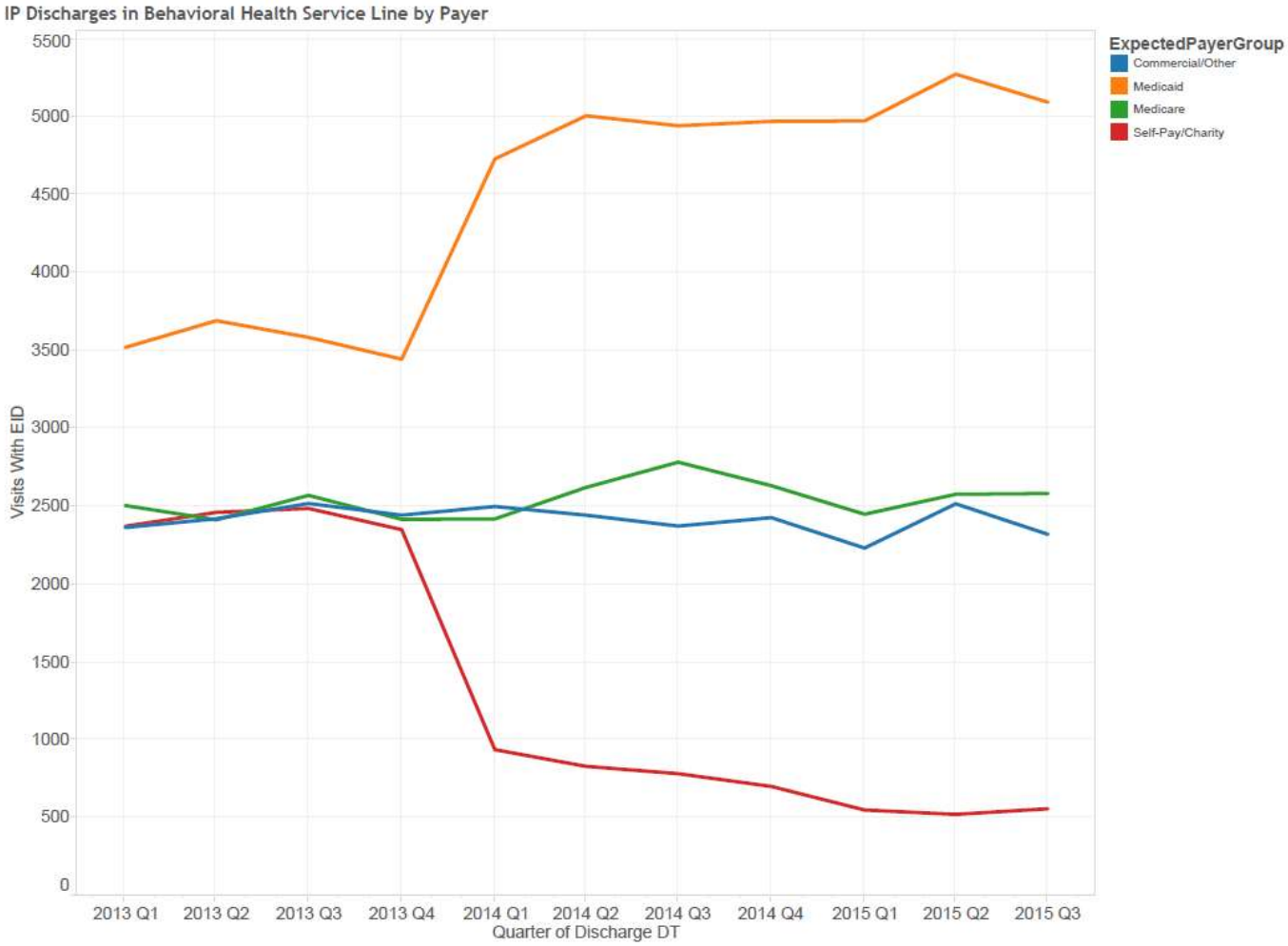
Status of Hospital Partnerships with Community Behavioral Health Providers

Figure 1. Inpatient Discharges in Psychiatric and Substance Abuse Service Lines



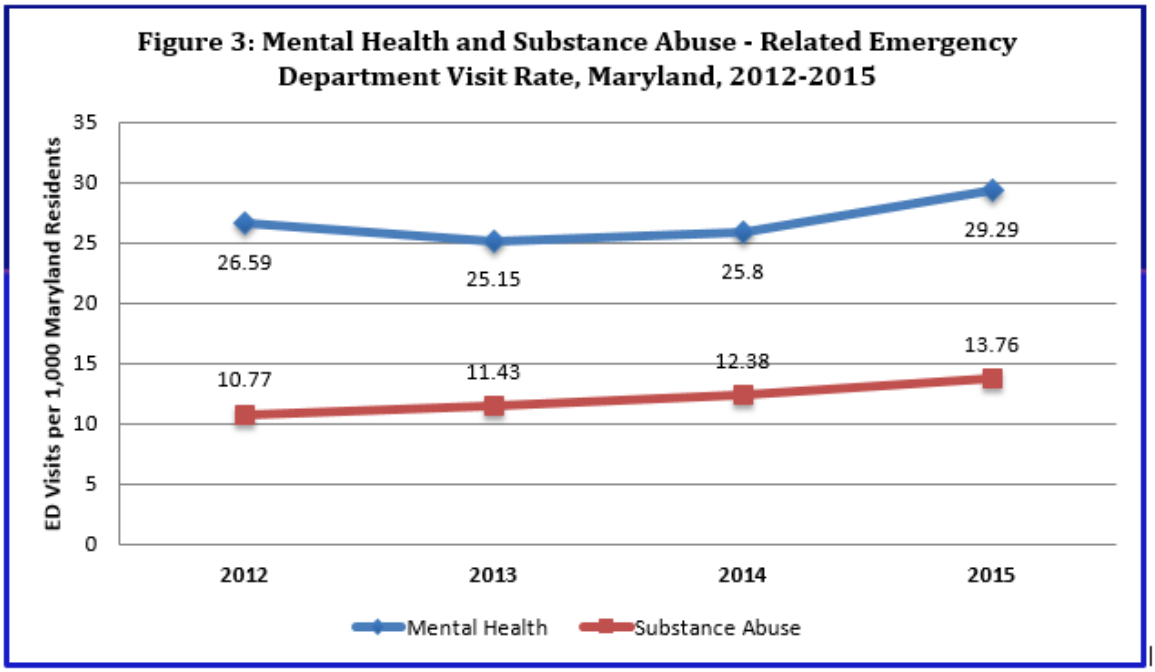
Concurrently, the primary payer source for inpatient behavioral health charges has shifted to Medicaid beginning in January 2014, which aligns with the Medicaid expansion in Maryland. See Figure 2.

Figure 2: Inpatient Discharges in Behavioral Health Service Line by Payer



Although inpatient admissions and discharges for behavioral health services have remained stable, Emergency Department visits related to behavioral health diagnoses have continued to rise (see Figure 3).[1]

[1] HSCRC is currently presenting Condition-Specific ED Volume through September of 2015. The Maryland Department of Health and Mental Hygiene is currently working to update the behavioral health diagnosis codes to align with the shift to ICD-10, which occurred in October 2015.



Source: Data Source: HSCRC outpatient data, 2012-2015.

The Maryland Hospital Association recently conducted an environmental scan of behavioral health services, which similarly suggested that "emergency departments throughout Maryland are seeing an increase in behavioral health patients."[2] The HSCRC has deployed several resources to help hospitals better coordinate care and reduce avoidable utilization related to behavioral health expenditures, as detailed in the section below.

Additionally, the HSCRC, in fulfillment of a requirement of the FY 2017 Update Factor for Specialty Hospitals, is convening a sub-group of the Performance Measurement Workgroup, called the Behavioral Health Performance Measurement Sub-group (BHPMS). The BHPMS will convene within the next two months and discuss current quality measures related to behavioral health, as well as build a way to integrate specialty hospital admissions and readmissions into HSCRC's existing readmissions reduction strategies. This sub-group will include representatives from both hospitals and community providers, as the HSCRC hopes to further foster collaboration in improving integrated behavioral health care.

<u>HSCRC Expenditures Related to Behavioral Health</u>

In addition to discussing the role of hospitals in providing behavioral health services, the JCR requires the HSCRC to report on the partnerships between hospitals and community-based behavioral health providers and the amount of money dedicated from the transformation grants to that end. As described below, the HSCRC has estimated expenditures related to (1) Global Budget Revenue Infrastructure Investments, (2) Transformation Implementation Grants, and (3) a high-level summary of psychiatric hospital efforts to reduce potentially avoidable utilization. To

[2] Behavioral Health Task Force - Environmental Scan, *Maryland Hospital Association*, September 2016, page 2.

date, acute and psychiatric specialty hospitals have received rate support and competitive grant funding to pursue improved population health investments, including several targeted investments to improve behavioral health.

1. Global Budget Revenue Infrastructure

The HSCRC has provided over $200 million in rate support in fiscal years 2014-2016 related to infrastructure expenditures. Maryland hospitals have been given broad latitude with regards to how to best utilize these infrastructure dollars to further the goals of the All-Payer Model. While inexact, HSCRC estimates that hospitals have spent approximately $7.68 million in FYs 2014 and 2015 toward programs focused on psychiatric services, substance use disorders, or other behavioral health investments. Investments included: specialized case management and care coordination tailored to behavioral health patients, partial hospitalization programs, off-site psychologists, and additional primary care supports for patients with substance use disorders.

Expenditures were slightly more difficult to estimate in FY2016 given a change in the reporting template; however, HSCRC estimates that hospitals allocated approximately $17.56 million in FY2016 for investments in which hospitals partnered with at least one behavioral health clinical partner. These investments included - post-discharge and transitional care services, ED referral services, regional partnership work, and broader population health investments. Of these dollars, approximately $2.53 million went toward investments in which hospitals partnered with at least one behavioral health clinical partner that is independent of the hospital or health system.

2. Transformation Implementation Grants

The Commission voted in June 2015 to authorize up to 0.25 percent of total hospital rates to be distributed to grant applicants under a competitive process for “shovel-ready” care transformation improvements that will generate more efficient care delivery in collaboration with community providers and achieve immediate results under the metrics of the All-Payer Model. In June 2016, the Commission approved nine proposals for a total of approximately $30.57 million.

Of these awardees, eight are currently involved in behavioral health initiatives. Preliminary reporting, received by the HSCRC in October 2016, suggests that $5.04 million of these transformation dollars will be spent toward behavioral health initiatives. Of these dollars, approximately $2.90 million are dollars that are spent toward providers who are independent of hospitals.[3] These reports are preliminary at this time and as such, HSCRC is currently unable to determine the outcome of these dollars. The awardees are required to continue to report to the Commission on outcomes and use of dollars and will periodically update the Commission in public session on those results. It is the expectation of the Commission that these new partnerships with community behavioral health providers represent a promising shift toward greater collaboration to reduce potentially avoidable utilization.

[3] This amount is an estimate, given limitations in the drill-down detail of the reports.

Status of Hospital Partnerships with Community Behavioral Health Providers

Specific behavioral health-related partnerships mentioned in the Transformation Implementation Grants include:

Regional Partnership	**Community Organization**
Bay Area Transformation Partnership	Arundel Lodge
Community Health Partnership of Baltimore	Behavioral Health System of Baltimore Our Daily Bread Employment Center
GBMC	Sheppard Pratt Health System; Kolmac Outpatient Recovery Centers; Mosaic Community Services
Howard County	Way Station, Inc.
Nexus Montgomery	Cornerstone Montgomery; Primary Care Coalition of Montgomery County
Trivergent Health Alliance	Archway Station; Allegany County EMS; Potomac Case Management Services, Inc.
UM - St. Joseph	Maxim Healthcare Services; VNA of Maryland; Baltimore County Health and Human Services; Chase Brexton; Baltimore Medical System;
UM - Upper Chesapeake, Union Hospital of Cecil County	Healthy Harford; Healthy Cecil

Additional detail on the status of planned and implemented partnerships and funding amounts is available in the behavioral health reports shown in the Appendix.

3. Specialty Hospitals' Work to Reduce Avoidable Utilization

As part of the Update Factor for Psychiatric and Specialty hospitals, the HSCRC provided some infrastructure dollars toward psychiatric hospitals. HSCRC's rate-supported psychiatric hospitals, Adventist Behavioral Health, Brook Lane, and Sheppard Pratt, provided narrative summaries on their work to reduce readmissions and other avoidable utilization. Some common themes among these summaries were efforts to increase the rate of follow-up visits after discharge through expanded outpatient services and post-discharge phone calls. These centers are also working with regional partnerships in their communities (i.e., the Behavioral Health Task Force of Healthy Montgomery, the Trivergent Health Alliance).

<u>Conclusion</u>

The HSCRC continues to work with hospitals to reduce avoidable utilization under the All-Payer Model. An increasing focus on behavioral health is integral to our continued success under this

model. As such, the HSCRC has provided incentives (financial and otherwise) to hospitals to improve the quality of care related to behavioral health. Based on the reporting that is currently available to the Commission, it appears that partnering and sharing of funds for behavioral health services is increasing from year to year. Given the fact that a high percentage of high utilizers tend to have a behavioral health condition, it is expected that, as hospitals improve risk stratification and the efficacy of their care coordination activities, behavioral health collaborations will become even more prevalent in the future.

As we move toward further accountability under the Progression Plan of the All-Payer Model, the HSCRC will expect to see further collaboration between hospitals and community health providers, particularly in addressing behavioral health.

Appendix

October 17, 2016

Dear HSCRC Representative,

Good afternoon. Please accept the attached status from the Bay Area Transformation Partnership per your request for behavioral health plans, expenditures and partnerships associated with the Transformation Implementation grant.

Our implementation grant proposal includes hospital and health system staffing and programs. Although we do not provide funding directly to any external behavioral health entities, we are working closely with them to improve care coordination and reduce potentially avoidable utilization, in particular through the use of Care Alerts and secure texting.

The Anne Arundel Medical Center initiatives include:

- A behavioral health navigator program is staffed by two (2) navigators who began work in October, serving both the ED and community populations by facilitating referrals to behavioral health services within 48 hours of request.
- The infrastructure and program is in place to pilot using a licensed clinical social worker to provide services in a primary care setting, with hiring in progress.
- An external behavioral health home, Arundel Lodge, with over 130 psychiatric rehabilitation participants, is working closely with AAMC to provide appropriate and useful information to providers, in particularly ED providers, through the use of Care Alerts. ED providers are able to quickly identify and securely text or call staff at Arundel Lodge to discuss complex, vulnerable patients with serious mental illness and somatic disease who frequent the ED.

The University of Maryland Baltimore Washington Medical Center initiatives includes:

- A High Risk Care Coordinator who focuses on high utilizers with behavioral health diagnoses, facilitating cross-disciplinary discussions with primary care, specialist, behavioral health and ED providers to craft meaningful, useful Care Alerts and Care Plans.
- Placing two (2) licensed clinical social workers and an administrative assistant in primary care offices to pilot the integration of behavioral health services.
- Hiring a Psychiatrist to address the significant need for additional psychiatric support, including medication management and consultative support to primary care physicians.

Additional details are provided in the attached template.

Thank you again for the opportunity to assist in improving care coordination and reducing PAU.

Please let me know if you have questions about this submission by emailing cindygingrich@gmail.com or calling (231) 735-1243.

Best Regards,

Cynthia Gingrich MSIM, PMP, CPHIMS
Project Management Consultant, Bay Area Transformation Partnership
(231) 735-1243

Status of Hospital Implementation Grant Partnerships with Community Behavioral Health Providers
As of October 1, 2016 (report due October 17, 2016)

Behavioral Health Partner in Implementation Application	Owned by Hospital or Independent	Total Funding Allocation from Application	Funding Provided to Partner to Date from each hospital	Purpose of Partnership as Stated in Implementation Application	Status of Partnership and Meeting Goals of the Application	Partner Contact (phone and e-mail)
Anne Arundel Medical Center						
AAMC Behavioral Health Navigator Program	Hospital (new hires)	$107,668	$104,587 Amount allocated for salaries and implementation costs for FY17	AAMC service for primary care providers will facilitate referrals to behavioral health resources and provide evaluation appointments within 48 hours, with careful tracking of patients to ensure follow-up. This service, staffed by two (2) behavioral health navigators serves patients with mental illness and/or substance use who need urgent (but not emergent) care beyond the primary care setting.	On Target. Both behavioral health navigators have been hired and start work in October. Dawn Hurley, Executive Director of Behavioral Health, estimates that we will reach our original goals of referring 500 patients during FY17.	Dawn Hurley (410) 573- 9000 Dhurley@aahs.org
AAMC Integration of behavioral health resources into primary care setting (LCSW and front desk coordinator)	Hospital (new hires for the Centreville Clinic)	$51,600 (cost minus revenue)	$ 0	This AAMC pilot project will provide patients with timely access to behavioral health evaluations, interventions and treatment in the primary care setting. This model promotes better outcomes for behavioral and somatic health with the goal of decreasing PAU.	Program readiness - on target. Hiring – in progress (late) The operational processes, physical space and EHR build are complete. A candidate accepted and then rescinded, so we are back to actively recruiting. Given that this is a cost minus revenue request, we still feel that we will meet our goals as stated in the application if we can hire this calendar year.	Sandy Hudson, Practice Director, Primary Care (443) 481-5479 shudson1@aahs.org

Behavioral Health Partner in Implementation Application	Owned by Hospital or Independent	Total Funding Allocation from Application	Funding Provided to Partner to Date from each hospital	Purpose of Partnership as Stated in Implementation Application	Status of Partnership and Meeting Goals of the Application	Partner Contact (phone and e-mail)
Care Alerts: Arundel Lodge Behavioral Health Home Program	Independent	$2400	There are no direct funds provided to this partner. Rather, hospital clinicians and staff work with Arundel Lodge to identify the cohort, create applicable Care Alerts, and enter them into the hospital EHR. Cost is included in BATP budget for Care Alert entry by clinicians. $750 identification and setup of care alerts plus $150/month to maintain the alerts for patients with serious mental illness and somatic disease who frequent the ED.	The purpose of this partnership is to improve care coordination through the use of Care Alerts and secure texting for behavioral health home patients. Through the use of Care Alerts, providers at the hospital (ED in particular) will be able to quickly identify and securely text or call Arundel Lodge providers to discuss complex, vulnerable patients with serious mental illness and somatic disease who frequent the ED.	On target. All patients (approximately 130) who use Arundel Lodge as their behavioral health home now have a Care Alert in Epic, and a process for maintaining the alerts has been implemented. The Care Alerts provide information on who to contact and how, in addition to other helpful information for ED providers and PCPs.	Michael Drummond, Executive Director, Arundel Lodge (443) 433-5900 Mdrummond @arundellodge. org

Behavioral Health Partner in Implementation Application	Owned by Hospital or Independent	Total Funding Allocation from Application	Funding Provided to Partner to Date from each hospital	Purpose of Partnership as Stated in Implementation Application	Status of Partnership and Meeting Goals of the Application	Partner Contact (phone and e-mail)
University of Maryland Baltimore Washington Medical Center						
UM BWMC High Risk Care Coordinator for Behavioral Health Care Alert Development	Hospital employee	$78,457	$78,457 New hire begins 11/7/16, full allocation of $78,457 for FY17	Hospital employee who will facilitate development of Behavioral Health Care Alerts and Plans with cross-disciplinary teams. UM BWMC Care Alerts contain focused, patient-specific plans that help with managing patient care, facilitating care coordination with care team members and reducing PAU.	On track to meet volume goals to write 100 behavioral health focused Care Alerts in FY2017.	Dwight Holmes, Director, Psychiatric Services (410) 787-4590 Dwight.Holmes @umm.edu
UM BWMC Behavioral Health Integration in Primary Care Clinics	University of Maryland Community Medical Group (UM CMG) health system employees	$ 351,016	$231,184 Allocated funds for two (2) LCSWs and Admin assistant starting November 1, 2016 ($157,851), Miscellaneous support fees ($57,333) and recruitment costs for Psychiatrist ($16,000)	UM CMG employees will focus on behavioral health integration and support in the primary care setting.	On target for 2 LCSWs and an administrative assistant to start work on 11/1/16 (8 months of service per original plan). Psychiatrist – accelerated recruitment has resulted in finding and retaining a Psychiatrist who will start 7/1/17. In the meantime, we will use our LCSWs in the clinic for this pilot.	Dwight Holmes, Director, Psychiatric Services (410) 787-4590 Dwight.Holmes @umm.edu

Status of Hospital Implementation Grant Partnerships with Community Behavioral Health Providers
As of October 1, 2016 (report due October 17, 2016)

Community Health Partnership of Baltimore (CHPB)

Behavioral Health Partner in Implementation Application	Owned by Hospital or Independent	Total Funding Allocation from Application	Funding Provided to Partner to Date from each hospital	Purpose of Partnership as Stated in Implementation Application	Status of Partnership and Meeting Goals of the Application	Partner Contact (phone and e-mail)
Bridge Team	Owned by Partnership Hospitals	$606,715 per fiscal year	$10,358	**Goal:** The goal of the Bridge Team is to engage individuals, provide support services needed to maintain stability in the community, and facilitate the transition of patients to longer-term more comprehensive behavioral and/or medical care. **Model of Care:** The Bridge Team is modeled after Assertive Community Treatment (ACT) teams model that traditionally have been used to assist people with high behavioral health needs by providing ongoing care in the community (SAMHSA, 2008). In contrast, the Bridge Team duration of services to be delivered is 30 days on average with flexibility of up to 60 days. **Care team members:** The team is a community based, multidisciplinary intervention made up of a Health Behavior Specialist (HBS), a Psychiatrist, and two Peer Support Specialists (PSPs).	• Hiring is on course with an HBS Team Lead in place, 2 PSPs in final interviews, and a Psychiatrist tentatively scheduled to begin in January. • Space for the team has been identified at Our Daily Bread Employment Center. • Developing model of care and identifying services rendered by Bridge Team in coordination with other interventions • Continuing to develop workflows for referrals, engagement, communication, and data	**Liana Burns** Senior Program Administrator 410-689-1105 lburns@jhhc.com **Robert Findling, MD, MBA** Division of Child and Adolescent Psychiatry Johns Hopkins Medicine 410-614-3225 rfindli1@jhmi.edu

				Trigger/Transition: We will work with the Behavioral Health System of Baltimore (BHSB), the local behavioral health authority for Baltimore City, to ensure transitions to longer term treatment for mental health and substance abuse disorders. **Need:** We anticipate that, given the intensity of services that will be needed to engage people in care, this team will be able to manage 300 to 400 people during the course of a year.	collection. • Continuing to educate Hospital, ERs and primary care practices in the Partnership of the Bridge Team's services. • Developing metrics for patient outcomes related to Bridge team interventions.	
Community Care Teams with Health Behavioral Specialists	Owned by Partnership Hospitals	$497,293 per fiscal year	$40,512	**Goal:** The goal of the Community Care Teams is to provide high-need, high-risk patients with comprehensive care coordination services. The teams will expand on existing services where necessary to decrease potentially avoidable utilization and improve health outcomes. **Model of Care:** Regionally deployed Community Care Teams (CCTs) coordinate care across primary care settings by expanding upon existing services for high-risk individuals with medical and mental health or substance abuse needs. If psychosocial needs are identified, the CM/HBS works with the CHW in the community to address needs. **Care team members:** The team consists of a case manager (CM) who is a nurse or social worker, two community health workers (CHWs), and a health behavior specialist working with a primary care	• In the process of hiring additional Health Behavioral Specialists (HBS) • Identifying physical space across region for CCTs • Developing workflow processes for coordination across team (CM-HBS-CHWs). • Developing metrics for patient outcomes related to CM/HBS team interventions.	**Liana Burns** Senior Program Administrator 410-689-1105 lburns@jhhc.com **Regina Richardson** Senior Director, Care Management Johns Hopkins HealthCare LLC 410-762-5386 RRichardson@JHHC.com

				practice. **Health Behavioral Component:** The HBS is responsible for assessing, planning, implementing, coordinating, and monitoring the behavioral health options and services available to patients and their families. HBSs are skilled in offering interventions that are based on a Cognitive Behavioral Model (CBT). The HBS: • identify and guide referred patients through protocols and therapeutic interventions relevant to their needs; • facilitates referrals to psychiatry if the patient's psychiatric condition is beyond the scope of the HBS services available; • coordinates care for mental health and substance abuse services received outside of the primary care clinic; and • evaluates and develops a safety plans for patients with a mental health crisis		

Narrative Description of Hospital Implementation Grant Partnerships with Behavioral Health Providers

Community Health Partnership of Baltimore (CHPB)

The Community Health Partnership of Baltimore is a regional approach to an all-payer, all-population care coordination strategy consisting of six hospitals: The Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Mercy Medical Center, Sinai Hospital of Baltimore, MedStar Franklin Square Hospital, and MedStar Harbor Hospital, in addition to community-based organizations, Sisters Together And Reaching, the Men and Families Center, and Health Care for the Homeless.

The focus of the Partnership is to address current gaps in the regional system's ability to coordinate care for high-risk Medicare and dual eligible beneficiaries in 19 zip codes, which represent the combined community, benefit service areas of the partner hospitals. Through multiple interventions that coordinate care across hospitals, primary care practices, and community organizations, the Partnership aims to reduce unnecessary health service utilization, decrease costs, and improve outcomes for patients.

Bridge Team

The Bridge Team is a community-based, multidisciplinary intervention that engages high-risk individuals who have an immediate need for behavioral health or substance abuse treatment and are more difficult to engage in appropriate primary care services. It is modeled after the Assertive Community Treatment (ACT) team model that traditionally has been used to assist people with high behavioral health needs by providing ongoing care in the community (SAMHSA, 2008). The Bridge Team is based on an ACT staffing model with modifications made for the short duration of services to be delivered (30 days on average with flexibility up to 60 days). The team is comprised of a Health Behavior Specialist (a LCSW), a Psychiatrist, and two Peer Support Specialists/Community Health Workers.

The primary goal of the Bridge Team is to engage individuals, provide support services needed to maintain stability in the community, and facilitate the transition of patients to longer-term more comprehensive behavioral and/or medical care. After the Bridge Team has provided services and stability, it will transition the patient to the Community Care Teams (CCTs), which are regionally deployed across primary care settings to expand upon existing services for high-risk individuals with medical and mental health or substance abuse needs.

The Bridge Team receives referrals directly from all partner hospitals and community physicians in the Partnership. We anticipate that, given the intensity of services that will be needed to engage people in care, this team will be able to manage 300 to 400 people during the course of a year.

The Bridge Team provides:

- Barriers to care assessments that focus on identifying the social, mental, and physical needs of the individual
- Linkages to community organizations and social services to address the social determinants of health and assistance in getting needed resources: housing, employment, documents (ID, birth certificate, etc.)
- Psychiatric clinical assessment and psychopharmacologic treatment let by the Community Bridge psychiatrist
- Facilitated referral to Substance Use Disorder (SUD) program or Mental Health (MH) program
- Overdose education provided to patients with substance use disorders

The Bridge Team will be primarily based out of Our Daily Bread Employment Center in Baltimore City, but will be mobile to meet patient needs at all partner hospitals.

Community Care Teams with Health Behavioral Specialists

As noted above, the CCTs are regionally deployed care coordination teams that work within existing primary care services to meet the needs of the high-risk population across the Partnership's 19 zip code catchment area. The teams consist of Case Managers (RN or LCSW), Community Health Workers, and Health Behavior Specialists (LCSW). Referrals will come directly from partner hospitals, as well as from a list of high risk patients who meet Partnership criteria identified by CRISP. Additionally, the CCTs will continue to manage the care of patients referred from the Bridge Team, relying on the expertise of the HBS team member.
The HBS is responsible for assessing, planning, implementing, coordinating, and monitoring the behavioral health options and services available to patients. They are skilled in offering interventions that are based on a Cognitive Behavioral Model (CBT). The HBS:

- identifies and guides referred patients through protocols and therapeutic interventions relevant to their needs;
- facilitates referrals to psychiatry if the patient's psychiatric condition is beyond the scope of the HBS services available;
- coordinates care for mental health and substance abuse services received outside of the primary care clinic; and
- evaluates and develops a safety plans for patients with a mental health crisis.

Greater Baltimore Medical Center

Behavioral Health – Narrative Summary October 2016

The Greater Baltimore Medical Center (GBMC) is currently implementing its proposed Behavioral Health Enhanced Patient-Centered Medical Homes (BHE-PCMH). Mental health professionals are being embedded into primary care practices to provide screening, short-term intervention, ongoing counseling/behavioral management, care management, and telephonic support. Since receiving the transformational grant award for these initiatives, GBMC has completed a Request for Proposal (RFP) process and selected contractual partners to successfully and rapidly implement the proposed model. GBMC is partnering with Sheppard Pratt Health System and Sheppard Pratt Physicians, P.A., Kolmac Outpatient Recover Centers, and Mosaic Community Services in this effort.

Sheppard Pratt is committed to placing psychiatrists in the GBMC PCMH practices. 0.1 FTE started July 2016, 0.2 additional started September 2016, 0.2 additional to start in November, 0.3 additional by March 2017 and 0.2 additional by July 2017. Psychiatric consultation occurs both on and off site, and is available by telephone or telehealth devices to provider teams and to patients. These psychiatrists will also be responsible for regular, systematic caseload reviews and consultation for patients who do not show clinical improvement.

Sheppard Pratt is also hiring licensed clinical social workers to fill the Behavioral Health Consultant (BHC) role in each practice. We are currently jointly interviewing candidates with plans to have 5 full time BHCs in place by November 2016. The BHC will offer brief behavioral intervention/structured psychotherapy to patients in the primary care setting and in collaboration with the primary care team. This includes behavioral counseling and support to patients with chronic conditions who can benefit from behavioral changes and lifestyle adjustments to improve compliance, self-management, and overall health status. The BHC will also connect those patients who require specialty behavioral health treatment (outside the scope of the primary care setting) to a psychiatrist in the Behavioral Health Network, and link patients to community-based resources that operate in collaboration with the BHE-PCMH program.

Kolmac has identified 0.5 FTE of an addiction specialist that will be devoted to GBMC patients with substance abuse and addiction issues. This will occur by November 2016. Mosaic is providing preferential access to GBMC patients for community resources. Mosaic will also place a community health worker in the GBMC emergency department and Support Our Elders (SOE) program by the end of the calendar year.

GBMC, Kolmac, and Mosaic partners have been meeting at least weekly to discuss and monitor implementation timelines and outcomes metrics. GBMC expects the proposed program will help lower morbidity rates and have lasting effects on quality of life and the costs of care for Baltimore County residents. GBMC is intent on reducing rates of serious mental illness, improving quality of life, and empowering more Baltimore County residents take charge of their health, use health care resources/community supports available, and reduce morbidity rates. In order to best monitor the impact and effectiveness of the BHE-PCMH, GBMC has contracted with Vision Technologies to provide additional support in data and analytics efforts.

Status of Hospital Implementation Grant Partnerships with Community Behavioral Health Providers
As of October 1, 2016 (report due October 15, 2016)

Behavioral Health Partner in Implementation Application	Owned by Hospital or Independent	Total Funding Allocation from Application	Funding Provided to Partner to Date from each hospital	Purpose of Partnership as Stated in Implementation Application	Status of Partnership and Meeting Goals of the Application	Partner Contact (phone and e-mail)
Sheppard Pratt Health System and Sheppard Pratt Physicians, P.A.	Independent	$469,800 (full amount $1,150,000 less Part B 680,200)	$0	Sheppard Pratt is integrating psychiatrists and behavioral health consultants into GBMC patient centered medical home primary care practices. Sheppard Pratt will also provide education to practices regarding behavioral health. The goal is to reduce unnecessary utilization related to behavioral health as well as to improve quality for patients with lifestyle barriers to treatment regimens for chronic conditions.	Sheppard Pratt has integrated psychiatrists into the GBMC patient centered medical home primary care practices with plans for expansion. The psychiatrists see GBMC patients 4 hours per practice per week. 0.1 FTE started July 2016, 0.2 additional started September 2016, 0.2 additional to start in November, 0.3 additional by March 2017 and 0.2 additional by July 2017. Actively recruiting and hiring 5 full time behavioral health consultants by November 2016, 3 additional by March 2017, 2 additional by July 2017.	Lynn Flanigan 410-938-3407 LFlanigan@sheppardpratt.org
Kolmac Outpatient Recovery Centers	Independent	$40,000	$0	Kolmac will integrate an Addition Specialist into GBMC patient centered medical home primary care practices on a part time basis. Kolmac will also provide education and training to the practices and on-call support. Kolmac will provide GBMC patients with preferential access to addiction treatment services.	Kolmac has identified addiction specialist candidate for placement in GBMC patient centered medical home primary care practices 0.5 FTE by 11/1/16.	Mark Santangelo 301-589-0255 msantangelo@kolmac.com

Mosaic Community Services	Independent	$0	$0	Mosaic will provide GBMC patients with preferential access to outpatient mental health services and other outpatient services as needed	Referral pathways created and implemented. Mosaic will also place a community health worker in the GBMC emergency department and Support Our Elders (SOE) program by the end of the calendar year.	Jeff Richardson 410-453-9553 ext. 1158 jeff.richardson@mosaicinc.org
Vision Technologies (Infrastructure)	Independent	$43,528	$0	Vision to provide technical reporting support for both reporting build and data analysis related to population health grant activities including behavioral health.	Contract and work order signed and executed 9/30/16 for 1 FTE report writing support 11/1/16 through 12/31/16.	Cheryl Johnson 443-330-4118 CJohnson@vistechs.com

Howard County General Hospital
Administration
5755 Cedar Lane
Columbia, MD 21044

HOWARD COUNTY GENERAL HOSPITAL
JOHNS HOPKINS MEDICINE

October 15, 2016

Ms. Donna Kinzer
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Ms. Kinzer:

Howard County General Hospital (HCGH) is pleased to submit a status update on our partnerships with community behavioral health providers.

Per the instructions provided in the July 8, 2016 letter from Stephen Ports, enclosed please find the following information:

1. Completed "Status of Hospital Implementation Grant Partnerships with Community Behavioral Health Providers" Template

2. Narrative description of partnerships

It is important to note that our primary partnership with a community behavioral health provider is supported with Infrastructure dollars instead of Transformation Implementation Program (TIP) funding. We utilized Infrastructure money to fund the pilot year (9/1/15-8/31/16) of the Rapid Access Program (RAP) with Way Station, Inc. and will do the same for year 2.

As part of our primary care management intervention for the Howard Health Partnership[1], we have included a social worker on the multidisciplinary Community Care Team (CCT) and this individual works to address behavioral health issues for patients as part of the CCT intervention. CCT staff are employed by the hospital. We have also hired a social worker to serve as our behavioral health program manager. This position is tasked with developing new partnerships with community behavioral health providers to address gaps in the continuum of care. The behavioral health program manager is jointly funded by TIP and Infrastructure dollars; she is a hospital employee and her start date was 10/4/16.

[1] Effective 9/13/16, the Howard County Regional Partnership was renamed the Howard Health Partnership.

Please do not hesitate to contact me directly with any questions – ekromm@jhmi.edu or 410-740-7734. You may also contact Tracy Novak, Director of Population Health Programs at tnovak2@jhmi.edu or 410-720-8762.

Sincerely,

Elizabeth Edsall Kromm, PhD, MSc
Vice President, Population Health and Advancement

Status of Hospital Implementation Grant Partnerships with Community Behavioral Health Providers

HOWARD COUNTY GENERAL HOSPITAL (HCGH)

Behavioral Health Partner in Implementation Application	Owned by Hospital or Independent	Total Funding Allocation from Application	Funding Provided to Partner to Date from each hospital	Purpose of Partnership as Stated in Implementation Application	Status of Partnership and Meeting Goals of the Application	Partner Contact (phone and e-mail)
Way Station, Inc.	Independent	$0 in Transformation Implementation Program (TIP) $75,000 in Infrastructure funds	$75,000	The Rapid Access Program (RAP) is designed to provide access to urgent, outpatient, crisis stabilization services within two business days of discharge for Howard County adults in need of immediate access to short term, psychiatric, problem-focused intervention. This service is intended to prevent further emotional distress and decompensation which otherwise would result in accessing more acute levels of care. Social workers conduct the screening in the Emergency Department and on inpatient units in order to assess eligibility and coordinate the referral. Patients have access to up to six counseling and two medication monitoring visits with Way Station.	We piloted this program from 9/1/15 to 8/31/16. This is co-funded with the Horizon Foundation ($50,000). During that time, a total of 492 referrals were made to RAP and 387 patients were ultimately served by the program (patient showed for intake and completed at least one appointment). The program had an overall connection rate of 77%. HCGH and Way Station hold monthly case conferences to share clinical information and coordinate care of referred clients, review logistics and workflow of the referral process, and examine program results in order to make adjustments as necessary to ensure clients receive the most efficient and effective care possible.	Scott Rose 410-740-1901 srose@waystationinc.org

Narrative Description of Hospital Implementation Grant Partnerships with Community Behavioral Health Providers

HOWARD COUNTY GENERAL HOSPITAL (HCGH)

Rapid Access Program (RAP)

The Rapid Access Program (RAP) is a new approach to coordinating care for an at-risk population where access to services is quite limited. This program is designed to provide access to urgent, outpatient, crisis stabilization services within two business days of discharge for Howard County adults in need of immediate access to short term, psychiatric, problem-focused intervention. This service is intended to prevent further emotional distress and decompensation which otherwise would result in accessing more acute levels of care. Social workers conduct the screening in the ED and on inpatient units in order to assess eligibility and coordinate the referral.

Services are provided through Way Station's Outpatient Community Mental Health Clinic (OMHC) in Columbia, Maryland. Once connected, the patient takes part in an "episode of care" that includes: one psychiatric evaluation with a nurse practitioner with two follow up medication management sessions and an initial clinical evaluation with a therapist with up to six follow up therapy sessions. Way Station then works to transition the patient, if needed, to a permanent community provider after the episode of care. Through the use of a novel online scheduling system, HCGH is able to make the initial appointment with Way Station prior to when the patient is discharged. This means that the patient leaves with an appointment in hand and all the necessary paperwork is received by Way Station in advance of the visit. If a patient fails to show for the first appointment, HCGH is notified and we work with Way Station to contact the client and reschedule.

The target population for RAP is payer agnostic and therefore not limited to Medicare beneficiaries. We piloted this program from 9/1/15 to 8/31/16. This is co-funded with support from the Horizon Foundation ($50,000). During that time, a total of 492 referrals were made to RAP and 387 patients were ultimately served by the program (patient showed for intake and completed at least one appointment). The program had an overall connection rate of 77 percent. HCGH and Way Station hold monthly case conferences to share clinical information and coordinate care of referred clients, review logistics and workflow of the referral process, and examine program results in order to make adjustments as necessary to ensure clients receive the most efficient and effective care possible.

Community Social Worker with the Community Care Team

This position was referenced in the cover letter but not included in the template because it is a hospital staff person and not a partnership with a community provider. The Community Care Team (CCT) is the primary care management intervention for the Howard Health Partnership (HHP). It is a multidisciplinary team that delivers services to our target population of Medicare high utilizers including health education, disease-specific management, medical reconciliation, connection to and coordination with health care providers and equipment as needed, care plan development and extensive social support and advocacy. The CCT social worker addresses behavioral health issues for CCT clients.

Behavioral Health Program Manager

This position was also referenced in the cover letter but not included in the template because it is a hospital staff person and not a partnership with a community provider. The program manager, a social worker, develops and support the behavioral health initiatives of HCGH with special emphasis on community-based programs. This position is responsible for ensuring alignment and coordination of all hospital activities linked to behavioral health, performing certain data analysis and reporting functions and serving as the liaison to community stakeholders such as the health department, Local Health Improvement Coalition and Mental Health Authority. In addition, the staff member provides post-discharge stabilization and support for a small number of high-risk patients and connect to community providers as well as to a primary care home. The program manager started on 10/4/16.

Nexus Montgomery Regional Partnership

Status of Hospital Implementation Grant Partnerships with Community Behavioral Health Providers

As of October 1, 2016 (report due October 17, 2016)

Behavioral Health Partner in Implementation Application	Owned by Hospital or Independent	Total Funding Allocation from Application	Funding Provided to Partner to Date from each hospital	Purpose of Partnership as Stated in Implementation Application	Status of Partnership and Meeting Goals of the Application	Partner Contact (phone and e-mail)
Cornerstone Montgomery	Independent	$796,361	MMMC: $35,263.21 Suburban $54,387.07 WAH: $52,970.35 SGAH: $79,933.23 HCH: $95,939.05 HCGH: $11,507.10 **TOTAL** $ 330,000	Purpose: To reduce hospital utilization by severely mentally ill frequent utilizers. Method: Build community capacity in appropriate therapeutic settings, specifically Assertive Community Treatment Teams (ACT) and an additional 8-bed Residential Crisis House. Note: ACT begins as a Mobile Treatment Team. Once at full staff and client load, undergoes a model fidelity audit to be deemed an Assertive Community Treatment team.	• Contract Executed with Partner • Mobile Treatment Team started July 2016. Staff recruitment is ahead of work plan schedule; only 3 positions remain to hire. 35 clients enrolled as of September 30, 2016, 5 additional in engagement stage. 20% referred by the NMRP hospitals or recently hospitalized. Expected to achieve fidelity as an ACT well in advance of October 2017 work plan date. • New Residential Crisis House under contract for purchase in October 2016; house will be made wheelchair and handicap accessible. Crisis House opening expected in early 2017, ahead of work plan schedule. • Crisis Program Manager: role filled, in process of documenting ACT and crisis house referral procedures with each NMRP hospital.	Jeff Bracken jeff.bracken@cornerstonemontgomery.org (301) 896-4255
Primary Care Coalition	Independent	$100,575	$0	Purpose: Effect systems change to reduce hospital utilization by severely mentally ill patients. Method: Inter-organization activities to identify and resolve barriers to initiation of treatment at, or timely transfer to, appropriate community care settings.	• Contract executed with Partner • Local Core Service Agency and DHHS have provided final input to position description (position will be partially embedded with Core Service Agency). • Position recruitment in process.	Leslie Graham Leslie_Graham@primarycarecoalition.org (301) 628-3410

Submitted by Primary Care Coalition on behalf of the six Nexus Montgomery Regional Partnership member hospitals.

Submitted on behalf of the three partner hospitals:
Western Maryland Regional Medical Center,
Frederick Memorial Hospital,
And
Meritus Medical Center

Regional Care Transformation
Behavioral Health Interim Report

Presented to the
Maryland Health Services Cost Review Commission (HSCRC)

OCTOBER 14, 2016

Regional Care Transformation
Behavioral Health Interim Report

On behalf of the Trivergent Health Alliance (THA) Regional Partnership (RP), comprised of Western Maryland Health System (WMHS), Meritus Medical Center (MMC) and Frederick Memorial Hospital (FMH) we would like to thank you for the opportunity to quantify our Care Transformation Programs' investment in community based Behavioral Health (BH) services. During FY 17, the Partnership budgeted to invest $956,325, (or 31 %) of the $3.1M award to support the Behavioral Health Models of Care described in the revised implementation proposal and revised budget report. Allegany, Washington and Frederick counties lack access to Behavioral Health professionals which delays patient treatment, hinders patient compliance with follow up, and does not meet current demand. With a lack of access, patients turn to the Emergency Department (ED) for services that would otherwise not necessitate emergency care. If adequate resources were present, our BH target population could be treated and managed in an outpatient setting. Effectively managing and treating the target population in a community based setting will improve the quality of care delivered, improve patient satisfaction, and decrease inpatient and ED utilization; including their associated costs. The Care Transformation grant funding will support meeting the need of the targeted population by providing needed resources to overcome the current barrier due to lack of or insufficient reimbursement for provision of these services when embedded in Primary Care.

MMC and FMH have contracted with Potomac Case Management Services, Inc. (PCM) to provide outpatient Community Based BH Case Management for the target population as described within our proposal. A total of $336,840 will be paid to PCM for the BH Case Mgmt. service in FY 16. With the grant funding PCM will add 5.1 FTE (full time employee resource) between the two counties. At this time PCM does not service Allegany County and the origin of this strategy was modeled after the successful implementation of the BH case mgmt. program WMHS created to fill their BH patient need.

The RP will invest a total of $475,765 to embed a total of 6 BH professional FTEs into health system employed or ACO affiliated Primary Care Physician Practices as described within the proposal to integrate BH services into Primary Care to identify patients at-risk and link them to appropriate resources. Current reduced funding under the grant and lack of waivers required to clinically integrate with independent community practices, impedes the ability to place such resources within unaffiliated PCP offices at this time.

WMHS is investing $143,720 of their grant funding for a Psychiatric Nurse Practitioner (1FTE) whose skill set and time will be utilized to provide Allegany County the following three community based resources: embedded psychiatric NP in primary care locations for provision of integrated BH care to the regional ACO, free/in-kind services on-site at Archway Station (a community based agency) to support the chronic mentally ill and the Developmental Disabilities Administration (DDA) population served by this agency, and embedded NP with Allegany County EMS to complete home visits on at risk patients and provide treatment to the patient in the most appropriate setting.

The Behavioral Health Models of Care currently being deployed, as described throughout the proposal submission and revision process will reduce avoidable hospital utilization through improvements in:

- Transitions of care by increasing direct linkage and follow up with a behavioral health care provider
- Integration between medical and behavioral health, improving patient compliance and successful care plan achievement of patient centered goals.
- Reducing unnecessary ED revisits and future hospitalization
- Avoidance of delays in receiving follow-up BH care
- Collaboration with PCPs, due to increased access to BHP for consultation and direct patient care support.

Please refer to the attached BH template for additional information related to the specific funding provide by each sponsor hospital per community based program in the process of implementation.

Regional Care Transformation
Behavioral Health Interim Report

Respectfully submitted,

Trivergent Health Alliance Regional Partnership

Status of Hospital Implementation Grant Partnerships with Community Behavioral Health Providers
As of October 1, 2016 (report due October 15, 2016)

Sponsor Hospital in THA Regional Partner-ship	Behavioral Health Partner in Implementation Application	Owned by Hospital or Independent	Total Funding Allocation from Application	Funding Provided to Partner to Date from each hospital	Purpose of Partnership as Stated in Implementation Application	Status of Partnership and Meeting Goals of the Application	Partner Contact (phone and e-mail)
1 WMHS	Multiple Primary Care Providers in the Community	Some owned by Hospital, some independent.	$143,720 Budget Report:	Funding will be invested in the services of a psychiatric NP to provide free care at these providers	Provide a psychiatric nurse practitioner to be embedded in Primary Care locations for provision of integrated behavioral health care to the regional ACO.	**Status:** Recruitment process is complete; state board credentialing process complete, on-boarding process underway. Targeted deployment date: Oct.31st. **Goal #1** – Embed Psychiatric Provider in Primary Care Provider (PCP) locations, both WMHS and Non-WMHS sites to support care coordination and behavioral health case management efforts and provide intensive services to adults discharged from ED or inpatient. Services provided will be non-billable, in-kind services to fully implement an integrated care model. **Target population:** Adults with a behavioral health (BH) and/or substance abuse diagnosis **Key Metrics:** • Number of persons referred • Number of persons assessed • BH Emergency Dept. (ED) total visits • BH revisits within 30 days • BH total admission rate • BH readmission rates within 30 days ***Please note: WMHS had already implemented an integrated model of care with Primary Care Providers (PCPs) in the community	Jeff O'Neal, Director (240) 964-2222 jdoneal@wmhs.com Kathy Whitecare, Manager (240) 964-8589 kwhitacre@wmhs.com

						using social workers. Therefore, the full integration model of care required the addition of a nurse practitioner to the team to support PCPs in this psychiatrically underserved area.	
Sponsor Hospital in THA Regional Partner-ship	**Behavioral Health Partner in Implementation Application**	**Owned by Hospital or Independent**	**Total Funding Allocation from Application**	**Funding Provided to Partner to Date from each hospital**	**Purpose of Partnership as Stated in Implementation Application**	**Status of Partnership and Meeting Goals of the Application**	**Partner Contact (phone and e-mail)**
2 WMHS	Archway Station	Independent	Funding detailed in Row 1 is inclusive of this item.	Funding will provide a psychiatric nurse practitioner, to provide **free service to these providers**.	Provide a psychiatric nurse practitioner on-sight at Archway Station to support the Chronic Mentally Ill and DDA population served by this agency as a means to reduce unnecessary ED Visits, unnecessary admissions and provide treatment to the patient in the most appropriate setting.	**Status:** Same as line item #1: Recruitment process is complete; state board credentialing process complete, on-boarding process underway. Targeted deployment date: Oct.31st. **Goal #2** – Embed Psychiatric Provider in Archway Station to support the chronically ill population in the most appropriate setting. Services provided will be non-billable, in-kind services to fully implement an integrated care model to Archway. **Target population:** Adults with a behavioral health and/or substance abuse diagnosis **Key Metrics:** • Number of persons referred • Number of persons assessed • BH ED total visits of Archway Patients • BH revisits within 30 days of Archway patients • BH total admission rate of Archway patients • BH readmission rates within 30 days of Archway patients	Dr. Joy Reckley Murphy, LCSW-C Executive Director 301-777-1700, ext. 105 joy.reckley-murphy@archwaystation.net

Sponsor Hospital in THA Regional Partner-ship	Behavioral Health Partner in Implementation Application	Owned by Hospital or Independent	Total Funding Allocation from Application	Funding Provided to Partner to Date from each hospital	Purpose of Partnership as Stated in Implementation Application	Status of Partnership and Meeting Goals of the Application	Partner Contact (phone and e-mail)
3 WMHS	Allegany County EMS	Independent	Funding detailed in Row 1 is inclusive of this item.	Funding will provide a psychiatric nurse practitioner, to provide **free service to these providers**.	Provide a psychiatric nurse practitioner to go with Allegany County EMS to complete home visits on at risk patients and provide treatment to the patient in the most appropriate setting.	**Status:** Same as line item #1: Recruitment process is complete; state board credentialing process complete, on-boarding process underway. In the process of completing application that reflects Allegany County specific protocols in alignment with approved MIEMSS MICH pilot program. Target Date to submit application: December 1, 2016 **Goal #3**– Send Psychiatric Provider into the community based geographic "Hot Spots" to provide intensive services to adults discharged from ED or inpatient or those who are unable to engage in traditional services but are in need. Services provided will be non-billable, in-kind services to fully implement an integrated care model. **Target population:** Adults with a behavioral health and/or substance abuse diagnosis **Key Metrics:** • Number of persons referred • Number of persons assessed • BH ED total visits • BH revisits within 30 days • BH total admission rate • BH readmission rates within 30 days	Dick DeVore, Director 301-876-9155 ddevore@allconet.org

Sponsor Hospital in THA Regional Partner-ship	Behavioral Health Partner in Implementation Application	Owned by Hospital or Independent	Total Funding Allocation from Application	Funding Provided to Partner to Date from each hospital	Purpose of Partnership as Stated in Implementation Application	Status of Partnership and Meeting Goals of the Application	Partner Contact (phone and e-mail)
4 MMC	Potomac Case Manage-ment Services, Inc. (PCM)	Independent	$243,240	$14,094.57 10/2016	To provide community case management service to persons with a behavioral health diagnosis	**Status:** Formal agreement completed 8/24/2016 Initial coordination meeting 9/9/2016 Began accepting referrals 9/12/2016 **Goal:** Provide intensive behavioral health case management to adults discharged from ED or inpatient **Target population:** Adults with a behavioral health and/or substance abuse diagnosis **Key Metrics:** • Number of persons referred • Number of persons assessed with care plan • BH ED total visits • BH revisits within 30 days • BH total admission rate • BH readmission rates within 30 days	PCMS Dawn Johns, Program Director 301-791-3087 djohns@pcmsinc.org

Sponsor Hospital in THA Regional Partner-ship	Behavioral Health Partner in Implementation Application	Owned by Hospital or Independent	Total Funding Allocation from Application	Funding Provided to Partner to Date from each hospital	Purpose of Partnership as Stated in Implementation Application	Status of Partnership and Meeting Goals of the Application	Partner Contact (phone and e-mail)
5 MMC	Multiple Primary Care Providers in the Community:	MMC owned Medical Group	$234,765	Funding will provide a psychiatric LCSW, to provide free, in-kind service to these providers. Start date projected for Fall 2016.	Expand embedded access to Bachelor's prepared Behavioral Health Professional (BHP) in Primary Care and ACO locations for provision of integrated behavioral health care.	**Status:** Recruitment complete. Anticipated date to begin accepting expanded case load/referrals on 10/31/2016. **Goal #1** – Embed Psychiatric Bachelor's prepared BHP in PCP location to support care coordination and behavioral health case management efforts and provide intensive services to adults discharged from ED or inpatient. Services provided will be non-billable, in-kind services to fully implement an integrated care model. **Target population**: Adults with a behavioral health and/or substance abuse diagnosis **Key Metrics:** • Number of persons referred • Number of persons assessed • BH ED total visits • BH revisits within 30 days • BH total admission rate • BH readmission rates within 30 days	Allen Twigg, Director 301-790-8688 Allen.Twigg@meritushealth.com

Sponsor Hospital in THA Regional Partner-ship	Behavioral Health Partner in Implementation Application	Owned by Hospital or Independent	Total Funding Allocation from Application	Funding Provided to Partner to Date from each hospital	Purpose of Partnership as Stated in Implementation Application	Status of Partnership and Meeting Goals of the Application	Partner Contact (phone and e-mail)
6 FMH	Multiple Primary Care Providers in the Community: 1.Parkview Medical 2.Internal Medicine Associates 3.Care Clinic	All three are part of FMH employed medical group: Monocacy Health Partners.	$241,000	Funding will provide a psychiatric LCSW, to provide free, in-kind service to these providers. Start date projected for Fall 2016.	Provide a psychiatric LCSW to be embedded in Primary Care locations for provision of integrated behavioral health care to the regional ACO and employed primary care providers.	**Status:** Recruitment is underway. Once open positions are filled the program will be implemented. **Goal #1** – Embed Psychiatric LCSW in PCP location to support care coordination and behavioral health case management efforts and provide intensive services to adults discharged from ED or inpatient. Services provided will be non-billable, in-kind services to fully implement an integrated care model. **Target population**: Adults with a behavioral health and/or substance abuse diagnosis **Key Metrics**: • Number of persons referred • Number of persons assessed • BH ED total visits • BH revisits within 30 days • BH total admission rate • BH readmission rates within 30 days	Michael McLane Director (240) 566-3066 mmclane@fmh.org

Sponsor Hospital in THA Regional Partner-ship	Behavioral Health Partner in Implementation Application	Owned by Hospital or Independent	Total Funding Allocation from Application	Funding Provided to Partner to Date from each hospital	Purpose of Partnership as Stated in Implementation Application	Status of Partnership and Meeting Goals of the Application	Partner Contact (phone and e-mail)
7 FMH	Potomac Case Manage-ment Services, Inc. (PCM)	Independent	$93,600	Invoice for start-up costs and first installment are anticipated to arrive in Oct. 2016	To expand current community case management service from 1 FTE, to 2.5FTE to reach targeted patients with a behavioral health diagnosis as described in the proposal.	**Status:** Initial coordination meeting to expand current Memorandum of Understanding (MoU) held 8/9/2016. Revised MoU is anticipated to be in place by the end of Sept., mid- Oct. 2016; MoU is currently under legal review. PCM began accepting increased volume of referrals 9/1/2016. **Goal:** Provide intensive behavioral health case management to adults discharged from ED or inpatient **Target population:** Adults with a behavioral health and/or substance abuse diagnosis **Key Metrics:** • Number of persons referred • Number of persons assessed with care plan • BH ED total visits • BH revisits within 30 days • BH total admission rate • BH readmission rates within 30 days	PCMS Dawn Johns, Program Director 301-791-3087 djohns@pcmsinc.org

UNION HOSPITAL

WATCH Program

UNIVERSITY of MARYLAND UPPER CHESAPEAKE HEALTH

Status of Hospital Implementation Grant Partnerships with Community Behavioral Health Providers
As of October 1, 2016 (report due October 15, 2016)

Behavioral Health Partner in Implementation Application	Owned by Hospital or Independent	Total Funding Allocation from Application	Funding Provided to Partner to Date from each hospital	Purpose of Partnership as Stated in Implementation Application	Status of Partnership and Meeting Goals of the Application	Partner Contact (phone and e-mail)
UMUCH-UHCC Behavioral Health Collaborative (Behavioral Health Management Services LLC)	Joint Venture between UHCC and UMUCH	$0 This Joint Venture is funded separately/ outside of the grant by the two hospital organizations	N/A	UMUCH and UHCC Behavioral Health Collaborative was included in the RP planning process to integrate access to BH services with the target population of the Wellness Action Teams of Cecil and Harford (WATCH) program. The collaborative combines strategic planning, recruitment and management of hospital-based and ambulatory services in the two counties. The Executive Director of the Collaborative, Rod Kornrumpf, was a co-author of the implementation funding grant and a member of the WATCH program Operations Committee.	The collaborative, outside of the grant, has: a) expanded access to Behavioral Health services, through physician recruitment: Harford Memorial: Psych MD (2) and Psych NP (1) Union Hospital: Psych MD (1) and Psych NP (1) Upper Chesapeake: Psych NP (1) Ambulatory: Embedded (Implemented and/or Planned) Social Workers in Primary Care (2), Urgent Care (1), Women's Services (2), Oncology (1) b) Increased ambulatory access through consolidation of IOP and Outpatient practice at Harford Memorial and Union Hospitals. c)Trained teams on person-centered care and trauma informed care.	Rod Kornrumpf, Regional Executive Director-443-945-2516 (cell) 443-674-1295 (Office-Union)

Healthy Harford Healthy Cecil	Separate 503c3 organization (Executive Director Position Funded by UMUCH)	$3,500	$0 – Payment to be completed after November session.	Provide Mental Health First Aid Training for the WATCH program. Eight (8) hours sessions may also include community stakeholders such as first responders.	Completed one training session in July for initial 13 WATCH members hired, including Social Workers (2), Nurse Care Managers (2), Clinical Coordinator (1), and Community Health Workers (8). Second Training Scheduled for November 11th.	Sharon Lipford (Ex. Director) (443) 643-3356 slipford@uchs.org

UM St. Joseph Medical Center Transformation Grant Report:

Status of Hospital Implementation Grant Partnerships with Community Behavioral Health Providers

Submitted:
Oct 14, 2016

UM SJMC Status of Hospital Implementation Grant Partnerships with Community Behavioral Health Providers
As of October 1, 2016 (report due October 15, 2016)

Behavioral Health Partner in Implementation Application	Owned by Hospital or Independent	Total Funding Allocation from Application	Funding Provided to Partner to Date from each hospital	Purpose of Partnership as Stated in Implementation Application	Status of Partnership and Meeting Goals of the Application	Partner Contact (phone and e-mail)
Maxim Transition Assist	Independent	*$300,000	0	Maxim to provide Community Health Workers or Behavioral Health Technician to patients post discharge for in-home non-clinical services to augment their clinical care. Maxim assessed high risk med/surg patients with behavioral health needs can be referred to the Behavioral Health Center for timely proper treatment to augment clinical care.	Community health workers have received specialized behavioral health training to better manage the needs of this unique patient population. The program is being rolled out in conjunction with Behavioral Health Center team in mid-October.	Justin Kile jukile@maxhealth.com 410-616-1523
Behavioral Health Center Team/Staffing Drs. Brandt/Crawford (Chief of Psychiatry SJMC)	Independent	*$635,304 Yr 1 $614,661,Yr 2	0	To provide program development including staffing the Center with appropriate clinical team: psychologist, psychiatrist and LCSWs to support the clinical care of target patients	Contract with behavioral health partners finalized on September 21st, 2016. 1 LCSW and psychiatrist hired. Roll out of bridge program on Oct 11, 2016 Recruitment in progress for 2 additional LCSWs and psychologist.	Dr. Harry Brandt HarryB@umm.edu 443-506-4000
SJMG Transitional Care Center: Medical/Surgery patients	Owned by UM St. Joseph Health	0	0	To provide an access point for medical and chronic disease patients with underlying behavioral health factor that impedes their successful transition back into the community setting.	Finalizing ambulatory assessment format, anticipated roll out in second quarter.	Alice Chan alicechan@umm.edu 410-337-4508

SJMG Primary Care Provider Group	Owned by UM St. Joseph Health	0	0	To provide an access point for community providers' patients with underlying behavioral health factors that impedes their successful transition back into the community setting.	Finalizing ambulatory assessment format, anticipated roll out in second quarter.	Alice Chan alicechan@umm.edu 410-337-4508
VNA	Independent	0	0	To provide an access point for community providers' patients with underlying behavioral health factors that impedes their successful transition back into the community setting.	Finalizing ambulatory assessment format, anticipated roll out in second quarter.	Beth Gray B.Gray@vnamd.com 410-277-5825
Baltimore County Health and Human Services	Independent	0	0	The goal is to create a support network and identify appropriate resources for our partners to successfully transition patients back to the community.	Created referral format. We anticipate partnering in referrals of patients who need social resources with BCHHS and working in tandem towards holistic patient care transitions back into the community	Phyllis Hall phall@baltimorecountymd.gov 410-887-8291
Chase Brexton	Independent	0	0	Work in progress. The goal is to create a support network and identify appropriate resources for our partners to successfully transition patients back to the community.	Have met and will now join formalized UMMS work group to discuss shared patients. This process is still in development phase.	Judy Shahan jshahan@chasebrexton.org 410-837-2050 ext.1094
Baltimore Medical System	Independent	0	0	The goal is to create a support network and identify appropriate resources for our partners to successfully transition patients back to the community.	This process is still in development phase.	Adelline Ntatin Adelline.Ntatin@bmsi.org 410-558-4881

*The total funding indicated in this table is solely for partnership funds flow and does not include start up expense cost for the Behavioral Health Center. A budgeted line item expense for the awarded $1,147,000 was submitted on August 15th for budget reporting to HSCRC.