## 

University of Maryland St. Joseph Medical Center

Transformation Implementation Program

Behavioral Health Center

Development of Behavioral Health Transitional Bridge Center

December 21, 2015

## 

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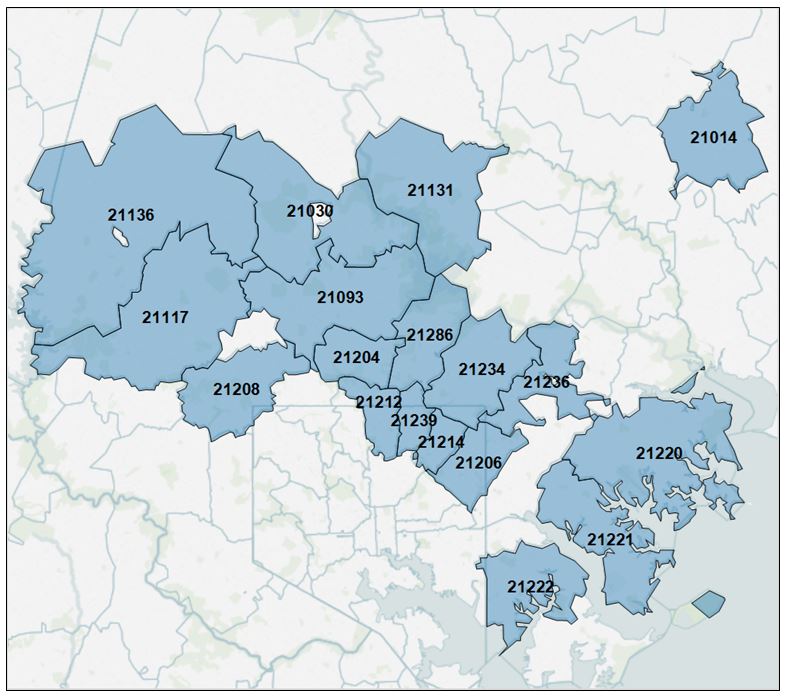
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## SECTION 1: TARGET POPULATION

**Institution Profile**

University of Maryland St. Joseph Medical Center (“UM SJMC”) is a 263-bed, acute care, non-profit regional medical center located in Towson, Maryland. UM SJMC is part of the University of Maryland Medical System, a multi-hospital system with academic, community and specialty services offered throughout the State of Maryland.

The Primary Service Areas of UM SJMC by zip code are concentrated within the Baltimore Metropolitan area. UM SJMC is located in Towson, Maryland, 21204:

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*UM SJMC PSA by zip code.*

UM SJMC has made several strategic investments to decrease potentially avoidable utilization and positively impact population heath as referenced in UM SJMC’s Strategic Hospital Transformation Plan[[1]](#footnote-1) Providing for the behavioral health patient population represents an opportunity for UM SJMC to build upon the success of existing initiatives while strengthening alignment with non-hospital providers. Through these efforts, UM SJMC will be positioned to better serve the health needs of our community.

**Effect of Mental Illness on Patient’s Health**

UM SJMC has long recognized the distinctive needs of patients who require mental health treatment.

It stands alone as the first community-based hospital in Maryland to develop a psychiatric unit, and of the few acute care facilities in the Baltimore area with both an inpatient unit and a partial hospitalization program. As other community hospitals backed away from care of the mentally ill, UM SJMC has remained steadfast in its commitment to this population with great needs. The psychiatric programs at UM SJMC have been staffed and directed by regionally recognized psychiatric providers affiliated with the nationally recognized Centers for Eating Disorders for 20 years.

It is well-established that a patient’s mental health is one of the major drivers in health care utilization. Studies have shown that 70% or more of all primary care visits were driven in part by psychological factors, and that distressed patients utilized healthcare at rates 2 to 3 times higher than non-distressed patients.[[2]](#footnote-2) Additionally, correlations have been shown between mental illness and chronic non-psychiatric medical conditions.[[3]](#footnote-3) Members of the UM SJMC patient community have identified mental illness as a community health concern.[[4]](#footnote-4)

In response to the recognized correlation among mental illness, chronic conditions and hospital service utilization, UM SJMC will establish a Behavioral Health Transitional Bridge Center (Behavioral Health Center or “BHC”), which will complement existing initiatives to provide comprehensive health management services and mental health resources to a targeted patient population identified by the following criteria.

**Target Patient Population (“TPP”)**

UM SJMC will target a subset of its patient population for the following proposed mental health interventional services. To establish eligibility for potential program participants, all of the following criteria must be met:

* **Criterion 1**: Medicare patients treated at UM SJMC
* **Criterion 2**: Patients identified having a mental health or substance abuse diagnosis (based upon FY 2015 data)
* **Criterion 3**: Patients identified as high utilizers (based upon FY 2015 data)
  + 2 or more inpatient or observational bedded care admissions of greater than 24 hours within the past year
* **Criterion 4**: Patients identified as suffering from at least 1 Chronic Condition, as identified from Inpatient, Observational, and ED data
  + Chronic Conditions (10 possible): Hypertension, Diabetes, CAD, CHF, Chronic Kidney Disease, Obesity, COPD, Septicemia, Pneumonia and Hepatitis

Application of all 4 criteria to UM SJMC patient population based on FY 2015 data yielded **606** unique patients, with an average annual charge per patient of **$35,091**. UM SJMC will work collaboratively with non-hospital providers to capture additional patient volume in the community-based and post-acute care settings. The BHC will serve as a resource to patients with major mental health diagnosis across the care continuum with the ultimate goal of transitioning patients back into community-based care *(Figure 1).*

Community-Based Care

Acute

Care

Post-Acute

Care

BHC

*Figure 1*.

**UM SJMC Behavioral Health Center Overview**

Flow of patients with primary psychiatric disorders and medical patients with comorbid psychiatric illness has increased dramatically in the past year at UM SJMC. Recent data suggests that ER evaluation of behavioral health patients have nearly doubled over the past 12-18 months. This is, in part, a result of UM SJMC’s recent designation as one of the hospitals to receive Emergency Petition patients by the Maryland Department of Health and Mental Hygiene. Further, UM SJMC is receiving significant overflow volume from the Sheppard Pratt Crisis Walk-in Center, as well as medical/surgical referrals from their inpatient psychiatric units. These factors, coupled with very limited transition options for patients with major mental health diagnoses, have created an urgent need for focused outpatient behavioral health resources in the service area.

Through this grant, UM SJMC will establish, operate and staff the BHC offering comprehensive health management services to identified patients, specifically providing for those patients with major mental health diagnosis including bipolar disorder, schizophrenia and other psychiatric illnesses associated with high rates of repeated hospitalizations. For patients discharged from the hospital, the program will provide comprehensive care management in the outpatient setting for TPP members for a period of 60-90 days following inpatient discharge. A multi-disciplinary care team including a psychiatrist, a psychiatric social worker, a psychiatric nurse, and psychologists will treat patients in the BHC as well as remotely via telephonic consults. During the 60-90 day treatment period, the care team will develop a full, structured outpatient plan for each patient, assign and treat patients in a series of evidence-based relapse prevention strategy groups, and ultimately connect the patient to well-established community-based resources for continuing outpatient treatment. The goal of the BHC will be to provide an intensive treatment to prevent relapse, provide post-hospitalization bridge services during a period with high risk of relapse, and ultimately, to support successful transition of patients back into the local community.

For patients who are currently treated in community-based and post-acute settings, the BHC will utilize its resources to provide better care for these patients by working with primary-care physicians and local community providers to improve management of patients with mental health conditions, aligning with home health agencies to screen patients, offering treatment options in the BHC, and pairing patients with appropriate community resources.

An element shown to be effective in decreasing relapse in this population has been Assertive Community Treatment (ACT). In this light, in addition to investing in the on-campus BHC, UM SJMC will fund an expansion of the Maxim Transition Assist (MTA) program. Maxim is a private health services entity that contracts with UM SJMC. Currently, the program provides clinical health services within the community to medical-surgical patients for 30 days post-discharge, following a program risk stratification assessment. The expanded Maxim program will provide management services to TPP members through Behavioral Technicians; community health workers specifically trained to assist and furnish in-home services to patients with major mental health diagnoses. TPP members will be followed by Maxim providers for 60 to 90 days post-discharge depending on the patient needs. The BHC will serve as a bridge resource for patients until they can be successfully enrolled and transitioned to existing community resources and programs, patients will be visited by and have the ability to contact BHC team members following transition, if any problems arise.

The successful management of mental health diagnoses in the target patient population will lead to a reduction in hospital utilization, generating savings and successfully meeting the requirements of Maryland’s triple aim: improving health, enhancing quality and patient satisfaction, and reducing cost.

## SECTION 2: PROPOSED PROGRAM/INTERVENTIONS

**Complementary Existing Initiatives**

As outlined in the Strategic Hospital Transformation plan, UM SJMC has undertaken to address the needs of chronically ill, high-utilizing patients.[[5]](#footnote-5) Of those initiatives, two will be complemented by the BHC:

1. Post-Discharge Center

Beginning in March, 2016 UM SJMC will establish a Post-Discharge Center (PDC). The targeted, (though not exclusive) population for the program will be chronically-ill Medicare patients. Patients will be electronically flagged and referred by hospitalists based on meeting the following criteria:

* one or more chronic condition(s)
* two or more inpatient or observational bedded care admissions of greater than 24 hours within a rolling 12 months.

These patients will be followed and managed by an outpatient care team consisting of a hospitalist, a pharmacist, a social worker and a medical assistant/clinical coordinator. In order to capture a greater number of chronically ill Medicare high-utilizers the PDC will hire two additional transitional nurse navigators (TNN) that will work within the hospital. These TNNs will work closely with the outpatient PDC staff to coordinate appropriate follow-up for patients 60-90 days post-discharge. Further, the PDC will engage in comprehensive mental health screening to capture patients with comorbid major mental health diagnoses who would be eligible for and benefit from BHC services.

2. Expansion of Maxim

In January 2015, UM SJMC brought two industry partners together: Maxim Healthcare Services and RightCare Solutions, to form Maxim Transition Assist LLC (MTA). Maxim is a healthcare staffing company and RightCare is the creator of a proprietary multifactorial risk stratifying software that flags “high risk” patients based on socio-economic and psychosocial determinants. Together, MTA provides in-home, post-discharge 30-day follow-up for “high risk” medical/surgical patients. MTA employs a team which includes a hospital based nurse practitioner and several community health workers. To date MTA has provided over 4000 hours of in-home service to over 800 UM SJMC unique discharges. UM SJMC’s vision is to expand the role of MTA community health workers to engage additional TPP. Specifically, community health workers will receive focused training to function as Behavioral Technicians. These specialized community health workers will be equipped to support patients with both mental illness and chronic medical conditions. For this patient population, UM SJMC will extend in-home services for a period of 90 days, with the purpose of achieving a reduction in recidivism over a larger population.

**Program Background/Description**

The PDC, BHC, and MTA at UM SJMC will work together to provide comprehensive health services to TPP members with major mental health diagnoses.  UM SJMC reviewed evidence-based practices to reduce morbidity and relapse for this difficult population. Both the literature and existing initiatives provide strong support for UM SJMC to address the unmet needs and create new solutions for high-risk patients with mental illness as well as the chronically ill medical patients impacted by mental illness.

The BHC will provide comprehensive, relapse-reducing treatment for 60 to 90 days to include ongoing psychiatric management with state-of-the-art pharmacological treatment, a series of evidence-based cognitive group psychotherapies coupled with clinical case management and aspects of assertive community treatment.  The BHC will be staffed with psychiatrists, psychiatric social workers, psychiatric nurses, and psychologist therapists. This team will offer evaluation, treatment and support to patients in collaboration with existing providers.  The program will link with existing programs at UM SJMC to provide care for the mental health of transitioning patients, while serving as a resource for existing providers following patient discharge back into the community. Funding will also aid in the expansion of UM SJMC’s MTA in-home community health worker program.

**Target Patient Population**

As addressed in Section 1, the target patient population (“TPP”) for the BHC will meet all of the below mentioned criteria:

* Medicare patients
* Who suffer from a major mental health diagnosis
* Identified as high utilizers
* Who have been diagnosed with one or more chronic conditions

Program goals will include: focusing on managing patient care, improving and arranging access to mental health services, and to provide support and expertise for affiliated providers as they address the specific needs of patients with major mental health diagnoses.

**Services**

The UM SJMC BHC will integrate a series of interventions that have been successful in reducing re-hospitalization of chronic psychiatric patients and high-risk medical patients with influencing psychiatric comorbidities. Upon enrollment, patients will receive comprehensive diagnostic screening and a review of pertinent medical records will be conducted, assessing factors leading to past relapse. Each patient will receive a comprehensive psychiatric evaluation and medication assessment/reconciliation. A psychiatric social worker will assess external supports and remain available for crisis-oriented psychotherapy. Patients will be referred after assessment to one or more of the following interventions: (1) Ongoing psychiatric medication management visits, where the BHC will be equipped to provide, if indicated, “depot” antipsychotic medication for patients with a history of repeating psychosis and medication non-adherence, (2) Cognitive Behavioral Therapy (CBT) – relapse prevention group, (3) CBT- substance abuse group, (4) Dialectical Behavioral Therapy (DBT) – skills training group, (5) Motivational Enhancement Therapy (MET) group using motivational interviewing techniques.

A majority of patients in the BHC will receive elements of Assertive Community Intervention including home visits, med adherence assessment, integration with family support and transport to and from the BHC via the MTA program.

Patients will be treated in the BHC for a period of 60-90 days. During their span of clinical intervention, they will be connected with outpatient resources through Sheppard Pratt’s Mosaic, Keypoint, or Alliance (as needed). The BHC will establish and maintain a strong, working connection with care providers treating the chronically mentally ill.

**Delivery**

Care will be delivered by clinical staff upon referral to the BHC. Referrals will be accomplished across the care continuum and existing initiatives as depicted in Figure 2. To establish consistency with the referral process to the BHC UM SJMC will work with partners across in the community based setting and post-acute care setting to develop a uniform risk stratification tool.

* Patients under the care of primary care providers (PCP) will be eligible for program participation via a referral to the BHC. Care team members will work with the PCPs and community providers to better care for patients within the community setting.
* Patients in the acute care setting identified by case management as members of the TPP with a psychiatric diagnosis will be handed off to BHC as a bridge to community services. The BHC care team will actively manage patients’ care, and support transitions back into their respective communities.
* Patients in the post-acute setting, such as home care, will be screened via tools such as the Physicians Health Questionnaire through collaboration with the Visiting Nurses Association of Maryland.
* UM SJMC is currently in active discussions with Sheppard Pratt leadership to work collaboratively to meet the needs of these patients.
* Community agencies such as Mosaic and Keypoint are outpatient community programs that have invested resources in caring for mental health patients. Both, Jeff Richardson Executive Director of Mosaic and Karl Webber, CEO of Keypoint have expressed a strong desire to work collaboratively with UM SJMC and will be a resource for the ongoing care of this population post 60-90 day treatment period.
* Regional collaborative efforts will involve extending BHC board positions to key providers including the leadership Community based primary care physicians, Sheppard Pratt, home-care, sub-acute rehabilitation centers, and community agencies. The addition of stakeholders engaged in direct care of patients with mental health diagnoses will benefit the BHC’s continued development of unique and successful care delivery models.

UM SJMC is obtaining letters of support from each of these respective entities to work collaboratively in efforts to best serve our patients.

**Additional Investment- Maxim Transition Assist Expansion to BHC Patients**

A key to the success of the BHC will be the mechanism by which patients remain engaged outside of the BHC setting. Expansion of UM SJMC’s MTA program will accomplish the often difficult task of maintaining patient contact and engagement. MTA will focus on the mental health needs of the TPP by assigning Behavioral Technicians (BT), specifically trained to care for the TPP, to follow patients into the community. In the first year this workforce will provide approximately 4300 hours of in-home support to the target patient population for a period of 60-90 days. Services will include:

* Establishing therapeutic and trusting relationship with patients and patient’s care givers;
* Ensuring that the patient is consistently maintaining their schedule, staying organized and attending all appointments as planned;
* Providing basic coping skills support such as working with the patient around problem solving skills;
* Identifying and mitigating any barriers to care such as lack of transportation, lack of caregiver support, lack of resources to pay for medications, poor housing, poor nutritional status, poor functioning status, etc.
* Making sure the patient is taking their medications as prescribed and following through on all physician orders;
* Helping the patient adhere to their plan and achieve their post-discharge goals;
* Assisting patient in finding appropriate and available community resources;
* Facilitating communication between the patient and their primary care provider.

The PDC, BHC and MTA will work together across the care continuum as displayed below. (Figure 2).

Community-Based Care

Acute

Care

Post-Acute

Care

MTA

Community-Based Care

MTA

MTA

*Figure 2*

**Key Staff Profiles**

Care Team Members

Dr. Harry Brandt, UM SJMC Chief of Psychiatry and Dr. Steven Crawford, UM SJMC Assistant Chief of Psychiatry will lead development of the BHC. Both are US News and World Report Top Doctors with a long history of building highly effective treatment initiatives which have had sustained success. Additionally, they co-direct the Center for Eating Disorders at Sheppard Pratt and the Center for Eating Disorders, PA (CED) outpatient programs. They will draw on their experience in building effective treatment models to address extremely difficult clinical populations with high rates of relapse, and access to clinicians from their existing programs with expertise in evidence-based cognitive treatments.

**Psychiatrist**

* Clinical evaluation of patient and assessment of factors leading to illness recurrence
* Review and construct treatment plan for patient
* Conduct pharmacologic review, reconcile medications, and consider use of “depot” meds for psychosis if indicated
* Lead multidisciplinary care team
* Engage in telephonic support for remote access patients

**Psychiatric Social Worker (LCSW)**

* Utilize specialized experience in short-term crisis management
* Utilize functional knowledge of available community resources to develop post-BHC treatment plan
* Assist in assigning patients to evidence-based relapse prevention strategy groups
  + Motivational Interviewing/Motivational enhancement therapy group
  + Cognitive Behavioral Therapy – Relapse Prevention group
  + Dialectical Behavioral Therapy –Skills training group
  + Cognitive Behavioral Therapy - Substance abuse group
* Assist patient in transitioning from program to community-based resources
  + Including community outpatient support programs such as
    - Mosaic
    - Alliance
    - Keypoint

**Psychologists**

* Psychologists with specialized experience in providing manualized CBT and DBT will be utilized to lead the four group therapy treatments at the BHC.

**Psychiatric Nurse**

* Psychiatric nurse will provide screening for BHC patients, administration of depot antipsychotic injections, and supportive psychotherapy intervention to patients.

**Maxim Transition Assist (MTA)**

* MTA will build upon its training program provided to Community Health Workers to develop Behavioral Technicians, trained in addressing the needs of BHC patients. Behavioral Technicians will provide regular in-home patient monitoring functions and serve as community liaisons between the patients and the BHC care team.

**Transitional Nurse Navigators (TNN)**

* UM SJMC has experienced success with placing a TNN in the ED to care plan for high utilizers of the emergency department. We have assessed the success of this by looking at pre and post intervention utilization rates, realizing over a 50% reduction in utilization as measured by ED and Inpatient visits, imaging studies and medication utilization. UM SJMC is seeking to add two additional TNNs that will be inpatient hospital centric to further hone in on Medicare high utilizers with chronic medical conditions.

## SECTION 3: MEASUREMENT AND OUTCOME

**Programmatic Metrics**

The programs’ initial iterations will have the following programmatic metrics, subject to revision as the programs reach full implementation:

Process metrics will be formulated and consist of the following data elements:

|  |
| --- |
| * # of monthly encounters: BHC visits |
| * # of monthly encounters: telephonic (CM) |
| * # of encounters by initial admission DRG |
| * % of High Risk patients scheduled at BHC prior to discharge |
| * No show rate for patients scheduled at BHC |
| * Average number of days between discharge and being seen at BHC |
| * % of patients with hand off to PCP or appropriate specialist within 90 days |
| * % of patients with medication reconciliation |
| * % of patients with Advanced Care planning |
| * % of patients who test positive for mental health diagnosis |
| * Referral source |
| * Average number of days between 2nd visit to BHC (if applicable) |

Also captured will be outcome statistics for the program, as well as satisfaction of participating patients.

|  |
| --- |
| * Clinical Outcomes Post-Intervention |
| * + % of pts. receiving pharmacy support |
| * + % of patients receiving NP/MD support |
| * + % of patients receiving social work support |
| * + % of referrals made to community programs |
| * + 90 day utilization rates (since enrollment into program) |
| * + - Admissions |
| * + - Observations |
| * + - ED visits |
| * Patient Satisfaction Surveys |
| * + Sample Questions will include: |
| * + - **Access** |
| * + - * a. "When you needed care right away, did you get the care soon enough" |
| * + - **Quality** |
| * + - * b. "Did your care-team spend the amount of time you needed at the visit" |
| * + - **Communication** |
| * + - * c. "Did you care team adequately explain things in a way that that was easy to understand" |

Additionally, programs will maintain core process measures as listed in Appendix A Table 1 and 1A and Table 2 of the grant application.[[6]](#footnote-6)

## SECTION 4: RETURN ON INVESTMENT



## SECTION 5: SUSTAINABILITY AND SCALABILITY

**Sustainability**

The BHC program will be sustained independent of the grant award through:

* Services provided by the BHC will reduce Potentially Avoidable Utilization, thereby generating savings for the hospital. This savings will be channeled back into the program for development and expansion of staff and services
* Additional billing for services rendered to the Medicare population by BHC will be retained by the program

**Scalability**

Savings generated by the reduction in Potentially Avoidable Utilization will allow the program to expand services to all payers that present with established criteria. Such expansion will require:

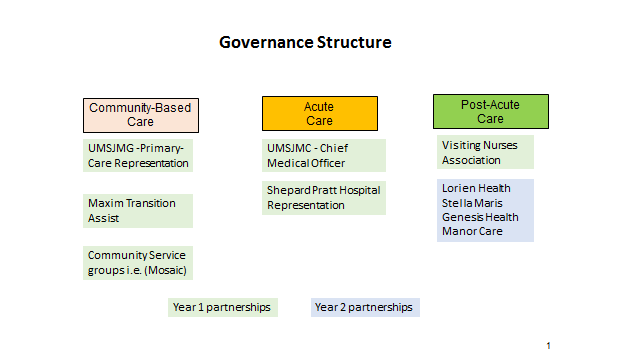
* Addition of team members
* Evaluation of BHC’s physical location for space
* Evaluation of BHC’s IT capabilities
* Expansion of MTA’s contract to provide for additional patients
* Review and addition of community providers and affiliated entities

Expansion efforts will be appropriately scaled and funded by savings generated as a result of the program’s sustainability efforts.

## SECTION 6: PARTICIPATING PARTNERS AND DECISION MAKING PROCESS

**Governance**

Governance of the BHC will be through a governance council, in which member individuals and entities, who agree to participate via submitted letters of intent are stratified across three continuums of care served by the BHC: Community-based, Acute and Post Acute.[[7]](#footnote-7) Within the first year, the members of each stratum will form the governing council of the BHC, providing critical analysis and advice on service offered and protocols implemented, with ultimate decision residing with UM SJMC leadership. Council membership by strata follows:



* From Community-based care, a primary care representative from the SJ Medical Group, a representative from the Maxim transition assist program and a representative from existing community service groups, to include Mosaic
* From the Acute care, UM SJMC Chief Medical Officer and a representative from Sheppard Pratt
* From Post-Acute care, a member from the Visiting Nurses Association. Within the second year, additional organizations will join, including sub-acute rehabilitation providers such as Lorien Health, Stella Maris, Genesis Health and Manor Care.

**Funds Flow**

Grant funds awarded to UM SJMC through rates will be used to create the BHC, hire and train appropriate staff, and provide appropriate equipment. The BHC will operate out of the same unregulated space as the Post-Discharge Center, allowing for economies of scale and cost savings. Funds will also be used to execute an amended contract with MTA, to extend the community health worker model to additional eligible patients at the BHC.

For future program iterations, the BHC plans to work collaboratively with non-hospital providers to formulate pay for performance incentives for partners across the care continuum. These models will develop subject to existing legal limits, and will be reconciled with potential State initiatives upon development.

Community Based Care

* + Working with Primary Care Providers to capture Medicare’s Chronic Care Management fee for services rendered to eligible patients
* Working with community agencies (i.e. Mosaic and Keypoint) with a focus on successfully transitioning patients back into the community

Acute Care

* + Working with Shepard Pratt Health System to figure to develop a funds flow arrangement with a focus on preventing patients from seeking duplicative interventions between facilities

Post-Acute Care

* + Working with home-health care agencies and sub-acute rehabs to develop a pay for performance structure

## SECTION 7: IMPLEMENTATION WORK PLAN

The Implementation Work Plan has been completed in the required MS Project format. It accompanies this electronic submission.

## **SECTION 8: BUDGET AND EXPENDITURES**

|  |  |
| --- | --- |
| Hospital/Applicant: | UM SJMC |
| Number of Interventions: | 1 |
| Total Budget Request ($): | $1,147,000 |

|  |  |  |
| --- | --- | --- |
| Workforce/Type of Staff | Description | Amount |
| **Behavioral Health Center Staffing**   1. Psychiatrist 2. Licensed Clinical Social worker 3. Psychotherapists 4. Medical Director 5. Program Development 6. Support Staff | 1. BHC, 0.6 FTE salary plus benefits 2. BHC, 1.0 FTE salary plus benefits 3. BHC, 0.6 FTE salary plus benefits 4. BHC 5. BHC 6. BHC, 1.0 FTE | 1. $156,000 2. $80,000 3. $100,000 4. $25,000 5. $15,000 6. $40,000 |
| **Maxim Expansion**  Behavioral-Technician development/expansion | 4,300 hours of in-home services to target patient population | $300,000 |
| **Transitional Nurse Navigators Expansion** | 2.0 FTE (PDC and BHC shared incremental inpatient resources) | $180,000 |
| **BHC Startup Expense**   1. Office Supplies 2. Transportation Voucher Fund 3. Medication Voucher 4. Education Materials 5. Operating Supplies (disposables) 6. Operating equipment (initial) 7. Estimated Rent 8. Overhead | 1. Supply expense 2. Supply expense 3. Supply expense 4. Supply expense 5. Supply expense 6. Supply expense 7. Rent 8. UM SJMC Administration/Mgmt. | 1. $10,000 2. $50,000 3. $50,000 4. $6,000 5. $5,000 6. $25,000 7. $29,800 8. $75,200 |
| **Total Direct Expenses (Grant Funded)** |  | **$ 1,147,000** |
| Indirect Costs (Non-Grant Funded) |  | $96,010 |

## **SECTION 9: BUDGET AND EXPENDITURES NARRATIVE**

The incremental investments UM SJMC is seeking to make will build upon existing initiatives to better serve the needs of our community.

**Behavioral Health Center**

UM SJMC’s existing initiatives and investmentsprovide strong and compelling support for UM SJMC to address the unmet needs and create innovative solutions for high-risk patients with mental illness as well as the chronically ill medical patients impacted by mental illness.

The BHC will offer this high-risk cohort comprehensive case management services in the outpatient setting for 60-90 days by a team including: Psychiatrist consultant, Psychiatric social worker, Psychotherapists, Medical Director, and Ancillary support staff. Overall the staffing cost is estimated to be $416,000.

This 60-90 day period of time will serve a bridge for most patients from hospitalization to the development of a full, structured outpatient plan for each patient.   The BHC start-up operational and startup costs are $251,000.

**Expansion of Maxim Transition Assist**

UM SJMC and MTA are seeking expand the outpatient community health worker (in-home) engagement for the identified target patient population. In the first year, these CHWs will provide approximately 4,300 hours of in-home support to the target population. The cost of both program development and expansion is projected to be $300,000.

**Expansion of Transitional Nurse Navigators**

To further hone in on the Medicare high utilizers admitted to UM SJMC, we will invest in two additional transitional nurse navigators that will channel patients to the post-discharge center and potentially the behavioral health center (as needed). This expansion costs for 2.0 FTE is $180,000.

**Indirect Costs**

The indirect costs are approximately 8% of total direct costs. These include standard clinical operation start-up costs and licenses, communication planning, and EMR implementation.

## SECTION 10: SUMMARY OF PROPOSAL

|  |  |
| --- | --- |
| Hospital/Applicant: | University of Maryland-Saint Joseph Medical Center |
| Date of Submission: | 12/21/15 |
| Health System Affiliation: | University of Maryland Medical System |
| Number of Interventions: | 1 |
| Total Budget Request ($): | $1,147,000 |

|  |
| --- |
| Target Patient Population (Response limited to 300 words) |
| In the program’s initial iteration, the Behavioral Health Center (“BHC”) at University of Maryland Saint Joseph Medical Center (“UM SJMC”) will provide specialized psychiatric outpatient resources focused on relapse reduction coupled with community health worker in-home support to a target patient population who meet the following criteria:   * Medicare patients * Who suffer from a Major Mental Health diagnosis   + Schizophrenia, Bi-Polarity, or other psychotic disorder * Identified as high utilizers   + 2+ bedded care admissions of greater than 24 hours within past year * Who also suffer from at least 1 chronic condition   The BHC will function in tandem with UM SJMC’s Post Discharge Center (PDC), currently under development, to offer treatment to those patients whose mental health conditions manifest as a Major Mental Health illness, separate but not exclusive from depression or related illness. There are very limited transition options for these patients, and the BHC will serve as an important and essential bridge resource for patients in the community. |
| Summary of program or model for each program intervention to be implemented. Include start date, and workforce and infrastructure needs (Response limited to 300 words) |
| The BHC will provide comprehensive psychiatric management of the target patient population, with interventions to include: pharmacological treatment, evidence-based cognitive group psychotherapies and Centeral case management. The BHC will work out of the existing space utilized by the PDC on UM SJMC campus. BHC staff will include psychiatrists, psychiatric social workers, psychiatric nurses and psychologist therapists, who will offer evaluation, a specialized treatment focused on relapse prevention, and support to patients in collaboration with existing providers. Following the period of supervision, the BHC will transition the patient to existing community resources, allowing for continuity of treatment.  To ensure patient well-being in the community, UM SJMC will fund an expansion of its Maxim Transition Assist (MTA) program, to offer in-home services to BHC patients. MTA is a private health services entity that already provides care management to UM SJMC patients for a period following discharge, will staff Behavioral Technicians dedicated to furnishing services to BHC patients, in line with Assertive Community Treatment models. It is anticipated that the BHC and MTA expansion will come online shortly after grant award, with BHC operations beginning February 29, 2016. |

|  |  |
| --- | --- |
| Measurement and Outcomes Goals (Response limited to 300 words) | |
| In the program’s initial iteration, programmatic metrics will be consist of:   * process metrics with the following data elements: # monthly encounters: center visits/telephonic CM; # of encounters by initial admission DRG; % of High Risk patients scheduled at center prior to discharge; No show rate for patients scheduled at center; Average number of days between discharge and being seen at center; % of patients with: hand off to PCP or appropriate specialist within 90 days; medication reconciliation; Advanced Care planning, who test positive for mental health diagnosis; Referral source; Average number of days between 2nd visit to center (if applicable). * Clinical outcomes, post-intervention, including: % of patients receiving pharmacy support, NP/MD support; % of referrals made to community programs; 90 utilization rates for Admissions, Observations and ED visits. * patient satisfaction surveys addressing Access, Quality and Communication   The program will also maintain core process measures provided by the HSCRC to include: Use of CRISP (Encounter Notification Alerts, etc.); Completion of Health Risk Assessments; Established longitudinal care plans; Shared care profile, and target population with contact from an assigned care manager. | |
| Return on Investment. Total Cost of Care Savings. (Response limited to 300 words) | |
| The ROI calculated for the calendar years 2017-2019 are **1.48, 2.23, and 2.23** respectively. UM SJMC is anticipating that by addressing mental and behavioral health needs of the Medicare patient population this will impact PAUs and PQIs, and the hospital will re-invest these savings to expand upon the proposed program for continued cost savings. UM SJMC is strategically planning to focus on the Medicare portion of the high utilizer population during the grant period (CY 2016) to secure the highest ROI in the short term. Thereafter, UM SJMC will reinvest into the program with scalability plans for Dual Eligibles, followed by Medicaid beneficiaries, and finally to commercial payers. Our goal is to meet the waiver requirements and to achieve the mandate of the all payer system. | |
| Scalability and Sustainability Plan (Response limited to 300 words) | |
| The UM SJMC program is strategically targeting the Medicare patient population and building core competencies around mental health programs to address their needs. With yearly program evaluations and meeting established outcomes and metrics, the BHC will be scaled to other payers such as Medicaid, Duals and Commercial payers. Year 1 and 2 expense will be offset by avoidable utilization savings which will be reinvested into the program. In future models, the program will expand to provide services to all payers with major mental health conditions. Such expansion will require additional staff, technology and infrastructure, that will be supported by the program’s sustainability efforts.  The program will be sustained primarily through savings generated through the reduction of PAUs, and funds captured through the permanent rate increase authorized by the grant award. Additionally, any billings for services rendered to the target patient population will be retained by the program. | |
| Participating Partners and Decision-making Process. Include amount allocated to each partner. (Response limited to 300 words) |
| The BHC will receive advice and strategy on program structure and interventions from a governance council, made up of members from UM SJMC leadership and a number of stakeholders, categorized into three distinct categories along the care continuum: Community-Based Care, Acute Care and Post-Acute Care. The below mentioned members have submitted Letters of Intent to work closely with UM SJMC to best impact our Medicare target patient population: Primary care physicians, MTA, leadership from the Visiting Nurses Association, and Post-Acute providers: Lorien Health, Stella Maris, Genesis Health and Manor Care.  Sheppard Pratt leadership and community service groups such as Mosaic and Keypoint have also expressed a strong interest to work collaboratively with UM SJMC.  In the first year of this collaborative, decision-making power rests with UM SJMC. |
| Implementation Plan (Response limited to 300 words) |
| The attached implementation plan kicks off February 1st. The BHC is anticipated to be opened within 30 days of the grant award. Prior to that, UM SJMC is working towards solidifying workflow processes, communication plans to the targeted patient population, and continuing to work with providers.  UM SJMC anticipates a patient ramp-up time of 3-4 months. |
| Budget and Expenditures: Include budget for each intervention. (Response limited to 300 words) |
| Findings from literature and existing initiatives provide strong and compelling support for UM SJMC to address unmet needs and develop creative new solutions for high-risk patients with severe and chronic mental illnesses as well as the chronically ill medical patients impacted by psychiatric comorbidities. The goal is to offer this high-risk cohort a relapse preventing treatment program coupled with comprehensive case management services in the outpatient setting for 60-90 days. Treatment will be provided by a highly trained team: psychiatrist with extensive pharmacological experience, psychiatric social workers with specialized experience in short-term crisis management and psychotherapy, as well as full knowledge of the breadth of community resources available to this population. The budget includes the expansion of MTA which will build off of their community health worker model (CHW) to assist with successfully transitioning this specific group of patients back into the community. To further hone in on the Medicare high utilizers that are admitted to UM SJMC, we will deploy two additional transitional nurse navigators that will channel patients to the post-discharge center and potentially the behavioral health center (as needed). |

## APPENDIX A

Please see UM SJMC Strategic Hospital Transformation Plan submitted with this electronic application. The attachment is saved as a .pdf file, labeled “Appendix A.”

## APPENDIX B

Table 1



Table 1 (a)



## 

## APPENDIX C

Governance Committee Letter of Intent template

December 18, 2015

Dear\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

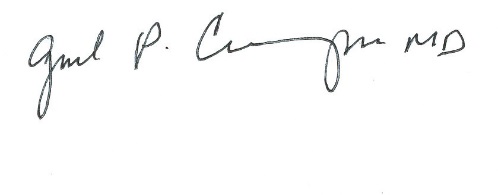
Thank you for your willingness to serve on the UM St. Joseph Medical Center behavioral health governance committee as we work to expand the needs of these patients in our community. As a valuable community partner, your collaboration and partnership is essential to expand existing services and help UM SJMC establish a dedicated behavioral health center that will provide office space for providers, hold group therapy sessions and help transition patients back into the community.

Your participation on the governance committee will help shape the offerings and services provided and your trusted advice, counsel and knowledge of the patient population will only help to strengthen the model.

As a next step, please sign and return the letter to Jay Mittal ([JayMittal@umm.edu](mailto:JayMittal@umm.edu)) as recognition of your willingness to participate on the UM SJMC behavioral health governance committee by December 11th. Please feel free to nominate another individual within your organization by providing their name and contact information so we can reach out.

Again, thank you for your ongoing partnership and for your dedication to this vulnerable population.

Sincerely,



Gail Cunningham, MD FACEP

Vice President of Medical Affairs

Chief Medical Officer

University of Maryland St. Joseph Medical Center

Organization Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Governance Committee Member Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. See Appendix A: UM SJMC Strategic Hospital Transformation Plan. [↑](#footnote-ref-1)
2. Maxim Literature Review, Leavitt Partners, *Psychiatric Patients and the Impact of Community Health Workers*, 1 (December 3, 2015)(*citing* Weiss AJ, Barrett ML, Steiner C. *Trends and projections in inpatient hospital costs and utilization, 2003–2013*. HCUP Statistical Brief #175. July 2014. Agency for Healthcare Research and Quality, Rockville, MD. *at* <http://www.hcupus.ahrq.gov/reports/statbriefs/sb175-Hospital-Cost-Utilization-Projections-2013.pdf>.) [↑](#footnote-ref-2)
3. *See* n. 3. [↑](#footnote-ref-3)
4. *See* University of Maryland, St. Joseph Medical Center, *Community Health Needs Assessment: Final Summary Report*, (March 2013). [↑](#footnote-ref-4)
5. *See* Appendix A: UM SJMC Strategic Hospital Transformation Plan. [↑](#footnote-ref-5)
6. *See* Appendix B. [↑](#footnote-ref-6)
7. *See* Appendix C. [↑](#footnote-ref-7)