

## Update: Howard County Regional Partnership (HCRP)

Prepared for LHIC  
September 21, 2016


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## Discussion Agenda

- Timeline Recap
- Target Population & Interventions
- Partnership Name
- Governance & Management Team


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## Maryland's Vision for Transformation

- Realize the "Triple Aim"
  1. Improve the **health** of the population;
  2. Enhance the **patient experience** of care;
  3. Reduce the **per capita cost** of care.
- Focus on multidisciplinary care teams, coordination across settings, patient-centered care
- Establish Regional Partnerships to manage health of a defined community (initial focus on Medicare)


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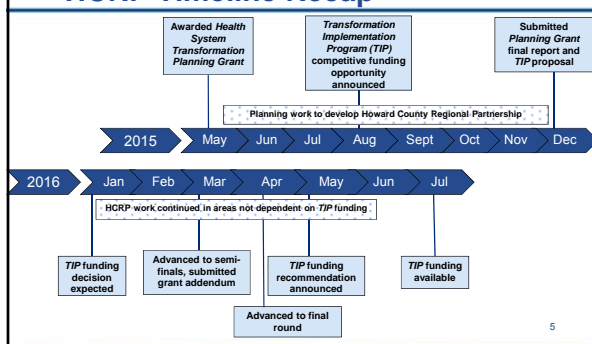
## Transformation Implementation Program (TIP)

- Competitive grant program with \$37 million available
- 22 proposals submitted, totaling \$90 million
- 9 partnerships funded
- Required schedule of savings to purchasers from each hospital starting in 2018
  - CY18: - 10% of award amount
  - CY19: - 20% of award amount
  - CY20: - 30% of award amount


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## HCRP Timeline Recap



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## HCRP Target Population

- Howard County Resident,  $\geq 18$  yrs
- Medicare or dual eligible
- At least 2 HCGH encounters in past 365 days (inpatient, observation or ED visit)

*Initial focus on high utilizers. Population health improvement is long term goal.*

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### HCRP Target Population

- Clustered in 5 zips: 21044, 21045, 21043, 21042 and 21075
- 80% are ≥ 65yrs + (51% are ≥ 80yrs )
- 66% have multiple chronic conditions
- 42% of visits are for chronic issues or conditions that could be managed outside of a hospital

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### HCRP Interventions

- Complex Care Management**
  - Community Care Team (CCT)
  - Support Our Elders (Gilchrist)
  - Remote Patient Monitoring (Johns Hopkins Home Care Group)
- Seamless Care Transitions**
  - Community Health Workers embedded in Emergency Dept & Primary Care Offices
  - Skilled Nursing Facility Collaborative (Lorien)
  - Rapid Access Program for Behavioral Health (Way Station)
  - Transitions & Care Choices programs (Gilchrist)
- Self Management Supports**
  - Journey to Better Health (J2BH)
  - Powerful Tools for Caregivers (Office on Aging & Independence)
  - CAREApp (Health Dept)

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### HCRP Main Outcomes for Target Population

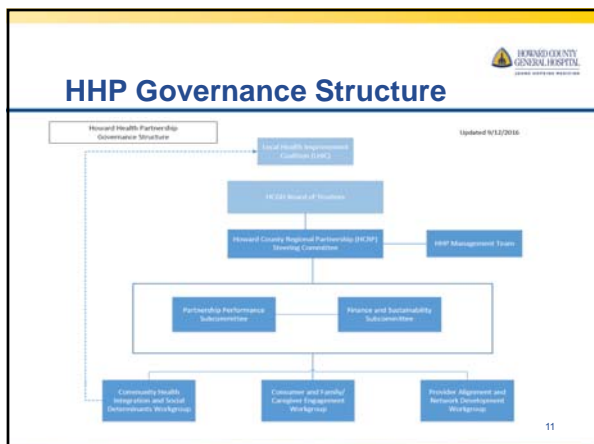
- Improved patient experience
- Improved care coordination
- Reduced readmissions
- Reduced potentially avoidable hospital utilization
- Reduced total cost of care
- Generate savings to payers and to reinvest in HCRP

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### HCRP Name Change

1. Steering Committee developed short list on June 13
2. HCGH marketing and communications shared feedback on short list
3. Options presented to Joint Inpatient and Outpatient Patient and Family Advisory Council on July 25. (New options were also offered by members.)
4. Options presented to the LHIC Workgroups during the week of August 25 and ballots completed.

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### LHIC & HHP

**Community Health Integration & Social Determinants Workgroup**

- **Objective:** To serve as the explicit link between HHP & LHIC. Ensure alignment of goals & strategies across the two groups.
- **Functions:**
  1. Review LHIC workgroup action plans (in particular, Healthy Aging & Access to Care) to identify areas of overlap with HHP.
  2. Review patterns/trends in social needs identified through HHP interventions to identify service gaps. Share information with LHIC & collaborate on development of potential solutions. Recommend changes or updates as needed to both HHP & LHIC action plans.
  3. Assess utility of CAREApp across HHP interventions. Provide advice on increasing use and effectiveness.


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## HCRP Management Team

- **Tracy Novak, Population Health Director**
  - Oversees daily operations, budget & committee management
- **Eric Hamrock, Interventions & Analytics Manager**
  - Manages intervention implementation, guides the use of data for real-time decision support for interventions
- **Kate Talbert, Complex Care Management Manager**
  - Oversees Community Care Team, J2BH & Million Hearts programs
- **Project Manager – Esther Duvall**
  - Provides project management & coordination, including managing communication across all partners
- **Lead Data Analyst - TBD**
  - Provides data analytics & develops dashboards & reports used to monitor performance

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## Stay Tuned!

***October LHIC Forum***  
will offer additional information  
about the  
Howard Health Partnership.

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