# Peninsula Regional Medical Center
# MDCTO-0096
# Summary Information

*Maryland Primary Care Program, 2018 Application Cycle*

## CTO Overview

| CTO Information | | |
|---|---|---|
| Application ID Number | MDCTO-0096 | |
| Status of the Proposed CTO | The proposed CTO is owned and operated by a healthcare organization and is currently in existence. | |
| Organization Site Name | Peninsula Regional Clinically Integrated Network | |
| DBA Name | Peninsula Regional Medical Center | |
| Website (if applicable) | http://prcin.org/ | |
| **Ownership & Legal Structure** | | |
| Owned by Health Care Organization | Yes | |
| Name of Parent Organization | Peninsula Regional Health System | |
| Legal Structure | Non profit 501: Healthcare | |
| **Service Area** | | |
| Counties Served | Somerset County; Wicomico County; Worcester County | |
| **Partnerships** | | |
| Formal Partnerships | N/A | |
| Informal Partnerships | Area agency on Aging, MAC, Inc. Lower Shore Enterprises, Wicomico Worcester and Somerset County Health Departments, Local Health Improvement Coalition, Salisbury City Fire Department, Peninsula Regional Partnership, United Way | |
| **Services Offered** | | |
| Tele-diagnosis | Currently in place | |
| Tele-behavioral health | Planned for future | |
| Tele-consultation | Currently in place | |
| Remote Monitoring | Currently in place | |
| Other | N/A | |
| **HIT** | | |
| CRISP Connectivity | We currently educate and support practices on the use of services from the State-Designated Health Information Exchange (CRISP).; We assist practices in establishing electronic health information exchange with CRISP or a community-based health information exchange network.; We use CRISP to view data.; We send administrative encounter data to CRISP on a regular basis.; We send clinical data (CCDAs or QRDAs) to CRISP on a regular basis. | |
| HIT Vendor | Epic | Epic |
| HIT Product Name | Ambulatory | Healthy Planet |

## Care Team Members

| Category | Currently in place: How many? | Planned for future: How many? |
|---|---|---|
| **Administrative Support** | N/A | N/A |
| **Behavioral Health Counselor** | N/A | 5 |
| **Billing/Accounting Support** | N/A | N/A |
| **Care Managers - RNs** | 7 | 15 |
| **Care Managers - Medical Assistants** | N/A | N/A |
| **Care Managers - Other** | N/A | 5 |
| **Community Health Workers** | N/A | 5 |
| **Data Analysts** | 1 | 1 |
| **Health IT Support** | 1 | 10 |
| **Licensed Social Workers** | N/A | 4 |
| **Nutritionist** | N/A | 2 |
| **Pharmacists** | N/A | 1 |
| **Practice Transformation Consultants** | N/A | 3 |
| **Psychiatrist** | N/A | N/A |
| **Psychologist** | N/A | N/A |
| **Care Coordination Specialists** | N/A | 5 |

## Vision

Peninsula Regional Clinically Integrated Network (PRCIN) is an existing Accountable Care Organization, well positioned within the community to leverage scale and develop and operationalize a Care Transformation Organization (CTO). This CTO will promote evidence-based, multilevel interventions to achieve comprehensive care delivery within the primary care practices of Wicomico, Worcester and Somerset Counties. Guided by the Comprehensive Primary Care Plus model, the PRCIN CTO will facilitate team-based care through effective partnerships with patients, their caregivers/families, community-based service organizations and providers. Leveraging care coordination and integration strategies, including telehealth, health information technology, and data analytics the PRCIN CTO will create economies of scale providing primary care practices solutions to achieve robust and sustainable innovations. Creating a collaborative synergy will enhance patient and community activation and engagement resulting in improved health for the communities we serve. PRCIN CTO is uniquely positioned for success given our long-standing history within the tri-county area and the strong partnerships that have evolved among our community members, providers and service organizations. Leveraging existing competencies and relationships and developing new provider relationships, we will facilitate the implementation of a comprehensive interdisciplinary care coordination model. A team comprised of RN's, community health workers, care coordination specialists, social workers and pharmacists will ensure patient centered, goal driven care to provider's empaneled patients. To further nurture the relationship between the provider and patient/caregiver, and drive continued improvement, the CTO will also facilitate the development of patient and family advisory councils. Given the significant cost and limited experience and competency to implement advanced care strategies, the CTO will use current care coordination experience gained through the ACO as well as future planned resources to provide services in support of achieving the aim of the Maryland Primary Care Program. PRCIN CTO will also provide data analytics and informatics support to further stimulate transformational change within the practices. Epic Healthy Planet and other EHR tools including patient portals, will be leveraged to risk stratify patients to appropriate levels of care, facilitate longitudinal care planning, optimize team-based care, and promote patient activation and engagement. Collectively these robust workflow, communication, and data and analytics tools will allow practices to become learning organizations which drive continual improvement through the application of quality, cost, utilization, and outcome metrics. Applying principles of change leadership, practice transformation specialists, in collaboration with members of the governance team, practice teams, and the patient/family advisory councils, will develop, deploy and diffuse change tactics to achieve comprehensive improvements in care delivery.

## Approach to Care Delivery Transformation

PRCIN's CTO is well positioned and has developed a cohesive leadership team that is acutely aware of the community's needs and challenges, and is committed to facilitate primary care practice integration. A structured care delivery portfolio of active and innovative programs will be deployed across primary care practices. These services include: Care Coordination; Support for Care Transitions; Data Analytics and Informatics; Standardized Screening and Practice Transformation. Lead care coordinator nurses (LCC) embedded in primary care offices will assist the practice team in risk stratification and patient empanelment. The LCC in collaboration with the practice team will drive care coordination through the development a comprehensive plan of care to maintain a patient's health or manage chronic conditions, support episodic transitional care, and engage supportive services when necessary. Practices and LCCs will be supported by 3 levels of services including: clinical; practice transformation; and data analytics and informatics. A triad model inclusive of a care coordination specialist, a community health worker, and a social worker will provide clinical level support to LCC's to address care coordination - transitions of care, screening and prevention, as well behavioral and social needs. Nutritionists, pharmacists, and behavioral health consultants will also be integrated to provide an expanded level of care across primary care settings. Practices will have practice transformation consultants who will help lead initiatives to promote workflow optimization, alternative care delivery strategies, and care optimization including group, home and/or telehealth visits. Data analytic and informatics services will support enhanced technology solutions to promote clinical data interoperability which will guide shared integrated decision making capacity based on quality, cost and utilization metrics.