Bay Area Transformation Partnership

Appendices

A. HSCRC Core Outcome Measures Data (supplied by BRG)

B. Berkeley Research Group High Utilizer Strategy Report for Anne Arundel Medical Center and University of Maryland Baltimore Washington Medical Center

C. CRISP Patient Total Hospital (PaTH) Report for AAMC and UM BWMC Total All Payer High Utilizer Patients

D. The Coordinating Center West Baltimore Readmission Reduction Collaborative, ROI

E. Anne Arundel County Department of Aging & Disabilities, Senior Triage Team Proposal

F. BATP 4-year HSCRC Core Return on Investment Calculator

G. BATP Microsoft Project Implementation Work Plan

H. BATP Draft Memorandum of Understanding between AAMC and UM BWMC

Appendix A

Table 1A

Anne Arundel Medical Center & Baltimore Washington Medical Center - PSA/SSA Populations by Category

Calendar Year 2014

AAMC + BWMC PSA/SSA Zip Codes	County	City	All Payer	Medicare FFS	2+ Conditions Medicare FFS	People 3+ IP/Obs>24 All Payer	People 3+ IP/Obs>24 Medicare FFS
20711	Anne Arundel	Lothian	6,643	1,036	1,036	6,643	1,036
20733	Anne Arundel	Churchton	2,672	313	313	2,672	313
20751	Anne Arundel	Deale	2,343	366	366	2,343	366
20764	Anne Arundel	Shady Side	4,176	469	469	4,176	469
20765	Anne Arundel	Galesville	514	115	115	514	115
20776	Anne Arundel	Harwood	3,289	466	466	3,289	466
20778	Anne Arundel	West River	2,009	248	248	2,009	248
20779	Anne Arundel	Tracys Landing	1,182	191	191	1,182	191
21012	Anne Arundel	Arnold	21,317	2,597	2,597	21,317	2,597
21032	Anne Arundel	Crownsville	8,848	1,153	1,153	8,848	1,153
21035	Anne Arundel	Davidsonville	7,815	1,157	1,157	7,815	1,157
21037	Anne Arundel	Edgewater	20,618	2,661	2,661	20,618	2,661
21054	Anne Arundel	Gambrills	10,127	1,552	1,552	10,127	1,552
21060	Anne Arundel	Glen Burnie	29,223	3,945	3,945	29,223	3,945
21061	Anne Arundel	Glen Burnie	53,684	5,903	5,903	53,684	5,903
21106	Anne Arundel	Mayo	-	-	-	-	-
21114	Anne Arundel	Crofton	25,225	2,014	2,014	25,225	2,014
21122	Anne Arundel	Pasadena	60,576	6,745	6,745	60,576	6,745
21140	Anne Arundel	Riva	3,457	411	411	3,457	411
21144	Anne Arundel	Severn	31,884	2,645	2,645	31,884	2,645
21146	Anne Arundel	Severna Park	26,705	4,009	4,009	26,705	4,009
21225	Baltimore City	Brooklyn	33,545	3,379	3,379	33,545	3,379
21401	Anne Arundel	Annapolis	36,012	6,986	6,986	36,012	6,986
21402	Anne Arundel	Annapolis	5,217	11	11	5,217	-
21403	Anne Arundel	Annapolis	30,269	4,613	4,613	30,269	4,613
21404	Anne Arundel	Annapolis	-	-	-	-	-
21405	Anne Arundel	Annapolis	544	127	127	544	127
21409	Anne Arundel	Annapolis	20,064	2,485	2,485	20,064	2,485
21619	Queen Annes	Chester	5,848	957	957	5,848	957
21666	Queen Annes	Stevensville	12,309	1,505	1,505	12,309	1,505
AAMC + BWMC PSA Subtotal			466,115	58,059	58,059	466,115	58,048
20601	Charles	Waldorf	24,156	1,922	1,922	24,156	1,922
20602	Charles	Waldorf	24,955	1,964	1,964	24,955	1,964
20603	Charles	Waldorf	28,967	1,400	1,400	28,967	1,400
20610	Calvert	Barstow	-	-	-	-	-
20613	Prince Georges	Brandywine	11,860	1,372	1,372	11,860	1,372
20623	Prince Georges	Cheltenham	2,744	165	165	2,744	165
20639	Calvert	Huntingtown	14,227	1,463	1,463	14,227	1,463
20678	Calvert	Prince Frederick	11,045	1,351	1,351	11,045	1,351
20689	Calvert	Sunderland	1,694	204	204	1,694	204
20695	Charles	White Plains	6,794	768	768	6,794	768
20701	Howard	Annapolis Junction	2	1	1	2	1
20706	Prince Georges	Lanham	38,692	3,760	3,760	38,692	3,760
20708	Prince Georges	Laurel	25,546	1,876	1,876	25,546	1,876
20714	Calvert	North Beach	4,345	473	473	4,345	473
20715	Prince Georges	Bowie	26,382	3,826	3,826	26,382	3,826
20716	Prince Georges	Bowie	20,787	2,097	2,097	20,787	2,097
20720	Prince Georges	Bowie	21,031	1,443	1,443	21,031	1,443
20721	Prince Georges	Bowie	27,016	2,851	2,851	27,016	2,851
20724	Anne Arundel	Laurel	16,093	990	990	16,093	990
20732	Calvert	Chesapeake Beach	9,919	746	746	9,919	746
20735	Prince Georges	Clinton	35,421	4,043	4,043	35,421	4,043
20736	Calvert	Owings	8,904	947	947	8,904	947
20754	Calvert	Dunkirk	6,951	879	879	6,951	879
20755	Anne Arundel	Fort George G Meade	9,302	47	47	9,302	47
20758	Anne Arundel	Friendship	721	125	125	721	125
20769	Prince Georges	Glenn Dale	6,604	609	609	6,604	609
20770	Prince Georges	Greenbelt	25,173	1,823	1,823	25,173	1,823
20771	Prince Georges	Greenbelt	-	-	-	-	-
20772	Prince Georges	Upper Marlboro	42,625	3,785	3,785	42,625	3,785
20773	Prince Georges	Upper Marlboro	-	-	-	-	-
20774	Prince Georges	Upper Marlboro	43,013	4,517	4,517	43,013	4,517
21056	Anne Arundel	Gibson Island	267	71	71	267	71
21062	Anne Arundel	Glen Burnie	-	-	-	-	-
21076	Anne Arundel	Hanover	12,952	1,042	1,042	12,952	1,042
21077	Anne Arundel	Harmans	224	46	46	224	-
21090	Anne Arundel	Linthicum Heights	9,784	1,723	1,723	9,784	1,723
21108	Anne Arundel	Millersville	17,964	2,023	2,023	17,964	2,023
21113	Anne Arundel	Odenton	30,469	2,524	2,524	30,469	2,524
21123	Anne Arundel	Pasadena	-	-	-	-	-
21226	Anne Arundel	Curtis Bay	7,561	639	639	7,561	639
21227	Baltimore	Halethorpe	33,534	4,300	4,300	33,534	4,300
21240	Anne Arundel	Baltimore	-	-	-	-	-
21601	Talbot	Easton	23,597	5,367	5,367	23,597	5,367
21607	Queen Annes	Barclay	583	62	62	583	62
21617	Queen Annes	Centreville	9,907	1,470	1,470	9,907	1,470
21620	Kent	Chestertown	12,853	2,819	2,819	12,853	2,819
21623	Queen Annes	Church Hill	2,111	231	231	2,111	231
21625	Talbot	Cordova	2,719	388	388	2,719	388
21628	Queen Annes	Crumpton	556	113	113	556	113
21629	Caroline	Denton	9,555	1,484	1,484	9,555	1,484
21636	Caroline	Goldsboro	1,186	159	159	1,186	159
21638	Queen Annes	Grasonville	4,934	813	813	4,934	813
21639	Caroline	Greensboro	4,408	501	501	4,408	501
21640	Caroline	Henderson	1,632	190	190	1,632	190
21644	Queen Annes	Ingleside	111	13	13	-	-
21649	Caroline	Marydel	1,858	129	129	1,858	129
21654	Talbot	Oxford	1,236	455	455	1,236	455
21657	Queen Annes	Queen Anne	777	97	97	777	97
21658	Queen Annes	Queenstown	3,862	760	760	3,862	760
21660	Caroline	Ridgely	4,063	436	436	4,063	436
21668	Queen Annes	Sudlersville	1,904	308	308	1,904	308
21670	Caroline	Templeville	-	-	-	-	-
21679	Talbot	Wye Mills	483	67	67	483	67
AAMC + BWMC SSA Subtotal			696,059	73,677	73,677	695,948	73,618
AAMC + BWMC PSA/SSA Total			**1,162,174**	**131,736**	**131,736**	**1,162,063**	**131,666**

Appendix A

Table 1. Core Outcome Measures

Anne Arundel Medical Center & Baltimore Washington Medical Center - Core Outcome Measures

Anne Arundel Medical Center & Baltimore Washington Medical Center Core Outcome Rates

	Total Unique Patients	Total Hospital Cost per Capita	Total Health Care Cost per Person	Total Hospital Admits per 1,000 Population	ED Visits per 1,000 Population	Readmissions per 1,000 Population	Potentially Avoidable Utilization Cost per Capita	Hospital Specific High Utilizers	Hospital Specific Population Target	Patient Experience
All Payer	32.2%	$2,241	-	108.1	348.6	10.4	$303	109.16	-	-
Medicare FFS	51.0%	$7,266	-	336.6	457.9	49.1	$1,504	178.21	178.21	-
2+ Conditions Medicare FFS	32.7%	$6,052	-	292.8	329.9	45.6	$1,420	-	-	-
People 3+ IP/Obs>24 All Payer	0.7%	$516	-	27.4	19.0	7.9	$180	2.54	-	-
People 3+ IP/Obs>24 Medicare FFS	3.1%	$2,317	-	128.3	71.5	37.6	$913	-	8.75	-

Anne Arundel Medical Center & Baltimore Washington Medical Center Core Outcomes - Numerators

	Total Unique Patients	Total Hospital Cost	Total Health Care Cost per Person	Total Hospital Admits	ED Visits	Readmissions	Potentially Avoidable Utilization Cost	Hospital Specific High Utilizers	Hospital Specific Population Target	Patient Experience
All Payer	374,224	$2,604,549,262	-	125,633	405,151	12,142	$352,650,692	126,861	-	-
Medicare FFS	67,236	$957,146,031	-	44,346	60,321	6,465	$198,097,546	23,477	23,477	-
2+ Conditions Medicare FFS	43,112	$797,234,526	-	38,577	43,455	6,007	$187,063,575	-	-	-
People 3+ IP/Obs>24 All Payer	7,608	$600,158,760	-	31,854	22,057	9,171	$209,624,501	2,953	-	-
People 3+ IP/Obs>24 Medicare FFS	4,074	$305,044,730	-	16,891	9,413	4,949	$120,234,188	-	1,152	-

Anne Arundel Medical Center & Baltimore Washington Medical Center Core Outcomes - Denominators (Populations)

All Payer	1,162,174	1,162,174	1,162,174	1,162,174	1,162,174	1,162,174	1,162,174	1,162,174	1,162,174	1,162,174
Medicare FFS	131,736	131,736	131,736	131,736	131,736	131,736	131,736	131,736	131,736	131,736
2+ Conditions Medicare FFS	131,736	131,736	131,736	131,736	131,736	131,736	131,736	131,736	131,736	131,736
People 3+ IP/Obs>24 All Payer	1,162,063	1,162,063	1,162,063	1,162,063	1,162,063	1,162,063	1,162,063	1,162,063	1,162,063	1,162,063
People 3+ IP/Obs>24 Medicare FFS	131,666	131,666	131,666	131,666	131,666	131,666	131,666	131,666	131,666	131,666

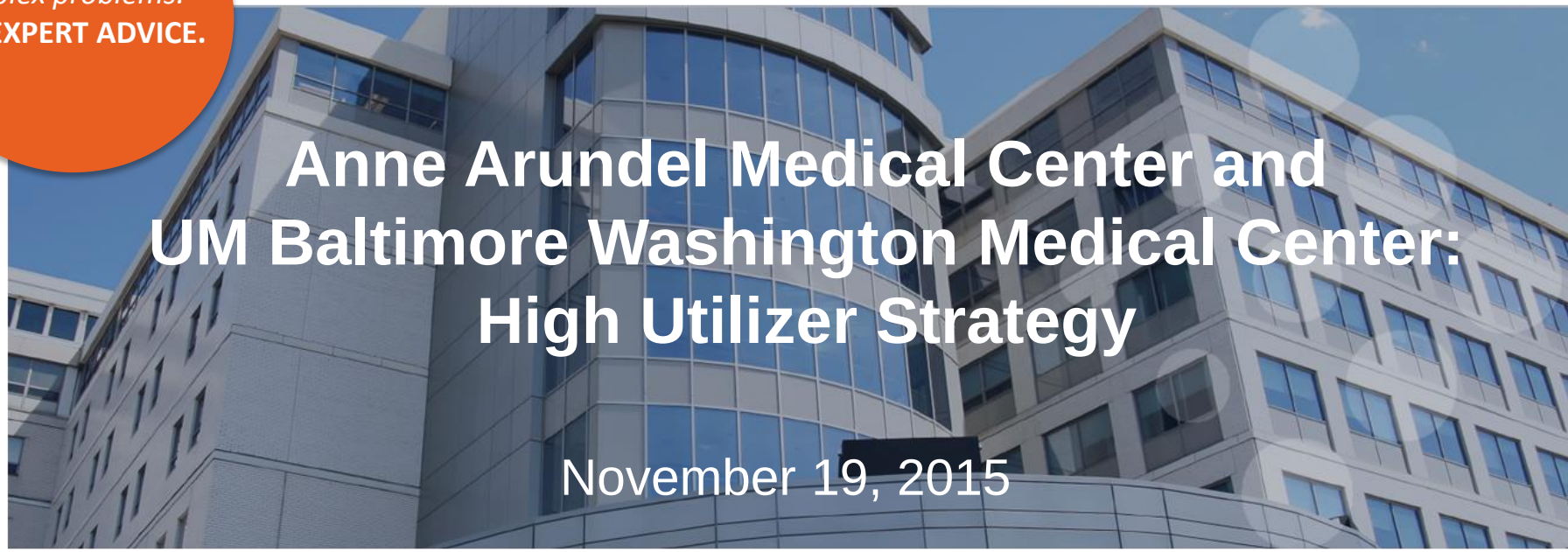
Notes:

[1] Numerator and denominator are based upon PSA and SSA Zipcodes per the attached summary. See Table 1A.

Appendix B

BRG Healthcare

complex problems.
EXPERT ADVICE.



Anne Arundel Medical Center and UM Baltimore Washington Medical Center: High Utilizer Strategy

November 19, 2015

High Utilizer Definition

- FY15 High Utilizer patients identified across both AAMC and BWMC using SSN, DOB, and Zip Code
- High Utilizer Definition:
  - Data period: Fiscal Year 2015
  - ≥ 3 Inpatient or Observation ≥24hrs encounters (Bedded Care) in the year
  - Exclusions: Age 0-17; Mortalities
- 2,120 patients are identified as All Payor High Utilizers
- High Utilizers are then split into cohorts by payor, with focus on the Medicare population

	Total Hospital	All Payor High Utilizers	Medicare Only	Medicaid Only	Dual Eligible	Other
Unique Patients	126,861	2,120	1,152	313	247	408
Total Charges	$667.4 M	$100.4 M	$52.8 M	$14.7 M	$14.3 M	$18.6 M
Total Visits	214,661	12,293	5,738	2,529	1,864	2,162
IP Visits	49,839	7,398	3,937	1,126	980	1,355
OBV Visits ≥24hrs	4,646	812	349	181	131	151
OBV Visits <24hrs	6,148	260	106	63	47	44
ER Visits	156,872	4,374	1,587	1,286	790	711
Avg Charge/Patient	$5.3 K	$47.4 K	$45.9 K	$46.9 K	$57.8 K	$45.7 K
Avg Visits/Patient	1.7	5.8	5.0	8.1	7.5	5.3
(IP+OBV≥24)/Patient	0.4	3.9	3.7	4.2	4.5	3.7
ER/Patient	1.2	2.1	1.4	4.1	3.2	1.7

Payor Cohort:

MEDICARE POPULATION

Medicare High Utilizers

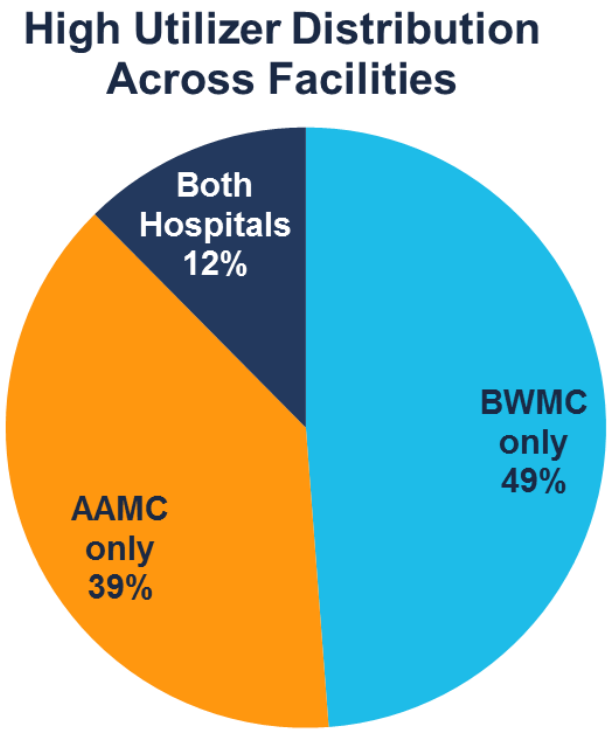
- 1,152 patients (54% of high utilizers) are Medicare patients
  - Medicare payor includes FFS and MCO
  - Medicare High Utilizers excludes dual eligible population
- 5% of total Medicare patients are high utilizers, accounting for 20% of total AAMC/BWMC Medicare charges

	Medicare High Utilizers	Total AAMC+BWMC Medicare Patients	MC HU % of Total Medicare	Total All Payor High Utilizers	MC % of Total High Utilizers
Unique Patients	1,152	23,477	5%	2,120	54%
Total Charges	$52.8 M	$260.5 M	20%	$100.4 M	53%
Total Visits	5,738	40,574	14%	12,293	47%
IP Visits	3,937	17,731	22%	7,398	53%
OBV Visits ≥24hrs	349	1,690	21%	812	43%
OBV Visits <24hrs	106	1,855	6%	260	41%
ER Visits	1,587	20,308	8%	4,374	36%

Medicare High Utilizers: By Provider

- 1,152 patients are identified as AAMC/BWMC Medicare High Utilizers
- 143 patients (12%) had an encounter at both AAMC and BWMC
- High Utilizers by provider:

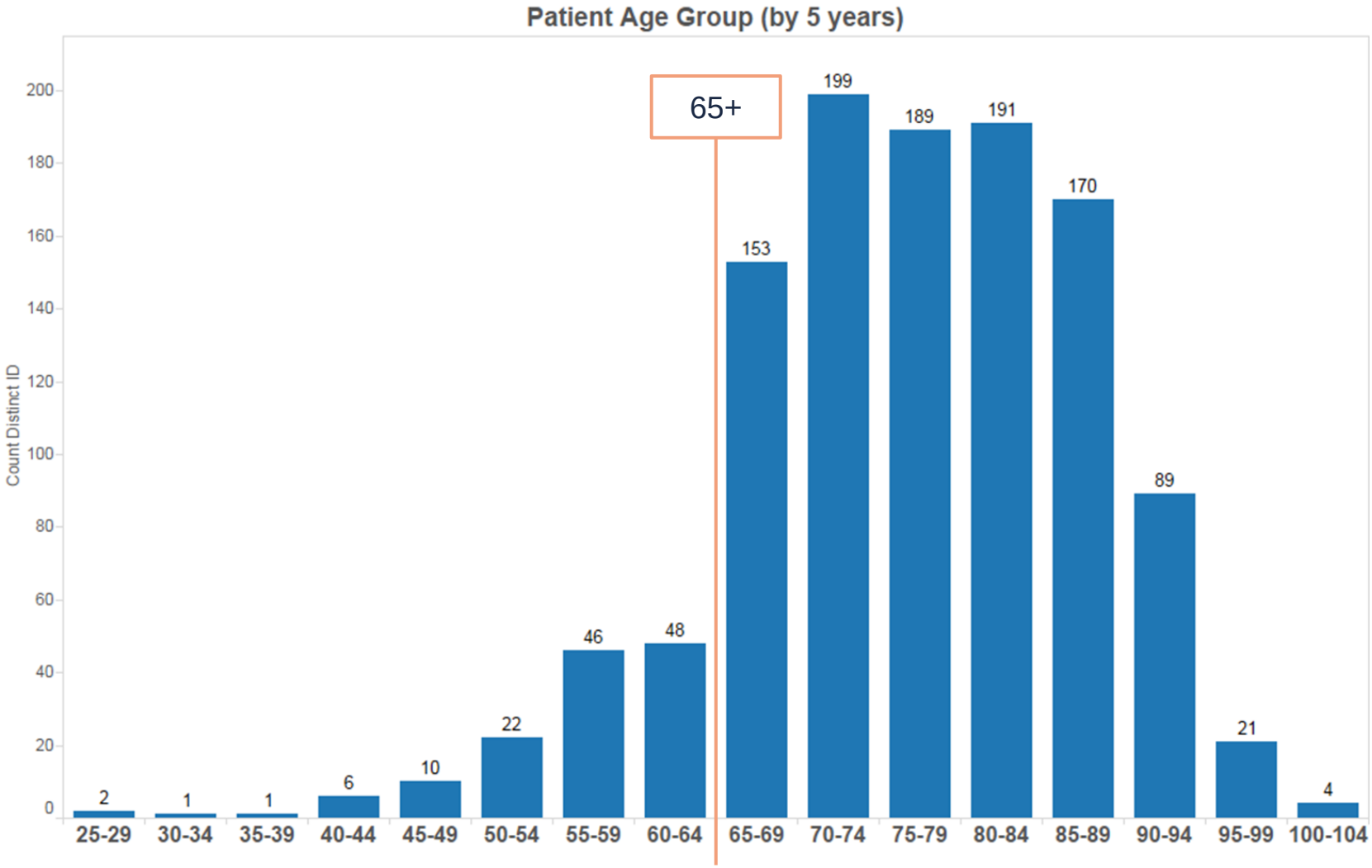
	AAMC Patients	BWMC Patients	Total Medicare High Utilizers
Unique Patients	590	705	1,152
Total Charges	$22.3 M	$30.6 M	$52.8 M
Total Visits	2,425	3,313	5,738
IP Visits	1,745	2,192	3,937
OBV Visits ≥24hrs	106	243	349
OBV Visits <24hrs	34	72	106
ER Visits	540	1,047	1,587
Avg Charge/Patient	$37.7 K	$43.4 K	$45.9 K
Avg Visits/Patient	4.1	4.7	5.0
(IP+OBV≥24)/Patient	3.1	3.5	3.7
ER/Patient	0.9	1.5	1.4



Note: Unique patients by hospital will not sum to total High Utilizers due to patients with utilization at more than one hospital being counted in each column

Medicare High Utilizers: Age Distribution

- Limited to the 1,152 Medicare High Utilizers



Medicare High Utilizers: By Primary Diagnosis

- Limited to the 1,152 Medicare High Utilizers

	ICD-9 Primary Diagnosis	Patients	IP Cases	OBV Cases	ER Cases	Total Cases	Total Charges	Avg. Charge per Case
0389	Unspecified septicemia	120	146	-	-	146	$3,350,086	$22,946
486	Pneumonia, organism unspecified	152	156	3	15	173	1,565,671	9,050
49121	Obstructive chronic bronchitis with (acute) exacerbation	100	133	17	28	164	1,445,335	8,813
5990	Urinary tract infection, site not specified	166	158	10	61	224	1,283,574	5,730
42731	Atrial fibrillation	103	119	12	8	136	1,125,987	8,279
5849	Acute kidney failure, unspecified	83	111	-	-	111	1,029,373	9,274
42823	Acute on chronic systolic heart failure	55	71	-	-	71	1,025,489	14,444
4280	Congestive heart failure, unspecified	98	103	7	16	121	968,445	8,004
42833	Acute on chronic diastolic heart failure	67	85	2	-	87	921,993	10,598
51884	Acute and chronic respiratory failure	26	35	-	-	35	697,120	19,918
5070	Pneumonitis due to inhalation of food or vomitus	47	53	-	-	53	656,460	12,386
99859	Other postoperative infection	27	33	-	2	35	640,130	18,289
49322	Chronic obstructive asthma with (acute) exacerbation	34	53	1	2	55	600,716	10,922
43491	Cerebral artery occlusion, unspecified with cerebral infarction	48	54	1	1	56	586,873	10,480
00845	Intestinal infection due to Clostridium difficile	37	45	1	1	47	535,974	11,404
6826	Cellulitis and abscess of leg, except foot	42	56	5	1	62	528,181	8,519
99649	Other mechanical comp. of internal orthopedic device, implant, graft	12	13	-	-	13	493,619	37,971
51881	Acute respiratory failure	31	32	2	2	34	462,549	13,604
82021	Closed fracture of intertrochanteric section of neck of femur	23	23	-	-	23	446,292	19,404
44024	Atherosclerosis of native arteries of the extremities with gangrene	14	19	-	-	19	413,709	21,774
	Subtotal		1,498	61	137	1,665	$18,777,576	$11,278
	All Other		2,439	394	1,450	4,073	34,069,056	8,365
	Total	**1,152**	**3,937**	**455**	**1,587**	**5,738**	**$52,846,632**	**$9,210**

Notes:

[1] Patient count by diagnosis will not sum to total high user patients due to patients being counted for the primary diagnosis on each case.

[2] Table sorted on total charges.

Medicare High Utilizers: Prevention Quality Indicator (PQI) Summary

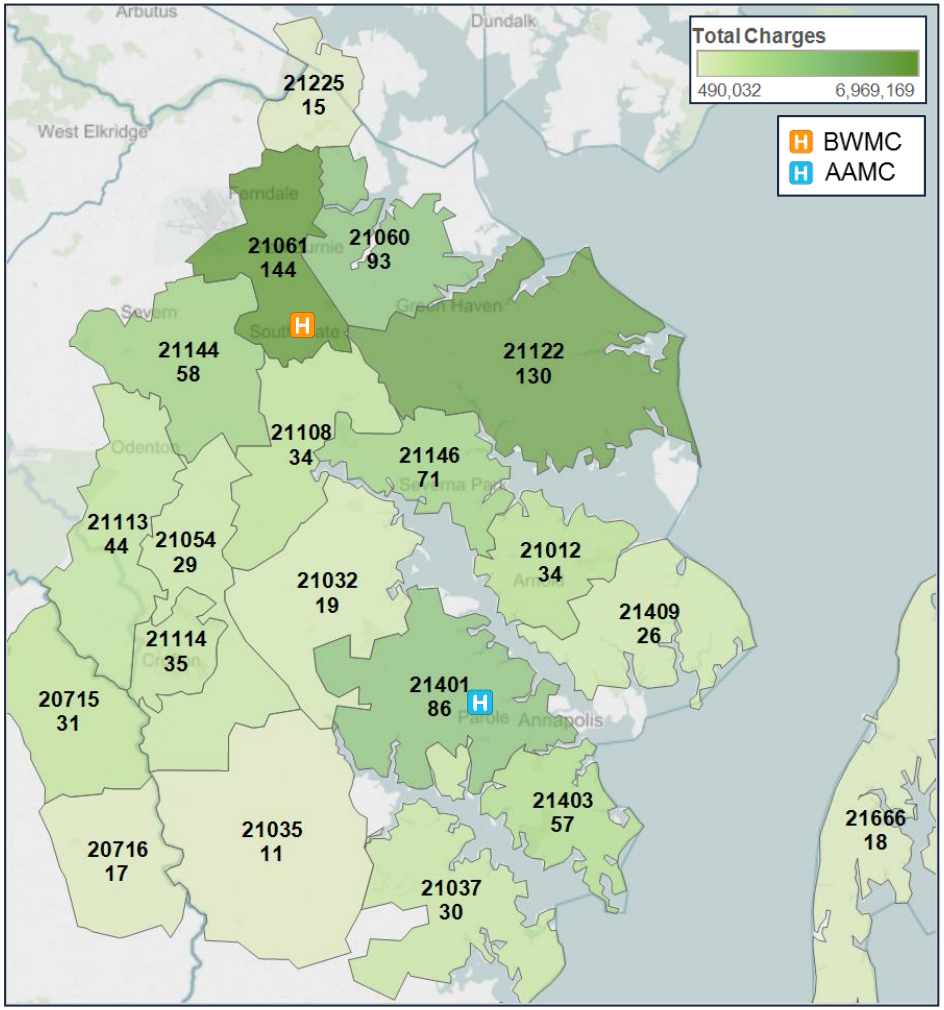
- Limited to the 1,152 Medicare High Utilizers
- 916 (21%) of 4,286 Medicare High Utilizer Inpatient + Observation cases ≥24 hours are for a PQI diagnosis

	PQI	Unique Patients	Inpatient Cases	Observation cases ≥24 hrs	Total PQI Cases	Total Charges
	Cardiac PQIs	**218**	**301**	**9**	**310**	**$3,145,773**
PQI 08	Heart Failure	200	281	9	290	2,909,279
PQI 07	Hypertension	14	16	0	16	172,797
PQI 13	Angina w/o Procedure	4	4	0	4	63,697
	Diabetes	**55**	**71**	**4**	**75**	**$962,906**
PQI 03	Diabetes: Long-Term Complications	35	39	2	41	374,623
PQI 01	Diabetes: Short-Term Complications	11	23	1	24	328,315
PQI 16	Diabetes: Lower-Extremity Amputation	6	7	0	7	238,715
PQI 14	Uncontrolled Diabetes	3	2	1	3	21,253
	Infections	**232**	**258**	**12**	**270**	**$2,322,589**
PQI 11	Bacterial Pneumonia	108	117	3	120	1,185,543
PQI 12	Urinary Tract Infection	124	141	9	150	1,137,046
	Asthma and COPD	**137**	**178**	**19**	**197**	**$1,977,898**
PQI 05	COPD or Asthma in Older Adults	136	177	19	196	1,968,830
PQI 15	Asthma in Younger Adults	1	1	0	1	9,068
PQI 10	**Dehydration**	**60**	**57**	**7**	**64**	**$572,179**
	Total	**559**	**865**	**51**	**916**	**$8,981,345**

Notes: [1] PQI cases include Inpatient and Observation cases ≥24 hours.
[2] Unique patients by PQI type will not sum to total because patients who fall into more than one PQI category will be counted in each category.

Medicare High Utilizers: By Zip Code

Unique Patients by Zip Code



Zip Code	Unique Patients	Total Visits[1]	Total Charges
21061	144	874	$7.0 M
21122	130	621	6.3 M
21060	93	476	4.0 M
21401	86	383	4.0 M
21146	71	354	2.9 M
21144	58	300	3.0 M
21403	57	300	2.2 M
21113	44	218	1.6 M
21114	35	152	1.4 M
21012	34	176	1.9 M
21108	34	160	1.6 M
20715	31	136	1.5 M
21037	30	157	1.3 M
21054	29	138	1.2 M
21409	26	140	1.1 M
21032	19	103	0.8 M
21666	18	74	0.7 M
20716	17	76	0.6 M
21225	15	76	0.6 M
21619	12	57	0.6 M
All Other	169	767	$8.5 M
Total	**1,152**	**5,738**	**$52.8 M**

Notes: [1] Visits include Inpatient, Observation, and ER encounters

Medicare High Utilizers: By Chronic Condition

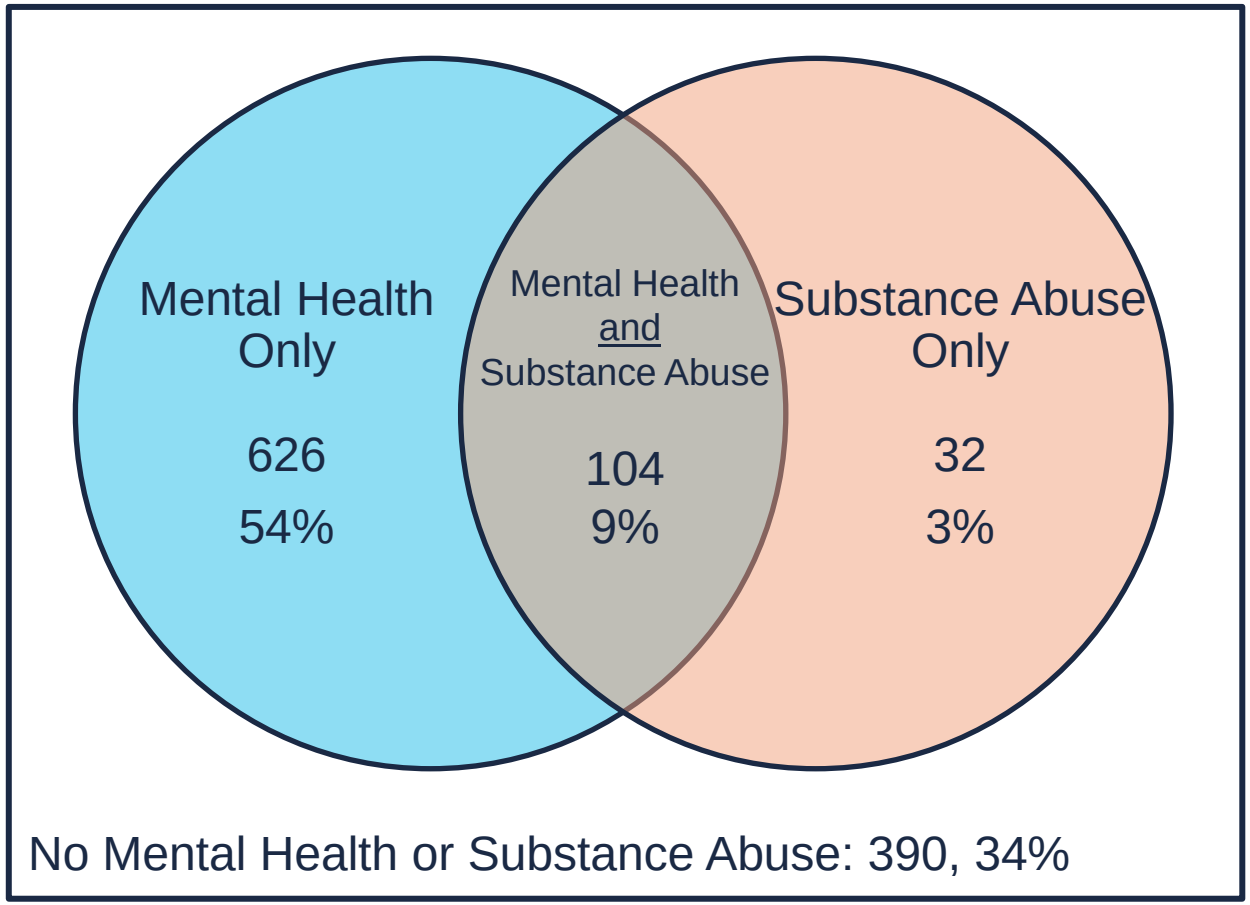
- Limited to the 1,152 Medicare High Utilizers
- 1,764 (41%) of 4,286 Medicare High Utilizer "bedded care" cases (IP/OBV≥24hrs) have a Chronic or Potentially Avoidable Condition as the primary diagnosis.

	Primary Diagnosis				Across All Diagnoses			
Chronic Condition[1]	Unique Patients	IP/OBV ≥24Hr Cases	ER/OBV <24Hr Cases	Total Cases	Unique Patients	IP/OBV ≥24Hr Encounters	ER/OBV <24Hr Encounters	Total Encounters[2]
Hypertension	61	53	23	76	1,050	3,634	1,043	4,677
Coronary Artery Disease (CAD)	33	34	2	36	631	3,869	868	4,737
Congestive Heart Failure (CHF)	269	404	13	417	595	2,535	225	2,760
Diabetes	71	84	33	117	563	2,048	527	2,575
Chronic Obstructive Pulmonary Disease (COPD)	162	263	34	297	530	1,627	338	1,965
Chronic Kidney Disease	10	10	0	10	513	1,789	299	2,088
Obesity	1	1	0	1	416	1,512	73	1,585
Pneumonia	162	174	14	188	369	507	18	525
Septicemia	165	208	1	209	207	535	1	536
Hepatitis	4	7	0	7	31	70	6	76
Chronic Condition Total	**683**	**1,238**	**120**	**1,358**	**1,136**			
Mental Health	56	50	41	91	730	2,950	624	3,574
Substance Abuse	19	15	16	31	136	402	61	463
Chronic + Mental Health / Sub Abuse Total	**720**	**1,303**	**177**	**1,480**	**1,149**			
Potentially Avoidable Endocrine System Conditions	118	96	34	130	1,016	4,234	263	4,497
Potentially Avoidable Circulatory Conditions	251	222	129	351	981	4,030	697	4,727
Potentially Avoidable Digestive Conditions	119	135	29	164	809	2,158	110	2,268
Tobacco Use	0	0	0	0	751	2,172	573	2,745
Potentially Avoidable Infectious Diseases	13	7	6	13	608	1,495	81	1,576
Potentially Avoidable Respiratory Conditions	10	1	9	10	88	96	16	112
Grand Total	**902**	**1,764**	**384**	**2,148**	**1,152**			

Notes: [1] Conditions identified are based on AHRQ CCS level 3 classification. CCS Codes used to identify Chronic Conditions can be found in the Appendix.
[2] Encounters is a count of diagnosis codes across all 30 positions for each patient. Therefore, encounters will be much higher than the count of total visits.
Table sorted on unique patient count across all diagnoses.

Medicare High Utilizers: Mental Health / Substance Abuse

- 762 of 1,152 Medicare High Utilizers **(66%)** have a Mental Health or Substance Abuse diagnosis on an encounter in any position



Medicare High Utilizers: Multiple Chronic Conditions

- Limited to the 1,152 Medicare High Utilizers
- Focus on 10 Chronic Conditions: Hypertension, Diabetes, CAD, CHF, Chronic Kidney Disease, Obesity, COPD, Septicemia, Pneumonia, and Hepatitis
- Looking across all diagnosis code positions to identify patients with overlapping Chronic Conditions, as well as Mental Health or Substance Abuse
- Includes Inpatient, Observation, and ER data

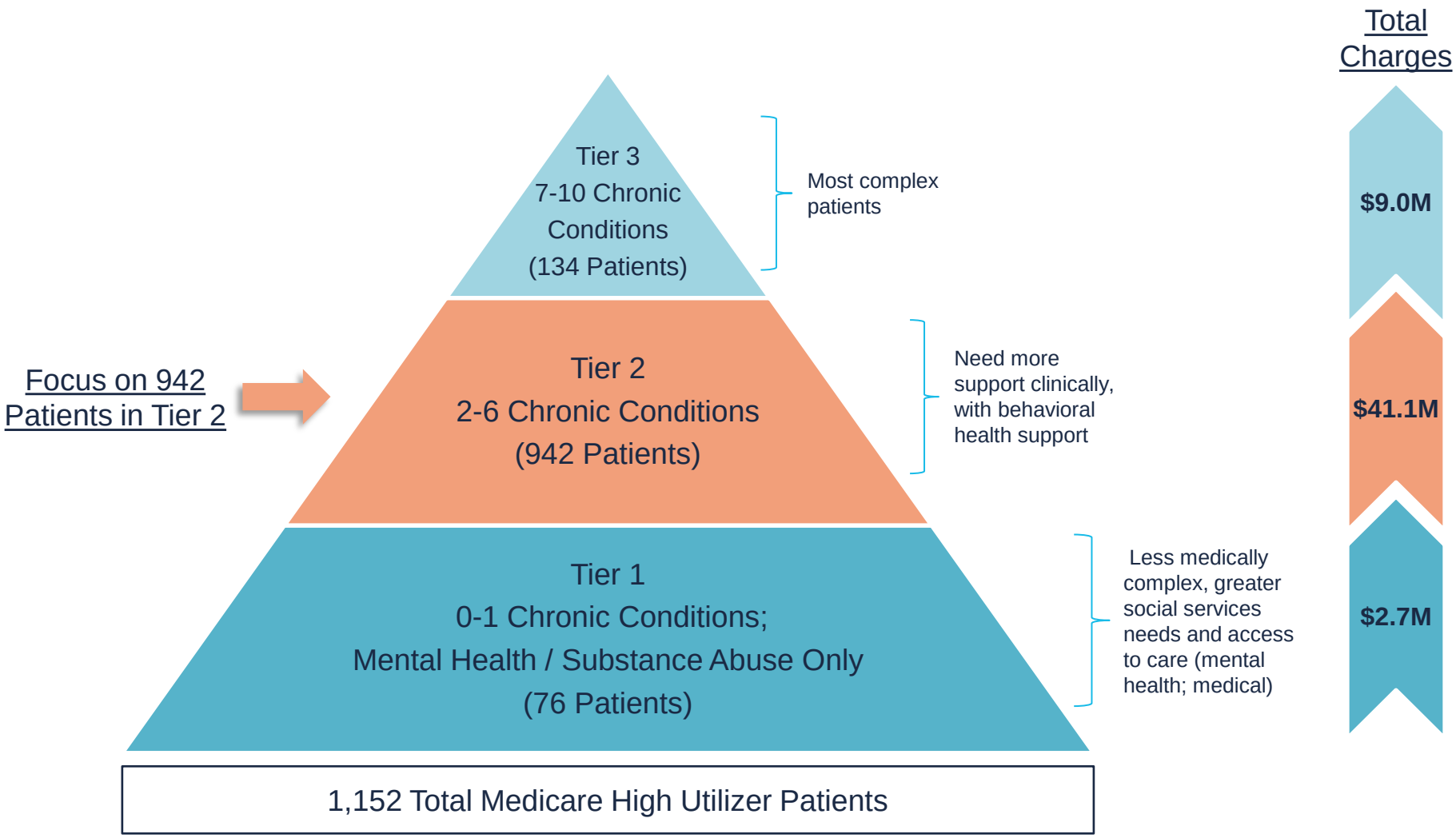
# of Chronic Conditions for Patient	Unique Patients	Chronic Cases	Charges on Chronic Cases	Average Charge per Patient		Chronic + MH/SA Patients
10	0	0	$0	$0		0
9	8	38	$643,818	$80,477		4
8	37	244	$2,989,308	$80,792		22
7	89	461	$5,403,135	$60,709		61
6	166	847	$8,655,862	$52,144		115
5	221	1,155	$10,541,449	$47,699		154
4	224	1,110	$9,143,928	$40,821		143
3	195	894	$7,733,129	$39,657		122
2	136	644	$5,073,113	$37,302		91
1	60	259	$2,167,075	$36,118		37
Chronic Subtotal	**1,136**	**5,652**	**$52,350,817**	**$46,083**		**749**
MH/SA Only	13	73	$400,822	$30,832		
Total	**1,149**	**5,725**	**$52,751,639**	**$45,911**		**762**

Notes: [1] CCS Codes used to identify Chronic Conditions can be found in the Appendix

Of the 1,152 Medicare High Utilizers:

- 99% of patients (1,136) have at least 1 Chronic Condition
- 99% of cases and 99% of charges are associated with Chronic Conditions
- 93% of patients (1,076) have at least 2 different Chronic Conditions
- 66% of patients (762) have a Mental Health or Substance Abuse condition

Medicare High Utilizers: Tiered Patient Population



Tier 2 Medicare High Utilizers: By Chronic Condition

- Limited to the 942 Tier 2 Medicare High Utilizers
  - Tier 2 patients are those with 2-6 Chronic Conditions

	Primary Diagnosis				Across All Diagnoses			
Chronic Condition[1]	Unique Patients	IP/OBV ≥24Hr Cases	ER/OBV <24Hr Cases	Total Cases	Unique Patients	IP/OBV ≥24Hr Encounters	ER/OBV <24Hr Encounters	Total Encounters[2]
Hypertension	40	33	14	47	881	3,011	855	3,866
Coronary Artery Disease (CAD)	31	32	2	34	512	3,025	698	3,723
Congestive Heart Failure (CHF)	198	303	9	312	463	1,841	143	1,984
Diabetes	56	77	21	98	441	1,523	388	1,911
Chronic Obstructive Pulmonary Disease (COPD)	122	207	26	233	412	1,232	255	1,487
Chronic Kidney Disease	10	10	0	10	392	1,290	188	1,478
Obesity	1	1	0	1	301	1,047	57	1,104
Pneumonia	128	141	11	152	279	383	14	397
Septicemia	123	160	0	160	153	398	0	398
Hepatitis	3	6	0	6	20	46	5	51
Chronic Condition Total	**555**	**970**	**83**	**1,053**	**942**			
Mental Health	44	39	32	71	598	2,435	533	2,968
Substance Abuse	17	13	15	28	112	348	54	402
Chronic + Mental Health / Sub Abuse Total	**584**	**1,022**	**130**	**1,152**	**942**			
Potentially Avoidable Endocrine System Conditions	92	76	25	101	827	3,394	193	3,587
Potentially Avoidable Circulatory Conditions	204	184	108	292	800	3,257	577	3,834
Potentially Avoidable Digestive Conditions	100	116	23	139	668	1,814	90	1,904
Tobacco Use	0	0	0	0	609	1,784	473	2,257
Potentially Avoidable Infectious Diseases	11	6	5	11	500	1,249	66	1,315
Potentially Avoidable Respiratory Conditions	8	1	7	8	70	81	12	93
Grand Total	**730**	**1,405**	**298**	**1,703**	**942**			

Notes: [1] Conditions identified are based on AHRQ CCS level 3 classification. CCS Codes used to identify Chronic Conditions can be found in the Appendix.
[2] Encounters is a count of diagnosis codes across all 30 positions for each patient. Therefore, encounters will be much higher than the count of total visits.
Table sorted on unique patient count across all diagnoses.

Appendix

CCS codes used to identify Chronic and Potentially Avoidable Conditions

Appendix

- Diseases of the Circulatory System
  - Hypertension
    - 7.1.1 - ESSENTIAL HYPERTENSION [98.]
    - 7.1.2 - HYPERTENSION WITH COMPLICATIONS AND SECONDARY HYPERTENSION [99.]
  - Coronary Artery Disease (CAD)
    - 7.2.4 - CORONARY ATHEROSCLEROSIS AND OTHER HEART DISEASE [101.]
  - Congestive Heart Failure (CHF)
    - 7.2.6 - PULMONARY HEART DISEASE [103.]
    - 7.2.11 - CONGESTIVE HEART FAILURE; NONHYPERTENSIVE [108.]
  - Other Potentially Avoidable Circulatory
    - 7.2.5 - NONSPECIFIC CHEST PAIN [102.]
    - 7.3.4 - TRANSIENT CEREBRAL ISCHEMIA [112.]
    - 7.4.1 - PERIPHERAL AND VISCERAL ATHEROSCLEROSIS [114.]
    - 7.4.2 - AORTIC; PERIPHERAL; AND VISCERAL ARTERY ANEURYSMS [115.]
    - 7.4.3 - AORTIC AND PERIPHERAL ARTERIAL EMBOLISM OR THROMBOSIS [116.]
    - 7.4.4 - OTHER CIRCULATORY DISEASE [117.]
    - 7.5.1 - PHLEBITIS; THROMBOPHLEBITIS AND THROMBOEMBOLISM [118.]
    - 7.5.2 - VARICOSE VEINS OF LOWER EXTREMITY [119.]
    - 7.5.3 - HEMORRHOIDS [120.]
    - 7.5.4 - OTHER DISEASES OF VEINS AND LYMPHATICS [121.]

- Diseases of the Genitourinary System
  - Chronic Kidney Disease
    - 10.1.3 - CHRONIC KIDNEY DISEASE [158.]

Appendix

- Endocrine; nutritional; and metabolic diseases and immunity disorders
  - Diabetes
    - 3.2 - DIABETES MELLITUS WITHOUT COMPLICATION [49.]
    - 3.3.1 - DIABETES WITH KETOACIDOSIS OR UNCONTROLLED DIABETES
    - 3.3.2 - DIABETES WITH RENAL MANIFESTATIONS
    - 3.3.3 - DIABETES WITH OPHTHALMIC MANIFESTATIONS
    - 3.3.4 - DIABETES WITH NEUROLOGICAL MANIFESTATIONS
    - 3.3.5 - DIABETES WITH CIRCULATORY MANIFESTATIONS
    - 3.3.7 - DIABETES WITH OTHER MANIFESTATIONS
  - Obesity
    - 3.11.2 – OBESITY
  - Other Potentially Avoidable Endocrine
    - 3.5.1 - UNSPECIFIED PROTEIN-CALORIE MALNUTRITION
    - 3.5.2 - OTHER MALNUTRITION
    - 3.7 - GOUT AND OTHER CRYSTAL ARTHROPATHIES [54.]
    - 3.8.1 - HYPOSMOLALITY
    - 3.8.2 - HYPOVOLEMIA
    - 3.8.3 - HYPERPOTASSEMIA
    - 3.8.4 - HYPOPOTASSEMIA
    - 3.8.5 - OTHER FLUID AND ELECTROLYTE DISORDERS
    - 3.11.3 - OTHER AND UNSPECIFIED METABOLIC; NUTRITIONAL; AND ENDOCRINE DISORDERS

- Diseases of the Respiratory System
  - Pneumonia
    - 8.1.1 - PNEUMONIA (EXCEPT THAT CAUSED BY TB OR STD) [122.]
  - Chronic Obstructive Pulmonary Disease (COPD)
    - 8.2.1 - EMPHYSEMA
    - 8.2.2 - CHRONIC AIRWAY OBSTRUCTION; NOT OTHERWISE SPECIFIED
    - 8.2.3 - OBSTRUCTIVE CHRONIC BRONCHITIS
    - 8.2.4 - OTHER CHRONIC PULMONARY DISEASE
    - 8.3.1 - CHRONIC OBSTRUCTIVE ASTHMA
    - 8.3.2 - OTHER AND UNSPECIFIED ASTHMA
  - Other Potentially Avoidable Respiratory
    - 8.1.5 - OTHER UPPER RESPIRATORY INFECTIONS [126.]

Appendix

- Infectious and Parasitic Diseases
  - Septicemia
    - 1.1.2 - SEPTICEMIA (EXCEPT IN LABOR) [2.]
  - Hepatitis
    - 1.3.2 - HEPATITIS [6.]
  - Other Potentially Avoidable Infectious Disease
    - 1.1.1 - TUBERCULOSIS [1.]
    - 1.1.3 - SEXUALLY TRANSMITTED INFECTIONS (NOT HIV OR HEPATITIS) [9.]
    - 1.1.4 - OTHER BACTERIAL INFECTIONS [3.]
    - 1.2.1 - CANDIDIASIS OF THE MOUTH (THRUSH)
    - 1.2.2 - OTHER MYCOSES
    - 1.3.1 - HIV INFECTION [5.]
    - 1.3.3 - OTHER VIRAL INFECTIONS [7.]
    - 1.4 - OTHER INFECTIONS; INCLUDING PARASITIC [8.]
    - 1.5 - IMMUNIZATIONS AND SCREENING FOR INFECTIOUS DISEASE [10.]

- Diseases of the Digestive System
  - Potentially Avoidable Digestive
    - 9.4.2 - GASTRODUODENAL ULCER (EXCEPT HEMORRHAGE) [139.]
    - 9.6.1 - APPENDICITIS AND OTHER APPENDICEAL CONDITIONS [142.]
    - 9.6.4 - DIVERTICULOSIS AND DIVERTICULITIS [146.]
    - 9.8.2 - OTHER LIVER DISEASES [151.]
    - 9.9.1 - ACUTE PANCREATITIS
    - 9.9.2 - CHRONIC PANCREATITIS
    - 9.9.3 - OTHER PANCREATIC DISORDERS
    - 9.10.1 - HEMORRHAGE FROM GASTROINTESTINAL ULCER
    - 9.12.1 - CONSTIPATION
    - 9.12.2 - DYSPHAGIA

BRG Appendix

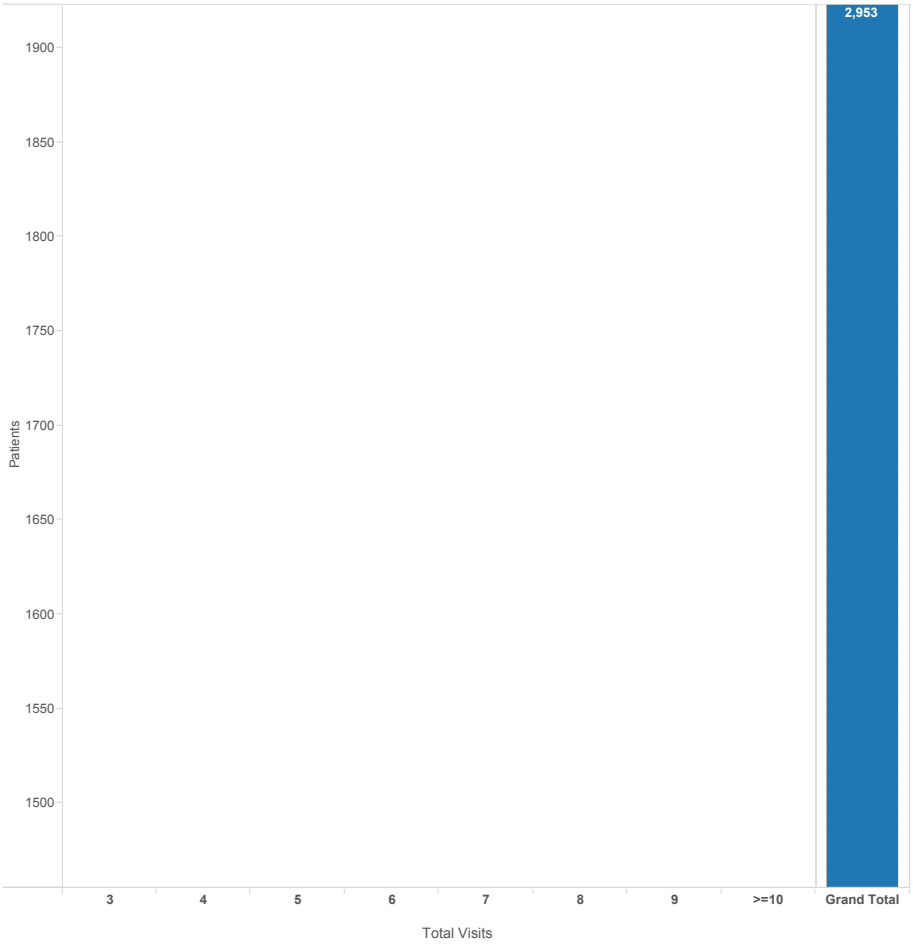
- Mental Health
  - 5.1 - ADJUSTMENT DISORDERS [650]
  - 5.2 - ANXIETY DISORDERS [651]
  - 5.3.1 - CONDUCT DISORDER [6521]
  - 5.3.3 - ATTENTION DEFICIT DISORDER AND ATTENTION DEFICIT HYPERACTIVITY DISORDER [6523]
  - 5.4 - DELIRIUM DEMENTIA AND AMNESTIC AND OTHER COGNITIVE DISORDERS [653]
  - 5.5.1 - COMMUNICATION DISORDERS [6541]
  - 5.5.2 - DEVELOPMENTAL DISABILITIES [6542]
  - 5.5.3 - INTELLECTUAL DISABILITIES [6543]
  - 5.5.4 - LEARNING DISORDERS [6544]
  - 5.6.3 - PERVASIVE DEVELOPMENTAL DISORDERS [6553]
  - 5.7 - IMPULSE CONTROL DISORDERS NOT ELSEWHERE CLASSIFIED [656]
  - 5.8.1 - BIPOLAR DISORDERS [6571]
  - 5.8.2 - DEPRESSIVE DISORDERS [6572]
  - 5.9 - PERSONALITY DISORDERS [658]
  - 5.10 - SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS [659]
  - 5.13 - SUICIDE AND INTENTIONAL SELF-INFLICTED INJURY [662]
  - 5.14.1 - CODES RELATED TO MENTAL HEALTH DISORDERS [6631]
    - *Excluding ICD-9 code V1582 – Personal history of tobacco use*
  - 5.15.2 - EATING DISORDERS [6702]
  - 5.15.3 - FACTITIOUS DISORDERS [6703]
  - 5.15.4 - PSYCHOGENIC DISORDERS [6704]
  - 5.15.5 - SEXUAL AND GENDER IDENTITY DISORDERS [6705]
  - 5.15.7 - SOMATOFORM DISORDERS [6707]
  - 5.15.8 - MENTAL DISORDERS DUE TO GENERAL MEDICAL CONDITIONS NOT ELSEWHERE CLASSIFIED [6708]
  - 5.15.9 - OTHER MISCELLANEOUS MENTAL CONDITIONS [6709]

- Substance Abuse
  - 5.11 - ALCOHOL-RELATED DISORDERS [660]
  - 5.12 - SUBSTANCE-RELATED DISORDERS [661]
  - 5.14.2 - CODES RELATED TO SUBSTANCE-RELATED DISORDERS [6632]

Appendix C

Patient Total Hospitalizations Summary - Patients by Number of Visits
Inpatient/Obv High Utilizers

Last 12 Months Patients by Total Number of Visits
Select one or multiple bars from top to bottom to view total visits at all hospitals



Hospital Name
All

Time Period
Last 12 Months

Utilization at All

Total Charges
All values

Total Visits
3 to 21

Readmissions
All values

Ambulatory ER Visits
All values

Bedded Care (IP + Obv>=24 hrs)
All values

MRN

Zip on Recent Visit

Primary Payer
All

Secondary Payer
Multiple Values

Age Group
Multiple Values

High Utilizers Across All Hospitals
Inpatient/Obv High Utilizers

Conditions

Chronic

Asthma
All

COPD
All

Chronic Kidney Disease
All

Diabetes
All

Heart Failure
All

Hyperlipidemia
All

Hypertension
All

Mental Health

Alzheimers/Other Dementia
All

Depression
All

Oncology

Colorectal Cancer
All

Endometrial Cancer
All

Female/Male Breast Cancer
All

Lung Cancer
All

Prostate Cancer
All

Other

Anemia
All

Atrial Fibrillation
All

Hip/Pelvic Fracture
All

Ischemic Heart Disease
All

Osteoporosis
All

Stroke/Transient Ischemic Attack
All

Last 12 Months Total Visits and Charges Across All Hospitals

HSCRC, 2015. Tableau dashboards developed by CRISP.
- Data source: HSCRC Inpatient and Outpatient Case Mix Data with CRISP EID. Data from calendar years 2014 - 2015.

Case Mix Data Through
August 2015

Click here for extended notes

Appendix D

GET WELL

West Baltimore Readmission Reduction Collaborative

30-Day Intervention

3,119 participants

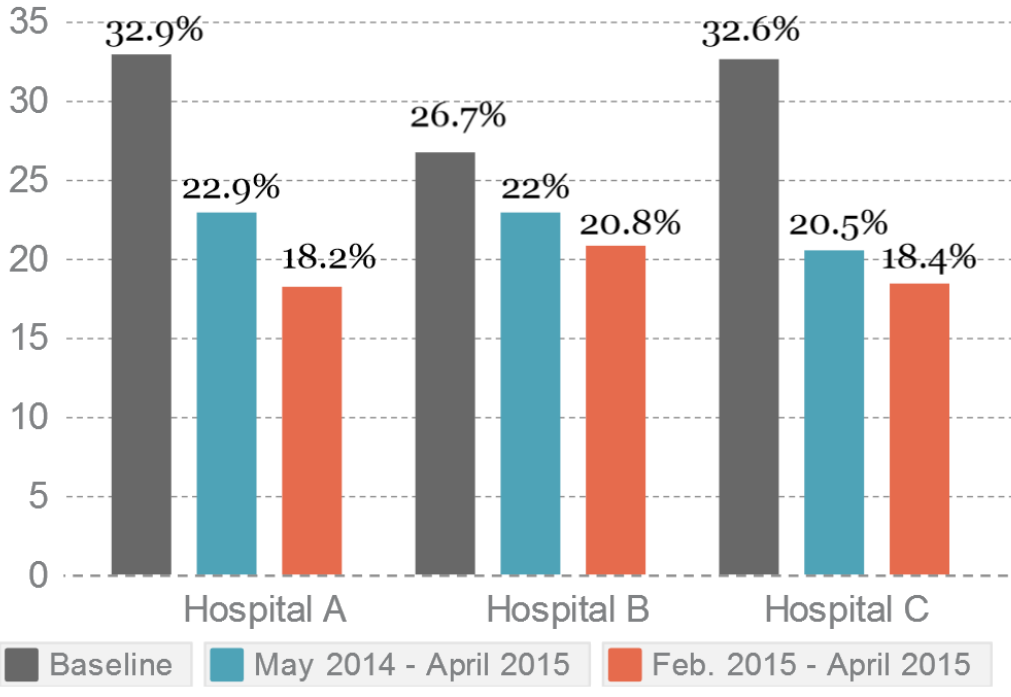
May 2014-
April 2015

Cost and Savings

$1,185,220
Intervention
Costs

$3,434,049
Rehospitalizations
Avoided

189.7%
Return on
Investment



The readmission data presented here are calculated using raw, unadjusted Medicare claims for the specified periods of time. They do not indicate impact or take trends or other initiatives into consideration. These metrics are provided by CMS for performance monitoring purposes only and while they inform evaluative results, they do not constitute the entirety of the program evaluation.

THE COORDINATING CENTER
INSPIRED SOLUTIONS

Anne Arundel County Department of Aging and Disabilities

2015

Triage Team Proposal

A Care Coordination Initiative to Improve Community Health through Social and Clinical Systems Approach

Triage Team for Critical Cases
A Department of Aging and Disabilities (DoAD) / Anne Arundel Medical Center (AAMC)/University of Maryland Baltimore Washington Hospital (UM BWMC)/Anne Arundel County Fire/EMS Department Partnership Proposal for Health Promotion

Overview

The intent of this proposal is to design and implement a social and clinical support model to prevent and address the dependency of super-utilizers on emergency systems of intervention and environments of care. Through qualitative case analysis, the "super-utilizer" demonstrates critical care needs that require care coordination using both clinical models of support and complex social service needs delivered preventatively through immediate structure of supports that are sustainable over time. A more discrete data analysis was conducted through the Anne Arundel County Department of Health (November 2014), who analyzed hospital discharge data obtained from Maryland Health Services Cost Review Commission (HSCRC) for calendar year 2013. The data sets evaluated during this analysis qualified super-utilizers as individuals hospitalized 3 or more times in a 12 month period. This targeted analysis demonstrated that super-utilizers or "high-utilizing population" among both Medicaid and Dual-Eligible populations were geographically present in high concentrations in both northern portions of the county and in small pocketed areas central to the Annapolis region. Of those, high-utilizers evaluated for AAMC hospitalizations, 57% were designated Medicare eligible, 9% Medicaid eligible, and 12% Dual Eligible. At UM BWMC, high-utilizers evaluated for hospitalizations were 56% Medicare eligible, 11% Medicaid eligible, and 11% Dual Eligible. At AAMC, 90% of Medicare high-utilizers and 57% of Dual Eligible high-utilizers were age 65 and older, which is the demographic of individual that can best be supported through programs and supports offered at the Department of Aging and Disabilities.

In addition to the services provided within the Triage Team, the full weight and support of the Department of Aging & Disabilities' numerous in-house programs make this program not only a short term fix, but rather a long term solution. These programs, in concert with this proposal, offer a holistic approach to providing support to individuals in need. This array of programs will be available as a resource connection for the Triage Team inclusive of grants and emergency funds for each.

Information and Assistance (I & A) provides both resource referral and options counseling to navigate a personal plan of supports for individuals with disabilities, seniors, and their caregivers. I & A Specialists are trained and credentialed to have an expert level of knowledge of community resources, Federal and State entitlement programs, and DoAD support programs.

I & A Specialists provide assessment and screening to link individual services and wrap social services around the person so they may live and age in place in their homes. Providing these resources and supports lowers the individual's dependencies on medical systems of care and reliance on emergency or crisis supports. For advocacy and support, several of our Maryland Access Point programs are available. The State Health Insurance Program (SHIP) provides unbiased information and support to Medicare recipients and assistance with navigation of insurance benefits. For those in skilled nursing facilities or rehabilitation facilities, the Ombudsman Program provides advocacy and support. For those seeking assistance regarding assisted living facilities, individuals can receive unbiased, impartial information from our Assisted Living Program that maintains current knowledge and rapport with small 4-16 bed facilities, providing both regulatory oversight and subsidy allocation. The National Family Caregiver Support Program provides numerous programs to help individuals and their families including: training, support groups, respite care, telephone reassurance, and caregiver grants.

Our Long Term Care Bureau offers numerous programs providing case management and in-home care services, depending on the individual's insurance information, functional abilities, and financial situation. The Senior Care Program is available to individuals with functional needs over the age of 65. Services can range from case management only to limited in-home custodial care services. In addition, our Community Personal Assistance Services (CPAS,) Community First Choice (CFC) Program, and Community-Based Waiver services are available to individuals receiving Medicaid, and also provide in-home care and supports designed to help individuals stay in the community.

In terms of transportation, our Department offers two programs. The curb to curb donation based van transportation program is available for medical appointments and transportation to and from senior centers, within Anne Arundel County. This curb to curb service is open to adults with disabilities and residents 55 and older. The other transportation program we offer is the Taxi Voucher Program, which allows older adults and adults with disabilities to purchase deeply discounted cab fare, providing a flexibility that is not possible through the van service.

The Department offers activities through our seven senior activity centers, located in communities throughout the county. These centers offer classes through Anne Arundel Community College, fitness, shows, socialization, trips, and nutrition, Monday through Friday. Eligibility for senior activity centers is limited to ages 55 and up. There is no charge to become a member. Many of the clients that would be encountered in this proposed program may require additional structure and supervision to allow them to utilize the senior centers. For such individuals, our Senior Center Plus program is available, offering 2 days a week of structured, supervised activity at county senior centers for a small fee.

Additionally, this proposal includes the formation of a multi-disciplinary approach and inter-dependency on Anne Arundel County's Core Human Services team through the formation of "Silver CRICT" to further make available supports to the Triage Team across a multitude of social

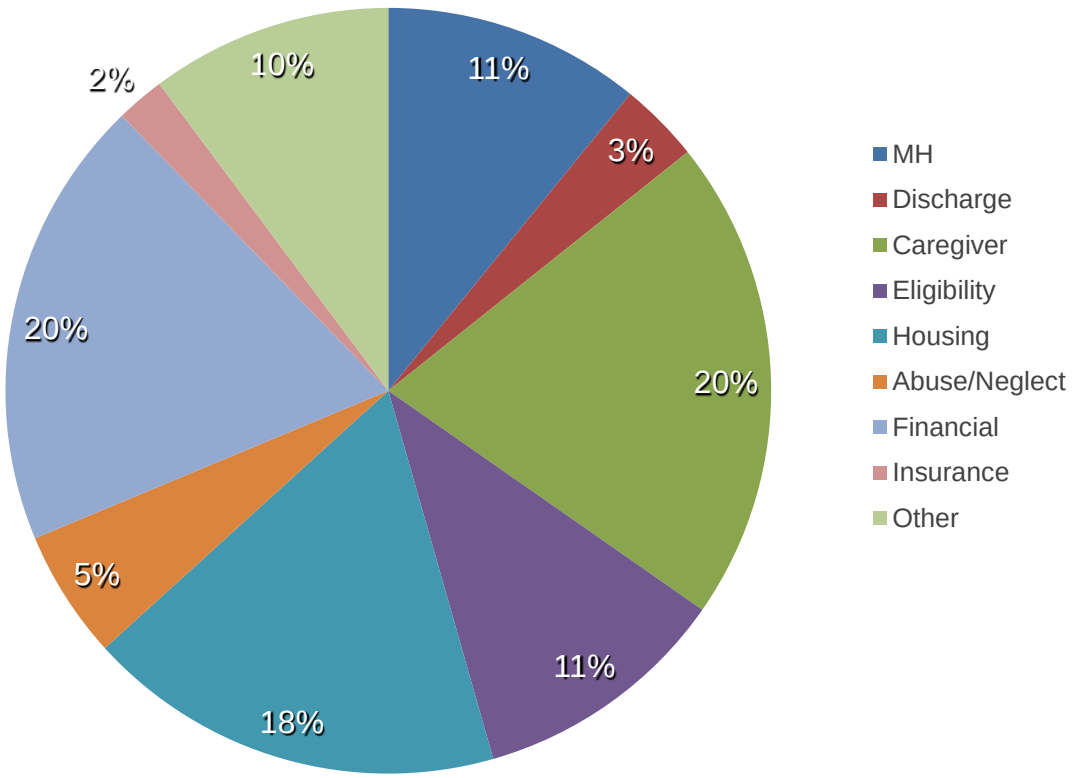
and human service resources, programs, and will provide critical evaluation to each case as presented by the Triage Team. "Silver CRICT" which is an Aging/Senior population Community Resource Initiative Care Team (CRICT) will be developed to support the Triage Team through providing access to referral information across agencies and provide community resources with the assistance of multiple agencies working together on each case. The Silver CRICT Team will be led by a navigator and member of the Department of Aging and Disabilities Triage Team and will convene weekly for case review. A multi-agency action plan will be developed to assist with long term connections to supports and services in addition to the immediate assessment and care management provided by a member of the Triage Team.

Through a recent qualitative case analysis of critical cases received through the Department of Aging and Disabilities, Maryland Access Point, key indicators of critical care coordination were determined for critical cases effecting emergency environments and/or systems of care and response. The critical cases that were reviewed had one or multiple themes that demanded immediate attention and support of social resources to maintain a safe and healthy quality of life. These cases required multiple interventions across several community agencies through immediate case management. The cases presented multiple challenges with eligibility, lack of available resources, loss or lack of a natural support or caregiver, housing needs and/or pending homelessness, financials that were "just above Medicaid" entitlements, and required the need for intense navigation of social systems.

Critical Case Review 3/2015-8/2015	
Theme	Number of cases
MH	16
Discharge	5
Caregiver	30
Eligibility	16
Housing	26
Abuse/Neglect	8
Financial	28
Insurance	3
Other	15

52 Cases were reviewed across three gateway programs (Information and Assistance, SHIP, and Housing) using a six month sample of care notes in AIM. Cases were provided for measurement that met the definition of a "critical case." Information was qualitatively analyzed to achieve a case summary of challenge, create a list of "ineffective remedies" provided, which expressed determinants that controlled the inability to "remedy" or provide support to the situation within the current function and design of social programs and human services agencies, and a list of key indicators was created to determine largely the key challenges or "themes" across all cases represented.

Percentage of themes relevant to critical cases measured



Critical cases demonstrated significant challenges in themes of housing, lack or loss of caregiver, and individuals having financial barriers. The 3% listed as "discharge" refers to the critical cases that were reviewed having an unsafe hospital discharge. Housing was a larger theme and representative of lack of affordable housing (assisted living and senior apartments,) waitlists for congregate and low income housing, and pending homelessness. Caregiver barriers were represented through the lack or loss of a caregiver or natural support that without the support the individual was unsafe or at risk living independently. Additionally, the individuals represented could not afford in-home care necessary to age in place. Financial barriers were reported as individuals that were scaled slightly over income/asset thresholds for many entitlement programs, however, could not afford to live independently.

This Department of Aging and Disabilities Proposal aligns with our Mission Statement: Develop and administer services and programs which promote choice, independence and dignity for seniors, adults with disabilities and their families and caregivers; advocate and protect the rights of vulnerable older persons and adults with disabilities.

In 2009 AA County DoAD received a three-year-pass-through grant funded by CMS and the Administration on Aging (AoA.)
This grand enabled us to set up a transition program to assist clients with self-management of their chronic diseases, so that we could reduce the frequency of preventable hospital and emergency department admissions. Our partner in this endeavor was Anne Arundel Medical Center.

The success of this team approach has prompted us to again seek help from the community to set up a program to expedite the care of those clients who present with critical needs. By pulling resources, we will be better able to empower our clients and to "Make Life Better" for those we serve as well as prevent burn-out in providers and caregivers who serve this population.

Population Statistics-AAMC, UM BWMC and Fire

The triage team will work with AAMC, UM BWMC and Fire to develop a dashboard that will capture meaningful metrics to source future projections and quality assurance outcomes. Prior to implementation of the Triage Team, a representative from AAMC, UM BWMC, Fire, and DoAD will evaluate and establish metrics to track in each department.

Initial Data

Number of unduplicated Medicare/Dual-Eligible patients having ED/Hospitalizations:

	12 months	6 months
UMBWMC		
≥3 visits	2305	729
≥5 visits	541	264
AAMC		
≥3 visits	945	932
≥5 visits	756	238

In looking at initial metrics obtained from both hospitals given a 12 month look back of unduplicated Medicare and Dual Eligible individuals having 3 or more hospitalizations/ED visits, the data suggests that an initial target of service needs to start with the highest end of the super-utilizers having 5 or more hospitalizations/ED visits in a 6 month period.

In 2014, the Anne Arundel County Communications Center dispatched 77,500 calls having 85%-90% of the calls designated for medical emergencies. Obtaining more discrete and meaningful data sets will be an initial priority of the Triage Team and partners.

Purpose

The mission of the triage team is congruent with the Older Americans Act of 1965 (OAA) and the Anne Arundel County Department of Aging and Disabilities, in that the triage team will focus on "Making Life Better" for those we serve. The triage team, through coordination and implementation of immediate supports and services, will empower the individual to age in place or in the least restrictive environment possible that is self-directed and person-centered. The triage team will support the individual to create a healthy, sustainable, and holistic environment as a determinant of health, and to become independent from unnecessary emergency care.

Triage Team:

(1 FTE) Nurse (RN) Clinical Case Manager-Project lead in coordination, program oversight, triage team member, and CRICT Navigator
(1 FTE) Geriatric Mental Health Case Manager-Triage Team member
(1 FTE) Geriatric Social Worker LCSW-C-Triage Team member
(1 PTE) Case Manager
(1 PTE) RN Case Manager

Program Directors from Maryland Access Point Customer Service and Long Term Care Bureaus of the Department of Aging and Disabilities will provide supervision for the Triage Team. Supervision between these bureaus will enhance a joint understanding and relationship between LTC and gateway services resulting in enhanced and immediate coordination of services.

*The triage team will have a three pronged assignment of care coordination with the ultimate goal of what we hope will be **proactive** support and resource coordination.*

1. *The triage team will work with discharge planners at AAMC and UM BWMC to identify clients who frequently return to the ED/Hospital, whose interaction with the triage team will have a combined effect on decreased ED visits and a possible reduction in ED costs for visits that do occur and may need less medical intervention and/or discharge planning.*

2. *The triage team will receive internal referrals from Information and Assistance that meet indicators of critical care needs. This is a proactive measure to reduce ED visits where critical needs are presenting that without provision of resource and support will likely become dependent on emergency service environments.*

3. *The triage team will work in partnership with Anne Arundel County EMS/Fire to identify super-utilizers of EMS in Anne Arundel County. This is a proactive care coordination approach in advance of EMS contact to establish an assessment of need and provide immediate support coordination as a deterrent to emergency response for non-emergency needs and/or to address support needs that when left unmet develop clinical emergencies.*

Mission of the Triage Team

To provide person-centered, holistic care to Anne Arundel County seniors and the disabled population utilizing a triage of care model blending social and clinical systems of care through a sustainable community-hospital partnership.

Program Goals:

1. *Through coordination of immediate supports and services, will empower the individual to age in place or in the least restrictive environment possible that is self- directed and person-centered.*
2. *Decreased calls to the EMS System and decreased admission to the Emergency Department and/or hospital admission through short-term case management, providing attention to clients' discharge needs.*
3. *"Making Life Better" for our clients.*

Objectives of Care:

1.) Improve positive health outcomes
2.) Improve the quality of life for every individual
3.) Increase individual independence through the alignment of person-centered sustainable resources
4.) Decrease social dependence on clinical emergency systems and environments

Metrics align with the four objectives listed above to demonstrate evidenced-based care coordination delivery in and among systems of care.

Roles of each player:

Department of Aging and Disabilities:

1. *The triage team will provide care coordination and support to individuals received on referral or existing on caseload, 7 days per week, 8am-4:30pm daily.*
2. *Provide immediate care coordination to individuals received through referral to provide assessment and structure immediate supports to prevent dependency on emergency systems and environments.*
3. *Overall administration, operational oversight and supervision of the Triage Team.*
4. *Liaison with other department programs, county agencies, and private resources.*
5. *Determine appropriateness of client through evaluation of key indicators of critical care coordination.*
6. *Maintain appropriate client record, case review, assessments, and key metrics.*
7. *Provide partial Emergency funds to pay for needed services for clients under the supervision of the Triage Team.*
8. *The Triage Team will meet on a monthly basis (more often if deemed necessary) with our partner, Anne Arundel Medical Center and any other resource partners necessary to review a person- centered plan for the client.*

Anne Arundel Medical Center and University of Maryland Baltimore Washington Hospital:

1. *Provide funding for the positions of the Triage Team.*
2. *Provide a liaison at the hospital as contact for the Triage Team.*
3. *Allow the Triage Team access to clients being admitted and/or discharged who fit the criteria of the program.*
4. *Provide Triage Team with hospital resources, training, and classes that would benefit the clients.*
5. *Liaison to attend monthly Triage Team meetings.*

Anne Arundel County-EMS/Fire:

1. *Allow Triage Team access to individuals who fit the criteria of the program.*
2. *Provide referral and attend monthly Triage Team meetings*
3. *Provide a liaison at EMS/Fire as contact for the Triage Team.*

Actions and Scope of Work: AAMC, UM BWMC, EMS/Fire, Department of Aging and Disabilities

The scope of work and referral base is largely dependent on the primary agencies that interface with the super-utilizer in a critical setting. Additionally, we know that determinants of health present primarily as social support, environment, community, and behavior. When barriers to these determinants are removed through care coordination, unnecessary utilization of both emergency response and health care systems are improved. The triage team will position an integrated community/medical model with a robust knowledge of care coordination, behavioral health, and social systems navigation. The Triage Team will have the ability to perform immediate assessment and develop an action plan to limit or extinguish barriers that create dependency on emergency and health systems. The Triage Team is uniquely positioned to have immediate access to professionals and programs of DoAD through co-location with both gateway services and Long Term Care Bureaus. Additionally, the team will have access to flexible emergency spending accounts to assist with immediate care needs that present barriers for the individuals before a long term sustainable plan can be implemented. The Triage Team will also have weekly case reviews with other key human service agencies that can provide their resource and expertise as critical cases present multiple variables.

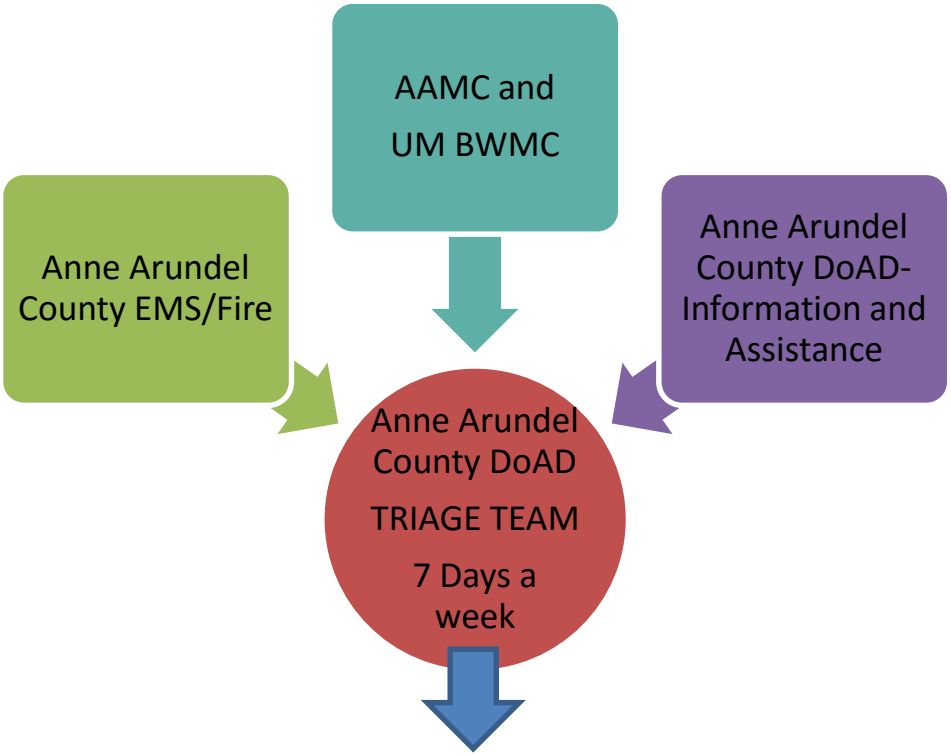
Action A: *The Triage Team will receive, through Memorandum of Understanding, referrals from Anne Arundel Medical Center and University of Maryland Baltimore Washington Hospital. The Triage Team will receive notification upon admission of a pre-identified super-utilizer* (initially the highest as defined as 5 or more visits within a six month period) and begin a hospital visit to assess existing environment and determine support needs related to discharge within 24-48 hours of admission or observation and no later than 60 hours following discharge should an admission have a short-term stay. The Triage Team will provide assessment, care coordination, and short term case management for at minimum 60 days, not to exceed when a personal plan becomes safe and sustainable without triage team support.*

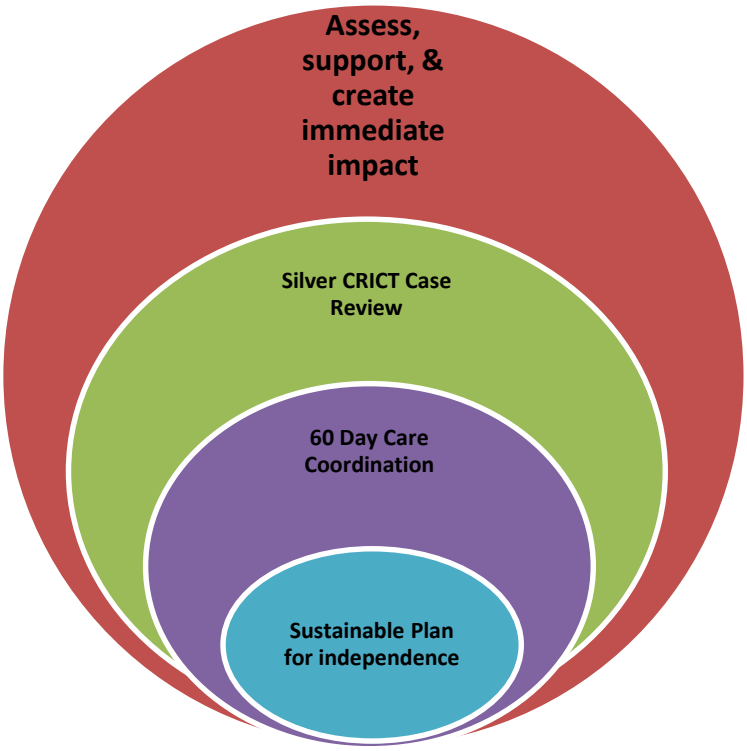
Action B: *The Triage Team will work in partnership with Anne Arundel County EMS/Fire to identify a list of individuals 55 and older that are super-utilizers of the emergency response system and require one or more of the indicators listed in Action A to maintain safe and sustainable living. The triage team will provide this group of individuals with intense prehospital case management to reduce repeat EMS calls. This will have a combined effect on decreased EMS calls, ED visits, and a possible reduction in ED costs for visits that do occur and may need less medical or discharge intervention from the hospital.*

Action C: *The Triage Team will receive internal referrals from Information and Assistance that meet, based on assessment, indicators of immediate response to care coordination. Indicators established are based on the qualitative analysis of the crisis case review that include: pending homelessness/immediate housing needs, lack of finances for immediate medication/adaptive equipment/home modification that poses an immediate risk to health and safety if left unmet, lack or loss of a natural support or caregiver that poses an immediate risk to health and safety if left unmet, abuse/neglect/financial exploitation that meets APS definition (coordinated with APS as per mandated reporting standards,) and mental health challenges or potential dementia as reported or demonstrated through either maladaptive behavior or an altered mental state/impaired orientation. The Triage Team will work with emergency resources and funding to provide immediate relief to the individual and provide short-term case management to place supports/services and navigate a personal plan that is sustainable following case management.*

**Super-utilizer as identified in the hospital setting shall be defined through agreement as an individual having three or more hospital admissions during the past year.*

Model of Services and Supports





The Triage Team will receive referalls from 3 entities and operate 7 days per week, providing an innovative and proactive approach to high-utilization on emergency systems and environments. Utilizing a community-medical infrastucture supported through strong core human services support in Silver CRICT, the Triage Team will have at hand a bank of resources from which to provide immediate service and support to critical cases.

The Triage Team will receive referalls from Anne Arundel Medical Center, University of Maryland Baltimore Washington Hospital, Anne Arundel County EMS/Fire Department, and internally through Information and Assistance for critical cases only.

Critical Case: An individual having one or multiple themes that demand the immediate attention and support of resources to maintain a safe quality of life. These cases typically require multiple interventions across several community agencies through immediate short term case management. These cases present multiple challenges with eligibility, lack of available resources, loss of natural or caregiver support, housing needs or pending homelessness, financials that are "just above Medicaid," lack of medical coverage, and a need for intensive navigation of social systems and resources to prevent dependency on emergency systems and environments.

The Triage Team will have both a referral system and a professional on-call direct line for partners to access 7 days per week (8am-4:30pm.) The Triage Team Lead will accept referrals from all entities listed above and appropriately assign and coordinate with the team upon receipt of referral as described in the aforementioned "Action A, B, and C." The Triage Team will perform a risk assessment to assess barriers to community independence, health and safety, and quality of life. The risk assessment will account for all key indicators of a critical case (e.g. housing, caregiver, etc.) so that immediate supports can be coordinated through the use of entitlements, resource navigation, provide an Adult Evaluation and Review Service (AERS) assessment for access to programs and future long-term case management, and the potential use of emergency funds to immediately meet the needs of the individual as priority. The Triage Team will provide a face-to-face visit in the existing environment of the individual and their caregiver. Following discharge (hospital) or in their current environment, the Triage Team will perform a home visit inclusive of a medication review, coordinate follow-up appointments/care, and assist with the on-going arrangement of support. The initial face-to-face visit will initiate the beginning of a plan of care to assist the individual to remain in a safe environment and at the same time decrease EMS calls, ED visits, and hospital admissions. The Triage Team under the direction of the RN lead will initiate the first visit to include but will not be limited to:

- *A full systems check of the individual*

- *Vital Signs*
- *A complete medication review*
- *A review of last hospital discharge plan*
- *Discussion of medical appointments the individual has scheduled and those the individual will need to schedule*
- *Forming a list of all medical appointments and therapy appointments with contact information for each*
- *Discussion with individual and caregiver regarding physical health of the individual*
- *Arranging transportation to and from all therapies and medical appointments*
- *List and discuss all resources and natural supports in place, new eligibilities to programs/supports, identify service/support barriers and gaps*
- *Provide emergency funding (based on critical need) to prevent reliance on emergency settings until service gaps are addressed through a sustainable action plan*
- *Complete applications and referrals to all necessary resources*
- *Design Care Action Plan with individual*
- *Provide Triage Team Contact information*
- *Arrange next home visit*
- *Evaluation of insurance coverage*

The Triage Team will evaluate the effectiveness of the risk assessment and support provision established at the initial point of contact and begin an action plan for short-term 60 day case management. Case Management will be an in-person visit and coordination of supports and services for the first 60 days and occur at least weekly dependent on need and risk for contact with emergency systems and environments. During the first week of the 60 day review, the Triage Team will submit a referral to Silver CRICT for weekly case review among the core human services agency respective to Anne Arundel County. The Triage Team will navigate the Silver CRICT case review and create an action plan with the ultimate goal of independent and sustainable supports and services. Following the 60 days of short-term case management, the individual will receive long term case management based on need through DoAD's Senior Care Program.

Human Services/Silver CRICT:

The Triage Team will meet on a weekly basis to conduct a human services review of caseload. The Triage Team will present new and on-going cases that may require the immediate support and strategy of other key human services agencies. The IDT will review each case and offer recommendation and support to the triage team based on the necessary involvement of their area of expertise and service to the individual or presenting need. The Triage Team will also have access to each IDT member or designee should a case review require immediate response that surpasses the level of expertise and resources of the triage team.

IDT Members: The following List includes but is not limited to the possible Human Resource partners that would provide benefit to care coordination:

AA County Mental Health Core Services

(2) DSS/APS

Housing Authority

Children and Family Services

State Attorney's office

Health Department

Mobile Crisis/CIT

Food Bank

Budget/Funding

The budget is largely structured to support the personnel costs of three full-time positions and two part-time positions interdependent on the unique skill sets and professional designations each bring to the Triage Team. Ancillary costs include materials, technology, and communications to support the mobile abilities of this team. Exclusions of this budget are defined as emergency fund support provided directly to the individual supported by the Triage Team, which are fiscally supported through a variety of means across many agencies. Having immediate use of alternate emergency funding sources is instrumental to the success of the Triage Team in order to establish a safe and immediate stabilization of the environment.

Examples of Alternate Funding:

1. *Supplemental Senior Care Emergency funding designated for a variety of assistance to those presenting critical needs. There is no prescribed income/asset limitation to these funds, however, financial need is closely evaluated by the Program Director/Designee.*
2. *Interdisciplinary team resources for emergency care (Silver CRICKET flex spending as designated by each human services partner.)*
3. *$15,000 will be designated from Department of Aging and Disabilities Federal Financial Participation (FFP) funding to be used for care and clinical resources.*
4. *Grants: National Family Caregiver Support Program (NFCSP award) for Respite Care up to $250/pp for a caregiver grant.*
5. *Friends of Arundel Seniors (FOAS) is a non-profit organization comprised of volunteers to provide in-home adaptive supports and emergency funding that is evaluated on a case-by-case basis decided by a Board of Directors.*
6. *Numerous non-profit entities specific to Anne Arundel County e.g. Partners In Care, Anne Arundel Community Development, etc.*

Personnel/Staffing	AAMC/UM BWMC	DoAD
CM (LISW-C)-1 FTE	$ 52,000.00	
CM (Geriatric MH)-1 FTE	$ 52,000.00	
CM (RN)-1 FTE	$ 62,400.00	
CM (2-PTE)	$ 68,640.00	
Total	$ 235,040.00	$ -

Materials	AAMC/UM BWMC	DoAD
Brochures		$ 500.00
Office Supplies		$ 800.00
Information/Referral pkg.		$ 600.00
Total	$ -	$ 1,900.00

Technology	AAMC/UM BWMC	DoAD
Laptops-3/SA PC-2		$ 7,500.00
Mobile Printer		$ 1,500.00
Total	$ -	$ 9,000.00

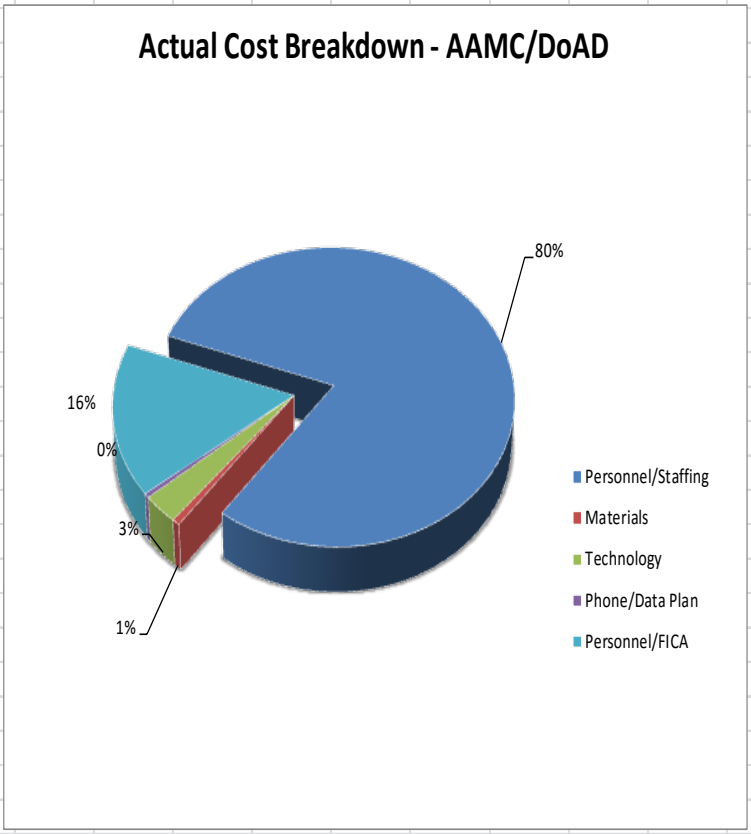
Phone/Data Plan	AAMC/UM BWMC	DoAD
Cell Phone 1		$ 450.00
Cell Phone 2		$ 450.00
Cell Phone 3		$ 450.00
Total	$ -	$ 1,350.00

FICA and FTE Benefits	AAMC/UM BWMC	DoAD
CM (LISW-C)-1 FTE	$ 13,978.00	
CM (Geriatric MH)-1 FTE	$ 13,978.00	
CM (RN)-1 FTE	$ 14,774.00	
CM (2 PT)	$ 5,251.00	
Total	$ 47,981.00	$ -

Growth Plan		
Diabetes Self Management		
Nutrition		
Total	$ -	$ -

Emergency Funds		
FFP Funding		$ 15,000.00
Hospital Match	$15,000.00	
Total	$ 15,000.00	$ 15,000.00

Total Expenses	AAMC/UM BWMC	DoAD
	$ 298,021.00	$ 27,250.00



Budget Exclusion/Resource Development

Certain budget exclusions exist as they do not support the Triage Team operations, however, are directly distributed on behalf of or to the individual based on presentation of critical needs. Examples of expenditures include: medications, adaptive equipment to live independently, clothing, dental care, emergency in-home care, BGE bills, etc. Exclusions include the contributions of social services resource entities, indiviudal-based non-profits grants achieved on bealf and to solely benefit the individual, senior care emergency funds, Friends of Arundel Seniors (FOAS) benefits distributed to the individual or vendor on behalf o f the individual, National Family Caregiver Support Program (NFCSP) individual grants to caregivers, and Federal Financial Participation (FFP) emergency funds budgeted at $15,000 per year for and determined by individuals and their presenting critical need.

Key Metrics and Projections

In order to evaluate the success of the Triage Team and impact on all three systems, the Triage Team will obtain and track monthly metrics congruent to objectives of support and will present effectiveness on a quarterly basis to all partners. The partners will evaluate and formulate metrics prior to inception and will test each for reliability and function at each quarter's end. Possible core measurements could include:

- *The number of 30-day readmissions (Medicaid, Medicare, and Dual-Eligible)*
- *The number of readmissions with age range*
- *Diagnosis associated with readmissions*
- *The number of emergency responses by geographical area*
- *Preventative outpatient quality indicators*
- *Average cost of a 30-day readmission*
- *Average cost of each EMS response (initial evaluation, transport, and time spent at the hospital)*
- *The number of super-utilizers of both systems (3 or more hospitalizations and 3 or more EMS calls in a 12 month period)*

The level of intensity in care coordination/case management is variable and dependent on personal circumstance, health (mental and physical), economic position, etc. Therefore, given the staffing of the current proposal and in doing a brief labor hour analysis, a range of deliverables can be projected. Given a 2 month period of coordination per case, labor hours can range from 15-30 hours dependent again on level of need and the variables listed above. The current staffing plan provides 6,996 labor hours/year across all positions. All labor hours cannot be counted to support case work as there will be CRICT meetings, planning, review, etc. Therefore, the current structure provides coordinating sustainable services for 350 individuals/year at 20 hours on average per caseload.

Population Growth and Demand: Triage Team Growth Plan

Anne Arundel County is standing on the precipice of a population doubling for the demographic of individuals aged 65 and older residing in our county. In 2010, 11.8% of Anne Arundel County residents were of age 65 and older. Projections to 2020 indicate that this population will almost double to 22.4% of the total county population age 65 and older. Source: Maryland Department of Planning, Projections & Data Analysis, May 2011. Furthermore, this growing demographic in our County is expected to continue rapid growth to the year 2040. The Department of Aging and Disabilities serves the county's population of seniors, adults having disabilities, and caregivers. This increase not only represents a significant change in the county environment, but for the Department of Aging and Disabilities represents a dramatic growth in the exact demographic we are mandated to serve. Additionally, as the 65 and older percent of the population grow, in tandem, the percent of family caregivers will also double requiring a higher percentage of services and supports through our department.

The populations of seniors are not only growing at rapid speed, but are generationally different from yesterday and todays senior. Visible trending in supports and services indicate that seniors and their caregivers in Anne Arundel County are requiring more support to age in place through assistance with short term case management, care transitioning, in-home supports, affordable day/respite programming, housing, crisis response, and most importantly education. These are current service gaps in both the public and private sector that are either not provided or provided to a small portion of the population that is Medicaid eligible or through private payment.

Looking forward, many opportunities for growth exist. This would be an excellent opportunity for our nursing and social work interns from the University of Maryland to get some hands on clinical experience. They would also have the unique opportunity to be part of an interdisciplinary team and witness how many different pieces of the puzzle must coordinate to provide the best care. Our Chronic Disease Management classes, available through the Department, are an invaluable resource, especially our Diabetic Self-Management and Nutrition programs. Through this partnership, we will be able to reach more clients to better educate them on the best ways to manage their health. This knowledge could help many clients avoid repeat trips to the ED and decrease emergency calls. Continuing with education, providing more opportunities for education for our caregiving clients would have numerous benefits as well. Many times, our caregivers are elderly as well, and providing them with support and education will help keep them healthy, as well as help to manage the health and well-being of the loved one for whom they are caring. In the future, the development of a PSA, as well as print advertisements would be essential in helping to spread the word to the community that the

Triage Team exists and is here to aid the aging and disabled population in our community. Working with area businesses and organizations to create and foster a dementia/aging friendly community would benefit everyone in our county. By providing resources and education to area businesses and certifying them as "dementia/aging friendly", we are creating an environment of support, patience and understanding that will benefit all of our potential target clients as well as the community as a whole. Another area for growth in the future is partnering with AACPS to create a support and education structure for children that are finding themselves in a caregiving role, as well as working with AACPS to deliver various opportunities to students interested in pursuing careers in healthcare to encourage them to choose a path towards helping the aging population.

Appendix F

HSCRC Core Return on Investment (ROI) Calculator								
Increase in # of patients each year			**400**		**647**		**646**	
High Utilizers Target #	**1260**		**1660**		**2307**		**2953**	
Table 3. Core Return on Investment Measures	**Medicare and Aged Dual-Eligibles**		**Additional Medicare (PSA)**		**Begin to address 'All Payer'**		**Address 'all payer'**	
	High Utilizers >=3 IP/Obs >=24 hours							
	2016		**2017**		**2018**		**2019**	
Number of Patients (total high utilizers - all payers)	2,120		2,120		2,953		2,953	
Number of Target Population	1,260		1,660		2,307		2,953	
Annual Intervention Cost/Patient Using HSCRC Funding	$ 3,183		$ 2,416		$ 1,738		$ 1,358	
Annual Intervention Cost (B*C) (Annual HSCRC Funding, not including incremental reinvestment of savings)	$ 4,010,576		$ 4,010,576		$ 4,010,576		$ 4,010,576	
Annual Charges (baseline)	$ 58,000,000		$ 76,360,000		$ 107,027,800		$ 137,648,200	
Annual Gross Savings (x% * E)	$ 9,280,000	**16%**	$ 11,454,000	**15%**	$ 12,843,336	**12%**	$ 13,764,820	**10%**
Variable Savings (F * 50%)	$ 4,640,000		$ 5,727,000		$ 6,421,668		$ 6,882,410	
Annual Net Savings (G-D)	$ 629,424		$ 1,716,424		$ 2,411,092		$ 2,871,834	
HSCRC Funding ROI (G / D)	1.157		1.428		1.601		1.716	
Strategy	2016: Begin several new interventions, focus on Medicare High Utilizers, 2+ chronic conditions in primary service area and aged Dual Eligibles		2017: First full year with all interventions in place. Continue and expand focus on Medicare High Utilizers, 2+ chronic conditions and aged Dual Eligibles in PSA		2018: Expand services to 'all payer' ie Medicaid. $400K extra AAMC available (CCN costs go away) Both hospitals reinvest in Care Management and other successful interventions, Leverage Payer infrastructure		2019: Expand services to additional all-payer high utilizers (commercial, other, self-pay) Leverage Payer infrastructure for Chronic Care Management, Reinvest in Care Management and other successful	

Appendix G Bay Area Transformation Partnership Work Plan

ID	Task Name	Work	Start	Finish	% Work Comple	% Comple	Predecessors	Resource Names
1		0 hrs			0%	0%		
2		0 hrs			0%	0%		
3	**HSCRC Deliverables**	**280 hrs**	**Mon 12/7/15**	**Mon 12/21/15**	**31%**	**39%**		
4	Submit Multi-Year Strategic Hospital Plan	80 hrs	Mon 12/7/15	Thu 12/10/15	50%	67%		Pat Czapp,Laurie Fetterman
5	Submit Regional Transformation Final Report	200 hrs	Mon 12/7/15	Fri 12/11/15	24%	24%		Cindy Gingrich,Pat Czapp,Laurie Fetterman,Becky Paesch,Heather Matheu,Renee Kilroy
6	Implementation RFP Due	0 hrs	Mon 12/21/15	Mon 12/21/15	0%	0%		
7	RFP Award Announcement (Feb)	0 hrs	Tue 2/2/16	Tue 2/2/16	0%	0%		
8	**Bay Area Transformation Partnership Work Plan**	**15,455.32 hrs**	**Wed 1/14/15**	**Sat 12/31/16**	**31%**	**15%**		
9	**BATP Planning Activities**	**4,605 hrs**	**Mon 7/20/15**	**Tue 12/13/16**	**93%**	**66%**		
10	**Gather Problem Statements**	**178 hrs**	**Mon 7/20/15**	**Tue 9/1/15**	**88%**	**94%**		
11	Basecamp Feedback - Hospitalists, IP Care Mgt, Comm Care Mgt, ED, Physician Practices, etc.	100 hrs	Mon 7/20/15	Mon 8/24/15	80%	80%		Pat Czapp,Hospitalists,DoAD,DSS,ChildrenYouth&Families AAMC,ED BWMC,IP Care Mgrs,TCC
12	Provider Focus Group 1	2 hrs	Wed 8/12/15	Wed 8/12/15	100%	100%		Pat Czapp,Providers AAMC
13	Provider Focus Group 2	2 hrs	Mon 7/20/15	Mon 7/20/15	100%	100%		Pat Czapp,Providers AAMC
14	Follow-up w/Comm Health Agencies re: Problems and Requiremer	20 hrs	Wed 8/26/15	Tue 9/15/15	100%	100%		Laurie Fetterman,Cindy Gingrich,Pat Czapp
15	Follow-up w/Behavioral Health re: Problems and Requirements	10 hrs	Wed 8/26/15	Tue 9/15/15	100%	100%		Sandeep Sidana,Ray Hoffman,PM Team
16	ED Focus Group	2 hrs	Mon 9/21/15	Mon 9/21/15	50%	50%		Pam Brown
17	Plan Strategies for Engaging Consumers (goals, metrics, roles/responsibilities, etc)	42 hrs	Thu 10/22/15	Thu 10/22/15	100%	100%		PFAC Advisory Committee,Pat Czapp,Heather Matheu,Renee' Kilroy,Cindy Gingrich,Laurie Fetterman,Becky Paesch
18	**Product Demo's**	**3 hrs**	**Wed 8/5/15**	**Wed 8/5/15**	**100%**	**100%**		
19	Healthy Planet	2 hrs	Wed 8/5/15	Wed 8/5/15	100%	100%		AA Analyst, AA Dir Amb, BATP PM, CRISP Tech Dir, UM_BW Tech Analyst
20	DocBook (secure text)	1 hr	Thu 9/10/15	Thu 9/10/15	100%	100%		Dave Mooradian,Pat Czapp,Hung Davis,DocBook Rep,Cindy Gingrich,BArbara,BArbara Baldwin,Renee Kilroy,Henry Archibong
21	**Project Management**	**848 hrs**	**Sat 8/15/15**	**Thu 9/3/15**	**68%**	**59%**		
22	**Planning**	**848 hrs**	**Tue 9/1/15**	**Tue 12/13/16**	**68%**	**59%**		
23	Identify Teams (PM, Governance, Advisory, etc)	48 hrs			0%	0%		Pat Czapp,Cindy Gingrich,Becky Paesch,Laurie Fetterman,Renee' Kilroy,Heather Matheu
24	Identify Project Teams (Care Alerting, Care Management, other)	40 hrs	**Tue 9/1/15**	**Sat 12/5/15**	100%	100%		Pat Czapp[20%],Heather Matheu[20%],Cindy Gingrich[20%],Laurie Fetterman[20%],Becky Paesch[20%]
25	Define Goals & Objectives for BATP and Subprojects	80 hrs	**Tue 9/1/15**	**Sat 12/5/15**	50%	66%		Pat Czapp[20%],Heather Matheu[20%],Cindy Gingrich[20%],Laurie Fetterman[20%],Becky Paesch[20%]
26	Define Scope for all subprojects	40 hrs	**Tue 9/1/15**	**Mon 9/7/15**	100%	100%		Pat Czapp[20%],Heather Matheu[20%],Cindy Gingrich[20%],Laurie Fetterman[20%],Becky Paesch[20%]
27	Coordinate with CRISP for all related work (SNF Rptg,MOU,CareAlerts/Plans)	80 hrs	Wed 9/16/15	Tue 2/16/16	40%	40%		Cindy Gingrich
28	Build BATP Work Plan	100 hrs	Tue 9/29/15	Tue 11/3/15	100%	100%		Cindy Gingrich,Project Teams
29	Develop Detailed Budget	200 hrs	Thu 10/1/15	Mon 12/5/16	100%	100%		Cindy Gingrich,Pat Czapp,Laurie Fetterman,Becky Paesch,Renee' Kilroy,Heather Matheu
30	Manage Sharing of Care Alerts / Care Plans Subproject	120 hrs	Tue 9/1/15	Tue 12/13/16	10%	10%		Cindy Gingrich
31	Develop Reports (Final Plan, RFP)	140 hrs	Thu 10/1/15	Mon 12/21/15	80%	80%		Cindy Gingrich,Pat Czapp,Laurie Fetterman,Becky Paesch,Renee' Kilroy,Heather Matheu
32	**BATP Subproject Analysis and Design**	**2,945 hrs**	**Mon 8/10/15**	**Mon 11/30/15**	**100%**	**100%**		
33	Gather Role-specific Business Requirements (from BATP problem identification and discussions)	200 hrs	Mon 8/17/15	Fri 9/25/15	100%	100%		Cindy Gingrich,Pat Czapp,PM Team,Carol Marsiglia,Chris Crabbs,Chris DeBorja,Heather Matheu,Joel Klein,Karrisa Gouin (DoAD),Kristi Lanciotti,Laurie Fetterman,Min Kim,Pam Brown,Pam Hinshaw,Paul Thompson,Ray Hoffman,Renee' Kilroy,Ryan Bramble,Sandeep Sidana
34	Review Scope and Requirements with Stakeholders & Obtain Sign-	0 hrs	Fri 9/4/15	Fri 10/30/15	100%	100%		
35	Determine Target Patient Population	2,544 hrs	Thu 9/17/15	Mon 11/30/15	100%	100%		Becky Paesch,Chris DeBorja,Cindy Gingrich,Laurie Fetterman,Pat Czapp,Rebecca Altman
36	Identify technical solutions/options that align with business requirements	200 hrs	Mon 8/10/15	Fri 8/14/15	100%	100%		AA Dir Amb,Dave Lehr,Paul Thompson,Ryan Bramble,Steve Caramanico
37	Obtain Clinical Stakeholder Signoff on proposed solution (Care Alerts)	1 hr	Thu 10/15/15	Thu 10/15/15	100%	100%		AA Analyst, AA Dir Amb,Cindy Gingrich,Dave Lehr,Heather Matheu,Joel Klein,Pat Czapp,Renee' Kilroy
38	**Care Alert Planning**	**328 hrs**	**Wed 9/9/15**	**Fri 10/16/15**	**100%**	**100%**		
39	Mtg 1 - Review requirements and discuss high-level solutions	56 hrs	Wed 9/9/15	Wed 9/9/15	100%	100%		CRISP Tech Analyst, CRISP Tech Dir, BATP PM, UM_BW Tech Analyst, AA Analyst, AA Dir Amb,AA Tech Analyst
40	Mtg 2 - Continue tech solution review	56 hrs	Tue 9/29/15	Tue 9/29/15	100%	100%		CRISP Tech Analyst, CRISP Tech Dir, BATP PM, UM_BW Tech Analyst, AA Analyst, AA Dir Amb,AA Tech Analyst
41	Mtg 3 - Firm-up tech solutions and estimates	56 hrs	Wed 9/9/15	Wed 9/9/15	100%	100%		AA Tech Analyst, AA Dir Amb, AA Analyst, UM_BW Tech Analyst, BATP PM, CRISP Tech Dir, CRISP Tech Analyst
42	Mtg 4 - Present to Stakeholders for feedback and approval	56 hrs	Wed 9/9/15	Wed 9/9/15	100%	100%		AA Tech Analyst, AA Dir Amb, AA Analyst, UM_BW Tech Analyst, BATP PM, CRISP Tech Dir, CRISP Tech Analyst
43	Weekly Care Alert/Care Plan Tech Team Meetings	56 hrs	Wed 9/9/15	Wed 9/9/15	100%	100%		Joel Klein, AA Analyst, AA Dir Amb, BATP PM,Dave Lehr,Paul Thompson,Steve Caramanico
44	**Care Plan Requirements Gathering**	**48 hrs**	**Thu 9/17/15**	**Fri 10/16/15**	**100%**	**100%**		
45	Mtg 1 - Gather Care Plan Requirements (Content, format, UI design)	40 hrs	Thu 9/17/15	Thu 9/17/15	100%	100%		AA Analyst, AA Dir Amb, BATP PM,Pat Czapp, CRISP Tech Dir,Karrisa Gouin (DoAD),Beth Tingo,Pam Hinshaw,Chris Crabbs,Carol Marsiglia
46	Mtg 2 - Analysis of Cross-Organizational Care Plan data needs	2 hrs	Thu 10/15/15	Thu 10/15/15	100%	100%		AA Analyst, AA Dir Amb, BATP PM,Pat Czapp, CRISP Tech Dir,Karrisa Gouin (DoAD),Beth Tingo,Pam Hinshaw,Chris Crabbs,Carol Marsiglia
47	Mtg 3 - Determine work plan & budget for 2016	6 hrs	Fri 10/16/15	Fri 10/16/15	100%	100%		AA Analyst, AA Dir Amb, BATP PM,Pat Czapp, CRISP Tech Dir
48	**Data Analytics / Risk Stratification**	**303 hrs**	**Thu 9/10/15**	**Mon 11/23/15**	**97%**	**88%**		

ID	Task Name	Work	Start	Finish	% Work Comple	% Comple	Predecessors	Resource Names
49	AAMC Analytics Planning Mtg	6 hrs	Thu 9/10/15	Thu 9/10/15	100%	100%		Pat Czapp,Heather Matheu,Cindy Gingrich,Dave Lehr,Brian MacElroy,Renee' Kilroy
50	Determine Metrics for Care Alert and Care Plan Populations	240 hrs	Mon 11/2/15	Fri 11/6/15	100%	100%		Pat Czapp,Heather Matheu,Cindy Gingrich,Dave Lehr,Brian MacElroy,Renee' Kilroy, AA Dir Amb
51	AAMC Plan Registry for High Utilizers	40 hrs	Fri 9/25/15	Thu 10/8/15	80%	80%		Dave Lehr[50%]
52	Review of CRISP Reports and Capabilities (CRS, Tableau)	8 hrs	Thu 9/10/15	Thu 9/10/15	100%	100%		Dave Lehr,Cindy Gingrich,Daniel Donaldson
53	**Engage BRG for Data Analytics (Hospital data)**	**9 hrs**	**Wed 11/4/15**	**Wed 11/4/15**	**100%**	**99%**		**Cindy Gingrich,Rebecca Altman,Pat Czapp,Kathy Fridley**
54	BRG Delivered Baseline Hospital Metrics	0 hrs	Wed 11/4/15	Wed 11/4/15	100%	100%		Rebecca Altman
55	Review of BRG Report w/BATP Leadership	1 hr	Mon 11/23/15	Mon 11/23/15	100%	100%		Pat Czapp,Mitch Schwartz,Bob Riley,Cindy Gingrich,Laurie Fetterman,Becky Paesch,Kathy McCollum,Al Pietsch,Chris DeBorja
56	**BATP Implementation Work Streams**	**10,850.32 hrs**	**Wed 1/14/15**	**Sat 12/31/16**	**4%**	**5%**		
57	**Shared Care Alerts and Shared Care Plans**	**4,775.6 hrs**	**Tue 9/22/15**	**Sat 12/31/16**	**8%**	**13%**		
58	Care Alert/Care Plan Tech Team Meetings	300 hrs	Thu 11/12/15	Sat 12/31/16	100%	100%		Joel Klein, AA Analyst, AA Dir Amb, BATP PM,Dave Lehr,Paul Thompson,Steve Caramanico
59	**Technical Requirements & CRISP Environment Prep**	**285 hrs**	**Tue 9/22/15**	**Mon 5/30/16**	**31%**	**23%**		
60	Gather Requirements for Care Alert send/receive messages from AAMC & BWMC	10 hrs	Tue 9/22/15	Tue 9/22/15	100%	100%		AA Analyst, AA Dir Amb, BATP PM, CRISP Tech Dir, UM_BW Tech Analyst,AA Tech Analyst
61	CRISP Build Repository for Care Alerts and Plans	80 hrs	Sun 11/1/15	Mon 12/7/15	80%	80%		Mirth Eng
62	CRISP Develop Mirth channels and Interface Engine IP/Ports	40 hrs	Mon 12/7/15	Fri 12/18/15	38%	75%		CRISP Eng,Steve Caramanico
63	QA Testing for receipt and sending of Care Alerts	55 hrs	Fri 12/25/15	Sat 1/30/16	0%	0%		CRISP Tech Analyst, UM_BW Tech Analyst,AA Tech Analyst
64	QA Testing for receipt and sending of Care Plans	100 hrs	Tue 3/1/16	Mon 5/30/16	0%	0%		CRISP Tech Analyst, UM_BW Tech Analyst,AA Tech Analyst
65	**AAMC Care Alerts and Care Plans**	**2,190.6 hrs**	**Tue 12/1/15**	**Sat 12/31/16**	**0%**	**0%**		
66	Develop Care Alert Training Material	8 hrs	Tue 12/1/15	Wed 12/23/15	0%	0%		Pat Czapp,Joel Klein,AA Trainer
67	Care Alert Entry in AAMC Epic Start	0 hrs	Mon 1/4/16	Mon 1/4/16	0%	0%		
68	Create Print Groups	130 hrs	Mon 1/4/16	Fri 1/29/16	0%	0%		AA Analyst,AA Mgr,AA Tester,AA Trainer,AA Physician
69	Setup AAMC Test Environment CareEverywhere to CRISP Intf Er	10 hrs	Mon 12/14/15	Fri 12/18/15	0%	0%		AA Analyst,AA Mgr
70	Test care alert CCD Exchange to/from CRISP	55 hrs	Mon 1/4/16	Fri 1/8/16	0%	0%		AA Analyst,AA Mgr,AA Tester,AA Trainer,AA Physician
71	AA Move CCD sending to prod	11 hrs	Mon 1/11/16	Sat 1/30/16	0%	0%	70	AA Analyst,AA Mgr,AA Tester,AA Trainer,AA Physician
72	*Go-Live Shared Care Alerts (AAMC)*	26 hrs	Fri 1/29/16	Fri 1/29/16	0%	0%		Dave Lehr,CRISP Eng,Justin Clites,Paul Thompson
73	Build Care Management Registry	74 hrs	Mon 1/4/16	Fri 2/26/16	0%	0%		AA Analyst,AA Mgr,AA Tester,AA Trainer,AA Physician
74	Build workqueue reports in RW	56 hrs	Mon 2/1/16	Fri 2/26/16	0%	0%		AA Analyst,AA Mgr,AA Tester,AA Trainer,AA Physician
75	Evaluate changes to CareEverywhere settings	22 hrs	Mon 1/4/16	Mon 1/11/16	0%	0%		
76	AAMC Build and training for LPOC (CARE PLANS)	706 hrs	Mon 1/4/16	Fri 2/12/16	0%	0%		AA Analyst,AA Mgr,AA Tester,AA Physician
77	Radar Dashboard Design Build and Security updates	175 hrs	Mon 2/1/16	Fri 3/18/16	0%	0%		AA Analyst,AA Mgr,AA Tester, BATP PM,CRISP Eng
78	Navigator Changes	410 hrs	Mon 2/1/16	Fri 2/19/16	0%	0%		AA Analyst,AA Mgr,AA Tester, BATP PM,CRISP Eng
79	Update Patient headers, lists and flags	100 hrs	Mon 2/1/16	Fri 2/19/16	0%	0%		AA Analyst,AA Mgr,AA Tester, BATP PM,CRISP Eng
80	Communication Management Activity	9.6 hrs	Mon 2/1/16	Fri 2/19/16	0%	0%		AA Analyst,AA Mgr, BATP PM,CRISP Eng
81	Ongoing BATP Team meetings	108 hrs	Fri 1/1/16	Sat 12/31/16	0%	0%		AA Analyst, BATP PM, CRISP Tech Analyst, UM_BW Tech Analyst,AA Tech Analyst
82	Ongoing creation, maintenance and reporting of Care Alerts	100 hrs	Mon 1/4/16	Sat 12/31/16	0%	0%		AA Physicians, AA Analyst
83	QA Testing for receipt and sending of Care Plans	150 hrs	Tue 3/15/16	Wed 3/23/16	0%	0%		CRISP Tech Analyst, UM_BW Tech Analyst,AA Tech Analyst
84	Go-Live Shared Care Plans (AAMC)	40 hrs	Thu 6/30/16	Thu 6/30/16	0%	0%		AA Analyst,AA Mgr,AA Tester, BATP PM,CRISP Eng
85	**BWMC Care Alerts and Care Plans**	**1,848 hrs**	**Sat 1/2/16**	**Fri 7/1/16**	**0%**	**0%**		
86	**UMMS_BW Sending / Receiving CCDs to/from CRISP**	**562 hrs**	**Mon 1/4/16**	**Mon 2/1/16**	**0%**	**0%**		**UM_BW Tech Analyst**
87	Analysis and Design	45 hrs	Sat 1/2/16	Mon 2/1/16	0%	0%		UM_BW Vince
88	Build	20 hrs	Sat 1/2/16	Mon 2/1/16	0%	0%		UM_BW Paul's Team
89	Integrated testing	25 hrs	Mon 2/1/16	Tue 2/16/16	0%	0%		UM_BW Paul's Team
90	**UMMS Care Alert Work**	**382 hrs**	**Sat 1/2/16**	**Wed 3/30/16**	**0%**	**0%**		
91	Analysis and Design	80 hrs	Sat 1/2/16	Mon 2/1/16	0%	0%		UM_BW Paul's Team
92	Build	40 hrs	Sat 1/2/16	Mon 2/1/16	0%	0%		UM_BW Paul's Team
93	Develop Care Alert Content	40 hrs	Sat 1/2/16	Mon 2/1/16	0%	0%		UM_BW Paul's Team
94	Unit testing	60 hrs	Sat 1/2/16	Mon 2/1/16	0%	0%		UM_BW Paul's Team
95	Integrated testing	60 hrs	Mon 2/1/16	Tue 2/16/16	0%	0%		UM_BW Paul's Team
96	Training Development and Execution	16 hrs	Mon 2/1/16	Mon 2/15/16	0%	0%		UM_BW Paul's Team
97	Communication Development and Execution	16 hrs	Mon 2/1/16	Mon 2/15/16	0%	0%		UM_BW Paul's Team
98	*UM BWMC Go-live Shared Care Alerts*	20 hrs	Tue 3/15/16	Tue 3/15/16	0%	0%		UM_BW Paul's Team
99	Maintenance and Support	40 hrs	Wed 3/16/16	Wed 3/30/16	0%	0%	98	UM_BW Paul's Team
100	Evaluation	10 hrs	Wed 3/16/16	Wed 3/16/16	0%	0%	98	
101	**UMMS_BW Care Plan Analysis & Build**	**282 hrs**	**Sat 1/2/16**	**Thu 6/30/16**	**0%**	**0%**		UM_BW Paul's Team
102	Analysis and Design	20 hrs	Sat 1/2/16	Tue 3/15/16	0%	0%		UM_BW Paul's Team
103	Build	80 hrs	Sat 1/2/16	Tue 3/15/16	0%	0%		UM_BW Paul's Team
104	Unit testing	40 hrs	Sat 1/2/16	Tue 3/15/16	0%	0%		UM_BW Paul's Team
105	Integrated testing	40 hrs	Sat 1/2/16	Tue 3/15/16	0%	0%		UM_BW Paul's Team
106	Training Development and Execution	16 hrs	Sat 1/2/16	Tue 3/15/16	0%	0%		UM_BW Paul's Team
107	Communication Development and Execution	16 hrs	Sat 1/2/16	Tue 3/15/16	0%	0%		UM_BW Paul's Team
108	*UMBW Go-live Shared Care Plans*	20 hrs	Thu 6/30/16	Thu 6/30/16	0%	0%		UM_BW Paul's Team
109	Maintenance and Support	40 hrs			0%	0%		UM_BW Paul's Team
110	Evaluation	10 hrs			0%	0%		UM_BW Paul's Team
111	**UM BWMC Analytics and Reporting for Care Alerts and Care Pl**	**662 hrs**	**Sat 1/2/16**	**Fri 7/1/16**	**0%**	**0%**		
112	Create Reports to track Care Alert metrics (utilization and cost before and after Care Alerts were created for each patient) - monthly	100 hrs	Sat 1/2/16	Fri 4/29/16	0%	0%		CRISP Report Analyst,UMBW Report Writer,Clarity Admin
113	Implement Healthy Planet Transitions of Care	100 hrs	Sat 1/2/16	Thu 6/30/16	0%	0%		ASAP,Inpatient Team Mbr
114	Create Registry or predictive logic for Patients who should have Care Alerts	100 hrs	Sat 1/2/16	Thu 6/30/16	0%	0%		Metrics Programmer
115	Create Registry for Emergency Encounters and Inpatient Encounters	60 hrs			0%	0%		ASAP,Inpatient Team Mbr

ID	Task Name	Work	Start	Finish	% Work Comple	% Comple	Predecessors	Resource Names
116	Create Registry's for contributing Chronic Diseases	120 hrs	Sat 1/2/16	Thu 6/30/16	0%	0%		Ambulatory Team member
117	Unit testing	40 hrs	Mon 5/2/16	Thu 6/30/16	0%	0%		ASAP,Inpatient Team Mbr,UMBW Tester
118	Integrated testing	40 hrs	Mon 5/2/16	Thu 6/30/16	0%	0%		ASAP,Inpatient Team Mbr,UMBW Tester,Ambulatory Team member
119	Training Development and Execution	16 hrs	Mon 5/2/16	Thu 6/30/16	0%	0%		ASAP,Inpatient Team Mbr,Ambulatory Team member,UMBW Technical Writers
120	Communication Development and Execution	16 hrs	Mon 5/2/16	Thu 6/30/16	0%	0%		UMBW Project Mgr
121	*UMMS Analytics Go-live / Production*	**20 hrs**	**Wed 6/1/16**	**Wed 6/1/16**	**0%**	**0%**		ASAP,Inpatient Team Mbr,UMBW Tester,UM_BW Paul's Team
122	Maintenance and Support	40 hrs	Thu 6/2/16	Fri 6/10/16	0%	0%	121	ASAP,Inpatient Team Mbr
123	Evaluation	10 hrs	Wed 6/1/16	Fri 7/1/16	0%	0%	121	Ambulatory Team member
124	**Single Signon to CRISP Portal from Epic**	**342 hrs**	**Sat 1/2/16**	**Mon 2/15/16**	**0%**	**0%**		
125	Analysis and Design	20 hrs	Sat 1/2/16	Mon 2/1/16	0%	0%		Paul Thompson
126	Build EPIC	80 hrs	Sat 1/2/16	Mon 2/1/16	0%	0%		Ambulatory Team member,ASAP
127	Build UMMS	40 hrs	Sat 1/2/16	Mon 2/1/16	0%	0%		Ambulatory Team member,ASAP
128	Integration Team Unit testing	40 hrs	Mon 2/1/16	Mon 2/15/16	0%	0%		ASAP,Inpatient Team Mbr,UMBW Tester,Ambulatory Team member
129	Application Team Unit testing	40 hrs	Mon 2/1/16	Mon 2/15/16	0%	0%		ASAP,Inpatient Team Mbr,UMBW Tester,Ambulatory Team member
130	Integrated testing	16 hrs	Mon 2/1/16	Mon 2/15/16	0%	0%		ASAP,Inpatient Team Mbr,UMBW Tester,Ambulatory Team member
131	Training Development and Execution	16 hrs	Mon 2/1/16	Mon 2/15/16	0%	0%		ASAP,Inpatient Team Mbr,Ambulatory Team member,UMBW Technical Writers
132	Communication Development and Execution	20 hrs	Mon 2/1/16	Mon 2/15/16	0%	0%		UMBW Project Mgr
133	UMMS Single Signon Go-live / Production	20 hrs			0%	0%		ASAP,Inpatient Team Mbr,Ambulatory Team member,UMBW Technical Writers
134	Maintenance and Support	40 hrs			0%	0%		ASAP,Inpatient Team Mbr
135	Evaluation	10 hrs			0%	0%		Ambulatory Team member
136	**UM BWMC Hire Care Alert Resources**	**152 hrs**	**Tue 12/1/15**	**Wed 5/11/16**	**0%**	**0%**		
137	Write Job Descriptions	8 hrs	Tue 12/1/15	Thu 12/31/15	0%	0%		Laurie Fetterman
138	Post Positions via HR	4 hrs	Wed 2/3/16	Wed 2/3/16	0%	0%		Laurie Fetterman[50%]
139	Hire Behavioral Health Care Plan Creator	20 hrs	Mon 5/2/16	Mon 5/2/16	0%	0%	138FS+60 days	Laurie Fetterman,Chris DeBorja,Mary Joswik
140	Hire Risk Care Plan Creator	40 hrs	Mon 5/2/16	Wed 5/4/16	0%	0%	138FS+60 days	Beth Tingo,Laurie Fetterman
141	Hire Admin Assistant	40 hrs	Mon 5/2/16	Wed 5/4/16	0%	0%		Beth Tingo,Laurie Fetterman
142	Train BH and High Risk Care on Care Alert/Plan Creation	40 hrs	Wed 5/4/16	Wed 5/11/16	0%	0%	141	Beth Tingo
143	**CRISP Connect BATP Ambulatory Practices & SNFs to ENS & Clinical Portal**	**322 hrs**	**Thu 1/29/15**	**Fri 3/11/16**	**0%**	**0%**		
144	Identify Ambulatory & SNFs for 2016 ENS/Clinical Portal connectiv	32 hrs	Fri 10/30/15	Fri 10/30/15	0%	0%		Pat Czapp,Beth Tingo,Becky Paesch,Laurie Fetterman
145	Contact SNFs and Ambulatory Practices	30 hrs	Tue 12/15/15	Sun 1/31/16	0%	0%		CRISP Eng
146	Build Work Plan for connecting SNFs and Ambulatory Practices	20 hrs	Thu 1/29/15	Sat 1/31/15	0%	0%		CRISP PM
147	Connect 80% of BATP provided list (Amb Practices and SNFs)	200 hrs	Mon 2/15/16	Fri 3/11/16	0%	0%		CRISP Eng
148	Train SNFs & Ambulatory on ENS	40 hrs	Mon 2/2/15	Tue 6/30/15	0%	0%		CRISP Trainer
149	**CRISP / BATP SNF Reporting Pilot Project**	**399.72 hrs**	**Thu 10/15/15**	**Sat 12/31/16**	**0%**	**0%**		
150	Contact SNFs and Explain the initiative	8 hrs	Sun 11/1/15	Thu 11/5/15	0%	0%		Pat Czapp,Beth Tingo
151	Provide list of SNFs to CRISP	8 hrs	Thu 10/15/15	Sun 11/1/15	0%	0%		Pat Czapp,Beth Tingo
152	Provide draft report requirements to CRISP	10 hrs	Thu 10/15/15	Sun 11/1/15	0%	0%		Cindy Gingrich,Pat Czapp,Pam Hinshaw,Beth Tingo
153	CRISP onboard SNFs to ENS	200 hrs	Sat 1/2/16	Thu 6/30/16	0%	0%		CRISP Eng
154	CRISP Develop Reports	80 hrs	Fri 1/15/16	Thu 3/31/16	0%	0%		CRISP Report Analyst
155	CRISP Deliver SNF Reports	8 hrs	Thu 3/31/16	Thu 3/31/16	0%	0%		CRISP Report Analyst
156	AAMC / UM BWMC Use Reports to Track SNF Activity and inform improvements	85.72 hrs	Fri 4/1/16	Sat 12/31/16	0%	0%		Pat Czapp,Pam Hinshaw,Beth Tingo,Renee Kilroy,SNFs
157	**Data Analytics / Risk Stratification**	**500 hrs**	**Wed 11/4/15**	**Fri 12/30/16**	**0%**	**0%**		
158	BRG Delivered Baseline Hospital Metrics	0 hrs	Wed 11/4/15	Wed 11/4/15	100%	100%		Rebecca Altman
159	BRG Deliver Quarterly BATP Reports	200 hrs	Thu 3/31/16	Fri 12/30/16	0%	0%		Rebecca Altman
160	AAMC/UMMS/BWMC/BRG Data Analytics Team Mtgs	300 hrs	Thu 11/10/16	Fri 12/30/16	0%	0%		Cindy Gingrich[0%],Daniel Donaldson[0%],Dave Lehr[0%],Laurie Fetterman[0%],Rebecca Altman[0%],Albert Zanger
161	**Joint Patient & Family Engagement**	**294 hrs**	**Wed 10/21/15**	**Sat 12/31/16**	**0%**	**0%**		
162	Develop PFAC presentation to gather feedback	6 hrs	Wed 10/21/15	Thu 10/22/15	0%	0%		Pat Czapp,Cindy Gingrich
163	Document meeting minutes & distribute	8 hrs	Fri 10/23/15	Fri 10/23/15	0%	0%		Cindy Gingrich
164	Incorporate PFAC Feedback into BATP subprojects	80 hrs	Wed 10/28/15	Sat 12/31/16	0%	0%		Cindy Gingrich,Pat Czapp,Laurie Fetterman,Renee Kilroy,Becky Paesch
165	Hold Joint PFAC Committee Mtgs in 2016	200 hrs	Mon 1/4/16	Sat 12/31/16	0%	0%		PFAC AAMC,PFAC BWMC
166	**Develop Governance Structure**	52 hrs	Fri 9/11/15	Fri 11/6/15	54%	2%		
167	Mtg # 1 - BATP Governance Planning Discussion BWMC/AAMC	1 hr	Fri 9/11/15	Fri 9/11/15	100%	100%		Bob Riley,Al Pietsch,Chris DeBorja,Kathy McCollum,Mitch Schwartz,Pat Czapp
168	Mtg # 2 - BATP Governance Planning - Structure, MOU Arrangements	1 hr	Fri 10/16/15	Fri 10/16/15	100%	100%		Bob Riley,Al Pietsch,Chris DeBorja,Kathy McCollum,Mitch Schwartz,Pat Czapp
169	Mtg # 3 - BATP Governance - Review of budgets, MOU status, ROI	1 hr	Tue 10/20/15	Fri 10/23/15	100%	100%		Bob Riley,Al Pietsch,Chris DeBorja,Kathy McCollum,Mitch Schwartz,Pat Czapp
170	Develop MOU w/legal (Hospitals & 3rd party)	4 hrs	Tue 10/20/15	Tue 10/20/15	100%	100%		Bob Riley,Al Pietsch
171	Identify Advisory Council	1 hr	Mon 11/30/15	Mon 11/30/15	100%	100%		PM Team
172	Draft MOU's	20 hrs	Thu 11/26/15	Thu 11/26/15	100%	100%		Bob Riley,Al Pietsch,Legal
173	Hold Quarterly Meetings	24 hrs	Fri 1/1/16	Sat 12/31/16	0%	0%		Bob Riley,Al Pietsch,Kathy McCollum,Chris DeBorja,Pat Czapp,Mitch Schwartz,Cindy Gingrich
174	**Ambulatory Care Support Projects**	**1,087 hrs**	**Wed 1/14/15**	**Thu 7/14/16**	**0%**	**0%**		
175	**One Call Care Management**	**265 hrs**	**Wed 1/14/15**	**Wed 6/1/16**	**0%**	**0%**		
176	Write LCSW Job Descriptions	4 hrs	Mon 12/14/15	Thu 12/31/15	0%	0%		Chris Crabbs
177	Post LCSW Positions w/ HR	5 hrs	Wed 2/3/16	Wed 2/3/16	0%	0%	7FS+1 day	Chris Crabbs[62%]
178	Prepare office space (desks, computers, phones)	28 hrs	Thu 2/4/16	Thu 2/4/16	0%	0%	177FS+1 day	IT,Facilities
179	Develop One Call algorithms (call triage)	20 hrs	Wed 1/14/15	Mon 2/15/16	0%	0%	176FS+5 days	Chris Crabbs,Pat Czapp
180	Hire LCSW AAMC	8 hrs	Tue 4/26/16	Tue 4/26/16	0%	0%	7FS+3 mons	Chris Crabbs

ID	Task Name	Work	Start	Finish	% Work Comple	% Comple	Predecessors	Resource Names
181	Perform Training (Cross-organization) Epic, IP Care Mgt, Call Ctr Ops, Govt Agency, TCC	80 hrs	Tue 4/26/16	Thu 5/26/16	0%	0%	180	Chris Crabbs,Debbie Roper, AA Analyst,Pam Hinshaw,TCC,Karrisa Gouin,DSS
182	Develop educational material for PCPs	40 hrs			0%	0%		LCSW
183	Educate PCPs on new One Call service	80 hrs			0%	0%		LCSW
184	Go-Live One Call Care Management	0 hrs	Wed 6/1/16	Wed 6/1/16	0%	0%	181FS+3 day	
185	**Ambulatory Care Quality Coordinators**	**145 hrs**	**Tue 12/1/15**	**Tue 6/28/16**	**0%**	**0%**		
186	Write Quality Coordinator (MA) Job Descriptions	0 hrs	Tue 12/1/15	Wed 12/30/15	0%	0%		
187	Post Positions via HR	5 hrs	Wed 2/3/16	Wed 2/3/16	0%	0%	7FS+1 day	
188	Arrange office space (desks, computers, phones)	20 hrs	Thu 2/4/16	Thu 2/4/16	0%	0%	187FS+1 day	
189	Hire 4 QCs	80 hrs	Tue 3/1/16	Wed 5/25/16	0%	0%	187FS+1 day	Chris Crabbs[8%],Renee' Kilroy,Pat Czapp
190	Train QCs (Epic, dashboards, registries, patient follow-up)	40 hrs	Thu 5/26/16	Mon 6/27/16	0%	0%	189	
191	Start Quality Coordinators in Clinics	0 hrs	Tue 6/28/16	Tue 6/28/16	0%	0%	190	
192	**Dept of Aging & Disabilities Senior Triage Team**	**308 hrs**	**Wed 1/13/16**	**Wed 6/1/16**	**0%**	**0%**		
193	Develop Material for Senior Triage Team	40 hrs	Mon 1/25/16	Fri 1/29/16	0%	0%		Karrisa Gouin (DoAD)
194	Write Job Descriptions	20 hrs	Wed 1/13/16	Fri 1/15/16	0%	0%		Karrisa Gouin (DoAD)
195	Hire RN Clinical Case Manager	40 hrs	Tue 4/26/16	Mon 5/2/16	0%	0%	7FS+60 days	Karrisa Gouin (DoAD)
196	Hire Geriatric Mental Health Case Manager	40 hrs	Tue 4/26/16	Mon 5/2/16	0%	0%	7FS+60 days	Karrisa Gouin (DoAD)
197	Hire Geriatric Social Worker LCSW-C	40 hrs	Tue 4/26/16	Mon 5/2/16	0%	0%	7FS+60 days	Karrisa Gouin (DoAD)
198	Hire part-time Case Manager	20 hrs	Tue 4/26/16	Thu 4/28/16	0%	0%	7FS+60 days	Karrisa Gouin (DoAD)
199	Hire part-time Case Manager	20 hrs	Tue 4/26/16	Thu 4/28/16	0%	0%	7FS+60 days	Karrisa Gouin (DoAD)
200	**Train Senior Triage Team**	**88 hrs**	**Tue 5/10/16**	**Wed 6/1/16**	**0%**	**0%**		
201	DoaD Service/Support Training	16 hrs	Tue 5/10/16	Tue 5/10/16	0%	0%	195FS+5 days	Karrisa Gouin (DoAD),Sr. Triage Team
202	Epic Training	24 hrs	Wed 5/11/16	Wed 5/11/16	0%	0%	201	Debbie Roper, AA Analyst,Sr. Triage Team
203	The Coordinating Center Training	16 hrs	Thu 5/12/16	Thu 5/12/16	0%	0%	202	Sr. Triage Team,TCC
204	BWMC-specific Training	16 hrs	Fri 5/13/16	Fri 5/13/16	0%	0%	203	Sr. Triage Team,Beth Tingo
205	AAMC-specific Training	16 hrs	Mon 5/16/16	Mon 5/16/16	0%	0%	204	Sr. Triage Team,Pam Hinshaw
206	Begin Senior Triage Team Case Management	0 hrs	Wed 6/1/16	Wed 6/1/16	0%	0%		
207	**Integrating and Coordinating Physical and Behavioral Health**	**369 hrs**	**Wed 9/23/15**	**Thu 7/14/16**	**1%**	**1%**		
208	Transformation Webinar # 8 - Behavioral Health	1 hr	Thu 9/24/15	Thu 9/24/15	100%	100%		MHA
209	Obtain feedback from ED Focus Group	2 hrs	Wed 9/23/15	Wed 9/23/15	100%	100%		Pam Brown,Cindy Gingrich,Laurie Fetterman
210	Meet w/Behavioral Health Leadership re: BH Scope for CY2016 (& beyond)	2 hrs	Fri 10/9/15	Fri 10/9/15	100%	100%		Dwight Holmes, MD,Sandeep Sidana,Ray Hoffman,Shirley Knelly
211	**AAMC LCSW Support**	**66 hrs**	**Tue 12/1/15**	**Wed 5/25/16**	**0%**	**0%**		
212	Write Job Description	4 hrs	Tue 12/1/15	Fri 1/15/16	0%	0%		Dawn Hurley
213	Post Position	2 hrs	Wed 2/3/16	Wed 2/3/16	0%	0%	7FS+1 day	Dawn Hurley
214	Hire LCSW	20 hrs	Thu 4/28/16	Thu 4/28/16	0%	0%	213FS+60 days	Dawn Hurley
215	Training	40 hrs	Fri 5/20/16	Tue 5/24/16	0%	0%	214FS+15 days	LCSW,Dawn Hurley
216	AAMC Start Behavioral Health Service in Clinics	0 hrs	Tue 5/24/16	Wed 5/25/16	0%	0%	215	
217	**BWMC Behavioral Health Subproject**	**208 hrs**	**Tue 12/1/15**	**Thu 7/14/16**	**0%**	**0%**		
218	Write Job Descriptions	4 hrs	Tue 12/1/15	Fri 1/15/16	0%	0%		Sandeep Sidana[1%]
219	Post Positions via HR	4 hrs	Wed 2/3/16	Wed 2/3/16	0%	0%	7FS+1 day	Laurie Fetterman[50%]
220	Hire Psychiatrist	160 hrs	Thu 6/23/16	Wed 7/6/16	0%	0%	219FS+5 mons	Sandeep Sidana,Dwight Holmes
221	Hire Therapists (2)	20 hrs	Thu 3/31/16	Mon 4/4/16	0%	0%	219FS+2 mons	Laurie Fetterman
222	Hire Admin Assistants (2)	20 hrs	Thu 3/31/16	Mon 4/4/16	0%	0%	219FS+2 mons	Laurie Fetterman
223	Training	0 hrs	Mon 4/25/16	Tue 4/26/16	0%	0%	221FS+15 da	
224	BWMC Begin Therapy Services in Clinics	0 hrs	Tue 4/26/16	Wed 4/27/16	0%	0%	223	
225	BWMC Begin Psychiatrist Services in Clinics	0 hrs	Thu 7/14/16	Thu 7/14/16	0%	0%	220FS+5 day	
226	**AAMC Behavioral Health Navigator Program**	**90 hrs**	**Tue 12/1/15**	**Tue 5/31/16**	**0%**	**0%**		
227	Write Job Descriptions (BH Navigator & Referral Specialist)	8 hrs	Tue 12/1/15	Fri 1/15/16	0%	0%		Dawn Hurley[3%]
228	Post Positions	2 hrs	Wed 2/3/16	Wed 2/3/16	0%	0%	7FS+1 day	Dawn Hurley[25%]
229	Hire Behavioral Health Navigator	20 hrs	Thu 4/28/16	Mon 5/2/16	0%	0%	228FS+60 days	Dawn Hurley
230	Hire Referral Specialist	20 hrs	Thu 4/28/16	Mon 5/2/16	0%	0%	228FS+60 days	Dawn Hurley
231	Training	40 hrs	Thu 5/26/16	Fri 5/27/16	0%	0%	230	LCSW[83%],Ref Spec[83%],Dawn Hurley[83%]
232	AAMC Start Behavioral Health Navigator Service in Clinics	0 hrs	Mon 5/30/16	Tue 5/31/16	0%	0%	231	
233	**BWMC Hire Population Health Manager**	**30 hrs**	**Tue 12/1/15**	**Mon 5/2/16**	**0%**	**0%**		
234	Write Job Description	6 hrs	Tue 12/1/15	Tue 12/1/15	0%	0%		Laurie Fetterman
235	Post Positions via HR	4 hrs	Wed 2/3/16	Wed 2/3/16	0%	0%	7FS+1 day	Laurie Fetterman[50%]
236	BWMC Hire Population Health Manager	20 hrs	Mon 5/2/16	Mon 5/2/16	0%	0%	235FS+60 days	Laurie Fetterman,Chris DeBorja,Mary Joswik
237	**AAMC Clinical Transformation Specialist**	**330 hrs**	**Fri 7/31/15**	**Wed 5/25/16**	**0%**	**0%**		
238	Write Job Description	272 hrs	Tue 12/1/15	Fri 1/15/16	0%	0%		Pam Hinshaw
239	Post Position	2 hrs	Fri 7/31/15	Fri 7/31/15	0%	0%		Pam Hinshaw
240	Hire Clinical Transformation Specialist	16 hrs	Thu 4/28/16	Thu 4/28/16	0%	0%	239FS+60 days	Pam Hinshaw,Pat Czapp
241	Training	40 hrs	Fri 5/20/16	Tue 5/24/16	0%	0%	240FS+15 days	Pam Hinshaw,AAMC Clinical Transformation Specialist
242	AAMC Clinical Transformation Specialist start	0 hrs	Tue 5/24/16	Wed 5/25/16	0%	0%	241	
243	**Skilled Nursing Facility Collaborative & CRISP Reporting Pilot**	**948 hrs**	**Tue 12/1/15**	**Sat 12/31/16**	**0%**	**0%**		
244	Notify SNFs of Collaborative Opportunity	8 hrs	Fri 1/1/16	Fri 1/1/16	0%	0%		Pat Czapp
245	AAMC Write RFI (for preferred partners)	20 hrs	Fri 12/11/15	Tue 12/15/15	0%	0%		Pat Czapp
246	Review and accept SNFs into Collaborative	120 hrs	Thu 1/21/16	Mon 2/1/16	0%	0%		Pat Czapp,Pam Hinshaw
247	Schedule & Hold Monthly Meetings for goal setting and quality review	120 hrs	Wed 1/13/16	Fri 1/15/16	0%	0%		Heather Matheu,Pat Czapp,Pam Hinshaw,Beth Tingo,Mary Joswik,Chris Crabbs,Renee' Kilroy
248	Schedule & Hold Quarterly Meetings for BATP SNF Collaborative	120 hrs	Tue 2/2/16	Thu 2/4/16	0%	0%	246	Heather Matheu,Pat Czapp,Pam Hinshaw,Beth Tingo,Mary Joswik,Chris Crabbs,Renee' Kilroy
249	**Hire Hospital Resources for SNF Collaborative**	**120 hrs**	**Tue 12/1/15**	**Wed 4/27/16**	**0%**	**0%**		
250	Write Job Descriptions	16 hrs	Tue 12/1/15	Fri 1/15/16	0%	0%		Pat Czapp[3%],Beth Tingo[3%]
251	Post Jobs	4 hrs	Wed 2/3/16	Wed 2/3/16	0%	0%	7FS+1 day	

ID	Task Name	Work	Start	Finish	% Work Comple	% Comple	Predecessors	Resource Names
252	AAMC Hire Post Acute Care Manager	40 hrs	Tue 4/26/16	Tue 4/26/16	0%	0%	7FS+60 days	
253	BWMC Hire High Risk Coordinator (SNFs)	40 hrs	Tue 4/26/16	Tue 4/26/16	0%	0%	7FS+60 days	
254	Training	20 hrs	Wed 4/27/16	Wed 4/27/16	0%	0%	253	Pam Hinshaw,Chris Crabbs,Beth Tingo,Pat Czapp
255	Hold Quarterly SNF Collaborative Meetings	140 hrs	Fri 1/1/16	Fri 12/30/16	0%	0%		Pat Czapp[1%],Pam Hinshaw[1%],Beth Tingo[1%],Heather Matheu[1%],Renee Kilroy[1%],Cindy Gingrich[1%],Laurie Fetterman[1%],Becky Paesch[1%],SNFs[1%]
256	Develop & Hold SNF Education Sessions	300 hrs	Mon 2/15/16	Sat 12/31/16	0%	0%		Pam Hinshaw,Beth Tingo,SNFs
257	**AAMC Collaborative Care Network (Clinically Integrated Network)**	**2,112 hrs**	**Fri 1/1/16**	**Sat 12/31/16**	**0%**	**0%**		
258	Develop contract/work order	100 hrs	Fri 1/1/16	Sun 1/31/16	0%	0%		Pat Czapp
259	Establish clinical integration network structure, governance	160 hrs	Mon 2/1/16	Sat 4/30/16	0%	0%		Charlyn Slade,Carol Olsen
260	Execute participation agreements	120 hrs	Mon 2/1/16	Sat 4/30/16	0%	0%		Charlyn Slade,Carol Olsen
261	Train physician leaders	100 hrs	Mon 2/1/16	Sat 4/30/16	0%	0%		Charlyn Slade,Carol Olsen
262	Establish key committees	20 hrs	Mon 2/1/16	Sat 4/30/16	0%	0%		Charlyn Slade,Carol Olsen
263	Acquire baseline clinical, utilization, and patient access data of participating providers	160 hrs	Mon 2/1/16	Sat 4/30/16	0%	0%		Charlyn Slade,Carol Olsen
264	Develop clinical performance measures, standards and reporting mechanisms	32 hrs	Mon 2/1/16	Sat 4/30/16	0%	0%		Charlyn Slade,Carol Olsen
265	Begin registries and data collection	140 hrs	Mon 5/2/16	Thu 5/12/16	0%	0%		Charlyn Slade,Carol Olsen
266	Promote use of One-Call Care Management, Behavioral Health Navigator, Senior Triage Team	80 hrs	Mon 5/2/16	Fri 5/6/16	0%	0%		Charlyn Slade,Carol Olsen
267	Develop Patient Outreach Program	140 hrs	Mon 5/2/16	Thu 5/12/16	0%	0%		Charlyn Slade,Carol Olsen
268	Explore gainsharing and bundling through Medicare Shared Savings Program ACO	200 hrs	Mon 1/11/16	Wed 6/1/16	0%	0%		Charlyn Slade,Carol Olsen
269	Develop performance improvement plan and process	200 hrs	Mon 5/2/16	Wed 5/18/16	0%	0%		Charlyn Slade,Carol Olsen
270	Begin NCQA accreditation application for ACO	120 hrs	Mon 5/2/16	Wed 5/11/16	0%	0%		Charlyn Slade,Carol Olsen
271	Review and evaluate current inpatient care management design, oversight	40 hrs	Mon 8/1/16	Tue 8/2/16	0%	0%		Charlyn Slade,Carol Olsen
272	Define common approach to patient and family engagement in care coordination and transitions	80 hrs	Mon 8/1/16	Sat 12/31/16	0%	0%		Charlyn Slade,Carol Olsen
273	Implement post-acute strategies system-wide	120 hrs	Mon 8/1/16	Sat 12/31/16	0%	0%		Charlyn Slade,Carol Olsen
274	Develop Reports for Data Analytics, Decision Support, Provider Progress Reporting	120 hrs	Mon 8/1/16	Sat 12/31/16	0%	0%		Charlyn Slade,Carol Olsen
275	Pursue gainsharing and bundling	100 hrs	Fri 7/1/16	Fri 12/30/16	0%	0%		Charlyn Slade,Carol Olsen
276	Submit NCQA accreditation application for ACO	80 hrs	Mon 8/1/16	Sat 12/31/16	0%	0%		Charlyn Slade,Carol Olsen

Privileged and Confidential *DRAFT*

MEMORANDUM OF UNDERSTANDING

BAY AREA TRANSFORMATION PARTNERSHIP

This Memorandum of Understanding sets forth the key terms of a proposed affiliation and collaboration between the Anne Arundel Medical Center, Inc. ("AAMC") and the University of Maryland Baltimore Washington Medical Center ("BWMC"), together with their respective affiliates referred to individually as a "Party" and collectively as the "Parties" to operate a collaborative effort to improve health in their collective and respective service area operating under the name Bay Area Transformation Partnership ("BATP" or the "Company").

WHEREAS, the Members have engaged in a deliberative process initially aided by a grant from the Health Services Cost Review Commission ("HSCRC") to explore ways in which to more efficiently and effectively link healthcare services towards an improved patient-focus in their respective service regions, including Anne Arundel and surrounding counties; and

WHEREAS, In furtherance of their respective charitable objectives, the Members' discussions have culminated in the Members' mutual desire to collaboratively explore through BATP the development of programs and services to improve access to and quality of health care provided to patients, lower health care costs, and create other efficiencies for the Members and their patients, ensuring that the Members' respective charitable objectives will continue to be met long into the future; and

WHEREAS, The Members intend to be active participants in the collaborative projects developed through BATP and undertake in good faith to collaborate with each other and other participants who are members of the Advisory Council of BATP in the consideration and development of programs and services in furtherance of BATP's purpose and the Members' respective charitable objectives; and

WHEREAS, the Parties will file an application for grant funding through amounts included in each of the Party's rates to be collected with the net proceeds thereof to be used in fulfillment of the objectives of BATP as described in the application ("Application") filed with and approved by the HSCRC and Department of Health and Mental Hygiene ("DHMH").

NOW THEREFORE, the Parties mutually agree to the following terms and conditions

1. DEFINITIONS. Capitalized terms used but not otherwise defined herein have the meanings set forth in the definitions appendix hereto.

2. PURPOSE. The purposes of the Company are charitable and educational within the meaning of Code § 501(c)(3), and the Company shall be operated and managed in a manner that is exclusively in furtherance of the Members' common tax-exempt charitable and educational purposes under Code § 501(c)(3), including, promoting health and providing or expanding access to healthcare services for a broad cross section of the communities served by the Members in a manner that complies with and is in furtherance of the community benefit standard in Revenue Ruling 69-545 and otherwise complies with the requirements applicable to organizations described under Code § 501(c)(3).

3. MISSION. The vision of the Company is to collaboratively explore the development of programs and services to improve access to and quality of health care provided to patients, lower health care costs, and create other efficiencies for the Members and their patients, develop innovative strategies to improve patient transitions between care and community settings, improve quality of care, reduce avoidable hospitalizations for high-risk patients, and improve the quality of care in the communities served by the members of the Company. The Company will collaborate, encourage, and support effective partnerships committed, among other goals, to reducing 30-day readmission rates, including reductions in adverse drug events, and potentially preventable conditions.

4. MEMBER QUALIFICATIONS; CONTRIBUTIONS

4.1 Member Qualifications. Each Member shall be, at its election, either the parent organization of its health system or the hospital. Absent the unanimous approval of the Members, each Member must be a Person exempt from federal income Tax under Code § 501(c)(3).

4.2 Contributions. Each Member agrees that it shall fund the purposes of the Company using the funding amount included in each Member's hospitals' revenue by the HSCRC for each year of operation in connection with the grant application filed by the Company under the Budget Reconciliation and Financing Act (the "BRFA Grant"). The funding amount shall reflect the anticipated revenue to be collected by the hospital from the gross revenue amount of the BRFA Grant ("Net Collections") for each hospital (the "Required Contribution"). Net Collections shall be calculated as set forth in the grant funding, if so defined in the grant, and if not, by deducting from the gross grant amount the amount equal to multiplying the gross grant amount by 100% less the hospital's approved markup percentage. A direct expenditure by a Member in support of a Company initiative described in the Application will be considered part of the Required Contribution.

4.3 Contribution Defaults. If any Member fails to make any Required Contribution (a "Contribution Default"), then such Member (a "Defaulting Member") will thereafter be subject, without further consent from such Member, to the provisions of this Section .

(a) If a Contribution Default occurs, the non-defaulting Member has the right to contact the HSCRC to request reallocation of BRFA grant funding from the Defaulting Member to the non-Defaulting Member; and/or adjust the Budget for the year to which the default applies to reduce the expenditures under the Budget to match the adjusted sources of funds without the Defaulting Member's contribution.

(b) If a Contribution Default occurs the Company may pursue all remedies available at law or in equity with respect to a Contribution Default, who

will be liable for and pay on demand all costs and expenses (including attorneys' fees and expenses) incurred by or on behalf of the Company in connection with the enforcement of this Section 4 because of the Contribution Default by such Defaulting Member.

(c) If a Contribution Default occurs, then (A) whenever the vote, consent or decision of the Members (or any subset thereof) is required or permitted under this Agreement or under the Maryland Act, a Defaulting Member will not be entitled to participate in such vote or consent or to make such decision or be counted toward quorum in respect of any such vote, consent or decision, and such vote, consent or decision will be determined by the non-defaulting Members (or any subset thereof) in accordance with this Agreement

4.4 Tax Exempt Status of Members. All Members are non-profit organizations, exempt from federal income tax under Code § 501(a) by reason of being organizations described in Code § 501(c)(3). To the extent possible, the Company will be managed and operated in a manner substantially related to the tax-exempt purposes of the Members within the meaning of Code § 513(a)and/or will be for the convenience of the patients of the Members so that the operations of the Company will not result in allocations of profits constituting "unrelated business taxable income" (as that term is defined in Code § 512(a)) to any of the Members. If a Member in good faith reasonably believes that its participation in the activities carried on by the Company can reasonably be expected to (a) result in or present a material risk of revocation of the federal tax-exempt status of that Member, (b) result in the Member's allocations of profits of the Company being subject to unrelated business income tax under Code § 511(a), or (c) prohibit or restrict the ability of the Member or any Affiliate of the Member to issue tax-exempt bonds, certificates of participation or other tax-exempt financial obligations, that Member will give written notice of the foregoing to the other Members. Upon receipt of such written notice, the Members will cooperate in good faith to incorporate into this Agreement and/or the operations of the Company changes intended to preserve the tax-exempt status of all Members that are tax-exempt entities and to minimize the extent to which the operations of the Company generate unrelated business taxable income for any Member or impair the ability of a Member to issue or maintain any tax-exempt obligations.

5. GOVERNANCE

5.1 Management by the Board of Managers. Except when the approval of the Members is expressly required by this Agreement, management of the Company's business and affairs is vested in a Board of Managers (the "Board"), including but not limited to approval of the services to be offered by the Company, the material terms of Company contracts

(including but not limited to the compensation, duration and termination terms of Company contracts), the offering of products and services to Third Parties, and the entry by the Company into any participation, service or other agreements, and the exercise of any powers that the Company may have as a member, shareholder, partner or otherwise of another corporation, limited liability company, partnership, joint venture or other organization. The Board of Managers may not delegate any of its authority to act on behalf of the Company as a member, shareholder, partner or otherwise of another corporation, limited liability company, partnership, joint venture or other organization." A member of the Board who is a Member Manager (a "Member Manager") must be a representative of a Member.

5.2 Actions by the Board. In managing the business and affairs of the Company and exercising its powers, the Board may act through meetings and written consents pursuant to Section 5.5 and through any Officer(s) or Manager(s) to whom the Board delegates authority and duties pursuant to Section 5.8. Any Person, other than a Member, dealing with the Company may rely conclusively upon the power and authority of the Board and on the authority of any Officer in taking any action in the name of the Company without inquiry into the provisions of this Agreement or compliance herewith.

5.3 Board Composition. Each Member shall have and appoint (or remove) its own Member Managers, consisting of at least one person, but not to exceed three persons. Only Member Managers have the right to vote. Upon the withdrawal or removal of a Member, the related class of Member Managers will be automatically eliminated and the Member Managers in that class of Managers will be automatically removed from office. All Managers shall serve a term of one year, or until their successor is elected to take their place.

5.4 Resignation or Removal of a Manager. If, for any reason, a Member elects to remove one of its Member Managers, then the Person shall immediately, and without further action or notice, be deemed to have resigned as Manager and will have no further rights or obligations with respect to the Company, and that Manager position shall remain vacant until a successor is appointed by the Member to which class the Member Manager belongs**.**

5.5 Meetings of and Voting by the Board.

(a) **Regular Meetings of the Board.** Regular Board meetings will be held at such times and place as the Board may designate by resolution from time to time. Notice of regular Board meetings will not be required. The Chairperson will preside over all regular Board meetings.

(b) **Waiver of Notice.** Any Manager may waive notice of any Board meeting. The attendance of a Manager at any Board meeting will constitute a waiver of notice of such meeting, except where a Manager attends such meeting for the express purpose of objecting to the transaction of any business because such meeting is not lawfully called or convened.

(c) **Quorum.** A quorum will exist at a Board meeting if at least one Manager from each Member is present at the meeting. In the absence of a quorum at any Board meeting, the Chairperson or a majority of the Managers present may adjourn such meeting to another date, time and place with notice to the Managers given in the same manner in the case of a special meeting. If a quorum is not present at a meeting, then a majority of the Managers present may adjourn such meeting from time to time with notice to all Managers until a quorum is present.

(d) **Presumption of Assent.** There shall be no presumption of assent. No action of the Company can be taken unless the Managers from each Member vote in favor of the action.

(e) **Participation by Electronic Means.** Any Manager may participate in a Board meeting by means of telephone conference or similar communications equipment by which all persons participating in such meeting can hear each other at the same time. Such participation will constitute presence in person at such meeting.

(f) **Written Board Actions.** Any action required or permitted to be taken at any Board meeting may be taken without a meeting if the Managers are given prior written notice of such proposed action and the Managers sufficient to approve the action pursuant to the terms of this Agreement consent thereto in writing. Reasonably prompt notice of the taking of any action without a meeting by less than unanimous written consent, together with a copy of the action taken, will be given to those Managers who have not consented in writing.

(g) **Voting.** Each Member's Managers will be entitled to vote upon all matters submitted to the Board, and the affirmative vote of the Managers from each Member (voting as a block) shall be required to take any action.

(h) **Chairperson.** At its first meeting, the Board will elect one of the Member Managers to serve as the initial Chairperson of the Board and President to serve for a term of one year. The Board will elect a successor Chairperson from among the Managers appointed by

the other Original Member, and the position shall alternate on an annual basis.

(i) **Officers.** The Board may elect such other officers as it deems useful, to serve such term as the Board shall determine.

5.6 Advisory Council. The Board may initiate any part of the work of the Company through an Advisory Council, comprised of such number of Member representatives and advisors and community members as the Board deems appropriate from time to time. The Advisory Council will coordinate the (i) identification and development of Company projects and related annual work plans and goals, (ii) identification and communication of project issues to the Board, (iii) provision to the Board of ongoing status reports for project implementation, including the submission of periodic progress reports regarding the attainment of Board-established project goals, (iv) such other project development matters as the Board may delegate from time to time; and (v) serve as the sounding board for input and communication of the views and needs of the community. The Advisory Council shall meet at least quarterly. The Advisory Council shall adopt such rules as it deems appropriate to govern its activities.

5.7 Other Committees.

a) The Board may form committees as the Board deems appropriate from time to time; provided, however, that each Member has the right to appoint one voting member of each such committee. Any such additional Board committee, to the extent provided in Board resolutions, may have and exercise any powers and authority of the Board.

b) With respect to each committee formed by the Board, the Board may adopt, or delegate to such committee the authority to adopt, such additional committee governance rules and regulations (including regulations regarding committee chairpersons, quorum, voting requirements, etc.) as the Board deems appropriate from time to time. The Board may dissolve any committee except the Advisory Council at any time.

5.8 Limitation of Duties and Liability. No Manager (in such Person's capacity as a Manager) has any duties (including fiduciary duties) or corresponding liabilities to the Company, the Members or the other Managers, except as specifically and expressly provided in this Agreement and except for implied covenants of good faith and fair dealing under applicable Law. Managers will not be (a) personally liable for any debts, obligations or liabilities of the Company (including any debts, obligations or liabilities arising under any Order), (b) obligated to cure any deficit, or (c) required to lend any funds to the Company.

6. MEMBERS.

6.1 Limitation of Liability. The Company's debts, obligations and liabilities (whether arising in contract, tort or otherwise) are solely debts, obligations and liabilities of the Company, and no Member is personally obligated for any such debt, obligation or liability solely because such Member is a Member or acting as a Member. Except as otherwise provided in this Agreement, a Member's liability as a Member for the Company's liabilities and losses is limited to such Member's share of the Company's assets; *provided that* a Member will be required to return to the Company any distribution received in a clear and manifest accounting or similar error. The immediately preceding sentence constitutes a compromise to which all Members have consented. Any contrary provision in this Agreement notwithstanding, the Company's failure to observe any formalities or requirements relating to the exercise of its powers or management of its business and affairs under this Agreement will not be grounds for imposing on the Members personal liability for liabilities of the Company.

6.2 Lack of Authority. No Member, in its capacity as such, has the authority or power to (a) act for or on behalf of the Company in any manner, (b) take any action that would be (or could be construed as) binding on the Company, or (c) make any expenditures on behalf of the Company. The Members expressly consent to the exercise by the Board of the powers conferred on it by this Agreement and applicable Law, and recognize that the Board may approve a Member's direct expenditure or contract on behalf of the Company and in furtherance of one of the approved goals listed in the Application.

6.3 No Right of Partition. No Member may seek or obtain partition (by court decree or operation of law) of any Company property or the right to own or use particular or individual assets of the Company.

6.4 Strategic Opportunities and Conflicts of Interest. Nothing in this Agreement requires any of the Members and their Affiliates to pursue any activity through the Company or prohibits the Members and their Affiliates from engaging in any collaborative activity or obtaining any service from any Person who is or is not a Member, an Affiliate of a Member or part of an affiliation among Members, and the involvement of any Member, Manager, Officer or Affiliate thereof in any such activity or service relationship will not constitute a conflict of interest with respect to the Company or any Member, Manager or Officer. The Member, Managers and Officers and their Affiliates may engage in other activities or ventures of any nature, independently or with other Persons (including other Members, Managers and Officers and their Affiliates). None of the

Members, Managers, Officers of the Company and their Affiliates is obligated (by virtue of this Agreement, their investments in the Company or their service as a Member, Manager or Officer) to inform or present to the Company or any other Member, Manager, Officer or any of their Affiliates any particular acquisition, collaboration, investment or other opportunity, and none of the Members, Managers, Officers and their Affiliates will acquire or be entitled to any interest or participation in any such opportunity by virtue of the participation therein by any Member, Manager, Officer or Affiliate thereof.

6.5 Dispute Resolution. In the event of any dispute regarding the rights and obligations of the Member under this Agreement, prior to asserting a claim in any court or other tribunal, a Member will provide written notice to the other Members identifying such dispute. For a period of sixty (60) days after the delivery of such notice, the Chief Executive Officers (or their appointee) of the Members shall meet informally to resolve the dispute. If this effort is unsuccessful, a Dispute Resolution Committee consisting of the Chairpersons of the Members shall meet for an additional sixty (60) day period. During both sixty-day periods, the individuals meeting will act in good faith to seek a resolution acceptable to all of the Members. If the Members have not reached a mutually satisfactory resolution after exhaustion of the above processes, each Member retains the right to bring legal or action in an appropriate forum, and none of the discussions or other communications among the Members during these two sixty-day periods will be used in evidence during any subsequent dispute resolution process.

7. BOOKS, RECORDS, ACCOUNTING AND REPORTS

7.1 Records and Accounting. The Company will keep appropriate books and records with respect to the Company's business, including such books and records necessary to provide any information, lists and copies of documents required to be provided pursuant to this section or applicable Law. The Board will have discretion to make in good faith all determinations in respect of the relative amount of allocations and distributions among the Members pursuant to accounting procedures and determinations, and other issues not specifically and expressly addressed in this Agreement, and any such determination by the Board will be final and bind the Members absent manifest clerical error. The Board shall commission an audit in any year.

7.2 Fiscal Year. The fiscal year (the "Fiscal Year") of the Company is the 12-month period ending on [June 30th] of each calendar year (or such other date as the Board determines with written notice to the Members).

7.3 Reports. If determined to be necessary by the Tax Partner, the Company will use commercially reasonable efforts to deliver or cause to be delivered, within 90 calendar days after the end of each Fiscal Year, to each Person who was a Member at any time during such Fiscal Year all information necessary for the preparation of such Person's United Stated federal and state income Tax Returns, including such Member's K-1 for such Fiscal Year.

8. TRANSFER.

8.1 Transfer to an Affiliate; Transfer to a Third Party; Notice of Potential Change of Control Transfer. Unless otherwise approved by all of the other Members, no Member may, directly or indirectly, Transfer any interest in Units except to a successor parent Affiliate.

9. DISQUALIFICATION. A Member shall be automatically disqualified if such Member or its hospital subsidiary is excluded from participation in any "*federal health care program*" as defined in 42 U.S.C. § 1320a-7b(f) (including Medicare, Medicaid, TRICARE and similar or successor programs with or for the benefit of any governmental authority) or other debarment from contracting with any governmental authority.

10. WITHDRAWAL.

10.1 Withdrawal. A member may withdraw as a Member following the last year in which the grant funding described in 4.2 terminates by giving written notice of withdrawal to the other Member. Both Members must agree to continue the Company following the termination of grant funding.

10.2 Withdrawal Process. The Members acknowledge that the withdrawal of a Member may impact the operations and financial condition of the Company, and may adversely impact the Company's ability to perform its contractual obligations. Accordingly, the withdrawing Member and the Company agree to engage, starting as soon as possible after the Company's receipt of a voluntary withdrawal notice, in good faith discussions with respect to an agreement setting forth the specific post-withdrawal requirements and obligations of the withdrawing Member ("withdrawal agreement").

11. DISSOLUTION AND LIQUIDATION

11.1 Dissolution. The initial term of the Company will be from the date of this Agreement and expiring on the last day of the grant of funding for the

Company's operations by the HSCRC, unless the Members unanimously approve to continue the Company for an additional term.

11.2 Liquidation and Termination. Upon the dissolution of the Company, the Board will act as liquidator or may appoint any other Persons to serve as liquidators. The Company's liquidators will proceed diligently to wind up the affairs of the Company and make final distributions as provided herein. The Company will bear the costs of liquidation as a Company expense. Until final distribution, the Company's liquidators will operate the Company's properties with all power and authority of the Board.

(a) To effect the liquidation of the Company, the Company's liquidators will:

(i) pay, satisfy or discharge from the Company assets all debts, liabilities and obligations of the Company (including expenses incurred in liquidation) or otherwise make adequate provision for the payment, satisfaction or discharge thereof (including the establishment of a cash fund for contingent liabilities in such amount and for such term as the Company's liquidators reasonably determine);

(ii) as promptly as practicable thereafter, (i) determine the fair market value of the Company's remaining assets (including, without limitation, Company-Owned Intellectual Property) (the "Liquidation Assets"), (ii) determine the amounts to be distributed to each Member in accordance with Section 12.2(a)(iii), and (iii) deliver to each Member a statement (the "Liquidation Statement") setting forth the fair market value of the Liquidation Assets and the amount and recipients of such distributions; and

(iii) thereafter the Company's liquidators will promptly distribute the Company's Liquidation Assets to the holders of Units in accordance with Section 4.1.

(b) In making distributions under Section 11.2(a) (iii), the Company's liquidators will allocate each type of Liquidation Assets (i.e., cash or cash equivalents, securities, etc.) among the Members ratably based upon the aggregate amounts to be distributed with respect to the Units held by each Member. The distribution of cash and/or property to a Member in accordance with the provisions of Section 11.2(a) (iii) will constitute a complete return to the Member of its Contributions and a complete distribution to the Member of its interest in the Company and all the Company's property and will constitute a compromise to which all Members have consented.

To the extent that a Member returns funds to the Company, it has no claim against any other Member for those funds.

11.3 Reasonable Time for Winding Up. The Members will allow a reasonable amount of time for the orderly winding up of the Company's business and affairs and the liquidation of its assets pursuant to Section 11.2 to minimize any losses otherwise attendant upon such winding up.

11.4 Return of Contributions. The return of Contributions to the Members, if any funding remains, will be made solely from Company assets and the Company's liquidators or other Members in the event of dissolution will not be personally liable for the return of Capital Contributions.

12. OWNERSHIP OF INTELLECTUAL PROPERTY LICENSE GRANTS AND RESTRICTIONS

12.1 Use of Intellectual Property. The Company may apply for protection for any of its claims for intellectual property rights ("Intellectual Property"), including trademarks or similar protections, under state or federal law. Company hereby grants to all the Members and their Affiliates and ACOs a perpetual, non-exclusive, non-transferable, royalty-free, irrevocable license to access, copy, use, modify, combine with other intellectual property, and create improvements from, any such protected Intellectual Property. Any Member may propose at any time to license any of its intellectual property to the Company for the use of the Company, the other Members and their Affiliates and ACOs in accordance with the terms of a license agreement to be negotiated between the parties.

12.2 Restrictions.

(a) Use of Licensed Trademarks. Each of the Parties acknowledges and agrees that the trademarks, service marks, certification marks, collective marks, logos, symbols, slogans, trade dress, trade names (including social network user account names), corporate names, domain names, other source or business identifiers (and all translations, adaptations, derivations and combinations of the foregoing) of the Company and its Affiliates, together with all of the goodwill of the business associated with each of the foregoing (the "Trademarks"), represents the valuable goodwill and reputation of the Company or its Affiliates and serves as an indicator of a high quality of healthcare and related services offered by the Company or its Affiliates. Each of the Parties acknowledges and agrees that it is of great importance that these high standards and reputations be maintained. Accordingly, each party agrees that all use of the Trademarks of the Company and all services provided in connection with such Trademarks by itself or by its Affiliates, ACOs or Subsidiaries will (i) be of high quality in

keeping with the reputation of each Party, and (ii) comply with all applicable Laws, standards and requirements, including standards set by the Company from time to time. No Party will or will permit any of its Affiliates, ACOs or Subsidiaries to, either during or subsequent to the term of this Agreement, use, advertise, promote or register any certification mark, trademark, service mark, trade name, insignia, logo or other mark that is confusingly similar to or a colorable imitation of any of the Trademarks.

(b) Limitations on Use of Licensed Intellectual Property. No Party may license or transfer any of the license rights or interests granted to it under this Article XIII for a fee or otherwise, to any Third Party without the prior written consent of the Company.

(c) Termination.

(i) The perpetual license granted pursuant to Section 12.1 will be subject to termination by the Company only in the event of a material breach by the applicable licensee of its obligations under this Agreement.

(ii) This Section 12 will survive and continue in full force and effect in accordance with its terms indefinitely beyond termination of this Agreement; provided, however, that any license with respect to Trademarks shall terminate for all Members immediately upon termination of this Agreement and for any one Member immediately upon that Member ceasing to be a Member.

13. GENERAL PROVISIONS

13.1 Expenses. Except to the extent expressly authorized in this Agreement, each Member will pay all expenses (including attorneys' fees and expenses) incurred by such Member and its designated Managers in connection with the formation, management and operation of the Company and the other Company Group entities. The Members acknowledge that grant funding from the HSCRC for the purpose of planning the operations of the Company are to be expended prior to any funding from the Members.

13.2 Notices. All notices and other communications required or permitted under this Agreement (a) must be in writing, (b) will be duly given (i) when delivered personally to the recipient, (ii) one Business Day after being sent to the recipient by nationally recognized overnight private carrier (charges prepaid), or (iii) four Business Days after being mailed to the recipient by certified or registered mail (postage prepaid and return receipt requested), and (c) sent to the recipient's address on the

Company's books and records or to such other address as the recipient may designate by notice given in accordance with the provisions of this Section 13.2.

13.3 Further Action. The Members agree to execute and deliver all documents, provide all information and take or refrain from taking such actions as may be necessary or appropriate to achieve the purposes of this Agreement.

13.4 Title to Company Assets. Company assets are deemed to be owned by the Company as an entity, and no Member, individually or collectively, has any ownership interest in any Company asset or any portion thereof. Legal title to Company assets may be held in the name of the Company or one or more nominees, as the Board may determine. Any Company assets for which legal title is held in the name of any nominee will be held in trust by such nominee for the use and benefit of the Company in accordance with the provisions of this Agreement. The Company will record all Company assets as property of the Company on its books and records, irrespective of the name in which legal title to such Company assets is held.

13.5 Entire Agreement. This Agreement constitutes the complete agreement and understanding among the Members regarding the subject matter of this Agreement and supersedes any prior understandings, agreements or representations regarding the subject matter of this Agreement.

13.6 Amendments. Subject to the right of the Board to amend this Agreement as expressly permitted in this Agreement, the provisions of this Agreement may be amended, modified, or waived only with the unanimous written consent of all of the Members.

13.7 Non-Waiver. The parties' respective rights and remedies under this Agreement are cumulative and not alternative. Neither the failure nor any delay by any party to this Agreement in exercising any right, power or privilege under this Agreement will operate as a waiver of such right, power or privilege, and no single or partial exercise of any such right, power or privilege will preclude any other or further exercise of such right, power or privilege or the exercise of any other right, power or privilege. No waiver will be effective unless it is in writing and signed by an authorized representative of the waiving party to this Agreement. No waiver given will be applicable except in the specific instance for which it was given. No notice to or demand on a party to this Agreement will constitute a waiver of any obligation of such party or the right of the party giving such notice or demand to take further action without notice or demand as provided in this Agreement.

13.8 Binding Effect; Benefit; Creditors. This Agreement will inure to the benefit of and bind the Members and their respective successors and permitted assigns. Nothing in this Agreement, express or implied, may be construed to give any Person other than the Members and their respective successors and permitted assigns any right, remedy, claim, obligation or liability arising from or related to this Agreement. This Agreement and all of its provisions and conditions are for the sole and exclusive benefit of the Members and their respective successors and permitted assigns. No provision of this Agreement may be construed as for the benefit of or enforceable by any Company creditor or its Affiliates, and no creditor making a loan to the Company or any of its Affiliates may have or acquire (except pursuant to the express terms of a separate agreement executed by the Company in favor of such creditor), as a result of making the loan any direct or indirect interest in Company profits, losses, distributions, capital or property other than as a secured creditor.

13.9 Severability. If any court of competent jurisdiction holds any provision of this Agreement invalid or unenforceable, then the other provisions of this Agreement will remain in full force and effect. Any provision of this Agreement held invalid or unenforceable only in part or degree will remain in full force and effect to the extent not held invalid or unenforceable.

13.10 References. The headings of Articles and Sections are provided for convenience only and will not affect the construction or interpretation of this Agreement. Unless otherwise provided, references to "Article(s)," "Section(s)," and "Schedule(s)" refer to the corresponding article(s), section(s), and schedule(s) of or to this Agreement. Each Schedule is hereby incorporated into this Agreement by reference. Reference to a statute refers to the statute, any amendments thereto or successor legislation, and all regulations promulgated under or implementing the statute, as in effect at the relevant time. Reference to a contract, instrument or other document as of a given date means the contract, instrument or other document as amended, supplemented and modified from time to time through such date.

13.11 Construction. Each party to this Agreement participated in the negotiation and drafting of this Agreement, assisted by such legal and tax counsel as it desired, and contributed to its revisions. Any ambiguities with respect to any provision of this Agreement will be construed fairly as to all parties to this Agreement and not in favor of or against any party to this Agreement. All pronouns and any variation thereof will be construed to refer to such gender and number as the identity of the subject may require. The terms "include" and "including" indicate examples of a predicate word or clause and not a limitation on that word or clause.

13.12 Governing Law. THIS AGREEMENT IS GOVERNED BY THE LAWS OF THE STATE OF MARYLAND, WITHOUT REGARD TO CONFLICT OF LAWS PRINCIPLES.

13.13 Consent to Jurisdiction. The Company and each Member hereby (a) agrees to the exclusive jurisdiction of any state court within Anne Arundel County, Maryland or, if it can obtain jurisdiction, the United States District Court for the District of Maryland (and the appropriate appellate courts) with respect to any claim or cause of action arising under or relating to this Agreement, (b) waives any objection based on forum non conveniens and waives any objection to venue of any such suit, action or proceeding, (c) waives personal service and process upon it, and (d) consents that all services of process be made by registered or certified mail (postage prepaid, return receipt requested) directed to it in accordance with Section 14.2 and service so made will be complete when received. Nothing in this Section 14.13 will affect the rights of the Company or any Member to serve legal process in any other manner permitted by applicable Law.

13.14 Waiver of Trial by Jury. EACH MEMBER HEREBY WAIVES ITS RIGHT TO A JURY TRIAL IN CONNECTION WITH ANY SUIT, ACTION OR PROCEEDING (ARISING IN CONTRACT, TORT OR OTHERWISE) ARISING FROM OR RELATED TO THIS AGREEMENT, THE TRANSACTIONS CONTEMPLATED HEREBY OR THE RELATIONSHIPS AMONG THE PARTIES ESTABLISHED HEREBY.

13.15 Equitable Relief. Because a breach or threatened breach of any covenant contained in this Agreement by a party to this Agreement would cause the non-breaching parties to suffer immediate and irreparable harm that could not be fully remedied with the payment of monetary damages, a non-breaching party will be entitled to specific performance, preliminary and permanent injunctive relief and other available equitable remedies, in addition to any other remedies available, to restrain a breach or threatened breach of any covenant contained in this Agreement, without the need to post bond or other security.

13.16 Tax Matters. The Members will meet to determine whether the Company is required to file any state or federal tax return, and to appoint one of them as a Tax Matters Partner. The Company will arrange for the preparation and timely filing (including extensions) of any Tax Return required to be filed by the Company, which shall be a Company expense.

NOW, THEREFORE, the undersigned hereby execute this Operating Agreement effective as of the date first written above.

ANNE ARUNDEL MEDICAL CENTER

By: _____
Name: _____
Title: _____
Date: _____

By: _____
Name: _____
Title: _____
Date: _____

UNIVERSITY OF MARYLAND BALTIMORE-WASHINGTON HOSPITAL

By: _____
Name: _____
Title: _____
Date: _____

By: _____
Name: _____
Title: _____
Date: _____

BAY AREA TRANSFORMATION PARTNERSHIP
ADVISORY COUNCIL CHARTER

Article I – Name

The name of the Company shall be Bay Area Transformation Partnership, (the "Company"), and this Charter shall serve as the organizational and operational guide for the Company's Advisory Council ("Council"),

Article II – Mission & Vision

The purposes of the Company are charitable and educational within the meaning of Code § 501(c)(3), and the Company shall be operated and managed in a manner that is exclusively in furtherance of the Members' common tax-exempt charitable and educational purposes under Code § 501(c)(3), including, promoting health and providing or expanding access to healthcare services for a broad cross section of the communities served by the Members in a manner that complies with and is in furtherance of the community benefit standard in Revenue Ruling 69-545 and otherwise complies with the requirements applicable to organizations described under Code § 501(c)(3).

This vision of the Company is to collaboratively explore through the Company the development of programs and services to improve access to and quality of health care provided to patients, lower health care costs, and create other efficiencies for the Members and their patients, develop innovative strategies to improve patient transitions between care and community settings, improve quality of care, reduce avoidable hospitalizations for high-risk patients, and improve the quality of care in the communities served by the members of the Company. The Company will collaborate, encourage, and support effective partnerships committed, among other goals, to reducing 30-day readmission rates, and potentially avoidable utilization.

Notwithstanding anything to the contrary in this Agreement, the Company may not carry on any activities that may not be carried on by an organization exempt from tax because it is described in Code § 501(c)(3) (including participating in, or intervening in, any political campaign on behalf of (or in opposition to) any candidate for public office).

Article III – Purposes

1. To build and sustain a hospital funded, community centered transformation coalition (the "Company") with a focus on improving transitions of care with an initial focus on Medicare beneficiaries, among others;
2. To be a vehicle for the patient and family voice in health care;
3. To encourage person-centered and person-directed models of care with participation by all parties involved in the provision of care in the communities served;

4. To collaborate and encourage efforts of organizations with shared visions.
5. To identify and develop Company projects and related annual work plans and goals, including developing an annual budget.
6. To provide to the Members ongoing status reports for project implementation, including the submission of periodic progress reports regarding the attainment of Member-established project goals.
7. To serve as the sounding board for input and communication of the views and needs of the community.

Article IV – Participation

A. Members

The Anne Arundel Medical Center, Inc., on behalf of itself and all of its affiliates. ("AAMC"), and the University of Maryland Baltimore Washington Medical Center on behalf of itself and all of its affiliates. ("BWMC"), referred to individually as a "Party" and collectively as the "Parties" have created BATP to operate a collaborative effort to improve health in their collective and respective service areas operating under the name Bay Area Transformation Partnership ("BATP" or the "Company"), and shall be the Members for all purposes of this Agreement.

B. Collaboration

Participation in the Advisory Council to the Company is open to organizations and individuals interested in fostering the vision by actively engaging in the planning and work of the Company. Parties that wish to participate will be invited to join the Advisory Council and participate in the development of strategies and plans to achieve the purposes of the Company, subject to any limitations imposed by the Members.

All participants in the Company and the Advisory Council should join in a commitment to:

- Share interventions, successes, best practices, lessons learned, and barriers with post-acute care providers, other hospitals, physicians and governmental entities
- Mentor partners and providers
- Maintain and safeguard the confidentiality of privileged data or information—whether generated or acquired by the team—that can be used to identify an individual patient, practitioner, hospital, facility, health plan, or patient population
- Promote implementation of evidence-based and promising practice interventions

Participant categories in the Advisory Council include:

- Healthcare Providers (e.g., hospitals, physician practices, home health agencies, home care, assisted living facilities, pharmacies, dialysis facilities, hospice organizations, palliative care organizations, etc.)

- Provider Associations
- Consumer Advocacy Organizations
- Government Organizations (e.g. Health Department, Aging and Disabilities, Social Services)
- Community and Long-Term Support Services Organizations (Area Agency on Aging, etc.)
- Educational Organizations/Academics
- Professionals
- Patient and Family Advisory Councils and other consumer representatives

Section C - Meeting Attendance

Members of the Company and Advisory Council agree to attend in person or by teleconference a minimum of fifty (50) percent of scheduled meetings each year with not more than two (2) consecutive absences. Substitute representatives within organizations are permissible to ensure consistent representation.

Section D – Committees

Advisory Council members agree to assist in the activities required for Company projects, including leadership or participation in smaller workgroups, as needed.

Article V – Meetings

A - **Annual Meeting**

There shall be an Annual Meeting of the Company, at which time all participants of the Advisory Council and the Company will review membership, committee reports, develop annual goals, and other business.

B - Regular Meetings

Meetings of the Advisory Council will be held at least quarterly. Regular meetings will not impact the progress of the smaller workgroups. Meetings may take place in person or remotely via teleconference.

Article VI – Procedural Policies

A - Conflicts

No one may profit financially from membership in the Company by sales or solicitation at meetings or workshops. Participants will disclose any actual or potential conflicts of interest to the Company.

B - Decision Making

In the spirit of the Company, all Company business shall be conducted based on the philosophy of mutual respect. Actions of the Company require the approval of all of the Members. Simple majority rules will apply with respect to all actions of the Advisory Council. Member participants in the Council are entitled to one vote per member.

C – Voting

Voting on the business of the Company may be conducted by those in attendance at the meeting either in person or by teleconference. Proxy voting via email is permissible.

D – Conduct of Meetings

The members of the Council shall elect a presiding officer, a vice presiding officer and one or more other officers. The presiding officer (or vice presiding officer in the event of absence) shall preside at meetings.

LIST OF INITIAL MEMBERS OF THE ADVISORY COUNCIL

Bay Area Transformation Partnership: BATP partners include the following:

Anne Arundel Medical Center
The medical staff of AAMC

University of Maryland Baltimore-Washington Medical Center
The medical staff of UM BWMC (employed and community-based)

The AAMC and UM BWMC Patient and Family Advisory Councils

The Anne Arundel County Departments of Health, Aging and Disabilities

Anne Arundel County Mental Health Agency, Inc.

CRISP

DEFINITIONS APPENDIX

ACO" means an accountable care organization operating under the Medicare Shared Savings Program.

"Additional Member" means a hospital admitted to BATP as a Member by the unanimous vote of the Parties.

"Affiliate" means, with respect to a particular Person, (i) any other Person that, directly or indirectly, controls, is controlled by or is under common control with such Person, (ii) if such Person is a partnership, any partner thereof, (iii) any of such Person's spouse, siblings (by law or marriage), ancestors and descendants, and (iv) any trust for the primary benefit of such Person or any of the foregoing. The term "control" means possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of another Person, whether through membership, the ownership of voting securities or equity interests, by contract or otherwise.

"Agreement" means this Memorandum of Understanding, as amended, modified or waived from time to time.

"Board" is defined in Section 5.1.

"Business Day" means a day that is not a Saturday, Sunday or legal holiday on which banks are authorized or required to be closed in New York, New York.

"Code" means the United States Internal Revenue Code of 1986, 26 U.S.C. § 1, et. seq.

"Company" means Bay Area Transformation Partnership.

"Confidential Information" means all (a) confidential, proprietary and trade secret information (including all tangible and intangible embodiments thereof) that concerns the Company Group, the Members, their respective businesses or the services, processes, therapies, treatments or products offered by them, including lists of and information regarding current and prospective patients, customers, referral sources, payors, vendors and suppliers, personnel information, computer programs, unpatented inventions, discoveries or improvements, treatment techniques and results, marketing, manufacturing, or organizational research and development, contracts and contractual relations, licenses, accounting ledgers and financial statements, business plans, forecasts and projections, business methods, pricing and financial information, information concerning planned or pending acquisitions or divestitures, and information concerning purchases of real property or major equipment or other personal property, and any other information or data that the Company Group or any Member treats as proprietary or designates as confidential information, whether or not owned or developed by the Company Group; and (b) all Intellectual Property; provided, however, that "Confidential Information" does not include any information that (a) is or becomes generally available to the public (other than through a Member's breach of this Agreement), (b) is lawfully received from a third-party having rights in the information without restriction and received without notice of any restriction

against its further disclosure, or (c) is disclosed to a Member with an affirmative acknowledgement that the Member may further disclose such information without restriction.

"Fiscal Year" means the Company's annual accounting period established pursuant to Section 7.2.

"Improvements" means any improvement, enhancement or modification to, or derivative work developed from, Intellectual Property.

"Law" means any federal, state, local, municipal, foreign, international, multinational or other constitution, statute, law, rule, regulation, ordinance, code, principle of common law or treaty.

"Manager" is defined in Section 5.1.

"Member" means a Person listed as a signatory to the Agreement or admitted to the Company as a Substituted Member or Additional Member.

"Order" means any order, injunction, judgment, decree, ruling, assessment or arbitration award of any governmental authority or arbitrator.

"Party" means the Company and each Member.

"Person" means any natural individual, corporation, partnership, limited liability company, joint venture, association, bank, trust company, trust or other entity, whether or not legal entities, or any governmental entity, agency or political subdivision.

"Subsidiary" means, with respect to a Party, any corporation, partnership, limited liability company, joint venture, association, bank, trust company, trust or other entity in which the Party owns or controls, directly or indirectly, (i) a majority of the total voting power of the equity securities, partnership interests or membership interests entitled (without regard to the occurrence of any contingency) to vote in the election of directors, managers or trustees of such entity or (ii) a majority of such entity's total economic interest.

"Substituted Member" means a Person that is admitted to the Company as a Member pursuant to Section 10.1.

"Tax" means any federal, state, local or foreign income, gross receipts, franchise, estimated, alternative minimum, add-on minimum, sales, use, transfer, registration, value added, excise, natural resources, severance, stamp, occupation, premium, windfall profit, environmental, customs, duties, real property, personal property, capital stock, social security, unemployment, disability, payroll, license, employee or other withholding or other tax, including any interest, penalties (civil or criminal) or additions to tax or additional amounts in respect of the foregoing.

"Tax Matters Partner" is defined in Code § 6231 and the Treasury Regulations thereunder.

"Tax Return" means any return, declaration, report, statement and other document required to be filed in respect of any Tax.

"Taxable Year" means the Company's accounting period for federal income tax purposes.

"Third-Party" means any Person other than the Company.

"Transfer" means to sell, assign, pledge, gift, convey or otherwise dispose of (including by way of any merger, consolidation, membership substitution, change of control or similar corporate event or other transfer by operation of law) or grant a security interest in the subject matter of the Transfer.

"Transferee" means a Person to whom Units are transferred in accordance with the terms of this Agreement, but who has not become a Member pursuant to Article X.

"Treasury Regulations" or "Treas. Reg." means the income tax regulations promulgated under the Code and in effect, as amended, supplemented or modified from time to time.

"Withdrawal Event" means, with respect to a particular Member, such Member's voluntary withdrawal pursuant to Section 10 or the occurrence of any compulsory withdrawal event specified in Section 9.