Anne Arundel Medical Center

2001 Medical Parkway
Annapolis, Md. 21401
443-481-1000
TDD: 443-481-1235
askAAMC.org

December 4, 2015

Mr. Steve Ports, Director
Center for Engagement and Alignment
Maryland Health Services Cost Review
4160 Patterson Avenue
Baltimore, MD 21215

Re: AAMC 2016 Strategic Hospital Transformation Plan

Dear Mr. Ports:

Attached, please find Anne Arundel Medical Center's 2016 Strategic Hospital Transformation Plan (STP).

AAMC's 2016 STP describes interventions and partnerships that will focus on working with the Medicare population, skilled nursing facilities, behavioral health, and physicians toward Maryland's goals of improving care coordination and chronic care, reducing potentially avoidable utilization, and aligning with physicians and other non-hospital providers. The STP overlaps significantly with AAMC's Regional Partnership activities (Bay Area Transformation Partnership) and Final Plan, as well as the activities proposed in our Regional Partnership's Competitive Transformation Application.

We are pleased to present the Commission with this document that outlines AAMC's commitment to meeting the goals of the All-Payer Model and beginning to prepare our greater medical community to assume accountability for the quality and total cost of care for the regional population we serve.

Sincerely,

Victoria W. Bayless
President & CEO

Attachments

Anne Arundel Medical Center
2016 Strategic Transformation Plan

Executive Summary

Anne Arundel Medical Center (AAMC) has adopted a strategic framework to improve care delivery and population health in the region it serves. This document, the Strategic Transformation Plan (STP), outlines AAMC's community partnerships and our planned collaborative interventions in 2016 that will reduce utilization and improve chronic care. AAMC's STP is informed by the detailed analysis of its target population for 2016: Medicare and aged Dual-Eligible patients with 2-6 chronic conditions who are high-utilizers ($\geq$ 3 episodes of bedded care in a year). *See Appendix A, AAMC's 2016 Population Health Improvement Logic Model.*

Putting in motion the long-term vision: In 2016, AAMC will focus on the target population by engaging behavioral health resources, skilled nursing facilities (SNFs), public and private sector care coordinators, and physicians to create a better-integrated and aligned Community of Practice, consistent with AAMC's strategic vision since 2009, "Living Healthier Together". The foundational work of 2016 involves coordination, integration, and alignment activities to prepare our greater medical community for future accountability for the quality and total cost of care for our regional population. *See Appendix B, a diagram of integration and alignment activities that will prepare AAMC's regional medical community to succeed in a value-based payment environment.*

Building infrastructure to improve the health of our regional population: Significant investments already undertaken by AAMC include launching a Diabetes Program, developing an Outpatient Psychiatry Program (for adults and children), piloting a Behavioral Health Navigator Program, expanding AAMC's Community Health Clinics, establishing new primary care providers and patient-centered medical homes (PCMHs) in the region, engaging community-based care management providers, and sponsoring a Medicare Shared Savings Program Accountable Care Organization (MSSP ACO). In 2016, AAMC will expand upon these and other initiatives that bolster capacity in the ambulatory environment to provide needed care at the right time and place, and thus decrease hospital utilization. *See Appendix C, a diagram showing how past, current, and future GBR and community benefit investments support AAMC's STP.*

Collaborating with non-traditional partners to improve care through The Regional Transformation Plan: In order to achieve its population health improvement goals, AAMC has engaged the University of Maryland Baltimore/Washington Medical Center (UM BWMC) in a Regional Partnership: the Bay Area Transformation Partnership (BATP). **BATP's planned interventions, outlined in its implementation funding proposal, overlap with and complement this STP.** BATP addresses the community's medical needs as well as social and behavioral health needs that present obstacles to improved health outcomes. New collaborations will be formed and existing relationships will be expanded with community-based behavioral health resources and private and public sector providers of care management in order to improve the health of our target population. *See Appendix D, a diagram of BATP activities as they relate to AAMC's STP.*

Serving as a laboratory for the State's IT Infrastructure: As part of BATP, AAMC and UM BWMC are working together with Chesapeake Region's Information System for our Patients (CRISP) to design, test and pilot State IT infrastructure that will support real-time, critical information-sharing among providers of care in order to decrease potentially avoidable utilization (PAU) by our target population. Once tested and implemented, the infrastructure's tools and features will be propagated broadly to other hospitals and community-based private and public sector providers and coordinators of behavioral health and somatic care. *See Appendix E for an illustration of how Care Alerts, Care Plans and Secure Texting will improve coordination of care and decrease PAU.*

Aligning with physicians: AAMC's Collaborative Care Network (CCN): AAMC has created a clinically integrated network that serves as a platform for independent and employed physicians to share data, resources, and opportunities to improve care. This physician-led organization creates the framework for physician alignment in a GBR environment. *See Appendix F, a diagram of CCN activities in 2016 that will create opportunities for improved outcomes and efficiencies.*

Responding to community needs: In addition to detailed analysis of our target population, this document is also informed by the voice of our community, the 2015 Anne Arundel County Community Health Needs Assessment (CHNA), currently in draft form, and supplemented by AAMC's Patient and Family Advisory Council (PFAC), an active group of 80 individuals. Also, AAMC's Health Enterprise Zone (HEZ), an initiative that answers the needs of high-utilizing Medicare and Dual-Eligible individuals, has paved a culturally proficient path toward effective patient engagement and activation, and those activities will be expanded in 2016. AAMC further addresses its local uninsured population by assisting eligible individuals and families in using Maryland Health Connection to obtain insurance coverage. *See Appendix G for a diagram showing how the community needs are addressed in AAMC's STP.*

AAMC's STP, as outlined in this document, supports the State's goals of improved care delivery and population health with a focus on:

1. Chronic disease supports
2. Long-term and post-acute care integration and coordination
3. Physical and behavioral health integration and coordination
4. Primary care supports
5. Case management and other supports for high needs and complex patients
6. Episode improvements, including quality and efficiency improvements
7. Clinical consolidation and modernization to improve quality and efficiency
8. Integration of community resources relative to social determinants of health and activities of daily living

See Appendix H for a grid demonstrating how AAMC's STP addresses the State's 8 domains in 2016.

1. Describe your overall goals.

In 2016, AAMC will:

A. **Reduce PAU (ED visits, admissions and readmissions):** AAMC will address the target population defined above and connect "medically homeless" patients encountered in the ED to PCMHs supplemented by behavioral health and specialty services, in an integrated system of care that anticipates and avoids crises. ED physicians will be equipped with novel CRISP tools (shared Care Alerts) and other means to assure they can offer patients a safe alternative to admission. Hospitalists and ambulatory providers will be supported with newly integrated care coordination services (One-Call Care Management) and know their treatment plans will be implemented in the community. SNFs will have needed information and resources to avoid unplanned transfers and to do "warm hand-offs" to home and/or other providers.

B. **Improve patient satisfaction:** AAMC will improve HCAHPS scores and will enhance the care experience of individuals and families across care settings by addressing needs voiced by patients in our PFAC and our CHNA: they need help accessing and navigating the system of care. AAMC will provide that help. For example, patient satisfaction surveys will be completed as part of several BATP initiatives, including a Senior Triage Team DoAD initiative that focuses on our *super*-utilizers (>=5 IP/Observation visits).

C. **Expand behavioral health services and integrate them with primary care:** AAMC has developed an outpatient psychiatry services program for adults and children and will in 2016 implement a partial hospitalization program (PHP) and an intensive outpatient program (IOP) for adults and adolescents. AAMC will in 2016, as part of BATP, begin integrating behavioral health resources with somatic care by expanding a community-based referral/navigation program and piloting the provision of behavioral health services in primary care settings. *Notably, AAMC has a long-term vision of providing full-spectrum behavioral health services, including inpatient psychiatric services.*

D. **Integrate and coordinate care management across care settings:** AAMC will identify members of the target population and assign to each a care manager who will perform a health risk assessment and follow the individual in the community. Care Managers from across the care continuum (community, inpatient, government, payer) can contribute to a shared Care Plan (built using Epic's Healthy Planet module). CRISP will make Care Plans available in their portal and enable sharing of plans across hospitals as part of BATP. These shared care plans will reduce rampant duplication of effort, and increase the visibility, accessibility and accountability of assigned care managers. A One-Call system will help community-based providers connect their high-risk patients with care management in order to head off a crisis and/or avoidable hospitalization.

E. **Improve chronic disease management in the ambulatory setting**: Mindful of tomorrow's high-utilizers, AAMC will identify the "rising risk" population in ambulatory practices and provide supports to close care gaps and create paths to effective patient self-management. Both behavioral and somatic health conditions will be addressed. Primary care support services (Quality Coordinators) will be implemented in order to expand the capacity of the team-based PCMH model. For those patients with advanced complex illnesses who are entering life's final downward trajectory, a new model of collaborative care (Community Care for

Complex Illness, 3CI) will provide medical and social support services to patients and caregivers in their homes.

F. **Align physicians in meeting All-Payer Model goals**. AAMC's Collaborative Care Network will in 2016 implement governance and infrastructure resources to support episode improvements (quality and efficiency), focusing on both acute care and ambulatory measures of access, quality, and cost. Physicians will be presented with personal performance data and will be given support to meet targets.

2. List the overall strategies.

A. Design, test and implement new CRISP provider-to-provider communication tools for the care of our high-utilizing patients. This BATP strategy answers AAMC and UM BWMC clinicians' needs to coordinate care of complex patients, and in fact was designed by them. The new features are Care Alerts, Care Plans, and Secure Texting. Care Alerts are "need to know right now", succinct provider-to-provider communications within the EMR that are delivered seamlessly to the provider in real time, in the context of care. A Care Alert advises a fellow provider of information about the patient in front of him that may obviate an admission, e.g. "Mr. X usually presents with X symptoms and responds to X treatment. Text me *first* if you feel he needs to be admitted." A Care Plan is more detailed and helps the inpatient or ED care manager avoid starting from scratch because it displays stored information from the care manager in the ambulatory environment. It also decreases duplication of services and resources because the patient's care manager "in charge" is clearly identified, along with contact information. Secure texting allows provider-to-provider, rapid communication and sharing of images so as to avoid admission and ensure safe follow up. All three features can be shared between AAMC and UM BWMC, and will eventually be implemented statewide to include all hospitals and even ambulatory providers and care coordinators.

B. Provide a Senior Triage Team of experts to intervene and address the nonmedical needs of individuals in the target population. This BATP strategy involves a new and specialized, mobile team from the Anne Arundel County Department of Aging and Disabilities (DoAD) to address the home situation of a vulnerable Medicare/Dual-Eligible patient who would otherwise "live " at one of our hospitals for (literally) months due to lack of safe discharge disposition. Local EMS teams will also identify individuals for this intervention because they are frequently called by these patients. The Senior Triage Team will address nonmedical barriers to care, e.g. prescription costs, living arrangements, food, shelter, utilities, behavioral health needs and more.

C. Form a SNF Collaborative to share data, problem-solve, and improve performance on length of stay (LOS), unplanned transfers and readmissions. This BATP project will establish the role of a Post-Acute Care Manager who will be in charge of building and maintaining relationships with regional SNFs for the purpose of sharing quality performance data, aligning goals, improving on quality and cost of care, and decreasing unplanned transfers. Clinical educational resources (e.g. infection control, wound care, care management) will be deployed to SNFs. The focus will be on elevating the quality of care patients receive and also decreasing length of stay (LOS) and improving patient self-management strategies upon discharge from the SNFs.

D. Integrate behavioral health and primary care, provide navigational support to patients with behavioral health needs. This is also a BATP project. While AAMC expands offerings in outpatient behavioral health AND plans for inpatient psychiatric services, we will continue to expand relationships with community-based behavioral health resources. A screening tool for urgent behavioral health needs, already in use, will be deployed to an expanded number of medical practices, and backed up by a provider referral line such that patients referred by medical practices receive evaluation for behavioral health services within 48 hours. A Behavioral Health Navigator will track patients to make sure they access services. For less urgent needs, an embedded LCSW will provide behavioral health counseling services to native patients in one or more large primary care practices. This embedded model will be a pilot effort in 2016 to determine feasibility and scope for future expansion.

E. Develop the Collaborative Care Network (CCN) and begin sharing data, resources and opportunities with independent and employed physicians. The CCN has an ongoing project, an MSSP ACO, which affords access to claims data that can be attributed to physicians and other care providers, e.g. SNFs. Analysis of these data has revealed opportunities to improve care episode efficiencies. The ACO vehicle also allows the CCN to explore gain sharing and bundling activities for specialists. Other payer initiatives beyond the ACO are planned through the CCN. All projects serve to educate and prepare physicians for a pay-for-value environment and align them with All-Payer Model goals. Importantly, the CCN will also manage the BATP initiatives that provide care coordination and population health management support to community practices.

F. Implement PCMH-based "Quality Coordinators" who manage panels of patients, identifying and addressing care gaps. AAMC has created patient and disease-specific registries for ambulatory physicians such that they can be aware of patients with care gaps. Quality Coordinators are medical assistants specifically trained to "scrub" the disease registries to look for patients with gaps in care and bring them back to the practice and/or assign them to care management, if the patients have non-medical needs that are obstacles to health.

G. Implement a One-Call Care Management solution for ambulatory providers to access care management services for vulnerable, complex patients. This BATP project will be initiated at AAMC in 2016 and expanded to include UM BWMC in 2017. Ambulatory providers and their staff are ill-equipped to identify which care management services high-risk patients are eligible for, let alone access them. By providing a One-Call solution, we will allow physician practices to access services and streamline the referral process, but also avoid duplication of services because of the skills and resources of the person answering the call. One-Call LCSWs will have access to patients' Care Alerts, and Care Plans, so they will connect to a patient's established care manager "in charge", if applicable. They will be specially trained to identify payer-provided care management services and connect patients to them.

H. Implement home-based services that enable vulnerable patients to receive care at home, decrease hospital use and improve quality of life. There are patients who cannot negotiate transportation to appointments, yet their needs become emergent when their conditions deteriorate because they have no access to services that would have otherwise been managing their chronic conditions. AAMC will collaborate with a regional vendor, Capital Coordinated Medicine, to provide at-home medical services. Additionally, in the community there are other patients who have advanced, complex illness and needs that will predictably increase in the

future as they begin to succumb. AAMC has partnered with Chesapeake Palliative Medicine to create the 3CI Program (Community Care for Complex Illness). 3CI clinicians and staff provide patients and caregivers with anticipatory guidance and strategies to self-manage exacerbations at home, often obviating the need for a hospitalization.

I. Intensify readmission reduction efforts to look for patterns that lead to clinical misadventures. Multiple interventions to decrease readmissions are described in the literature. What is known is that there are site-specific factors that contribute to readmissions. AAMC predicts that most readmissions that occur within 15 days are likely due to something that happened (or didn't happen) at AAMC. We will examine each of those carefully, including clinician, patient and family interviews, to elicit patterns that point to process or system errors that may be remediated. We intend to implement a nurse clinician with special skills to meet this need.

J. Leverage CRISP regionally in our community of practice and assist in the development of new features to coordinate care. Community-based clinicians are sometimes familiar with the Encounter Notification System (ENS) but are unaware of other CRISP reports and features, including new efforts to share clinical data from the ambulatory environment. AAMC will enlist local ambulatory practices and SNFs in not only the ENS feature but also integration with CRISP to share clinical data, consistent with CRISP's goals and objectives for 2016. As part of BATP, by the end of 2Q2016, CRISP plans to have 80% of AAMC-associated SNFs connected to ENS and, depending on system capabilities, to the clinical portal, for the purposes of sharing clinical data.

3. Describe the specific target population for each major strategy:

A. Design, test and implement new CRISP provider-to-provider communication tools for the care of our high-utilizing patients. Target Population: Medicare and Dual-Eligible patients with 2-6 chronic conditions who are high utilizers (≥ 3 episodes of bedded care in 12 months). We will also target behavioral health patients who have complex medication regimens that a non-mental health provider may unintentionally disrupt and in so doing precipitate a crisis. Other initial target populations include patients with advanced complex illness who are enrolled in the3CI program, for which they have an assigned care team. Alerting other providers of their enrollment in 3CI will allow treatment to be tailored to the 3CI patients' defined goals of care.

B. Provide a Senior Triage Team of experts to intervene and address the nonmedical needs of vulnerable seniors and disabled individuals. Target population: **super** high-utilizing Medicare and dual-eligible patients with > 5 ED/Observation visits or hospitalizations in the past 12 months.

C. Form a SNF Collaborative to share data, problem-solve, and improve performance on length of stay (LOS), unplanned transfers and readmissions: Target population: AAMC discharges approximately 2,700 (mostly Medicare and dual-eligible) patients per year to SNFs. We expect to engage the SNFs that care for at least 80% of that population.

D. Integrate behavioral health and primary careby providing navigational support to patients with behavioral health needs: Target population: We know that 66% of our regional partnership Medicare high utilizer population has a mental health (54%) or substance misuse (3%) diagnosis, with 9% having both diagnoses. All individuals in need of urgent behavioral health interventions, as identified by community medical

practices, who would otherwise decompensate and need ED intervention will have access to our behavioral health navigators. The target population for the primary-care embedded LCSW model will be those patients whose behavioral health needs are presenting obstacles to effective self-management of somatic disease, as identified by the primary care clinicians.

E. Develop the Collaborative Care Network (CCN) and begin sharing data, resources and opportunities with independent and employed physicians. Target population: all patients with multiple chronic diseases who are high-utilizers or are in the rising-risk pool, in a region that serves 1 million patients in total. Target *provider* population: those clinicians who provide care to the high-risk and rising risk populations: ED physicians, intensivists, hospitalists, primary care physicians, key specialty practices.

F. Implement PCMH-based "Quality Coordinators" who manage panels of patients, identifying and addressing care gaps. Target population: patients with diabetes, hypertension, lung and heart disease in primary care panels, at least 15,000 patients. (at least 200 patients per FTE primary care provider).

G. Implement a One-Call Care Management solution for ambulatory providers to access care management services for vulnerable, complex patients. Target population: high-risk patients with nonmedical needs that put them at risk for future ED use or hospitalization owing to ineffective self-management of disease, as identified by ambulatory clinicians.

H. Implement home-based services that enable vulnerable patients to receive care at home, decrease hospital use and improve quality of life: Target population: Medicare or Dual-Eligible patients with chronic disease and no transportation, also patients with advanced, complex illness (3CI patients).

I. Intensify readmission reduction efforts to look for patterns that lead to clinical misadventures. Target population: As part of BATP, AAMC will employ a Readmissions Clinical Analyst, who will research and create an action plan for each readmitted patient (approximately 150/month), with special emphasis on those readmitted within 15 days

J. Leverage CRISP regionally in our community of practice and assist in the development of new features to coordinate care. Target population: As part of BATP, AAMC will create CRISP-dependent interventions, including shared Care Alerts, Care Plans, and the SNF Collaborative for patients who are high-utilizers or rising-risk in ambulatory primary care and specialty care practices. The target *provider* population are those key practices in the community that provide care to high-risk or rising-risk individuals: primary care, cardiology, endocrinology, nephrology, etc.

4. Describe the specific metrics that will be used to measure progress, including patient satisfaction, quality, outcomes, process and cost metrics for each major strategy:

AAMC's aggregate performance will continue to be assessed using outcome measures, to include total hospital cost per capita, total hospital admits per capita, total health cost per person, ED visits per capita, readmissions, potentially avoidable utilization, HCAPHS scores, and composite quality measures as reported by HSCRC and/or CRISP. *What follows is a description of the metrics unique to each AAMC strategy.*

A. Design, test and implement new CRISP provider-to-provider communication tools for the care of our high-utilizing patients: Specific metrics: Number/percent of target population with Care Alerts and Care Plans, number of providers enrolled in secure texting solution. CRISP will assist in measuring pre- and post-intervention hospital activity and charges for those patients with Care Alerts and Care Plans.

B. Provide a Senior Triage Team of experts to intervene and address the medical and nonmedical needs of vulnerable seniors and disabled individuals. Specific metrics: Number of **super** high-utilizing Medicare and dual-eligible patients (≥ 5 ED/observations/admissions in past 12 months) who are being managed by the Senior Triage Team. In addition to documenting patient goals, progress and services/supports patients are receiving, patient satisfaction will be measured via a survey at the end of the care engagement. Since this team will also visit the hospital and assist with patients who have no safe discharge disposition, the number of guardianships that are established by the team will be tracked. CRISP will assist in measuring pre-and post-intervention hospital activity and charges for those patients addressed by the team.

C. Form a SNF Collaborative to share data, problem-solve, and improve performance on length of stay (LOS), unplanned transfers and readmissions. Specific metrics: This BATP initiative includes a SNF Reporting Pilot with CRISP. This reporting pilot will monitor for each SNF the number of hospital discharges, subsequent unplanned transfers to any other facility, and readmission data. Each SNF will participate in setting and meeting quality goals, commensurate with their capabilities and resources, and will be offered educational opportunities and best practice guidance. Patient satisfaction will be measured at the SNF level. Staffing models will be measured, as well as rates of potentially preventable complications.

D. Integrate behavioral health and primary care, provide navigational support to patients with behavioral health needs. Specific metrics for the Behavioral Health Navigator Program include numbers of medical practices enrolled, numbers of community behavioral health providers enrolled, number of patients enrolled, how many patients have accessed the service, plus drop-out metrics. Specific metrics for integrated behavioral health, using LCSWs in the clinics, will include: number of unduplicated patients seen, number of new and follow-up visits, patient satisfaction, financial analysis and sustainability of model.

E. Develop the Collaborative Care Network (CCN) and begin sharing data, resources and opportunities with independent and employed physicians. Specific metrics: Quality and cost performance per physician, patient access measurements (e.g. time to get appointment), aggregate service-line patient satisfaction or specific clinician-related patient satisfaction.

F. Implement PCMH-based "Quality Coordinators" who manage panels of patients, identifying and addressing care gaps. Specific metrics: performance on quality measures for management of chronic disease per clinician panel for attributed patients, e.g. diabetes and hypertension control; patient satisfaction measures per clinician.

G. Implement a One-Call Care Management solution for ambulatory providers to access care management services for vulnerable, complex patients. Specific metrics: numbers of calls, patient zip codes, types of services needed, number of referrals to community Care Management services, number of referrals for social services and supports, and mapping of needed services (to provide a real-time community health needs assessment so that future interventions can be planned and implemented).

H. Implement home-based services that enable vulnerable patients to receive care at home, decrease hospital use and improve quality of life: Specific metrics: number of patients referred for home-based medical care, number of patients enrolled in 3CI, hospital activities and charges pre-and post 3CI enrollment for this cohort of patients (measured by CRISP reporting services). Patient satisfaction will be monitored in 3CI population.

I. Intensify readmission reduction efforts to look for patterns that lead to clinical misadventures: Specific metrics: HSCRC readmission rate, number of readmissions analyzed, number of performance improvement activities implemented.

J. Leverage CRISP regionally in our community of practice and assist in the development of new features to coordinate care. Specific metrics: numbers of key ambulatory practices, SNFs and physicians that are participating in the ENS and contributing clinical data to the CRISP clinical query portal.

5. List other participants and describe how other partners are working with you on each specific major strategy.

A. Design, test and implement new CRISP provider-to-provider communication tools for the care of our high-utilizing patients. We have engaged the IT teams and physicians and PFACs of both AAMC and UM BWMC to work with CRISP to develop, test, implement, refine and promote these tools and features so that they meet patient and clinician requirements.

B. Provide a Senior Triage Team of experts to intervene and address the medical and nonmedical needs of vulnerable seniors and disabled individuals. We have engaged the DoAD, county EMS, plus hospital-based and community-based care management to identify high-risk individuals. The DoAD itself has access to numerous community-based resources that they may apply to for any individual, including resources that supply assisted living resources or assistance with ADLs in patients' homes.

C. Form a SNF Collaborative to share data, problem-solve, and improve performance on length of stay (LOS), unplanned transfers and readmissions. AAMC is inviting all area SNFs to take part in the Collaborative and we expect 8 or 9 facilities in our region, responsible for at least 80% of our discharges to SNFs, will join. We will, as part of the Collaborative, invite other parties to provide their expertise, e.g. the Senior Triage Team, clinical experts in infection control, wound management, and care management, and members of the PFAC with the aim of improving quality of care and patient experience. Also, CRISP is providing SNF Reporting.

D. Integrate behavioral health and primary care, provide navigational support to patients with behavioral health needs. Currently 7 community-based behavioral health resources have agreed to expeditiously take referrals from the Behavioral Health Navigator program: First Step Recovery Center, Adept Behavioral Health, Oasis, AAMG Mental Health Specialists, Pathways, Arundel Lodge, and Spectrum Behavioral Health. The embedded behavioral health LCSW model will involve at least one moderate-sized employed primary care practice or two smaller sized primary care practices as a pilot. These practices are being identified currently.

E. Develop the Collaborative Care Network (CCN) and begin sharing data, resources and opportunities with independent and employed physicians. Advocate Physician Partners Advisors is engaged as our consultant as we develop the governance and infrastructure to support physician alignment and initiatives that will improve care episodes, reduce utilization, and control costs. Key practices include hospital-based

clinicians (ED, hospitalists, intensivists) and community-based providers in primary and specialty care. Supplementing the effort by providing ancillary services are our collaborative, community-based partners such as Capital Coordinated Medicine, and Chesapeake Palliative Medicine, The Coordinating Center (a community-based care management vendor) and our regional SNF community. Data analytics (the provision of performance reports) will involve AAMC's native resources.

F. Implement PCMH-based "Quality Coordinators" who manage panels of patients, identifying and addressing care gaps. This strategy will be piloted with our employed primary care practices that are part of the ACO. Quality Coordinators will be hired by the AAMC management services organization and their work will be monitored by the CCN. Quality Coordinators will access partnering care management resources (The Coordinating Center, others) by following established algorithms.

G. Implement a One-Call Care Management solution for ambulatory providers to access care management services for vulnerable, complex patients. AAMC's established call center will provide this new service which will be integrated with the Care Alert/Care Plan features as well as community-based care managers in both private (The Coordination Center, payer-provided services) and public sectors (DoAD's Senior Triage Team).

H. Implement home-based services that enable vulnerable patients to receive care at home, decrease hospital use and improve quality of life. Capital Coordinated Medicine will provide home-based medical services. 3CI (a program of Chesapeake Palliative Medicine) will provide home-based and telephonic-based services for patients with advanced, complex illness. Community medical practices will refer patients to either program.

I. Intensify readmission reduction efforts to look for patterns that lead to clinical misadventures. This project will involve intense review by one individual hired by AAMC, and will be supported by AAMC data analytic resources. Care process improvement initiatives that arise from the role's investigative efforts will be implemented by multidisciplinary teams (e.g. nursing, care management, pharmacy, physicians).

J. Leverage CRISP regionally in our community of practice and assist in the development of new features to coordinate care. CRISP's ambulatory integration services will reach out to the multiple ambulatory practices and SNFs that AAMC engages and recruits.

6. Describe the overall financial sustainability plan for each major strategy:

A. Design, test and implement new CRISP provider-to-provider communication tools for the care of our high-utilizing patients: Financial sustainability: The "heavy lifting" for Care Alert and Care Plan technology for AAMC, UM BWMC , and CRISP technology experts will be done in the first half of 2016. The downstream benefit of the features will best be demonstrated by CRISP's ability to measure hospital costs and events before and after the Care Alert and Care Plan features are implemented, per patient. Initial pilot results at UM BWMC have demonstrated a 60% reduction in intra-hospital utilization.

B. Provide a Senior Triage Team of experts to intervene and address the nonmedical needs of vulnerable seniors and disabled individuals. Financial sustainability: AAMC will ensure that the interventions provided actually avoid costs and/or decrease costs for our super-utilizers. For example, the Senior Triage Team will off-load the

work of inpatient care coordinators by taking responsibility for establishing guardianship of abandoned adults, an activity that otherwise consumes many person-hours. The cost of the intervention will be tracked and balanced against the avoidance of an extended LOS at the hospital. If the intervention is successful, it will pay for itself in reducing PAU.

C. Form a SNF Collaborative to share data, problem-solve, and improve performance on length of stay (LOS), unplanned transfers and readmissions. Financial sustainability: The costs of this initiative are primarily resources: Post Acute-Care Manager (PCM) and Readmissions Clinical Analyst positions, with some cost for quarterly 'all hands' SNF meetings. The PCM resource will lead communication and quality improvement activities that welcome and guide SNF participation and improvement. Financial sustainability of the model will be predicated on the decrease in readmissions and unplanned transfers that would count as PAU, which will be measured.

D. Integrate behavioral health and primary care, provide navigational support to patients with behavioral health needs. Financial sustainability: Two-thirds of AAMC's target population of high-utilizers suffers from some behavioral health disorder. The medical community can, with this intervention, address behavioral health needs of the target population by implementing the behavioral health navigator program. This will increase the likelihood that somatic health will be better-managed and hence PAU will decrease. The primary care-embedded behavioral health LCSW will be billing for services, and that will support sustainability for this program. Also AAMC will be able to track behavioral health ED visits; we expect to see those decrease if the Behavioral Health Navigator Program is successful.

E. Develop the Collaborative Care Network (CCN) and begin sharing data, resources and opportunities with independent and employed physicians. Financial sustainability will be acquired at multiple potential sources. For example, if gain sharing and bundling efforts are successful, the financial sustainability is apparent. If per member per month payments are afforded through new insurance products' high-performing network strategy, that will sustain care coordination efforts in primary care. If incentive programs are developed with, for example, the ICU physicians or ED physicians to reduce PAU, the effort will be sustainable financially.

F. Implement PCMH-based "Quality Coordinators" who manage panels of patients, identifying and addressing care gaps. Financial sustainability: in direct and indirect ways, better management of chronic disease at the population level creates its own sustainability, particularly if there is a payer partner. In Maryland, the ultimate payer partner is the All-Payer Model. If we better manage chronic disease at the ambulatory practice level, we will prevent some rising-risk patients from becoming tomorrow's high-utilizers and will decrease PAU. Other payers, e.g. CareFirst, directly reward primary care providers for better performance on quality measures, providing sustainability.

G. Implement a One-Call Care Management solution for ambulatory providers to access care management services for vulnerable, complex patients. Financial sustainability: this model is an investment that creates efficiencies and reduces the wasted effort and expense of paying for duplicative care management resources. By hiring and cross-training staff on available resources and status of services from hospital, public, private, government and payer organizations to handle these calls and access Care Alerts and Care Plans, we can safely and efficiently redirect patients to responsible care managers in the ambulatory environment.

H. Implement home-based services that enable vulnerable patients to receive care at home, decrease hospital use and improve quality of life. Financial sustainability: house call services and chronic care management are billable services for Capital Coordinated Medicine. Chesapeake Palliative Medicine has a grant for 3CI and will soon start a CMMI demonstration project to supplement its services to patients in the area.

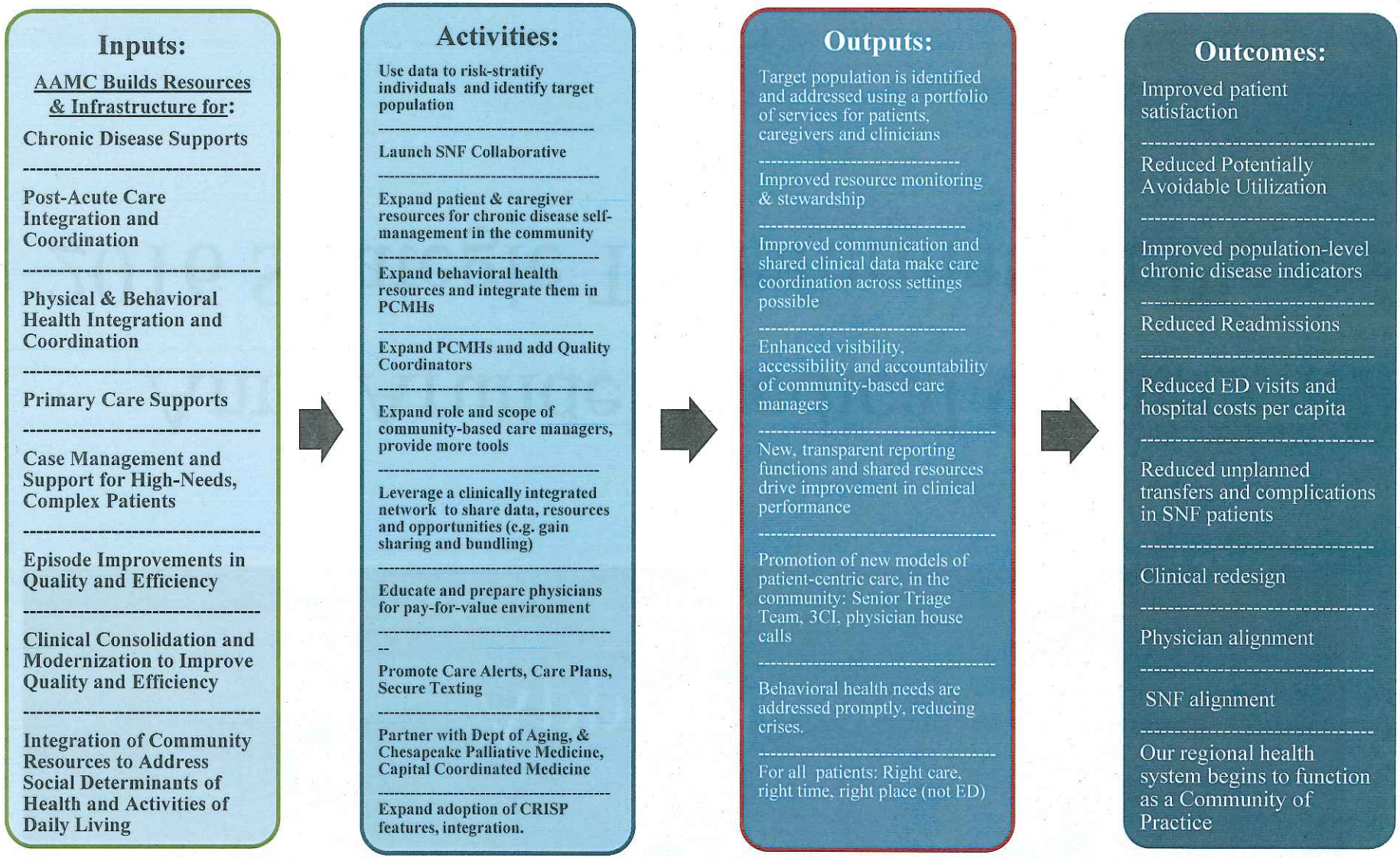
I. Intensify readmission reduction efforts to look for patterns that lead to clinical misadventures. Financial sustainability: this expense is an investment in targeting and reducing readmissions for AAMC and helping avoid penalties for readmissions as well as PAU. It should thus pay for itself.

J. Leverage CRISP regionally in our community of practice and assist in the development of new features to coordinate care. Financial sustainability: this is a nominal-cost feature for AAMC and will involve recruiting practices and SNFs in CRISP's efforts to integrate clinical data into the clinical query portal and expand the ENS feature which will benefit the practices and patients as well as AAMC.

Appendices

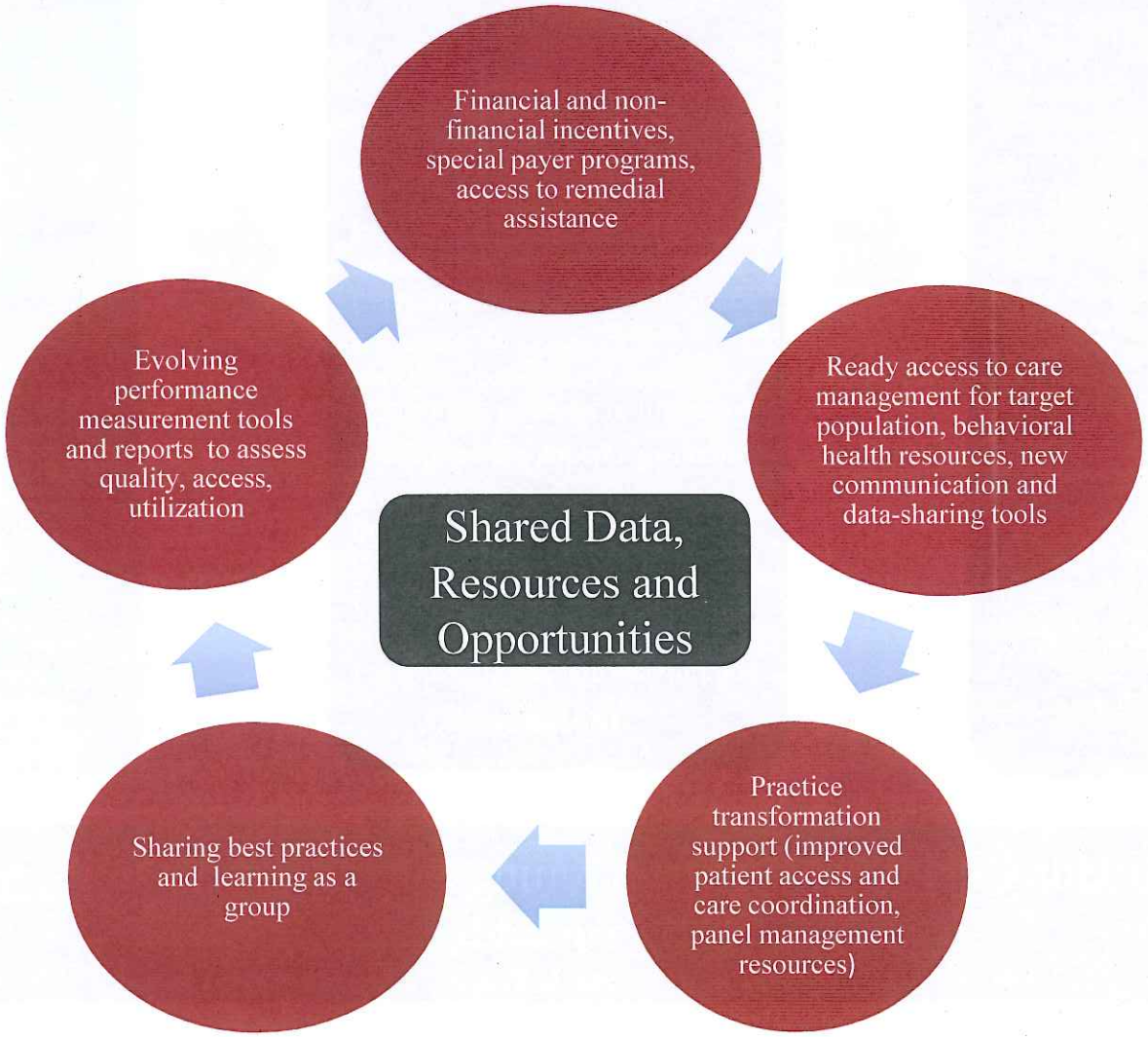
Anne Arundel Medical Center
2016 Strategic Transformation Plan

Appendix A
AAMC's 2016 Population Health Improvement Logic Model



Appendix B
Preparing the AAMC Community of Practice* for a Value-Based Payment Environment

*Independent and Employed Inpatient and Ambulatory Physician Practices, SNFs, Dialysis Centers



Appendix C
How AAMC's Past, Current, and Future GBR Investments Support the STP

Prior to 2015

- Established New and Expanded Existing Primary Care Practices
- Adopted NCQA PCMH Model
- Established MSSP ACO
- Established a Health Enterprise Zone
- Expanded portal to non-Epic physician practices, public health, SNFs.
- Promoted patient portal to enhance patient engagement and activation.
- Established Neurology practice (critical need)
- Established bilingual community clinics for uninsured, under-insured patients
- Contracted with community-based care management vendors for high-risk ACO patients and all patients at risk for readmission
- Launched palliative care program

Current

- Establishing outpatient adult and child psychiatry practices
- Establishing partial hospitalization and intensive outpatient behavioral health programs
- Establishing Diabetes Program
- Continuing to assist uninsured in applying for state-sponsored coverage
- Establishing clinically integrated network
- Establishing new data analytic capabilities to complement CRISP reports and provide clinicians with performance data
- Expanding scope of community-based care management
- Creating patient panel disease registries
- Piloting behavioral health navigator
- Expanding palliative care program

Future (2016)

- Leveraging ACO for gain sharing and bundling to promote physician alignment
- Providing practice supports to manage populations
- Partnering with public sector care management to share data and resources to address non-medical needs of high-utilizers
- Expanding Behavioral Health Navigator program to ensure timely treatment of urgent needs
- Creating a new collaborative relationship with post-acute providers to drive clinical performance
- Designing and testing clinical communication tools with CRISP and UM BWMC that will be propagated statewide.
- Creating a One-Call Care Management resource for clinicians
- Expanding navigational resources for patients needing financial and other resources to self-manage disease successfully

Appendix D, Page i
How Bay Area Transformation Partnership's Activities Relate to AAMC's 2016 Strategic Transformation Plan

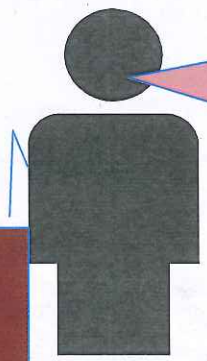
The majority of activities outlined in AAMC's STP relate directly to the BATP Implementation Plan, *see next page*

Appendix D, Page ii
How Bay Area Transformation Partnership's Activities Relate to AAMC's Strategic Transformation Plan

These Planned 2016 AAMC STP Activities are part of the BATP Implementation Plan and Regional Transformation Funding Proposal:

Shared Care Alerts	Shared Care Plans	Secure Texting
One-Call Care Management	Senior Triage Team (Dept of Aging & Disabilities)	SNF Collaborative
Behavioral Health Navigator Program	Integration of Behavioral Health in PCMH	Clinically Integrated Network
Expansion of Community-based Care Management	Physician house calls	Readmissions Clinical Analyst
PCMH-based Quality Coordinators	CRISP Ambulatory Integration	Post-Acute Care Manager

Appendix E, page i
How Care Alerts, Care Plans, and Secure Texting Coordinate Care and Reduce Potentially Avoidable Utilization



"A Care Alert is like an electronic MedicAlert bracelet that follows me across the health system and keeps me safe." – PFAC member

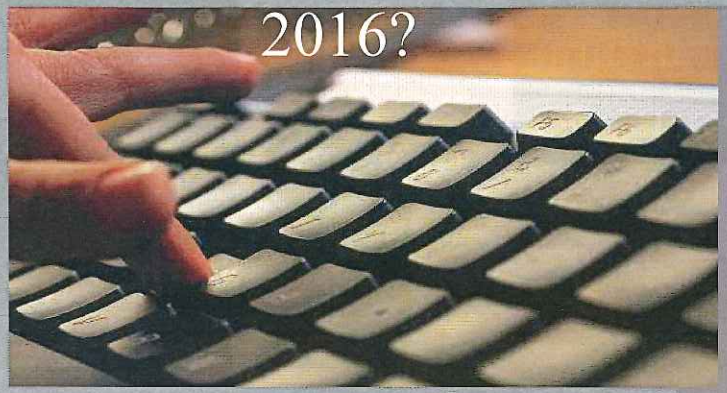
Care Alert:

Mr. P is a diabetic who has frequent exacerbations of CHF, usually due to missed doses of medication or dietary indiscretion. He usually does well with 40 mg IV furosemide and close follow up the next day. Securely text Dr. Y to arrange follow up or discuss his case if you feel admission or further evaluation may be necessary.

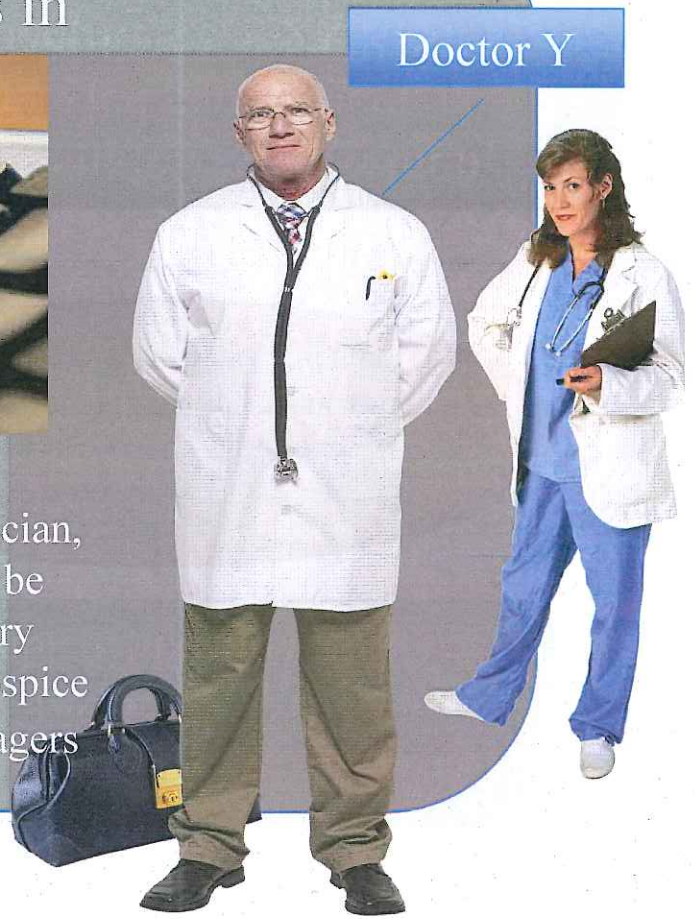
Case Example: Mr. P, a high-utilizing Medicare patient, has been identified using CRISP's PaTH report. His physician, Dr. Y, has written a Care Alert to break the cycle of admission and readmission. The Care Alert is uploaded in the local Epic EMR in a specific field recognized by CRISP.

Appendix E, page ii
How Care Alerts, Care Plans, and Secure Texting
Coordinate Care and Reduce Potentially Avoidable Utilization

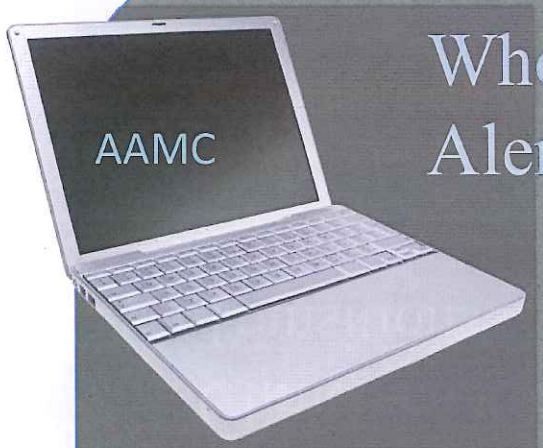
Who Will Create Care Alerts in 2016?



In Mr. P's case, Dr. Y, his house call physician, wrote the Care Alert. Care Alerts can also be created by ED and inpatient and ambulatory clinicians, behavioral health clinicians, hospice or palliative care providers, and care managers inside or outside the hospital.



Appendix E, page iii
How Care Alerts, Care Plans, and Secure Texting
Coordinate Care and Reduce Potentially Avoidable Utilization



Who Sees Care Alerts in 2016?

Thanks to CRISP technology, whether Mr. P arrives at AAMC or UM BWMC, his Care Alert appears instantly when he registers. Epic clinicians, such as AAMC or UM BWMC ED clinicians, specialists, hospitalists, and ambulatory providers, have instant, effortless access to the Care Alert; no searching or separate log-on is necessary. Non-Epic users have access to Care Alerts through the CRISP Portal.

Appendix E, page iv
How Care Alerts, Care Plans, and Secure Texting
Coordinate Care and Reduce Potentially Avoidable Utilization

Secure Texting in 2016 Will Connect Clinicians, Coordinate Care, Create Safe Transitions:

"Mr.P is here again at AAMC ED, fluid-overloaded but labs are okay. Here's an image of his EKG, nothing new. He's responding to 40 mg furosemide. I can send him home if you can see him tomorrow."

"That sounds fine. He's on my route for house calls tomorrow anyway. Tell him I'll be at the house around 3 PM and to take another 20 meq of potassium tonight."

"Will do. "

What's different? Rapid, HIPAA-compliant information-sharing without the hassles of operators, front desks, or voice mail.

Appendix E, page v

How Care Alerts, Care Plans, and Secure Texting Coordinate Care and Reduce Potentially Avoidable Utilization

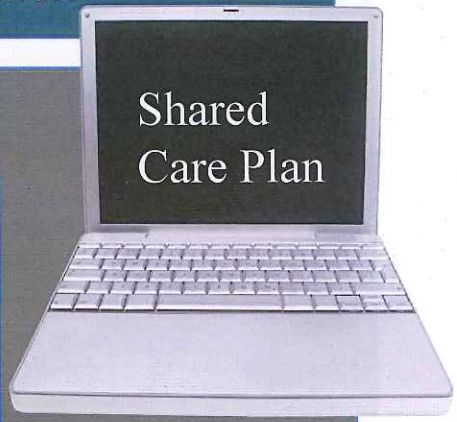
Care Plans, created by community-based care managers, and shared through CRISP, will aid inpatient and ED clinicians and care managers by

-Saving time & resources: needed information about the patient's living situation, obstacles, and progress is already documented.

-Ensuring safe transitions: the inpatient or ED care manager can contact and collaborate with the community-based care manager.

-Improving outcomes: Care Plans list patient-centric goals of care and advance care plans so treatment can be tailored to match.

-Coordinating the coordinators: the community-based care manager assigned to the patient is visible, accessible, and accountable.



Appendix E, page vi
How Care Alerts, Care Plans, and Secure Texting
Coordinate Care and Reduce Potentially Avoidable Utilization

Care Plan Example

Our patient, Mr. P, has been assigned a community-based care manager, Ms. Q, who visits him, performs a health risk assessment, and formulates a Care Plan within Epic's Healthy Planet feature. The Care Plan is shared electronically through CRISP.

A sample of Mr. P's Care Plan's features:

- A list of his medical and nonmedical needs
- His goals and advance care plans
- Progress toward his goals
- A list of his care team members and how to reach them
- Current medications
- A risk score that automatically changes with his clinical status
- A feature that alerts Ms. Q when his risk score changes or he is due for an intervention

Appendix F
The Collaborative Care Network's 2016 Activities to Improve Outcomes and Efficiencies

Creating Governance and Infrastructure

- Convening combined physician/ health system board of managers, and committees for effective and responsible decision-making
- Encompassing and building upon ACO activities and infrastructure
- Expanding data analytic capabilities and care management portfolio of services

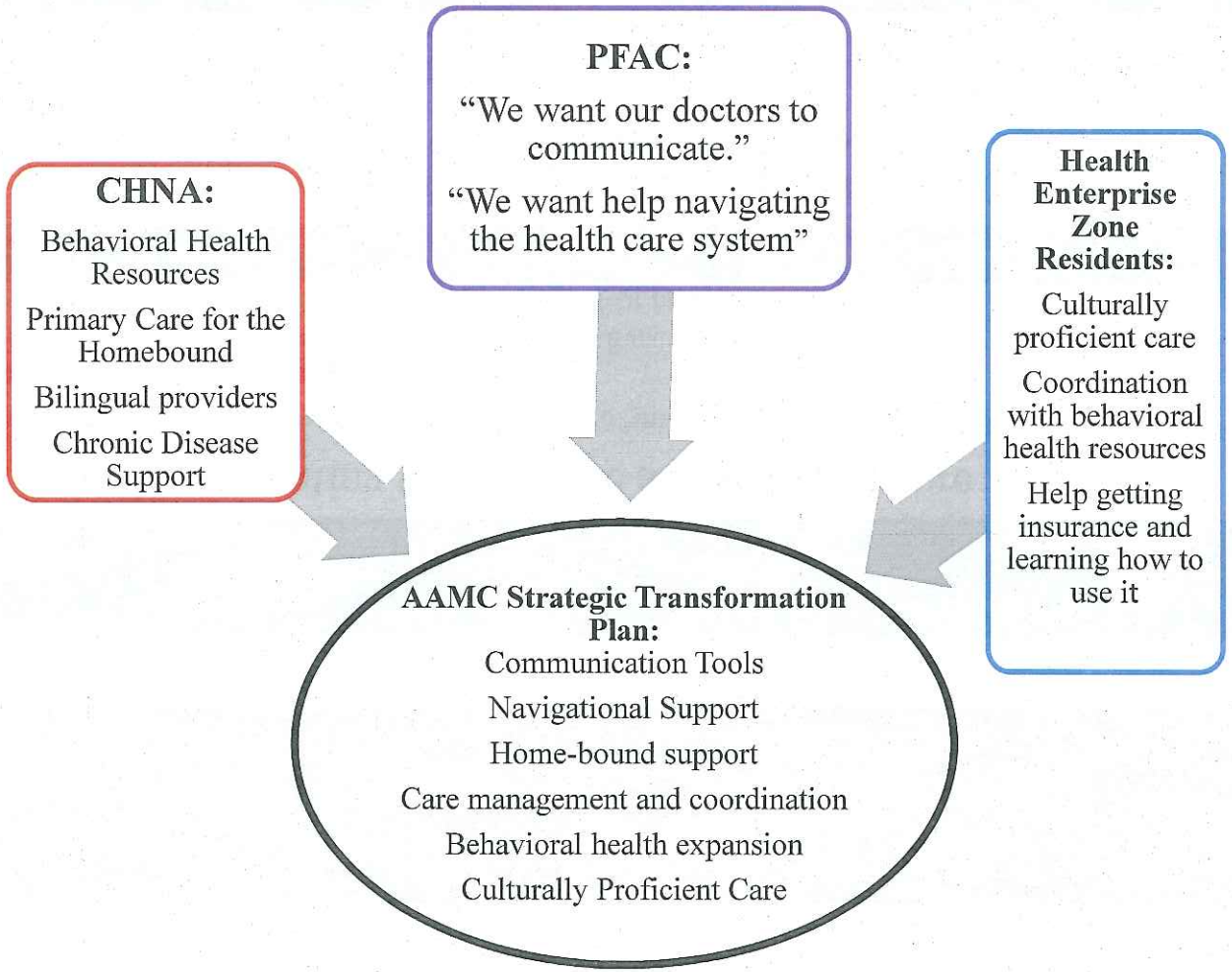
Managing Projects and Resources

- Managing the work of BATP: e.g. SNF Collaborative, PCMH Quality Coordinators, One-Call Care Management
- Promoting and monitoring Care Alerts, Care Plans, Secure Texting
- Monitoring community-based care management effectiveness and ROI

Exploring New Opportunities

- Leveraging the MSSP ACO for gain sharing and bundling arrangements
- Providing support for documentation and billing of TCM and CCM codes when applicable
- Educating providers and preparing them for risk-sharing and accountability for TCOC

Appendix G
Community Needs Inform AAMC's 2016 STP



Appendix H
Addressing the State's 8 Domains: AAMC's STP for 2016

Domain:	AAMC STP Initiatives in 2016 that address the domain:
Chronic Disease Supports	Shared Care Plans, Community Care for Complex Illness, Physician House Calls, One-Call Care Management, Quality Coordinators (patient panel managers) in PCMHs, Senior Triage Team, Behavioral Health Navigator Program, PFAC
Long-term and Post-Acute Care Integration and Coordination	SNF Collaborative activities, Post-Acute Care Manager role, Care Alerts, Care Plans, Secure Texting, Readmissions Clinical Analyst, Physician Housecalls, CRISP/SNF reporting pilot and integration, PFAC
Physical and Behavioral Health Integration and Coordination	PCMH-embedded behavioral health resources, Behavioral Health Navigator Program, Care Alerts, Care Plans, Secure Texting, PFAC
Primary Care Supports	PCMH-embedded Quality Coordinators, Collaborative Care Network, Care Alerts, Care Plans, One-Call Care Management, PFAC
Case Management and other Supports for High Needs and Complex Patients	Care Alerts, Care Plans, secure texting, One-Call Care Management, Physician Housecalls, Senior Triage Team
Episode improvements, including quality and efficiency improvements	Collaborative Care Network, SNF Collaborative, Readmissions Clinical Analyst, Care Alerts, Care Plans, secure texting, Behavioral Health Navigator program, PCMH-embedded behavioral health resources
Clinical consolidation and modernization to improve quality and efficiency	PCMH-embedded behavioral health resources, Collaborative Care Network, PCMH-embedded Quality Coordinators, One-Call Care Management, Behavioral Health Navigators, Community Care for Complex Illness
Integration of community resources to address social determinants of health	Senior Triage Team, Care Plans, One-Call Care Management, Physician Housecalls, Readmissions Clinical Analyst