Strategic Hospital Transformation Plan

Executive Summary:

University of Maryland Baltimore Washington Medical Center's (UM BWMC) mission is to provide the highest quality health care services to the communities we serve. We provide emergency, inpatient and outpatient services in more than forty specialties. In addition to clinical care, we offer a variety of community benefit activities including outreach and education, screenings, workforce development, and other community-building activities. Our clinical and community benefit programs and services are developed in response to our Community Health Needs Assessment (CHNA), analysis of hospital specific data and feedback from our patients and their families, medical staff and community partners.

UM BWMC's strategic transformation plan goal is the "Triple Aim" of improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care in support of Maryland's All-Payer model. Our plan calls for improved care delivery and population health, consistent with Maryland's framework for health system transformation. Our plan includes University of Maryland Medical System (UMMS) initiatives being deployed across our system; programs and services to respond to the specific needs of UM BWMC's patients, medical staff and surrounding community; and collaborative partnerships with interventions that are aligned with UM BWMC/UMMS initiatives. UM BWMC's plan requires working with internal and external partners to move beyond addressing acute medical and behavioral health conditions to addressing the range of factors that affect health (e.g. social determinants of health, care transitions, proactive chronic disease self-management). This long-term plan for population health improvement requires significant investments and strong leadership.

Specific strategic transformation investments detailed in this plan include:

A. UMMS Clinical Performance Improvement Councils
B. UM BWMC Transitional Care Center
C. UM BWMC Emergency Department Care Management
D. UM BWMC Skilled Nursing Facility Readmission Reduction Collaboration
E. UM BWMC Palliative Care Program
F. UM BWMC Population Health Leadership
G. Bay Area Transformation Partnership (Regional Transformation Partnership)
H. Healthy Anne Arundel Coalition (Local Health Improvement Coalition)

UM BWMC's plan also contains inpatient medical management, ambulatory care network development and expansion of behavioral health care services. These strategies include the UMMS initiatives described in Appendix I and UM BWMC-specific process improvements and ambulatory supports. In FY16-17, UM BWMC will focus on decreasing observation hours and

restructuring our hospitalist program. In CY17, we plan to offer behavioral health navigation services to primary care and OB/GYN practices as part of a larger strategic plan for behavioral health services currently under development.

Our strategic transformation plan includes partnerships with patients (specifically the Medicare population and high-utilizers of health care services); primary care, behavioral health and specialist providers; skilled nursing facilities and home health agencies; government agencies (e.g. Anne Arundel County Departments of Health, Aging and Disabilities and Social Services), social service agencies; community organizations and others. These working relationships are essential to our efforts to improve population health.

A significant component of our hospital strategic transformation plan includes the portfolio of projects included in the Bay Area Transformation Partnership (BATP) Implementation Plan (Appendix II) in collaboration with Anne Arundel Medical Center (AAMC). This plan addresses current gaps in the health care system with an emphasis on improving clinical workflows, risk stratifying the population, increasing provider communication using CRISP tools, expanding care coordination services and improving care transitions, integrating community resources, addressing social determinants of health and increasing physician alignment. The BATP enhances and expands existing successful programs, such as UM BWMC's ED Case Management and SNF readmission reduction programs. This plan was informed by input from provider focus groups, discussions with stakeholders throughout the region, findings from our CHNA and the input of both hospitals' patient and family advisory councils. The projects in this plan are intended to be able to be replicated and scaled up throughout the state.

Another component of our plan is strategic investments in community benefit programming. Our community benefit programming includes health promotion and outreach services to provide people with the education and tools to lead healthier lives, screenings so that people can be diagnosed with diseases when they are most treatable, financial assistance to those who could not otherwise afford health care services, provider subsides to increase access to care, health care workforce development, and other community building activities. UM BWMC's FY15 HSCRC Community Benefit Report (Appendix III) describes these initiatives and their alignment with the State Health Improvement Process and other Maryland priorities for population health improvement. UM BWMC's CHNA (conducted July-December 2015) will inform our next community benefit plan. That plan will be developed in the first half of 2016 and will complement the population health strategies outlined in this plan and state-level priorities.

UM BWMC's investments in clinical services efficiency and effectiveness, care coordination and care transitions, community benefit, collaborative partnerships and clinical leadership will help drive improvements in population health. UM BWMC is a leader in helping to connect community members with the medical, behavioral and social resources necessary to help them lead healthier lives. Ultimately these investments will result in improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care in support of Maryland's All-Payer model. Measures that will be used to track our progress include increases in the numbers of patients receiving care coordination services, reductions in potentially avoidable utilization (especially readmissions), decreases in length of stay, increases in patient satisfaction, and reduced costs.

UNIVERSITY of MARYLAND
BALTIMORE WASHINGTON
MEDICAL CENTER

Hospital Strategic Transformation Plan

1. Describe your overall goals:

   University of Maryland Baltimore Washington Medical Center's (UM BWMC) mission is to provide the highest quality health care services to the communities we serve. As part our mission, our overall goal for population health improvement is the "Triple Aim" of improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care in support of Maryland's All-Payer model.

   Our plan supports improved care delivery especially for chronic health conditions, reductions in health care utilization and costs, increases in patient satisfaction and improvements in population health. This plan is consistent with Maryland's health system transformation framework of:

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

2. List the overall major strategies (3-10) that will be pursued by your hospital individually or in collaboration with partners (and answer questions 3-6 below for each of the major strategies listed here):

<u>UM BWMC/UMMS Initiatives</u>

A. Clinical Performance Improvement Councils: These physician-led councils were developed to create system-wide standards and processes to objectively establish UMMS as a high value provider of key clinical services. The councils have engaged physicians sharing their knowledge base to demonstrate top performance in clinical and patient-oriented outcomes across our system, providing the highest quality of clinical care at the lowest possible cost. The twelve councils include: Hospitalist Care, Critical Care, Emergency Medicine Care, Sepsis, Palliative Medicine, Interventional Cardiology, Cancer Care, Radiation Oncology, Surgical Care, Spine Surgery, Total Joint Surgery and OB Care. This initiative was included in the UMMS GBR Infrastructure Report.

B. Transitional Care Center: In an effort to reduce 30 day readmissions and revisits UM BWMC will be opening this center in January 2016 offering medical stabilization, medicine reconciliation, self-management education and care coordination services to patients identified through our high risk care managers. The center will provide continuity of care and follow up to help patients maintain optimum health outside the hospital while teaching them to navigate the right care in the right setting. The center will help transition patients into the care of a permanent primary care provider.

C. Emergency Department Care Management: In 2012, UM BWMC added two care managers to the ED to ensure patients are being treated at the appropriate level of care, either within or outside of the hospital. These care managers are key members of a multidisciplinary team that creates care alerts for ED high-utilizers to improve care coordination and reduce potentially avoidable utilization (PAU). Care alerts, shared within our medical record system, have been written for 46 patients, resulting in reductions in UM BWMC ED visits (68%), CTs (59%), MRIs (40%), X-rays (30%), ED length of stay (64%), and inpatient admissions (69%). This initiative was included as patient centered investment in the UM BWMC GBR Infrastructure Report. Our BATP Implementation Plan calls for increased staffing to create and manage care alerts and the ability to share care alerts with AAMC via CRISP.

D. Skilled Nursing Facility Readmission Reduction Collaboration: UM BWMC collaborates with the leadership at five skilled nursing facilities (SNFs) that care for a significant volume of our post-acute patients to set readmission reduction targets based on HSCRC and UMMS standards. This program has helped to reduce SNF readmission rates. The BATP Implementation Plan calls for an expansion of this program that includes working with Anne Arundel Medical Center (AAMC) to offer a regional SNF Learning Collaborative, training and other resources to improve quality of care and care transitions. Collaborating with CRISP to improve data sharing with SNFs is also part of our BATP Implementation Plan.

E. Palliative Care Program: At the beginning of FY16, UM BWMC launched a formal palliative care program with dedicated resources to support patients with palliative care needs in order to better manage advanced complex illnesses. This program has demonstrated some preliminary successes and the program is expected to continue to grow in CY16. This program is designed to improve the quality of care, increase patient satisfaction, decrease readmissions and reduce unnecessary utilization. This initiative was included as a patient centered investment in the UM BWMC GBR Infrastructure Report.

F. Population Health Leadership: UM BWMC established several leadership roles to drive improvements in population health. UM BWMC will be starting a Population Health Medical Director position in 2016. This position will complement the existing inpatient team co-director position and the utilization review physician advisor position that are already in place using GBR population health funding. These positions help assure appropriate utilization and quality of care, while also facilitating improved care coordination and care transitions. These roles are essential to improving the quality of care, increasing patient satisfaction, reducing PAU and decreasing costs. This initiative was included as a provider/care team investment in the UM BWMC GBR Infrastructure Report and is supplemented by other hospital revenue sources.

Collaborative Initiatives

G. Bay Area Transformation Partnership (BATP; Regional Transformational Partnership): The BATP goals are focused on the improving the "Triple Aim" for patients served at AAMC and UM BWMC. BATP's CY2016 interventions include a portfolio of projects that will integrate and provide supports for primary care and behavioral health; improve care coordination and care transitions; increase coordination, integration and quality of care among post-acute and long-term care providers; and integrate community resources to assist with the social determinants of health. Increasing communication across providers and care setting by leveraging CRISP technologies are other key components of our plan. Specific sub-projects include:
   i. sharing care alerts and care plans via CRISP, and adding additional staff to increase capacity for creating and managing them;
   ii. providing ambulatory care supports (one-call care coordination service for use by primary care providers with future expansion to specialists, providing outpatient care management services and linking high-risk patients with a physician house call service);
   iii. integrating and coordinating physical and behavioral health (co-locating behavioral health services in our senior and primary care offices, offering consultative psychiatric service to primary care providers;
   iv. integrating and coordinating post-acute and long-term care services through a regional SNF Learning Collaborative to increase quality of care, improve care transitions and reduce PAU;
   v. deploying an Anne Arundel County Department of Aging and Disabilities Senior Triage Team to address the non-medical needs of approximately 350 Medicare patients with five or more inpatient admissions within six months;
   vi. increasing patient and family engagement by soliciting and incorporating feedback through joint meetings of the UM BWMC and AAMC Patient and Family Advisory Councils;
   vii. facilitating the expansion of CRISP services and adoption of CRISP features in order to drive clinical process improvements, increase care coordination and reduce PAU;

   The BATP Implementation Plan is detailed in Appendix II. This plan provides the necessary strategies to achieve our collective health system transformation goals while also being responsive to the individual operational needs of each hospital.
   The BATP will be submitting a proposal for CY16 implementation funding.

H. Healthy Anne Arundel Coalition (HAAC; Local Health Improvement Coalition): The HAAC serves in a convening or advisory capacity to population health improvement initiatives throughout the county. Several key components of the BATP Implementation Plan emerged out of earlier work from the Coalition including State Innovations Model planning and a previous Center for Medicare and Medicaid Innovation grant application. UM BWMC serves as Co-Vice Chair of the Coalition and actively participates on each of the Coalition's Subcommittees. The HAAC is conducting a Community Health Needs Assessment (CHNA) that is scheduled to be published in January 2016. The CHNA findings will inform a new Action Plan for the Coalition. UM BWMC will be actively involved in the development and implementation of this Action Plan and will devote resources in continued support of

the Coalition. This HAAC Action Plan will be aligned with and complement BATP and individual hospital plans and the strategic plans of other HAAC partners (e.g. County government departments). The current HAAC Action Plan is attached as Appendix IV. This plan focuses on obesity prevention since it is a major contributing risk factor to many chronic health conditions (e.g. diabetes, heart disease, cancer), the prevention and management of behavioral health conditions, and reducing health disparities among racial and ethnic minorities. Other identified health improvement priorities for the Coalition that have come into increasing focus since the Action Plan was last updated in July 2014 include increasing health care access and appropriate utilization of health care resources. Increasing chronic disease and behavioral supports, and improving access to the right care, at the right place, at the right time are integral strategies for transforming Maryland's health care system to improve health outcomes, increase patient satisfaction, reduce PAU and decrease costs.

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

   A. Clinical Performance Improvement Councils: The target population for these councils is two-fold. The primary target population is patients and caregivers who benefit from the outcomes of these workgroups. The second target population is the physicians and the care team who benefit from the efforts of these workgroups
   B. Transitional Care Center: This clinic will initially target patients whom are high utilizers of the emergency department, have repeat observation or inpatient admissions, have chronic conditions, have unmet psycho-social needs and who do not have a primary care physician. UM BWMC plans to eventually expand this program to other patients and offer treatment for behavioral health conditions. We anticipate approximately at least 50% of transitional care patients will be Medicare recipients.
   C. Emergency Department Care Management: The primary target population for this program is high-utilizers of the ED (three or more visits within three months). Based on FY15 data, 36% of ED high-utilizers (3 or more visits within one year) between UM BWMC and AAMC are Medicare patients.
   D. Skilled Nursing Facility Readmission Reduction Collaboration: The target population includes UM BWMC's post-acute patients at the SNFs that provide post-acute care to large numbers of our patients: North Arundel Health and Rehabilitation Center, Glen Burnie Health and Rehabilitation Center, Genesis Healthcare Severna Park Center, FutureCare Chesapeake, and Marley Neck Health and Rehabilitation Center. UM BWMC discharges approximately 2,170 patients per year to SNFs with 95% of those patients being Medicare recipients.
   E. Palliative Care Program: The target population for this service is patients who have been diagnosed with advanced complex illness and their caregivers. This program targets the 5% of patients who use more than 50% of the healthcare resources, often in the last year of their lives. The majority of our palliative care patients are Medicare patients.
   F. Population Health Leadership: The target population for the increased public health leadership is the UM BWMC medical staff, our community partners and our patients. The Population Health Medical Director/Utilization Review Physician Advisor will direct the continued success of the ED Case Management, SNF and Palliative Care

programs. The Population Health Medical Director will also provide leadership to the development of our community benefit plan and implementation of the BATP plan. Our population health leadership will also educate our physicians about the health system transformation and advocate the adoption of strategies and tactics to improve the quality or care, increase care coordination, reduce utilization and decrease costs.

G. Bay Area Transformation Partnership: The BATP target population for 2016, the first phase of the portfolio of projects, are Medicare/Dual-Eligible individuals with a utilization pattern of three or more ED visits, observation stays or hospitalizations in the past twelve months. Each project has target sub-populations/capacities. For example, UM BWMC expects to develop 150 care alerts shared via CRISP for patients with primary medical conditions and another 150 care alerts for patients with primary behavioral health conditions. We expect to develop at least 280 care plans (based on an average of 60 days of services per patient) in CY16 for high-need patients through contracted outpatient care coordination services with The Coordinating Center. The SNF collaborative project will reach the five SNFs that UM BWMC has historically worked most closely and additional SNFs in the region identified by AAMC. Appendix II details our target populations for each BATP sub-project.

H. Healthy Anne Arundel Coalition: HAAC's target population is Anne Arundel County residents and population health stakeholders. HAAC emphasizes reaching County residents impacted by obesity and related chronic somatic health conditions, behavioral health conditions, and racial/ethnic health disparities. Population health stakeholders that the Coalition seeks to engage include health care providers across all settings of care, government agencies and policy makers, community and faith based organizations, educational institutions, businesses and others.

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**:

A. Clinical Performance Improvement Councils: Each council has identified specific metrics for their respective service lines to measure the success of their goals to improve the quality of care, enhance the patient experience and reduce costs. Common metrics tracked by these councils include readmissions, length of stay, potentially preventable complications and costs of care.

B. Transitional Care Center: Metrics to measure progress include clinic volumes (by individual services offered and in aggregate), patients transitioned to primary care providers within ninety days, reduced utilization (ED visits, observation stays, inpatient admissions) and variable hospital cost savings.

C. Emergency Department Care Management: Metrics to measure progress include a decrease in ED visits among patients receiving care management services and decreased costs of care. The ED Care Management program has resulted in 103 adverted admissions and 32 adverted readmissions in the first four months of FY16. Care alerts, shared within our medical record system, have been written for 46 patients, resulting in reductions in UM BWMC ED visits (68%), CTs (59%), MRIs (40%), X-rays (30%), ED length of stay (64%), and inpatient admissions (69%).

D. Skilled Nursing Facility Readmission Reduction Collaboration: Each year, UM BWMC sets readmission reduction targets with the leadership at each of the five SNFs that care for

a significant volume of our post-acute patients. Each month, individual readmissions are reviewed by the collaborative multi-disciplinary team and readmission rates are calculated and tracked for each facility.

E. Palliative Care Program: The initial metric for measuring the success of this program is the number of palliative care referrals/consults (target of 360 in FY16).
F. Population Health Leadership: Decreases in PAU (especially readmissions) and cost reductions are used to help measure progress. Qualitative feedback received from our medical staff is also used to evaluate the effectiveness of our population health leadership.
G. Bay Area Transformation Partnership: The BATP will be using the core outcome measures identified by the HSCRC/DHMH to measure the overall outcomes for our portfolio of inter-related projects for our target patient population: total hospital cost per capita, total hospital admits per capita, total health care cost per person, ED visits per capita, all cause 30 day readmissions, potentially avoidable utilization and patient experience (HCAPHS). The BATP will also be using the core process measures identified by the HSCRC/DHMH (e.g. use of CRISP ENS, use of shared care plans, patients having contact with a care manger, variable savings). BATP will also use the regional partnership ROI calculator. Additionally, we will track process and outcomes measures by specific sub-projects as outlined in the BATP Implementation Plan attached as Appendix II. For example, we will measure the number of patients who had a care alert created and the resulting decreases in utilization and costs. BATP will utilize program records, CRISP reports and analyses competed by hospital staff and Berkley Research Group to measure progress and assess return on investment.
H. Healthy Anne Arundel Coalition: The Coalition's Action Plan contains metrics to measure progress. These metrics include process measures and timelines for specific action steps and State Health Improvement Process (SHIP) outcome measures. SHIP measures include increasing the proportion of adults who are at a healthy weight, reducing the proportion of youth who are obese, reducing the rate ED visits related to behavioral conditions and reducing the rate of drug-induced deaths. Additionally, although difficult to measure, one of the Coalition's best outcomes is that it brings diverse partners together to work on improving population health and has served as a springboard for other collaborative initiatives including the BATP.

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

   A. Clinical Performance Improvement Councils: UMMS employed physicians, University of Maryland School of Medicine faculty members and community physicians lead these councils. Partners include nursing executives, quality improvement and data analytics staff, hospital and service line leadership, supply chain and vendors. Other partners include other physician specialties as these workgroups collaborate across specialties to improve patient care and outcomes. Physician leadership consults with other clinical leaders from Maryland and the U.S.
   B. Transitional Care Center: The clinic staff will collaborate with primary care providers (including FQHCs), specialist providers (including mental health and substance abuse providers), governmental agencies (Department of Health, Aging and Disabilities, Social Services, Mental Health Agency) and community-based agencies to meet the

medical, behavioral and social needs of patients.

C. Emergency Department Care Management: The ED Care Managers collaborate with primary care providers (including FQHCs), specialist providers (including mental health and substance abuse providers), governmental agencies (Departments of Health, Aging and Disabilities, Social Services, Mental Health Agency) and community-based agencies to meet the medical, behavioral and social needs of patients.
D. Skilled Nursing Facility Readmission Reduction Collaboration: The SNFs include North Arundel Health and Rehabilitation Center, Glen Burnie Health and Rehabilitation Center, Genesis Healthcare Severna Park Center, FutureCare Chesapeake, Marley Neck Health and Rehabilitation Center. Other partners include UM BWMC clinical (inpatient, primary care, senior care) and care management leadership and staff, home health care agencies and hospice providers.
E. Palliative Care Program: Key partners for the palliative care program include physician and nurse leadership, front-line clinical staff, care management staff, patients and their families. Hospice of the Chesapeake/Chesapeake Palliative Medicine was an integral partner in developing our program.
F. Population Health Leadership: UM BWMC's population health leadership will work collaboratively with all of the partners identified in throughout our strategic transformation plans and throughout the state. Examples of partners that our population health leadership will work with include medical staff members, nursing and care management staff, community outreach staff, SNFs, home health agencies, behavioral health providers and many others. Our population health leadership works with these partners to identify patient and provider needs, identify opportunities for improvement and develop strategies for reducing potentially avoidable utilization and enhancing care coordination.
G. Bay Area Transformation Partnership: BATP partners include the following: AAMC, the Healthy Anne Arundel Coalition, the County Departments of Health, Aging and Disabilities, and Social Services, Anne Arundel County Mental Health Agency, Inc., Anne Arundel County Partnership for Children, Youth and Families, CRISP, the medical staff of AAMC and UM BWMC (employed and community-based), SNFs, and the AAMC and UM BWMC Patient and Family Advisory Councils. All of these entities provided input in the planning process and will be involved in the successful implementation of the BATP Implementation Plan. Many of the aforementioned organizations will be invited to have a representative serve on the BATP Advisory Council. The BATP Implementation Plan includes detailed descriptions of the roles and responsibilities of partner organizations.
H. Healthy Anne Arundel Coalition: The Healthy Anne Arundel Coalition includes representatives from health care providers, government agencies, community and faith based organizations, businesses and others. A partial listing of Coalition members is as follows: Anne Arundel Medical Center; Anne Arundel County Executive's Office and Departments of Health, Aging and Disabilities, Recreation and Parks, and Social Services; Anne Arundel County Mental Health Agency, Inc.; Anne Arundel County Public Schools; Anne Arundel County Partnership for Children, Youth and Families; CareFirst; Priority Partners; MedStar Harbor Hospital; outpatient health care providers (including primary care, OB/GYN, mental health, substance abuse); Anne Arundel County Community College; City of Annapolis; NAACP-Anne Arundel County;

Empowering Believers Church; Heritage Community Church; Light of the World Family Ministries; Restoration Community Development Corporation; Helping Hands, Seeds4Success; the Housing Commission of Anne Arundel County and many others. These partners help to develop and implement the Healthy Anne Arundel Coalition's Action Plan. Partners also provide direct and indirect resources to support of the Coalition's work. Identified health improvement priorities for the Coalition include obesity prevention, prevention and management of behavioral health conditions, increasing health care access and appropriate utilization of health care resources, and reducing health disparities among racial and ethnic minorities.

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

All of UM BWMC's transformation strategies will receive continued financial support through the mechanisms outlined below. It is not feasible to separate out sustainability according to each specific strategy since financial resources may be re-allocated as most appropriate based on available funding sources, identified community needs, program outcomes and returns on investment. Some expenditures will be one-time expenses and reimbursement will be received for clinical services which further enhances the reasonableness of financial sustainability. If certain strategies are not resulting in a satisfactory return on investment they will be modified.

a. Continued GBR Population Health Infrastructure Rate Support: UM BWMC will continue to use this funding stream to support population health initiatives in support of the "Triple Aim" and the All-Payer model.
b. Regional Health System Transformation Partnership Rate Support: UM BWMC and AAMC are committed to the successful implementation of the BATP. HSCRC has indicated that the rate support for the regional partnership grantees is intended to be a permanent rate increase as long as a satisfactory return on investment and progress toward meeting the goals of the All-Payer model are being achieved.
c. PAU Reductions: Decreased ED visits, observations stays, inpatient admissions, readmissions and shorter lengths of stay will lower the cost of care.
d. Grants: UM BWMC will continue to seek and apply for grants that can be used to fund population health initiatives. Grant funds will be used to sustain, expand or enhance existing strategies or implement new ones.
e. UM BWMC Foundation: UM BWMC's Foundation could be utilized to raise funds to support population health strategies designed to improve the quality of care and enhance patient experience. The Foundation has begun to raise funds to support capital projects that will improve our behavioral health infrastructure and improve patient quality, safety and patient satisfaction.
f. Partnerships: UM BWMC's staff serves in leadership roles to a number of collaborative initiatives to improve population health. These partnerships include the Healthy Anne Arundel Coalition, Conquer Cancer Coalition, Fetal and Infant Mortality Review and others. The partnerships help with financial stability by allowing us to pool our collective resources for the benefit of the communities we serve and prevent unnecessary duplication of resources.
g. Community Benefit: UM BWMC's community benefits strategies include providing health education and outreach to help people lead healthier lives, prevent health problems and manage chronic conditions. By helping to keep people healthier and out

of the hospital, we will also reduce the cost of health care.

h. General Operating Expenses: UM BWMC will continue to allocate necessary resources from our operating income to support population health initiatives that are not supported by other funding sources.

Appendixes:

I. University of Maryland Medical System Population Health Strategy
II. Bay Area Transformation Partnership Implementation Plan
III. UM BWMC FY15 HSCRC Community Benefit Report Narrative
IV. Healthy Anne Arundel Action Plan

Appendix I:

University of Maryland Medical System Population Health Strategy

UNIVERSITY of MARYLAND MEDICAL SYSTEM

UMMS Population Health Strategy

The University of Maryland Medical System (UMMS) is committed to transforming the current health care delivery system to better manage populations of patients, particularly those patients with multiple chronic diseases. In order to achieve this goal, UMMS has embarked on a two-pronged strategy focusing on inpatient medical management, a key driver of success under Global Budget Revenue, and the development of an ambulatory care network that engages community physicians.

Consistent with UMMS' mission and larger strategic vision, the system seeks to create a population health management capability that will enable it to successfully perform under value-based contracting arrangements (i.e., better patient experience, improved outcomes, reduced cost growth, and enhanced provider satisfaction) with various commercial, Medicaid, and Medicare Advantage payers. This vision includes the following:

- Enabling a significant and growing portion of system revenues to come from sustainable and mutually beneficial risk contracts.
- Operationalizing a high-performing population health management function (i.e., a Population Health Services Organization) and care delivery model that is all-payer and all-patient capable.
- Establishing an attractive and scalable physician clinical integration vehicle that can be systematically deployed across regions.

In implementing these strategies, UMMS has engaged two operating partners with expertise in successfully developing and implementing these types of programs – Davita HealthCare Partners and Lumeris.

Inpatient Medical Management

UMMS has engaged Davita HealthCare Partners (DHCP) to improve the inpatient medical management capabilities at each of the hospitals in the system. The goals of the engagement with DHCP are to:

- Improve the quality of care
- Improve patient satisfaction
- Reduce unnecessary admissions
- Reduce readmissions
- Reduce length of stay

UMMS' engagement with DHCP focuses on specific areas:

- Designing, developing, and enhancing hospitalist programs

- Designing, developing, and enhancing transitions of care programs. This includes developing collaborative programs with post-acute providers including Skilled Nursing Facilities, Home Health Programs, Hospices, and other providers.
- Enhancing UMMS' existing care management and discharge planning programs
- Identifying alternative sites of care for patients to utilize as an alternative to the emergency room or inpatient stays

Ambulatory care network

UMMS has engaged Lumeris as an operating partner to accelerate the transition from volume- to value-based care and deliver improved clinical and financial outcomes. With a combination of clinical, operational, and information technology expertise, Lumeris is partnering with UMMS to set up a Population Health Services Organization (PHSO) as a shared service within the organization.

The PHSO will provide services to the UMMS Quality Care Network, a Clinically Integrated Network of providers that have a shared responsibility for the care of a defined population of patients and can contract as one entity with payers.

A PHSO employs a portfolio of people, programs and interventions including but not limited to:

- Care managers deployed toward high risk individuals
- Transitions of care programs
- Dedicated programs for high risk patients
- Pharmacy and therapeutics management programs
- Patient engagement technologies
- Practice transformation
- Provider education, coaching, support, and information

The PHSO and its staff are enabled by robust technology that is focused on:

- Consolidating disparate data sources into a single source of truth about a patient
- Supporting deep analytics related to segmentation, utilization, costing, and expectations
- Enabling care management work flows by various care managers and affiliated providers
- Supporting active and sustainable financial management of affiliated risk bearing entities

Appendix II:

Bay Area Transformation Partnership Implementation Plan

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

December 7, 2015

Dear Mr. Ports:

The Bay Area Transformation Partnership (BATP) is pleased to submit our Regional Partnership Implementation Plan. The BATP, led by Anne Arundel Medical Center (AAMC) and University of Maryland Baltimore Washington Medical Center (UM BWMC), has developed a multifaceted new health care delivery model which will standardize the identification of high-risk individuals, integrate data and workflows to support care coordination, increase access to behavioral health care services, expand outpatient care management services and create opportunities for population health support across different health care providers and care settings.

BATP has worked closely with Chesapeake Regional Information System for Our Patients (CRISP), the Healthy Anne Arundel Coalition, both hospitals' Patient and Family Advisory Councils and medical staffs, The Coordinating Center, the Anne Arundel Country Department of Aging and Disabilities and other partners to develop this plan to enhance patient care, improve population health and lower total health care cost consistent with Maryland's vision for health system transformation and the "Triple Aim" of health care. Our plan includes:

1. Working with CRISP to create and share care alerts and care plans for vulnerable patients.
2. Integrating behavioral and physical health care services and providing additional supports to ambulatory care practices.
3. Streamlining and facilitating communication between providers of care, including promoting the use of CRISP tools and resources.
4. Integrating health and social resources and increasing access to outpatient care management services to address the needs of vulnerable, chronically ill individuals.

All of these strategies are designed to improve patient care and decrease potentially avoidable hospital utilization including Emergency Department visits and hospitalizations.

AAMC and UM BWMC have worked together on many efforts to improve patient care and population health in our region. We serve as Co-Vice Chairs to our local health improvement coalition. Examples of the coalition's work include two joint Community Health Needs Assessments, an Action Plan to address local health priorities, grant-funded obesity projects, and the creation of a Pediatrician's Toolkit for Behavioral Health Resources. Our hospitals other collaborations range from sharing of best practices, emergency preparedness planning and joint community benefit offerings, to name just a few examples.

We believe that the proposed model is an innovative approach to improving health care delivery, promoting population health and lowering costs in support of Maryland's All-Payers Model. Thank you for granting us the funding that allowed us to develop this plan. We believe this plan is an investment in Maryland's health system and we look forward to submitting a response to the RFP for implementation funding.

Sincerely,

Victoria Bayless
President and CEO
Anne Arundel Medical Center

Karen E. Olscamp
President and CEO
University of Maryland Baltimore Washington Medical Center

Regional Partnership for Health System Transformation
Regional Transformation Plan – Final Report
Due: December 7, 2015

Regional Partner: Bay Area Transformation Partnership (BATP)

***Maryland's Vision for Transformation*:** Transform Maryland's health care system to be highly reliable, highly efficient, and patient-centered. HSCRC and DHMH envision a health care system in which multi-disciplinary teams can work with high need/high-resource patients to manage chronic conditions in order to improve outcomes, lower costs, and enhance patient experience. Through aligned collaboration at the regional and state levels, the state and regional partnerships will work together to improve the health and well-being of the population.

***Regional Partnerships*:** In order to accelerate effective implementation, Maryland needs to develop regional partnerships that can collaborate on analytics, target services based on patient and population needs, and plan and develop care coordination and population health improvement approaches. The Regional Partnerships for Health System Transformation are a critical part of the state's approach to foster this collaboration. As referenced in the RFP, the Regional Partnership plan will describe, in detail, the proposed delivery and financing model, the infrastructure and staffing/workforce that will support the model, the target outcomes for reducing utilization/costs and improving quality and the health of the populations targeted, and effective strategies to continuously improve overall population health in the region. In order to fulfill healthcare savings commitments by Maryland to CMS, the initial target populations have been identified as high utilizers such as Medicare patients with multiple chronic conditions and high resource use, frail elders with support requirements, and dual eligibles with high resource needs.

The Care Coordination Workgroup identified these populations as most likely to yield the biggest gains from the Regional Partnerships' efforts. The Workgroup also recommended the development of state-level integrated care coordination resources and in some areas recommended standardization and collaboration. The Care Coordination Workgroup's final report can be found at: http://www.hscrc.state.md.us/documents/md-maphs/wg-meet/cc/Care-Coordination-Work-Group-Final-Report-2015-05-06.pdf.

The Regional Partnership grants will culminate in the development of a regional transformation plan due in December 2015. Given the importance of regional collaboration to meet the goals of the new model, multi-year strategic plans for improving care coordination, chronic care, and provider alignment are required of all Maryland hospitals.

To achieve transformation on a regional and state-level, the following nine domains have been developed. These domains are meant to be a guide to the Regional Partnerships and other Maryland hospitals and serve as action steps during the planning process.

Nine Transformation Domains

1. Clearly articulate the goals, strategies, and outcomes that will be pursued and measured
2. Establish formal relationships through legal, policy, and governance structures to support delivery and financial objectives
3. Understand and leverage currently available data and analytic resources
4. Identify needs and contribute to the development of risk stratification levels, heath risk assessments, care profiles and care plans

5. Establish care coordination people, tools, processes, and technology
6. Align physicians and other community-based providers
7. Support the transformation with organizational effectiveness tools
8. Develop new care delivery models
9. Create a financial sustainability plan

As you utilize this template and develop your Regional Transformation Plan, please refer to the "Transformation Framework" as a reference guide.

Regional Transformation Plan Template

Goals, Strategies and Outcomes

The Bay Area Transformation Partnership (BATP) goals are focused on the triple aim: improving population health, improving the experience of care, and decreasing per capita hospital costs for patients served at Anne Arundel Medical Center (AAMC) and University of Maryland Baltimore Washington Medical Center (UM BWMC). In 2016, we will focus on our hospitals' Medicare/aged Dual Eligible high-needs/high-resource population. Our strategy for CY2016 is to rapidly implement those interventions that most profoundly affect these individuals. BATP's early interventions will coordinate care in order to reduce potentially avoidable utilization in the hospital setting. Importantly, these interventions are strategically designed to prepare our greater Community of Practice (i.e., the regional medical community as a whole) to assume risk for the *total cost of care* for the population we serve.

Our approach includes a) identifying and risk-stratifying our populations through the use of CRISP and Berkeley Research Group (BRG) and hospital data analytics; b) deploying resources and implementing workflows to identify and manage our target population across care settings and providers; and c) providing a portfolio of cross-organization, scalable interventions that can be used for *any* patient population going forward.

Our target population for 2016, the "first phase" of the project, are Medicare/aged Dual-Eligible individuals with a utilization pattern of ≥3 inpatient or observation ≥24 hours encounters (bedded care) in FY2015 at either or both hospitals. This target population represents 1,260 patients who on a yearly basis are responsible for $58M in hospital costs. The overarching goal of BATP for 2016 is to decrease the potentially avoidable hospital utilization (PAU) of our target population and realize an annual gross savings of $9.8M (17%), resulting in $4.9M in variable savings.

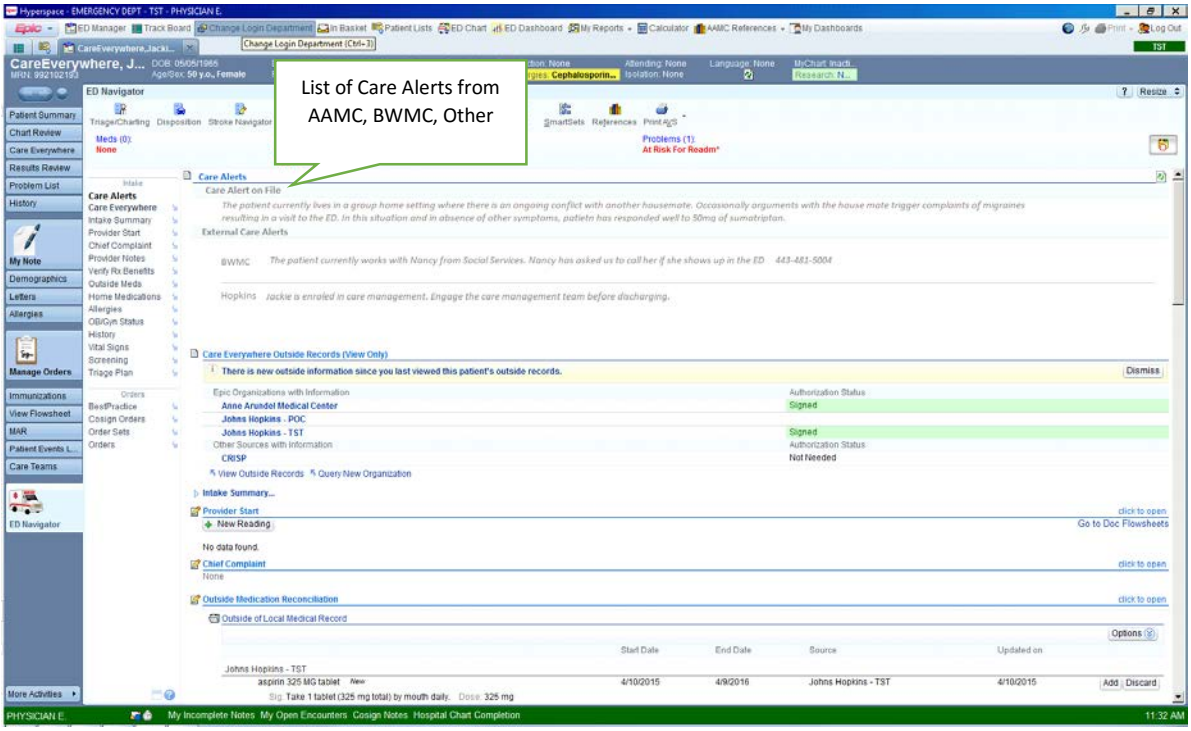
1. Goal # 1: Shared Care Alerts This physician-designed and tested intervention delivers essential 'need to know now' patient information at the point of care in order to decrease potentially avoidable utilization (PAU) and/or prevent clinical misadventures for high-utilizer, Medicare / aged Dual Eligible patients at AAMC and UM BWMC.

Strategy: BATP will implement a cross-organizational, multi-disciplinary approach to documenting and instantaneously sharing succinct, vital information on complex, high-utilizing patients such that patient safety is enhanced, and admissions, duplicate testing and unnecessary and potentially harmful

interventions may be avoided. Care Alerts will provide ED physicians and others with rapidly consumable information regarding each complex patient's usual clinical presentation, medical needs and home support structure. Care Alerts are readily visible within Epic at the point of care at both hospitals, from both hospitals, and are viewable within the CRISP portal by any authorized clinician in the state.

An example of a typical Care Alert: *"Mr. X is a pleasant, 69 year old low-literate gentleman who visits the ED frequently, usually reporting vague, atypical chest and abdominal symptoms. His vital signs, physical exam, and lab and imaging results are usually unremarkable. He suffers from depression, COPD, PSVT, and sleep apnea, all of which are well controlled when he adheres to his medical regimen. ED visits fulfill his non-medical needs, particularly during holidays and long weekends. He is followed by Dr. Y in a primary care office located in his public housing unit. He can be seen there, daily. PLEASE text her securely at _____ to discuss his case PRIOR to ordering tests or admitting to hospital or changing his medical regimen. He is also followed by a community-based care manager, Ms. Z, who can be reached by securely texting _____."*

The illustration below demonstrates how Care Alerts are readily visible to clinical providers as they encounter patients in the context of care. This patient, "Ms. Jackie CareEverywhere," happens to have a Care Alert from the native hospital as well as two from other hospitals that she frequents.



Expected Volume and Outcomes: In 2016, AAMC will create and share via CRISP a minimum of 350 Care Alerts for unique patients in the target population. UM BWMC will create and share via CRISP a minimum of 300 additional Care Alerts, adding to the 40 already in production and including 150

behavioral health alerts affecting at least 340 individual patients. Please note: *Local preliminary results at UM BWMC have already resulted in intra-hospital PAU reductions of 60% for their high-utilizing pilot target population.* The value of a Care Alert will be realized at both hospitals, essentially 'following' the patient, regardless of which hospital he visits.

Additional Care Alert Volume from a BATP Commercial Payer Partner, CareFirst: The region's largest commercial payer, CareFirst, plans to contribute to the Care Alert effort by adopting the functionality for their own high- and super-utilizing patients, as part of their portfolio of resources in their Primary Care-Centered Medical Home Program. Early adoption of Care Alerts by a commercial payer will provide BATP additional opportunity for broader promotion and scalability beyond the initial 2016 target population.

2. Goal # 2 – Shared Care Plans - Different from but complementary to Care Alerts, the longitudinal Care Plans will be living documents, created and shared across public, private and government agencies and settings. They will provide detailed information and will "coordinate the coordinators" by documenting for each complex individual the responsible care manager, recent care management activities, patient goals, and next steps. Sharing Care Plans will reduce waste and duplication of services and effort, and improve patient safety and satisfaction.

Strategy – BATP will provide a cross-organization longitudinal Plan of Care within Epic EMR that is customized to capture data that Care Managers, regardless of their environment (inpatient, outpatient, government, payer), need to share with one another in order to improve the patient experience, decrease rework, avoid duplicate, wasteful care management assignments and make care transitions safe and effective. This strategy includes the ability to create and share Care Plans between hospitals via CRISP as well as display them in the CRISP portal. Care Plan content is described in detail on page 27.

Expected Volume and Outcomes: - AAMC will create and share 250 Care Plans; UM BWMC incorporates a *significant* amount of care plan information into their Care Alerts and will expand their use of Care Plans as part of utilizing outpatient community Care Managers in 2016 and beyond.
Community-based care managers are the planned primary authors of the Care Plans, although hospital-based and even payer-based care managers will contribute to and benefit from the feature.
Coordination of care management using shared Care Plans will increase the efficiency and effectiveness of care management because no one encountering the complex patient will need to "start from scratch". Care managers, particularly those based in the community, will also be more visible, accessible and accountable for their assigned patients' care and outcomes, a feature that will enhance providers' confidence in the community-based care management model and promote team-based care across settings. Ultimately the shared longitudinal Plan of Care will thus decrease PAU by demonstrating to providers that, compared to the "business as usual" admission or readmission, safe and effective alternatives exist in the community and will be carried out by an accountable team.

3. Goal # 3 – Provide support to Ambulatory Care by a) providing an "easy button" approach to accessing and coordinating care management and non-clinical services across the continuum of care, for public, private and government agencies, b) offering access to a physician house call service as a

new/additional resource for PCPs and Care Managers, and c) providing Quality Coordinators who utilize dashboards and registries to focus on patient outreach for target population patients.

Strategy A– One Call Care Management - This is a single phone number primary care (and eventually specialty care) practices can use to access care management resources in the community who will be able to track patients across care settings, including the home (telephonically and/or in person). This feature answers a need expressed by community practices: it is difficult to ascertain which patients are eligible for which services that are provided by which entities. One-Call Care Management will be staffed by highly trained navigators who will determine patient needs, match them to eligible services and rapidly direct patients to appropriate resources in the private and public sectors. The One-Call system will determine, for each patient, current and future care management assignments, facilitate social service needs and determine insurance implications for services/supports.

Expected Volume and Outcomes– AAMC community providers will access the One-Call system in 2016, expanding to include UM BWMC in 2017. We anticipate, at capacity, 20-30 calls per day, Monday through Friday business hours, ranging from simple interventions to detailed management of complex needs of vulnerable individuals. Given the hiring lead-time and setup of the One Call Care Management system, we anticipate a July 1 go-live and close to 1800 calls in 2016.

The intervention will allow immediate access to care management resources and assignments for high needs patients as identified by ambulatory practices. Targeted individuals will be today's high-utilizers but also rising risk, future high-utilizers. The One-Call system will serve as the conduit to provide non-medical supports that can prevent vulnerable patients from becoming high-utilizers. The service will leverage the Epic population health management feature, Healthy Planet. The One-Call system will also monitor types and volumes of calls to assess community needs, gathering valuable information in real time to help us plan for future resource allocations. For example, if patients in a certain zip code are frequently in need of behavioral health resources, we can plan for the future implementation of those resources in their community.

Strategy B - Physician House calls: Both hospitals will use established vendors, such as Capital Coordinated Medicine, to provide regular medical care to home-bound Medicare and aged Dual-Eligible individuals.

Expected Volumes and Outcomes: An estimated 500 homebound individuals live in our region and require medical services in the home. Recent market forces have made it difficult for community-based physicians to provide this care. With this strategy, AAMC and UM BWMC ambulatory practices will have a reliable and effective resource to provide care at home for vulnerable individuals who would otherwise rely on ambulance transport to our EDs for care.

Strategy C – Quality Coordinators will support AAMC Primary Care Practices by managing multiple EMR-based registries and dashboards for target populations. In particular, their assistance in managing disease-specific registries (e.g. diabetes, COPD, CHF, hypertension) that identify care gaps will allow primary care physicians to know which patients need follow-up care in the practice or more resource-

intense interventions, such as community-based care managements. Quality Coordinators will use an efficient, effective outreach methodology to engage patients in self-care. The model will later be scaled to support independent primary and specialty care practices.

Expected Volumes and Outcomes - Each AAMC primary care doctor, on average, has 2,000 patients and several hundred with complex, chronic disease. Our intervention will touch over 60 physicians, with a focus on the Medicare and Dual-Eligible patients in our region. Better management today of patients with chronic disease will decrease their PAU of tomorrow.

4. Goal # 4 – Integrate and coordinate physical and behavioral health by a) increasing access to behavioral health resources from within primary care practices and b) piloting telephonic Psychiatric Consulting services for primary care physicians.

Strategy A– Expand psychiatric services at each hospital; UM BWMC will add a full-time Psychiatrist, 2 outpatient therapists and 2 administrative support to provide behavioral health services at geriatric clinics and primary care practice locations. AAMC will pilot an LCSW and a Referral Specialist to cover 2 primary care practices with a high number of patients with mental health needs.

Expected Volumes and Outcomes: At UM BWMC, the Psychiatrist will see approximately 133 new patients, with 330 follow-up visits and will also provide consultative support to primary care providers and supervise the therapists. Two (2) new Behavioral Health Therapists will handle 150 new patient visits and 3,000+ follow-up visits.

AAMC: An LCSW will provide over 300 new patient visits and over 650 follow-up visits in 2016. Existing psychiatric staff will provide consultative support to the LCSW as well as the primary care physicians who daily provide mental health services already but need support with diagnosis/treatment considerations.

This strategy will provide additional behavioral health resources and integrate them with primary care so that a greater number of patients receive timely access to psychiatric consultations and treatment, thus enhancing the likelihood of better outcomes for somatic health and decreasing PAU.

Strategy B – Expand a proven, successful Behavioral Health Navigator program that facilitates PCP referrals and provides evaluation appointments within 48 hours, with careful tracking of patients to ensure follow-up. This service is for patients with mental illness and/or substance misuse who need urgent (but not emergent) needs beyond the primary care setting. UM BWMC plans to explore a similar Behavior Health Navigator Program in 2017.

Expected Volumes and Outcomes: Facilitate and track 990 behavioral health referrals for unique patients during 2016 for AAMC. Reduce ED visits and need for hospitalization owing to behavioral health crisis. Note: AAMC's early efforts in piloting this program in less than a year have resulted in over 500 patients with high needs for mental health services receiving prompt care in the non-hospital setting.

5. Goal # 5 – Reduce preventable hospitalizations in the future by a) employing an experienced community-based care management vendor to address high-utilizer Medicare patients with multiple chronic conditions and b) dedicating resources to scrutinize and address today's readmissions and potentially avoidable utilization for patterns of medical and non-medical care gaps.

Strategy A – Both hospitals will utilize services from a community care management vendor, The Coordinating Center (TCC), who has a proven track record for successfully reducing 30-day readmissions and reducing episodes of bedded care and associated costs. These services are a significant, key intervention to reducing utilization of our target patient population.

Expected Volume and Outcomes: AAMC currently uses TCC for 150-175 patients per month and will add 125 additional patients/month in 2016. BWMC will begin using TCC services in 2016 at a volume of 140 patients/month. The length of engagement per client is determined individually and can range anywhere from days to several months. We predict a 10% reduction in episodes of bedded care of the target population served by TCC care managers, based in part on TCC's historical success in Baltimore.[1] Our prediction is conservative because we are taking into consideration the possibility that our local population may be more or less receptive than Baltimore's population to the TCC interventions.

Strategy B - Thoroughly examine patient readmissions using dedicated AAMC **Readmissions Clinical Analyst** and UM BWMC High Risk Coordinator who will use CRISP reports, hospital data analytics, patient case review and interviews of high-utilizers to make recommendations and devise action plans for reducing readmissions.

Expected Volumes and Outcomes: AAMC experiences 150-200 readmissions per month that will be analyzed. BWMC will review approximately 100 readmissions per month. The AAMC Readmissions Clinical Analyst and UM BWMC High Risk Care Coordinator will review data and conduct interviews to detect patterns that point to hospital-, patient-, or community-based factors that predict post-discharge failure in the community setting. Examples include prescribing a medical regimen that a patient cannot adhere to, having no safe discharge setting for a patient, or a patient with end-stage disease who needs a treatment plan that respects his body's condition. Remedies may include hospitalist education, palliative care interventions, community-based resource deployment or SNF support/education, for examples. Ultimately the outcome is reduced all-cause readmissions.

Strategy C - Focus on PAU from Skilled Nursing Facilities (SNFs). Partners in care of our most vulnerable and high-utilizing Medicare and aged Dual-Eligible patients, SNFs impact our goal of reducing PAU. We estimate that currently, in the aggregate, 24% of patients discharged from either hospital to a SNF are readmitted to a hospital within 30 days. We will develop a formal SNF Collaborative with a focus on understanding individual SNF capabilities, setting quality goals, sharing performance data and best

[1] Estimate is based on The Coordinating Center West Baltimore Readmission Reduction Collaborative where Care Management services for 3,119 patients over a 1 year period covering 3 hospitals produced an average of 10% reduction in hospital costs associated with readmissions.

practices to improve quality of care, make care transitions safer and reduce PAU. The BATP SNF Reporting Pilot with CRISP will provide data analytics, allowing SNFs to see their own performance as well as that of others. A dedicated **Post-Acute Care Manager** (AAMC) and **High Risk Coordinator** (UM BWMC) will facilitate this effort, including goal-setting, data-gathering, monitoring census, performing needs assessments of SNFs, and hosting group learning events.

Expected Volumes and Outcome: AAMC and BWMC *EACH* discharge approximately 2700 patients per year to SNFs. The goal of this intervention will be to reduce PAU (especially readmissions) as well as potentially preventable complications (wounds, infections) for SNF patients.

Strategy D- Deploy a Department of Aging & Disabilities (DoAD) Senior Triage Team to address the non-medical needs of AAMC and UM BWMC Medicare/aged Dual Eligible super utilizers patients with >=5 inpatient/observation visits in the past 6 months. The Senior Triage Team will coordinate with hospital discharge planners and EMS teams to identify patients so that care management and social services and supports can be provided to this population in order to sustain safe placement at home. This strategy includes coming to the hospitals for patients when there is no safe discharge disposition and creating a plan for shortened length of stay in the hospital and appropriate supports in the community. Without this resource, AAMC and UM BWMC must seek guardianship for vulnerable patients who otherwise would "live" in our hospital for months.

Expected Volumes and Outcomes: Approximately 230 extremely high-need Medicare/aged Dual-Eligible patients will be addressed in 2016. The expected outcomes include decreased utilization of EMS, ED, decreased length of stay and empowering the individuals to age in place or in the least restrictive environment possible that is self-directed and person-centered.

6. Goal # 6 – Facilitate expansion of CRISP services and adoption of CRISP features by providers and organizations in order to drive clinical performance, reduce PAU, and promote care coordination.
As a result of studying the region's cross-discipline, cross-organizational problem statements concerning population health management, care coordination improvements and patient satisfaction, we determined that creating intervention strategies in close collaboration with CRISP was the key to the fastest, most effective means of impacting the vast majority of patients in the region.

Strategy A - Complementing Goal/Strategy 5C, this subproject includes a **CRISP/BATP/SNF Integration (Clinical Portal) and Reporting (ENS) Pilot** project to onboard SNFs to the ENS feature and make data more transparent regarding to which SNFs patients are being discharged, which SNFs are experiencing unplanned transfers and to which hospitals, and whether patients are readmitted after discharge to home from the various SNFs. Eventually the project will expand further such that clinical data will be shared between hospitals and SNFs through CRISP's Clinical Portal, with the goal of coordinating care and avoiding/reducing PAU by enhancing clinical communication and interventions that can prevent unplanned transfers.

Expected Volumes and Outcomes: Our goal is for BATP to enroll SNFs such that > 80% of our hospitalized patients who are discharged to SNFs receive care at a facility integrated with CRISP's ENS and Clinical Portal, in other words, approximately 5,000 patients at high-risk for PAU.
By having access to SNF ENS data, the Collaborative will be able to analyze and focus patient interventions, examine process improvements and provide targeted SNF training (e.g. wound care, infection control) to decrease 30 day all cause hospital readmissions in 2016. Another notable outcome: the subproject will also prepare SNFs for a value-based payment environment and new regulations, e.g. the IMPACT act of 2014, and assumption of risk through bundling or other payment mechanisms.

Strategy B- Identify ambulatory practices that will send/receive ENS alerts and share clinical data with the CRISP Clinical Portal in 2016. We will recruit key clinical practices whose EMRs are not integrated with Epic such that we will enhance all of our other strategies, e.g. Care Alerts, Care Plans, as well as share key clinical data that can coordinate care and reduce duplication of services. One example is the sharing of recent imaging results that may prevent having to order advanced imaging twice on the same patient for the same reason.

Expected Volumes and Outcomes: We will recruit primary care and key specialty care practices in the region that practice on EMRs compatible with CRISP's abilities for integration, impacting hundreds of thousands of patients. The outcome is to reduce PAU for our target population, and to prepare a Community of Practice to be successful in a value-based payment environment and become accountable for total cost of care.

Strategy C – BATP will pilot the CRISP secure texting solution in early 2016, having actively contributed to gathering the requirements of this solution during the planning phase. Providers are frustrated by difficulties encountered when trying to reach one another through traditional mechanisms, e.g. calling a practice or ED to reach a clinician. PAU can be avoided if quick consultations are readily available, for example, ensuring today's ED patient can be seen in the practice tomorrow or that an EKG finding does not warrant further testing or admission. Secure texting allows providers to reach one another quickly and share images and lab results from mobile devices. Secure texting vendors also offer other safety features such as "message not read" alerts and team directories for call groups or shift workers, which is essential to the dynamic operations of a health system.

Expected Volumes and Outcomes: We anticipate all ED clinicians plus key specialists and primary care providers to enroll in secure texting. Our expected outcome is expedited, critical clinician-to-clinician communication in order to improve hand-offs and prevent PAU by reducing obstacles to communication. This feature will provide infrastructure in building an accountable Community of Practice responsible for the total cost of care for the population served. The feature also complements and accelerates the effectiveness of the shared Care Alerts and Care Plans, Goals 1 and 2 above.

7. Goal # 7 – Incorporate Patient and Family Advisory Council (PFAC) feedback within and across *all BATP initiatives.*

Strategy – A **joint** AAMC/BWMC PFAC Committee has already provided valuable feedback to the development of the BATP implementation. The PFACs decided that they would like to continue to hold **joint** quarterly meetings to guide this initiative and help us to incorporate patient and family perspectives. BATP leadership has incorporated numerous suggestions from this group and will continue to do so by including them in the implementation and evaluation process. Each PFAC will also be represented on the BATP Advisory Council. The joint PFAC feedback has been and will continue to be used in BATP education, training, Care Alert and Care Plan content and SNF Collaborative program development, to name a few. BATP strategies and interventions will have a greater likelihood of adoption and promotion because they are informed by the experiences of patients and families, the consumers of care. Clinical providers will know that BATP strategies have been vetted by patients in the region. Additionally, a recommendation in the HSCRC Consumer Outreach Task Force Report (August 2015) is to continue to give consumers a voice in the transformation of Maryland's health system. This goal supports that HSCRC recommendation and also supports the part of the "Triple Aim" focused on improving the patient experience of care.

Outcomes: Increased patient and family engagement in the health system transformation process, consistent with HSCRC recommendations, the "Triple Aim" and Maryland's vision for health system transformation.

8. Goal # 8 - AAMC will form a clinically integrated network focused on transforming care delivery and improving quality in the ambulatory setting.

Strategy: Implement an AAMC Collaborative Care Network (CCN), a clinically integrated network which will provide the infrastructure for community providers to transform care delivery at the practice level regardless of hospital affiliation or employment status.

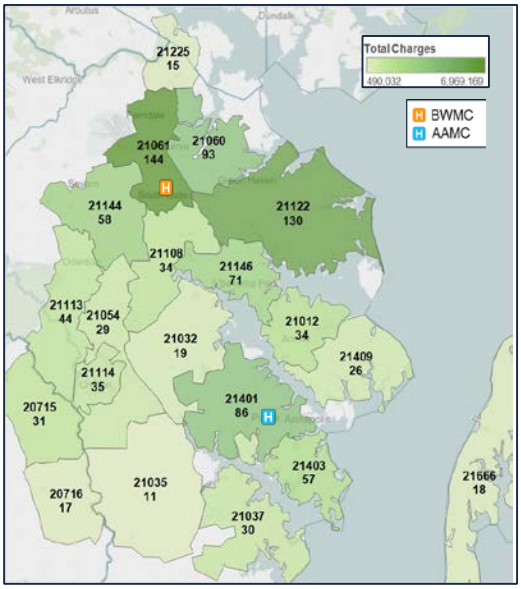
Expected Volumes and Outcomes: The AAMC CCN will in 2016 and 2017 engage approximately 500 physicians in independent and employed primary and specialty care practices that together care for hundreds of thousands of area patients. The CCN will provide the infrastructure and governance platform wherein practices can take part in incentive programs, such as gainsharing and bundling (through the CCN's Medicare Shared Savings Program ACO) that make possible episode improvements that drive clinical performance and decreased costs. The CCN will also provide the infrastructure to help practices pursue payment mechanisms (such as Care Coordination Management codes) that sustain efforts in ambulatory-based care coordination, and provide the field support to promote the use of One-Call Care Management and Quality Coordinators. Please note that UMMS has a separate CIN strategy that is not part of this proposal, which will include UM BWMC once developed.

Describe the target population that will be monitored and measured, including the number of people and geographical location.

Based on recent data analytics provided by Berkeley Research Group (BRG), the Bay Area Transformation Partnership hospitals provided care to a total of 23,477 Medicare patients costing $260.5M in FY2015. Of those, 1,152 are Medicare high utilizers (>= 3 Inpatient/Observation>=24 hour visits) representing $52.8M in total charges and 5,738 visits across the 2 hospitals. Of the 1,152 high utilizer patients, 590 visited AAMC and 705 visited BWMC, with 143 (12%) representing patients who visited both hospitals. *The Medicare high utilizer population represents 5% of the 23,477 AAMC/UMBWMC Medicare patients, and 20% of the cost.* In addition, BATP will address 108 aged Dual-Eligibles representing $5.2M in hospital charges in FY2015. Table 1 contains a map of Medicare high utilizer patients by zip code, number of unique patients, associated number of visits and total charges.

Table 1. Medicare High Utilizers 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

Describe specific metrics that will be used to measure progress including patient satisfaction, quality, outcomes metrics, process metrics and cost metrics. Describe how the selected metrics draw from or relate to the State of Maryland's requirements under the new model.

Core Outcome Measures, per HSCRC requirements, will be tracked as well as intervention-specific metrics. BRG will provide the core outcome measure data, and CRISP and hospital data analysts will provide intervention-specific metrics.

All Hospital and per hospital statistics for AAMC and BWMC:
Total hospital cost per capita
Total hospital admits per capita
Total health care cost per person
ED visits per capita
All Cause 30 day Readmissions
Potentially avoidable utilization
Patient Experience (HCAPHS)

BATP Intervention-specific metrics
Shared Patients across hospitals
a) # of high-utilizers that AAMC and UM BWMC share - we want to know the total number of individuals and reduce the hazard of duplicating effort on mutual patients and over- or under-reporting our success.

Care Alerts
a) % of high-utilizers with Care Alerts, and % that are shared via CRISP
b) ED utilization of patients with Care Alerts, before and after Care Alert creation
c) Inpatient admissions of patients with Care Alerts, before and after Care Alert creation
d) Per patient charges before and after Care Alert creation

Care Management / Care Plans
a) % of high-utilizers with Care Plans and % that are shared via CRISP
b) ED utilization of patients before and after Care Management services were started
c) Inpatient admissions of patients with Care Managers, before and after Care Manager engagement
d) Per patient charges before and after Care Management services began
e) % of high-utilizers with assigned Care Managers
f) % of high-utilizers who have been offered and have declined Care Management Services

HRA's
% of target population with completed Health Risk Assessments

One Call Care Management
a) # and types of calls received and from what geographic areas
b) # of referrals provided for Care Management assignment
c) # of referrals to DoAD, DSS

Physician House Calls
# of patients referred and receiving services.

AAMC Quality Coordinators (Medical Assistant ambulatory care panel management)
Improvement in diabetes, hypertension control and CAD management, as evidenced by percent of patients meeting NQF and/or MSSP ACO measures, per clinician, per practice, per division.

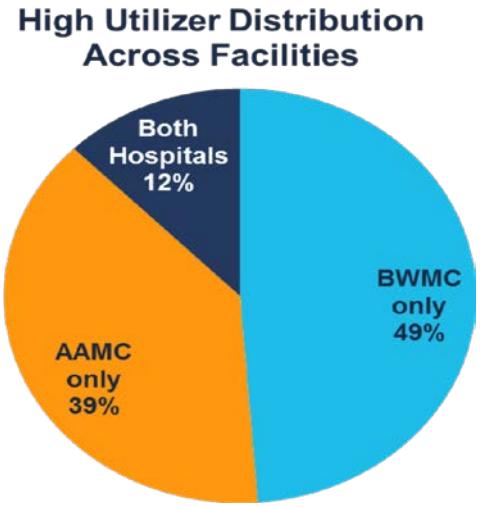
Senior Triage Team
a) # of super-utilizers (>=5 visits) being managed by Senior Triage Team
b) EMS Utilization per patient, before and after Senior Triage Team engagement
c) ED Visits per patient, before and after Senior Triage Team engagement
d) Length of Stay, per patient, before and after Senior Triage Team engagement
e) # of guardianships established

Skilled Nursing Facility Collaborative
a) # of additional Ambulatory and SNF facilities utilizing CRISP ENS and/or Clinical Query Portal.
b) 30-day readmission rates of high utilizers going to/from SNFs who are participating in the SNF Collaborative
c) # of patients with completed MOLST forms

Describe the regional partnership's current performance (target population) against the stated metrics.

Intervention-specific metrics will be tracked in 2016 and provided to BATP Governance and Advisory Committees for performance evaluation and to inform continuous process improvement activities. The current performance for the target population is outlined below. We anticipate having PAU and Readmission rates from BRG for the target population in the near future. In 2016 reporting, we will include target population baseline metrics for the 108 aged Dual-Eligibles as well.

	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

Intervention-specific metrics will be available once the interventions begin in 2016.

Target population baseline metrics will be supplied by CRISP and BRG at a future date.

Define the data collection and analytics capabilities that will be used to measure goals and outcomes.

AAMC and BWMC will rely on 3 sources of data; Berkeley Research Group (individual and combined hospital analytics), CRISP (PaTH, Readmissions, etc.) and hospital data analytics. We will use a cross-organizational data analytics team from these 3 sources to discuss, compare and adjust to ensure that we are accurately measuring and tracking our performance for the target population.

CRISP has extensive all-hospital data and BATP is utilizing several reports, including piloting the new PaTH reports. BRG has provided baseline data and that engagement is planned to continue, pending implementation funding award, including detailed reports that contain shared patient analysis and risk

stratification. Specific risk stratification has been performed already, including tiering chronic conditions and associated charges. Notably, Tier 2 patients (for whom we predict BATP interventions will have the greatest positive impact) with 2-6 chronic conditions comprise 942 of our 1,152 high utilizers and account for $41.1M in charges.

The recurring theme in our approach to meeting our overall goals for reducing PAU, is to build tools, technologies, processes and measures that take advantage of *cross-organizational teams*. For data analytics, this means continual learning and coordination around hospital/BRG/CRISP data sources, queries, and patient population reporting capabilities. Working together to streamline the data analytics gathering and utilization is key to success, and ensures that we are avoiding duplication of effort with limited, valuable IT resources.

List the major areas of focus for year one. (For the completion of this plan, if various areas of focus require different descriptions, please identify each area under the following sections of the plan).

1) Enhancing communication and coordination among providers of care as they encounter our high-utilizing Medicare/aged Dual-Eligible population. Care Alerts, Care Plans, secure texting, One-Call Care Management, integration of ambulatory practices and SNFs with CRISP, and the AAMC Collaborative Care Network support this aim.

2) Long-term care and post-acute care integration and coordination: The SNF Collaborative along with the CRISP SNF Reporting Pilot, ENS and clinical query portal integration support this aim to share data and resources to improve care and reduce cost.

3) Integration and coordination of physical and behavioral health services: The Behavioral Health Navigator Program and embedding behavioral health resources in primary care support this aim.

4) Integration of community resources relative to social determinants of health and activities of daily living: the One-Call care management system and the Senior Triage Team support this aim.

5) Primary care supports: Care Alerts, Care Plans, enhanced provider communication, increased capacity and streamlined access to behavioral and social resources, Quality Coordinators and the AAMC Collaborative Care Network support this aim.

6) Patient- and family-centeredness: The joint PFAC Committee supports this aim, along with process improvement designed to enhance quality of care and patient experience (e.g. shared Care Alerts and shared Care Plans and increased resources (Senior Triage Team, physician house calls) to meet patient and caregiver needs.

Formal Relationships and Governance

List the participants of the regional partnership such as hospitals, physicians, nursing homes, post-acute facilities, behavioral health providers, community-based organizations, etc. Specify names and titles where possible.

Role	Name	Title	Organization
Governance			
	Mitchell Schwartz, MD, MBA	Chief Medical Officer	AAMC
	Bob Reilly	Chief Financial Officer	AAMC
	Patricia Czapp, MD	Chair of Clinical Integration	AAMC
	Kathy McCollum	Chief Operating Officer and Senior Vice President	UM BWMC
	Al Pietsch, CPA	Chief Financial Officer and Senior Vice President	UM BWMC
	Christopher DeBorja, MD	Chairman, Department of Medical Services	UM BWMC
Advisory Council (TBD)			
	Patricia Czapp, MD	Chair of Clinical Integration	AAMC
	Renee Kilroy, MA	Executive Director, Collaborative Care Network	AAMC
	Rebecca Paesch	VP Strategy & Business Development	UM BWMC
	Christopher DeBorja, MD	Chairman, Department of Medical Services, Medical Director of Population Health	UM BWMC
	Joel Klein, MD, FACEP	President, Baltimore Washington Emergency Services; Epic Product Development, UMMS	UM BWMC
	Dave Mooradian, MD	Chief Medical Information Officer	AAMC
	Pamela Hinshaw, MSN, RN, CCM	Clinical Director of Care Management	AAMC
	Christine Crabbs, MS	Director, Community Health Improvement	AAMC
	Beth Tingo, RN, MSN, CMC	Director, Care Management	UM BWMC
	Mary Jozwik, RN,MHSA,CPHQ	Vice President, Quality and Patient Safety	UM BWMC
	Carol Marsiglia, MS, RN, CCM	Sr. Vice President, Strategic Initiatives and Partnerships	The Coordinating Center
	Pamela Jordan	Director	Anne Arundel Co. Dept. of Aging & Disabilities
	Dawn Hurley	Executive Director Behavioral Health	AAMC

	Sandeep Sidana, MD	Chairman, Department of Psychiatry	UM BWMC
	Jinlene Chan, MD MPH	Health Officer	Anne Arundel Co. Dept of Health
	Adrianne Mickler	Executive Director	Anne Arundel Co. Mental Health Agency, Inc.
	PFAC Member	To be determined	AAMC
	PFAC Member	To be determined	UM BWMC
Community Partner List			
	Jennifer C. Baldwin, RN MPH	Sr. Vice President Patient Centered Medical Home CareFirst	CareFirst
	Carol Marsiglia, MS, RN, CCM	Sr. Vice President, Strategic Initiatives and Partnerships	The Coordinating Center
	Laura Gambrill, RN, BSN, CCM	Director, Health Plan Services	The Coordinating Center
	Jinlene Chan, MD, MPH	Health Officer	Anne Arundel Co. Dept. of Health
	David Rose, MD	Deputy Health Officer	Anne Arundel Co. Dept. of Health
	Pamela Jordan	Director	Anne Arundel Co. Dept. of Aging & Disabilities
	Karrisa Gouin	Director of Aging & Disabilities Resource Center Planning & Programming	Anne Arundel Co. Dept. of Aging & Disabilities
	Adrienne Mickler	Executive Director	Anne Arundel Co. Mental Health Agency, Inc.
	Carnitra White	Director	Anne Arundel Co. Dept. of Social Services
	Jon Wendell, MD, FACEP	Medical Director AA County EMS	Anne Arundel Co. EMS
	Pamela Brown, PhD	Executive Director	Anne Arundel Co. Partnership for Children Youth and Families
	Adrianne Mickler	Executive Director	Anne Arundel Co. Mental Health Agency, Inc.
	Jinlene Chan, MD MPH	Health Officer	Anne Arundel Co. Dept of Health
Skilled Nursing Facilities			
	Hung Davis, MD	CEO/CMO - Physicians Inpatient Care Specialists	
	Terri Powers	Director of Nursing	Genesis
	Holly O'Shea	Director of Nursing	FutureCare
	Wendy Colliflower	Director of Nursing	SAVA: North Arundel Health & Rehab, Glen Burnie Health & Rehab
CRISP Partners			

	Karan Mansukhani	CRISP Project Manager, ICN	CRISP
	Ross Martin	Program Director, Integrated Care Network	CRISP
	Craig Behm	Director, Reporting Analytics	CRISP
	Ryan Bramble	Director, Integration	CRISP
	Steve Caramanico	Integration for Care Alerts & Plans	CRISP
	Calvin Ho	Director of Ambulatory Integration	CRISP
	Mary Pohl	Report Access	CRISP
	Cheryl Jones, MBA, MHA	Director of Marketing & HR, Ambulatory / SNF connectivity	CRISP
BATP Portfolio Management			
	Patricia Czapp, MD	Chair of Clinical Integration	AAMC
	Cindy Gingrich MSIM,PMP	Project Management Consultant, BATP	Gingrich Consulting
	Laurie Fetterman	Strategic Planning Project Manager	UM BWMC
	Rebecca Paesch	VP Strategy and Business Development	UM BWMC
	Renee Kilroy, MA	Exec Director, Collaborative Care Network	AAMC
	Heather Matheu	Clinically Integrated Network Coord., CCN	AAMC
Care Management / Care Plan Advisory Team			
	Pamela Hinshaw, MSN, RN, CCM	Clinical Director of Care Management	AAMC
	Christine Crabbs, MS	Director, Community Health Improvement	AAMC
	Beth Tingo, RN, MSN, CMC	Director, Care Management	UM BWMC
	Mary Jozwik, RN,MHSA,CPHQ	Vice President, Quality and Patient Safety	UM BWMC
	Carol Marsiglia, MS, RN, CCM	Sr. Vice President, Strategic Initiatives and Partnerships	The Coordinating Center
	Laura Gambrill, RN, BSN, CCM	Director, Health Plan Services	The Coordinating Center
	Jinlene Chen	Health Officer	Health Dept
	Pam Jordan (Karrisa Gouin)	Director of Aging & Disabilities Resource Center Planning & Programming	Dept. of Aging & Disabilities
Behavioral Health Advisory Group			
	Raymond Hoffman, MD	Medical Director, Behavioral Health	AAMC
	Dawn Hurley	Executive Director, Behavioral Health	AAMC
	Helen Reines	Executive Director, Pathways	AAMC
	Sandeep Sidana, MD	Chairman, Department of Psychiatry	UM BWMC
	Dwight Holmes, MD	Director, Psychiatric Services	UM BWMC

	Kurt Haspert, NP	Nurse Practitioner	UM BWMC
	Shirley Knelly	VP Quality & Patient Safety, Pathways	AAMC
Care Alert Clinical Stakeholders			
	Patricia Czapp, MD	Chair of Clinical Integration	AAMC
	Joel Klein, MD, FACEP	President, Baltimore Washington Emergency Serivces; Epic Product Development, UMMS	UM BWMC
	Dave Mooradian, MD	Chief Medical Information Officer	AAMC
	Renee Kilroy, MA	Executive Director, Collaborative Care Network	AAMC
Care Alert and Care Plan Technical Team & Management			
	Joel Klein, MD, FACEP	President, Baltimore Washington Emergency Services; Epic Product Development, UMMS	UM BWMC
	Debra Roper, RN, MSM, PMP	Director, Ambulatory information Systems	AAMC
	David Lehr	Executive Director, Analytics	AAMC
	Daniel Donaldson	Director of Decision Support	UM BWMC
	Paul Thompson	Sr. Clinical Systems Analyst	UM BWMC
	Ryan Bramble	Director of Integration	CRISP
	Barbara Baldwin	Chief Information Officer	AAMC
	Kristi Lanciotti	Sr. Director, University of Maryland Medical Group	UM BWMC
	Craig Behm	Director of Reporting and Analytics	CRISP
	Anna Schoenbaum	Director, Enterprise Portfolio Epic Clinical Applications	UMMS
IT Analysts & Epic Leads			
	Angela Clubb	Epic Analyst (IP / OP)	AAMC
	Justin Clites	Epic Analyst – Interfaces	AAMC
	Min Kim	Manager Clinical Documentation	UMMS
	Tara Newman-Bell	Director of Enterprise Application Integration	UMMS
Data Analytics Team			
	Albert Zanger	Sr Manager, Reimbursement & Revenue Advisory Services	UMMS
	David Lehr	Executive Director, Analytics	AAMC
	Daniel Donaldson	Director, Finance Decision Support	UM BWMC
	Rebecca Altman	Managing Director	Berkeley Research Group
PFAC Coordinators			
	Jeanne Morris, RN	Patient and Family Centered Care Coordinator	AAMC
	Danielle Wilson, MSN, RN	Director, Service Excellence	UM BWMC
	John Thorn	PFAC Committee Member	AAMC
	Montrese Garner-Sampson	PFAC Committee Member	UM BWMC

	Colleen Young	PFAC Committee Member	UM BWMC
	Dave Lanham	PFAC Committee Member	UM BWMC
	Rose Mahoney	PFAC Committee Member	UM BWMC
	Joyce Wetzel	PFAC Committee Member	UM BWMC
	Annie Sanford	PFAC Committee Member	UM BWMC
	Edra Oliver	PFAC Committee Member	AAMC
	Earl Shellner	PFAC Committee Member	AAMC
	Eduardo Vazquez	PFAC Committee Member	AAMC
	Charlene Van Meter	PFAC Committee Member	AAMC

Clinical Provider Focus Groups – Care Alerts

Name	Specialty	Organization
Pat Czapp, MD	Chair Clinical Integration	AAMC (Facilitator for this group)
Barbara Hutchinson MD PhD FACC DABSM	Cardiology	Chesapeake Cardiac Care
Will Maxted, MD	Cardiology	Cardiology Associates
Ron Elfenbein, MD	Emergency Medicine	St. Mary's Hospital Emergency Room
Brian Baker, MD	Emergency Medicine	Doctors Emergency Service
Debra Smith, NP	Emergency Medicine	AAMC ED
Ken Gummerson, MD	Emergency Medicine	Doctors Emergency Service
Hung Davis, MD, CMD, WCC	Hospitalist/SNFist	CEO/CMO - Physicians Inpatient Care Specialists
Kathryn O'Connell, MD	Hospitalist/SNFist	AAMC Adult Medicine Hospitalist
Aimee Yu, MD	Intensivist	Annapolis Asthma, Pulmonary and Sleep Specialists
Susan Zimmerman, MD, MBA.	Pain Management	Physical Medicine & Pain Management Associates - Annapolis
Thomas Walsh, MD	Primary Care	PCP Queenstown
Ramona Seidel, MD	Primary Care	Bay Crossing Family Medicine
Andrew McGlone, MD	Primary Care	Annapolis Primary Care
Kari Alperovitz-Bichell, MD	Primary Care	AAMC Community Clinics - Morris Blum
Lisa Wannamaker	Pediatrics	Practice Administrator - Annapolis Pediatrics
Margaret Turner, MD	Pediatrics	Annapolis Pediatrics
Chip Parmele, MD	Pediatrics	Annapolis Pediatrics
LaTanya Wooten	Oncology/Hematology	Chesapeake Oncology Hematology Associates
Emily Ulmer, MD	Weight Loss	Medical Center for Healthy Weight Loss, LLC
Nnaemeka Agajelu, MD	Primary Care	
Barbara Onumah, MD	Endocrinologist	AAMC Diabetes

Chirag Chaudhari MD	Emergency Department	Baltimore Washington Emergency Physicians
Joel Klein, MD	Emergency Department	Baltimore Washington Medical Center Emergency Department
Carol Ann Sperry, RN, MS, CEN	Emergency Department	Director, Emergency Nursing, UM Baltimore Washington Medical Center
Michele Cox-Spivey	Ortho	Practice Manager - Anne Arundel Orthopedic Surgery
Amir Moinfar, MD	Ortho	Elite Orthopedic & Musculoskeletal Center
Sarah Merritt, MD	Pain Management	Lifestream Health Center - Bowie
Yvette Shelton	Primary Care	Practice Manager - Physician's House Calls
Bahador Momeni, MD	Primary Care	Medical Director UM CMG
Joseph Musialek	Primary Care	Manager Primary Care UM CMG
Marta Markman, MD	Pediatrics	Marta Markman, MD & Associates - Glen Burnie
Alex Hertzman, MD	Rheumatology	Glen Burnie
Brooke Buckley, MD FACS	Surgery	Medical Director Acute Care Surgery - AAMC
Jorge Perez-Alard, MD	Primary Care	Docs of Wellness
Catherine Gray	Behavioral Health	AA County Mental Health Agency
Ray Hoffman, MD	Behavioral Health	Medical Director, Behavioral Health, AAMC
Russell DeLuca, MD	Oncology	Chesapeake Oncology Hematology Assoc.
Yudhish Markan, MD	Oncology	Chesapeake Oncology Hematology Assoc.
Adam Weinstein, MD	Nephrology	Shore Regional Health

Describe the governance structure or process through which decisions will be made for the regional partnership. List the participants of the structure/process.

The Governance Structure for BATP includes a Governance Board consisting of three members from each hospital and an Advisory Council consisting of representatives spanning the public, private, government and payer sectors. The Council will include participants who are actively engaged in the various interventions to improve care coordination and population health for our target population.

After careful review of the BATP subprojects with external legal counsel, hospital leadership determined that the most efficient, effective governance structure would be to use formal MOUs. There will be one MOU between AAMC and UM BWMC as co-leaders, and one MOU for third parties. Business Associate Agreements will be used for data sharing between the hospitals, and between third parties, as appropriate.

Governance Board Members

Mitchell Schwartz, MD, MBA	Chief Medical Officer	AAMC
Bob Reilly	Chief Financial Officer	AAMC
Patricia Czapp, MD	Chair of Clinical Integration, Primary BATP Lead	AAMC
Kathy McCollum	Sr. Vice President, Clinical Integration and Chief Operating Officer	UM BWMC
Al Pietsch, CPA	Sr. Vice President and Chief Financial Officer	UM BWMC
Christopher DeBorja, MD	Associate Chairman, Dept. of Medical Services; Chairman, Internal/Family Medicine	UM BWMC

The board will govern the BATP subprojects and reporting during quarterly meetings, to review progress and provide guidance on issue resolution. Primary responsibilities will include budget approval, oversight, allocations and adjustments. The board will look to the Advisory Council for recommendations and opinions on subproject performance and effectiveness.

Advisory Council Members

Patricia Czapp, MD	Chair of Clinical Integration	AAMC
Renee Kilroy	Executive Director, Collaborative Care Network	AAMC
Christopher DeBorja, MD	Chairman, Department of Medical Services, Medical Director of Population Health	UM BWMC
Joel Klein, MD, FACEP	President, Baltimore Washington Emergency Services; Epic Product Development, UMMS	UM BWMC
Dave Mooradian, MD	Chief Medical Information Officer	AAMC
Pamela Hinshaw, MS, RN, CCM	Clinical Director of Care Management	AAMC

Rebecca Paesch	VP Strategy & Business Development	UM BWMC
Christine Crabbs, MS	Director, Community Health Improvement	AAMC
Elizabeth Tingo, RN, MSN, CMC	Director, Care Management	UM BWMC
Mary Jozwik	Vice President, Quality and Patient Safety	UM BWMC
Carol Marsiglia, MS, RN, CCM	Sr. Vice President, Strategic Initiatives and Partnerships	The Coordinating Center
Pamela Jordan	Director	Dept. of Aging & Disabilities
Dawn Hurley	Executive Director Behavioral Health	AAMC
Sandeep Sidana, MD	Chairman, Department of Psychiatry	UM BWMC
Jinlene Chan, MD MPH	Health Officer	Anne Arundel Co. Dept of Health
Adrianne Mickler	Executive Director	Anne Arundel Co. Mental Health Agency, Inc.
PFAC Member	To be determined	AAMC
PFAC Member	To be determined	UM BWMC

Identify the types of decisions that will be made by the regional partnership.

The Governance board will make the following types of decisions:

- Funds management, including distribution, change management and reporting
- Project Management oversight and guidance
- Subproject and overall portfolio accountability and reporting requirements

Each hospital is responsible for tracking and reporting expenses at the subproject level, noting that HSCRC reporting requirements for CY2016 are pending.

The Advisory Council will meet regularly, and be responsible for tracking subproject interventions evaluating metrics, providing advice on issue resolution and risk management, and making recommendations to the Governance board.

Describe the patient consent process for the purpose of sharing data among regional partnership members.

The Bay Area Transformation Partnership will continue to utilize the patient consent process that is in place as part of the CRISP data sharing agreement, which provides the patients with information about how to fully opt-out of data sharing if they wish to do so. If a patient does not explicitly opt-out, the default opt-in (all in) method of data sharing is used. We understand that CRISP is working to offer additional levels of opt-out granularity to patients through their portal in the future.

For data sharing between hospitals and third parties (such as the Department of Aging & Disabilities Senior Triage Team and CareFirst), AAMC and BWMC will use Business Associate Agreements.

Describe the processes that will be used by the regional partnership and the MOUs or other agreements that will be used to facilitate the legal and appropriate sharing of Care Plans, Care Alerts and other data as described in the process.

Care Alerts are clinician-to-clinician notes. Care Plans are care manager to care manager information about the patient. Both Care Alerts and Care Plans are an integrated part of the legal medical record, and are treated the same as any clinical information being accessed by *authorized* clinicians for treatment, payment or operations. The CRISP data sharing agreement covers the sharing of this data to authorized clinicians for the purpose of treatment, payment or operations.

Attach the list of HIPAA compliance rules that will be implemented by the regional partnership.

The Regional Partnership will comply with all HIPAA Privacy, Security, Enforcement and Breach Notification rules (45 CFR 160 - 164), including:

1. HIPAA Privacy Rule, which protects the privacy of individually identifiable health information;
2. HIPAA Security Rule, which sets national standards for the security of electronic protected health information;
3. HIPAA Breach Notification Rule, which requires covered entities and business associates to provide notification following a breach of unsecured protected health information; and
4. The confidentiality provisions of the Patient Safety Rule, which protect identifiable information being used to analyze patient safety events and improve patient safety.

The Department of Health and Human Services, Office of Civil Rights provides an abbreviated description of these rules here: HIPAA Administration Simplification Abbreviated Text 45 CFR 160-164

Additionally, BATP will follow CRISP Participation Agreement and other guidance on consent and data sharing thru the HIE.

Data and Analytics

Define the data collection and analytics capabilities that will be used to measure goals and outcomes, including specific metrics and measures.

BATP will rely heavily on CRISP for reports, as they have extensive all-hospital data. We are anticipating CRISP enhancements to their reporting capabilities for patient-level detail for Care Managers, and plan to use that functionality in 2Q16.

The hospitals will also use Berkeley Research Group (BRG) to provide baseline and ongoing, detailed reports that contain shared patient analysis and risk stratification metrics.

We will also utilize in-house data analysts who will supply intervention-specific metrics (listed above). They will study both hospital-specific and CRISP reports for similarities, differences, anomalies and trends. Risk stratification will be implemented along with Epic's Healthy Planet feature. Performance on disease-specific registries will be measured automatically within Epic. Clinical measures are tracked within Epic.

Describe with specificity the regional partnership's plan for use of CRISP data.
The following CRISP Reports will be used to track both baseline and metrics for target populations. Hospital-based data analysts may also run comparative reports for verification, validation and understanding of parameters and data completeness.

The CRISP Patient Total Hospital (PaTH) Report will be used to track metrics for AAMC and BWMC Medicare/aged Dual Eligible, high utilizers (>=3 IP/Obs visits in 12 months), including ED utilization and Inpatient/Observation utilization.

Potentially Avoidable Utilization hospital reports will be used for baseline and ongoing metrics.

The All Hospital Readmissions Rate report will be used to obtain baseline and ongoing metric data on overall 30 day all-cause readmissions across all hospitals.

The Readmissions by Clinical Service Line report will be used to drill-down to service line level information to determine where to focus interventions.

High Utilizer use of EDs and ED Visits by Zip Code reports will be used to target those populations where the highest utilization is occurring.

New metrics for new tools – CRISP will be developing reports to track the new BATP interventions. The new reports will include (but not be limited to) the following, which will be instrumental in determining effectiveness of ROI and planned interventions in reducing PAU:

1) Number of shared Care Alerts and the pre- and post-Care Alert hospital charges and events for each patient (e.g. 6 months pre- and 6 months post.
2) Number of patients assigned to Care Managers, and pre and post care management assignment hospital charges and events for each patient, as above.
3) Number of patients with longitudinal Care Plans that are shared via CRISP
4) SNF unplanned transfers and readmissions to Hospitals, per SNF, per hospital

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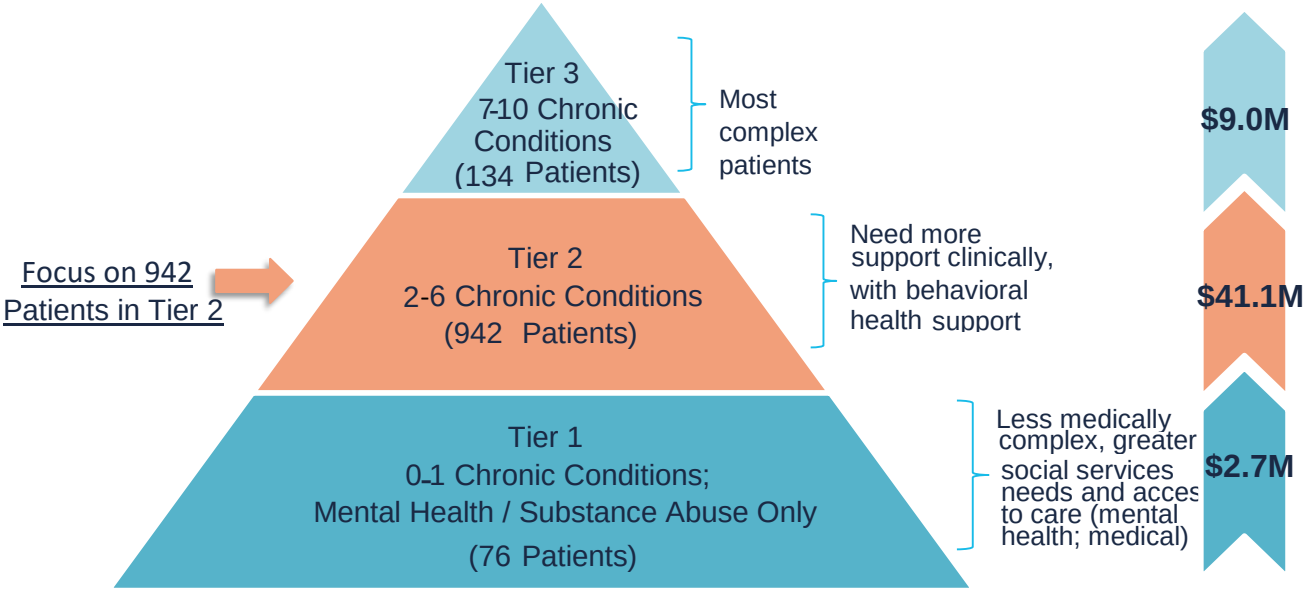
Risk Stratification, Health Risk Assessments, Care Profiles and Care Plans

Describe any plans for use of risk stratification, HRAs, care profiles, or care plans. Describe how these draw from or complement the standardized models being developed.

We will use CRISP-generated risk stratification tools as well as those native to Epic's Healthy Planet feature. It will be useful to use more than one risk stratification tool in order to validate our data and processes. Patients identified as high risk will be assigned a care manager and an HRA will be

completed. The HRA will also populate parts of the longitudinal Care Plan. The Coordinating Center, a key BATP partner provided community-based care management services,
also uses an automated risk assessment and communication tool between field-based Health Coaches and an RN Team lead. Scores are sent in real-time from the Health Coach to the RN Lead, who assesses whether or not additional intervention or assistance is needed for the patient, and takes appropriate action.
CRISP Care Profiles will be built using summarized data from various CRISP sources, and BATP will assess the use cases for Care Profiles as they become available.
For risk stratification, include the types of patients, risk levels, data sources, accountabilities (who is accountable to do what?)

BRG has provided risk stratification for the target Medicare high-risk population based on number of chronic conditions. Tier 1 are those patients with 0-1 chronic conditions, Tier 2 are those with 2-6 chronic conditions, and Tier 3 are those patients with 7 or more chronic conditions.



BRG has recommended that initially focusing interventions on individuals in Tier 2 will result in the highest cost savings, which will be realized by moving care from the expensive acute care setting to the less expensive community setting. On a quarterly basis, BRG will supply the Medicare and aged Dual-Eligible/chronic condition/risk-stratified list of high utilizers to BATP. The project management team will assess which patients are currently receiving interventions and which are not. For patients in Tier 2, we will work with CRISP to identify a care management strategy by utilizing the PaTH reports that are built for Care Management analysis and target population focus. These reports show geographic location as well as the specific patients, # of cross-hospital visits, and charges for the patients. In addition, we will consider for each patient case the other intervention options (Care Alerts, Care Plans, DoAD Senior Triage Team, Physician House Calls, social services and supports, etc.) to determine whether they would

be helpful either in addition to or in lieu of a care manager assignment. Care Managers will contribute information about the patient engagement in the shared Care Plan section of Epic, and may also contribute to Care Alerts. Additional analysis will be performed to better understand Tier 3 patients, for example, BRG will work with us to determine how many of them are in SNFs, can we reach them through our SNF Collaborative and CRISP Reporting Pilot initiative, or are they home bound and need physician house call services and so on.

For HRAs, include the types of screenings, who is accountable for completing, and where information is recorded.

Care Managers, as part of an initial patient assessment, perform Health Risk Assessments. All patients with Care Managers will have an HRA. Information is recorded in systems specific to the outpatient Care Management organizations at this time, *with key information being included* in the longitudinal Plan of Care that is part of Epic, and will be shared via CRISP as part of the shared Care Plan initiative.

For care profiles and/or care plans, include the key elements that will be included, the systems through which they will be accessible, the people who will have access. Standardized care profiles are anticipated to be developed by the state-level integrated are coordination infrastructure.

During the planning phase, BATP brought inpatient Care Management Directors, outpatient Care Management Executives and Nurses, Department of Aging and Disabilities Care Management experts **together** with hospital IT business analysts to map out what a shared Care Plan should contain. This extensive analysis included workflow and data identification, discussions of gaps, areas for collaboration and standardization and process improvement ideas *with a patient-centered focus*.

Information that will be included in the shared Care Plan (pending further refinement) includes:

- Care Manager identification (name, contact information) for inpatient, outpatient, and payer care managers
- Patient goals (person-specific, affecting quality of life)
- Care Team goals
- Short and long-term goals and progress toward the goals
- Recent physician visits and recommendations
- Upcoming physician appointments
- Brief update on how the patient is feeling and how their condition is impacting them
- ER visits and hospitalization history (at least the past year) – this helps to determine trends or departure from 'normal' activity
- Who is this patient's Care Team (PCP, Specialists, Behavioral Health, OP and IP Care Managers, Care Giver)
- Community referrals and resources
- Issues and barriers – need these *before* hospitalization, *upon admission* and *prior* to discharge:
- Can the patient afford their medications?
- Does the patient (still) have a caregiver?

- Does the patient have transportation to their appointments?
- An understanding/visual of the home environment that is key to understanding the patient (for example, physical obstacles, evidence of dementia and/or self-neglect, substance misuse)
- Psycho-social needs

Identify the training plan for any new tool identified in this section.

Care Alerts have been in use, and successful, at UM BWMC for several months. There is a team approach to assessing patients and building their Care Alerts that includes ED physicians, behavioral health professionals, inpatient care management, social worker, and nursing input. At AAMC, Care Alert focus groups not only identified the need for Care Alerts, but have engaged in hands-on writing of example Care Alerts during the planning phase. For implementation, Care Alert training will occur through several channels focusing on the ED, PCP, Inpatient and Community Care Managers and Behavioral Health Specialists as well as CareFirst's Local Care Coordinators. Training material on what to include and what not to include in Care Alerts will be provided, including a brief training video. UM BWMC lessons learned will be incorporated into the training.

Shared Care Plans – The Coordinating Center (TCC) Care Managers already access and contribute to the Care Plan at AAMC. Redesign of the plan using Epic's Healthy Planet capabilities will enable the coaches to enter information that is focused and useful for inpatient care managers. Training will be minimal for TCC using AAMC Epic. At UM BWMC, the use of TCC community care managers will be introduced as part of the BATP initiative. Training for TCC care managers will be reviewed as part of that newly acquired capability. Since AAMC/BWMC and TCC are working together on the Care Management/Care Plan Team for BATP, they have jointly participated in identifying the data that should be included (and who should enter it) in the shared Care Plans. UM BWMC is moving to a new Epic design in 1Q2016, which will have expanded capabilities for entry/update of patients needing care management and transitional care.

The DoAD Senior Triage Team will be trained on the use of Epic and will contribute to Care Alerts and services/support information for the super-utilizer patients. As this information is shared via CRISP, it will be visible in the clinical query portal and within either hospital system EHR. The DoAD Senior Triage Team will also offer their expertise through the Care Management/Care Plan Team and educate community and inpatient care managers about the services and supports that are available and how to access them.

PCP offices will be made aware of One-Call Care Management services by the LCSWs who staff that phone line. As part of their initial month of training, they will be going to PCP offices and educating them about the new service to assist in finding Care Management or social services/supports for patients. We will also use phone stickers and other marketing material in the PCP offices to remind them that this service is available to them for their patients.

Care Coordination

Describe any new care coordination capabilities that will be deployed by the regional partnership.
The cross-organization, multi-disciplinary collaboration that is being put into motion by BATP is the first time these particular organizations have joined forces to not only work and learn together, but to build powerful tools that enable cross-communication of patient care management. The planning phase of the regional partnership brought experts with years of experience in their field together to share stories, identify gaps, define problems and build tools to address them. New care coordination capabilities include:

a) Care Alerts supplemented by secure texting, which will allow rapid exchange of information regarding the most vulnerable and complex patients.
b) Shared Care Alerts and Care Plans will be accessible by all care team members, thus we expect to see reduced duplication of effort and increased efficiencies.
c) The Senior Triage team will facilitate the patients' enrollment in community-based programs that create safe discharges.
d) One-Call Care Management call center for PCPs will enable physicians to have a quick way to arrange for patient care management or other support services.

Identify the types of patients that will be eligible for care coordination and how they will be identified and by whom.

Our target population in CY 2016 are high-utilizing Medicare/aged Dual Eligible patients at both UM BWMC and AAMC. CRISP has offered to provide reports to Care Managers in 1Q2016 pending the release of CRISP advanced PaTH reports for Care Managers. Our Project Management Team and Care Management/Care Plan Advisory Team (which includes TCC, DoAD, AAMC inpatient care management and UM BWMC inpatient care management) will use these reports to assist in further refining and prioritizing the lists of high utilizers for Care Management services or other intervention options listed herein.

Inpatient or community-based physicians may also select patients for care coordination based on self-evident patterns of use and predictable patient decline. AAMC's Readmissions Clinical Analyst will also identify "first time" re-admitters who may be rising risk and could be candidates for Care Alerts and Care Plans. In addition, the AAMC Readmissions Clinical Analyst and UM BWMC High Risk Coordinator will also recommend patients for community care management and other interventions.

Define accountability of each person in the care coordination process.
a) Care Manager: performs HRA and completes and updates Care Plan. If an inpatient care manager, s/he communicates with the community-based care manager. If a community-based care manager, s/he follows patients across care settings, including home and hospital.

b) Physician: writes or assists in writing Care Alert; updates as needed, heeds Care Alerts, communicates with fellow clinicians as needed via secure texting.
c) Senior Triage Team Member: assesses home situation and coordinates resources for safe discharge, coordinates non-medical services and supports with access to a full spectrum of DoAD services
d) Patient/family: participates in goal setting and associated action plans, cooperates with care team, voices concerns.
e) Readmissions Clinical Analyst: identifies individuals or cohorts of individuals with special needs and brings these to the attention of director of care management.
f) Quality Coordinator: identifies patients with special needs who may need care management and/or follow up in primary care practice.
g) Project Support: monitors adoption and promotion of care management across care settings, monitors Care Alerts for quality and need for updating
h) Behavioral Health Resources: identifies individuals with social needs and connects them to care managers, thus integrating behavioral health with social supports.
i) One-Call Care Management: rapidly triages and addresses a broad variety of social and non-medical needs.

Describe staffing models, if applicable.

Care Alert staffing – UM BWMC will hire two (2) FTEs to enhance the current Care Alert creation and maintenance process. A High Risk Care Alert Coordinator, and a Behavioral Health Care Alert Creator, noting that UM BWMC incorporates a significant amount of Care Plan information within their Care Alerts. An administrative assistant will also assist with coordination activities related to BATP subprojects.

Community Care Manager staffing - UM BWMC will engage community care managers to handle approximately 140 patients per month in CY2016, and AAMC currently utilizes 150 to 175 patient per month volume with TCC. They expect to increase community-based care management by approximately 125 *additional* patients per month in 2016.

One-Call Care Management staffing – AAMC will employ two (2) full-time LCSWs answering PCP calls Monday thru Friday, 8:30am-5:30pm. UM BWMC will join this initiative in 2017 and add one 1 LCSW to support the call line for added capacity.

Clinically Integrated Network – AAMC will engage Advocate Physician Partners Advisors, primarily two (2) consultants with additional advisors available as needed. The CCN will provide the infrastructure for the region's physician practices and community providers to transform care delivery at the practice level, regardless of hospital affiliation or employment status. Please note the UMMS has a separate CIN strategy that is not part of BATP.

Quality Coordinators – AAMC will employ four (4) FTEs covering 60+ physicians' panels.

Behavioral Health expansion of services and integration with Physical Health – UM BWMC will hire 1 Psychiatrist, 2 Therapists and staff a geriatric clinic. AAMC will hire 1 Therapist and 1 support staff to provide services to one or more primary care practices where there is high need for behavioral health resources.

Readmissions Clinical Analyst – AAMC will employ a dedicated readmissions clinical analyst to review all readmissions and devise action plans.

Skilled Nursing Facility Collaborative staffing – AAMC will hire a Post-Acute Care Manager (PCM) who will be the primary liaison between the SNFs and the hospital. UM BWMC will hire a High Risk Coordinator who is the primary liaison between the SNFs and the hospital.

Senior Triage Team staffing - The Department of Aging & Disabilities staffing model consists of the following resources:

- (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.

Program Oversight – AAMC and BWMC will engage a certified Project Management consultant to oversee the subprojects for BATP. BWMC will hire a Population Health manager to supervise the various subprojects, provide BATP related reports and work closely with BATP Project Management. AAMC will leverage Collaborative Care Network staff to supervise and manage BATP subprojects.

A Clinical Transformation Specialist will be hired by AAMC to work closely with the Inpatient Care Manager to adjust work processes and analysis related to BATP initiatives, including One-Call Care Management, which will be housed and managed at AAMC.

Describe any patient engagement techniques that will be deployed.

Patient engagement through Care Management, particularly in the community setting, is one of the strongest patient engagement techniques in our plan, and both hospitals plan to make significant additional investments in 2016. Care Managers identify patient goals, motivators, priorities and barriers, and address those in order to create a productive relationship. Patients' non-medical needs must often be addressed before their medical needs can become a priority to them. Only a care

manager actually sees the home environment and spends hours with a patient, getting to know them and their needs. Having this level of patient-centered information in the shared Care Plans, viewable by authorized inpatient, community, government and payer organizations in Epic or via CRISP will impact the efficiency of care and demonstrate to the patient that we're listening to them and communicating with one another.

The Department of Aging & Disabilities (DoAD) Senior Triage Team, providing care management services to our highest utilizers, will be led by registered nurses with the full support of the Information & Assistance (I&A) staff. 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 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.

BATP will use the already-formed joint Patient & Family Advisory Councils from both healthcare systems to provide ongoing feedback on the patient engagement techniques, tools, and communication processes being put in place to reduce potentially avoidable utilization.

In addition, our One-Call Care Management initiative will act as a bridge between complex insurance, care management options and social service/support offerings and use patient-friendly wording to engage the patient in the process for obtaining necessary resources.

Physician Alignment

Describe the methods by which physician alignment will be created.

Maryland physicians are in the process of learning about state and federal payment reform initiatives that will affect their practices. There is anxiety in the physician community, a phenomenon leveraged by newly formed clinically integrated networks and mega-single specialty groups, as well as venture capitalists engaging independent practices in modified messenger models in Maryland. Physicians feel the need to align with someone, somehow, and sometime soon, in order to maintain autonomy and safety in a changing market. AAMC's strategy for physician alignment acknowledges this phenomenon and also physicians' own desires to create a practice environment that is less frustrating and hazardous. Please note that UMMS has a separate CIN strategy that is not part of this proposal.

Physician alignment with BATP activities takes the following forms:

1) Incentives: Currently, direct financial incentives include examples such as AAMC hospitalist contracting that now rewards readmission reduction performance and patient satisfaction, and the primary care physicians in the ACO being incentivized to reduce utilization and improve quality and patient satisfaction. Other examples in 2016 will include exploring gain sharing and bundling opportunities through AAMC's MSSP ACO.
2) Supports: The Collaborative Care Network provides the opportunity to share data, resources and opportunities for independent and employed practices and helps them monitor and improve

performance in value-based reimbursement. Care Alerts provide a unique form of support to physicians encountering difficult-to-manage patients, and in fact the concept and design of Care Alerts arose organically from physicians' own needs and experiences. Quality Coordinators help physicians improve their performance on quality metrics that improve their likelihood of financial reward in existing programs (e.g. CareFirst PCMH, MSSP ACO) and future opportunities (e.g. Evergreen High Performance Network, Medicare Advantage programs).

3) Leadership and Steering Opportunities: BATP's key features arose from physicians voicing their remedies for frustrations common to both patients and physicians: the need to have rapid means of communicating between providers (Care Alerts, secure texting), the need to coordinate the coordinators (Care Plans), the need to manage patients inside and outside the practice (One-Call Care Management, community-based care managers, Quality Coordinators), the need to centralize practice supports and extend them to independent practices (the Collaborative Care Network). Because BATP took special care and time to incorporate their recommendations, physicians are more likely to adopt and promote BATP features, and they are more likely to continue on in their advisory and leadership roles, allowing us to refine existing BATP features and design new ones.

Describe any new processes, procedures and accountabilities that will be used to connect community physicians, behavioral health and other providers in the regional partnership and the supporting tools, technologies and data that will assist providers in the activities associated with improved care, cost containment, quality and satisfaction.

BATP's features that will connect community physicians, behavioral health and other providers are described above, and will be listed again here:

1) Care Alerts: provide rapidly accessible and consumable "need to know now", succinct information, in the context of care, regarding individuals of the target population, with the end goals of reducing PAU and preventing clinical misadventures. Success of Care Alerts in meeting these goals will be measured by BATP.
2) Care Plans: Coordinating the coordinators, Care Plans provide standardized, longitudinal, continually updated "transcripts" that identify the patients' care managers and care teams, goals of care, obstacles to care, and the latest progress.
3) Secure Texting: Allows providers to contact each other quickly and easily, circumventing the "front desk" obstacles, allowing transmission of images and results, backed up by safety features and designed to coordinate care, reduce duplicate work-ups, and promote safe alternatives to hospitalization.
4) Behavioral Health Navigator program: will allow rapid identification and early and effective outpatient treatment of ambulatory patients with urgent behavioral health needs that are encountered in primary care practices.
5) One-Call Care Management System: will allow practices an "easy button" to use to connect patients with community-based care management resources.

6) Quality Coordinators: allow primary care practices to reach beyond today's schedule of patient visits and find and address patients with care gaps who are lost to follow up and at rising risk of high utilization.
7) CRISP Integration: BATP will recruit physician practices and SNFs with CRISP's ENS and ambulatory integration effort that will allow clinical data-sharing.
8) SNF Collaborative: will engage regional SNFs and monitor their performance in reducing unplanned transfers, will also provide comparative performance data, share best practices, and promote remedial actions.
9) AAMC Collaborative Care Network: will assist physician practices in choosing specialty-specific metrics and monitoring their performance in quality, patient access, and utilization, providing remedial help to those who need it, and preparing the medical community to become accountable for the quality and total cost of care for the regional population.

Describe any new value-based payment models that will be employed in the regional partnerships
New value-based payment models will be those allowed by AAMC having a MSSP ACO that permits gainsharing and bundling activities. These will be important in engaging specialist physicians in improving cost and quality performance. The AAMC Collaborative Care Network will undertake an implementation in 2016 as allowed by state and federal laws. Potential initial areas include intensive care unit stays and joint replacements.

Organizational Effectiveness Tools
Attach the implementation plan for each major area of focus (**with timelines and task accountabilities)**

Please see **Appendix A** for a detailed Microsoft Project work plan for all activities.

Describe the continuous improvement methods that will be used by the regional partnership.

BATP will use data analytics, cross-organizational planning and implementation activities and associated issue and risk tracking to continually monitor and improve performance. For each subproject we have defined metrics and capacity planning goals, which will be monitored on a monthly basis. As we receive our quarterly reports from BRG and monitor the CRISP PaTH and other reports, we will see whether we are meeting our goals for # of interventions, determine whether our planned # and types of interventions are producing the core measure results we had predicted, and make adjustments to either the quantity and/or quality of the interventions. It will most likely take several months to see the needle move, noting that several interventions require hiring and training of staff, but the foundational work of identifying the problems associated with recurring admissions, development of specific solutions to solve those problems, systems and data analysis and design of new tools used across disparate organizations, and integration of numerous data sources with CRISP, will all come together to assist us in meeting our patient and financial goals.

Attach a copy of the metrics dashboard that will be used to manage performance over time with an explanation of associated processes that will be used to monitor and improve performance.

In order to meet BATP performance goals, the project management team will ensure two things: a) that we are applying enough of our interventions to enough of the target population in a timely and effective manner; and b) whether the interventions are having the desired effect of reducing PAU.The project management team will thus monitor, on a monthly basis, the number of target population patients who have received interventions. If volumes (i.e. number of patients touched) are falling short of expectations, then remedial actions will be applied to recover to target volume projections.

In addition to monitoring capacity and volumes for our interventions, we must determine whether the interventions are producing the desired effect of reducing PAU. The project management team will thus review aggregate outcomes of those interventions, as measured and provided by BRG and HSCRC on a quarterly basis, to determine BATP's effectiveness in reducing PAU. Because target population patients may be recipients of multiple interventions, we will need to conduct case review to examine trends to determine, if possible, which interventions are most effective. In this effort, our expanded team (High-Risk Care Coordinator, Readmissions Clinical Analyst, Post-Acute Care Manager and others) will supply valuable insights.

Monthly and quarterly performance will be reviewed with the Advisory Council and recommendations will be made to the Governance Team to redirect, decrease or increase resources to various subprojects in order to meet BATP goals.

Please see **Appendix B** for sample process and outcome measure dashboards.

Describe the work that will be done to affect a patient-centered culture.

Patient-defined and agreed-upon goals and non-medical services and supports will be in the patient's medical record in the shared Care Plans. Patient-centered 'need to know now' information will be in their shared Care Alerts. *This is information that, to date, has not been shared, or consistently shared, across disciplines or organizations. Collecting data at the most knowledgeable source, documenting it, and sharing it with authorized clinicians, is a highly patient-centric process.* It saves the patient from repeating information (they can just verify it, and find comfort in knowing that disparate entities are talking to one another). It enhances patient safety and builds trust among the patient, their care giver(s) and the cross-organizational healthcare team, including ambulatory, inpatient, government and payer care managers, PCPs, Specialists, ED physicians and social service organizations.

New Care Delivery Models

Describe any new delivery models that will be used to support the care coordination outcomes. (For instance, tele-visits, behavioral health integration or home monitoring).

Community-based care management: Expanding on AAMC's relationship with The Coordinating Center (TCC), UM BWMC will, in BATP, engage TCC to provide services to approximately 140 of their patients per month. This means that hundreds of patients in our target population will now have the benefit of an assigned care manager who has weeks if not months to get to know them, their caregivers and their unique challenges. TCC care managers visit patients at their homes and perform in depth health risk assessments as well as "kitchen table" medication reconciliation to determine if and how a patient is following the correct medication regimen. TCC care managers have as their goal the graduation of their patients to effective self-management, not continued use of their services.

Behavioral Health Delivery: Behavioral Health leaders from AAMC and UM BWMC have been working together, beginning with the regional transformation planning process, to discuss the problems and potential solutions to integrating behavioral and physical health in the region. From our data analysis, we know that 66% (762 of our 1,152) of our Medicare high utilizers have a mental health or substance misuse diagnosis. Of those, 626 (54%) have a mental health diagnosis, 32 (3%) have a substance misuse diagnosis, and 104 (9%) have both a mental health and substance misuse diagnosis. Recognizing the significance of these data, and being realistic in our goals to impact this population in 2016, the hospitals have chosen to carefully but aggressively approach this problem, while meeting the 'shovel ready' requirements of the HSCRC.

Expanding psychiatric services at each hospital; UM BWMC will add a full-time Psychiatrist, 2 outpatient therapists, and 2 administrative assistants to provide behavioral health services at geriatric and primary care practice locations. AAMC will pilot an LCSW and coordinator to cover 2 primary care clinics.

At UM BWMC, the Psychiatrist will see approximately 133 new patients, with 330 follow-up visits and will also provide consultative support to primary care providers and supervise the therapists. Two new Behavioral Health Therapists will handle 150 new patient visits and 3,000+ follow-up visits.
AAMC: A Licensed Clinical Social Worker (LCSW) will provide over 300 new patient visits and over 650 follow-up visits in 2016. Existing psychiatric staff will provide consultative support to the LCSW as well as the primary care physicians who daily provide mental health services already but need support with diagnosis/treatment considerations. This strategy will provide additional behavioral health resources and integrate them with primary care so that a greater number of patients (roughly eight hundred) receive timely access to psychiatric consultations and treatment, thus enhancing the likelihood of better outcomes for somatic health and decreasing PAU.

Contributing behavioral health data to the Care Alerts – Although behavioral health clinicians are currently part of a team contributing to Care Alerts at UM BWMC, the need is significant enough to warrant hiring a dedicated person to create behavioral health focused Care Alerts in 2016 and beyond. Notably, 66% of our Medicare high-utilizers have a mental health or substance abuse diagnosis on an encounter in any position.

The DoAD Senior Triage Team will implement a new social and clinical support model to prevent and address the dependency of super-utilizers on emergency systems and the acute care environment. This model brings a DoAD team together with inpatient care managers and EMS to identify, target and provide immediate care coordination and arrange supports to prevent dependency on emergency or hospital services. Along with the referral service, the Triage team will have a direct on-call line (7 days/week 8am – 4:30pm). They will perform health risk assessments that cover all key indicators for a critical case (housing, caregiver, independence, health & safety and quality of life). The integration of this team and their contribution to the shared Care Alerts and longitudinal Care Plans is truly a new and promising delivery model for care coordination.

Identify how the regional partnership will identify patients, new processes, new technology and sharing of information.

The Bay Area Transformation Partnership, as part of the planning grant activities, has performed extensive problem definition, business analysis, team formulation and work planning in preparation for moving forward with all projects in CY2016, if funds are awarded. Our process for identifying new patients will include building registries and dashboards that are monitored to manage the activities and supports for our target high utilizer population. BATP will be centrally managed as a portfolio of related projects that is organized to achieve overall objectives and goals across organizations. We will utilize a Governance Structure, Advisory Council, engaged Clinical Leadership Stakeholders, a certified Project Management Professional, Project Management Supports, experienced Data Analysts, and effective Care Management resources in public, private, government and payer organizations to deliver planned financial and operational results. Given this portfolio approach to project management, new processes will be evaluated on a continual basis and shared with all key team members so as to develop the most efficient, effective processes across the various organizations. Key technologies that are planned for this initiative (Shared Care Alerts and Shared Care Plans) are well underway, with Care Alerts moving into test mode in early January with CRISP, AAMC and UM BWMC, followed by Care Plans within the second quarter of 2016.

Financial Sustainability Plan

Describe the financial sustainability plan for implementation of these models.

The interventions we are building are a set of tools that will be used as needed for the target population, with numerous interventions being used per patient as deemed appropriate by the clinicians and care managers working with the patients. *We have carefully planned how many instances of each intervention we can perform and will use those metrics to track whether we are achieving our goals for number of interventions.* Notably, the 'shared' Care Alerts and Plans will be a 'create once/use many times' type of intervention which should compound the savings. The savings per intervention will be tracked primarily thru CRISP reports showing pre- and post- intervention costs as outlined in the metrics section.

Our estimated costs for all interventions in this plan is $4.2M for the regional partnership. Using a bottom-up calculation for each type of intervention and considering both the total number of patients we will touch with each intervention and the expected impact, we estimate that we will 'touch' over 10,000 patients and that approximately 900 patients will have decreased or avoided utilization. The expected impact (# of patients who will avoid utilization) is based upon the following supporting information:

1. The Coordinating Center (TCC) historical ROI data from the West Baltimore 30-day readmission initiative. An average of 10% savings in hospitalizations across 3 hospitals was realized in a 1 year time period, with up to a 14% savings achieved at 2 of the hospitals.
2. UM BWMC and UM SJMC emergency departments created over 398 Care Alerts (46 and 352 respectively) for unique patients in CY2015. Intra-hospital results on # of ED visits and # of inpatient admissions pre- and post- Care Alert creation were tracked. Although inter-hospital data has not been evaluated and other factors related to the decrease in utilization have not been researched, an impressive 57% decrease in ED Visits and 71% decrease in hospital admissions was observed. Given the caveats noted above, we estimate our results from Care Alerts to be a conservative 30% decrease in utilization for those patients who have Care Alerts in 2016.
3. Extensive research by the Anne Arundel County Department of Aging & Disabilities contained in their Triage Team Proposal 'A Care Coordination Initiative to Improve Community Health through Social and Clinical Systems Approach', which contains detailed target population analysis. (Appendix C)

Volume estimates for each type of intervention for AAMC, UM BWMC, The Coordinating Center and the Department of Aging & Disabilities are as follows:

Intervention	# of planned interventions
Care Alert/Care Plans	690
One Call Care Mgt hotline	2100
Behavioral Health/Physical	783
Community Care Mgt	1380
Senior Triage Team	233
SNF Collaborative	4400
Physician House Calls	500
Total Patients	10086

Based on the BRG data from FY2015, a positive ROI should be achievable in 2016, equating to approximately $9.8M in annual gross savings which represents a 17% decrease in annual gross charges.

In terms of mitigation strategies, we will assess the impact of interventions on an ongoing basis as described in the metrics section above. If the expected volume and cost savings are not being met, we will look at several factors.

For Care Alerts, we will examine quality and content to determine what is most effective in assisting ED and other physicians with avoiding hospitalizations.

The effectiveness of community Care Management (The Coordinating Center and DoAD Senior Triage Team) as measured by CRISP reports showing pre- and post- intervention charges, will help us understand and adjust activities such as lengthening the care management engagement for some patients, adding additional social supports and/or educating SNFs and caregivers.

The SNF Collaborative mitigation is inherent in the process of setting goals, measuring them monthly with each SNF and adjusting accordingly. Often these adjustments are due to capabilities (or lack thereof) at the SNF, in which case SNF education, additional clinical support or reassessment of patient SNF placement are considered.

The impact to ED and inpatient visits will be measured for those patients who have utilized behavioral health services in the PCP environment. Mitigation may require additional supports or other types of interventions, such as Care Alerts or non-medical services/supports.

Describe the specific financial arrangements that will incent provider participation.
Although we do not plan to compensate providers directly as part of CY2016 activities, the health system providers from both hospitals, as represented through numerous focus groups, see the value of shared Care Alerts and are onboard with creating them, recognizing that shared Care Alerts:

- **Save time for providers** so that they can make informed, efficient decisions, and not have to "start from scratch" with each encounter
- **Improve patient and clinician satisfaction** by demonstrating that cross-organizational care teams are communicating with one another to better serve the patient.
- **Result in appropriate level of care both within and outside hospital walls** because providers have more information about the entire patient story, including non-clinical, behavioral health and support structure.
- **Provide ED Physicians with information that may assist in avoiding admissions, readmissions and/or clinical misadventures.**
- **Provide patients with an Alert that follows them through the health system.**

Providers will also benefit from:

- **The AAMC Collaborative Care Network** organization and alignment of services
- **One-Call Care Management phone number** to obtain Care Managers for our most vulnerable Medicare high utilizer patients

- **Access to Behavioral Health Navigators and Psychiatry Consultants** in a limited capacity for 2016, expanding in 2017 and beyond as we study the impact of this model and need for expansion.
- **Quality Coordinators** at AAMC who will assist in managing the targeted patient population and providing outreach to patients who need appointments or screenings.
- **Gain sharing and bundling opportunities** as allowed by federal and state law, through AAMC's MSSP ACO.
- **Contractual arrangements that incentivize performance** on BATP's goals, including readmission reduction and patient satisfaction.

Population Health Improvement Plan

Provide detailed description of strategies to improve the health of the entire region over the long term, beyond just the target populations of new care delivery models. Describe how this plan aligns with the state's vision, including how delivery model concepts will contribute and align with the improvement plan, as well as how it aligns with priorities and action plans of the Local Health Improvement Coalitions in the region.

BATP envisions a health care system that works efficiently due to enhanced communication and data sharing (e.g. Care Alerts, Care Plans, sharing of critical data elements and encounter notifications across care settings, secure texting). The enhanced communication of health and social service providers will benefit all patients in Maryland's health care system. High-utilizing patients will be readily identified and the availability of "need to know now" information will help to expedite clinical workflows in both the inpatient and outpatient settings. Additionally, these process improvements will allow care providers to spend additional time intervening on the "rising-risk" wave of potential high-utilizers. The increased data sharing and analytics will also help the BATP collectively, and its individual entities, measure outcomes and deploy resources most effectively.

BATP is closely integrated with the Healthy Anne Arundel Coalition (HAAC), our local health improvement coalition. This Coalition brings together government agencies, health care providers, community and faith-based organizations, businesses and others to develop and implement plans to improve the health of Anne Arundel County. This Coalition is chaired by the County Health Officers, with representatives from both BATP applicant hospitals serving as Co-Vice Chairs.

HAAC serves as the primary convening entity for collaborative population health initiatives for Anne Arundel County and is led by BATP principals including the Anne Arundel County Department of Health, UM BWMC and AAMC. Many BATP planning process participants are also part of HAAC.

The BATP is just one piece of many interconnected initiatives of HAAC. HAAC's current health improvement priorities (Obesity and Behavioral Health) are correlated with the chronic conditions facing the BATP target population. BATP itself expanded upon previous care coordination and PAU reduction planning work that was undertaken in preparation for implementation of the State Innovation Model

Community-integrated Medical Home initiative.

Both hospitals have established working relationships with CRISP and BATP is another example of how these entities will continue to collaborate to improve the health of patients in Maryland. Furthermore, both hospitals have been working in a variety of internal and external initiatives to support the All Payer Model and the Triple Aim: Health Enterprise Zones, Patient-Centered Medical Homes, ACOs.

Appendix A

ID	Task Name	Work	Start	Finish	% Work Comple	% Comple	Predecessors	Resource Names
1	**Appendix A**	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

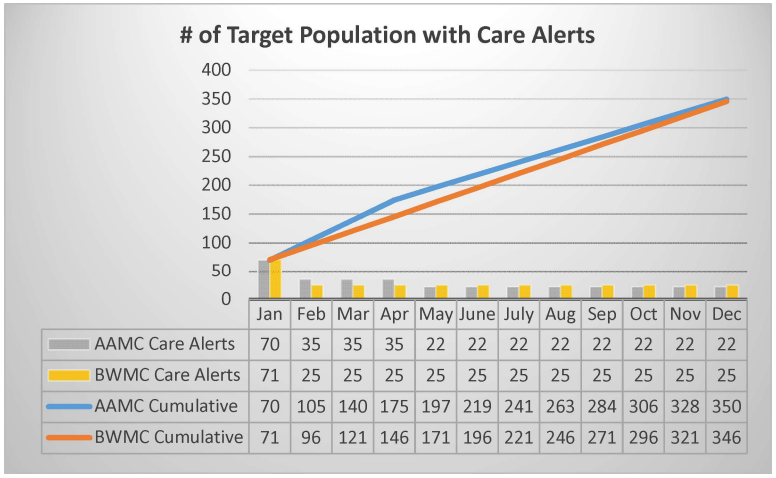
ID	Task Name	Work	Start	Finish	% Work Comple	% Comple	Predecessors	Resource Names
181	Perform Training (Cross-organization) Epic, IP Care Mgt, Call Ctr Ops, Govt Agency, TCC	80 hrs	Tue 4/26/16	Thu 5/26/16	0%	0%	180	Chris Crabbs,Debbie Roper, AA Analyst,Pam Hinshaw,TCC,Karrisa Gouin,DSS
182	Develop educational 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

Appendix B

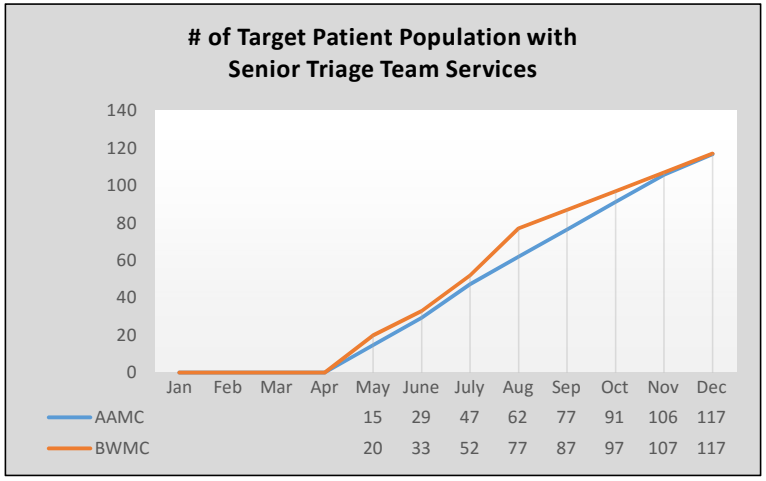
page 1

BATP Volume Tracking Dashboards (example)



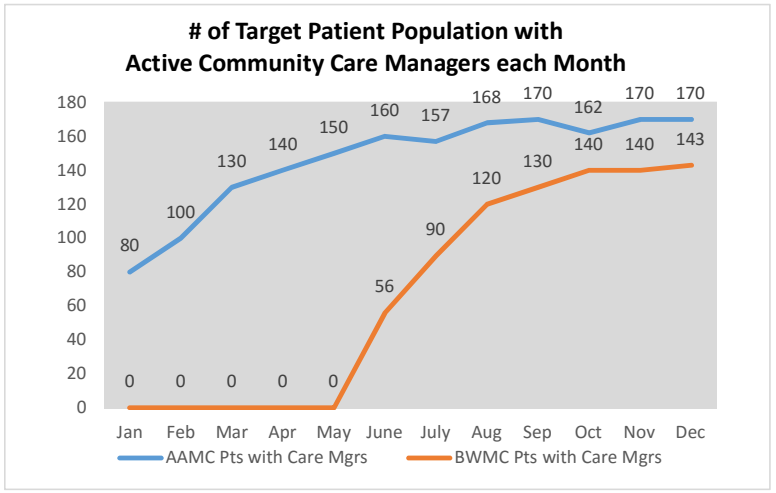
of Target Population with Care Alerts

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
AAMC Care Alerts	70	35	35	35	22	22	22	22	22	22	22	22
BWMC Care Alerts	71	25	25	25	25	25	25	25	25	25	25	25
AAMC Cumulative	70	105	140	175	197	219	241	263	284	306	328	350
BWMC Cumulative	71	96	121	146	171	196	221	246	271	296	321	346

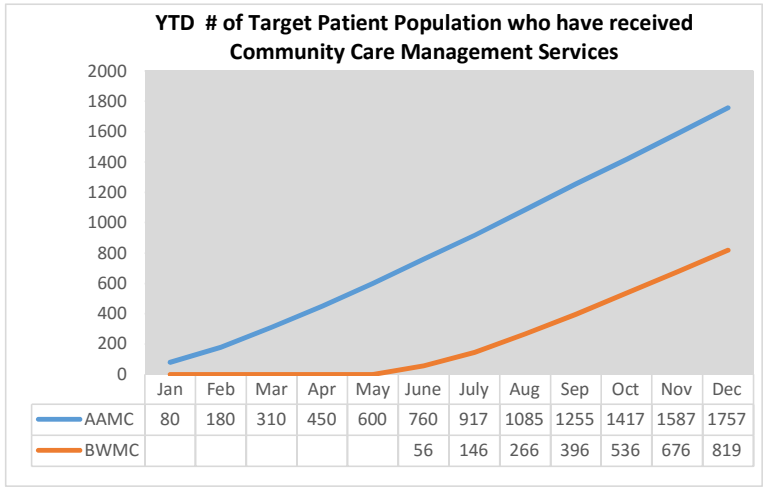


of Target Patient Population with Senior Triage Team Services

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
AAMC					15	29	47	62	77	91	106	117
BWMC					20	33	52	77	87	97	107	117



of Target Patient Population with Active Community Care Managers each Month

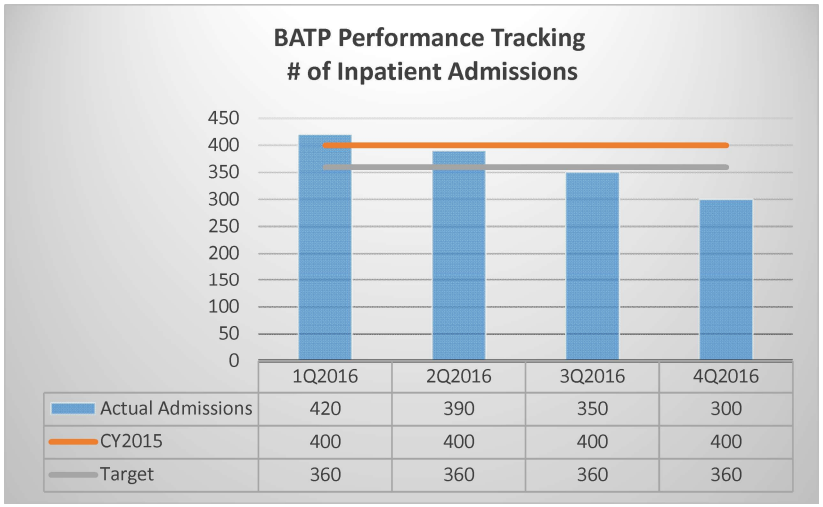


YTD # of Target Patient Population who have received Community Care Management Services

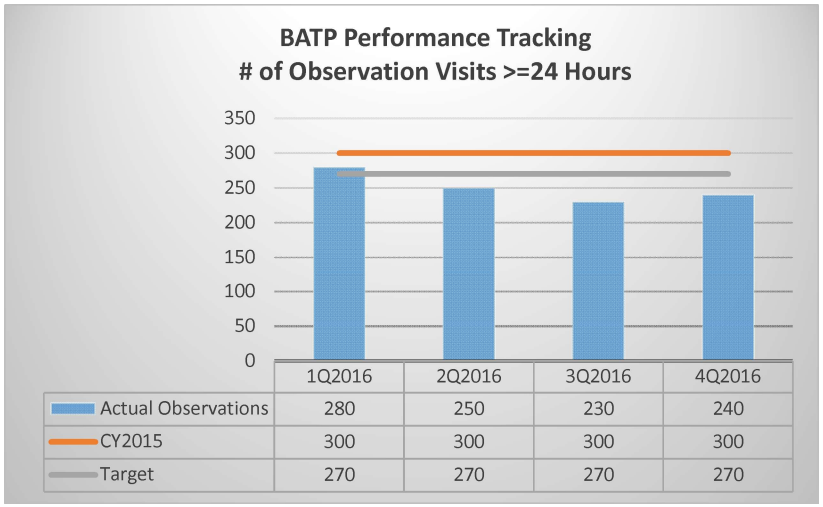
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
AAMC	80	180	310	450	600	760	917	1085	1255	1417	1587	1757
BWMC						56	146	266	396	536	676	819

Appendix B

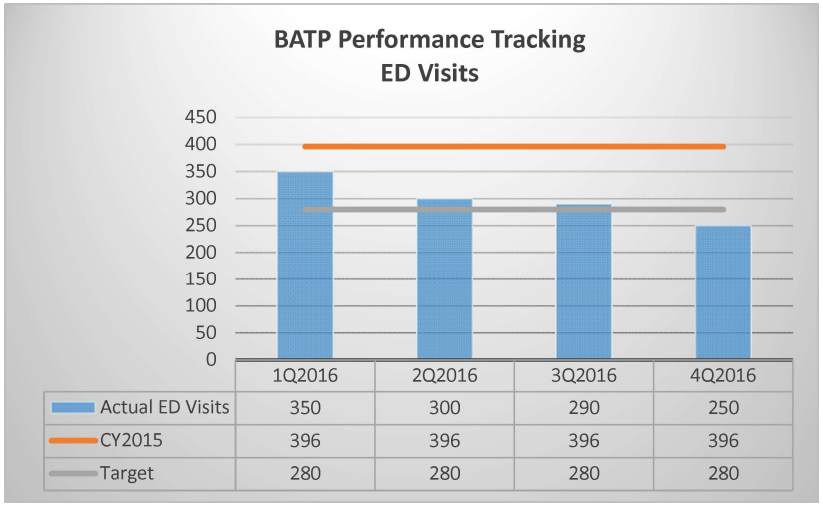
BATP Performance Tracking Dashboard (example)



	1Q2016	2Q2016	3Q2016	4Q2016
Actual Admissions	420	390	350	300
CY2015	400	400	400	400
Target	360	360	360	360



	1Q2016	2Q2016	3Q2016	4Q2016
Actual Observations	280	250	230	240
CY2015	300	300	300	300
Target	270	270	270	270



	1Q2016	2Q2016	3Q2016	4Q2016
Actual ED Visits	350	300	290	250
CY2015	396	396	396	396
Target	280	280	280	280

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

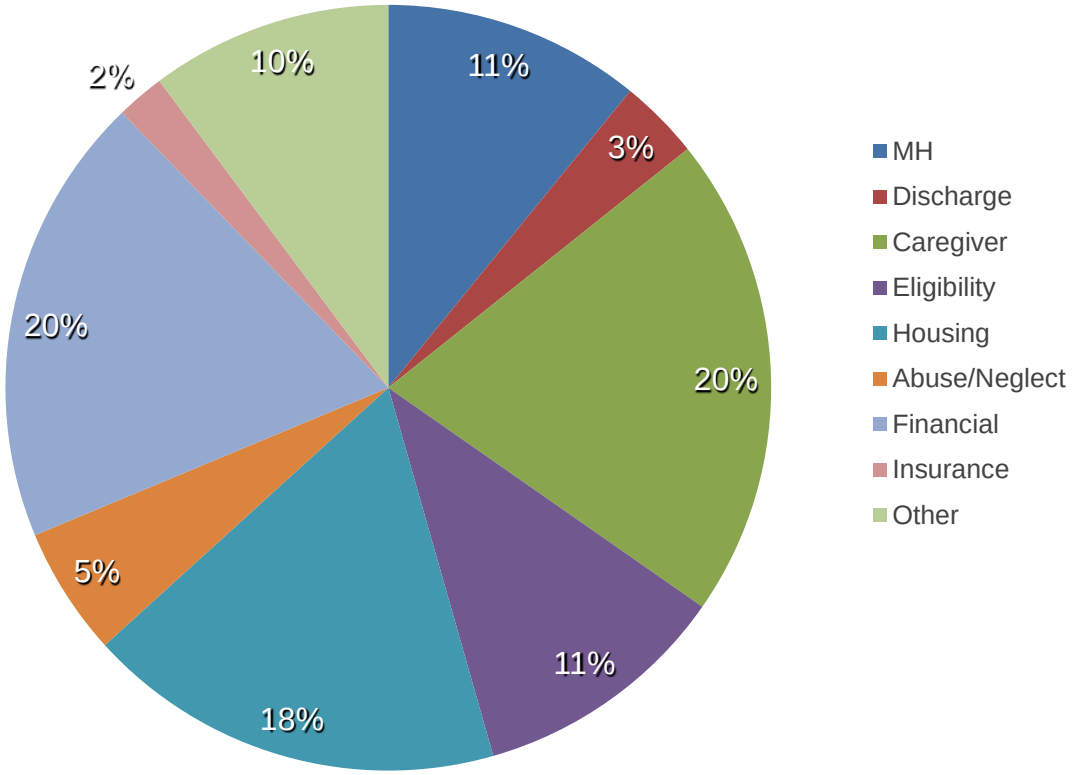
and human service resources, programs, and will provide critical evaluation to each case as presented by the Triage Team. "Silver CRICT" which is an Aging/Senior population Community Resource Initiative Care Team (CRICT) will be developed to support the Triage Team through providing access to referral 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.

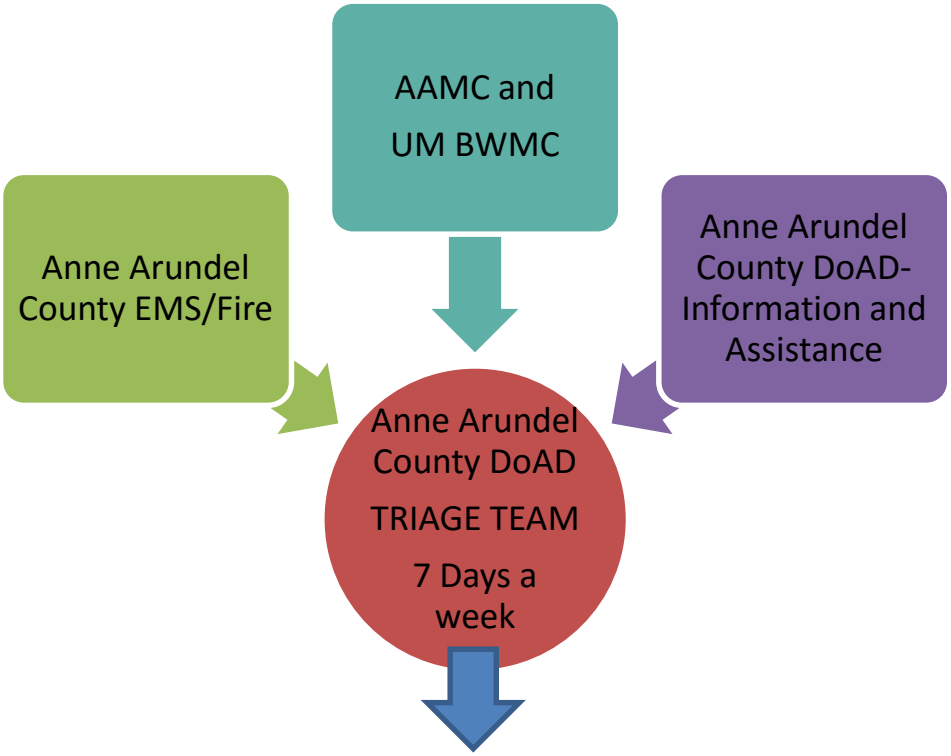
Action A: *The Triage Team will receive, through Memorandum of Understanding, referrals from Anne Arundel Medical Center and University of Maryland Baltimore Washington Hospital. The Triage Team will receive notification upon admission of a pre-identified super-utilizer* (initially the highest as defined 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.*

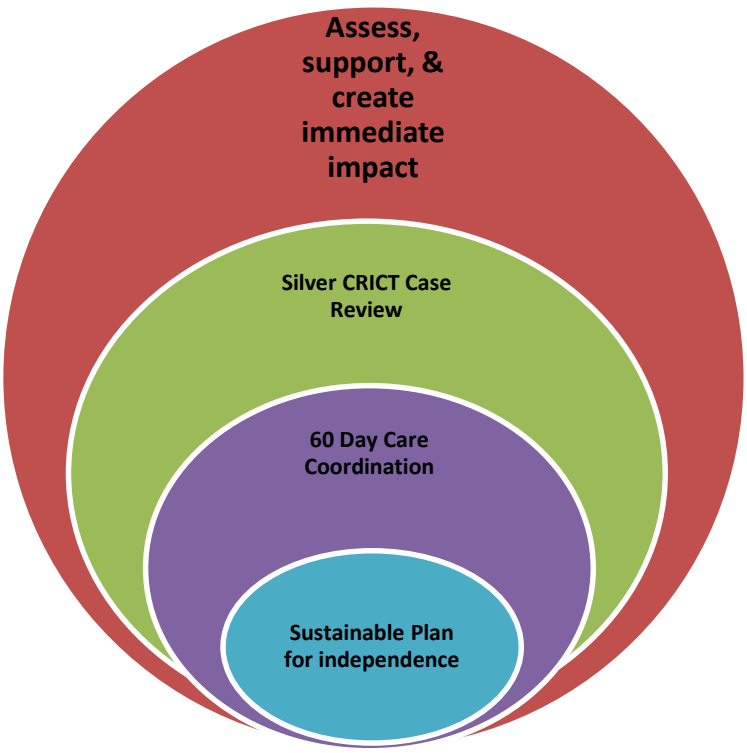
Action B: *The Triage Team will work in partnership with Anne Arundel County EMS/Fire to identify a list of individuals 55 and older that are super-utilizers of the emergency response system and require one or more of the indicators listed in Action A to maintain safe and sustainable living. The triage 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

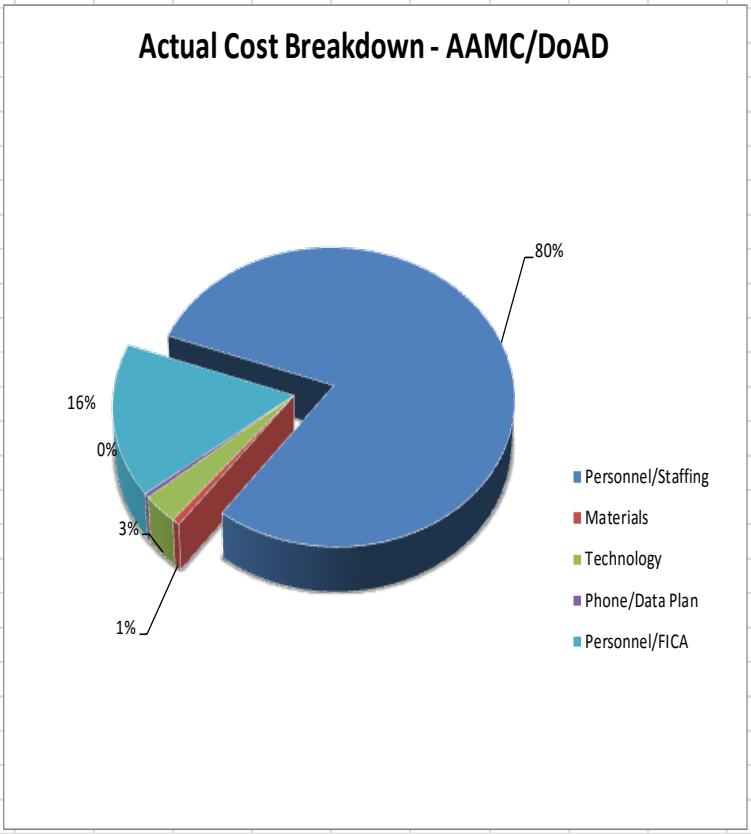
Phone/Data Plan	AAMC/UM BWMC	DoAD
Cell Phone 1		$ 450.00
Cell Phone 2		$ 450.00
Cell Phone 3		$ 450.00
Total	$ -	$ 1,350.00

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 III:

UM BWMC FY15 HSCRC Community Benefit Report Narrative

UNIVERSITY of MARYLAND
BALTIMORE WASHINGTON
MEDICAL CENTER

Community Benefit Report
FY2015

December 2015

University of Maryland Baltimore Washington Medical Center
301 Hospital Drive
Glen Burnie, MD 21061

www.mybwmc.org

GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. **Please list the following information in Table I below. For the purposes of this section, "primary services area" means the Maryland postal ZIP code areas from which the first 60 percent of a hospital's patient discharges originate during the most recent 12 month period available, where the discharges from each ZIP code are ordered from largest to smallest number of discharges. This information will be provided to all acute care hospitals by the HSCRC. (Specialty hospitals should work with the Commission to establish their primary service area for the purpose of this report).**

Table I

Bed Designation:	Inpatient Admissions:	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients, by County:	Percentage of Patients who are Medicaid Recipients, by County:
310 (FY15)	18,986 (FY15)	21061 21122 21060 21144 21146	Anne Arundel Medical Center 21061, 21122, 21146 Johns Hopkins Hospital 21061, 21122, 21060, 21144, 21146 MedStar Harbor Hospital 21061, 21122, 21060 University of Maryland Medical Center 21061, 21122, 21060, 21144 University of Maryland Rehabilitation and Orthopedic Institute 21061, 21122, 21060, 21144	Anne Arundel County: 5.4%	Anne Arundel County: 15.1%

			Sheppard Pratt Hospital 21061, 21122, 21060, 21144, 21146 Mt. Washington Pediatric Hospital 21061, 21122, 21060, 21144		

Source: FY14 service area data as provided by HSCRC via HSCRC Community Benefit Reporting website; Uninsured data from U.S. Census Bureau, 2014 American Community Survey 1-Year Estimates; Medicaid data provided by Anne Arundel County Department of Health, Office of Assessment and Planning (based on December 2015 Medicaid data and 2014 Population Estimate).

2. For purposes of reporting on your community benefit activities, please provide the following information:

a. Describe in detail the community or communities the organization serves. Based on findings from the CHNA, provide a list of the Community Benefit Service Area (CBSA) zip codes. These CBSA zip codes should reflect the geographic areas where the most vulnerable populations reside. Describe how the CBSA was determined, (such as highest proportion of uninsured, Medicaid recipients, and super utilizers, i.e. individuals with > 3 hospitalizations in the past year). This information may be copied directly from the section of the CHNA that refers to the description of the Hospital's Community Benefit Community.

Community Benefit Service Area

UM BWMC, in FY15, refined our Community Benefit Service Area (CBSA) to include all of Anne Arundel County. This is consistent with our continued and expanded leadership role in County-wide collaborative population health initiatives such as the Healthy Anne Arundel Coalition (local health improvement coalition) and the Bay Area Transformation Partnership (DHMH/HSCRC Regional Transformation Partnership). However, UM BWMC devotes additional community benefit resources to the areas where most of our discharges originate (over 60% as identified in Table I). The area surrounding UM BWMC where most of our discharges originate from has some of the most vulnerable, high-risk residents in Anne Arundel County based on socioeconomic and health data.[i] We make concerted efforts to reach vulnerable, at-risk populations, including the uninsured, racial/ethnic minorities, persons with risky health behaviors (e.g. smoking), and people with chronic health conditions (e.g. diabetes, cancer). Many community benefit activities being planned in FY15 involved reducing potentially avoidable utilization, including reducing re-admissions and enhancing care coordination for super-utilizers (super-utilizers being defined by each initiative, but generally at least 3 or more instances of potentially avoidable utilization within six months).

Anne Arundel County zip codes include:

Zip Code	City
20701	Annapolis Junction
20711	Lothian

20714	North Beach
20724	Laurel
20733	Churchton
20736	Owings
20751	Deale
20754	Dunkirk
20755	Ft. Meade
20758	Friendship
20764	Shady Side
20765	Galesville
20776	Harwood
20778	West River
20779	Tracys Landing
20794	Jessup
21012	Arnold
21032	Crownsville
21035	Davidsonville
21037	Edgewater
21054	Gambrills
21056	Gibson Island
21060	Glen Burnie (East)
21061	Glen Burnie (West)
21076	Hanover
21077	Harmans
21090	Linthicum Heights
21108	Millersville
21113	Odenton
21114	Crofton
21122	Pasadena
21140	Riva
21144	Severn
21146	Severna Park
21225	Brooklyn
21226	Curtis Bay
21240	BWI Airport
21401	Annapolis
21402	Naval Academy
21403	Eastport
21405	Sherwood Forest
21409	Annapolis

Anne Arundel County Community Benefit Service Area Overview

Anne Arundel County is the fifth largest jurisdiction in Maryland with approximately 560,133 residents.[ii] It is part of the Baltimore metropolitan area and is located on the Chesapeake Bay, encompassing a 454 square mile area. The City of Annapolis, the State Capitol, is centrally located between Baltimore and Washington, D.C. The northern part of the County is suburban and urban with the southern part primarily rural and agricultural.

Persons between the ages of 20 and 44 years old comprise the largest segment of the population at 34.1%, followed by persons age 45 to 64 at 27.5% of the population.[iii] Persons age 19 and under are 24.9% of the County population and those ages 65 and older comprise 13.4% of the population. The County's median age is 38.3 years. The County is split almost evenly between males (49.5%) and females (50.5%).[iv]

Anne Arundel County has a predominately White, non-Hispanic population; however, there has been continued growth in the County's minority population. The County's White, non-Hispanic population now accounts for 70.0% of the total population, followed by Black, non-Hispanic at 16.1%; Hispanic at 7.2%; Asian, non-Hispanic at 3.7% and others at 2.5%.[v] English is the County's predominant language spoken at home among persons five years of age and older (89.3%), followed by Spanish at (5.0%; all other languages combined totaling 5.7%).[vi]

While Anne Arundel County is generally considered an affluent county with a median income of $87,217, approximately 6.1% of the population lives in poverty.[vii] Income affects access to affordable housing, healthy foods, recreational opportunities and access to health care services. Additionally, it is important to note that racial and ethnic disparities exist with 8.3% of Blacks and 11.3% of Hispanics living in poverty, compared to only 4.7% of non-Hispanic whites.[viii] In the County, 5.4% of the population is uninsured.[ix] The white, Non-Hispanic population has the lowest percent uninsured at 4.5%, and the Hispanic, any race population has the highest percent uninsured at 14.1%.[x]

Racial and ethnic health disparities exist in Anne Arundel County, Maryland and the United States. Racial and ethnic minorities often have the highest incidence, prevalence and mortality rates from chronic diseases such as cardiovascular disease, diabetes and obesity.[xi] Additionally, language barriers can impact access to health services and health literacy.

Anne Arundel County has 126 public schools, serving approximately 81,000 students.[xii] The County also has many private primary and secondary schools, the award-winning Anne Arundel Community College, the U.S. Naval Academy, St. Johns College and satellite locations of other institutes of higher education. One of the most beneficial assets to Anne Arundel County is its well-educated population. Approximately 91.9% of the population over age 25 has obtained a high school diploma and approximately 38.8% of Anne Arundel County's population age 25 and over has either a bachelor's degree or a graduate professional degree.[xiii]

Anne Arundel County has a comprehensive system of recreational parks and programs. More than 140 parks and sanctuaries are overseen by the County Department of Recreation and Parks.[xiv] The Department also manages specialized recreational facilities, including two swim centers, two golf courses, and a baseball stadium and softball complex. The Department also offers a variety of recreational programming including educational classes, cooking lessons, arts and crafts programs, youth and adult athletics, school-age childcare and adaptive recreation.[xv] The County is also home to numerous youth and adult sport organizations that offer recreational activities for a range of ages and ability levels.

Overall, Anne Arundel County ranks eighth out of twenty-four Maryland jurisdictions in measures that indicate the overall health of the county.[xvi]

b. In Table II, describe the population within the CBSA, including significant demographic characteristics and social determinants that are relevant to the needs of the community and *include the source of the information in each response*. For purposes of this section, social determinants are factors that contribute to a person's current state of health. They may be biological, socioeconomic, psychosocial, behavioral, or social in nature. (Examples: gender, age, alcohol use, income, housing, access to quality health care, transportation, education and healthy environment, having or not having health insurance.) (Add rows in the table for other characteristics and determinants as necessary).

Table II: CBSA Population Description

Median Household Income within the CBSA *Source: U.S. Census Bureau, 2014 American Community Survey 1-Year Estimates*	Anne Arundel County: $87,217 White, Non-Hispanic: $91,377 Black: $80,553 Asian: $124,100 Hispanic, any race: $64,748
Percentage of households with incomes below the federal poverty guidelines within the CBSA *Source: U.S. Census Bureau, 2014 American Community Survey 1-Year Estimates*	Anne Arundel County: 6.1% White, Non-Hispanic: 4.7% Black: 8.3% Asian: 10.6% Hispanic, any race: 11.3%
Percentage of uninsured people by County within the CBSA *Source: U.S. Census Bureau, 2014 American Community Survey 1-Year Estimates*	Anne Arundel County: 5.4% White, Non-Hispanic: 4.5% Black: 5.3% Asian: 6.2% Hispanic, Any Race: 14.1%
Percentage of Medicaid recipients by County within the CBSA. *Source: Anne Arundel County Department of Health, Office of Assessment and Planning (based on December 2015 Medicaid data and 2014 Population Estimate)*	Anne Arundel County: 15.1%
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). *Source: Maryland DMHM, Vital Statistics Administration, Annual Vital Statistics Report, 2013*	Anne Arundel County: 79.8 years White: 79.9 years Black: 77.8 years
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available). *Source: CDC WONDER (by race – rates are age-adjusted per 100,000 population based on data from 2013)*	Anne Arundel County: 741.5 White: 774.0 Black or African American: 776.1 Asian or Pacific Islander: 505.2 Hispanic: 439.0
Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA. (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources) See SHIP website for social and physical environmental data and county profiles for primary service area information: http://dhmh.maryland.gov/ship/SitePages/measures.aspx	Access to Healthy Food: Approximately 69,000 (12%) of County residents live in neighborhoods categorized as food deserts. Transportation: Anne Arundel County lacks a reliable public transportation system. There are multiple bus routes in the County but they are concentrated in the northern region of the County

Access to Healthy Food Data Source: Anne Arundel County Department of Health Report Card of Community Health Indicators, 2015 *Transportation Data Source: Anne Arundel County Department of Health, Office of Assessment and Planning Education Data Source: U.S. Census Bureau, 2009-2013 American Community Survey 5-Year Estimates* *Housing Data Source: U.S. Census Bureau, 2009-2013 American Community Survey 5-Year Estimates; Maryland Department of Planning* *Environmental Factors Data Source: Anne Arundel County Department of Health, Office of Assessment and Planning (source data from Outpatient Discharge Data File 2013, Maryland Health Services Cost Review Commission)*	and the Annapolis area in the central part of the County. Approximately 8,860 (2%) of residents over 16 years of age lack personal transportation. This percentage is higher in the County's northern region. High School Graduate (includes equivalency) for Population 25 Years and Over by Race\Ethnicity in Anne Arundel County: Total: 90.7% White: 93.0% Black or African American: 88.0% Asian or Pacific Islander: 89.0% Hispanic: 67.0% Anne Arundel County Housing: Owner-occupied: 74.2% Renter-occupied: 25.8% Anne Arundel County Environmental Factors:11.6% of ED visits in 2013 for chronic conditions were due to asthma
Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions. http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx *Source: U.S. Census Bureau, 2014 American Community Survey 1-Year Estimates*	Anne Arundel County Race/Ethnicity: White, non-Hispanic (NH) 70.0% Black, NH 16.1% Hispanic 7.2% Asian, NH 3.7%; Others 3.0% Anne Arundel County Age: Under 5 years: 6.3% 5-19 years: 18.6% 20-44 years: 34.1% 45-64 years: 27.5% 65 years and over: 13.4% Median Age: 38.3 Anne Arundel County Male 49.5%; Female 50.5% Language Spoken at Home, 5 Years Old and Older: English only: 89.3% Spanish: 5.0% Other Indo-European languages : 2.9% Asian and Pacific Islander languages: 2.0% Other languages: 0.8%

Health Disparities (selected) *Data Source: Anne Arundel County Community Health Needs Assessment, 2016 (in process - source data from Outpatient Hospital Discharge File 2013, Maryland Health Services Cost Review Commission analyzed by Anne Arundel County Department of Health, Office of Assessment and Planning)*	Anne Arundel County Infant Mortality Rate (per 1,000 births): Total: 5.6 White, non-Hispanic: 3.9 Black, non-Hispanic: 10.8 Hispanic, any race: 7.3 Anne Arundel County rate of ED visits for asthma per 100,000 population: Total: 603.2 White, non-Hispanic: 266.7 Black, non-Hispanic: 1699.5 Hispanic, any race: 430.3 Asian, non-Hispanic: 88.8 Anne Arundel County rate of ED visits for heart disease per 100,000 population: Total: 306.6 White, non-Hispanic: 285.5 Black, non-Hispanic: 346.1 Hispanic, any race: 65.2 Asian, non-Hispanic: 64.1 Anne Arundel County rate of ED visits for diabetes per 100,000 population Total: 209.6 White, non-Hispanic: 141.1 Black, non-Hispanic: 463.7 Hispanic, any race: 120.0 Asian, non-Hispanic: 88.8 Anne Arundel County rate of ED visits for hypertension per 100,000 population: Total: 221.6 White, non-Hispanic: 139.8 Black, non-Hispanic: 514.0 Hispanic, any race: 109.5 Asian, non-Hispanic: not available Anne Arundel County rate of ED visits for Behavioral Health Conditions per 1,000 population: Total: 17.2 White, non-Hispanic: 16.2 Black, non-Hispanic: 18.8 Hispanic, any race: 7.5 Asian: 3.8

Other *Data Source: Anne Arundel County Department of Health Report Card of Community Health Indicators, 2015 (source data for leading causes of death: Maryland Vital Statistics Annual Report, Vital Statistics Administration, Maryland DHMH; source data for adult weight indicators: Maryland BRFSS, 2013; source data for birth indicators: Maryland Vital Statistics Annual Report, Vital Statistics Administration, Maryland DHMH; source data for cigarette smoking by adults: Maryland BRFSS, 2013); Anne Arundel County Department of Health, Overweight and Obesity in Children and Adolescents in Anne Arundel County, 2012 (pediatric weight data); Maryland Youth Risk Behavior Survey 2013 (youth tobacco use and alcohol consumption data); Maryland BRFSS, 2013 (chronic alcohol consumption data, influenza vaccination data)*	Anne Arundel County Top 10 Leading Causes of Death, 2012: Cancer, Heart Disease, Chronic Lower Respiratory Diseases, Stroke, Unintentional Injuries, Influenza and Pneumonia, Diabetes, Alzheimer's, Septicemia, Suicide Anne Arundel County Weight Status: Healthy Weight in Adults:36.8% Overweight in Adults: 32.6% Obesity in Adults 30.5% Youth ages 2-17 overweight: 15.1% Youth ages 2-17 obese: 17.3% Anne Arundel County First Trimester Prenatal Care: 74.2% Anne Arundel County Low Weight Births: 7.5% Anne Arundel County Cigarette Smoking by Adults: 18.0% Anne Arundel County Chronic Alcohol Consumption by Adults: 7.5% Anne Arundel County Tobacco Use by High School Students: 17.7% Anne Arundel County High Alcohol Consumption by High School Students in past 30 days: 34.9% Anne Arundel County adults that report having received Influenza vaccine in past 12 months: 47.1%

Note: Additional demographic, social determinant, health status and health behavior data is available in the Anne Arundel County Community Health Needs Assessment.

I. COMMUNITY HEALTH NEEDS ASSESSMENT

1. **Has your hospital conducted a Community Health Needs Assessment that conforms to the IRS definition detailed on pages 4-5 within the past three fiscal years?**

__X__ Yes
____ No

Provide date here. 5/31/2013 **(mm/dd/yy)**

If you answered yes to this question, provide a link to the document here. (Please note: this may be the same document used in the prior year report).

http://www.mybwmc.org/community-benefit

This link allows the viewer to download the UM BWMC abbreviated version of the complete Anne Arundel County Community Health Needs Assessment or visit the Anne Arundel County Community Health Needs Assessment web site. The Anne Arundel County CHNA web site includes summary information and downloads for the full report, secondary data analysis report, key informant survey report, focus group report and zip code level data tables.

The Anne Arundel County Community Health Needs Assessment was done under the auspices of the Healthy Anne Arundel Coalition, the County's local health improvement coalition. It was a collaborative effort between the Coalition, UM BWMC, Anne Arundel Medical Center, the Anne Arundel County Department of Health and the Anne Arundel County Mental Health Agency, Inc. Holleran Consulting conducted the secondary data analysis, key informant surveys and focus groups and wrote the report documents, with the exception of the zip code level data tables. The zip code level data tables were completed by the Anne Arundel County Department of Health. There were no significant gaps identified in the data collection.

2. **Has your hospital adopted an implementation strategy that conforms to the definition detailed on page 5?**

__X_Yes 5/31/2013 **(mm/dd/yy) Enter date approved by governing body here:**
___No

If you answered yes to this question, provide the link to the document here.

http://www.mybwmc.org/community-benefit

III. COMMUNITY BENEFIT ADMINISTRATION

1. **Please answer the following questions below regarding the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital? (Please note: these are no longer check the blank questions only. A narrative portion is now required for each section of question b,)**

a. Is Community Benefits planning part of your hospital's strategic plan?
_X__Yes

___No

If yes, please provide a description of how the CB planning fits into the hospital's strategic plan, and provide the section of the strategic plan that applies to CB.

UM BWMC's strategic plan references the findings of the Community Health Needs Assessment. One of UM BWMC's strategic goals identified in the plan is to be a leader in innovation and integrated care delivery. More specifically, we plan to advance the health of Marylanders ***in our community*** by transforming care delivery through clinical integration among providers and ***community partners***, while contributing to medical innovation and discovery and training Maryland's future physicians, nurses, clinicians and allied health professionals. Specific strategies for this goal include developing population health capabilities. Relevant strategic plan sections are included as Appendix VI.

Our FY15 Annual Operating Plan, which is derived from our strategic plan, included a focus on population health and reducing potentially avoidable utilization, specifically related to readmissions. Many UM BWMC Community Benefit initiatives focus on health outreach and education to help achieve/maintain a healthy weight and prevent/manage chronic health conditions in order to help people live healthier live and keep them out of the hospital.

b. What stakeholders in the hospital are involved in your hospital community benefit process/structure to implement and deliver community benefit activities? (Please place a check next to any individual/group involved in the structure of the CB process and describe the role each plays in the planning process (additional positions may be added as necessary)

i. Senior Leadership

1. _X__CEO
2. _X__CFO
3. _X__Other (please specify): Chief Operating Officer, Community Benefit Board of Directors

Describe the role of Senior Leadership.

1. CEO – Karen Olscamp - Provides executive oversight to the Community Benefit Program.

2. CFO – Al Pietsch - Participates in Community Benefit reporting and the development of annual reports to the HSCRC and IRS.

3. COO – Kathy McCollum - Provides executive oversight to the Community Benefit Program. Community Benefit program reports up to the COO.

4. UM BWMC Community Benefit Board of Directors - Provides oversight and guidance to UM BWMC's Community Benefit programming. Approves the implementation strategy and annual reports. Makes recommendations to the

UM BWMC Board of Directors regarding community benefit and monitors the implementation of community benefit activities.

a. Michael Caruthers – UM BWMC Board of Directors and Chairman, UM BWMC Community Benefit Committee
b. Penny Cantwell – UM BWMC Foundation Board of Directors
c. Donna Jacobs - Senior Vice President, Government and Regulatory Affairs and Community Health, University of Maryland Medical System
d. Karen Olscamp- President and Chief Executive Officer, UM BWMC
e. Al Pietsch – Senior Vice President & Chief Financial Officer, UMWMC
f. Kathy McCollum – Chief Operating Officer and Senior Vice President, Clinical Integration, UM BWMC
g. Ed DeGrange - Manager, Community Development and Business Relations, UM BWMC
h. Dr. Dawn Lindsay – President, Anne Arundel Community College
i. Lou Zagarino - UM BWMC Board of Directors

ii. Clinical Leadership

1. _X__Physician
2. _X__Nurse
3. ___Social Worker
4. ___Other (please specify)

Describe the role of Clinical Leadership

1. Christopher DeBorja, MD, Associate Chairman, Department of Medical Services; Chairman, Internal Medicine/Family Medicine; Utilization Review Advisor – Serves as the physician lead for the development and implementation of population health initiatives.
2. Beth Tingo, RN, Director, Care Management – Participates in initiatives to reduce potentially avoidable utilization and readmissions. Facilitates the advancement of care coordination initiatives.
3. William Flinn, Vascular Surgeon – Leads the Community Vascular Screening Program
4. Other clinicians provide support on a project specific basis as needed.

iii. Community Benefit Operations

1. _X__Individual (please specify FTE)
   a. Jen Canlapan, Community Outreach Coordinator (1.0 FTE, July-January 2015; 0.5 FTE, February-June)
   b. Kim Davidson, Director, Community Outreach (1.0 FTE, July- Jan. 2015)

2. _X__Committee (please list members)

UM BWMC Community Benefit Board

a. Michael Caruthers – UM BWMC Board of Directors and Chairman, UM BWMC Community Benefit Committee
b. Penny Cantwell – UM BWMC Foundation Board of Directors
c. Donna Jacobs - Senior Vice President, Government and Regulatory Affairs, University of Maryland Medical System
d. Karen Olscamp- President and Chief Executive Officer, UM BWMC
e. Al Pietsch – Senior Vice President & Chief Financial Officer, UM BWMC
f. Kathleen McCollum – Chief Operating Officer and Senior Vice President, Clinical Integration, UM BWMC
g. Ed DeGrange - Manager, Community Development and Business Relations, UM BWMC
h. Dr. Dawn Lindsay – President, Anne Arundel Community College
i. Lou Zagarino - UM BWMC Board of Directors

3. _X__Department (please list staff)

a. Planning and Business Development Department (effective February 2015)
   i. Laurie Fetterman, Strategic Planning Project Manager
   ii. Rebecca Paesch, Vice President, Strategy and Business Development
b. Financial Decision Support Department
   i. Daniel Donaldson, Director, Financial Decision Support
   ii. Franklin Brosenne, Manager, Financial Decision Support

4. ___Task Force (please list members)

5. __X_Other (please describe)

The Community Benefit program receives initiative-specific assistance from various hospital departments and staff members depending on the purpose and scope of the initiative.

Briefly describe the role of each CB Operations member and their function within the hospital's CB activities planning and reporting process.

1. Community Outreach Coordinator – Plans and executes community benefit programs, activities and events in partnership with UM BWMC staff and community partners. Builds relationships with community-based partners to extend the reach of community benefit programs and solicits community input into community benefit activities. Assists with community benefit reporting.
2. UM BWMC Community Benefit Board – Provides oversight and guidance to UM BWMC's Community Benefit programming. Approves the implementation strategy and annual reports. Makes recommendations to the UM BWMC Board of Directors regarding community benefit. Monitors the implementation of community benefit activities.
3. Planning and Business Development Department – Provides strategic planning support to the development, implementation, evaluation and reporting of community benefit activities. Helps to assure alignment between Community Benefit, Hospital Strategic Plans and Annual Operating Plans, and Population Health initiatives throughout UM BWMC and the University of Maryland Medical System. Manages the CHNA process, the development of the

community benefit implementation strategy, and community benefit reporting to meet state and federal requirements.

4. Financial Decision Support Department – Assist in the community benefit reporting process related to financial information.
5. Other - The Community Benefit program receives initiative-specific assistance from various hospital departments and staff members depending on the purpose and scope of the initiative.

Note: The previous Director of Community Outreach handled the functions of the Community Outreach Coordinator and Planning and Business Development Department. Upon that person's resignation the Community Outreach program was restructured to further increase alignment and integration between community benefit planning and population health strategy.

c. Is there an internal audit (i.e., an internal review conducted at the hospital) of the Community Benefit report?)

Spreadsheet ___X__yes _____no
Narrative ___X__yes _____no

If yes, describe the details of the audit/review process (who does the review? Who signs off on the review?)

Community Benefit reporting is coordinated by the Community Outreach Coordinator and the Strategic Planning Project Manager. All information is collected throughout the year, with annual reporting occurring at the close of fiscal years for some activities. The data is collected, validated and entered into Lyon Software's Community Benefit Inventory for Social Accountability (CBISA) program. The Strategic Planning Project Manager conducts audits to verify the accuracy of data entered into CBISA. Maryland HSCRC Community Benefit guidance is consulted to determine what category to report community benefit activities under, along with other resources such as the Catholic Health Association and the VHA. Additionally, the University of Maryland Medical System convenes a monthly Community Health Improvement Committee meeting that includes leaders for community benefit reporting across the system. There is a roundtable at each meeting to discuss any questions or concerns related to community benefit reporting.

Drafts of the HSCRC Community Benefit narrative report and data collection tool are reviewed and approved by the Finance Department, the Vice President for Strategy and Business Development, and the Chief Operating Officer. The draft document is reviewed and approved by the UM BWMC Community Benefit Board, the UM BWMC Board of Directors and shared services for community health at the University of Maryland Medical System level before submission to the Maryland HSCRC.

d. Does the hospital's Board review and approve the FY Community Benefit report that is submitted to the HSCRC?

Spreadsheet ___X__yes _____no
Narrative ___X__yes _____no
If no, please explain why.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

External collaborations are highly structured and effective partnerships with relevant community stakeholders aimed at collectively solving the complex health and social problems that result in health inequities. Maryland hospital organizations should demonstrate that they are engaging partners to move toward specific and rigorous processes aimed at generating improved population health. Collaborations of this nature have specific conditions that together lead to meaningful results, including: a common agenda that addresses shared priorities, a shared defined target population, shared processes and outcomes, measurement, mutually reinforcing evidence based activities, continuous communication and quality improvement, and a backbone organization designated to engage and coordinate partners.

a. Does the hospital organization engage in external collaboration with the following partners:

___X__ Other hospital organizations
___X__ Local Health Department
___X__ Local health improvement coalitions (LHICs)
___X__ Schools
___X__ Behavioral health organizations
___X__ Faith based community organizations
___X__ Social service organizations

b. Use the table below to list the meaningful, core partners with whom the hospital organization collaborated to conduct the CHNA. Provide a brief description of collaborative activities with each partner (please add as many rows to the table as necessary to be complete)

Organization	Name of Key Collaborator	Title	Collaboration Description
Healthy Anne Arundel Coalition	Jinlene Chan, MD, MPH, Health Officer Vanessa Carter Elin Jones	Chair, Health Anne Arundel Coalition (HAAC) Chairperson, Joint CHNA Subcommittee, HAAC Chairperson, Promotion and Publicity Subcommittee, HAAC	Provided project management support, coordinated the public release of the joint CHNA, developed the Coalition's CHNA website and provided assistance with recruiting key informants and focus group participants

Anne Arundel County Department of Health	Vanessa Carter Donna Perkins	Director, Administrative Services Epidemiologist	Provided project management support, zip code level data analysis, and assistance with recruiting key informants and focus group participants
Anne Arundel Medical Center	Christine Crabbs	Manager, Health Promotion	Provided input into the components of the CHNA and assistance with recruiting key informants and focus group participants
Anne Arundel County Mental Health Agency, Inc.	Frank Sullivan	Executive Director	Provided input into the components of the CHNA and assistance with recruiting key informants and focus group participants
Holleran Consulting	Lisa McCracken	President	Served as the project consultant to include conducting the secondary data analysis, developing and administering the key informant survey, conducting focus groups, writing the CHNA report documents and providing a CHNA findings presentation to the public at a HAAC meeting

c. Is there a member of the hospital organization that is co-chairing the Local Health Improvement Coalition (LHIC) in the jurisdictions where the hospital organization is targeting community benefit dollars?

___X__yes _____no

Rebecca Paesch, Vice President, Strategy and Business Development, is the Co-Vice Chair of the Healthy Anne Arundel Coalition. The other Co-Vice Chair is Christine Crabbs, Director, Community Health Improvement, Anne Arundel Medical Center. The Coalition is chaired by Jinlene Chan, MD, MPH, Health Officer, Anne Arundel County Department of Health.

d. Is there a member of the hospital organization that attends or is a member of the LHIC in the jurisdictions where the hospital organization is targeting community benefit dollars?

__X___yes _____no

In addition to serving as the Co-Vice Chair of the Coalition, UM BWMC also has at least one representative on all of the Coalition's Subcommittees.

- Leadership and Finance Subcommittee: Rebecca Paesch, Vice President, Strategy and Business Development
- Planning and Assessment (CHNA) Subcommittee: Rebecca Paesch, Vice President, Strategy and Business Development; Laurie Fetterman, Strategic Planning Project Manager
- Community Engagement Subcommittee: Jen Canlapan, Community Outreach Coordinator
- Obesity Prevention Subcommittee: Megan Larson, Clinical Nutrition Manager
- Co-Occurring Disorders Subcommittee: Kurt Halspert, Chemical Dependency Nurse Practitioner
- Promotion and Publicity Subcommittee: Kristin Fleckenstein, Director, Marketing and Communications

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

This information should come from the implementation strategy developed through the CHNA process.

1. **Please use Table III, to provide a clear and concise description of the primary needs identified in the CHNA, the principal objective of each evidence based initiative and how the results will be measured (what are the short-term, mid-term and long-term measures? Are they aligned with measures such as SHIP and all-payer model monitoring measures?), time allocated to each initiative, key partners in the planning and implementation of each initiative, measured outcomes of each initiative, whether each initiative will be continued based on the measured outcomes, and the current FY costs associated with each initiative. Use at least one page for each initiative (at 10 point type). Please be sure these initiatives occurred in the FY in which you are reporting. Please see attached example of how to report.**

***For example*: for each principal initiative, provide the following:**

a. **1. Identified need: This includes the community needs identified by the CHNA. Include any measurable disparities and poor health status of racial and ethnic minority groups. Include the collaborative process used to identify common priority areas and alignment with other public and private organizations.**

2. Please indicate whether the need was identified through the most recent CHNA process.

b. Name of Hospital Initiative: insert name of hospital initiative. These initiatives should be evidence informed or evidence based. (Evidence based initiatives may be found on the CDC's website using the following link: http://www.thecommunityguide.org/)
(Evidence based clinical practice guidelines may be found through the AHRQ website using the following link: www.guideline.gov/index.aspx)

c. Total number of people within the target population (how many people in the target area are affected by the particular disease being addressed by the initiative)?

d. Total number of people reached by the initiative (how many people in the target population were served by the initiative)?

e. Primary Objective of the Initiative: This is a detailed description of the initiative, how it is intended to address the identified need, and the metrics that will be used to evaluate the results.

f. Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative?

g. Key Collaborators in Delivery: Name the partners (community members and/or hospitals) involved in the delivery of the initiative.

h. Impact/Outcome of Hospital Initiative: Initiatives should have measurable health outcomes. The hospital initiative should be in collaboration with community partners, have a shared target population and common priority areas.

- **What were the measurable results of the initiative?**
- **For example, provide statistics, such as the number of people served, number of visits, and/or quantifiable improvements in health status.**

i. Evaluation of Outcome: To what degree did the initiative address the identified community health need, such as a reduction or improvement in the health indicator? Please provide baseline data when available. To what extent do the measurable results indicate that the objectives of the initiative were met? There should be short-term, mid-term, and long-term population health targets for each measurable outcome that are monitored and tracked by the hospital organization in collaboration with community partners with common priority areas. These measures should link to the overall population health priorities such as SHIP measures and the all-payer model monitoring measures. They should be reported regularly to the collaborating partners.

j. Continuation of Initiative: What gaps/barriers have been identified and how did the hospital work to address these challenges within the community? Will the initiative be continued based on the outcome? What is the mechanism to scale up successful initiatives for a greater impact in the community?

k. Expense:

A. What were the hospital's costs associated with this initiative? The amount reported should include the dollars, in-kind-donations, or grants associated with the fiscal year being reported.

B. Of the total costs associated with the initiative, what, if any, amount was provided through a restricted grant or donation?

UM BWMC's priorities as defined in the UM BWMC CHNA and Action Plan Document:

1. Chronic Diseases (Obesity, Heart Disease, Diabetes and Cancer)
2. Wellness and Access
3. Maternal/Child Health
4. Access to Healthy Food and Healthy Food Education
5. Influenza Education and Prevention
6. Violence Prevention

These priorities were determined and ranked based on CHNA data, clinical expertise/ capacities and available resources. Priorities were determined by hospital leadership (administrative and clinical), the UM BWMC Community Benefit Board and the UM BWMC Board of Directors.

Table III Initiative I – Color Your Heart 5K Run

a. 1. Identified Need 2. Was this identified through the CHNA process?	1.* UM BWMC CHNA/Action Plan Priority: Obesity, Heart Disease, Diabetes & Cancer * Anne Arundel County CHNA Priority: Obesity/Overweight, Chronic Illness (Diabetes, Heart Disease); Health Disparities * SHIP Priority: Healthy Living 2. In the CHNA, obesity/overweight was ranked as the #1 health concern in Anne Arundel County. It is a major health problem and it is a contributing factor to many other chronic health conditions. At the time of the CHNA, the percentage of obese and overweight adults in Anne Arundel County was nearly 68% (based on BRFSS 2010 data, above the percentage for Maryland and the U.S.). The focus group participants said that there needed to be more opportunities for children and adults to be active and that childhood obesity was a major concern.
b. Hospital Initiative	*Color Your Heart 5K Fun Run*: This event was created to encourage individuals and families to engage in fun, heart-healthy exercise. Exercise is an important aspect of leading a healthy lifestyle. Regular exercise, coupled with a healthy diet, can help reduce the risk of overweight/obesity, diabetes, cardiovascular disease, cancer and other conditions. The event was promoted as a fun run with the goal of engaging members of the community who would not typically participate in a 5K. The non-competitive event attracted runners and walkers of all ages and activity levels. Families, friends and even a Girl Scout troop participated together.
c. Total Number of People Within the Target Population	Anne Arundel County residents ages 5 and older: 524,845 (younger children were not included in the target population due to the colored powder that was thrown onto people). Participants represented a wide spectrum of ages, races/ethnicities and activity levels. Source: U.S. Census Bureau, 2014 American Communities Survey 1-Year Estimates
d. Total Number of People Reached by the Initiative Within the Target Population	500 5K participants (maximum number of participants that the race was able to host) along with families and friends that came out to spectate the participants.
e. Primary Objective of the Initiative	To encourage heart healthy physical activity and health behaviors in order to prevent overweight/obesity and related chronic conditions such as cardiovascular disease and diabetes.
f. Single or Multi-Year Initiative – Time Period	Multi-Year. The first Color Your Heart 5K Fun Run was held in May 2015 and will become an annual event.
g. Key Collaborators in Delivery of the Initiative	UM BWMC is the leading sponsor of this initiative. Additional supporting sponsors include the Anne Arundel County Department of Recreation and Parks, WRNR Radio, The Voice Media Inc., and other local sponsors.
h. Impact/Outcome of Hospital Initiative?	The first annual Color Your Heart 5K Fun Run had overwhelmingly positive response from the community. Many participants indicated that the Color Your Heart 5K was their first 5K and that they had never thought they could do such an activity. This race provided participants with the motivation and support they needed to take steps toward leading a healthier and more active lifestyle.
i. Evaluation of Outcomes:	Percentage of Anne Arundel County adults meeting physical activity guidelines (aerobic and strengthening): 2013: 24.2% ; 2012: 19.7%; 2011:18.9% Source: Maryland BRFSS (data by race/ethnicity not available at the County level)

	Maryland BRFSS Surveillance Data can be used to track trends in adult overweight/obesity over time. Weight status is multifactorial and is impacted by genetics, physical activity levels, nutrition and the built environment. UM BWMC recognizes that reducing obesity is a long term goal that will involve programs, policies and collaborations to effect positive change. Percentage of overweight/obese adults in Anne Arundel County: 2013: 63.1%; 2012: 63.7%; 2011: 63.1% (Source: Maryland BRFSS) Current, reliable data sources for pediatric overweight/obesity in Anne Arundel County are not available.	
j. Continuation of Initiative?	Yes. The first annual Color Your Heart 5K Fun Run had an overwhelmingly positive response from the community and overweight/obesity prevention is a long-term goal.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative: $41,762	B. Direct Offsetting Revenue from Restricted Grants: $17,204 ($12,504 offsetting revenue from participant fees and $4,700 in offsetting revenue from sponsorships)

Table III Initiative II – Heartbeat for Health

a. 1. Identified Need 2. Was this identified through the CHNA process?	1. * UM BWMC CHNA/Action Plan Priority: Obesity, Heart Disease, Diabetes & Cancer * Anne Arundel County CHNA Priority: Obesity/Overweight, Chronic Illness (Diabetes, Heart Disease); Health Disparities * SHIP Priority: Healthy Living 2. The CHNA identified heart disease as the leading cause of death in Anne Arundel County (191.6 deaths per 100,000 population based on 2008-2010 data). In the CHNA, obesity/overweight was ranked as the #1 health concern in Anne Arundel County. It is a major health problem and it is a contributing factor to many other chronic health conditions. At the time of the CHNA, the percentage of obese and overweight adults in Anne Arundel County was nearly 68% (based on BRFSS 2010 data, above the percentage for Maryland and the U.S.)
b. Hospital Initiative	*Heartbeat for Health:* UM BWMC hosted Heartbeat for Health, its annual family-friendly heart health event, on Saturday, February 21, 2015 at the Severna Park Community Center. Dance demonstrations and dance learning opportunities represented a variety of dance styles and cultural representations. The event was attended by over 250 Anne Arundel County residents who participated in heart healthy activities, health screenings and more. Attendees learned about the benefits of dance and exercise in the prevention of heart disease, diabetes, and overweight/obesity. Free health screenings for cholesterol, bone density, body mass index (BMI) and blood pressure were offered. Health education on a variety of topics was provided, including: heart disease, cancer, achieving/maintaining a healthy weight, making healthy food choices and diabetes prevention/management.
c. Total Number of People Within the Target Population	Anne Arundel County residents ages 5 and older: 524,845 (efforts were made to reach racial/ethnic minorities through grassroots event marketing and the types of dance included in the event) Source: U.S. Census Bureau, 2014 American Communities Survey 1-Year Estimates
d. Total Number of People Reached by the Initiative Within the Target Population	230+ (attendance was lower than anticipated due to inclement weather)
e. Primary Objective of the Initiative	The primary objectives of Heartbeat for Health include: • increasing education and awareness; • encouraging community members to make healthy lifestyle choices to reduce the incidence of obesity and related chronic conditions including heart disease, diabetes, high cholesterol and high blood pressure.
f. Single or Multi-Year Initiative – Time Period	Multi-year initiative beginning in 2006.
g. Key Collaborators in Delivery of the Initiative	UM BWMC is the lead sponsor of this initiative. Community partners include Advanced Radiology, Maryland Primary Care Physicians, McCarl Dental Group, and a variety of dance schools and exercise instructors.
h. Impact/Outcome of Hospital Initiative?	More than 230 area residents participated in Heartbeat for Health in 2015. Exit surveys were conducted and completed by 54 attendees. FY15 event outcomes include:

	• 60 participants were screened for total cholesterol. 23 (38%) participants had a total cholesterol result of 200 mg/dl or greater, indicating the need for physician follow-up for re-testing or other treatment based on the recommendation by the American Heart Association. • 76 participants had a vascular (carotid artery) screening conducted and no participants were found to have an abnormal result. • 45 attendees that completed the exit survey (83%) indicated they would likely make lifestyle changes as a result of information gained from attending Heartbeat for Health. • 44 attendees that completed the survey (81.5%) indicated that one or more of the following heath concerns were very important to them: high cholesterol, high blood pressure, vascular disease, heart disease, diabetes, cancer, stroke, losing weight/changing diet, stop smoking or women's health. Source: Program/Events Records and Exit Surveys	
i. Evaluation of Outcomes:	Percentage of Anne Arundel County adults meeting physical activity guidelines (aerobic and strengthening): 2013: 24.2% ; 2012: 19.7%; 2010: 18.9% Source: Maryland BRFSS (data by race/ethnicity not available at the County level) Mortality data can be used to track heart disease trends. Recent data demonstrates a decline in the heart disease mortality – 165.0 deaths per 100,000 population based on 20011-2013 data. Source: Maryland Vital Statistics Annual Reports, Vital Statistics Administration, Maryland DHMH Maryland BRFSS Surveillance Data can be used to track trends in adult overweight/obesity over time. Weight status is multifactorial and is impacted by genetics, physical activity levels, nutrition and the built environment. UM BWMC recognizes that reducing obesity is a long term goal that will involve programs, policies and collaborations to effect positive change. Percentage of overweight/obese adults in Anne Arundel County: 2013: 63.1%; 2012: 63.7%; 2011: 63.1%; 2010: 67.9% Source: Maryland BRFSS (data by race/ethnicity not available at the County level) Reliable data sources for pediatric overweight/obesity in Anne Arundel County are not available. UM BWMC also looks at CHNA data regarding ED visit rates for the County as a whole and by race for diabetes, hypertension and heart disease.	
j. Continuation of Initiative?	Yes. This program has been well-received by the community.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative: $25,629	B. Direct Offsetting Revenue from Restricted Grants: $0

Table III Initiative III – Smoking Cessation Classes

a. 1. Identified Need 2. Was this identified through the CHNA process?	1. * UM BWMC CHNA/Action Plan Priority: Heart Disease, Cancer * Anne Arundel County CHNA Priority: Cancer, Chronic Illness * SHIP Priority: Healthy Living 2. CHNA key informants ranked tobacco use 7th among Anne Arundel County's top health issues. Smoking is widely considered to be the leading cause of preventable death.	
b. Hospital Initiative	*Smoking Cessation Classes*: Smoking Cessation classes are offered to adults ages 18 and older. The classes educate participants on the health risks associated with tobacco use and provide the mechanisms (e.g. medication, counseling) to help people quit.	
c. Total Number of People Within the Target Population	Anne Arundel County Adults Ages 18 and over who are current smokers: 78,038 Source: U.S. Census Bureau, 2014 American Communities Survey 1-Year Estimates; Maryland BRFSS, 2013	
d. Total Number of People Reached by the Initiative Within the Target Population	17	
e. Primary Objective of the Initiative	The objective of the smoking cessation classes is to reduce the number of adults who smoke.	
f. Single or Multi-Year Initiative – Time Period	Multi-year initiative	
g. Key Collaborators in Delivery of the Initiative	UM BWMC offers smoking cessation classes with a grant from the Anne Arundel County Department of Health. They are offered in partnership with the Anne Arundel County Department of Health with funding from Maryland's Cigarette Restitution Fund.	
h. Impact/Outcome of Hospital Initiative?	In FY15, 19 people participated in the smoking cessation program. Twelve people completed the program (63%); 10 of whom quit smoking at the end of their session (83%). Three of the 10 participants who quit smoking remained smoke-free at three months post-program. While the program saw fewer participants in FY15 as compared to FY14, a greater percentage of the participants who completed the program quit and were smoke-free at three months post-program. It is typically difficult to reach participants for follow-up (e.g. phone number out of service, messages not returned) and the number of people who quit might be higher.	
i. Evaluation of Outcomes:	Percentage of Anne Arundel County adults ages 18 and older who are current smokers: 2013: 18.0%; 2012: 18.1%; 2011:22.9% Source: Maryland BRFSS Reductions in smoking are related to the availability of resources to help people quit and policy initiatives.	
j. Continuation of Initiative?	Yes. The smoking cessation classes provided by UM BWMC are a valuable resource for helping people to quit smoking.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting	A. Total Cost of Initiative: $7,920	B. Direct Offsetting Revenue from Restricted Grants: $5,657

Revenue		

Table III Initiative IV – Community Vascular Screening Program

a. 1. Identified Need 2. Was this identified through the CHNA process?	1. * UM BWMC CHNA/Action Plan Priority: Wellness and Access * Anne Arundel County CHNA Priority: Obesity/Overweight, Chronic Illness (Diabetes, Heart Disease); Health Disparities * SHIP Priority: Healthy Living 2. The CHNA identified that cerebrovascular disease is the third leading cause of death in Anne Arundel County. There were 41.4 deaths per 100,000 population (2008-2010). The leading cause of death was heart disease, a significant risk factor for stroke.
b. Hospital Initiative	*Community Vascular Screening Program*: Free screenings of vascular disorders are done using non-invasive, state-of-the-art ultrasound and Doppler technology. Screening results are reviewed with a physician or nurse practitioner immediately following the screening. Participants leave the screening with a copy of their results to share with their primary care provider.
c. Total Number of People Within the Target Population	Anne Arundel County residents ages 50 or older: 189,325 Source: U.S. Census Bureau, 2014 American Communities Survey 1-Year Estimates Screenings are offered to community members ages 50 or older who have one of the following risk factors: hypertension, diabetes, family history of vascular disease, high cholesterol or history of smoking. UM BWMC tries to reach racial/ethnic minority populations through promotion of screening events and collaborations with community partners who host screening events. Health data demonstrates that there are health disparities for conditions that are risk factors for vascular disease (e.g. heart disease, hypertension, diabetes - see table II for more details).
d. Total Number of People Reached by the Initiative Within the Target Population	269 people received free vascular screenings in FY15.
e. Primary Objective of the Initiative	The primary objectives of offering potentially life-saving vascular screenings are to: • identify people with abnormal screening results and refer them to follow-up care, • educate the community about the importance of vascular screenings as a tool in the early detection of carotid artery disease (linked to stroke), abdominal aortic aneurysms and peripheral arterial disease.
f. Single or Multi-Year Initiative – Time Period	Multi-year initiative. This program has demonstrated success in identifying vascular disorders requiring follow-up care and helps prevent morbidity and mortality associated with stroke.
g. Key Collaborators in Delivery of the Initiative	UM BWMC is the lead sponsor of the vascular screening initiative. UM BWMC partners with community organizations such as senior centers and churches to host the screenings.
h. Impact/Outcome of Hospital Initiative?	In FY15, of the 269 people screened, 13 abnormal results (4.8% abnormal rate) were found.
i. Evaluation of Outcomes:	Reduction in stroke mortality: Anne Arundel County: 41.4 deaths per 100,000 population (2008-2010, age-adjusted);

	37.6 deaths per 100,000 population (2011-2013, age-adjusted) Black, Non-Hispanic: 64 deaths per 100,000 population (2011-2013, age-adjusted) White, Non-Hispanic: 35.9 deaths per 100,000 population (2011-2013, age-adjusted) Source: Anne Arundel County Community Health Needs Assessment, 2012 (FY13) and Anne Arundel County Community Health Needs Assessment, 2016 (in process)	
j. Continuation of Initiative?	Yes. This program provides needed education and screening. Nearly 5% of screenings in FY15 discovered abnormal results requiring follow-up.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative: $104,218 (Note: Per HSCRC Guidance, this total is for screening-only events falling under A21: Screenings; screenings at health-fair events are counted separately under A10: Community Health Education)	B. Direct Offsetting Revenue from Restricted Grants: $0

Table III Initiative V – Subsidized Outpatient Services

a. 1. Identified Need 2. Was this identified through the CHNA process?	1.* UM BWMC CHNA/Action Plan Priority: Wellness and Access; Maternal/Child Health * Arundel County CHNA Priority: Access to Care * SHIP Priority: Access to Care; Quality Preventive Care; Healthy Beginnings 2. In the CHNA, it was reported that according to the County Health Rankings, the patient to primary care physician ratio in Anne Arundel (954:1) is worse than in Maryland (713:1) and the U.S. benchmark (631:1). When primary care physicians are not fully accessible or available, the Emergency Department is often utilized as a source of primary care.
b. Hospital Initiative	*Subsidized Outpatient Services:* UM BWMC subsidizes physicians that provided needed outpatient care (primary care, OB/GYN). There are gaps in the availability of providers in Anne Arundel County and there are significant health disparities, especially with respect to chronic health conditions (e.g. diabetes, hypertension) and maternal/infant health (e.g. infant mortality, preterm birth, low birth weight).
c. Total Number of People Within the Target Population	Anne Arundel County residents ages 18 and older: 433,543 Note: Our primary service area is smaller than the County as a whole and is focused on the northern region of the County near UM BWMC (see zip codes in table I).
d. Total Number of People Reached by the Initiative Within the Target Population	FY15 incremental increase of patient visits = 12,672
e. Primary Objective of the Initiative	Increase access to primary care services (primary care, senior care) and women's health services (OB/GYN).
f. Single or Multi-Year Initiative – Time Period	Multi-Year.
g. Key Collaborators in Delivery of the Initiative	University of Maryland Baltimore Washington Primary Care, University of Maryland Baltimore Washington Adult and Senior Care, University of Maryland Baltimore Washington Women's Health Associates (UM BWWHA)
h. Impact/Outcome of Hospital Initiative?	In FY15, UM BWMC's Physician Enterprise acquired a second primary care practice in Pasadena (21122). This acquisition added two additional providers. We also doubled the physical capacity of our primary care practices in Glen Burnie (21061) and Millersville (21108). Our senior care practice recruited and placed a Nurse Practitioner in a nursing home adjacent to UM BWMC to improve quality of care and care coordination and help prevent hospital readmissions. The practice also successfully recruited a second fellowship-trained geriatrician to work in our Millersville office (she began practicing shortly after the fiscal year end). In FY15, UM Baltimore Washington Women's Health Associates opened its second location for its CenteringPregnancy™ program in Glen Burnie (21061). This program has exemplary pregnancy and birth outcomes that far exceed the County as a whole and Healthy People 2020 goals.
i. Evaluation of Outcomes:	UM BWMC's primary care practices increased visits from FY14 by 53%. When primary care physicians are not fully accessible, the Emergency Department is often utilized as a source of primary care. It is expected that increased access to primary care will lead to decreased ED visits and improved management of chronic health conditions over time.

	UM BWHHA served 108 participants in FY15 in its CenteringPregnancy™ program, an increase of 29 participants from FY14. It is important to note that Anne Arundel County's Black, non-Hispanic population accounts for 16% of the County's total population, yet the Centering PregnancyTM program serves a much higher percentage of this population segment (33%), with the total percentage of minorities served being even higher. The continued growth of this program and our continued ability to engage minority populations will help to improve maternal and infant health and reduce health disparities.	
j. Continuation of Initiative?	Yes, UM BWMC will continue to seek opportunities to expand primary care to meet community needs Yes, UM BWHHA will continue to subsidize OB/GYN services in the community and grow the CenteringPregnancy.™	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative: $4,262,027 (Primary Care: $2,156,967; OB/GYN: $2,105,070)	B. Direct Offsetting Revenue from Restricted Grants: $0

Table III Initiative VI – Maryland Health Care for All Forum

a. 1. Identified Need 2. Was this identified through the CHNA process?	1. * UM BWMC CHNA/Action Plan Priority: Wellness and Access * Anne Arundel County CHNA Priority: Awareness of Service * SHIP Priority: Access to Care 2. The CHNA key informant survey and focus groups demonstrated that County residents did not have enough awareness about available services. There were calls for increased communication about available health services.	
b. Hospital Initiative	*Maryland Health Care for All Forum* – This event was one of eleven forums held across the state to engage and educate Marylanders about the health system transformation underway in our state.	
c. Total Number of People Within the Target Population	Anne Arundel County residents ages 18 and older: 433,543 Source: U.S. Census Bureau, 2014 American Communities Survey 1-Year Estimates	
d. Total Number of People Reached by the Initiative Within the Target Population	65 (attendance lower than anticipated, possibly due to the timing and location of the event)	
e. Primary Objective of the Initiative	The objective of this forum was to engage and educate the community about the health system transformation taking place in Maryland. Discuss innovative collaborations.	
f. Single or Multi-Year Initiative – Time Period	Single-Year Initiative. At this time, this is a single-year initiative. However, UM BWMC is in the process of planning additional community outreach activities to teach people how to effectively utilize their health insurance benefits (especially the newly insured as a result of the ACA) and select the appropriate care setting (primary care, retail health clinic, urgent care center or Emergency Department).	
g. Key Collaborators in Delivery of the Initiative	Maryland Health Care for All was the lead sponsor for this initiative. UM BWMC, Anne Arundel Medical Center, and the Anne Arundel County Department of Health collaborated with Maryland Health Care for All to offer this forum to the community. Other partners included the Healthy Anne Arundel Coalition, HSCRC, and the faith-based community.	
h. Impact/Outcome of Hospital Initiative?	65 attendees received education about Maryland's health system and Anne Arundel County initiatives to improve health. Potential collaborations were discussed.	
i. Evaluation of Outcomes:	Although this event did not engage as many participants as we had hoped, the feedback was positive. UM BWMC is in the process of planning additional community outreach activities to engage people in the health system transformation process and teach people how to utilize their health insurance benefits and select the appropriate care setting (primary care, retail health clinic, urgent care center or ED).	
j. Continuation of Initiative?	At this time, this was a single-year initiative. However, UM BWMC is in the process of planning additional community outreach activities to teach people how to effectively utilize their health insurance benefits (especially the newly insured as a result of the ACA) and select the appropriate care setting (primary care, retail health clinic, urgent care center or ED).	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting	A. Total Cost of Initiative: $1,413 (Additional costs were paid by other partners)	B. Direct Offsetting Revenue from Restricted Grants: $0

Revenue		

Table III Initiative VII – Stork's Nest

a. 1. Identified Need 2. Was this identified through the CHNA process?	1. * UM BWMC CHNA/Action Plan Priority: Maternal/Child Health; Wellness and Access * Anne Arundel County CHNA Priority: Health Disparities * SHIP Priority: Healthy Beginnings 2. The CHNA identified health inequities by race/ethnicity as one of the County's top five opportunities for health improvement. The CHNA identified disparities in the County's infant mortality rate and among related indicators such as prematurity and low birth weight. Anne Arundel County Infant Mortality Rate (per 1,000 live births): Anne Arundel County: 4.7 White: 3.3 Black: 10.9 Source: Maryland DHMH Vital Statistics Reports, 2010
b. Hospital Initiative	*Stork's Nest:* Stork's Nest is a prenatal education program that offers several sessions a year in English and Spanish. Participants earn points by attending classes, going to prenatal care appointments and adopting healthy behaviors. Participants continue to earn points until their baby turns one year old by attending well-baby checkups and making sure immunizations are received on time. Points can be used to "purchase" pregnancy and infant care items at the Stork's Nest Store.
c. Total Number of People Within the Target Population	Any pregnant Anne Arundel County resident is eligible to participate, however, the program targets pregnant women at the greatest risk for having poor pregnancy outcomes, specifically African-American women, teenagers, women of low socioeconomic status and women with previous poor pregnancy outcomes. 6,968 total births in Anne Arundel County, 2014 1,236 Black non-Hispanic births in Anne Arundel County, 2014 866 Hispanic births in Anne Arundel County, 2014 Source: Maryland DHMH Vital Statistics Administration, Annual Vital Statistics Report
d. Total Number of People Reached by the Initiative Within the Target Population	225 total in FY15 (164 racial minorities and 63 Hispanics; 80% of participants were also WIC recipients which is correlated with low socioeconomic status)
e. Primary Objective of the Initiative	The primary objectives of Stork's Nest include: • Reduce preterm birth and low birth weight • Reduce sudden unexpected infant deaths (SUIDs)/deaths due to unsafe sleep • Increase the proportion of pregnant women starting prenatal care in the first trimester • Decrease infant morality
f. Single or Multi-Year Initiative – Time Period	Multi-year initiative beginning in 2006.

g. Key Collaborators in Delivery of the Initiative	UM BWMC is the lead sponsor of this initiative. Additional supporting sponsors include the Anne Arundel County Department of Health, March of Dimes (Maryland Chapter) and Zeta Phi Beta Sorority.	
h. Impact/Outcome of Hospital Initiative?	Anne Arundel County residents participated in Stork's Nest in FY15. FY15 outcomes (for participants with due dates on or before 6/30/15) include: • Babies born >= 37 weeks gestation: 97% • Babies born >5 lbs. at birth: 97% • Babies put to sleep on their back: 96% • Babies taken to wellness visits: 100% • Participants breastfeeding for at least three months: 50% Source: Stork's Nest Database	
i. Evaluation of Outcomes:	Data provided by the Maryland DHMH Vital Statistics Reports indicates that overall infant health outcomes in Anne Arundel County since the Stork's Nest program started. <u>2006</u> Infant Mortality Rate (per 1,000 live births) – Anne Arundel: 7.7; White: 5.2; Black: 21.4; Hispanic: Not Available Low Birth Weight - Total: 9.1%; White, Non-Hispanic; Black: 14.8%; Hispanic: 6.2% Prematurity – MD (Anne Arundel County data nota available): 11.4%; White, Non-Hispanic: 104%; Black: 14.1%; Hispanic: 9.3% <u>2014</u> Infant Mortality Rate (per 1,000 live births) – Anne Arundel: 5.7; White: 3.8; Black: 13.7; Hispanic: Not Available Low Birth Weight – Anne Arundel: 8.1%; White: 6.9%; Black: 13.7%; Hispanic: 6.9% Prematurity – Anne Arundel: 9.1%; White, non-Hispanic: 8.2%; Black, non-Hispanic: 13.5%; Hispanic: 7.9% Source: Maryland DHMH Vital Statistics Administration, Annual Vital Statistics Reports	
j. Continuation of Initiative?	Yes. This program has had exemplary outcomes. See item h above.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative: $62,145	B. Direct Offsetting Revenue from Restricted Grants: $0

Table VIII Initiative VIII – Weight of the Nation Screening

a. 1. Identified Need 2. Was this identified through the CHNA process?	1. * UM BWMC CHNA/Action Plan Priority: Access to Healthy Food and Healthy Food Education * Arundel County CHNA Priority: Overweight/Obesity; Heath Disparities * SHIP Priority: Healthy Living, Healthy Communities 2. In the CHNA, obesity/overweight was ranked as the #1 health concern in Anne Arundel County. It is a major health problem in and it is a contributing factor to many other health conditions. At the time of the CHNA, the percentage of obese and overweight adults in Anne Arundel County was nearly 68% (based on BRFSS 2010 data, above the percentage for Maryland and the U.S.).
b. Hospital Initiative	*Weight of the Nation Screening:* UM BWMC offered a four-part Weight of the Nation (WOTN) educational series. During each session, a segment from WOTN series was viewed by participants and there was a discussion facilitated by an instructor from Anne Arundel Community College. Healthy dinners were served to demonstrate the components of a healthy meal. Participants received portion plates to educate them about proper portion sizes and food types, and water bottles to encourage drinking water.
c. Total Number of People Within the Target Population	Students and families of Freetown Elementary School (506 students) Freetown Elementary School's student population is composed of a majority of racial and ethnic minority students. Two-thirds of the student population qualifies for free or reduced price lunch. Source: National Center for Education Statistics (2013-2014 school year data)
d. Total Number of People Reached by the Initiative Within the Target Population	18 (5 mothers, 3 children)
e. Primary Objective of the Initiative	Increase access to healthy foods and healthy food education. Reduce overweight/obesity and related chronic conditions.
f. Single or Multi-Year Initiative – Time Period	Multi-Year (host location may change from year to year)
g. Key Collaborators in Delivery of the Initiative	UM BWMC partnered with Anne Arundel Community College and Freetown Elementary School to offer this educational, four-part screening.
h. Impact/Outcome of Hospital Initiative?	Feedback from participants was very positive. Participants reported that they learned about making health food choices (including portion sizes) and the importance of physical activity.
i. Evaluation of Outcomes:	Maryland BRFSS Surveillance Data can be used to track trends in adult overweight/obesity over time. Weight status is multifactorial and is impacted by genetics, physicial activity levels, nutrition and the built environment. UM BWMC recognizes that reducing obesity is a long term goal that will involve programs, policies and collaborations to effect positive change. Percentage of overweight/obese adults in Anne Arundel County: 2013: 63.1%; 2012: 63.7%; 2011: 63.1%; 2010: 67.9% Source: Maryland BRFSS (data by race/ethnicity not available at the County level) Reliable data sources for pediatric overweight/obesity in Anne Arundel County are not available.

j. Continuation of Initiative?	Yes. UM BWMC will continue to partner with Anne Arundel Community College and other community partners to offer this educational series.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	C. Total Cost of Initiative: $3,066	D. Direct Offsetting Revenue from Restricted Grants: $0

Table III Initiative IX – Influenza Education and Prevention

a. 1. Identified Need 2. Was this identified through the CHNA process?	1. * UM BWMC CHNA/Action Plan Priority: Influenza Education and Prevention * Anne Arundel County CHNA Priority: Access to Care * SHIP Priority: Quality Preventive Care 2. The CHNA identified that mortality rates for influenza/ pneumonia are higher in Anne Arundel County (18.0 per 100,000 population) compared to Maryland (17.3) and the U.S (15.1). Influenza/Pneumonia was the leading cause of death in Anne Arundel County (2008-2010 data).
b. Hospital Initiative	*Influenza Education and Prevention:* Education and outreach regarding the importance of receiving an influenza vaccine, prevention of disease transmission/self-care tips and free seasonal influenza vaccines are provided to the community.
c. Total Number of People Within the Target Population	Anne Arundel County residents ages two and older: 524,845 Source: U.S. Census Bureau, 2014 American Communities Survey 1-Year Estimates (data above is for ages 5 and older, data for ages 2 and older not available)
d. Total Number of People Reached by the Initiative Within the Target Population	In FY15, UM BWMC vaccinated 500 area residents (6 months and older) - an 82% increase in vaccines administered in FY14 (275). UM BWMC utilized mybwmc.org, social media (Facebook, Twitter, etc.) and health fairs to raise awareness about the importance of flu vaccination to the community.
e. Primary Objective of the Initiative	To prevent the transmission of seasonal influenza through education and vaccination.
f. Single or Multi-Year Initiative – Time Period	Multi-Year Initiative
g. Key Collaborators in Delivery of the Initiative	UM BWMC is the lead sponsor of this initiative. UM BWMC partners with community organizations to host the flu shot vaccinations.
h. Impact/Outcome of Hospital Initiative?	In FY15, UM BWMC vaccinated 500 area residents (6 months and older) against seasonal influenza.
i. Evaluation of Outcomes:	Percentage of Anne Arundel County adults receiving a flu-vaccine the past 12 months: 2013: 47.1% 2012:42.5% 2011: 43.0% Source: Maryland BRFSS (data by race/ethnicity not available at the County level) Despite increased percentages of adults being vaccinated, there were 19.5 influenza/pneumonia deaths per 100,000 population in Anne Arundel County based on 2011-2013 data. Source: Anne Arundel County Community Health Needs Assessment, 2016 (in process) There are many variables in influenza mortality including: vaccination status; the timing of the vaccination; how the strains in the vaccine match up to the strains circulating in the community; and personal health status.

j. Continuation of Initiative?	Yes. UM BWMC will continue to provide flu prevention education and flu vaccinations to our community. The CDC recommends annual influenza vaccination for all people aged six months and older to lower the annual incidence of flu in the community.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative: $7,038	B. Direct Offsetting Revenue from Restricted Grants: $0

2. **Were there any primary community health needs identified through the CHNA that were not addressed by the hospital? If so, why not? (Examples include other social issues related to health status, such as unemployment, illiteracy, the fact that another nearby hospital is focusing on an identified community need, or lack of resources related to prioritization and planning.) This information may be copied directly from the CHNA that refers to community health needs identified but unmet.**

   UM BWMC focuses the majority of our community benefit resources on our identified implementation strategies, as these areas are important to the health of the community and UM BWMC has the infrastructure, clinical expertise and other resources to support these strategies. The unmet needs not addressed directly by UM BWMC are being addressed through the action plan of the local health improvement coalition and its corresponding subcommittees which UM BWMC is actively involved, or other local government agencies and community partners. UM BWMC will continue to work with other health care providers and community partners to meet unmet needs and will provide assistance as resources are available.

   In FY15 UM BWMC decided to shift our community benefit resources and not focus on violence prevention. Other organizations in the county, including the YWCA, devote resources to violence prevention initiatives. There was not sufficient interest by community partners to offer the violence prevention programs outlined in UM BWMC' s Action Plan developed in FY13. The need for enhanced and improved coordination of behavioral health services (mental health and substance abuse) was a common theme throughout the assessment. This community need is being addressed by the Healthy Anne Arundel Coalition, our county's local health improvement coalition, with leadership from the Anne Arundel County Department of Health, Anne Arundel County Mental Health Agency, Inc., Anne Arundel Medical Center and UM BWMC. UM BWMC serves a co-vice chair of the Healthy Anne Arundel Coalition and also actively supports the coalition's subcommittee that focus on improving behavioral health (including access to care, quality of care and coordination of services).

   UM BWMC's Chemical Dependency Nurse Practitioner has a leadership role in many initiatives related to substance abuse prevention in Anne Arundel County. Examples of some of the county-wide committees that he participates on include the Co-Ordering Disorders Subcommittee (part of the Healthy Anne Arundel Coalition), the Change Agents Committee, the Drug and Alcohol Council Workgroup and the Fatal Overdose Review Team. In FY15, UM BWMC and the Anne Arundel County Department of Health developed a new initiative for Emergency Department patients addicted to prescription drugs and opioids. Peer Support Specialists from the Department of Health will be located in UM BWMC's Emergency Department to help addicted patients access treatment and recovery support services. This program will be implemented in FY16.

   Additionally, behavioral focus is a key focus of the Bay Area Transformation Partnership implementation plan. This plan calls for increasing access to behavioral health providers through increasing the number of providers and integrating them with primary care practices, developing care plans for high-risk or high-utilizers of health services, and enhancing care coordination in the community.

   Lack of affordable dental services, environmental health concerns and transportation barriers are community health needs identified through the CHNA not directly being addressed by UM BWMC. UM BWMC does not provide routine dental care at this time, but refers patients to low-cost dental clinics for care. We do subsidize oral surgery on-call services ($83,120 in FY15) and have oral surgeons on the medical staff. Environmental health concerns are being addressed by the Anne Arundel County Department of Health's Bureau of Environmental Health Services and

other local environmental advocacy organizations. Public transportation is not in the scope of services that UM BWMC can provide as a hospital; however, we do provide some transportation assistance through our care management program ($52,984 in FY15). We also provide transportation assistance for participants in our Stork's Nest prenatal education program and will be providing this service for participants in our Centering Pregnancy program. Anne Arundel and surrounding county governments are collaborating to expand access to public transportation in the Central Maryland region.

3. **How do the hospital's CB operations/activities work toward the State's initiatives for improvement in population health? (see links below for more information on the State's various initiatives)**

STATE INNOVATION MODEL (SIM) http://hsia.dhmh.maryland.gov/SitePages/sim.aspx
MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP)
http://dhmh.maryland.gov/ship/SitePages/Home.aspx
HEALTH CARE INNOVATIONS IN MARYLAND
http://www.dhmh.maryland.gov/innovations/SitePages/Home.aspx
MARYLAND ALL-PAYER MODEL http://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/
COMMUNITY HEALTH RESOURCES COMMISSION http://dhmh.maryland.gov/mchrc/sitepages/home.aspx

UM BWMC's community benefit operations are aligned with the State's initiatives for improvement in population health as described below:
State Innovations Model (SIM): UM BWMC actively participated in a workgroup convened by the Anne Arundel County Department of Health to begin implementation planning for the State Innovation Model: Community Integrated Medical Home grant project. This workgroup was convened at the beginning of FY15 in anticipation of an award being made to the Maryland Department of Health and Mental Hygiene and a subsequent RFP being released to local jurisdictions. This workgroup met throughout the first six months of FY15 and each meeting was attended by UM BWMC community benefit operations staff.

Maryland State Health Improvement Process (SHIP): UM BWMC's community benefit priorities are aligned with SHIP priorities as identified in Table III. UM BWMC serves as co-vice chair of the Healthy Anne Arundel Coalition, the local health improvement coalition established as part of SHIP. UM BWMC also has an active role in each subcommittee of the Coalition (Leadership Subcommittee, Obesity Prevention Subcommittee, Co-Occurring Disorders Subcommittee, Planning and Assessment Subcommittee, Community Engagement Subcommittee, and Promotion and Publicity Subcommittee). The Healthy Anne Arundel Coalition also serves in an advisory capacity to population health initiatives in the County (e.g. SIM CIMH, BATP).

Health Care Innovations in Maryland: UM BWMC reviews the Health Care Innovations in Maryland web site for ideas of how to improve population health based on the lessons learned by others in the state. UM BWMC is considering initiatives to submit for inclusion in the Health Care Innovations in Maryland web site.

Maryland All-Payer Model: UM BWMC's community benefit initiatives support the goals of Maryland All-Payer Model by virtue of their goal to improve population health. UM BWMC also has a Global Budget Revenue Agreement to support the All-Payer Model. As described below, UM BWMC is co-lead in the Bay Area Transformation Partnership, a regional partnership to accelerate the All-Payer system modernization.

Maryland Community Health Resources Commission: UM BWMC's community benefit activities are aligned with many initiatives supported by the Maryland Community Health Resources Commission. For example, as described above, UM BWMC serves in a leadership role to our local health improvement coalition. UM BWMC participated in one of the *Hospital Community Partnership Forums* hosted by the Commission in FY15 and has utilized the recommendations in the *Sustaining Community Hospital Partnerships to Improve Population Health* report that emerged from those forums. Additionally, UM BWMC reviews Commission (and other local, state, federal and private) funding opportunities and applies for grants to support community benefit and population health priorities as appropriate.

Regional Partnerships for Health System Transformation: UM BWMC collaborated with Anne Arundel Medical Center to jointly apply as lead applicants for the Bay Area Transformation Partnership (BATP). Our local health improvement coalition and numerous governmental agencies, health care providers, and community agencies are also part of this partnership. BATP was awarded a planning grant in the amount of $400,000 during FY15. BATP planning work continued into FY16. UM BWMC and AAMC decided to apply for implementation funding for the BATP transformation plan.

VI. PHYSICIANS

1. As required under HG§19-303, provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

There are gaps in the availability of providers in Anne Arundel County, particularly among primary care physicians, psychiatrists and general surgeons.[xvii]

UM BWMC, through its Emergency Department, inpatient services and outpatient physician practices (primary care and specialty), provides care to uninsured patients. Cardiac surgery services are not currently available at UM BWMC and require transfer to another facility. UM BWMC has submitted a Certificate of Need application to the Maryland Health Care Commission to offer this service. UM BWMC also does not provide routine care for infants born at less than thirty-two weeks gestation – these patients are transferred to other facilities.

As part of UM BWMC's financial assistance policy, once a patient has been determined to be eligible for financial assistance that determination applies to other University of Maryland Medical System entities. This further increases access to subspecialty care. Additionally, UM BWMC's Emergency Department on-call agreements stipulate that providers must provide care to uninsured patients or others unable to afford the care they receive. This stipulation requires providers to see patients in the Emergency Department and also provide follow-up care in their outpatient practice.

Psychiatry is an outpatient specialty that has a significant gap in the availability of providers to meet the needs of the uninsured (and insured patients as well). There are limited providers and many do not accept uninsured patients, patients with certain insurance plans, or accept no insurance at all. UM BWMC offers a psychiatric bridge clinic to help meet the needs of these patients and is actively exploring other strategies for increasing the availability of behavioral health providers in Anne Arundel County through the Bay Area Transformation Partnership.

Furthermore, in FY15, UM BWMC established a formal partnership with Chase Brexton Health Care, a federally qualified health center conveniently located across the street from the medical center, to help meet the primary care and specialist needs of uninsured patients.

2. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please indicate the category of subsidy, and explain why the services would not otherwise be available to meet patient demand. The categories include: Hospital-based physicians with whom the hospital has an exclusive contract; Non-Resident house staff and hospitalists; Coverage of Emergency Department Call; Physician provision of financial assistance to

encourage alignment with the hospital financial assistance policies; and Physician recruitment to meet community need.

Hospital-based physicians with whom the hospital has an exclusive contract:

Obstetrics Program (Hospital-based laborists): Without the availability of these practitioners, obstetrical patients would have to be transferred to another facility, potentially resulting in treatment delays and decreased patient satisfaction. A loss of $1,716,012 was incurred in FY15.

House Staff and Hospitalists (adult and pediatric): These providers ensure the continuum and quality of care for inpatients (pediatric hospitalists also provide care in the Emergency Department). FY15 losses include $708,400 for House Staff, $614,077 for adult hospitalists and $232,052 for pediatric hospitalists.

Psychiatry Program: Psychiatric services are provided allowing patients access to the scarcely available mental health services in Anne Arundel County. UM BWMC offers inpatient, partial hospitalization, intensive outpatient and bridge clinic services to help meet Anne Arundel County's behavioral health needs. UM BWMC is the only hospital in Anne Arundel County to offer an inpatient psychiatric unit. Without this service, patients would need to be transferred to another facility, potentially resulting in treatment delays and decreased patient satisfaction. A loss of $286,501 was incurred in FY15.

Coverage of On-Call Services for Emergency Department Patients:

Coverage of Emergency Department Call: UM BWMC provides physician subsidies to ensure there is always an appropriate level of specialist care in the Emergency Department to maintain quality patient care. Specialties that receive on-call subsidies include general surgery, cardiology, vascular surgery, orthopedic surgery, spine surgery, neurosurgery, gynecology, thoracic surgery, oral surgery, and otolaryngology. Without the availability on-call specialists, patients would have to be transferred to another facility for care, potentially resulting in treatment delays and decreased patient satisfaction. A loss of $1,395,398 was incurred in FY15.

Coverage of Interventional Cardiology On-Call: UM BWMC pays physician subsidies to ensure adequate interventional cardiologist coverage for our Maryland Institute for Emergency Medical Services Systems-designated Cardiac Interventional Center. A loss of was $386,018 incurred in FY15.

Anesthesia Subsidy: UM BWMC pays a physician subsidy to ensure adequate coverage for operating room and obstetrical anesthesiology services. Without the availability of 24/7 coverage anesthesiology services we would not be able to provide adequate emergency surgical services or pain relief for obstetrics patients. A loss of $1,250,000 was incurred in FY15.

Physician Recruitment to Meet Community Need:

Outpatient Health Services Subsidy – Primary Care:

UM BWMC provides physician subsides for outpatient primary care (includes senior care). A loss of $2,156,967 was incurred in FY15. Anne Arundel County's patient to primary care physician ratio is worse than in Maryland and top-performing counties nationwide.[xviii] There is a projected deficit of 115.3 FTE primary care physicians in Anne Arundel County by 2019.[xix] There is a demonstrated need to recruit and retain primary care physicians to Anne Arundel County.

In FY15, UM BWMC's Physician Enterprise acquired a second primary care practice in Pasadena (21122). This acquisition added two additional providers. Our senior care practice recruited and

placed a Nurse Practitioner in a nursing home adjacent to UM BWMC to help improve care transitions and reduce readmissions. The practice also successfully recruited a second fellowship trained geriatrician to work in our Millersville office (she began practicing shortly after the fiscal year end).

Outpatient Health Services Subsidy –OB/GYN:
UM BWMC offers OB/GYN services in three locations in Anne Arundel County to help improve maternal and infant health, incurring a loss of $2,105,070 in FY15. There are racial/ethnic disparities in maternal and infant health in Anne Arundel County, as described in detail earlier in this report. These disparities are most evident in the northern area of the County, further demonstrating the need for high-quality and accessible women's health services in the area where these outpatient practices are located. Furthermore, there is a projected deficit of 3.5 FTE OB/GYN physicians in Anne Arundel County by 2019[xx]

In FY15, UM Baltimore Washington Women's Health Associates (UM BWHHA) opened its second location for its CenteringPregnancy™ program in Glen Burnie (21061). UM BWWHA served 108 participants in FY15 in its CenteringPregnancy™ program, an increase of 29 participants from FY14. This innovative, group model of prenatal care has exemplary birth outcomes for program participants that far exceed the County as a whole and Healthy People 2020 goals.

It is important to note that Anne Arundel County's Black, non-Hispanic population accounts for 16% of the County's total population, yet the Centering Pregnancy™ program serve a much higher percentage of the this population segment (33%), with the total percentage of minorities served being even higher. The continued growth of this programs and our continued ability to engage minority populations will help to improve maternal and infant health and reduce health disparities.

[i] Anne Arundel County Community Health Needs Assessment, 2012. Available at: http://www.aahealth.org/chna.
[ii] U.S. Census Bureau. 2014 American Community Survey 1-Year Estimates
[iii] Ibid.
[iv] Ibid.
[v] Ibid.
[vi] Ibid.
[vii] Ibid.
[viii] Ibid.
[ix] Ibid.
[x] Ibid.
[xi] Maryland Department of Health and Mental Hygiene. State Health Improvement Process. Available at: http://www.dhmh.maryland.gov/ship; Anne Arundel County Community Health Needs Assessment, 2012. Available at: http://www.aahealth.org/chna.
[xii] Anne Arundel County Public Schools. Available at: http://www.aacps.org/aacps/boe/ADMIN/PINFO/fastfacts.pdf. Accessed October 20, 2015.
[xiii] U.S. Census Bureau. 2014 American Community Survey 1-Year Estimates
[xiv] Anne Arundel County Department of Recreation and Parks. Available at: http://www.aacounty.org/RecParks/aboutus/index.cfm. Accessed October 20, 2015.
[xv] Ibid.
[xvi] County Health Rankings 2015. Data available at http://www.countyhealthrankings.org/app/maryland/2015/rankings/outcomes/overall.
[xvii] UMMS Physician Needs Assessment, 2014, conducted by The Advisory Board Company
[xviii] County Health Rankings 2015. Data available at http://www.countyhealthrankings.org/app/maryland/2015/rankings/outcomes/overall.
[xix] UMMS Physician Needs Assessment, 2014, conducted by The Advisory Board Company
[xx] Ibid.

Appendix IV:

Healthy Anne Arundel Coalition Action Plan

JULY 2015

HEALTHY ANNE ARUNDEL COALITION ACTION PLAN

Submitted as part of the Maryland Department of Health and Mental Hygiene State Health Improvement Process

VERSION 2.1

www.healthyannearundel.org

www.facebook.com/healthyaa

Table of Contents

Introduction

The **Maryland Department of Health and Mental Hygiene (DHMH)** launched the **State Health Improvement Process (SHIP)** in 2011. The SHIP provides a framework for accountability, local action and public engagement by identifying key objectives for improving the health of all Maryland residents and calling for the establishment and long-term sustainability of **Local Health Improvement Coalitions (LHICs).**

The SHIP includes 41 measures in five focus areas that represent what it means for Marylanders to be healthy. The SHIP's five focus areas are:

1. Healthy Beginnings
2. Healthy Living
3. Healthy Communities
4. Access to Health Care
5. Quality Preventive Care

Many of the SHIP measures are a subset of the U.S. Department of Health and Human Services' Healthy People 2020 goals and objectives. Healthy People 2020 is a comprehensive set of 10-year national goals and objectives for improving health and wellness in the United States. SHIP measures were selected after a comprehensive review of national, state and local plans and indicators; consultations with public health and community leaders; and public feedback. Each SHIP measure has a data source and target that can be assessed at the local level where possible.

SHIP measures focus on critical prevention factors and population health outcomes. Several measures also target racial and ethnic health disparities. As the SHIP evolves at the state level, LHICs may be asked to take on additional roles to improve public health and support the evolvement of the health care system at the national, state and local levels.

LHICs were formed in 17 jurisdictions throughout the state. Each LHIC includes diverse representatives from sectors such as government, health care, education, private businesses, community and faith-based organizations, and local residents. LHICs are responsible for developing and implementing action plans that address locally prioritized SHIP measures and other local health concerns.

Anne Arundel County's LHIC is the **Healthy Anne Arundel Coalition**.

Additional information about the SHIP is available at www.dhmh.maryland.gov/ship.

Section 1: Overview of the Healthy Anne Arundel Coalition

The Healthy Anne Arundel Coalition was convened in December 2011 with leadership from the Anne Arundel County Department of Health, Anne Arundel Medical Center and the University of Maryland Baltimore Washington Medical Center.

The Coalition developed mission and vision statements and priority health improvement focus areas in January 2012. The Coalition considered County health and demographic data, state and national health data and plans, existing resources and gaps to identify and prioritize the County's health needs. The Coalition decided to focus the Coalition's initial efforts on two areas: (1) Obesity Reduction and Prevention and (2) Prevention and Management of Behavioral Health Disorders. The Coalition will also be targeting racial, ethnic and other demographic and geographic related health disparities with respect to these two focus areas.

Vision, Mission and Priority Health Improvement Focus Areas

Coalition Vision:
Healthy County, Healthy People

Coalition Mission:
Working together as a community to promote the health and wellness of Anne Arundel County residents.

Priority Health Improvement Focus Areas:

- ***Obesity Reduction and Prevention***
- ***Prevention and Management of Behavioral Health Disorders***

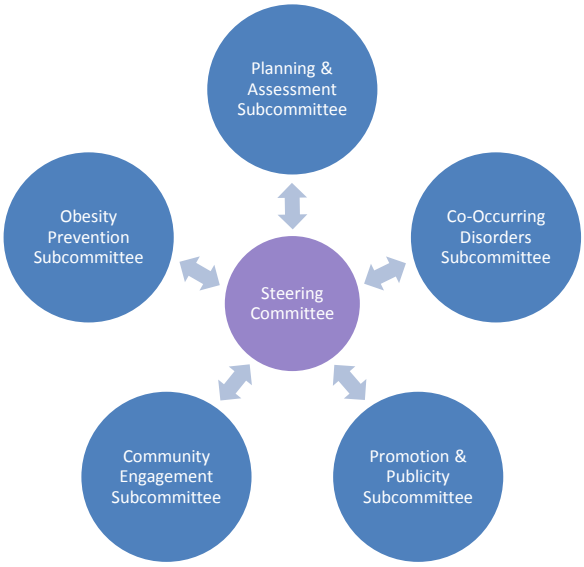
Note: The Coalition may choose to amend this Action Plan to address additional priority focus areas depending on DHMH guidance, the needs of the County and the capacity of the Coalition.

Process for Community Health Improvement

The diagram illustrates the Coalition's process for improving health in Anne Arundel County.

Structure, Leadership and Membership

The Healthy Anne Arundel Coalition consists of a Steering Committee, Leadership Team, five standing Subcommittees, Ad Hoc Work Groups and a network of Coalition supporters.



A description of the Coalition's structure is as follows:

Chair: County Health Officer (per DHMH guidance)

Vice Chairs: Designees of Anne Arundel Medical Center and
University of Maryland Baltimore Washington Medical Center

Steering Committee:

- The membership of the Steering Committee includes representatives from government agencies, health care providers, the local business community, academic institutions and community-based organizations. Member organizations have a service area that encompasses all of Anne Arundel County and/or the City of Annapolis. In addition, the chairperson(s) of Coalition Subcommittees are considered part of the Steering Committee.
- The role of the Steering Committee is to:
  - prioritize County health needs;
  - provide strategic guidance to the Coalition's Subcommittees;
  - develop and implement the Coalition's Action Plan in collaboration with the Coalition's Subcommittees, Ad Hoc Work Groups and partners; and
  - provide resources and collaborate in funding opportunities to support the success of the Coalition.

At-large Membership in the Coalition's Network:

- Coalition at-large membership is open to all interested individuals and organizations.
- Levels of engagement in the Coalition's at-large membership may include:
    - participating in a Subcommittee(s) or Ad Hoc Work Group(s);
    - attending Steering Committee meetings or other Coalition events;
    - helping to disseminate information about the Coalition and its activities into local communities; and/or
    - receiving communications from the Coalition.

Leadership Team:

- Consists of the Chairperson, Vice Chairs and Subcommittee Chairpersons and designees.
- The role of the Leadership Team is to provide overall leadership and strategic direction, set Steering Committee meeting agendas and manage the Coalition's finances.

Subcommittees and Ad Hoc Work Groups:

- Subcommittees and Ad Hoc Work Groups address specific priorities agreed to by the Steering Committee and Subcommittees. Subcommittees and Ad Hoc Work Groups may change based upon the needs of the Coalition.
- Each Subcommittee or Ad Hoc Work Group will have a Chairperson(s) who will be responsible for organizing the committee and advancing the committee's work. The Chairperson(s) will report about activities of their respective Subcommittees to the Steering Committee. Each Subcommittee and Ad Hoc Work Group will develop its own procedures for managing membership, meetings and activities.

Standing Healthy Anne Arundel Coalition Subcommittees include the following:

Obesity Prevention Subcommittee (OPS):

- Membership: Diverse stakeholders committed to the reduction and prevention of obesity.
- Role: Coordinates the development, implementation and evaluation of the obesity reduction and prevention initiatives outlined in the Coalition's Action Plan.

Co-occurring Disorders Subcommittee (COD):

- Membership: Diverse stakeholders committed to improving the management of co-occurring substance abuse and mental health disorders. This group pre-dated the formation of the Healthy Anne Arundel Coalition and is co-led by the Anne Arundel County Department of Health and the Anne Arundel County Mental Health Agency, Inc.
- Role: Coordinates the development, implementation and evaluation of the substance abuse and mental health initiatives outlined in the Coalition's Action Plan.

Planning and Assessment Subcommittee:

- Membership: Anne Arundel County Department of Health, Anne Arundel Medical Center, University of Maryland Baltimore Washington Medical Center and other interested organizations.
- Role: Coordinates the community health needs assessment that is planned to be conducted approximately every three years. Coordinates and/or conducts other planning and assessment activities to support the Coalition on an as-needed basis.

Promotion and Publicity Subcommittee (PPS):

- Membership: Anne Arundel County Department of Health, Anne Arundel Medical Center, University of Maryland Baltimore Washington Medical Center and other interested organizations.
- Role: Implements strategies related to raising awareness about the Coalition's activities; engages in ongoing media relations with local news outlets; and coordinates press releases, promotional materials, social marketing tools and special events.

Community Engagement Subcommittee:

- Membership: Community and faith-based leaders in Anne Arundel County
- Role: Assists with the implementation of the Coalition's Action Plan and disseminates information about the Coalition and health concerns into communities, especially those impacted by health disparities (e.g., racial/ethnic, geographic).

Current Steering Committee Membership and contact information for the Coalition's Officers, Subcommittees and Ad Hoc Work Groups are available on the Coalition's web page at www.HealthyAnneArundel.org.

The Coalition adopted a set of Standard Operating Procedures to govern the Coalition's operations. Please see Attachment I: Healthy Anne Arundel Coalition Standard Operating Procedures for additional information.

Communications

The Coalition maintains an active online presence on the Coalition's website at www.HealthyAnneArundel.org and Facebook page at www.facebook.com/healthyAA.

The Coalition's website provides a variety of useful information including:

- Contact Information
- Membership Information
- Meeting Schedules and Meeting Minutes
- Community Health Needs Assessment
- Obesity Reduction and Prevention Information
- Mental Health and Substance Abuse Information

The Coalition's Facebook page includes information such as:

- Tips for healthy lifestyles
- Calendar of activities and events
- Community announcements
- Cross promotion of the Facebook postings of Coalition partners and supporters

Section 2: Local Health Data

Community Health Needs Assessment

A Community Health Needs Assessment (CHNA) was conducted in 2012 to gather information about the health needs and health behaviors of County residents through a review of secondary data sources, a key informant survey of area professionals and stakeholders, and focus groups with County residents. The assessment examined a variety of indicators, including social determinants of health (e.g., poverty, housing, education), mortality rates, risky behaviors (e.g., alcohol use, tobacco use) and chronic health conditions (e.g., diabetes, heart disease). Key findings from the assessment include:

Community Strengths

- *Child Health*: Overall, the infant mortality rate in the County is slightly lower than both the Maryland and the U.S. rates.
- *Health Insurance*: The County has more individuals with health insurance (91.6%) than both the state and nation.
- *Injury, Violence and Crime*: The County has a lower homicide rate and accidental death rate than the state and nation.
- *Sexually Transmitted Infections*: Overall, incidence rates of sexually transmitted illnesses are lower than the state and nation.
- *Income and Education*: The County has a higher percentage of its population in the labor force than Maryland and the U.S. Overall, the County has a greater percentage of highly educated residents than both the state and nation.

Areas of Opportunity for Health Improvement

- *Obesity/Overweight*:* Nearly 68% of County adults are obese or overweight.
- *Mental Health/Substance Abuse**: The County suicide rate is above the state rate. The percentage of County adults who consume alcohol on a regular basis and who binge drink far exceeds state and national figures.
- *Cancer*: The incidence and mortality rates for lung and bronchus cancer and melanoma are higher in the County than in the U.S. and Maryland.
- *Chronic Illnesses*: Mortality rates for heart disease and diabetes exceed the state and national rates.
- *Health Disparities*: The mortality rate for African-American residents is 801.6 compared to 766.5 among white residents. The County's Hispanic/Latino population is among the most underserved.

* *Healthy Anne Arundel Coalition Priority Focus Areas*

The CHNA will help guide the Healthy Anne Arundel Coalition in developing and implementing strategies to improve the health status of County residents.

Please see Attachment II: Anne Arundel County Community Health Needs Assessment Executive Summary or visit www.HealthyAnneArundel.org for more details**.**

Anne Arundel County SHIP Profile

SHIP measures related to the Coalition's priority areas include:

Obesity Reduction and Prevention

	MD BASELINE	COUNTY BASELINE	COUNTY BY RACE/ ETHNICITY	MD 2014 GOAL	COUNTY 2015 GOAL*	SOURCE
Increase the proportion of adults who are at a healthy weight^ (BMI^ not over-weight or obese).	34.0%	33.5%	White, Non-Hispanic: 33.9% Black: 30.0%	35.7%	35.2%	BRFSS 2008-2010
Reduce the proportion of youth ages 12-19 who are obese (BMI in the 95th percentile or greater).	11.9%	10.8%	N/A	11.3%	10.36%	MYTS 2008

^ Body Mass Index (BMI) not over-weight or obese. BMI is calculated from a person's weight and height and provides indicator of body fatness that is used to screen for weight categories.

Prevention and Management of Behavioral Health Disorders

	MD BASELINE	COUNTY BASELINE	COUNTY BY RACE/ ETHNICITY	MD 2014 GOAL	COUNTY 2015 GOAL*	SOURCE
Reduce the rate of emergency department visits related to behavioral health conditions per 100,000 population	1,206.3	1,134.9	White: 1,146.9 Black: 1,450.6 Asian: 152.7 Hispanic: 203.6	1,146.0	1,078.2	HSCRC 2010
Reduce the rate of drug-induced deaths per 100,000 population	13.4	15.0	N/A	12.4	13.9	VSA 2007-2009
Decrease the rate of fatal crashes where the driver had alcohol involvement per 100 million miles	0.29	17 (count only due to rate instability)	N/A	0.27	15	SHA 2009
Reduce the rate of suicides per 100,000 population	9.6	9.6	N/A	9.1	9.1	VSA 2007-2009

*Based on the % difference between the state baseline and the state 2014 goal.

Please see Attachment III: Anne Arundel County SHIP Health Profile or visit www.HealthyAnneArundel.org for more details**.**

Section 3: Local Health Context

Anne Arundel County's population, economic diversity, geography, health care infrastructure and community resources all play a role in the County's unique local health context.

Population Changes[1]

In 10 years, Anne Arundel County's population grew by 9.4 percent, reaching 550,488 residents, becoming the fifth most populous jurisdiction in the State of Maryland. The County's demographic profile includes the following:

	2002	2012
Total Population	503,388	550,488
Gender	49.9% male; 50.1% female	49.5% male; 50.5% female
Median Age	Not available	38.4 years
65 Years of Age and Older	10.1%	12.7%
Under 5 Years of Age	6.7%	6.3%
Race and Ethnicity	82.3% Caucasian 20.5% Non-Caucasian including: 13.5% African-American 2.7% Hispanic (any race) 2.5% Asian; 1.4% Multi-racial 0.4% Other	76.9% Caucasian 29.7% Non-Caucasian including: 16.1% African-American 6.6% Hispanic (any race) 3.7% Asian; 2.8% Multi-racial 0.5% Other

The greatest growth took place in the 65 and over population, which experienced a 37.5% increase over the past 10 years (50,857 to 69,939 between 2002 and 2012). As the population ages, public health must increasingly focus on preventing and managing chronic diseases through broad community interventions that promote healthy lifestyle changes and appropriate health screenings.

The proportion of non-Caucasian, multi-racial and Hispanic residents in Anne Arundel County reached 29.7 percent of the population in 2012. Hispanics were the fastest-growing segment of the population, increasing nearly two and a half times from 2002 to 2012 to comprise 6.6 percent of the total population. Addressing health disparities among racial and ethnic groups will continue to be a priority for Anne Arundel County.

Economy

The median household income for Anne Arundel County is estimated at $86,987, which is substantially higher than national figures. Poverty affects an estimated 3.7 percent of all families in the County, but disproportionately affects specific populations. For example, over 19.6 percent of female-headed households with children under age 18 experience poverty, compared to 1.7 percent of households led by married couples with children.

Employment and health insurance are often closely related, with many employers providing coverage to employees and their families. As of May 2013, the unemployment rate for Anne Arundel County was 6.3 percent.[3] Approximately, 10 percent of County adults between the ages of 18-64 were estimated to lack health insurance as of 2011.[4] This is expected to decrease in 2014 and future years, as more residents have access to Medicaid and private health care insurance through the Maryland Health Connection, the state health benefit exchange. However, an uncertain but not insignificant number of County residents will be unable or unwilling to participate in the state's health reform efforts and will continue to have challenges in accessing needed preventive and clinical health services.

Geography

Anne Arundel County is approximately 30 miles from both Washington, D.C. and Baltimore City and has several unique geographic characteristics. The northern part of the County is urban and densely populated. This portion of the County is disproportionately affected by a number of health disparities; it has higher rates of poverty and greater proportions of racial and ethnic minority residents. In contrast, the southern part of the County is very rural. The central and western portions of the County are suburban, with the exception of the City of Annapolis, which shares many similarities with the northern part of the County. The County also includes an expansive 533 miles of linear shoreline and many peninsulas. The diverse geography of the County affects transportation, access to health care and the community environments in which residents live.

Health Care Infrastructure

The health care infrastructure that serves Anne Arundel County includes, but is not limited to, three major hospitals, several community health centers, ambulatory care centers and hundreds of providers. Anne Arundel Medical Center is located in the central region of the County in Annapolis. University of Maryland Baltimore Washington Medical Center is located in the northern region of the County in Glen Burnie. MedStar Harbor Hospital, while located just north of the County line in Baltimore City, provides services to many residents in the northern part of the County.

In addition to the hospitals, community health centers are located throughout the County. Those designated as Federally Qualified Health Centers (FQHCs) include Chase Brexton Health Care and the Family Health Centers of Baltimore, which are located in the western and northern parts of the County. Owensville Primary Care is a FQHC that serves the rural, southern region of the County. In addition to these FQHCs, Anne Arundel Medical Center operates three community health centers in the Annapolis area. The Department of Health operates five clinic sites and provides nursing support for the health rooms of 123 County public schools, offering an important source of health care for many of the County's youth.

Community Assets and Resources

The Healthy Anne Arundel Coalition is fortunate that there are many community assets and resources throughout the County and surrounding areas, including, but not limited to:

- A Department of Health that offers an array of personal and environmental health services, community education and outreach, and support for policies to improve health
- Three award-winning hospitals that offer acute care, a wide range of specialty providers and community health resources: Anne Arundel Medical Center, MedStar Harbor Hospital, and University of Maryland Baltimore Washington Medical Center
- Three Federally Qualified Health Centers: Chase Brexton Health Care, Family Health Services of Baltimore and Owensville Primary Care
- Anne Arundel County and City of Annapolis Departments of Recreation and Parks that offer large regional parks; community parks; public trails for walking, running and biking; public indoor swim centers; and numerous classes and programs to promote recreation and healthy lifestyles
- A Department of Aging and Disabilities that offers senior centers, transportation assistance, chronic disease management programs and a variety of other services to help community members
- An Arundel County Mental Health Agency, Inc. committed to improving the care and community supports to promote behavioral health.
- A well-regarded local public school system (Anne Arundel County Public Schools) and a variety of private schools
- An award-winning community college (Anne Arundel Community College) and close proximity to numerous prestigious four-year colleges and universities (University of Maryland, Johns Hopkins University and more)
- A strong Community Foundation of Anne Arundel County that invests in local organizations and initiatives
- Numerous other public and private agencies dedicated to promoting health, well-being and safety among individuals and communities.
- A robust business community with a local economic development corporation, seven chambers of commerce and two business associations, many of which are interested in initiatives to promote health and wellness
- Church networks committed to improving the health and wellness of their congregations
- More than 800 community-based organizations
- Ample recreational, educational, cultural and professional opportunities available due to proximity to the Chesapeake Bay, Maryland's Eastern Shore, Washington, D.C., and Baltimore, MD.
- An international airport and military base

Section 4: Local Health Planning Resources and Sustainability

The Healthy Anne Arundel Coalition builds upon a foundation of existing health improvement initiatives that numerous agencies, institutions and organizations have already undertaken within the County. The Coalition's Steering Committee consists of key stakeholders from a diverse set of community sectors. This broad representation of high-level members will help the Coalition to effectively leverage and utilize new and existing resources to improve the County's health.

Staffing support for the Coalition is provided by the Anne Arundel County Department of Health. Coalition members provide additional support to the Coalition, including staff time and expertise, administrative support, printing materials and hosting meetings.

The Healthy Anne Arundel Coalition applied for and received start-up funding in the amount of $75,000 from the Maryland Hospital Association in 2011. This funding was used for initial start-up and infrastructure building activities. The Coalition also applied for and received base implementation funding from the Maryland Community Health Resources Commission in the amount of $25,000 for obesity reduction and prevention initiatives. The Anne Arundel County Department of Health, in collaboration with the Coalition, applied for and received a grant from the CDC/DHMH in the amount of $175,000 for obesity reduction and prevention initiatives through the Million Hearts Initiative. The Coalition continues to actively search for and apply for funding opportunities that support its infrastructure and health improvement priorities.

The Coalition has partnered with the Community Foundation of Anne Arundel County to maintain a Healthy Anne Arundel Fund. This fund will allow the Coalition to pursue charitable dollars in addition to grant funding.

Sustainability of the Coalition's efforts will be attained through:

- Establishment of an infrastructure to support the Coalition
- Investment of staff and other resources by key partners
- Pursuing grant and charitable funding opportunities
- Leveraging free and low-cost health education materials available in the public domain
- Utilizing existing and emerging low-cost technologies

The Coalition looks forward to creating new partnerships, strengthening existing relationships and securing the resources necessary to achieve our mission of "*Working together as a community to promote the health and wellness of Anne Arundel County residents*" and realizing our vision of "*Healthy County, Healthy People*."

Section 5: Action Plan FY2013-2016 v 2.1

The Healthy Anne Arundel Coalition's Action Plan includes plans from the Coalition's Obesity Prevention, Co-Occurring Disorders, Community Engagement and Promotion and Publicity Subcommittees. These Action Plans are a summary of the Coalition's key goals, objectives and actions and are not meant to be an exhaustive description of the Coalition's planned work. The Coalition will engage in additional actions and strategies to support our mission of "*Working together as a community to promote the health and wellness of Anne Arundel County residents*" and realizing our vision of "*Healthy County, Healthy People*."

The Coalition's Action Plan version 2.0 is a refinement from the Coalition's original Action Plan that was developed in February 2012. This Action Plan was refined to reflect findings from the Community Health Needs Assessment, additional stakeholder participation and maturation of the Coalition's Subcommittees and infrastructure.

Priority # 1: Obesity Reduction and Prevention

Obesity Prevention Subcommittee's Action Plan

Baseline and Goal for 2015:

	MD BASELINE	COUNTY BASELINE	COUNTY BY RACE/ ETHNICITY	MD 2014 GOAL	COUNTY 2015 GOAL*	SOURCE
Increase the proportion of adults who are at a healthy weight (BMI** not overweight or obese).	34.0%	33.5%	White, Non-Hispanic: 33.9% Black: 30.0%	35.7%	35.2%	BRFSS 2008-2010
Reduce the proportion of youth ages 12-19 who are obese (BMI in the 95th percentile or greater).	11.9%	10.8%	N/A	11.3%	10.36%	MYTS 2008

*Based on the % difference between the state baseline and the state 2014 goal.
** Body Mass Index (BMI) is calculated from a person's weight and height. BMI provides a reliable indicator of body fatness for most people and is used to screen for weight categories that may lead to health problems.

Overview:

The health benefits of maintaining a healthy weight and participating in regular physical activity include the reduction of risk factors and the prevention of chronic diseases. Being overweight or obese increases the risk of diabetes, heart disease, cancer, stroke, high cholesterol, high blood pressure, sleep disorders and respiratory problems. In Anne Arundel County, the leading causes of death include cancer, heart disease, stroke and diabetes. County residents are more likely to be overweight and/or obese compared to the state and the nation. Recent information from the Community Health Needs Assessment showed that nearly 68 percent of Anne Arundel County adults are obese or overweight. However, Anne Arundel County adults (81 percent) are more likely to participate in physical activity than others in Maryland and in the U.S. Although improvements have been made in the last 10 years, health disparities among minorities and medically underserved populations continue to exist across the County in heart disease, diabetes and in some cancers. Obesity among the pediatric population is of concern because it is predictive of obesity in adulthood as well as associated conditions such as diabetes, joint problems and sleep apnea. The Anne Arundel County Pediatric Weight Survey, conducted in 2012, showed that 32.4 percent of children ages 2-19 are obese or overweight.

There are many factors that play a role in weight, including lifestyle and surrounding environment. Community-level changes such as implementing policy are more sustainable and have proven to impact infrastructure, and aid in shifting social norms. Education alone is not a viable change strategy because other factors impede its success, including access or affordability. The Obesity Prevention Subcommittee (OPS) is tasked with surveying and

identifying community strengths and areas of improvement regarding current policy, systems and environmental change strategies. By allowing stakeholders to work together in a collaborative process, the Healthy Anne Arundel Coalition (HAAC) will serve as the vehicle to developing and implementing positive changes in the community.

Goals, Objectives and Actions:

Goal 1: Increase Anne Arundel County's capacity and infrastructure to address obesity reduction and prevention.			
Rationale: An Obesity Prevention Subcommittee (OPS) comprised of key leaders from diverse sectors will help advance policies and initiatives to support healthy weight through healthier eating and increased physical activity. Assessing the current status of overweight and obesity in Arundel County will help the Subcommittee to implement activities to address the greatest need, prevent duplication of effort and maximize resource efficiency.			
Objective 1a: By May 31, 2012, bring together a wide array of stakeholders comprised of key leaders with initiatives in obesity reduction and prevention.			
ACTIONS	**WHO**	**WHEN**	**MEASURES**
Hold regular meetings to advance OPS Action Plan.			Meet six times a year
Objective 1b: By February 28, 2013, conduct and report on a Community Health Needs Assessment.			
ACTIONS	**WHO**	**WHEN**	**MEASURES**
Collaborate with the Planning and Assessment Subcommittee.	AAMC, UM BWMC, AACDOH		Completed CHNA
Objective 1c: By September 30, 2013 conduct and report on a survey of existing programs, initiatives and assets in the County and determine what interventions are supported by documented evidence-based practices.			
ACTIONS	**WHO**	**WHEN**	**MEASURES**
Develop OPS Wellness Program Survey.	OPS	February 2013	Survey developed
Distribute survey to Coalition member agencies and other community agencies to complete survey.	OPS	February 19 – May 31, 2013	Survey distributed
Collect and analyze data on existing individual, community, and structural programs and initiatives.	OPS	September 30, 2013	Report completed
Identify evidence-based and sustainable individual, community and structural interventions related to obesity prevention currently adopted by workplaces and the public school system.	OPS	Ongoing	# of evidence-based programs expanded/supported

Goal 2: Increase the awareness of obesity as a major public health threat.			
Rationale: Recent information from the Community Health Needs Assessment showed that nearly 68 percent of Anne Arundel County adults are obese or overweight.			
Objective 2a: By September 30, 2013, identify and select OPS member(s) to participate in the Promotion and Publicity Subcommittee.			
ACTIONS	**WHO**	**WHEN**	**MEASURES**
Nominate an OPS member(s) to represent Subcommittee.	OPS Membership	September 2013	OPS Representative attendance and participation.
Objective 2b: By October 31, 2014, develop awareness through a communications plan in collaboration with the Promotion and Publicity Subcommittee to raise awareness among County residents about the importance of 1) healthy weight, obesity reduction and prevention, and 2) current health disparities among minorities and medically underserved.			
ACTIONS	**WHO**	**WHEN**	**MEASURES**
Form ad hoc committee to develop communications and outreach plan.	PPS, CES, HACC EC	October 2014	Committee is formed.
Develop communications and outreach plan.	PPS, CES, OPS	December 2014	Plan
Coordinate ongoing community-wide communication and promotion to address access to healthy foods (CDC Strategy 1).	PPS, CES, OPS	Ongoing	# of promotions

Goal 3: Increase policy and environmental supports for healthy eating to reduce and prevent obesity in the community, schools, and businesses.			
Rationale: There are many factors that play a role in weight, including lifestyle and surrounding environment. Community-level changes, such as implementing policy, are more sustainable and have proven to impact infrastructure, and aid in shifting social norms.			
Objective 3a: By June 30, 2015, increase the availability, accessibility and usability of affordable, healthy foods and beverages based on CDC Strategies to Prevent Obesity*.			
ACTIONS	**WHO**	**WHEN**	**MEASURES**
Identify food deserts and model practices (CDC Strategy 2).	Maryland Hunger Solutions	June 2013	Mapping of AACo. Food Deserts available on HAAC and partner websites
Promote or expand farm-to-institution in school, hospital, workplaces (CDC Strategy 3). OPS Note: In other words, continue dialogue with the farmer regarding the process to get food to institutions.	AACPS Food and Nutrition Services, UM BWMC, AAMC, MD Dept. of Agriculture, AAEDC	Ongoing	Pounds of produce used For example from AACPS, 60,000 lbs to 80,000 lbs. AAEDC data
Promote use of and expansion of EBT in farmers' markets in all settings. (CDC Strategy 4 - Accepting SNAP and WIC Electronic Benefits Transfer (EBT) to overcome barriers of cost and availability for low-income families)	AAEDC, UM BWMC, Maryland Hunger Solutions	Spring 2015	Number of Markets that accept EBT
Utilize *Road Map to Maximize Nutrition and Student Wellness through Federal Nutrition Programs,* a Maryland Hunger Solutions strategic guide.	Maryland Hunger Solutions, Share Our Strength, AACPS, AACDOH, AAEDC, AACRP	2018	Number of programs in place Funding received
Objective 3b: By June 30, 2015, increase advocacy and public support for initiatives, policies and legislation that address health disparities and eliminate barriers to healthy food choices.			
ACTIONS	**WHO**	**WHEN**	**MEASURES**
Develop and promote Healthy Events Checklist, Policy and Education and Healthy Emergency Food Guidelines.	OPS	December 2013	Disseminate to # businesses # Organizations adopt their own policy
Create County Obesity Prevention Resolution.	AACDOH, UM BWMC AAMC, AACPS AACPZ, AACRP, CARP, AHA, ACS, PPS	June 2015	Resolution adopted

* Centers for Disease Control and Prevention. *Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Increase the Consumption of Fruits and Vegetables*. Atlanta: U.S. Department of Health and Human Services; 2011.

Goal 4: Increase policy and environmental supports to increase physical activity to reduce and prevent obesity in the community, schools and businesses.			
Rationale: There are many factors that play a role in weight, including lifestyle and surrounding environment. Community-level changes, such as implementing policy, are more sustainable and have proven to impact infrastructure, and aid in shifting social norms.			
Objective 4a: By June 30, 2015, increase the availability and accessibility of affordable places to be physically active based on CDC Strategies to Prevent Obesity*.			
ACTIONS	**WHO**	**WHEN**	**MEASURES**
Monitor and support progress of City of Annapolis and Anne Arundel County Pedestrian and Bike Master Plans.	AACDOH, AACRP, CARP, AACPS	Ongoing	# of events
Support expansion of initiatives that reduce cost and increase access for opportunities for physical activity.	AACRP, CARP	June 2015	# of initiatives
Objective 4b: By June 30, 2015, increase advocacy and public support for initiatives, policies and legislation that address health disparities and eliminate barriers to physically active lifestyles.			
ACTIONS	**WHO**	**WHEN**	**MEASURES**
Utilize local data sets (e.g., BRFSS, FitnessGram, Pediatric Survey) to inform initiatives and policy work.	OPS	Ongoing	Completed analysis
Create County Obesity Prevention Resolution.	AACDOH, UM BWMC, AAMC, AACPS, AACPZ, AACRP, CARP, AHA, ACS, PPS	June 2015	Resolution adopted
Develop and promote Healthy Events Checklist, Policy and Education.	OPS	December 2013	Disseminate to # businesses # Organizations adopt their own policy

* Centers for Disease Control and Prevention. *Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Increase Physical Activity in the Community*. Atlanta: U.S. Department of Health and Human Services; 2011.

Priority # 2: Prevention and Management of Behavioral Health Conditions

Co-Occurring Disorders Subcommittee's Action Plan

Baseline and Goal for 2015:

	MD BASELINE	COUNTY BASELINE	COUNTY BY RACE/ ETHNICITY	MD 2014 GOAL	COUNTY 2015 GOAL*	SOURCE
Reduce the rate of emergency department visits related to behavioral health conditions per 100,000 population.	1,206.3	1,134.9	White: 1,146.9 Black: 1,450.6 Asian: 152.7 Hispanic: 203.6	1,146.0	1,078.2	HSCRC 2010
Reduce the rate of drug-induced deaths per 100,000 pop.	13.4	15.0	N/A	12.4	13.9	VSA 2007-2009
Decrease the rate of fatal crashes where the driver had alcohol involvement per 100 million vehicle miles.	0.29	17 (count only due to rate instability)	N/A	0.27	15	SHA 2009
Reduce the rate of suicides per 100,000 population.	9.6	9.6	N/A	9.1	9.1	VSA 2007-2009

Overview:

Individuals with co-occurring psychiatric and substance disorders in Anne Arundel County are recognized as a population with poorer outcomes and higher costs in multiple clinical domains. Due to their complex needs, they often do not fit neatly into many traditional service systems, resulting in over-utilization of emergency departments and the criminal justice, homeless shelter and child protective systems. Adults with co-occurring disorders are also more likely to experience significant chronic somatic illness, such as obesity, high blood pressure and heart disease.

Children and adolescents with co-occurring disorders have increased risk of negative behaviors, including suicide and self-injury, with major consequences to their education, somatic health, safety, relationships with peers and family and involvement with the juvenile justice system.

The Co-Occurring Disorders Subcommittee is tasked with the design, support, and implementation of a fully integrated system of care, utilizing the CCISC model, in order to meet the complex mental health/substance and somatic needs of County residents.

Goals, Objectives and Actions:

Goal 1: Reduce the rate of emergency room visits for behavioral health-related conditions in Anne Arundel County by identifying strategies and resources available to providers and residents and ensuring an accessible continuum of care.			
Rationale: Behavioral health conditions are chronic conditions that are best managed through an active and effective disease management protocol versus episodic crisis treatment. By improving residents' ability to self-manage behavioral health conditions through improved community resources, access to care and treatment efficacy, individuals will achieve sustained recovery and improved quality of life.			
Objective 1a: By June 30, 2013, create a strategic plan to conduct outreach activities to somatic care providers.			
ACTIONS	**WHO**	**WHEN**	**MEASURES**
Conduct a Somatic Care Provider Survey, analyze the results and make recommendations to the COD Committee.	Change Agents	March 31, 2013 (Achieved)	Survey is conducted, summary report developed and shared with COD Committee.
Identify resources and create a toolkit for Somatic Care Providers.	Change Agents/MD Integration Learning Community	Sept. 30, 2014	Toolkit and resource lists are developed and approved by COD Committee.
Develop a plan to distribute toolkit and resource list to Somatic Care Providers.	Change Agents	Oct. 31, 2014	Distribution plan is developed and approved by COD Committee.
Develop trainings for Somatic Care Providers to increase screening skills.	Change Agents/MD Integration Learning Community	Feb. 28, 2015	Trainings are developed.
Objective 1b: By June 30, 2013, implement an Overdose Prevention Plan.			
ACTIONS	**WHO**	**WHEN**	MEASURES
Develop/write an Overdose Prevention Plan.	AACoDOH	June 30, 2013 (Achieved)	Plan is developed and submitted to DHMH.
Objective 1c: By June 30, 2014, develop and implement strategies to reduce the time spent waiting for services.			
ACTIONS	**WHO**	**WHEN**	**MEASURES**
Develop a workgroup to identify evidence-based practices that can be implemented by providers to reduce the wait for services.	COD Committee	Sept. 30, 2014	Workgroup members are identified.
Workgroup will report their findings to the COD Committee.	TBA	Dec. 31, 2014	Workgroup will file report with COD Committee.

Goal 2: Reduce health disparities by utilizing data from the Community Health Needs Assessment, to identify County residents at increased risk due to both geographical and demographical barriers to services.			
Rationale: Studies indicate that there are health disparities, including behavioral health, across select racial, ethnic and income groups within the County. In addition, there is evidence that certain geographical areas, (i.e., South County) lack adequate services to meet the population's needs. These factors often result in delayed care, an inadequate level of care, and an over-reliance on hospital emergency rooms.			
Objective 2a: Identify non-traditional "points of entry" into the system of care such as primary care providers, schools, faith-based and community partners, social service agencies, etc., to promote early identification and intervention.			
ACTIONS	**WHO**	**WHEN**	**MEASURES**
Analyze the 2013 Community Health Needs Assessment to identify both geographical and demographical barriers to service.	COD Committee	March 30, 2015	Barriers are identified.
Identify non-traditional "points of entry."	COD Committee	June 30, 2015	Points of entry are identified.
Identify alternative service options that currently exist or are being implemented.	COD Committee	June 30, 2015	Alternative service options are identified.
Objective 2b: Increase the availability of treatment providers in underserved areas.			
ACTIONS	**WHO**	**WHEN**	**MEASURES**
Identify and support providers who are in the early planning and/or implementation stage of opening services in underserved areas.	COD Committee	June 30, 2015	Providers in the early planning and/or implementation stage are identified.
Objective 2c: Increase the availability of treatment providers for persons with specific barriers, i.e., language, culture, mobility, insurance, etc.			
ACTIONS	**WHO**	**WHEN**	**MEASURES**
Develop and provide trainings to educate providers on co-occurring disorders and related topics.	COD Committee/ Core Service Agency	June 30, 2014 Partially Achieved-Ongoing	Trainings on co-occurring --ASAM Training; Sept. 16 & 17, 2014 Disorders and related topics will be provided
Identify and support providers in development of programs/services that specifically target: Uninsured, Aging Population, Hearing Impaired, Mobility Impaired, Trauma Survivors.	COD Committee Core Service Agency	June 30, 2015	Program and services are identified; Providers are developing programs/services that target specific barriers.

Goal 3: Develop and implement strategies that specifically address the co-occurring needs of adults and adolescents involved in the criminal justice system.			
Rationale: Research shows that former inmates are at high risk for death from drug overdose, especially in the immediate post-release period. During this crucial time period, former inmates often lack access to treatment because MA/PAC was suspended during detention. Studies have consistently found very high prevalence rates of mental illness and/or substance abuse among youth involved in the criminal justice system. Lack of appropriate assessment and treatment in youth may lead to further delinquency, adult criminality and adult mental illness.			
Objective 3a: Develop and implement a plan to allow continued enrollment in MA/PAC, pending disposition.			
ACTIONS	**WHO**	**WHEN**	**MEASURES**
Providers will identify clients eligible for PAC and enroll them to ensure continued coverage under the Affordable Health Care Act.	COD providers	Oct. 1, 2013 (Achieved)	PAC-eligible clients will be enrolled.
Objective 3b: Implement and fund a program that provides early identification of adolescents with mental health, substance abuse and co-occurring disorders			
ACTIONS	**WHO**	**WHEN**	**MEASURES**
Apply for a grant to provide screening and referrals for adolescents involved with DJS who are at risk for mental health, substance abuse and co-occurring disorders	Health Department	June 30, 2014 (Achieved) – Not awarded	Grant application is submitted.
Objective 3c: Establish Behavioral Health Treatment Courts for adults and adolescents.			
ACTIONS	**WHO**	**WHEN**	**MEASURES**
Establish a workgroup to study Behavioral Health Treatment Courts and make recommendations to COD Committee	Workgroup	Dec. 31, 2015	Workgroup study is completed and report submitted to COD Committee.

Goal 4: Identify and implement environmental strategies that promote public awareness of co-occurring disorders and its effects on community well-being.			
Rationale: The economic and human costs of mental illness, substance abuse and co-occurring disorders are far-reaching, serious public health problems in Anne Arundel County. Lack of knowledge and stigmatization exacerbates the issue, and they create unneeded barriers to treatment.			
Objective 4a: Develop and implement a campaign of events that promote public awareness and anti-stigmatization.			
ACTIONS	**WHO**	**WHEN**	**MEASURES**
Develop a Calendar of Events.	COD Committee, consumer groups, ROSC, Western AA County Substance Abuse, Northern Lights Coalition	June 30, 2015 – Partially Achieved	Calendar of Events is developed.
Create and implement a plan to disseminate Calendar of Events to the public.	COD Committee, consumer groups, ROSC, Western AA County Substance Abuse, Northern Lights Coalition, Promotion & Publicity Subcommittee, AACoDOH	June 30, 2015	Plan to disseminate Calendar of Events to the public is created and implemented.

Goal 5: Co-occurring Committee will disseminate information to providers regarding regulatory changes, i.e., workforce development, accreditation, reimbursement/funding, behavioral integration issues.			
Rationale: There is an ongoing need to provide information to providers about issues related to behavioral health.			
Objective 5a: COD will monitor ADAA and DHMH websites and make members aware of any regulatory changes via Provider Alerts, HD transmittals, linkages to BH Integration websites.			
ACTIONS	**WHO**	**WHEN**	**MEASURES**
Alert providers of regulatory changes that affect program/service delivery.	COD Committee	Thru June 30, 2015	Provider Alerts, HD transmittals sent.

Supporting the Success of the Coalition:

Steering Committee

The Steering Committee supports the development and implementation of the Coalition's Action Plan by providing strategic guidance and monitoring. Many Steering Committee member organizations play a vital role in the successful implementation of the Coalition's Action Plan. Additionally, many Steering Committee members lead or participate with one or more Subcommittees.

Promotion and Publicity Subcommittee

The Promotion and Publicity Subcommittee supports the Coalition's media and community relations projects. Clear, concise and consistent communication is important in order to convey the Coalition's vision, mission, public health priorities and initiatives to County residents. The Promotion and Publicity Subcommittee utilizes print media, broadcast media, online media, social networking, public displays and grassroots public relations to communicate with targeted County populations as well as with the general public. This Subcommittee works closely with the Coalition's other Subcommittees to support them as they publicize health information, initiatives, activities and special events.

Community Engagement Subcommittee

The Community Engagement Subcommittee works to engage minority and other disadvantaged or hard-to-reach populations with the work of the Coalition by collaborating with existing community and faith-based organizations. This Subcommittee works closely with the Coalition's other Subcommittees to assist them with promoting Coalition initiatives in local communities. Community engagement is a vital aspect of coalition building and reducing health disparities.

Planning and Assessment Subcommittee

The Planning and Assessment Subcommittee supports the Coalition by coordinating the Community Health Needs Assessment and other studies that are used to inform the Coalition's understanding of the County's health status and factors that contribute to public health and community well-being. The Community Health Needs Assessment provides vital information that is used for the development of the Coalition's Action Plan and the initiatives undertaken by the Coalition and partner agencies throughout the County.

References

[1]2012 U.S. Census, State and County Quick Facts; 2007-2011 American Community Survey

[2]2012 U.S. Census, State and County Quick Facts; 2007-2011 American Community Survey

[3]Maryland Department of Labor, Licensing and Regulation

[4]Behavioral Risk Factor Surveillance System, 2011

Appendix I

Healthy Anne Arundel Coalition Action Plan's Uses by Other Organizations

The Healthy Anne Arundel Coalition's Action Plan was developed as a planning and management tool for use by the Healthy Anne Arundel Coalition. The Action Plan was also developed to communicate the Coalition's goals, objectives and strategies to the public.

Additionally, the Healthy Anne Arundel Coalition's Action Plan will be used to guide the development of other planning activities throughout the County. The Coalition's Action Plan will serve as a reference and inspiration for the Department of Health's Strategic Plan and the Community Health Improvement Plans for Anne Arundel Medical Center and the University of Maryland Baltimore Washington Medical Center. Additionally, this plan will be utilized by other Healthy Anne Arundel Coalition Steering Committee organizations including, but not limited to, the City of Annapolis, Housing Authority of the City of Annapolis, Anne Arundel County Department of Aging and Disabilities, Anne Arundel County Department of Recreation and Parks, Anne Arundel County Mental Health Agency, Anne Arundel County Public Schools, the Community Foundation of Anne Arundel County and MedStar Harbor Hospital.

The Healthy Anne Arundel Coalition encourages all organizations throughout Anne Arundel County, including community-based organizations, faith-based organizations and businesses, to consult the Coalition's Action Plan as part of their own planning activities.

Appendix II

Healthy Anne Arundel Coalition Steering Committee Member Organizations

Anne Arundel Community College
Anne Arundel County Department of Aging and Disabilities
Anne Arundel County Department of Detention Facilities
Anne Arundel County Department of Health
Anne Arundel County Department of Recreation and Parks
Anne Arundel County Department of Social Services
Anne Arundel County Economic Development Corporation
Anne Arundel County Mental Health Agency, Inc.
Anne Arundel County NAACP
Anne Arundel County Office of the County Executive
Anne Arundel County Partnership for Children, Youth and Families
Anne Arundel County Public Schools
Anne Arundel Medical Center
CareFirst BlueCross BlueShield
City of Annapolis
Community Foundation of Anne Arundel County
Housing Authority of the City of Annapolis
MedStar Harbor Hospital
University of Maryland Baltimore Washington Medical Center

Appendix III

Acronyms Used in the Action Plan

AACo	Anne Arundel County
AACDOH	Anne Arundel County Department of Health
AACPS	Anne Arundel County Public Schools
AACPZ	Anne Arundel County Department of Planning and Zoning
AACRP	Anne Arundel County Department of Recreation and Parks
AAEDC	Anne Arundel Economic Development Corporation
AAMC	Anne Arundel Medical Center
ACS	American Cancer Society
AHA	American Heart Association
BRFSS	Behavioral Risk Factor Surveillance System
CES	HAAC Community Engagement Subcommittee
CHNA	Community Health Needs Assessment
CARP	City of Annapolis Recreation and Parks
DHMH	Maryland Department of Health and Mental Hygiene
FQHC	Federally Qualified Health Center
HAAC	Healthy Anne Arundel Coalition
HSCRC	Maryland Health Services Cost Review Commission
LHIC	Local Health Improvement Coalition
MYTS	Maryland Youth Tobacco Survey
OPS	HAAC Obesity Prevention Subcommittee
PHHS	Public Health and Health Services Block Grant
PPS	HAAC Promotion and Publicity Subcommittee
SHA	Maryland State Highway Administration
UM BWMC	University of Maryland Baltimore Washington Medical Center
VSA	Vital Statistics Administration, Maryland Dept. of Health & Mental Hygiene