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.

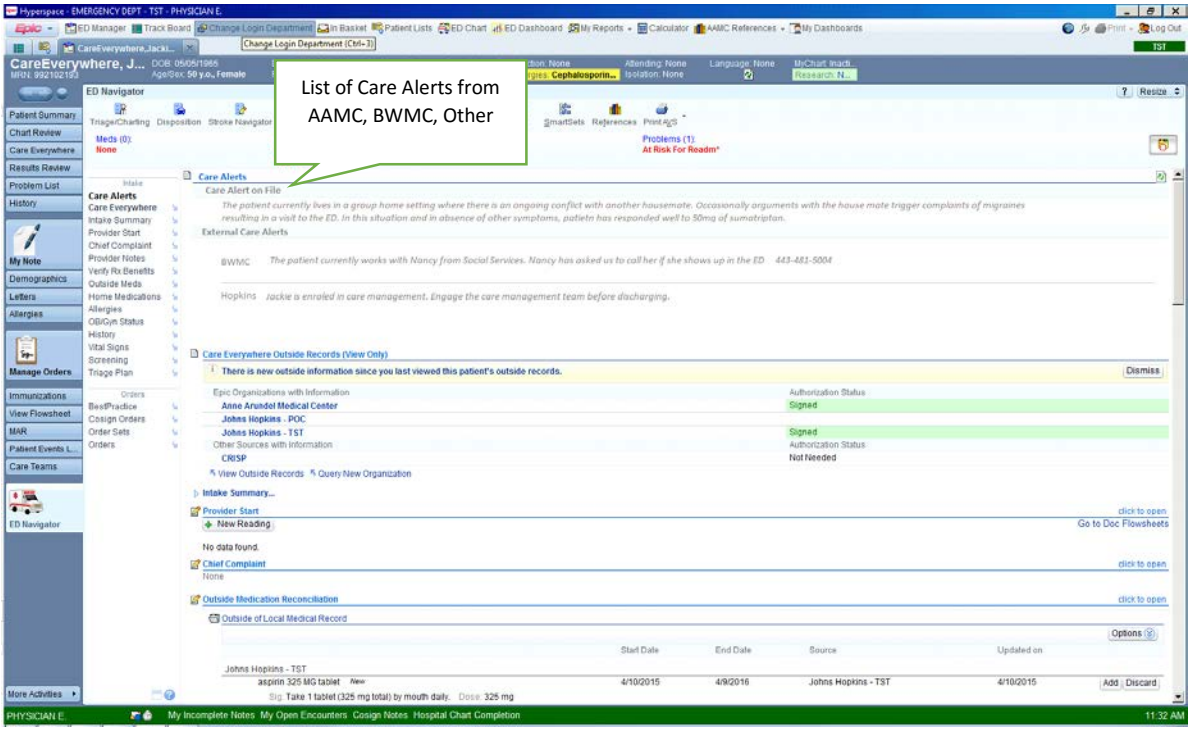
1. Goal # 1: Shared Care Alerts This physician-designed and tested intervention delivers essential 'need to know now' patient information at the point of care in order to decrease potentially avoidable utilization (PAU) and/or prevent clinical misadventures for high-utilizer, Medicare / aged Dual Eligible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

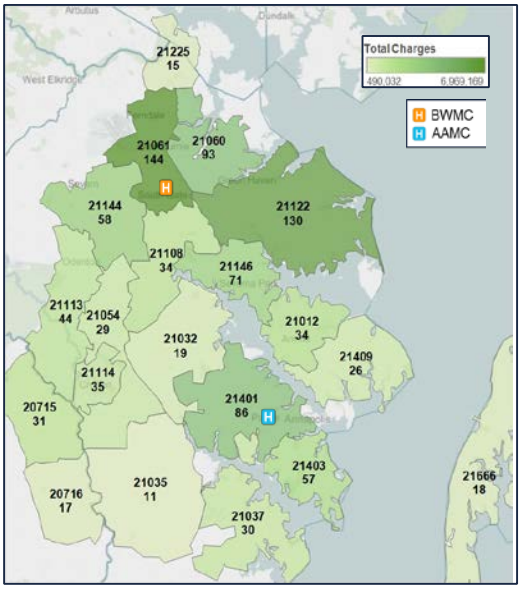
Expected Volumes and Outcomes: The AAMC CCN will in 2016 and 2017 engage approximately 500 physicians in independent and employed primary and specialty care practices that together care for hundreds of thousands of area patients. The CCN will provide the infrastructure and governance platform wherein 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.

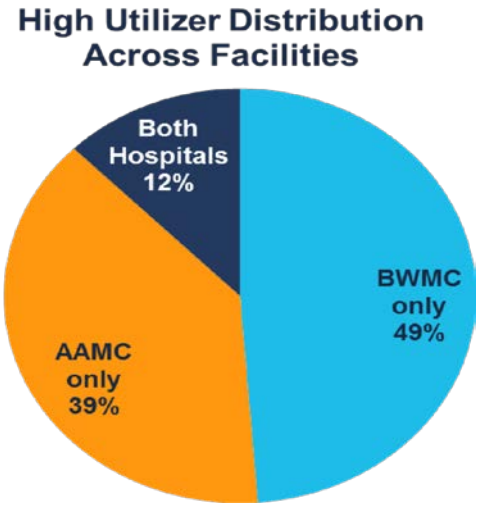
Senior Triage Team
a) # of super-utilizers (>=5 visits) being managed by Senior Triage Team
b) EMS Utilization per patient, before and after Senior Triage Team engagement
c) ED Visits per patient, before and after Senior Triage Team engagement
d) Length of Stay, per patient, before and after Senior Triage 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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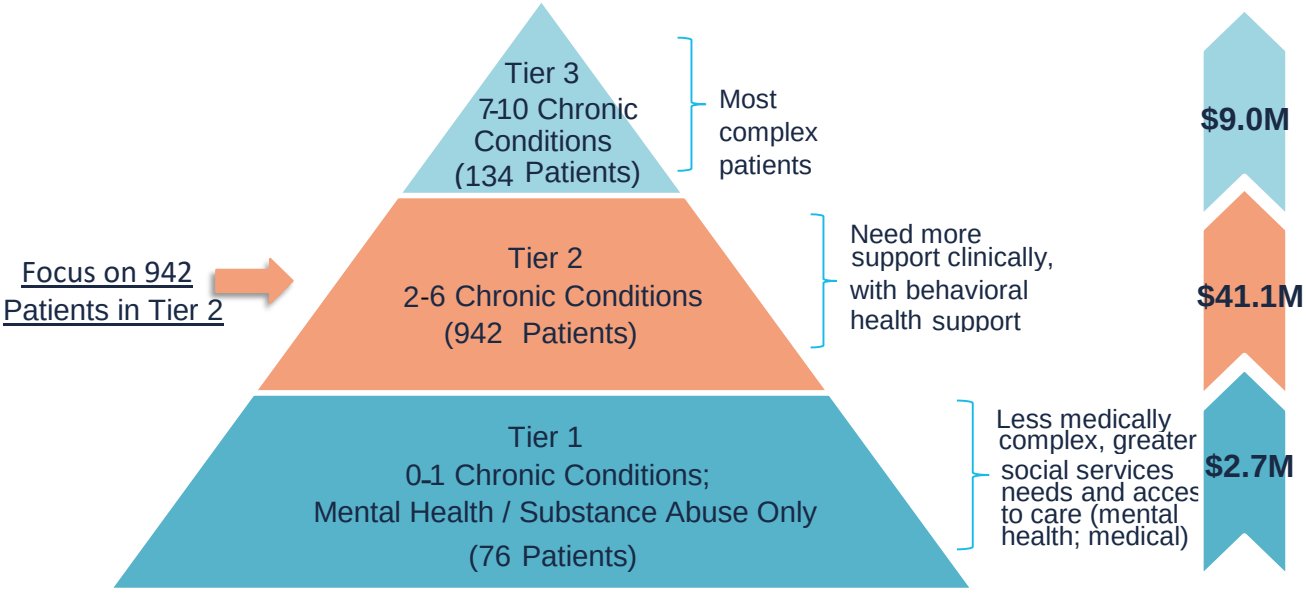
Risk Stratification, Health Risk Assessments, Care Profiles and Care Plans

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

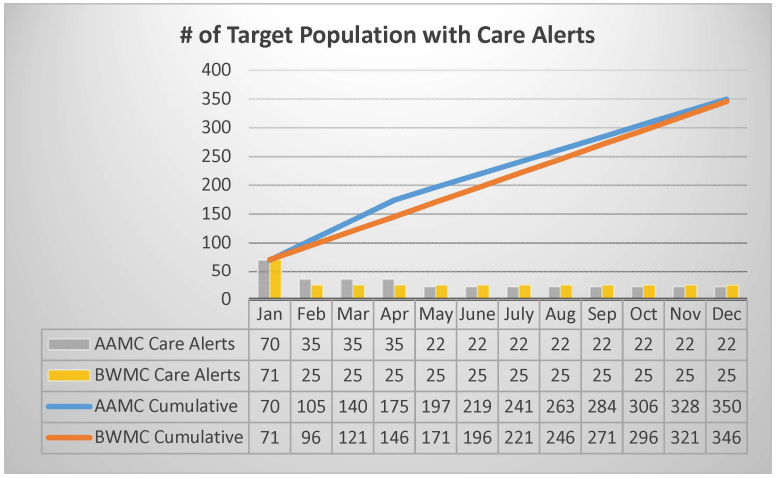
ID	Task Name	Work	Start	Finish	% Work Comple	% Comple	Predecessors	Resource Names
181	Perform Training (Cross-organization) Epic, IP Care Mgt, Call Ctr Ops, Govt Agency, TCC	80 hrs	Tue 4/26/16	Thu 5/26/16	0%	0%	180	Chris Crabbs,Debbie Roper, AA Analyst,Pam Hinshaw,TCC,Karrisa Gouin,DSS
182	Develop educational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

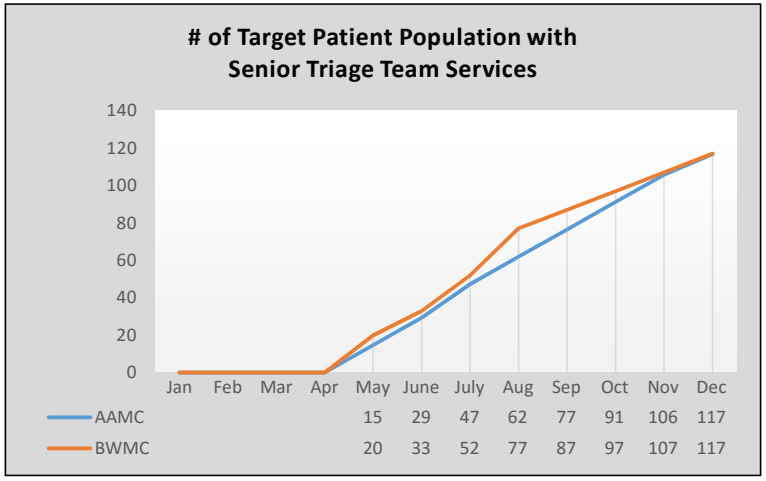
page 1

BATP Volume Tracking Dashboards (example)



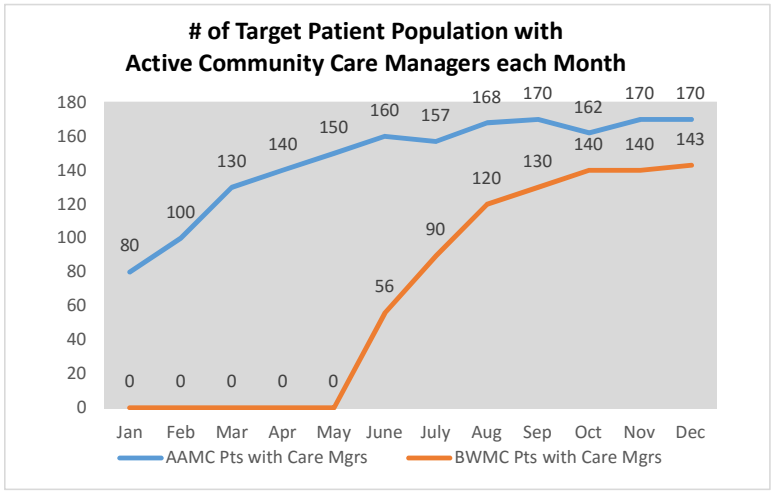
of Target Population with Care Alerts

	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

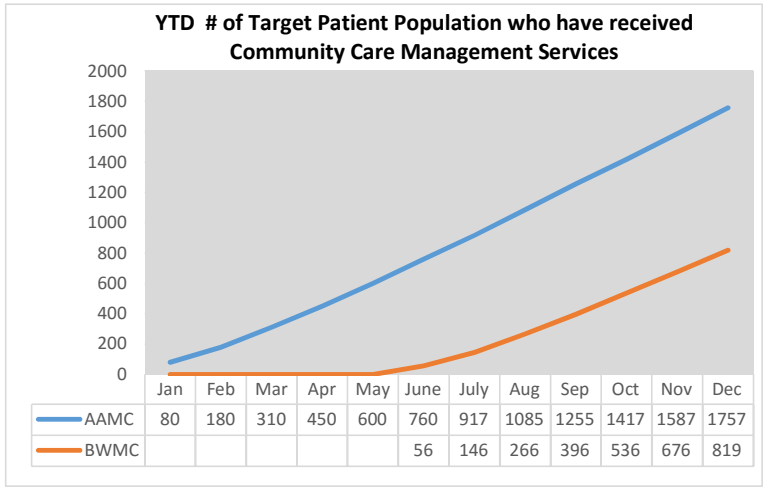


of Target Patient Population with Senior Triage Team Services

	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

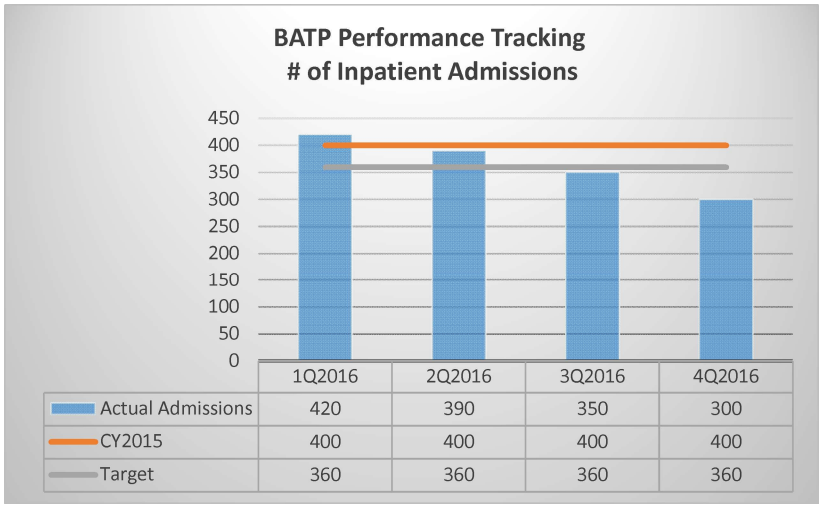


YTD # of Target Patient Population who have received Community Care Management Services

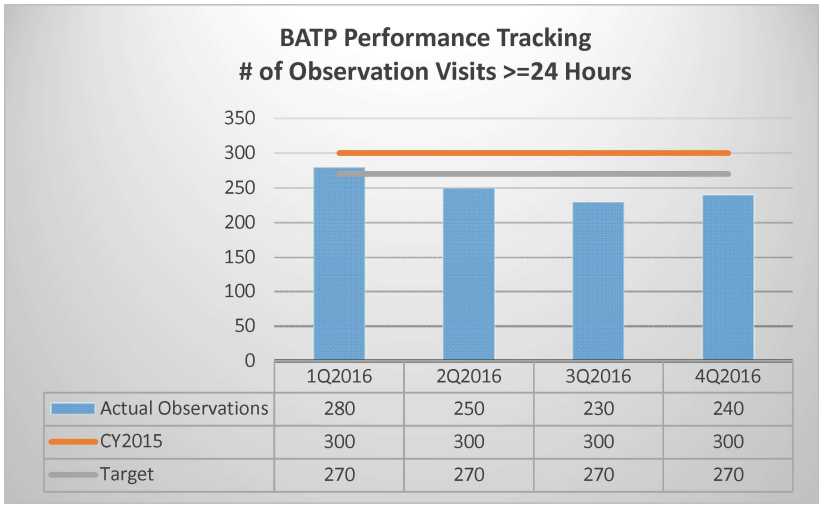
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
AAMC	80	180	310	450	600	760	917	1085	1255	1417	1587	1757
BWMC						56	146	266	396	536	676	819

Appendix B

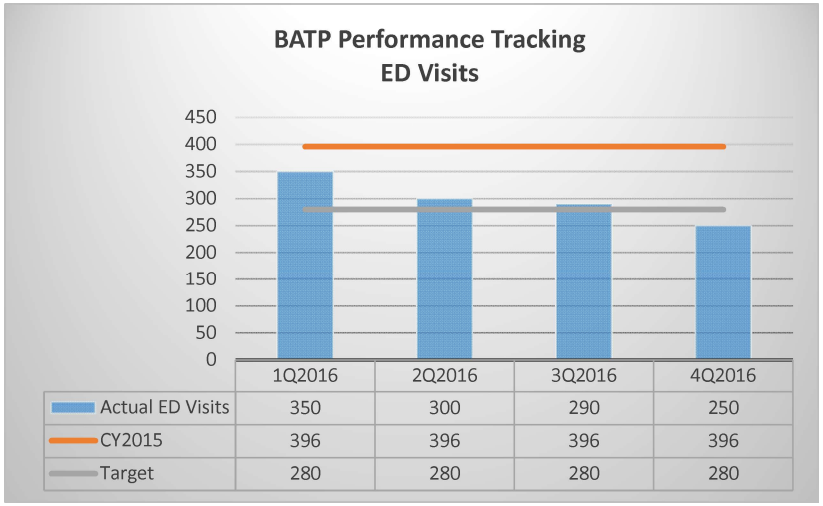
BATP Performance Tracking Dashboard (example)



	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

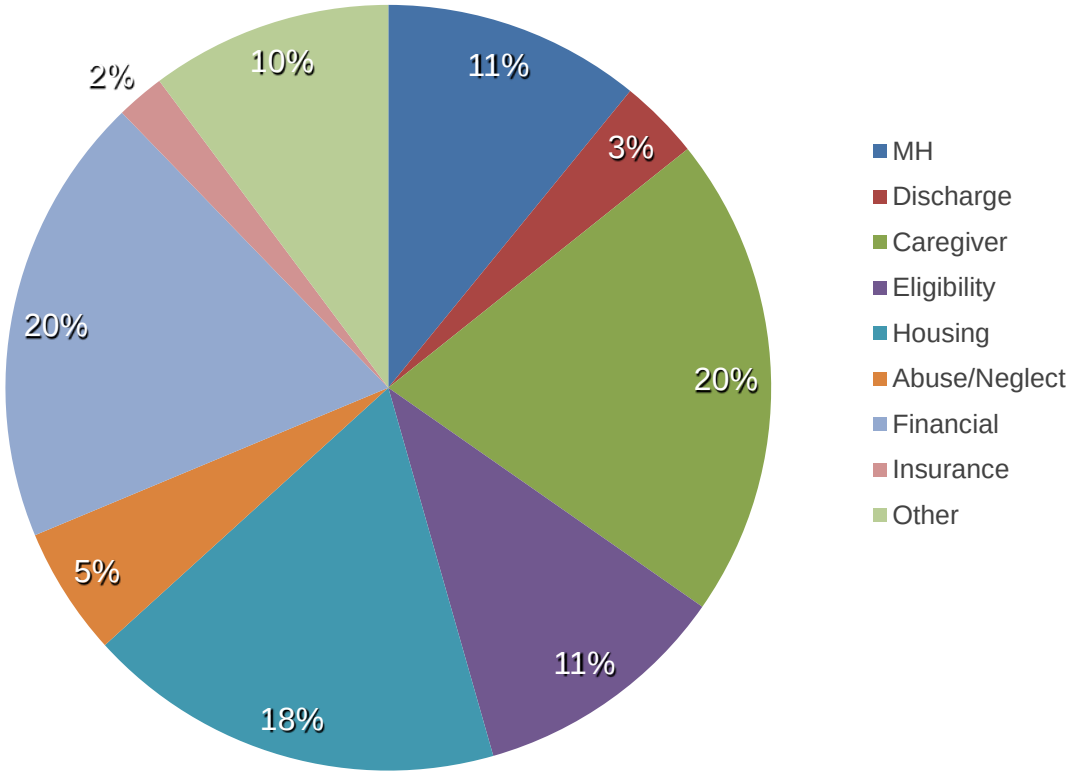
and human service resources, programs, and will provide critical evaluation to each case as presented by the Triage Team. "Silver CRICT" which is an Aging/Senior population Community Resource Initiative Care Team (CRICT) will be developed to support the Triage Team through providing access to referral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

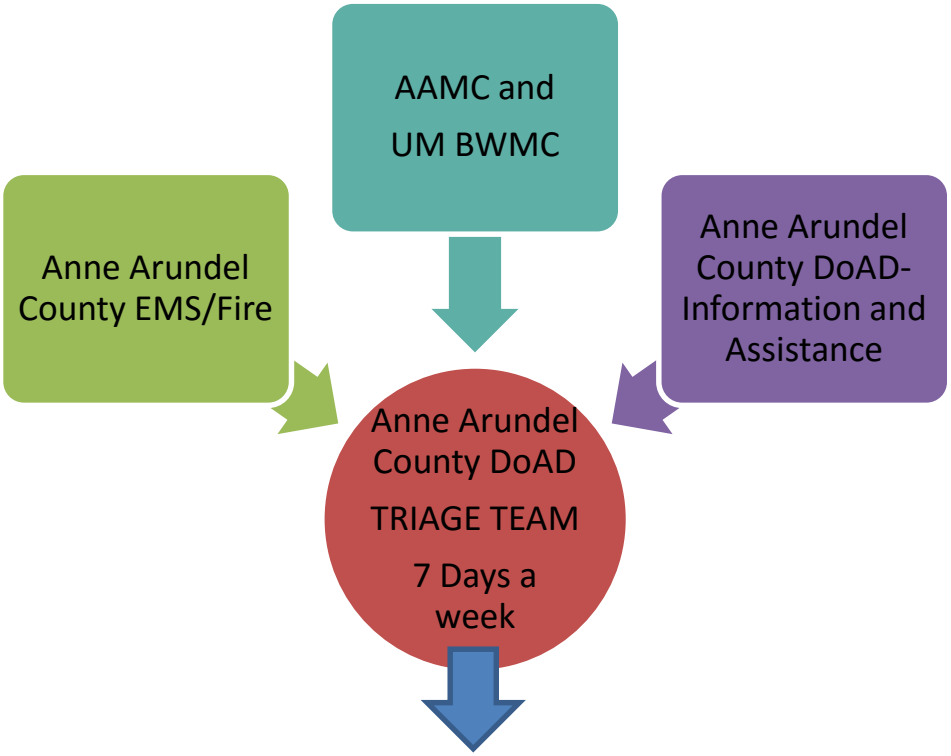
Action A: *The Triage Team will receive, through Memorandum of Understanding, referrals from Anne Arundel Medical Center and University of Maryland Baltimore Washington Hospital. The Triage Team will receive notification upon admission of a pre-identified super-utilizer* (initially the highest as defined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

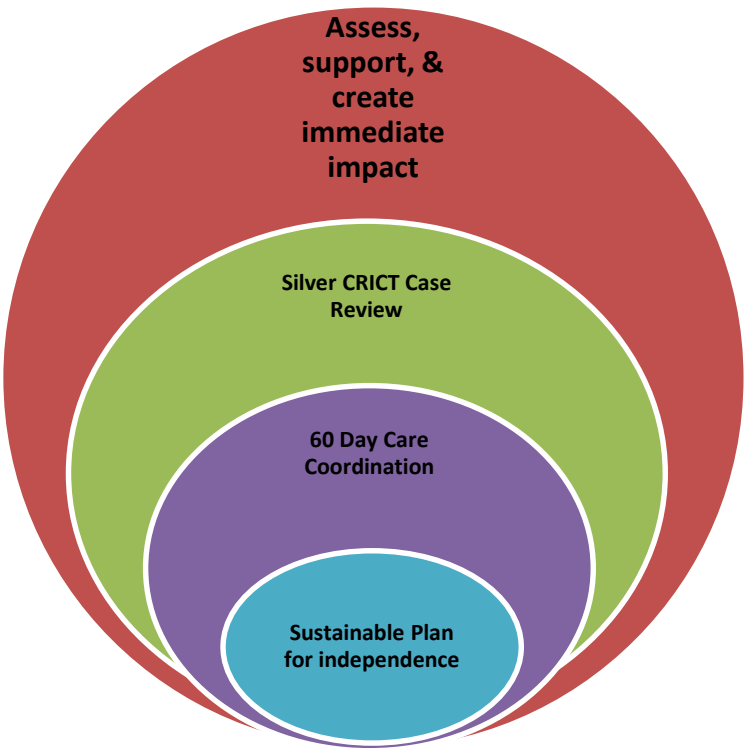
Action B: *The Triage Team will work in partnership with Anne Arundel County EMS/Fire to identify a list of individuals 55 and older that are super-utilizers of the emergency response system and require one or more of the indicators listed in Action A to maintain safe and sustainable living. The triage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

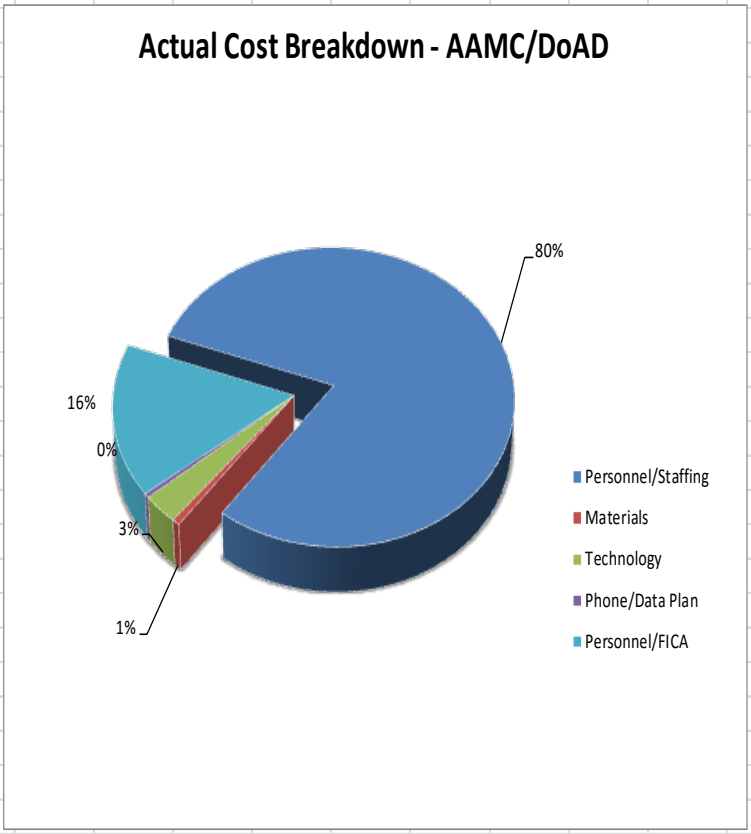
Phone/Data Plan	AAMC/UM BWMC	DoAD
Cell Phone 1		$ 450.00
Cell Phone 2		$ 450.00
Cell Phone 3		$ 450.00
Total	$ -	$ 1,350.00

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.