HSCRC
Health Services Cost Review Commission

Regional Partnership Program Summary

August 2019 Update

The following information is being collected to ensure public reporting about the Regional Partnerships is accurate. The information provided will be posted on the HSCRC website and included in periodic reports about the status of the Regional Partnership Grant Program.
Please complete and email the form to hscrc.rfp-implement@maryland.gov by Friday, September 6th.

Please ensure only one form per partnership is submitted.

Regional Partnership Information
Regional Partnership Name: Bay Area Transformation Partnership (BATP)
Participating Hospitals: Anne Arundel Medical Center University of Maryland Baltimore Washington Medical Center
Participating Community Based Organizations for whom grant funding is used: Anne Arundel County Department of Aging and Disabilities, Senior Triage Team The Coordinating Center Fire/EMS Queen Anne's County (DOH Mobile Integrated Care Unit) **Additional Participating Community Based Organizations (not grant funded):** Anne Arundel County Department of Health Department of Aging and Disabilities Department of Mental Health Adfinitas Health (skilled nursing facility providers and hospitalist groups) Arundel Lodge CareFirst Chesapeake Palliative Medicine CRISP Eastern Shore Psychological Services

Fire/EMS
- Prince Georges County
- Anne Arundel County

Skilled Nursing Facility Collaborative

Medical Directors, Administrators, Directors of Nursing and Corporate representation for:
- Cadia Healthcare of Annapolis
- Caroline Nursing and Rehab
- CommuniCare Marley Neck
- CommuniCare South River
- Crofton Care and Rehab
- Fairfield Nursing Center
- Futurecare Capital Region
- Futurecare Chesapeake
- Futurecare Irving
- Genesis Corsica Hills
- Genesis Severna Park
- Genesis Spa Creek
- Genesis Waugh Chapel
- Ginger Cove
- SAVA Glenburnie
- SAVA heritage Harbor
- SAVA North Arundel
- Signature Health Chesapeake Shores
- Signature Health Mallard Bay

Hospice Organizations
- Hospice of the Chesapeake
- Season's Hospice
- Heartland Hospice

Primary Care and Specialist Practices, AAMG (Collaborative Care Network Practices)

Primary Care and Specialist Practices, UM BWMC, UM Medical Group

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Geographic Service Area Covered by Regional Partnership (e.g., counties or zip codes):

BATP Primary Service Area (PSA)

Zip Code	
20711	Lothian
20715	Bowie
20716	Bowie
20733	Churchton
20751	Deale
20764	Shady Side
20765	Galesville
20776	Harwood
20778	West River
20779	Tracys Landing
21012	Arnold
21032	Crownsville
21037	Edgewater
21054	Gambrills
21060	Glen Burnie
21061	Glen Burnie
21106	Mayo
21108	Millersville
21113	Odenton
21114	Crofton
21122	Pasadena
21144	Severn
21146	Severna Park
21225	Brooklyn
21401	Annapolis
21402	Annapolis
21403	Annapolis
21404	Annapolis
21405	Annapolis
21409	Annapolis
21619	Chester
21666	Stevensville

In addition to our PSA we work with Queen Anne's County Mobile Integrated Care Program which covers zip codes in Queen Anne's County.

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Primary Point of Contact (Name, address, telephone, email):

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Program #1
Intervention Program Name: Shared Care Alerts (AAMC and UMBWMC)
Category of Intervention: • Other (Please describe) – Shared Care Alert development, maintenance and sharing
Short description of intervention: A single cross-encounter note in Epic that holds full care team, cross-organizational, 'need-to-know' information on patients with high utilization to enhance patient safety, reduce avoidable admissions, avoid duplicate testing and unnecessary and potentially harmful interventions. Care Alerts are displayed at the point of care, are actionable, durable and are shared with and via CRISP so that hospitals and other organizations are aware of important medical and non-medical information in a single note.

Program # 2
Intervention Program Name: One Call Care Management (AAMC and UMBWMC)
Category of Intervention: • Other – Non-medical assistance for primary care provider referrals
Short description of intervention: Primary care providers call a single phone number to refer patients who need non-medical assistance (transportation, insurance, caregiver support, medication assistance, home health, DME, hospice, palliative, home safety, dental, etc.)

Program # 3
Intervention Program Name: The Coordinating Center Community Care Management (AAMC and UMBWMC)
Category of Intervention: • Other - Community Care Management
Short description of intervention: The hospitals refer patients with high hospital/ED utilization to The Coordinating Center community care management program. The goals of the program are: a) to promote and motivate behavior change in those patients recently discharged from the hospital using a coaching approach that transfer and model skills and problem solving strategies to avoid unnecessary hospital encounters and b) to align patients with community services and supports and assist them in obtaining the services they need to avoid unnecessary hospital utilization in the long-term.

If more than 3 programs have been funded, please copy and paste additional "Program sections" on additional pages.

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Program #4
Intervention Program Name: Senior Triage Team, Anne Arundel County Department of Aging & Disabilities Community Care Management (UMBWMC)
Category of Intervention: • Other – Community Care Management
Short description of intervention: Intensive 60-day community care management program for UM BWMC's most complex high utilizer, Medicare FFS patients. Comprised of 2RN's, 2 social workers, a team lead and an administrator. The team has expert knowledge and access to 25 county programs.

Program #5
Intervention Program Name: Patient Panel Coordinators (AAMC)
Category of Intervention: • Other – Population health monitoring and outreach to primary care patients for health maintenance purposes.
Short description of intervention: Patient Panel Coordinators (3.5 FTE's) assisted 12 primary care offices and over 6,300 patients in FY19 by using dashboards to identify gaps in care and outreach to patients to assist in managing health maintenance for diabetes (A1C) control, hypertension control, colorectal cancer screening and tobacco use & cessation screening.

Program #6
Intervention Program Name: Integrated Behavioral Health in Primary Care (UM BWMC)
Category of Intervention: • Behavioral Health Integration
Short description of intervention: UMBWMC employs 2 psychotherapists, a psychiatrist and an administrative assistant who provide behavioral health services to approximately 500 unique patients per year (with multiple visits) from six (6) primary care clinics.

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Program #7
Intervention Program Name: Behavioral Health Navigators (AAMC)
Category of Intervention: • Behavioral Health Navigation
Short description of intervention: AAMC has two (2.0 FTE) behavioral health navigators. The *Community* Behavioral Health Navigator receives referrals from primary care providers whose patients have requested / accepted assistance in finding behavioral health services in the community. The *ED* Behavioral Health Navigator receives referrals from both ED and Inpatient providers and staff. Both navigators align patients based on their insurance with the most convenient services, and follow-up with them 30, 60 and 90 days after providing initial assistance.

Program #8
Intervention Program Name: Skilled Nursing Facility Collaboration (AAMC and UMBWMC)
Category of Intervention: • Other – Skilled Nursing Facility Collaborative
Short description of intervention: The BATP SNF Collaborative has been meeting quarterly since 2017. Facilitated by the hospital post-acute leads (1.0 FTE each) we bring SNF medical directors, administrators, directors of nursing and corporate representation together from 19 facilities, with additional partners, including Adfinitas Health, Hospice of the Chesapeake, Season's Hospice, Heartland Hospice, CRISP, The Coordinating Center and the Anne Arundel County Department of Aging Senior Triage Team. The goals of the collaborative are to use data analytics to identify and share best practices, to analyze and fix cross-organizational gaps in information and streamline communication to reduce readmissions and potentially avoidable utilization.

Program #9
Intervention Program Name: Joint Patient and Family Advisory Council
Category of Intervention: • Joint Patient and Family Advisory Council
Short description of intervention: A council of patient and family advisors from both hospitals, from whom the hospitals and community partners request guidance on how to improve the explanation and acceptance of BATP programs for patients and families, including review of and feedback on face-to-face discussion with patients, alignment with and marketing of services/support and training material.