The MARYLAND
HEALTH SERVICES COST REVIEW COMMISSION

Anne Arundel Medical Center

FY 2018 Community Benefit Narrative Report

PART ONE: ORIGINAL NARRATIVE SUBMISSION

Q1.
COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

The Maryland Health Services Cost Review Commission's (HSCRC's or Commission's) Community Benefit Report, required under §19-303 of the Health General Article, Maryland Annotated Code, is the Commission's method of implementing a law that addresses the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals.

The Commission developed a two-part community benefit reporting system that includes an inventory spreadsheet that collects financial and quantitative information and a narrative report to strengthen and supplement the inventory spreadsheet. The guidelines and inventory spreadsheet were guided, in part, by the VHA, CHA, and others' community benefit reporting experience, and was then tailored to fit Maryland's unique regulatory environment. This reporting tool serves as the narrative report. The instructions and process for completing the inventory spreadsheet remain the same as in prior years. The narrative is focused on (1) the general demographics of the hospital community, (2) how hospitals determined the needs of the communities they serve, (3) hospital community benefit administration, and (4) community benefit external collaboration to develop and implement community benefit initiatives.

The Commission moved to an online reporting format beginning with the FY 2018 reports. In this new template, responses are now mandatory unless marked as optional. Questions that require a narrative response have a limit of 20,000 characters. This report need not be completed in one session and can be opened by multiple users.

For technical assistance, contact HCBHelp@hilltop.umbc.edu.

Q2. Please confirm the information we have on file about your hospital for FY 2018.

	Is this information correct?		
	Yes	No	If no, please provide the correct information here:
The proper name of your hospital is: Anne Arundel Medical Center.	◉	○	
Your hospital's ID is: 210023.	◉	○	
Your hospital is part of the hospital system called N/A.	◉	○	
Your hospital was licensed for 385 beds during FY 2018.	○	○	
Your hospital's primary service area includes the following zip codes: 20711, 20733, 20751, 20764, 20765, 20776, 20778, 20779, 21012, 21032, 21035, 21037, 21054, 21106, 21114, 21140, 21146, 21401, 21402, 21403, 21404, 21405, 21409, 21619, 21666.	○	◉	21401 21403 21037 21012 21114 20715 21409 21146 21122 21113 21666 20716 21061 20774 21054 21032 21060
Your hospital shares some or all of its primary service area with the following hospitals: none.	○	◉	University of MD Johns Hopkins Hospital Harbor Hospital Baltimore Washington Medical Center

Q3. The next two questions ask about the area where your hospital directs its community benefit efforts, called the Community Benefit Service Area. You may find these community health statistics useful in preparing your responses.

Q4. (Optional) Please describe any other community health statistics that your hospital uses in its community benefit efforts.

AAMC uses the Community Health Needs Assessments for Anne Arundel, Prince George's and Queen Anne's Counties to identify underserved areas. The links are as follows: https://www.aahealth.org/wp-content/uploads/2018/01/CHNA2015-.pdf https://www.princegeorgescountymd.gov/Archive/ViewFile/Item/2884 https://pophealth.health.maryland.gov/Documents/Resources/MidShore%20CHNA%202016-2019.pdf AAMC also uses the following Maryland program web sites to access data: Maryland State Health Improvement Process (SHIP) measures http://ship.md.networkofcare.org/ph/ MD Vital Statistics Administration http://dhmh.maryland.gov/vsa/Pages/home.aspx The Maryland Report Card http://www.mdreportcard.org Community Health indicators http://wwwn.cdc.gov/communityhealth AAMC uses a variety of other data sources: CRISP and discharge information are also use to identify target populations at risk for re-admission. Nielsen Inc. County Data www.countyhealthrankings.org http://queenannes.md.networkofcare.org

Q5. (Optional) Please attach any files containing community health statistics that your hospital uses in its community benefit efforts.

Q6. Please select the county or counties located in your hospital's CBSA.

☐ Allegany County	☐ Charles County	☑ Prince George's County
☑ Anne Arundel County	☐ Dorchester County	☑ Queen Anne's County
☐ Baltimore City	☐ Frederick County	☐ Somerset County
☐ Baltimore County	☐ Garrett County	☐ St. Mary's County
☐ Calvert County	☐ Harford County	☐ Talbot County
☐ Caroline County	☐ Howard County	☐ Washington County
☐ Carroll County	☐ Kent County	☐ Wicomico County
☐ Cecil County	☐ Montgomery County	☐ Worcester County

Q7. Please check all Allegany County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q8. Please check all Anne Arundel County ZIP codes located in your hospital's CBSA.

☐ 20701	☐ 20764	☑ 21060	☑ 21144
☐ 20711	☐ 20776	☑ 21061	☑ 21146
☐ 20714	☐ 20778	☐ 21076	☐ 21226
☐ 20724	☐ 20779	☐ 21077	☐ 21240
☐ 20733	☐ 20794	☐ 21090	☑ 21401
☐ 20736	☑ 21012	☐ 21108	☐ 21402
☐ 20751	☑ 21032	☑ 21113	☑ 21403
☐ 20754	☐ 21035	☐ 21114	☐ 21405
☐ 20755	☑ 21037	☑ 21122	☑ 21409
☐ 20758	☑ 21054	☐ 21140	

Q9. Please check all Baltimore City ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q10. Please check all Baltimore County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q11. Please check all Calvert County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q12. Please check all Caroline County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q13. Please check all Carroll County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q14. Please check all Cecil County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q15. Please check all Charles County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q16. Please check all Dorchester County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q17. Please check all Frederick County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q18. Please check all Garrett County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q19. Please check all Harford County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q20. Please check all Howard County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q21. Please check all Kent County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q22. Please check all Montgomery County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q23. Please check all Prince George's County ZIP codes located in your hospital's CBSA.

- [ ] 20601
- [ ] 20607
- [ ] 20608
- [ ] 20613
- [ ] 20623
- [ ] 20705
- [ ] 20706
- [ ] 20707
- [ ] 20708
- [ ] 20710
- [ ] 20712
- [x] 20715
- [x] 20716
- [ ] 20720
- [ ] 20721
- [ ] 20722
- [ ] 20735
- [ ] 20737
- [ ] 20740
- [ ] 20742
- [ ] 20743
- [x] 20744
- [ ] 20745
- [ ] 20746
- [ ] 20747
- [ ] 20748
- [ ] 20762
- [ ] 20769
- [ ] 20770
- [ ] 20771
- [ ] 20772
- [ ] 20774
- [ ] 20781
- [ ] 20782
- [ ] 20783
- [ ] 20784
- [ ] 20785
- [ ] 20904
- [ ] 20912

Q24. Please check all Queen Anne's County ZIP codes located in your hospital's CBSA.

- [ ] 21607
- [ ] 21617
- [ ] 21619
- [ ] 21620
- [ ] 21623
- [ ] 21628
- [ ] 21638
- [ ] 21640
- [ ] 21644
- [ ] 21649
- [ ] 21651
- [ ] 21657
- [ ] 21658
- [x] 21666
- [ ] 21668
- [ ] 21679

Q25. Please check all Somerset County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q26. Please check all St. Mary's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q27. Please check all Talbot County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q28. Please check all Washington County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q29. Please check all Wicomico County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q30. Please check all Worcester County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q31. How did your hospital identify its CBSA?

- [ ] Based on ZIP codes in your Financial Assistance Policy. Please describe.
- [ ] Based on ZIP codes in your global budget revenue agreement. Please describe.
- [x] Based on patterns of utilization. Please describe.

  AAMC defines the CBSA as the primary service area for AAMC in which the HSCRC identified the zip codes that compose the highest number of in-patient discharges.

- [ ] Other. Please describe.

Q32. Provide a link to your hospital's mission statement.

https://www.aahs.org/About-Us/AAMC-Experience/Mission,-Vision-and-Values/

Q33. Is your hospital an academic medical center?

- ○ Yes
- ◉ No

Q34. (Optional) Is there any other information about your hospital that you would like to provide?

Anne Arundel County is bordered to the North by Baltimore City, in the east by the Chesapeake bay, in the south by Calvert County, and in the west by the Patuxent River and Howard and Prince George's Counties. It lies between two major cities – Washington D.C. and Baltimore. The County has a total area of 415 square miles. The northern, central and western parts are urban, while the southern part of the county is rural. There are 127 public schools, with 80,000 students. There are three institutions of higher education: Anne Arundel Community College, St. John's College and the United States Naval Academy. The county is also home to Fort George Meade military installation. The County's healthcare needs are served by two hospitals – AAMC and University of Maryland, Baltimore Washington Medical Center. Medstar Harbor Hospital is located within the Baltimore City line, but also serves residents of Northern Anne Arundel County. There are 4 Federally Qualified Health Centers, and 4 clinics offered by the health department. AAMC has 2 clinics. All serve the low income residents of the County. The County population estimates 556,348 residents and the demographics are as follows: 75.1% White, 15.5% Black, and 6.4%% Hispanic. The population has grown 11.2% since 2000 with the Hispanic population growing the fastest. Seniors are also a rapidly growing population. The median household income is $87,430 and the median family income is $101, 268. However, there is significant income disparity. Over 6 percent of county residents live below the federal poverty guideline. Twenty five of residents live in households with less than $50,000 annual income. Nearly 43 percent of county residents live in households that have more than $100,000 of income. Furthermore, there are pockets of need that are located at the most northern and southern ends of the county, and in Annapolis. While life expectancy rose to an average of 79.8 years, cancer remains the leading cause of death and heart disease is the second cause of death. These diseases account for 47 percent of deaths in the County. Infant mortality and low birth weight are also present in the County, and it is particularly disparate for Black infants and families. While many residents have access to health insurance and Medicaid due to the expansion of the Affordable Care Act, there is a shortage of primary care physicians and mental health providers in the County. In addition, dental insurance coverage is not widely available and thus residents lack access to care. Mental health and substance use disorders greatly impact the health of county residents. Specifically, children and adolescents have experienced a 14.5 percent and 9.6 percent increase respectively. The heroin and opioid epidemic have caused a significant need for treatment services too. The senior population is growing in the County, and 11 percent of Medicare beneficiaries were also eligible for Medicaid. These residents are aging, have multiple chronic conditions and can impact healthcare resources. As a result, Anne Arundel Medical Center and University of Maryland Baltimore Washington Medical Center along with additional community partners established the Bay Area Transformation Project through the HSCRC Transformation program. To address the increasing and complex medical and social issues associated with the Medicare population. In FY 2015 the BATP hospitals provided care to a total of 23,477 Medicare patients, costing $260.5M. Of those, 1,152 are Medicare high-utilizers (greater than or equal to 3 Inpatient/Observation and/or 24 hour visits in 12 months), representing $52.8M in total charges and 5,738 visits. Of the 1,152 high-utilizing Medicare patients, 590 visited AAMC, 705 visited UM BWMC, and 143 (12%) visited both hospitals. This Medicare high-utilizer population represents 5% of the 23,477 AAMC/UM BWMC Medicare patients, and 20% of the hospital-related cost of that same population. Notably, mental illness and/or substance misuse affects 66% of BATP's target Medicare population. The most vulnerable residents are located in the northern, southern parts of the County and in Annapolis. There are food deserts in those areas and a lack of connective transportation system. There is a higher percentage of residents without a high school education. Furthermore, Lothian, Edgewater, Annapolis (21403), Churchton, Deale, Glen Burnie, Curtis Bay, Friendship, and Brooklyn have higher ED visits for behavioral health conditions as well as other illnesses and conditions. Hospitalization rates for various illnesses are higher for residents who live in these vulnerable areas. An inadequate public transportation system in the County is a barrier for employment and healthcare. The County is situated along the western shore of the Chesapeake Bay and consists of a series of peninsulas which makes a comprehensive public transportation system too expensive to maintain. As a result, there are not adequate local bus lines to service many areas of the County. South County has only three bus stops in the Edgewater area which leaves a great portion of southern Anne Arundel County without public transportation. Public transportation is in need of additional routes. As a result, only 3.3 percent of Anne Arundel County residents utilize public transportation to get to work. Annapolis does operate a growing transit system, but it does not serve areas outside of the city. There are a few connections with the County bus service to sites such as the Casino at Arundel Mills and Fort Meade. The lack of public transportation is a significant issue throughout the County, since residents are limited in employment and access to healthcare. Housing and homelessness remains a problem in the County. In 2013, resident homeowners spent 34.3% and renters spent 49.5% of their income on housing. In March, 2015, nine thousand families were on a waiting list for public housing and 10,000 families were on a waiting list for Section 8 housing. Over 2,000 individuals receive case management for homelessness and 925 children do not have a home. But, an accurate count of homeless residents does not exist. Prince George's County is bordered by Washington D.C., Montgomery County, Howard County, Anne Arundel County, Calvert County and Charles County. Located in the heart of the Baltimore/Washington corridor, it is also 37 miles south of the city of Baltimore and encompasses almost 500 square miles. It is home to several landmarks and tourist attractions such as the National Harbor, the Gaylord National Resort, MGM National Harbor, the Capital Wheel, Rosecroft Raceway, FedEx Field and the Washington Redskins. It also hosts federal programs such as NASA/Goddard Space Flight Center, Andrews Air Force Base, the President's Air Force One aircraft, Merkle Wildlife Sanctuary, National Agricultural Library, National Archives at College Park, and the USDA's Agricultural Research Center. Several higher learning facilities are there such as the University of Maryland, Bowie State University, and Prince George's Community College. The County is home to more than 900,000 diverse residents and includes urban, suburban, and rural areas; one out of every five residents are immigrants. The county, while overall considered affluent, has many communities with higher needs and poor health outcomes. Poor social determinants of health drive many of the health disparities such as poverty, food insecurity, access to healthy food, affordable housing, employment, lack of educational attainment, and inadequate financial resources. Resources may be available in communities with greater needs, but they are often of poor quality. For example, a recent study in access to healthy foods in an urban area of the county show that there are many grocery stores, but they lack quality healthy food options. Access to health insurance through the Affordable Care Act has not helped everyone. Many residents still lack health insurance (did not enroll or not eligible) even with the passing of the Affordable Care Act. Residents with health insurance often cannot afford their co-pays. The healthcare system is challenging to navigate, and providers and support services need more coordination. While services are available, residents lack knowledge of or how to use available resources. The county does not have enough healthcare providers to serve the residents. There is a lack of behavioral health providers, dentists, specialists, and primary care providers. Many providers do not accept public insurance such as Medical Assistance. This further limits access to care for residents. In addition, the quality of care is perceived to be low by residents. As a result, they seek healthcare is surrounding areas. There is a lack of providers who accept public insurance. Finally, there is a lack of culturally competent and bilingual providers. The 2016 Community Health Needs Assessment identified and prioritized behavioral health, metabolic syndrome (heart disease, diabetes, stroke due to risk factors), and cancer as the top health needs of county residents. Strategies to address these issues must include consideration of the disparate social determinants of health. Residents have not adopted behaviors that promote a healthy lifestyle, such as healthy eating and active living. Approximately, two-thirds of residents are obese or overweight. The lack of physical activity and increased obesity is closely related to residents with metabolic syndrome, which increases the risk for heart disease, diabetes, and stroke. Behavioral health affects individuals, families and communities. For example, EMS, hospital staff, police, and the criminal justice system see many residents needing behavioral health services and treatment. Yet, the county lacks adequate resources needed to address significant behavioral health issues and the stigma surrounding behavioral health treatment is an ongoing problem in the county. Disparity in disease among residents still remains a challenge in the County. Metabolic syndrome is a group of risk factors that raises the risk of heart disease and other health problems such as diabetes and stroke. The risk factors include: a large waist, high triglycerides, low HDL, high blood pressure, and high blood glucose. Blacks have higher incidence of these risk factors. By cancer site, Black residents have a higher incidence and mortality rates for breast, colorectal, and prostate cancers. However, White non-Hispanic residents have a higher cancer mortality rate (2014). In 2013, the County had the second highest rate of HIV diagnoses in the state, and the highest number of actual cases in the state. For adults, Black county residents have an age-adjusted hospitalization rate due to asthma that is more than twice as high as White, non-Hispanic residents. More partnerships and collaborative efforts are needed to improve health outcomes and address social determinants of health. Care coordination and addressing systemic issues are possible solutions. Transportation barriers must be addressed and fixed. Additional funding and resources are needed to strengthen the health safety net and build capacity of local non-profits. More outreach and education is needed, and should be tailored at a community-level to be culturally sensitive and reach residents. Residents also need education about the available resources, and how to utilize and navigate them. Over 80 percent of the geographic are of the state of Maryland is considered rural. Queen Anne's County is one of the twenty-four counties in Maryland with a rural designation. The County is bordered north by Chester River, east by Delaware & Caroline County, south by Talbot County, and west by the Chesapeake Bay. The county has a total area of 511 square miles, of which 372 square miles is land and 139 square miles is water. There is one college (Chesapeake College). Addressing health in the mid-shore region is somewhat divided at the moment. There are two groups focusing on rural health, and they run on parallel tracks. Thus, Secretary Schrader has asked the group to bring the work together and combine the needs assessments and recommendations in order to work from one plan. The first group - the Maryland Rural Health Association set forth to update the state health plan during 2017 and was reaching all rural areas of Maryland. While Rural Maryland provides a rich culture for its community, it has negative implications in terms of access to health care. Across the 24 rural counties, they completed a Community Health Needs Assessment with a secondary data analysis and 2 focus groups from each county. Consumers identified that transportation, behavioral health treatment, and health insurance costs and network availability are barriers to care and service gaps. Providers also agreed that transportation and behavioral health treatment were barriers to access of care in addition to stable funding of resources. Consumers felt that the nursing program at Chesapeake College is a local asset to educating new healthcare workforce. This would help with the shortage of workforce. They also want a telehealth option expanded to increase access to specialty healthcare. Providers felt that the mobile crisis team worked well in the community. Adding community dental clinics and pharmacy delivery programs would also work. The focus groups prioritized the health needs as obesity, behavioral health, and access to care. Consumers stated that potential solutions to the health needs of the community would be physician employment incentives to stay in the County, integrated health centers, and dental care for all. Physicians suggested a greater investment in youth programs and elderly services would address the health needs, along with additional behavioral health resources and programs.

Q35. (Optional) Please upload any supplemental information that you would like to provide.

Q36.
Within the past three fiscal years, has your hospital conducted a CHNA that conforms to IRS requirements?

- ◉ Yes

○ No

Q37. Please explain why your hospital has not conducted a CHNA that conforms to IRS requirements, as well as your hospital's plan and timeframe for completing a CHNA.

This question was not displayed to the respondent.

Q38. When was your hospital's first-ever CHNA completed? (MM/DD/YYYY)

02/01/2013

Q39. When was your hospital's most recent CHNA completed? (MM/DD/YYYY)

02/23/2016

Q40. Please provide a link to your hospital's most recently completed CHNA.

https://www.aahealth.org/wp-content/uploads/2018/01/CHNA2015-.pdf

Q41. Did you make your CHNA available in other formats, languages, or media?

◉ Yes
○ No

Q42. Please describe the other formats in which you made your CHNA available.

Our CHNA is available on line at the link listed above. AAMC also makes written copies available to the public as requested. Last, a summary report is made available electronically and in print formats.

Q43. Please use the table below to tell us about the internal participants involved in your most recent CHNA.

	CHNA Activities										
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/Population Health Director (facility level)	☐	☐	☑	☑	☑	☑	☑	☐	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/ Population Health Director (system level)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☐	☑	☑	☑	☑	☐	☐	☑	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

Board of Directors or Board Committee (facility level)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	Approved CHNA and Implementation Plan.
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (system level)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (facility level)	☐	☐	☐	☑	☑	☐	☑	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (system level)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (system level)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit staff (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit staff (system level)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Physician(s)	☐	☐	☐	☑	☐	☑	☑	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Nurse(s)	☐	☐	☐	☑	☐	☑	☑	☑	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Social Workers	☐	☐	☐	☑	☐	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit Task Force	☐	☐	☐	☑	☐	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Hospital Advisory Board	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	Our patient family advisory council receives updates about CBR.
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other (specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

Q44. Please use the table below to tell us about the external participants involved in your most recent CHNA.

	CHNA Activities									Click to write Column 2
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other Hospitals -- Please list the hospitals here: UM- Baltimore Washington Medical Center	☐	☑	☑	☑	☑	☑	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Health Department -- Please list the Local Health Departments here: Anne Arundel County Department of Health	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Health Improvement Coalition -- Please list the LHICs here: Healthy Anne Arundel	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Health	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Human Resources	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Natural Resources	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of the Environment	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Transportation	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Education	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Area Agency on Aging -- Please list the agencies here: Anne Arundel Department of Aging and Disabilities	☐	☐	☐	☐	☐	☐	☑	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Govt. Organizations -- Please list the organizations here: Anne Arundel County Partnership for Children, Youth and Families	☐	☑	☑	☑	☑	☑	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Faith-Based Organizations	☐	☐	☐	☐	☐	☐	☑	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - K-12 -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Colleges and/or Universities -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School of Public Health -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Medical School -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Nursing School -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Dental School -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Pharmacy School -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Behavioral Health Organizations -- Please list the organizations here: Anne Arundel County Mental Health Agency	☐	☑	☑	☐	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Social Service Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Post-Acute Care Facilities -- please list the facilities here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community/Neighborhood Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Consumer/Public Advocacy Organizations -- Please list the organizations here: YWCA of Central MD	☐	☐	☐	☐	☑	☐	☑	☐	☐	

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other -- If any other people or organizations were involved, please list them here: Anne Arundel County Fire Department	☐	☐	☐	☐	☐	☑	☐	☐	☐	

Q45. Has your hospital adopted an implementation strategy following its most recent CHNA, as required by the IRS?

- (•) Yes
- ( ) No

Q46. Please enter the date on which the implementation strategy was approved by your hospital's governing body.

09/30/2016

Q47. Please provide a link to your hospital's CHNA implementation strategy.

http://aamcvekpsauth/uploadedFiles/Contents/Community%20Health%20Needs%20Assessment%20Implementation%20Plan%202016.pdf

Q48. Please explain why your hospital has not adopted an implementation strategy. Please include whether the hospital has a plan and/or a timeframe for an implementation strategy.

This question was not displayed to the respondent.

Q49. Please select the health needs identified in your most recent CHNA. Select all that apply even if a need was not addressed by a reported initiative.

- ☑ Access to Health Services: Health Insurance
- ☑ Access to Health Services: Practicing PCPs
- ☑ Access to Health Services: Regular PCP Visits
- ☑ Access to Health Services: ED Wait Times
- ☐ Adolescent Health
- ☐ Arthritis, Osteoporosis, and Chronic Back Conditions
- ☐ Blood Disorders and Blood Safety
- ☑ Cancer
- ☐ Chronic Kidney Disease
- ☐ Community Unity
- ☐ Dementias, Including Alzheimer's Disease
- ☑ Diabetes
- ☐ Disability and Health
- ☐ Educational and Community-Based Programs
- ☐ Emergency Preparedness
- ☑ Environmental Health
- ☐ Family Planning
- ☐ Food Safety
- ☐ Genomics
- ☐ Global Health
- ☐ Health Communication and Health Information Technology
- ☑ Health-Related Quality of Life & Well-Being
- ☐ Hearing and Other Sensory or Communication Disorders
- ☑ Heart Disease and Stroke
- ☐ HIV
- ☐ Immunization and Infectious Diseases
- ☐ Injury Prevention
- ☐ Lesbian, Gay, Bisexual, and Transgender Health
- ☑ Maternal & Infant Health
- ☑ Mental Health and Mental Disorders
- ☑ Nutrition and Weight Status
- ☑ Older Adults
- ☐ Oral Health
- ☑ Physical Activity
- ☐ Preparedness
- ☑ Respiratory Diseases
- ☐ Sexually Transmitted Diseases
- ☐ Sleep Health
- ☑ Social Determinants of Health
- ☑ Substance Abuse
- ☐ Telehealth
- ☑ Tobacco Use
- ☐ Violence Prevention
- ☐ Vision
- ☐ Wound Care
- ☑ Other (specify): Need for improved Care Coordination

Q50. Please describe how the needs and priorities identified in your most recent CHNA compare with those identified in your previous CHNA.

In 2013, the identified needs were obesity/ overweight, cancer, mental health/ substance use, chronic disease (heart disease and diabetes), services for un-insured and under-insured, access to care, and health disparity. In 2016, there were over 50 health needs communicated in the assessment. While many of the needs overlap or are needs we currently address, it was important to prioritize needs to support a strategic framework, maximize resources, and have an impact. Through a very structured strategic prioritization process, AAMC prioritized the following as health needs we would address: improved community based care-coordination, expansion of mental health/ substance use, senior care/ palliative care, infant mortality, and improved resource planning for regional health disparities. The health needs identified in 2013 still exist in the County. Healthy Anne Arundel Coalition (LHIC) includes workgroups to address obesity prevention, access to care, and mental health/substance use. AAMC continues to support those efforts by allocating resources to the LHIC. As a hospital, our focus us to address improved care coordination, chronic disease management, reduce re-admissions and un-necessary utilization, expand mental health and substance use programs, align with local end of life programs, and implement efforts to reduce infant mortality. We monitor our progress through stratified metrics that include race, ethnicity, and gender. AAMC either directly addresses or collaborates with community organizations to address the prioritized health needs in the County. AAMC's prioritized health needs are very similar to the needs that UMBWMC chose. Currently, the hospitals are collaborating on the BATP project which addresses improved care conditions, behavioral health, access to palliative care, and providing resources and support to the vulnerable communities. Both hospitals co-chair the LHIC, with the Health Officer serving as Chair of the committee. All organizations are committed to partnering and supporting the initiatives of the LHIC. Specifically, the needs are obesity, behavioral health, and access to care. AAMC provides staff to all sub-committees and support as needed to promote their work. The health department has taken the lead on these initiatives (all outlined in the CHNA) since they are public health measures.

Q51. (Optional) Please use the box below to provide any other information about your CHNA that you wish to share.

NOTE: For the purposes of the FY18 Community Benefit report, AAMC is using the FY16 Community Health Needs Assessment. There is a draft CHNA in circulation for final release during February, 2019. There were several key partners involved in the collaboration and planning process for the CHNA. Each organization utilized the CHNA for its own purpose, but the partners collaborate to extend the work of the LHIC (Healthy Anne Arundel Coalition). The LHIC has identified obesity prevention, behavioral health, and access to care as their prioritized health needs. Each need has a dedicated committee to establish objectives, develop work plans, identify and allocate necessary resources etc. Each partner has leadership roles on the LHIC Steering Committee and/or subcommittees. We assist with providing resources, oversight, etc. to achieve the goals of each subcommittee. Other partners include key LHIC members such as Anne Arundel County Department of Recreation and Parks, Anne Arundel Community College, Anne Arundel County Department of Social Services, Anne Arundel County Public Schools, Office of Economic Development, Care First/ Blue Cross Blue Shield, the Office of the Mayor of the City of Annapolis, and the NAACP. Together, the organizations can exchange ideas, maximize resource allocation, develop a county-wide program, and work together to meet targeted goals. There is a collaborative working arrangement in the County. Specifically, each April, the County hosts Healthy Anne Arundel Month. Each organization has the opportunity to showcase programs that reduce the health needs of the County. This increases awareness and fosters community. The CHNA report analyzed data from secondary and qualitative sources and individuals. The secondary data was gathered from a variety of local, state and national sources. Population and socioeconomic statistics were compiled using data from the United States (U.S.) Census Bureau's Population Estimates Program and the American Community Survey 1-Year and 5-Year Estimates. Birth and death data files were obtained from the Maryland Department of Health & Mental Hygiene, Vital Statistics Administration. The emergency department and inpatient hospital discharge data files were obtained from the HSCRC for topics like birth, mortality and hospital utilization. Other data sources used for this report were: Maryland Vital Statistics Annual Reports, Maryland Department of Health and Mental Hygiene's Annual Cancer Reports, Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention's CDC WONDER Online database, centers for Medicare and Medicaid Services, National Vital Statistics Reports, County Health Rankings and a variety of local databases. The Anne Arundel County Health Department conducted the secondary data analysis via the on-staff epidemiologist. The remainder of the report was researched and written via Pam Brown, Partnership for Children Youth and Families in Anne Arundel County. Dr. Brown has extensive expertise in conducting qualitative research and she is a collaborative community partner. The qualitative data was derived from a series of key informant interviews and focus groups with county leaders and residents. The interviews depicted qualitative data gathered from 12 key informants: • CEO, Anne Arundel Medical Center (AAMC) • CEO, University of Maryland, Baltimore Washington Medical Center • Executive Director, Anne Arundel County Mental Health Agency Health Officer, Anne Arundel County Department of Health • Health Consultant, Anne Arundel County • Director, Anne Arundel County Crisis Response • Clinical Director, Anne Arundel County Mental Health Agency • Community Health Director, AAMC • Two county legislative leaders • Director, Anne Arundel County Department of Aging and Disabilities • Program Director, Domestic Violence Program, YWCA of Annapolis and Anne Arundel County Additional data and information was gathered from 8 focus groups and included many community constituents. They are as follows: • Emergency Department and Emergency Response. Personnel from both hospitals' ERs, the EMS system, Anne Arundel County fire Department, and County Public School System psychologists and counselors (18). • Low-Income Youth such as job seekers, high school drop outs, Medicaid recipients, single parents (8). • North County community members, substance abuse professionals, health professionals, law enforcement, council member (12) • South County community members, substance abuse professionals, law enforcement, health professionals (10) • Behavioral Health residential providers, crisis response, mental health professionals, behavioral health providers (9) • Behavioral Health (parents and mental health providers) (5) • Seniors - including professionals, care coordinators and senior citizens (20) • Hispanic Community such as consumers, attorneys, non-profit leader (6).

Q52. (Optional) Please attach any files containing information regarding your CHNA that you wish to share.

Q53. Please use the table below to tell us about how internal staff members were involved in your hospital's community benefit activities during the fiscal year.

	Activities										
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/Population Health Director (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/ Population Health Director (system level)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☑	☑	☐	☑	☑	☐	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (facility level)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	The Board approved the CBR and activities.

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (system level)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (facility level)	☐	☐	☑	☑	☐	☐	☐	☐	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (system level)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (facility level)	☐	☐	☑	☑	☑	☐	☐	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (system level)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit staff (facility level)	☐	☐	☑	☑	☑	☐	☐	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit staff (system level)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Physician(s)	☐	☐	☑	☑	☐	☐	☐	☐	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Nurse(s)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Social Workers	☐	☐	☑	☑	☑	☐	☐	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit Task Force	☐	☐	☑	☑	☑	☑	☑	☐	☑	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Hospital Advisory Board	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	The patient advisory council provides input to initiatives.
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other (specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

Q54. Please use the table below to tell us about the external participants involved in your hospital's community benefit activities during the fiscal year.

	Activities									Click to write Column 2
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other Hospitals -- Please list the hospitals here: UM-BWMC	☑	☑	☐	☐	☑	☐	☑	☑	☐	Bay Are Transformation Project
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Health Department -- Please list the Local Health Departments here: Anne Arundel County Department of Health	☐	☐	☐	☐	☐	☐	☐	☐	☑	Provided input to initiatives
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Health Improvement Coalition -- Please list the LHICs here: Healthy Anne Arundel	☐	☐	☐	☐	☐	☐	☐	☐	☑	The coalition provided leadership in obesity prevention. behavioral health and access to care initiatives. AAMC provided some funding.
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Health	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Human Resources	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Natural Resources	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of the Environment	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Transportation	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Education	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Area Agency on Aging -- Please list the agencies here: Anne Arundel Department of Aging and Disabilities	☐	☐	☐	☐	☐	☐	☑	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Govt. Organizations -- Please list the organizations here: Partnership for Children, Youth and Families	☐	☐	☐	☐	☐	☐	☑	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Faith-Based Organizations	☐	☐	☐	☐	☐	☐	☑	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - K-12 -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Colleges and/or Universities -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School of Public Health -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Medical School -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Nursing School -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Dental School -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Pharmacy School -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Behavioral Health Organizations -- Please list the organizations here: Arundel Lodge, Anne Arundel County Department for Mental Health	☐	☐	☐	☐	☐	☐	☑	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Social Service Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Post-Acute Care Facilities -- please list the facilities here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community/Neighborhood Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Consumer/Public Advocacy Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other -- If any other people or organizations were involved, please list them here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

Q55. Does your hospital conduct an internal audit of the annual community benefit financial spreadsheet? Select all that apply.

- ☑ Yes, by the hospital's staff
- ☐ Yes, by the hospital system's staff
- ☑ Yes, by a third-party auditor
- ☐ No

Q56. Does your hospital conduct an internal audit of the community benefit narrative?

- ◉ Yes
- ○ No

Q57. Please describe the community benefit narrative review process.

AAMC has two Community Benefit Committees in addition to the Department of Community Health which maintains the on-going operations review, communication and documentation of CB activities. the first committee includes a group of educators across the organization (cancer prevention/ smoking cessation, women's health, Pathways/ substance use prevention, dietitians, community health nurses, and health educators) who meet monthly through the Community Education and Outreach Committee. This group reports regularly on past activities and future opportunities for community education and outreach. They identify populations and geographic areas in need and topics of interest. This group is responsible for implementing many of the community benefit activities across the organization. They maintain on-going communication within AAMC and the community. The second committee includes a leadership task force that meets 2 -3 times per year to outline strategic objectives for community benefit expense. This group identifies strategic priorities based on the Community Health Needs Assessment (CHNA) and the Annual Operating Plan (AOP). They ensure that community benefit, the AOP and the CHNA are in alignment. The group also audits the financial and narrative portions of the Community benefit report. Last, it is responsible to coordinate information dissemination to the Board for reporting and approval processes. Senior leadership (CEO, CFO, CSO, COO, CNO, CMO) reviews and approves the narrative and spreadsheet prior to submission to the HSCRC. The Board of Trustees completes the review of the narrative and spreadsheet in January (the month after submission). The spreadsheet is included as part of the financial audit process that the hospital undergoes annually and 990 Form submission to the IRS annually.

Q58. Does the hospital's board review and approve the annual community benefit financial spreadsheet?

- ◉ Yes
- ○ No

Q59. Please explain:

This question was not displayed to the respondent.

Q60. Does the hospital's board review and approve the annual community benefit narrative report?

- (•) Yes
- ( ) No

Q61. Please explain:

This question was not displayed to the respondent.

Q62. Does your hospital include community benefit planning and investments in its internal strategic plan?

- (•) Yes
- ( ) No

Q63. Please describe how community benefit planning and investments are included in your hospital's internal strategic plan.

AAMC's mission is to enhance the health of the people it serves. It is also guided by its core principles of compassion, trust, dedication, quality, innovation, diversity and collaboration. In February 2010, the Governing Board adopted a 10-year strategic plan and outlined a vision of Living Healthier Together." That means that the care that AAMC provides is centered on the patient. AAMC operates beyond the walls of the hospital and serves a broad geography and diverse population of patients. Our work builds on partnerships, relationships and connectivity. We hold shared accountability among patients, physicians, hospital, employees and community. We are driven by standards based on evidence and outcomes while remaining viable, cost-effective, and responsible. AAMC uses a strategic planning framework that categorized 35 initiatives into 5 strategic goal areas (Quality, Community Health, Workforce, Growth, and Finance). This is reviewed annually by senior leadership, clinical leadership, and administrative leadership to identify opportunities for growth and health improvement through planning retreats, meetings, and data analysis. These initiatives were chosen based on their ability to have significant impact on the care of patients and the community; improve health, increase quality, reduce costs, and strengthen workforce. Leaders identify Community Benefit through the strategic initiatives and report the data and information to Department of Community Health Improvement for collection and analysis. Community Health tracks the data and reports monthly to leadership through the True North Metrics process.

Q64. (Optional) If available, please provide a link to your hospital's strategic plan.

https://www.aahs.org/uploadedFiles/Contents/Eyebrow/About_Us/Promos/V20-brochure-FINAL-web3.pdf

Q65. (Optional) Is there any other information about your hospital's community benefit administration and external collaboration that you would like to provide?

AAMC provides leadership to the Healthy Anne Arundel Coalition (LHIC). The CHNA is an ad-hoc committee of Healthy Anne Arundel. We partner with community organizations through Healthy Anne Arundel to collaborate and extend the work of the Healthy Anne Arundel Coalition. The LHIC has identified obesity prevention, behavioral health, and access to care as their prioritized health needs. Each need has a dedicated committee to establish objectives, develop work plans, identify and allocate necessary resources etc. Each partner has leadership roles on the LHIC Steering Committee and/or subcommittees. We assist with providing resources, oversight, etc. to achieve the goals of each subcommittee. Other partners include key LHIC members such as Anne Arundel County Department of Recreation and Parks, Anne Arundel Community College, Anne Arundel County Department of Social Services, Anne Arundel County Public Schools, Office of Economic Development, Care First/ Blue Cross Blue Shield, the Office of the Mayor of the City of Annapolis, and the NAACP. Together, the organizations can exchange ideas, maximize resource allocation, develop a county-wide program, and work together to meet targeted goals. There is a collaborative working arrangement in the County. Specifically, each April, the County hosts Healthy Anne Arundel Month. Each organization has the opportunity to showcase programs that reduce the health needs of the County. This increases awareness and fosters community. There is additional information included in this report about collaboration in the community through the LHIC for the purposes of CHNA planning, strategy, and community benefit spending.

Q66. (Optional) Please attach any files containing information regarding your hospital's community benefit administration and external collaboration.

Q67. Based on the implementation strategy developed through the CHNA process, please describe *three* ongoing, multi-year programs and initiatives undertaken by your hospital to address community health needs during the fiscal year.

Q68. Initiative 1

Q69. Name of initiative.

Improved Community Care Coordination for Patients with Chronic Disease

Q70. Does this initiative address a need identified in your CHNA?

- (•) Yes
- ( ) No

Q71. Select the CHNA need(s) that apply.

- [x] Access to Health Services: Health Insurance
- [x] Access to Health Services: Practicing PCPs
- [ ] Access to Health Services: Regular PCP Visits
- [ ] Access to Health Services: ED Wait Times
- [ ] Adolescent Health
- [ ] Arthritis, Osteoporosis, and Chronic Back Conditions
- [x] Heart Disease and Stroke
- [ ] HIV
- [ ] Immunization and Infectious Diseases
- [ ] Injury Prevention
- [ ] Lesbian, Gay, Bisexual, and Transgender Health
- [ ] Maternal and Infant Health

- [ ] Blood Disorders and Blood Safety
- [x] Cancer
- [x] Chronic Kidney Disease
- [ ] Community Unity
- [ ] Dementias, Including Alzheimer's Disease
- [x] Diabetes
- [ ] Disability and Health
- [ ] Educational and Community-Based Programs
- [ ] Emergency Preparedness
- [ ] Environmental Health
- [ ] Family Planning
- [ ] Food Safety
- [ ] Genomics
- [ ] Global Health
- [ ] Health Communication and Health Information Technology
- [x] Health-Related Quality of Life and Well-Being
- [ ] Hearing and Other Sensory or Communication Disorders
- [x] Mental Health and Mental Disorders
- [x] Nutrition and Weight Status
- [x] Older Adults
- [ ] Oral Health
- [ ] Physical Activity
- [ ] Preparedness
- [x] Respiratory Diseases
- [ ] Sexually Transmitted Diseases
- [ ] Sleep Health
- [x] Social Determinants of Health
- [ ] Substance Abuse
- [ ] Telehealth
- [ ] Tobacco Use
- [x] Violence Prevention
- [ ] Vision
- [ ] Wound Care
- [ ] Other. Please specify.

Q72. When did this initiative begin?

07/01/2016

Q73. Does this initiative have an anticipated end date?

- ○ The initiative will end on a specific end date. Please specify the date.
- ○ The initiative will end when a community or population health measure reaches a target value. Please describe.
- ○ The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.
- ○ The initiative will end when external grant money to support the initiative runs out. Please explain.
- ○ The initiative will end when a contract or agreement with a partner expires. Please explain.
- ◉ Other. Please explain. This initiative is an on-going multi-year program that has no end date. However, it is anticipated that with the implementation of the MD Primary Care model initiative in 2019, we will no longer count this towards community benefit since it will be a reimbursed expense.

Q74. Enter the number of people in the population that this initiative targets.

179,000 (See report attached below)

Q75. Describe the characteristics of the target population.

The target population includes patients with various chronic disease such as CHF, COPD, diabetes, and cancer. Many have mental health and/or substance use as co-morbid diseases as well. They are often high utilizers of the healthcare system (not just at AAMC) and are at high risk of re-admission due to their disease and how they are affected by social determinants of health.

Q76. How many people did this initiative reach during the fiscal year?

5,000

Q77. What category(ies) of intervention best fits this initiative? Select all that apply.

- [x] Chronic condition-based intervention: treatment intervention
- [x] Chronic condition-based intervention: prevention intervention
- [ ] Acute condition-based intervention: treatment intervention
- [ ] Acute condition-based intervention: prevention intervention
- [x] Condition-agnostic treatment intervention
- [x] Social determinants of health intervention
- [x] Community engagement intervention
- [ ] Other. Please specify.

Q78. Did you work with other individuals, groups, or organizations to deliver this initiative?

- (•) Yes. Please describe who was involved in this initiative.

DSS
The Coordinating Center
Department of Aging and Disabilities (Anne Arundel, Queen Anne's, Prince George's Counties)
UM-BWMC
CRISP
Care Management Services by Johns Hopkins Healthcare
Healthy Anne Arundel Coalition

- ( ) No.

Q79. Please describe the primary objective of the initiative.

Reduce un-necessary utilization and charges for chronic disease patients who frequent acute care settings and improve the self management skills of these patients and families (caregivers).

Q80. Please describe how the initiative is delivered.

In a collaborative setting, AAMC refers patients at discharge from the in-patient setting to community based programs who can address social determinants of health (see partners above). Ambulatory physicians in the AAMC Collaborative Care Network refer at-risk patients to our out-patient care coordination program who also refer patients to community based programs who can address social determinants of health (see partners above). Patients are followed through an out-patient care coordination process to address medical and non-medical needs. This fiscal year, AAMC implemented a follow up system for all discharged patients to determine if additional health is required to address medical and non-medical needs (e.g., appointment setting, obtaining medications, understanding care instructions). AAMC also supports disease specific navigators to assist patients with social needs (Pulmonary disease). AAMC also pays for medical transportation for patients with medical and financial needs.

Q81. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

- [x] Count of participants/encounters — Number of patients assisted
- [ ] Other process/implementation measures (e.g. number of items distributed)
- [ ] Surveys of participants
- [ ] Biophysical health indicators
- [ ] Assessment of environmental change
- [ ] Impact on policy change
- [x] Effects on healthcare utilization or cost — We evaluate this annually and it is submitted to the HSCRC report via our Bay Area Transformation Project.
- [ ] Assessment of workforce development
- [ ] Other

Q82. Please describe the outcome(s) of the initiative.

Please see attached report below. Review projects for AAMC "Community Care Management - The Coordinating Center, " "One Call Care Management, " Collaborative Care Network." The projects were designed to support providers who care for patients with non-medical, social needs. These patients often have disjointed care or are unable to access care due to their housing, transportation, financial concerns. Community based care management (One Call Care Management, The Coordinating Center) are programs that work with providers and patient to address the social determinants of health. The attached report describes the coordinated efforts. The Collaborative Care Network (CCN) is a physician-led network that brings together primary care doctors, specialists, AAMC's regional health system and local health resources to better serve our community and the state of Maryland. The CCN cares for our patients and our providers. We give our providers support and resources that enhance collaboration and care coordination, so they can spend less time on administrative burdens and more time with patients. Our growing network includes more than 700 multi-specialty providers. These providers are committed to delivering high-quality, cost-effective care for the more than one million people in the communities we serve. One of the benefits of the CCN is access to community based care coordination as described previously. Cipher Health is a new technology that AAMC implemented in FY19, but the contract payments began in FY2018. Post discharge follow up from the in-patient setting is critical. CipherHealth calls or texts 100% of patients post-visit, post-discharge, or post-procedure to create meaningful touch-points and identify those most at risk of an adverse event. All patients are called 2 days post discharge and are asked about overall health status, understanding of discharge instruction, medication access and affordability. Patient who require additional assistance are re-routed back to AAMC to work with askAAMC and care management to find suitable solutions and better coordination post discharge care.

Q83. Please describe how the outcome(s) of the initiative addresses community health needs.

Community based care managers work with individual patients to link them to community resources for housing, transportation, affordable medications, health insurance etc. The 2016 Community Health Needs Assessment states that community based care coordination was a lacking service in Anne Arundel County.

Q84. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

Total Hospital Expenses = $1,475,601 Grants (Revenue) = ($573,812) Community Benefit Expense - $901,789

Q85. (Optional) Supplemental information for this initiative.

BATP_FY 2018 EOY Transformation Narrative Report FINAL cg v2 Copy.docx
521.3KB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

Q86. Initiative 2

Q87. Name of initiative.

Expansion of Mental Health Services

Q88. Does this initiative address a need identified in your CHNA?

- (•) Yes
- ( ) No

Q89. Select the CHNA need(s) that apply.

- [ ] Access to Health Services: Health Insurance
- [ ] Access to Health Services: Practicing PCPs
- [ ] Access to Health Services: Regular PCP Visits
- [ ] Access to Health Services: ED Wait Times
- [ ] Adolescent Health
- [ ] Arthritis, Osteoporosis, and Chronic Back Conditions
- [ ] Blood Disorders and Blood Safety
- [ ] Cancer
- [ ] Chronic Kidney Disease
- [ ] Community Unity
- [ ] Dementias, Including Alzheimer's Disease
- [ ] Diabetes
- [ ] Disability and Health
- [ ] Educational and Community-Based Programs
- [ ] Emergency Preparedness
- [ ] Environmental Health
- [ ] Family Planning
- [ ] Food Safety
- [ ] Genomics
- [ ] Global Health
- [ ] Health Communication and Health Information Technology
- [ ] Health-Related Quality of Life and Well-Being
- [ ] Hearing and Other Sensory or Communication Disorders
- [ ] Heart Disease and Stroke
- [ ] HIV
- [ ] Immunization and Infectious Diseases
- [ ] Injury Prevention
- [ ] Lesbian, Gay, Bisexual, and Transgender Health
- [ ] Maternal and Infant Health
- [x] Mental Health and Mental Disorders
- [ ] Nutrition and Weight Status
- [ ] Older Adults
- [ ] Oral Health
- [ ] Physical Activity
- [ ] Preparedness
- [ ] Respiratory Diseases
- [ ] Sexually Transmitted Diseases
- [ ] Sleep Health
- [ ] Social Determinants of Health
- [ ] Substance Abuse
- [ ] Telehealth
- [ ] Tobacco Use
- [ ] Violence Prevention
- [ ] Vision
- [ ] Wound Care
- [ ] Other. Please specify.

Q90. When did this initiative begin?

07/01/2016

Q91. Does this initiative have an anticipated end date?

- ○ The initiative will end on a specific end date. Please specify the date.
- ○ The initiative will end when a community or population health measure reaches a target value. Please describe.
- ○ The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.
- ○ The initiative will end when external grant money to support the initiative runs out. Please explain.
- ○ The initiative will end when a contract or agreement with a partner expires. Please explain.
- ◉ Other. Please explain. Mental Health has been and continues to be a significant health need for Anne Arundel County. AAMC is committed to developing (and continuing to build) access to mental health programs for our community residents. We anticipate that we will have community benefit committment to this expansion for the forseeable future.

Q92. Enter the number of people in the population that this initiative targets.

79,260 (See attached report for Initiative #1)

Q93. Describe the characteristics of the target population.

AAMC is committed to prevention and early detection/ access of mental health disorders. We have developed an education program targeted to residents as well as early access programs to prevent acute episodes. The target population are residents who are at risk for acute episodes of mental health issues.

Q94. How many people did this initiative reach during the fiscal year?

10,000

Q95. What category(ies) of intervention best fits this initiative? Select all that apply.

- ☑ Chronic condition-based intervention: treatment intervention
- ☑ Chronic condition-based intervention: prevention intervention
- ☐ Acute condition-based intervention: treatment intervention
- ☐ Acute condition-based intervention: prevention intervention
- ☐ Condition-agnostic treatment intervention
- ☐ Social determinants of health intervention
- ☐ Community engagement intervention
- ☐ Other. Please specify.

Q96. Did you work with other individuals, groups, or organizations to deliver this initiative?

- (●) Yes. Please describe who was involved in this initiative.

  Anne Arundel County Department of Health (LHIC and providers), Anne Arundel Mental Health Agency, Anne Arundel County Mobile Crisis Unit, Arundel Lodge, private providers (14 in total), commercial insurances.

- ( ) No.

Q97. Please describe the primary objective of the initiative.

Education about mental health and prevention of acute episodes - community educators work with schools and community groups to identify mental health and to describe pathways to access to care. Integration of Behavioral Health into Primary Care Setting - extend access for patients to be seen by a therapist (LCSW_C) in the primary care setting to reduce notable utilization of services due to mental health issues. Behavioral Health Navigators - Navigator receives referrals from PCP's whose patients have requested or agreed to have a navigator assist them in finding behavioral health services in the community. The behavioral health navigators establish relationships, workflows and referral processes with community partners. They create training material for PCPs, including patient-facing brochures with insurance and referral sources. Their primary role is to speak with patients, evaluate their needs and align them with services that match their insurance, timeline, therapy and medication needs.

Q98. Please describe how the initiative is delivered.

The behavioral health navigators establish relationships, workflows and referral processes with community partners. They create training material for PCPs, including patient-facing brochures with insurance and referral sources. Their primary role is to speak with patients, evaluate their need and align them with services that match their insurance, timeline, therapy and medication needs. the LCSW-C is embedded within a primary care office. Patients can access appointments where they seek regular care.

Q99. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

- [x] Count of participants/encounters: # of people reached
- [ ] Other process/implementation measures (e.g. number of items distributed):
- [x] Surveys of participants: Patient satisfaction
- [ ] Biophysical health indicators:
- [ ] Assessment of environmental change:
- [ ] Impact on policy change:
- [x] Effects on healthcare utilization or cost: Reduction in acute care services (ED and mobile crisis response)
- [ ] Assessment of workforce development:
- [ ] Other:

Q100. Please describe the outcome(s) of the initiative.

See report under Initiative 1 "Behavioral Health Navigators, "Embedded LCSW-C in Primary Care Practices."

Q101. Please describe how the outcome(s) of the initiative addresses community health needs.

The Emergency Department rate for Mental Health Disorders (SHIP data) for Anne Arundel County is 4509/100,000 (highest of the service area) and it is above the Maryland goal. The suicide rate is 10.4/100,000 and it is also above the Maryland goal. Anne Arundel County rates are used since they are the highest in the service area. These initiatives will reduce the high rates of suicide and opiate overdose.

Q102. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

Total cost = $714, 245 Less Revenue (BATP Grant) = $194,029 Total Community Benefit = $520,216

Q103. (Optional) Supplemental information for this initiative.

Q104. Initiative 3

Q105. Name of initiative.

Access to Care/ Patient Engagement

Q106. Does this initiative address a need identified in your CHNA?

- (•) Yes
- ( ) No

Q107. Select the CHNA need(s) that apply.

- [ ] Access to Health Services: Health Insurance
- [ ] Access to Health Services: Practicing PCPs
- [x] Access to Health Services: Regular PCP Visits
- [ ] Access to Health Services: ED Wait Times
- [ ] Adolescent Health
- [ ] Arthritis, Osteoporosis, and Chronic Back Conditions
- [ ] Blood Disorders and Blood Safety
- [ ] Cancer
- [ ] Chronic Kidney Disease
- [ ] Community Unity
- [ ] Dementias, Including Alzheimer's Disease
- [ ] Diabetes
- [ ] Disability and Health
- [ ] Educational and Community-Based Programs
- [ ] Emergency Preparedness
- [ ] Environmental Health
- [ ] Family Planning
- [ ] Food Safety
- [ ] Genomics
- [ ] Global Health
- [x] Health Communication and Health Information Technology
- [ ] Health-Related Quality of Life and Well-Being
- [ ] Hearing and Other Sensory or Communication Disorders
- [ ] Heart Disease and Stroke
- [ ] HIV
- [ ] Immunization and Infectious Diseases
- [ ] Injury Prevention
- [ ] Lesbian, Gay, Bisexual, and Transgender Health
- [ ] Maternal and Infant Health
- [ ] Mental Health and Mental Disorders
- [ ] Nutrition and Weight Status
- [ ] Older Adults
- [ ] Oral Health
- [ ] Physical Activity
- [ ] Preparedness
- [ ] Respiratory Diseases
- [ ] Sexually Transmitted Diseases
- [ ] Sleep Health
- [ ] Social Determinants of Health
- [ ] Substance Abuse
- [ ] Telehealth
- [ ] Tobacco Use
- [ ] Violence Prevention
- [ ] Vision
- [ ] Wound Care
- [ ] Other. Please specify.

Q108. When did this initiative begin?

07/01/2015

Q109. Does this initiative have an anticipated end date?

- ( ) The initiative will end on a specific end date. Please specify the date.
- ( ) The initiative will end when a community or population health measure reaches a target value. Please describe.
- ( ) The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.
- ( ) The initiative will end when external grant money to support the initiative runs out. Please explain.
- ( ) The initiative will end when a contract or agreement with a partner expires. Please explain.

- (•) Other. Please explain. This initative will be on-going and monitored. However, great effort was issued in FY18.

Q110. Enter the number of people in the population that this initiative targets.

950,000 encounters

Q111. Describe the characteristics of the target population.

This initiative targets AAMC in-patients and ambulatory patients to engage them in their health.

Q112. How many people did this initiative reach during the fiscal year?

80,000

Q113. What category(ies) of intervention best fits this initiative? Select all that apply.

- [x] Chronic condition-based intervention: treatment intervention
- [x] Chronic condition-based intervention: prevention intervention
- [ ] Acute condition-based intervention: treatment intervention
- [ ] Acute condition-based intervention: prevention intervention
- [ ] Condition-agnostic treatment intervention
- [ ] Social determinants of health intervention
- [ ] Community engagement intervention
- [x] Other. Please specify.

Patient engagement initiative

Q114. Did you work with other individuals, groups, or organizations to deliver this initiative?

- ( ) Yes. Please describe who was involved in this initiative.
- (•) No.

Q115. Please describe the primary objective of the initiative.

Patient engagement is a critical component to success in any population health initiative. AAMC has strategic plans to incorporate technology into patient engagement. MyChart is the patient portal for the EPIC platform and provides a convenient way for an individual to manage medical records in one place. MyChart provides a platform to email the doctor/provider, view test results, request prescription renewals, view prior visit information, keep track of and manage health, and access medical records on a mobile device. AAMC developed a process to support patients to enroll in MyChart at the time of visit.

Q116. Please describe how the initiative is delivered.

Patient receive MyChart enrollment instructions in written and verbal formats at the time of the visit (in-patient and out-patients). We have increased the number of active users and anticipate that communication between the patient and provider will be made easier and faster.

Q117. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

- [x] Count of participants/encounters Number of active users and new accounts
- [ ] Other process/implementation measures (e.g. number of items distributed)
- [ ] Surveys of participants
- [ ] Biophysical health indicators
- [ ] Assessment of environmental change
- [ ] Impact on policy change
- [ ] Effects on healthcare utilization or cost
- [ ] Assessment of workforce development
- [ ]

Other

Q118. Please describe the outcome(s) of the initiative.

After a 2 year effort to increase MyChart users, there were 72,238 enrollments (through the end of FY17). During FY18, an additional 36,602 patients enrolled which was a 33% increase in enrollment.

Q119. Please describe how the outcome(s) of the initiative addresses community health needs.

Access to providers and care was a health need stated in the FY16 Community Health Needs Assessment. AAMC determined that partnering with patients to engage in their health in an easy way would be one initiative to address access to care.

Q120. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

$223,003

Q121. (Optional) Supplemental information for this initiative.

Q122. (Optional) Additional information about initiatives.

Q123. (Optional) If you wish, you may upload a document describing your community benefit initiatives in more detail, or provide descriptions of additional initiatives your hospital undertook during the fiscal year. These need not be multi-year, ongoing initiatives.

Q124. Were all the needs identified in your CHNA addressed by an initiative of your hospital?

- ○ Yes
- ◉ No

Q125. Please check all of the needs that were NOT addressed by your community benefit initiatives.

- ☐ Access to Health Services: Health Insurance
- ☐ Access to Health Services: Practicing PCPs
- ☐ Access to Health Services: Regular PCP Visits
- ☐ Access to Health Services: ED Wait Times
- ☐ Adolescent Health
- ☐ Arthritis, Osteoporosis, and Chronic Back Conditions
- ☑ Blood Disorders and Blood Safety
- ☐ Cancer
- ☐ Chronic Kidney Disease
- ☐ Community Unity
- ☐ Dementias, Including Alzheimer's Disease
- ☐ Diabetes
- ☐ Disability and Health
- ☐ Educational and Community-Based Programs
- ☐ Emergency Preparedness
- ☐ Environmental Health
- ☐ Family Planning
- ☐ Food Safety
- ☑ Genomics
- ☑ Global Health
- ☐ Health Communication and Health Information Technology
- ☐ Health-Related Quality of Life and Well-Being
- ☑ Hearing and Other Sensory or Communication Disorders
- ☐ Heart Disease and Stroke
- ☑ HIV
- ☐ Immunization and Infectious Diseases
- ☐ Injury Prevention
- ☐ Lesbian, Gay, Bisexual, and Transgender Health
- ☐ Maternal and Infant Health
- ☐ Mental Health and Mental Disorders
- ☐ Nutrition and Weight Status
- ☐ Older Adults
- ☐ Oral Health
- ☐ Physical Activity
- ☐ Preparedness
- ☐ Respiratory Diseases
- ☐ Sexually Transmitted Diseases
- ☐ Sleep Health
- ☐ Social Determinants of Health
- ☐ Substance Abuse
- ☐ Telehealth
- ☐ Tobacco Use
- ☐ Violence Prevention
- ☐ Vision
- ☐ Wound Care
- ☐ Other. Please specify.

Q126. How do the hospital's community benefit operations/activities align with the State Health Improvement Process (SHIP)? The State Health Improvement Process (SHIP) seeks to provide a

framework for accountability, local action, and public engagement to advance the health of Maryland residents. The SHIP measures represent what it means for Maryland to be healthy. Website: http://ship.md.networkofcare.org/ph/index.aspx. To the extent applicable, please explain how the hospital's community benefit activities align with the goal in each selected measure.

Enter details in the text box next to any SHIP goals that apply.

Reduce infant mortality	Increase awareness in the community regarding good infant care such as promoting breastfeeding concepts in all populations, promote safe sleep education, and provide free childbirth parenting education classes to low income women.
Reduce rate of sudden unexpected infant deaths (SUIDs)	We are working with county partners to expand safe sleep initiatives in families.
Reduce the teen birth rate (ages 15-19)	N/A
Increase the % of pregnancies starting care in the 1st trimester	In partnership with the Anne Arundel County Department of Health, we are messaging earlier access to pre-natal care
Increase the proportion of children who receive blood lead screenings	We are partnering with the health department and county schools to support their efforts in this area.
Increase the % of students entering kindergarten ready to learn	In partnership with County Schools to address this issue.
Increase the %of students who graduate high school	N/A
Increase the % of adults who are physically active	AAMC supports Healthy Anne Arundel (LHIC) and their efforts to promote physical activity.
Increase the % of adults who are at a healthy weight	AAMC supports Healthy Anne Arundel (LHIC) and their efforts to promote obesity prevention.
Reduce the % of children who are considered obese (high school only)	AAMC supports Healthy Anne Arundel (LHIC) and their efforts to promote obesity prevention.
Reduce the % of adults who are current smokers	AAMC supports 2 Tobacco Cessation Specialists to promote the negative effects of smoking to adults and adolescents through a variety of forums. They also help current smokers quit. AAMC has been committed to this effort for over 20 years.
Reduce the % of youths using any kind of tobacco product (high school only)	See above.
Reduce HIV infection rate (per 100,000 population)	N/A
Reduce Chlamydia infection rate	N/A
Increase life expectancy	AAMC provides over 200 health talks and fairs annually in addition to community flu shot clinics, blood pressure and cholesterol screenings that guide community members to better health.
Reduce child maltreatment (per 1,000 population)	N/A
Reduce suicide rate (per 100,000)	See mental health initiative
Reduce domestic violence (per 100,000)	AAMC partners with the YWCA of Central Maryland. We also have a Domestic Violence program that serves the community.
Reduce the % of young children with high blood lead levels	See above.
Decrease fall-related mortality (per 100,000)	N/A
Reduce pedestrian injuries on public roads (per 100,000 population)	N/A
Increase the % of affordable housing options	N/A
Increase the % of adolescents receiving an annual wellness checkup	AAMC partners with community peditricians to reinforce this message.
Increase the % of adults with a usual primary care provider	See Initiative 3
Increase the % of children receiving dental care	N/A
Reduce % uninsured ED visits	AAMC provides access to low income and un-insured patients through 2 community clinics.
Reduce heart disease mortality (per 100,000)	AAMC is developing a comprehensive cardiac program that addresses prevention to end of life.
Reduce cancer mortality (per 100,000)	AAMC has an expansive oncology program (prevention to end of life) that serves to reduce deaths from cancer. All patients are seen, regardless of ability to pay.
Reduce diabetes-related emergency department visit rate (per 100,000)	AAMC has 2 sliding scale community clinics and a primary care clinic in partnership with Arundel Lodge to better manage diabetes. AAMC provides low cost care to diabetics through the Diabetes Center.
Reduce hypertension-related emergency department visit rate (per 100,000)	AAMC has 2 sliding scale community clinics that serve the un-insured and self pay patients.
Reduce drug induced mortality (per 100,000)	AAMC has an extensive prevention program to reduce alcohol and drug addictions.
Reduce mental health-related emergency department visit rate (per 100,000)	See Initiative 2
Reduce addictions-related emergency department visit rate (per 100,000)	AAMC has an extensive prevention program to reduce alcohol and drug addictions.
Reduce Alzheimer's disease and other dementias-related hospitalizations (per 100,000)	N/A
Reduce dental-related emergency department visit rate (per 100,000)	AAMC financially supports the dental clinic in the Stanton Center.
Increase the % of children with recommended vaccinations	AAMC partners with our community pediatricians.
Increase the % vaccinated annually for seasonal influenza	AAMC mandates that all staff, physicians, volunteers, and vendors receive annual flu shots. Free flu shots are provided to patients and the community.
Reduce asthma-related emergency department visit rate (per 10,000)	AAMC has 2 sliding scale community clinics to serve low income or uninsured/ underinsured patients.

Q127. (Optional) Did your hospital's initiatives in FY 2018 address other, non-SHIP, state health goals? If so, tell us about them below.

Q128. As required under HG §19-303, please select all of the gaps in physician availability in your hospital's CBSA. Select all that apply.

- [ ] No gaps
- [x] Primary care
- [x] Mental health
- [ ] Substance abuse/detoxification
- [x] Internal medicine

- [ ] Dermatology
- [x] Dental
- [x] Neurosurgery/neurology
- [x] General surgery
- [ ] Orthopedic specialties
- [ ] Obstetrics
- [x] Otolaryngology
- [ ] Other. Please specify.

Q129. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please indicate the category of subsidy, and explain why the services would not otherwise be available to meet patient demand.

Hospital-Based Physicians	Breast Center, Oncology Center, Obstetric Care, Oncology Survivorship Program, Pain Management Program and Surgeons (Surgical Specialists). Cancer is growing at an alarming rate in the County. Acces sto high quality surgical and cancer care is necessary for county residents, and reisdents of Bowie, Upper Marlboro (Prince George's County) and parts of the Eastern Shore (Queen Anne's County).
Non-Resident House Staff and Hospitalists	AAMC would not be able to maintain coverage 24 hours a day/ 7 days per week without Hospitalists. This team includes specialities such as Internal Medicine, Intensivists, Obstetricians, and Pediatricians.
Coverage of Emergency Department Call	AAMC reimburses the EC call team for Charity Care and call coverage. We serve nearly 90,000 patients annually and this subsidy ensures that our patients have access to high quality physician care.
Physician Provision of Financial Assistance	N/A
Physician Recruitment to Meet Community Need	Primary Care, psychiatry, and surgeons (all noted in the CHNA as gaps).
Other (provide detail of any subsidy not listed above)	Hospice, Behavioral health programs
Other (provide detail of any subsidy not listed above)	
Other (provide detail of any subsidy not listed above)	

Q130. (Optional) Is there any other information about physician gaps that you would like to provide?

AAMC provides low cost care to the un-insured and underinsured through 3 clinics, and our Kent Island Urgent Care. Specialty care is arranged through these clinics and care managers with our own providers. Maryland fares better at a 9 percent rate of insured residents as compared to Maryland (12 percent) and the US (11 percent). However, access to primary care and other specialties is worse in Anne Arundel County as compared to Maryland and the US. In fact, the patient to primary care physician ratio in Anne Arundel (1430:1) is worse than in Maryland (1045:1) and the U.S. benchmark (1131:1) meaning that more individuals are seeking care from fewer providers. This shortage results in seriously limited access to primary care in parts of our Community Benefit Service Area. Building primary care access is essential to the hospital's strategic plan, Vision 2020. Increased accessibility and coordinating health care increased the focus on prevention and improving the population health of our CBSA. Access to mental health providers is also worse in Anne Arundel County as compared to Maryland and the US. According to the 2015 County Health Rankings, the ratio of mental health providers to patients is 718:1 as compared to Maryland (502:1) and the US (386:1).

Q131. (Optional) Please attach any files containing further information regarding physician gaps at your hospital.

Q132. Upload a copy of your hospital's financial assistance policy.

FAP_June-2017.pdf
164.5KB
application/pdf

Q133. Upload a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e).

FAP-PLS_logo.pdf
66.4KB
application/pdf

Q134. What is your hospital's household income threshold for medically necessary free care? Please respond with ranges as a percentage of the federal poverty level (FPL).

Household income at or below 200% of poverty level or individuals enrolled in means-tested State or Local program.

Q135. What is your hospital's household income threshold for medically necessary reduced cost care? Please respond with ranges as a percentage of the FPL.

AAMC provides a sliding fee scale for individuals with household income at or below 330% of the US poverty guideline but deemed ineligible for County, State, or Federal Medicaid or other funding program. The sliding scale provides 80% financial assistance to individuals up to 230% of the poverty guideline; 60% financial assistance to individuals up to 260%; 40% financial assistance to individuals up to 300%; 20% financial assistance to individuals up to 330%.

Q136. What are your hospital's criteria for reduced cost medically necessary care for cases of financial hardship? Please respond with ranges as a percentage of the FPL and household income. For example, household income between 301-500% of the FPL and a medical debt incurred over a 12-month period that exceeds 25 percent of household income.

See above.

Q137. Provide a brief description of how your hospital's FAP has changed since the ACA Expansion became effective on January 1, 2014.

While AAMC has always been committed to serving un-insured, un-insured, and self pay patients, the policy reflected the specific levels of financial assistance based on income level and the federal poverty level.

Q138. (Optional) Is there any other information about your hospital's FAP that you would like to provide?

AAMC provides the above policy and information sheets in Spanish as well. It is on our website as follows: https://www.aahs.org/plan-your-visit/patient-resources/billing-and-insurance/financial-assistance/

Q139. (Optional) Please attach any files containing further information about your hospital's FAP.

Q140. You have reached the end of the questions, but you are not quite finished. When you click the button below, you will see a page with all of your answers together. You will see a link to download a pdf document of your answers, near the top of the page. You can download your answers to share with your leadership, board, or others as required by your internal processes. Your report will not be submitted to HSCRC until you have clicked the button at the bottom of the next page, the one with all your answers.

Location Data

Location: (38.989807128906, -76.550102233887)

Source: GeoIP Estimation

PART TWO: ATTACHMENTS

HSCRC Regional Partnership Transformation Grant Narrative

FY 2018

Bay Area Transformation Partnership

Anne Arundel Medical Center

and

University of Maryland Baltimore Washington Medical Center

Submitted on: September 14, 2018

Submitted by: Cynthia Gingrich, BATP Project Management Consultant

Table of Contents

HSCRC Transformation Grant FY2018 Report

The Health Services Cost Review Commission (HSCRC) is reviewing the following for FY 2018: this Report, the Budget Report, and the Budget Narrative. Whereas the Budget Report distinguishes between each hospital, this Summary Report should describe all hospitals, if more than one, that are in the Regional Partnership.

Regional Partnership Information – Bay Area Transformation Partnership

Regional Partnership (RP) Name	Bay Area Transformation Partnership (BATP)
RP Hospital(s)	Anne Arundel Medical Center University of Maryland Baltimore Washington Medical Center
RP POC	Cynthia Gingrich, Project Management Consultant
RP Interventions in FY 2018	Total Interventions in FY18: **21,220** AAMC: 3,989 + 13,589 (Patient Panel Coordinators) = 17,578 UM BWMC: 3,642
Total Budget in FY 2018 *This should equate to total FY 2017 award*	FY 2018 Award: $3,831,141
Total FTEs in FY 2018	**Employed: 22** AAMC: 12 UM BWMC: 10
	Contracted: 19 The Coordinating Center (for AAMC) 7.5 The Coordinating Center (for UM BWMC) 6.5 Anne Arundel County Dept of Aging Senior Triage Team (for UM BWMC) 4 BATP Project Manager (for both AAMC and UMBWMC) 1
Program Partners in FY 2018 *Please list any community-based organizations or provider groups, contractors, and/or public partners*	Anne Arundel County Crisis Response Department of Health Department of Aging and Disabilities Senior Triage Team (community care management) Department of Mental Health Adfinitas Health (providers in SNF facilities and hospitalist groups) Arundel Lodge CareFirst Chesapeake Palliative Medicine CRISP Eastern Shore Psychological Services Fire/EMS

	Prince Georges County Queen Anne's County (DOH Mobile Integrated Care Unit) Anne Arundel County (FY19) Hospice of the Chesapeake The Coordinating Center (community care management) Skilled Nursing Facility Collaborative (Medical Directors, Administrators, Directors of Nursing and Corporate) Communicare Corporate Communicare Marley Neck Communicare South River Crofton Care and Rehabilitation Center Fairfield Nursing Center FutureCare (Corporate FutureCare Chesapeake FutureCare Irvington Genesis Corporate Genesis Corsica Hills Genesis Severna Park Genesis Spa Creek Genesis Waugh Chapel Glen Burnie Health and Rehab SAVA Corporate SAVA Heritage Harbour SAVA North Arundel Adfinitas Hospice of the Chesapeake Optum Ginger Cove Signature Health Primary Care Practices, AAMC (Collaborative Care Network Practices) Primary Care Practices, UM BWMC, UMCMG and non-UM CMG Practices

Overall Summary of Regional Partnership Activities in FY 2018

The Bay Area Transformation Partnership activities in FY18 assisted over 4,000 unique patients and provided 21,220 interventions across twelve subprojects, reaching both high and rising risk populations. Our interventions consist of tools, services and collaboratives that improve communication within and across organizations and disciplines to provide better, more coordinated care, enable patients with self-management of chronic conditions, provide services and support systems, integrate behavioral and medical healthcare. We have developed continuous process improvements within and across services and use patient panels for monitoring and measure outcomes. Our interventions include:

Tools - Shared Care Alerts, Shared Care Plans, Secure Texting

Services

- Community Care Management (The Coordinating Center and the Department of Aging Senior Triage Team)
- One Call Care Management (a single phone number for PCP's to call for patient assistance with non-medical needs)
- Behavioral Health Navigators (align PCP referrals and ED/Inpatient referrals with services in the community)
- Integrated behavioral health in primary care (AAMC's 1 LCSW in Primary Care Clinic, and UMBWMC's two psychotherapists and psychiatrist for 6 clinics)

Collaboratives

- Skilled Nursing Facility (SNF) Collaborative – quarterly in-person meetings with 14+ SNFs and CRISP to identify and solve problems related to improving patient and family experiences, setting expectations across settings of care and reducing avoidable admissions.
- Joint Patient and Family Advisory Council –patient and family advisors from AAMC and UM BWMC who guide our vocabulary, communication and documentation associated with the BATP services.
- Regional Partnership Learning Collaborative –participate in (and co-chair) a group of 14 regional partnerships CRISP and HSCRC working together to understand programs, target patient populations, processes and measurement, and standardize reporting.

Some notable accomplishments this year include:

Exceeded our FY18 'year 2' goal of reaching 1,260 unique patients by reaching 2,512 for AAMC and 1,930 for UMBWMC (see figure 1).

Advances in data analytics – In FY17, we did not have skilled nursing facility readmission data per SNF, let alone risk-adjusted across all SNFs in the state. BATP worked with CRISP and hMetrix to provide requirements and review draft reports of risk-adjusted SNF utilization/charge/LOS reports, now available and updated monthly under 'monitoring' in the MADE CCLF tool.

Real-time admission and discharge information for PCP's and community partners – Assisted our largest community care management vendor in receiving real-time encounter notifications via secure texting for outreach to patients and care teams. Piloting streamlined encounter notifications via Epic inbasket folders for PCPs, so that primary care office staff have a real-time list of hospital and SNF discharge information. They can use the list to contact patients about their post-discharge needs and to schedule appointments in a timely manner.

Population health maintenance (AAMC) – reached 13,589 patients across 12 clinics with patient panel coordinators (AAMC) to bring diabetes A1c, influenza vaccines, mammogram and colonoscopy screenings in compliance.

Shared Care Alert development and maintenance of 2,074 alerts, and developed workflow to collaborate on shared patients.

Facilitated the SNF Collaborative, bringing key representatives from 14 SNFs together to perform problem identification and prioritization of hospital and skilled nursing facility challenges related to patient and family satisfaction and avoidable utilization and readmissions, with workgroups starting in FY19.

Our Behavioral Health interventions primarily serve rising risk and pre-rising risk patients, both in the primary care setting, where we worked with 789 patients, and in the Behavioral Health Navigator service for ED, inpatient and PCP referrals which assisted 558 patients in finding resources for therapy and medication assistance.

Our Community Care Management services assisted over 1,400 patients across three separate programs, and each one showed savings in utilization, per patient charges and per visit charges. Since we measure both FY18 and cumulative results for all patients seen by the services, we can see long-term effects, compare and research differences, and adjust models. Outcome metrics are available in Appendix A for applicable programs.

Total Interventions FY18 (unique per hospital, and non-unique per intervention)

BATP FY18 Interventions			
Unique Patients (per hospital)	**AAMC**	**UMBWMC**	
Non Behavioral Health Interventions	1791	1701	
Behavioral Health	721	609	
Total Unique Patients with Any Intervention*	**2512**	**1930**	
Non-Unique Across Subprojects (Unique within Subproject)			**Total**
Shared Care Alerts (active alerts)	1097	1205	2302
Shared Care Plans (patient goals)	450	671	1121
The Coordinating Center	562	659	1221
Senior Triage Team	N/A	180	180
One Call Care Management	1031	318	1349
Behavioral Health in Primary Care	180	609	789
Behavioral Health Navigator ED (AAMC)	318	N/A	318
Behavioral Health Navigator Community (AAMC)	351	N/A	351
# of interventions (non-unique) FY18	**3989**	**3642**	**7631**
Patient Panel Coordinators (AAMC)	13589		
Grand Total # of non-unique interventions FY18	**17578**	**3642**	**21220**
*excludes AAMC Patient Panel Coordinator work			

Figure 1 - BATP FY18 Intervention Totals

Intervention Program - Community Care Management, The Coordinating Center

Intervention	**Community Care Management, The Coordinating Center**
RP Hospitals Participating	Anne Arundel Medical Center UM Baltimore Washington Medical Center
Brief description of the Intervention *2-3 sentences*	The hospitals contract with The Coordinating Center to provide community care management and coaching to patients, including in-home assessment, patient-centered goal charting in the Epic Longitudinal Plan of Care, education and coordination of chronic condition management, and placement of non-medical support services. For AAMC, The Coordinating Center used a nurse/health coach team-based model with a 60-day average LOS. Staff included 3 RN's, 3 health coaches, .5 Program Manager and an Intake Coordinator. This program was used in FY17 and FY18. For UMBWMC, The Coordinating Center used a health coach model with a 30-day average LOS, 4 health coaches, .5 Program Manager, and an Intake Coordinator. This program was used in FY17 and FY18.
Participating Program Partners	Other partners to whom The Coordinating Center refer: Hospice of the Chesapeake, Palliative Care, and the Dept of Aging 25 programs and Senior Triage Team (for UMBWMC), home health agencies, and numerous other county and state programs.
Patients Served	# of Patients Served as of June 30, 2018: **1,221** AAMC: 2,273 new referrals resulting in 562 patients receiving service UM BWMC: 2,047 new referrals resulting in 659 patients receiving service
	HSCRC Population Denominator of Eligible Population: 66,823 Population Category: 3+ IP/Obs>=24 Visits, Medicare FFS Using the CY2017 RP Analytic File **BATP Denominator of Eligible Patients: 1,207** initial target population, expanding to **2,881** per below. Referrals to community care management are made by evaluating the hospital census. We assess: 3+ IP/Obs>24 Visits, Medicare FFS, 2 to 6 chronic conditions, 65+ years old (1,207 patients), which is our original target population; then we look at the same criteria but All Payer (1,463), then we refer 2+ IP/Obs Visits, 2 to 6 chronic conditions, Medicare FFS (2,831) then All Payer (2,881). This methodology results in capturing the patient mix from our census who have high utilization and high needs, without being too strict with the original 3+ bedded visit criteria.

Pre-Post Analysis for Intervention

Below is a summary of the Pre-Post Reports for The Coordinating Center programs. For each hospital, we show the results from the FY18 panel of patients for 3 and 6 months pre and post, followed by the results from cumulative panels (AAMC had a May 2016 start, UMBWMC began service in August 2016). The AAMC FY18 program with 60-day average LOS, nurse / health coach model resulted in a 3-month pre-post (9 months' worth of data) change in charges for 331 patients of (-$2.03M) and (-8.0) change in the rate of visits per 10 patients. This improved to (-11.0) visits per 10 members in 6-month pre/post. Per figure 3, UMBWMC's health coach model, 30-day LOS program shows a 3-month change in charges for 356 patients of (-$5.9M) with a decrease of (-8.9) change in the rate of visits per 10 members. The decrease in average charges per patient (-$12,841) and per visit (-$3,998).

AAMC – The Coordinating Center

FY18 Pre/Post 07/01/17 - 06/22/18									
2273 referred patients, 573 in panel, 453 had data for the analysis									
Months Pre and Post	Pts	Charges Pre	Charges Post	Change in Charges Pre to Post	Total Charges per Pt Change	Total Charges per Visit Change	Rate of Visits Change (per 10 pts)		
3-month	331	$ 5,055,493	$ 3,026,364	$ (2,029,129)	(2,583)	$ (737)	(8.0)	July 2017 thru March 2018	9 months
6-month	197	$ 4,181,782	$ 2,547,930	$ (1,633,852)	(5,755)	$ (853)	(11.0)	July 2017 thru Dec 2017	6 months
Cumulative Pre/Post	05/01/16 - 05/31/18 (June 2018 casemix)								
3,401 referred, 958 in panel, 875 had data for pre/post analysis									
Months Pre and Post	Pts	Charges Pre	Charges Post	Change in Charges Pre to Post	Total Charges per Pt Change	Total Charges per Visit Change	Rate of Visits Change (per 10 pts)		
3- month	695	$ 13,025,829	$ 7,377,427	$ (5,648,402)	(3,689)	$ (1,279)	(8.1)	May 2016 thru March 2018	22 months
6-month	596	$ 14,778,013	$ 11,007,588	$ (3,770,425)	(2,056)	$ (461)	(8.1)	May 2016 thru Dec 2017	18 months
12-month	335	$ 12,908,841	$ 11,986,819	$ (922,022)	1,847	$ (4)	(5.0)	May 2016 thru June 2017	13 months

Figure 2 AAMC Pre-Post for The Coordinating Center, FY18 and Cumulative

As we examine the longer-term goal to enable patients through education, services and supports to manage medical and non-medical conditions outside of the hospital setting, we look at the **cumulative** pre-post results, as indicated in the bottom sections of Figure's 2 and 3. In Figure 2, bottom section, looking 6 months before and after care management was provided; AAMC's 596 patients decreased visits by (-8.1) per 10 patients, decreased total charges by (-$3.77M) and averaged a decrease of (-$2,056) per patient and (-$461) per visit. Per Figure 3 bottom section, the UMBWMC health-coach model, 30-day LOS, reached 1,397 patients in the 6-month pre-post 17 months from Aug 2016 – Dec 2017, with decreases in total charges of (-$20.9M), decrease in average per patient charge of (-$9,696), decrease in average charge per visit of (-$1,188), and a decrease in the rate of all hospital visits of (-14.3) per 10 patients. The health coach model appears to outperform, according to pre-post. In discussing the results with the vendor and hospital care management, our belief is that the 60-day nursing model provided care and examined broader issues for several weeks prior to involving the health coach, rather than quickly focusing on patient goals and putting services and support systems in place to enable longer-term results.

UM BWMC – The Coordinating Center

FY18 Pre/Post 7/1/17 - 6/22/18 (June 2018 casemix)										
2047 referred patients, 652 in the panel, 491 had data for analysis										
Months Pre and Post	**Pts**	**Charges Pre**	**Charges Post**	**Change in Charges Pre to Post**	**Total Charges per Pt Change**	**Total Charges per Visit Change**	**Rate of Visits Change (per 10 pts)**			
3 month	356	$ 9,872,341	$ 3,951,676	$ (5,920,665)	(12,841)	$ (3,998)	(8.9)	July 2017 thru March 2018		9 months
6 month	184	$ 6,184,830	$ 3,719,480	$ (2,465,350)	(9,487)	$ (1,903)	(8.8)	July 2017 thru Dec 2017		6 months
Cumulative Pre/Post										
8/1/16 - 6/22/18 (using June 2018 casemix)										
3649 referred patients, 1887 in panel, 1732 had data for the analysis										
Months Pre and Post	**Pts**	**Charges Pre**	**Charges Post**	**Change in Charges Pre to Post**	**Total Charges per Pt Change**	**Total Charges per Visit Change**	**Rate of Visits Change (per 10 pts)**			
3-month	1541	$ 44,673,637	$ 20,895,877	$ (23,777,760)	(10,293)	$ (2,295)	(12.2)	August 2016 thru March 32018		20 months
6-month	1397	$ 54,150,411	$ 33,232,926	$ (20,917,485)	(9,696)	$ (1,188)	(14.3)	August 2016 thru Dec 2017		17 months
12-month	941	$ 55,039,180	$ 39,530,853	$ (15,508,327)	(10,982)	$ (668)	(18.2)	August 2016 thru June 2017		11 months

Figure 3 - UM BWMC Pre-Post for The Coordinating Center, FY18 and Cumulative

Please see Appendix A for pre-post summary pages.

Intervention-Specific Outcome or Process Measures

Community care managers from The Coordinating Center and the Department of Aging Senior Triage Team, perform the following actions for each active patient:

a) Add themselves to the patient's Care Team in Epic and remove themselves when they finish working with the patient.
b) Chart patient goals (Shared Care Plans) for each of their patients in the longitudinal plan of care in Epic, so that others can pick-up where they left off rather than starting from scratch. Care Plans are shared with CRISP via Continuity of Care Documents. (The CRISP Executive Dashboard does not yet reflect these counts as CRISP work to find and count the care plans is pending).
c) Create or update a Care Alert with their contact information.
d) Use secure texting to communicate with hospital and community care team members.

The hospitals use standardized monthly metric reports provided by the vendor, which include: new referrals, accepted service, successfully graduated, declined service (and why) and active clients (those who have at least had an initial, meaningful visit in the community). See appendix A for additional detail.
Key Metrics:

In FY18	AAMC	UM BWMC
New Referrals	2,273	2,047
Received Service (Pre/Post)*	536	659

Successes of the Intervention in FY 2018	For patients who accepted the service, we see a decrease in charges (total, per patient and per visit) and overall hospital utilization occurred, per above pre-post analyses.

	Using the results from capturing process metrics and pre/post analyses enable us to compare different care management program models and their results and adjust to more productive models. Incorporated CRISP 'all hospital' utilization data directly into Epic. The hospital referral sources, working within their own EHR, can readily identify, analyze and refer patients who meet criteria for referral to community care management or other services. This effort provided visibility of an additional 400+ IP/Obs high utilizers per hospital (those who presented 1 or 2 times at AAMC or UMBWMC but 2 or more times at other hospitals). This integrated 'all hospital' utilization information also enables flexibility in expanding target patient criteria to find additional referrals as needed. Both hospitals incorporated feedback from the Joint Patient Family Advisory Council to standardize and simplify vocabulary, improve marketing material, and make conversations at the bedside more engaging.
Lessons Learned from the Intervention in FY 2018	The biggest challenge for this service is converting referred patients to active patients (those who permit at least an initial in-home visit). The Coordinating Center believes that acceptance rates will increase if they are on-site at the hospitals to market their own service and hand off to their team. We are implementing this approach in FY19. The 30-day health-coach model used by UM BWMC appears to drive immediate action and produces significantly better results than the nurse/health coach 60-day model. We believe this is because it is a time-limited, patient-centric model that focuses on patient-identified goals and providing long-term services and support systems. Although the hospitals and care management programs have made great strides in standardizing monthly process metrics and definitions, it is currently a manually process which has proven to be error-prone and time consuming. Our goal in FY19 is to incorporate capture of referrals and statusing within Epic at each of the hospitals.
Next Steps for the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	Design and build referrals and statusing in hospital Epic systems, with community care management updating status in real-time. Strive to improve patient acceptance of the service through motivational engagement by hospital and vendor staff. Continue to prioritize Medicare FFS patients with high utilization, and expand target patient criteria to include All Payer, 2 or more visits of any type (IP/Obs>24, ED), prioritizing higher utilization first. Bring community care management to the bedside to represent their own services and streamline hand-off to their peers, to hopefully increase the rate of patients who accept (and follow- through with) the service. Study regional partnership-wide, statewide and nationwide approaches to and outcomes of community care management services for our target populations. Determine the best strategy moving forward.

Intervention Program – Department of Aging Senior Triage Team (for UMBWMC)

Intervention/Program Name	**Senior Triage Team** – Community Care Management Anne Arundel County Department of Aging & Disabilities
RP Hospitals Participating in Intervention	UM Baltimore Washington Medical Center
Brief description of the Intervention *2-3 sentences*	The Department of Aging and Disabilities 'Senior Triage Team' is an intensive 60-day community care management program. UM BWMC refers their most complex, high utilizer Medicare FFS patients to this team, comprised of 2 RN's, 2 social workers, a team lead and administrator. The team was designed around Medicare FFS high utilizers and has been working with BATP since 6/1/16. They have advanced knowledge of all services and supports in Anne Arundel County, and how to streamline requests for and access to services, including financial analysis and housing assistance.
Participating Program Partners	The Senior Triage Team model has a built-in support system called the Silver CRICT Team, an aging/senior population Community Resource Initiative Care Team, comprised of the Department of Social Services, the Housing Commission, Department of Mental Health, Core Service Agency, Crisis Response and others. The team develops a multi-agency action plan to assist with long term connections to support in addition to immediate assessment and care management provided by the Triage Team.
Patients Served	# of Patients Served as of June 30, 2018: **180**
	Denominator of Eligible *Population*: **66,823** RP Analytic File Denominator of Eligible *Patients*: **1,514** CY2017 RP Analytic File, 3+ IP or Obs>=24 Visits Medicare FFS BATP Denominator of Eligible Patients: **651** This intervention is for UM BWMC patients only (rather than regional partnership). Using the CRISP PaTH report filters to find UM BWMC eligible patients, our target patients for this intervention are IP/Obs high utilizers 3+ bedded stays in the last 12 months, 2 to 6 chronic conditions, Medicare FFS, 65+ years.
Pre-Post Analysis for Intervention (optional)	Please See Appendix A for cumulative pre-post results. Since 6/1/16 (2 years), The Senior Triage Team has, using a 6-month pre-post report, decreased total charges per patient by (-$12,966), (-$824) per visit, -18.4 decrease in rate of visits per 10 patients, and a change in charges of (-$2.76M).
Intervention-Specific Outcome or Process Measures (optional)	# accepted service 77% (high for this population) # assessed and declined 2% # declined service 18% (excellent) # unable to initially contact 5%
Successes of the Intervention in FY 2018	UM BWMC and the Senior Triage Team have, together, achieved a decline rate of only 18%, down from 31% in FY17. They attribute the success to the hospital targeting appropriate referrals and obtaining patient consent prior to referring to the service,

Free Response, up to 1 Paragraph	and the community care managers meeting patients at the bedside to introduce themselves and the program, developing a relationship with the patient and caregiver/family, and discussing patient goals and how the service can assist. Normally, the same care manager who meets the patient in the hospital also sees them in the community. The Senior Triage Team strengthened community partnerships and streamlined communication regarding outreach and service alignment using their Silver CRICT support structure. After working together and learning personnel and processes, the Senior Triage Team reaches out directly to request support, and the formal meetings are no longer necessary.
Lessons Learned from the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	The 60-day LOS is necessary for most patients in this model, as they are our most complex patients, although the team is cognizant of opportunities to assist and close the cases as soon as patients have reached goals or have the services that they need. Considering the amount of time to apply for and receive services/supports. it would be helpful to have additional telephonic follow-up after discharge from this program, to monitor long-term utilization of the services/supports. The process of referring patients to a service and having the service providers update the status of the referrals (accepted service, declined service and why) is a manual process currently. Incorporating referrals (by the hospital) and statusing (by the vendors) into our information systems (Epic) is required to improve operational workflows and key process metrics.
Next Steps for the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	Design and build referral tracking and statusing into Epic, and train staff on new charting and workflow. Continue to educate other community partners, including home health agencies, assisted living facilities, skilled nursing facilities and primary care providers, about the program, the mission and value, and how the patients who are in or who have graduated from the program are trained and supported to manage many conditions by recognizing early warning signs and contacting their PCP, so as to avoid emergency and hospital services when possible. Continue to improve behavioral health partnerships within the community and streamline workflows for referrals. Integrate this service with the UM BWMC new Transitional Nurse Navigator model, which is focused on key chronic condition management, to enhance services to patients.

Intervention Program – Shared Care Alerts

Intervention/Program Name	Shared Care Alerts
RP Hospitals Participating in Intervention	Anne Arundel Medical Center UM Baltimore Washington Medical Center
Brief description of the Intervention *2-3 sentences*	A Care Alert is special cross-encounter, multidisciplinary note, designed to provide a single location to present the most important, patient-centered information (medical and non-medical) for and by the entire Care Team. Care Teams may include clinicians and social workers both within the hospital and in the community, who have a treatment or working relationship with the patient. Shared Care Alerts are meaningful, actionable notes regarding important care and program support information for vulnerable, high risk patient. Care Alerts are shared in real-time from Epic to and via CRISP and are sent and received to/from over 35 hospitals statewide, regardless of EHR vendor.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	- AAMC and UM BWMC Hospital Emergency Departments - Primary Care Providers who are on Epic or who use CRISP - The Coordinating Center - Anne Arundel County Department of Aging Senior Triage Team - Arundel Lodge Behavioral Health Home - Hospice of the Chesapeake - End Stage Renal Disease Seamless Care Organization (ESCO) - Prince George's and Queen Anne's County Mobile Integrated Health Units
Patients Served	# of Patients Served as of June 30, 2018: Active Care Alert Counts: AAMC: 1,097 UM BWMC: 1,205
	Denominator of Eligible ***Population***: 550,445 Denominator of Eligible ***Patients***: 3,820 From CY2017 RP Analytic File: 3+ IP or Obs>=24 (All Payer)
Pre-Post Analysis for Intervention (optional)	Please see Appendix A for cumulative Care Alert pre/post report summaries, both hospitals.
Intervention-Specific Outcome or Process Measures (optional)	Each hospital has a quality improvement and maintenance processes in place for Care Alerts.

Successes of the Intervention in FY 2018	New processes were developed to maintain alerts across health systems, which strengthens alerts for shared patients and enhances maintenance of the alerts to keep them current. Created procedures for collaboration on Care Alert development and maintenance for shared high utilizer patients between the AAMC Readmissions Clinical Analyst and the UMBWMC Care Alert authors. Implemented continuous data improvement processes regarding feedback on the content of Care Alerts, so that they contain useful, actionable data for multi-disciplinary care teams.
Lessons Learned from the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	There is value in linking Care Alert actionable data with Care Team member outreach information (including secure texting) that can positively impact care and provide an opportunity to avoid utilization, if/as appropriate.
Next Steps for the Intervention in FY 2019	The hospitals will continue to create and maintain relevant, high quality Care Alerts for patients who frequently utilize our hospitals or who are at risk to do so. The number of active Shared Care Alerts will most likely remain close to current volumes given the current staffing models, retiring alerts that are no longer relevant and adding alerts for additional high utilizers. Ongoing maintenance of Care Alerts is required to ensure that current information is provided to ED, PCP and other care team members. We are piloting the use of Care Team assignment (in Epic) generating an ENS feed to PROMPT, so that as patients go into or out of hospitals or SNFs, the hospital staff who maintain Care Alerts can apply changes/updates based on reasons for admission and other data. Exploring bringing Payer Care Managers into the partnership care management workflows, including using the Care Alerts, Care Teams and secure texting. Assisting Payers in evaluating latest capabilities for receipt of ENS alerts a) in the field and b) at PCP offices for quick follow-up with discharged patients. Work with Fire/EMS teams to examine opportunities to use Care Alerts, Care Teams and secure texting to improve care coordination for ED high utilizers.

Intervention Program – One Call Care Management

Intervention/Program Name	One Call Care Management
RP Hospitals Participating in Intervention	Anne Arundel Medical Center UM Baltimore Washington Medical Center
Brief description of the Intervention *2-3 sentences*	A single phone number for Primary Care Providers and their staff to call to refer patients in need of non-medical assistance. Our One Call Care Managers then call the patient to discuss the reason for the referral, discover other needs and assist patients in obtaining the services they need. Some examples of non-medical assistance include transportation, insurance, behavioral health navigation, housing, community care management assistance, hospice or palliative care, dental needs, provider referrals, DME, caregiver support/respite care, support groups. This service fills an important need for patients who may not need a full community care management service but who benefit from la carte services. It also 'coordinates the coordinators' (aligns Care Management resources to avoid duplication of services).
Participating Program Partners	Our One Call Care Management services refer to: Anne Arundel County Department of Health (Healthy Start, REACH, Dental Program), house call providers, Hospice of the Chesapeake, Palliative Care, Mobile Integrated Care Unit (MICH), Food Bank, Partners in Care, The Coordinating Center, Behavioral Health Navigators, Pharmacists, Johns Hopkins Home Care, Chronic Condition support programs, etc.
Patients Served	# of Patients Served as of June 30, 2018: **1,298** AAMC: 1,031 (1.5 FTE's) UM BWMC: 318 (1.0 FTE)
	Denominator of Eligible *Population:* 550,445 CY2017 RP Analytic File: All Payer Population Denominator of Eligible *Patients*: 179,772 CY2017 RP Analytic File: All Payer Eligible Patients
Pre-Post Analysis for Intervention *(optional)*	Please see Appendix A for cumulative pre/post (since start of services). One Call Care Management serves about 2/3 of rising risk patients, 1/3 patients with some utilization. Since the referrals come from PCP visits rather than hospital utilization, using pre/post that utilizes start dates (and looks before and after that date) is not necessarily useful until 3 to 6 months after PCP visit.

Intervention-Specific Outcome or Process Measures

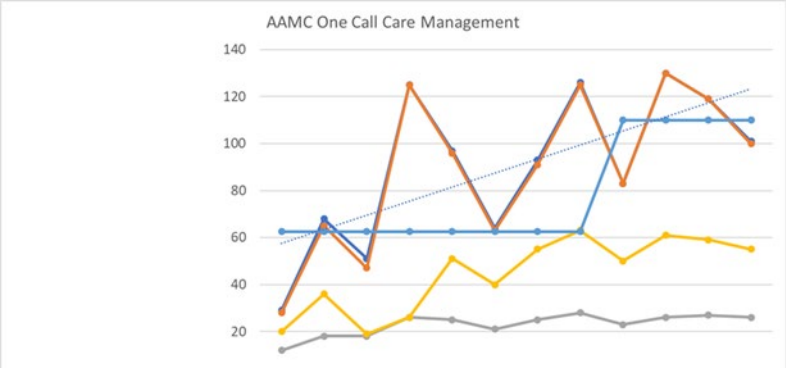
Referral Volume: AAMC met or exceeded referral goals throughout most of FY18, with an average of 96 referrals per month. *Close to 100% of patients accepted the service when referred by their primary care provider or office staff.*

Reason for Referral	FY17 EOY 12 mo	FY18 EOY 12 mo
Basic Needs	13	13
Family Lifestyle Concerns		1
Financial Concerns	12	29
Insurance Coverage	32	49
Medication Assistance	21	52
Social Security		1
Transportation	26	59
Home Safety	*	13
Housing	10	29
Behavioral Health	105	389
Mental Health		67
Substance Use		3
Care Management Enrollment	41	129
DOAD		2
Home Health	29	51
Personal care	10	8
Physician Housecall		3
Hospice & Palliative Care	7	6
Dental Health	3	3
Provider Referral	28	74
DME	12	19
Care Giver Support	24	69
Support Group	2	31
Senior Triage	4	0
Meal Assistance	1	0
* Home Safety was part of/combined with Home Heal		
	380	1100

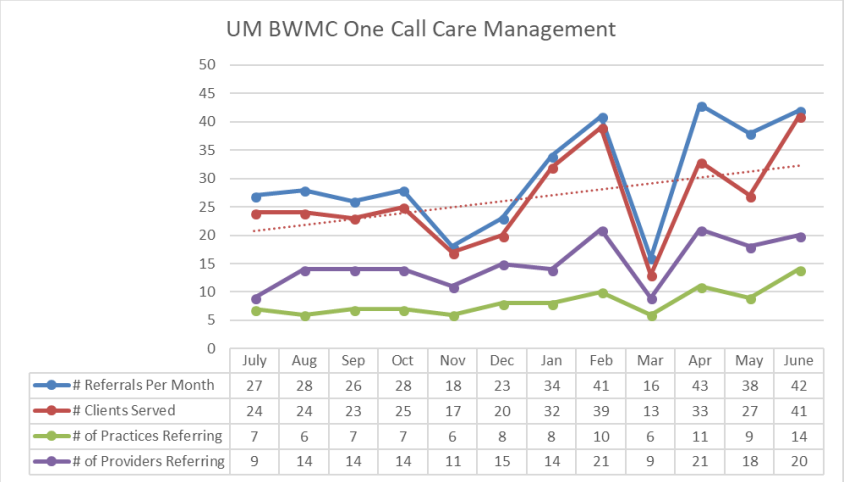
Types of Services Provided: 35% of calls were for behavioral health navigation services, 12% resulted in referral to community care management, 7% needed provider referrals, 5% needed home health and 6% need caregiver support.

Patient population: 61% of patients had any chronic condition, 39% had no chronic conditions (includes pediatrics).

Insurance 93% Commercial or other insurance, 15% Medicare FFS.



	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
# of Referrals Per Month	29	68	51	125	97	64	93	126	83	130	119	101
# of Clients Served *	28	65	47	125	96	63	91	125	83	130	119	100
# of Unique Practices Referring	12	18	18	26	25	21	25	28	23	26	27	26
# of Unique Providers by Practice Referring	20	36	19	26	51	40	55	63	50	61	59	55
Goal	63	63	63	63	63	63	63	63	110	110	110	110

	UM BWMC – The One Call Care Manager works with primary care offices and hospital liaisons to market and increase patient referral volumes. The services provided are similar to AAMC. The BATP hospitals worked together to build the One Call Care Management functionality in Epic so that recording and tracking of types of services can be reported across the partnership. Detailed service reporting will be available for UM BWMC in early FY19. 90% of patients had any chronic condition, 10% had no chronic conditions 91% Commercial or other insurance, 22% Medicare FFS 

	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
# Referrals Per Month	27	28	26	28	18	23	34	41	16	43	38	42
# Clients Served	24	24	23	25	17	20	32	39	13	33	27	41
# of Practices Referring	7	6	7	7	6	8	8	10	6	11	9	14
# of Providers Referring	9	14	14	14	11	15	14	21	9	21	18	20

Successes of the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	The AAMC One Call Care Management service, staffed by 1.5 FTE's, received 1,086 referrals from 160 unique Primary Care Providers representing 50 unique practices. This volume is up from 388 referrals in FY17 (a 9-month service for that year), an increase of 242% for a 9-month period. AAMC Collaborative Care Network (CCN) provides training via online modules to their primary care providers, with continuing education credits for many of the tools and services developed as part of the regional partnership. The UM BWMC One Call Care Management service which started in May 2017, is staffed by 1.0 FTE, received 364 referrals (for 318 patients) from 20 unique Primary Care Providers representing 14 unique practices in FY18. The UMBWMC OCCM works closely with all hospital and community care managers, transitional nurse navigators, Care Alert authors and county partners to assess and coordinate care and services.
Lessons Learned from the Intervention in FY 2018	A key factor in developing this service was not only educating primary care providers and practices but also incorporating standard questions into their daily patient conversations to assist with identifying non-medical needs and offering the service. This is an ongoing process with frequent reminders and

	office visits needed. Providers are not accustomed to being able to call a single number for any non-medical need. Once they adopt the behavior, they use the service consistently. Having hospital and community care managers using the same charting practices (Care Team, Care Alerts, Care Plans) in Epic enables collaboration and assists in avoiding duplication of services. One Call Care Management was designed to 'coordinate the coordinators' and is a key factor in avoiding duplication of effort and notifying current care managers if their patients need additional attention. The One Call Care Management Service has proven engagement rates, provides a la carte services for patients who do not need full community care management, and refers to our other regional partnership services as needed. We need to capture gaps in current services and services that are not available as discrete data, so that we have data to assist in prioritizing patient needs and backing our requests for expanded or new services.
Next Steps for the Intervention in FY 2019	Continually educate PCP's and staff on the ease of access and benefits of the service. Configure Epic to capture missing services and gaps in existing services, so that we can quantify and advocate for new or improved services based on patient need.

Intervention Program – Patient Panel Coordinators (AAMC)

Intervention/Program Name	Patient Panel Coordinators (AAMC)
RP Hospitals Participating in Intervention	Anne Arundel Medical Center
Brief description of the Intervention *2-3 sentences*	Patient Panel Coordinators (3.5 FTE's) assisted 12 primary care offices and with 8,861 patients and over 13,000 interventions by using dashboards to identify gaps in care or opportunities to control key health maintenance factors, including Diabetes (A1C and retinopathy screening), mammography screening and influenza vaccines.
Participating Program Partners	This service supports primary care providers who belong to the AAMC Collaborative Care Network. The patient panel coordinators also have an opportunity, when speaking with patients, to identify non-medical needs and can refer them to the One Call Care Management service.

Patients Served	# of Patients Served as of June 30, 2018: **8,861**
	Denominator of Eligible **Population**: 550,445 All Payer Population from CY2017 RP Analytic File Denominator of Eligible **Patients**: 179,772 All Payer Patients from CY2017 RP Analytic File Since this is an AAMC only intervention, the RP Analytic File denominators overstate the population by a significant amount. BATP denominator of Eligible Patients: 80,000 Those attributable to the CCN offices served by the Patient Panel Coordinators.
Pre-Post Analysis for Intervention	Not applicable

Intervention-Specific Outcome or Process Measures

Health Maintenance Measure	July 2017	April 2018
Diabetes: Hemoglobin A1c Poor Control Goal is for the percent of current diabetic patients age 18-75 with no A1c in past 12 months, or latest A1c is >9% to be less than 20%	3 of 12 offices had achieved goal	11 of 12 offices have achieved goal
Screening for Diabetic Retinopathy Goal is for the percent of current diabetic patients age 18-75 with a retinal exam in FY 18 or a negative retinal exam in FY 17 to be greater than 60%	4 of 12 offices had achieved goal	11 of 12 offices have achieved goal
Screening Mammography Goal is for the percent of female patients age 50-74 who had a mammogram between 3/3/16 and 7/1/18 to be greater than 80%	3 of 12 offices had achieved goal	11 of 12 offices have achieved goal
Influenza Vaccine Percent of patients age 6 months and up seen in last 12 months who have a flu vaccination between 8/1/17 and 3/31/18 to be greater than 80%	Measurement period August 2018-March 2019	11 of 12 offices achieved goal

Successes of the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	Key factors in the success of this intervention included: - Integrating the PPC's into practices to establish rapport and develop a team approach with providers and office staff. - Standardizing quality metric dashboards and processes. - Performing workflow analysis and redesign - Incorporating quality assurance of key data points - Training staff on efficient, accurate data entry that fits into their daily workflow.
Lessons Learned from the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	- Data quality is essential. Data analysis and clean-up are required as an initial step to ensure that dashboards accurately reflect patient. - Workflow and data quality analysis are essential to identifying and correcting processes that prevent timely, accurate data entry into the EHR.

Next Steps for the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	The PPC model, process and dashboards are standardized, allowing office staff from the original 12 offices to now take over maintenance and outreach to patients, while the PPC's move on to an additional 11 practices in FY19. Continue to utilize the CRISP PaTH reports and EPIC High Utilization List to identify patients appropriate for referrals to One Call Care Management, Behavioral Health Navigators and community care management services. Work with the Pulmonary Disease Navigation team to enroll COPD patients in outpatient education to prevent avoidable admissions.

Intervention Program – Integrated Behavioral Health in Primary Care

Intervention/Program Name	Integrated Behavioral Health in Primary Care
RP Hospitals Participating in Intervention	Anne Arundel Medical Center UM Baltimore Washington Medical Center
Brief description of the Intervention *2-3 sentences*	UMBWMC (through UM CMG) has 2 psychotherapists, a psychiatrist and an administrative assistant who provide services to patients from six (6) primary care clinics. AAMC has built a model for incorporating a 1.0 FTE LCSW into the primary care setting. Both models receive referrals from primary care providers and provide therapeutic counseling (and med management in the case of UMBWMC).
Participating Program Partners	Our behavioral health resources keep up-to-date lists of community resources and refer to them as part of their services. Resources include everything from additional mental health counseling and psychiatry for med consults, housing, substance abuse support, family support, etc.
Patients Served	# of Patients Served as of June 30, 2018: **789** AAMC: 180 (1.0 FTE) UM BWMC: 609 (4.0 FTE's)
	Denominator of Eligible Patients: 550,445 CY2017 RP Analytic File All Payer population The majority of the patients who receive behavioral health therapeutic services within the primary care setting from these programs do not have notable prior utilization of emergency or inpatient services.

Pre-Post Analysis for Intervention (optional)	The patients being referred to this service have little or no prior hospital utilization (rising risk), therefore pre/post is not a meaningful tool. CRISP is developing a way to track high utilizer pool movement over time (how many patients are moving into and out of the HU pool). If we can compare our panels for rising risk patients to the ever-changing set of high utilizers, we will be able to track whether those who received interventions avoided becoming high utilizers.
Intervention-Specific Outcome or Process Measures (optional)	The AAMC Centreville Clinic, with 1.0 FTE embedded social worker, tracks behavioral health visits per month and unique patients per month. During the last 6 months of FY18 the number of visits increased an average of 51% over the same period in FY17. Centreville Family Medicine BH Visits • FY17 Visits: 271 • Annual Goal: 300 unique patients • Unique Patients: 101 • FY18 Visits: 1,082 • Unique Patients: 226 The UM CMG Behavioral Health staff also track number of encounters and unique patients per month. This fiscal year they reported: • FY18 Visits: 3,348 • Unique Patients: 609 • No-show rate: 10% (very low)
Successes of the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	AAMC Built a successful, sustainable model for incorporating an LCSW into a primary care setting, with the cost of the service being covered by accounts receivables within 6-8 months. The cost of the service has been absorbed by the clinic, which has enabled an additional LCSW to be hired and expansion of the program to additional clinic(s) in FY19. Improved access to care on the Eastern Shore for Mental Health and Substance Use. Established comprehensive treatment plans containing integrated behavioral health and medical components. UM BWMC Patients and PCPs continue to report satisfaction with the quality and impact of care by both the psychotherapists and psychiatrist. A low 10% no-show rate
Lessons Learned from the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	Integrated behavioral health in primary care intervention is a valued service by both PCP's and patients alike, as indicated by the use of the service by providers, and patient satisfaction surveys, which are highly positive. The patient population tends to be patients with no or little prior utilization, making outcome measurement difficult. We are looking forward to the tool CRISP is developing to track the pool of high utilizers over time, so that we can compare patients who have

	received services, to determine whether we are keeping them from becoming high utilizers.
Next Steps for the Intervention in FY 2019	AAMC - Expand the LCSW in Primary Care pilot to an additional clinic(s). - Implement Primary Care Provider-to-Psychiatrist med consults with behavioral health prescriber (pilot). - Document reduction of re-admission to ED - Starting in May 2018, we began administering PHQ-9 and GAD-7 upon admission, again at the 4th visit, and at discharge. We track the results and monitor progress. UM BWMC - Continue serving six (6) clinics with the psychotherapists and psychiatrist, with full schedules. - Discussion has begun to evaluate the sustainability of the integrated behavioral health model in primary care and reallocate BATP resources to BH Peer Counselors for patients with High Risk Care Plans. Implementation projected for FY20 using FY19 to assess feasibility. - Examine ED High Utilizer population and integration of behavioral health support models. - Measure patient satisfaction

Intervention Program – Behavioral Health Navigators (AAMC)

Intervention/Program Name	Behavioral Health Navigators (Emergency Department) Behavioral Health Navigator (Community)
RP Hospitals Participating in Intervention	Anne Arundel Medical Center
Brief description of the Intervention	The *Community* Behavioral Health Navigator receives referrals from PCP's whose patients have requested or agreed to have a navigator assist them in finding behavioral health services in the community. About 35% of all calls to the One Call Care Management service are for behavioral health assistance. The *ED* Behavioral Health Navigator receives referrals from both ED and Inpatient providers. The behavioral health navigators establish relationships, workflows and referral processes with community partners. They create training material for PCPs, including patient-facing brochures with insurance and referral sources. Their primary role is to speak with patients, evaluate their need and align them with services that match their insurance, timeline, therapy and medication needs.

<table>
<tr><td>Participating Program Partners</td><td>14 behavioral health counseling and psychiatry centers throughout the BATP service areas.</td></tr>
<tr><td rowspan="2">Patients Served</td><td># of Patients Served as of June 30, 2018: 669

Community BHN: 638 referrals with 351 patients served

ED/Inpatient BHN: 607 referrals with 318 patients served</td></tr>
<tr><td>Denominator of Eligible Population: 550,445
CY2017 RP Analytic File, All Payer.
The RP Analytic File over states the eligible patients here because it includes all zip codes for both AAMC and UMBWMC, and this is an AAMC intervention only.

BATP Denominator For ED BH Navigator: 79,262
CRISP Patient Total Hospitalizations (PaTH) report, filtering on AAMC, All patients, All payer in FY18.

For Community BH Navigator: 179,000 (approximate)
Since referrals to the Community BH Navigator come from Collaborative Care Network (AAMC's integrated care network) PCP offices, the denominator for this population is all patients who see providers who are part of the CCN.</td></tr>
<tr><td>Pre-Post Analysis for Intervention (optional)</td><td>Since patients are referred to the Community Behavioral Health Navigator from primary care, the referrals are not related to hospital utilization, and most do not have notable previous utilization. Therefore, pre/post is not an effective tool for measuring efficacy for the Community BH Navigator. Instead, we track # of referrals and provide 30, 60 and 90-day follow-up calls.</td></tr>
<tr><td colspan="2">Intervention-Specific Outcome or Process Measures</td></tr>
<tr><td colspan="2">ED/Inpatient Behavioral Health Navigator Metrics FY18
<table>
<tr><th>Referrals</th><th>Insurance</th><th>Age</th></tr>
<tr><td>Attempted Contact: 607

Had contact with:318 (52%)

Accepted Assistance: 260 (82%)

Declined Assistance: 66 (21%)</td><td>Commercial : 244 (40%)

Medicare: 100 (16%)

Medicaid: 195 (32%)

Other: 23 (4%)

Uninsured: 45 (7%)</td><td>0-17: 143 (24%)

18-64: 399 (65%)

65+: 65 (11%)</td></tr>
</table>
The Community Behavioral Health Navigator assisted 318 patients in FY18, with an average of 65 referrals per month.</td></tr>
<tr><td>Successes of the Intervention in FY 2018
Free Response, up to 1 Paragraph</td><td>Redesigned the hospital referral process and charting, to ensure appropriate patients were referred and that they had agreed to the service. This change</td></tr>
</table>

	allowed the BH Navigator to spend time with the patients who need and want assistance. Developed and maintain a behavioral health community resource brochure for providers and patients, with explanations of what a counselor provides and what a psychiatrist provides. The brochure is also a quick-reference, by insurance type (Medicare, Medicaid and Private) with phone numbers and locations. PCPs can use the brochure and patients can reach-out directly to the services, or the BH navigators can assist. Created training videos explaining both community and ED navigator services, for use in Collaborative Care Network continuing education modules.
Lessons Learned from the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	One of the most important improvements to the ED/Inpatient Behavioral Health Navigator service in FY18 was to adjust the referral process, adjust the Epic configuration, and reeducate referring clinicians on the process for evaluating patient need, obtaining approval and referring to the service. These changes resulted in more relevant referrals, higher efficiency and better communication between referral source and the service. The service reaches primarily commercial payer patients, with 65% of them between the ages of 18 and 64. 11% are 65 years or older, 24% (143) were pediatric referrals.
Next Steps for the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	Provide additional education to outpatient providers about outpatient mental health and substance use treatment in the community and mental health assessments in the ED. Collaborate with AAMG Outpatient Mental Health Clinic and Eastern Shore Psychological Services.

Intervention Program – Skilled Nursing Facility Collaborative

Intervention/Program Name	**Skilled Nursing Facility Collaborative**
RP Hospitals Participating in Intervention	Anne Arundel Medical Center UM Baltimore Washington Medical Center
Brief description of the Intervention *2-3 sentences*	The SNF Collaborative, facilitated by the AAMC Post-Acute Care Manager and UMBWMC Transitional Nurse Navigator SNFs, brings *all* SNF partners, including corporate, medical directors, administrators and directors of nursing and CRISP together for quarterly on-site meetings at the hospitals, to discuss workflow, communication, challenges and opportunities to improve care and reduce avoidable utilization.
Participating Program Partners	Participants include corporate and facility administrators, directors of nursing, medical directors and hospital liaisons from:

	Communicare (Corporate, Marley Neck, South River) Crofton Care & Rehabilitation Fairfield Nursing Center FutureCare (Corporate, Chesapeake, Irvington) Genesis (Corporate, Corsica Hills, Severna Park, Spa Creek, Waugh Chapel) SAVA (Corporate, Heritage Harbour, North Arundel) Adfinitas Hospice of the Chesapeake CRISP Optum Ginger Cove Signature Health Additional attendees include: Anne Arundel County Dept of Aging & Disabilities The Coordinating Center Lifespan
Patients Served	# of Patients Served as of June 30, 2018: This intervention is population-based, with AAMC and UM BWMC having discharged approximately **7,360** patients to any SNFs in FY18. We do not measure outcomes on a more granular level but look at reducing PAU for the entire SNF population and use per SNF metrics as well. All SNF patients will benefit from the progress we make in process improvements around care coordination, education and setting expectations, ultimately looking to reduce PAU and improve patient experience.
	Denominator of Eligible Patients: 66,961 CY2017 RP Analytic File, All Medicare FFS patients
Pre-Post Analysis for Intervention (optional)	Currently not applicable. The scope of work for the collaborative is to improve processes, care coordination, communication between hospitals, Skilled Nursing Facilities, community care management and other community partners, patients and families. If we pilot a specific intervention we may measure it with pre-post.
Intervention-Specific Outcome or Process Measures	SNF Risk-Adjusted Readmissions, LOS and Charges Report (using HEDIS risk measures), available from CRISP MADE CCLF tool. The reports include: # of patients discharged to each SNF FY16 baseline and FY17 quarterly risk-adjusted 30-day readmissions, Average SNF payment and average length of stay. Star ratings
Successes of the Intervention in FY 2018	Hosted quarterly in-person meetings with consistent attendance and participation from 14 SNFs as noted above as Participating Partners.

Free Response, up to 1 Paragraph	We identified numerous issues between and within the hospital and the skilled nursing facilities that contribute to PAU and are developing workgroups to address as described below in next steps. Our post-acute and project management resources provided input to CRISP and hMetrix development of risk-adjusted (HEDIS) average SNF readmissions, LOS, and payments. FY16 baseline and FY17 quarterly reports were delivered in 4QFY18. This new capability gives us an apples-to-apples comparison for the first time, which we have shared with each SNF Collaborative participant to help them understand how their performance compares to their peers. With this data we can focus on learning from those with lower relative LOS's and readmissions. CRISP has also provided these reports on their Medicare CCLF reports under the 'monitoring' tab.
Lessons Learned from the Intervention in FY 2018	The initial quarterly meetings focused on identifying educational opportunities (hospital to SNF and SNF to hospital), inviting guest speakers, providing updates on care management and other BATP initiatives. We learned over the past year through break-out sessions and around-the-room discussions that it is most productive to work together on problem identification and prioritization for work that should reduce PAU and increase patient and family education and satisfaction. Data analytics is key to: a) understanding and comparing SNF performance and learning together from that performance. b) tracking real-time SNF readmissions to analyze and act on educational opportunities. We can now do the former, thanks to CRISP and hMetrix. We are awaiting the new PROMPT tool (data and filtering) to be able to do the latter in 2QFY19. Initially, we spent time on educating SNFs on definitions and calculations for readmissions and LOS, and asked them to provide monthly information to our post-acute contacts at the hospitals. This approach did not work as the calculations were not consistent and it was difficult with the SNF limited resources. Even if they had reported, it would not have been risk-adjusted across SNFs. CRISP, who participates in the SNF Collaborative, developed reports with hMetrix to solve this vitally important problem.
Next Steps for the Intervention in FY 2019	Pilot projects in FY19 to address priorities identified in FY18: a) Setting and managing patient and family expectations regarding the type and level of care they receive in the hospital versus the appropriate type and level of care they will receive in the SNF, and why that is appropriate as they move from one setting to the other. b) Improving data and communication during and after transitions of care.

	c) Standardizing our vocabulary and communication with patients and families (deliver the same message regardless of care setting). d) Identifying the right level of care for the patients and operationalizing those findings. e) Improve hospital discrete charting of SNF location on admission and discharge. Once this data is accurate and reliable within the ADT messages, we can pilot using ENS PROMPT to see, by SNF, which patients were readmitted to any hospital and why, in real-time, so that our post-acute resources at the hospitals can quickly identify opportunities to reduce PAU and examine process improvement opportunities. f) Primary Care Offices and Community Care Managers need a streamlined way to track SNF patient movement (hospital and SNF discharges). Our BATP Project Manager and Post-Acute Care leads have worked with CRISP over the past year to provide use cases and PROMPT data/tool analysis to represent this need. CRISP is in development to identify SNF ADT messages and applying LTC/SNF designation to them, which allows us to explicitly filter on SNF messages in our ENS feeds. We plan to evaluate the new ENS PROMPT tool and data in 2QFY19.

Intervention Program – Joint Patient and Family Advisory Council

Intervention/Program Name	Joint Patient and Family Advisory Council
RP Hospitals Participating in Intervention	Anne Arundel Medical Center UM Baltimore Washington Medical Center
Brief description of the Intervention	A council of patient and family advisors from both hospitals, formed as part of the original planning grant, to whom the hospitals and community partners take their toughest problems regarding how to improve the explanation and acceptance of BATP programs for patients and families.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	AAMC Patient and Family Advisors and PFAC Lead UM BWMC Patient and Family Advisors and PFAC Lead
Patients Served	# of Patients Served as of June 30, 2018: The Joint PFAC 'enhancements' to our interventions are not counted separately from the individual intervention results. The benefits of this advisory group reach all patients our interventions touch.
	Denominator of Eligible Patients: 550,445 CY2017 RP Analytic File, All Payer Population for BATP

Pre-Post Analysis for Intervention (optional)	Not applicable
Intervention-Specific Outcome or Process Measures (optional)	The Joint Patient and Family Advisory Council feedback influences and improves the delivery and acceptance by patients and families of BATP interventions. Therefore, their work directly impacts the outcome and process measures for each intervention.
Successes of the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	The Joint PFAC Advisory Council evaluated BATP programs, approaches, marketing material, scripts for bedside and care management engagement, and suggested changes to streamline and simplify the message to engage patients and families.
Lessons Learned from the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	Patients who will not permit community care management to go to their homes are often doing so because: a) concern for privacy, b) they are worried that they will be asked to move, c) their home is their only controlled, safe environment from their medical and non-medical challenges, d) they are homeless, e) embarrassed by home environment or family, f) do not believe that the service(s) will help them, g) believe that going to the ED is the right thing to do and normal for their condition h) have PCPs and/or home health who direct them to go to the ED. Simplification of wording is key to engagement. The hospitals should not review numerous programs as it is confusing to the patient and families. Focus on the patient goals and problem(s) that need to be solved, and how hospital services will help, who will be in touch and when, and make sure that the caregiver is included in the conversation and plans as appropriate.
Next Steps for the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	Reconvene with new PFAC leadership from both hospitals and plan FY19 activities.

Intervention Program – Collaborative Care Network (AAMC)

Intervention/Program Name	Collaborative Care Network (CCN)
RP Hospitals Participating in Intervention	Anne Arundel Medical Center
Brief description of the Intervention	The Collaborative Care Network is Anne Arundel Medical Center's integrated care network. As part of the broader scope of a fully integrated care network, the CCN is responsible for planning and implementing the BATP tools and service offerings throughout the network of Primary Care Providers and Specialists, which link them with our community services.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	The CCN works with primary care and specialist offices. In FY18 CCN membership included 89 practices, 729 providers with 103,000 attributed patients.
Patients Served *Please estimate using the Population category that best applies to the Intervention, from the CY 2017 RP Analytic Files.* *HSCRC acknowledges that the High Utilizer/Rising Risk or Payer designations may over-state the population, or may not entirely represent this intervention's targeted population.* *Feel free to **also** include your partnership's denominator.*	# of Patients Served as of June 30, 2018: **16,101** (2,512 unique patients touched by any AAMC intervention + 13,589 patients assisted by Patient Panel Coordinators) Since the CCN is responsible for implementing all BATP programs and services, the number of patients served would be 'all patients' served by any intervention (regardless of whether the patients had PCPs in the CCN). This numerator represents all patients who received any BATP service for AAMC in FY18.
	Denominator of Eligible Patients: 550,445 CY2017 RP Analytic File, All Payer Population (over-states the population as RP file is combined hospital zip codes and the CCN is an AAMC only). BATP (AAMC) Denominator of Eligible Patients: 103,000 This is an AAMC intervention only. This denominator represents the approximate number of patients who are served by providers who are part of the Collaborative Care Network.
Pre-Post Analysis for Intervention (optional)	Not Applicable
Intervention-Specific Outcome or Process Measures (optional)	The CCN work has a direct impact on the number of our patients who have and who are actively engaged with their PCPs through community care management outreach, One Call Care Management outreach, behavioral health navigator and LCSW in primary care outreach and other services.

	The CCN was responsible for the service planning, communication, training and management of Shared Care Alerts content, Patient Panel Coordinator program, Secure Texting for PCP's. The outcome and process metrics for those services is a direct result of leadership and management of the content and integration of the BATP tools and services by the CCN into the practices. Please see separate interventions for key measures.
Successes of the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	- Developed CE-based training modules and material for PCP's about BATP services (One Call Care Management, Shared Care Alerts, Shared Care Plans, Secure Texting, Behavioral Health Navigators) - Developed and implemented six (6) Integrated Care Pathways: New Type 2 Diabetic, Colorectal Cancer Screening, Behavioral Health, Smoking Cessation, Acute Urinary Retention, and Peri-procedural Management of Antithrombotic Agents. - Achieved 93% quality score in ACO and 100% on MIPS. - Connected 72% of practices on CRISP Tier 3. - Developed dashboard to track performance. - Prepared PCPs for success in the Maryland Primary Care Program. - Developed and launched Integrated Care Pathway website. - Established population health management competencies at practice level with Patient Panel Managers. - Met all quality goals through collaboration of Patient Panel Managers and practices. - Doubled number of practices referring to One Call Care Management. - Engaged 88% of members in practice transformation. - Launched All Member meetings. - Hosted 3 practice transformation learning collaborative events. - Circulated monthly newsletters and created the CCN website.
Lessons Learned from the Intervention in FY 2018 *Free Response, up to 1 Paragraph*	Involve end-user representatives and BATP intervention/service providers while developing training material. Regularly update training documentation and communication based on lessons learned from the BATP service providers. Include both in-scope and out-of-scope information when developing a service offering, to help manage provider and patient expectations. It is important to include specialists in the delivery of coordinated, collaborative care. Communication between all specialties is necessary to coordinate care and improve patient outcomes.
Next Steps for the Intervention in FY 2019 *Free Response, up to 1 Paragraph*	The CCN is leading the MD Primary Care Program (MD PCP) initiative as a Care Transformation Organization (CTO) through which the

	BATP services (and expansion/additions) will be implemented for Medicare FFS patients. New use cases for cross-organizational communication (such as Psychiatrist consults for PCPs and others) are developed and tested through the CCN partnerships. This will continue as our providers and community partners identify additional areas of opportunity.

Core Measures

Please fill in this information with the latest available data from the in the CRS Portal Tools for Regional Partnerships. For each measure, specific data sources are suggested for your use– the Executive Dashboard for Regional Partnerships, or the CY 2017 RP Analytic File (please specify which source you are using for each of the outcome measures).

Utilization Measures

Measure in RFP *(Table 1, Appendix A of the RFP)*	**Measure for FY 2018 Reporting**	**Outcomes(s)**
Total Hospital Cost per capita	**Partnership IP Charges per capita** Analytic File: 'Charges' over 'Population' (Column E / Column C)	All Payer Total Charges / BATP Population 1,479,211,949.89 / 550,445 $ 2,687.30
Total Hospital Discharges per capita	**Total Discharges per 1,000** Analytic File: 'IPObs24Visits' over 'Population' (Column G / Column C)	110
Total Health Care Cost per person	**Partnership TCOC per capita – Medicare** Total Cost of Care (Medicare CCW) Report 'Regional Partnership Cost of Care': 'Tab 4. PBPY Costs by Service Type' – sorted for CY 2017 and Total	$ 2,592
ED Visits per capita	**Ambulatory ED Visits per 1,000** Analytic File 'ED Visits' over 'Population' (Column H / Column C)	All Payer (ED Visits / Population) * 1000 (183,571 / 550,445) * 1000 333

Quality Indicator Measures

Measure in RFP *(Table 1 in Appendix A of the RFP)*	**Measure for FY 2018 Reporting**	**Outcomes(s)**
Readmissions	**Unadjusted Readmission rate by Hospital** (please be sure to filter to include all hospitals in your RP) Executive Dashboard: '[Partnership] Quality Indicators' – Unadjusted Readmission Rate by Hospital, reported as average 12 months of FY 2018 -or- Analytic File: 'IP Readmit' over 'EligibleforReadmit' (Column J / Column I)	3+ IP or Obs>24 Visits Medicare FFS 1463/4527 = 32.31% Medicare FFS 2064/14434 = 14.3% All Payer 5229/44859 = 11.65%
PAU	**Potentially Avoidable Utilization** Executive Dashboard: '[Partnership] Quality Indicators' – Potentially Avoidable Utilization, reported as **sum** of 12 months of FY 2018 -or- **Analytic File**: 'TotalPAUCharges' (Column K)	3+ IP or Obs Visits Medicare FFS $ 36,352,178.29 Medicare FFS $ 66,620,906.94 All Payer $ 155,866,327.30

CRISP Key Indicators (Optional)

These process measures tracked by the CRISP Key Indicators are new, and HSCRC anticipates that these data will become more meaningful in future years.

Measure in RFP *(Table 1 in Appendix A of the RFP)*	**Measure for FY 2018 Reporting**	**Outcomes(s)**
Established Longitudinal Care Plan	**% of patients with Care Plan recorded at CRISP** Executive Dashboard: 'High Needs Patients – CRISP Key Indicators' – % of patients with Care Plan recorded at CRISP, reported as average monthly % for most recent six months of data *May also include Rising Needs Patients, if applicable in Partnership.*	BATP community care managers write patient goal(s) (Care Plans) for each patient they provide services to. In FY18 that equates to 1,401 patients. BATP Care Plans (**patient goals**) are sent to CRISP via CCDs for patients who have community care managers. However, the work for CRISP to recognize and count the Care Plans in the Executive Dashboard under Key Indicators is pending.
Portion of Target Population with Contact from Assigned Care Manager	**% of patients with Contact from Assigned Care Manager** Executive Dashboard: 'High Needs Patients – CRISP Key Indicators' – % of patients with Case Manager (CM) recorded at CRISP, reported as average monthly % for most recent six months of data *May also include Rising Needs Patients, if applicable in Partnership.*	CRISP shows 27.8%, but that is not correct, as the integration work to recognize and count Care Managers and Care Plans (patient goals) from Epic to CRISP is pending. We know from our intervention process measures and charting practices, that all patients who had at least an initial care management visit, total 1,221 for the hospitals in FY18.

Self-Reported Process Measures

Shared Care Plans are being created for all patients with a community care manager. Shared Care Plans are recorded as 'patient goals' under the longitudinal plan of care in the hospital Epic systems. The plans are shared in two ways; the hospital and community care managers chart in the same Epic system, and the plans are also sent to CRISP. Although this information is sent in the continuity of care documentation each time a care manager closes an outreach encounter, the work to recognize the goals and count them toward having a care plan in the CRISP Executive Dashboard is pending.

Secure texting is also an important tool for our partnership. We supplement Care Alerts to let care teams know (this is who I am, this is what I do for the patient, you can securely text me for this type of assistance). We track # of providers and staff and # and types of organizations using secure texting, and their use cases.

Return on Investment

Indicate how the Partnership is working to generate a positive return on investment. Free Response, please include your calculation if applicable.

1. For those interventions where we are targeting referring patients with prior utilization, we use the CRISP Pre/Post reports to assess the change in utilization and charges prior to and after the date we applied an intervention. For ROI on a per intervention basis, we determine which time period (1,3,6 or 12 months) is most applicable to the panel. Then we take the difference in total charges pre and post divided by 2 (50%) to represent variable cost. We then subtract the cost of the intervention, and divide the result by the cost of the intervention.

   ((Change in Total Charges divided by 2) - cost of intervention) / (cost of intervention)

2. For behavioral health interventions, if there is billing associated with the intervention, we determine whether the payments received from the intervention exceeded the cost of the intervention. This applies to the Behavioral Health in Primary Care initiatives.

3. For interventions where patients have no or little prior utilization, we do not have a good method of determining return on investment from a utilization perspective. It is our understanding that CRISP is working on a tool to allow us to track our high utilizer pool of patients (and movement of patients into and out of that pool). We could then compare the panels of patients to the high utilizer cumulative pool to determine whether their utilization remained below high utilizer metrics. We are interested in learning how others are showing ROI for this population.

Conclusion

When we started our regional partnership journey, we estimated that our programs could reach 800 high utilizer Medicare FFS patients in year 1, 1260 in year 2, increasing to 2,307 high utilizers in year 3 (adding some all payer) and finally reaching 2,953 all payer high utilizers in year 4. We are pleased with the results of year 2, not just in terms of number of all payer unique patients we have assisted (2,512 AAMC, 1,930 UMBWMC), but in terms of the ever-growing relationships and collaboration across interventions and across organizations. Our teams are constantly striving to study and improve their processes and increase efficiencies and documentation. They are learning about the boundaries and constraints of the services available in the communities and will use that knowledge to guide providers and patients, and to request expansions to and additions of new services. For example, transportation (in particular across county lines) and respite care to help caregivers are two of the most highly requested, but difficult to provide, services.

While we continue to adjust how we learn about progress using data analytics for both process and outcome metrics per program and across programs within our own partnership, it would be of **great benefit** to have statewide, nationwide and regional partnership-wide data and information to learn and compare on a broader scale. HSCRC has guided the partnerships in working toward standardization of reporting, and each year we have better, more meaningful data from CRISP to help in assessing program efficacy. As we move into year three of the grant, our collaboration tools and services are established, and outcome measurement is improving. Moving forward, the following items would be most helpful, as we strive to improve, compare and adjust programs:

- HSCRC Consolidated Report: A cross-partnership summary of like services that examines success stories, lessons learned, accomplishments, what's working, what is not, to inform strategy for adjusting our programs and portfolio. Community care management services are of particular interest.
- Regional Partnership work versus overall Population Health: How do we show the value of the programs and then tie that to the overall improvement for total population health and TCOC reductions? Programs = panels. Population Health (full population) = high level metrics.
- Help with Control Groups using statewide data and logic: Partnerships struggle with defining control groups, and if we tackle the problem individually it will not be consistent. Could HSCRC and CRISP assist by providing the ability to load a panel of patients for whom our interventions have touched, and generate a control panel?
- Growth of High Utilizer Pool and comparison to panels: We need to understand the movement of patients into and out of our high utilizer pools across time (what is the growth rate, how many are new, how many died, how many are no longer high utilizers) and have the ability to compare our intervention-level panels (with start date of intervention) to the pool).

Thank you for giving us this opportunity to build programs that assist our most vulnerable populations, and for constantly working to improve the data analytics and tools that allow us to measure and monitor progress toward our regional partnership goals.

ADM1.1.91 - Patient Financial Services – Hospital Financial Assistance, Billing & Collection

Dates Previously Reviewed/Revised: N/A **Newly Reviewed By:** F&A 9/2012, BOT 9/2012, HPRC 1/2015 **Approval Date:** 6/2017 **Effective Date:** 7/2017	**Owner:** Director, Patient Financial Services
Approver Title: Chief Financial Officer On file _____ Approval Signature	

Scope: Anne Arundel Medical Center, Inc. (AAMC). Other providers delivering emergency and medically necessary care in AAMC are not covered by this policy.

Policy Statement: To promote access to all for medically necessary services regardless of an individual's ability to pay, to provide a method of documenting uncompensated care and to ensure fair treatment of all applicants and applications.

Purpose:

- To assure the hospital communicates patient responsibility amounts in a fair and consistent manner.
- To provide opportunity to resolve questions regarding charges or insurance benefits paid.
- To assure the hospital meets the requirements of Maryland standards for hospital billing and collection practices.
- To provide opportunity to resolve questions regarding charges or insurance benefits paid.
- To define the hospital's decision making process for referral for collection or legal action.
- To assure the hospital meets the requirements of Maryland standards for hospital billing and collection practices.

Definitions: None

Policy/Procedure:

Hospital Financial Assistance Communications:

- The Financial Assistance Signage is conspicuously displayed in English & Spanish in the Emergency Department, Cashiering & Financial Counseling.
- Financial Assistance Policy as well as a printable Uniform Financial Assistance application is posted on the AAMC website.
- English/Spanish table top tents display this information at every patient entry point and it is included in each patient guide located in the inpatient rooms.

- Registration staff and Financial Coordinators are trained on how to refer patients for financial assistance.

- The financial assistance application is available at all registration points – but in particular the Emergency Department.

- A brochure "What you need to know About Paying for Your Health Services" is available at every patient access point. The brochure was developed by Patient Financial Services with guidance from Public Relations. This brochure includes information regarding financial assistance/contact points and is available in English/Spanish. Also, it is posted on AAMC's website.

- It is mandatory that all inpatients receive the "What you need to know about paying for your health services" brochure as part of the admission packet.

- Informational "business cards" are available through the patient access/registration staff to provide to the uninsured or any individual concerned about paying their hospital bill directing them to the hospital Financial Counseling office for assistance.

- Hospital Patient Financial Service staff receive extensive training on the revenue cycle and are incentivized to obtain AAHAM Technical (CRCS) certification to demonstrate their expertise in billing and revenue cycle requirements.

Financial Assistance:

- A patient's payment for reduced-cost care shall not exceed the amount generally billed (AGB) as determined by the Health Services Cost Review Commission (HSCRC).

- Determination of Probable Eligibility: Within two business days following a patient's request for financial assistance, application for medical assistance, or both, the hospital must make a determination of probable eligibility.

- Once a request for financial assistance has been approved, dates of service twelve months before the approval and twelve months after the approval shall be included in the adjustment. Service dates outside this twenty-four month window may be included if approved by a Supervisor, Manager, or Director of the Patient Financial Services Department.

- AAMC provides 100% financial assistance to individuals with household income at or below 200% of the US Poverty guideline but deemed ineligible for any County, State or Federal Medicaid or other funding program.

- AAMC provides 100% financial assistance to individuals enrolled in a means-tested State or Local program. Patients who provide proof of enrollment in one of these programs do not have to complete an application or submit supporting documentation of income to be approved for financial assistance.

- A patient that has qualified for Medical Assistance (Medicaid) is deemed to automatically qualify for financial assistance under this policy. The amount due from a patient on these accounts may be written off to financial assistance with verification of Medicaid eligibility. Standard documentation requirements are waived.

- AAMC provides a sliding fee scale for individuals with household income at or below 330% of the US poverty guideline but deemed ineligible for any County, State or Federal Medicaid or other funding program. The sliding scale provides 80% financial assistance to individuals up to 230% of the poverty guideline; 60% financial assistance to individuals up to 260%; 40% financial assistance to individuals up to 300%; and 20% financial assistance to individuals up to 330%.

- AAMC provides financial assistance not only to the uninsured but to patients with a demonstrated inability to pay their deductibles, copayments and balance after insurance.

- The hospital excludes assets such as the patient's primary home, method of transportation and cash assets less than $15,000.

- For all income levels, AAMC will take into account special circumstances such as the amount of the bill compared to income and cumulative impact of all medical bills.

- AAMC developed an initiative with the Anne Arundel (AA) County Department of Health to help provide free prenatal diagnostic testing for uninsured unregistered immigrants. These individuals are not eligible for any Medicaid program.

- AAMC participates with an AA County specific program (REACH) administered through the AA County Department of Health to provide free care to low income uninsured or under-insured individuals (below 200% of the US Poverty Guideline). These individuals come to AAMC on an elective basis and are prescreened by the local Department of Social Services.

- Diagnostic and Treatment services are provide free of charge to referrals from the AAMC Outreach Free Clinic initiative located in downtown Annapolis.

- Payment plans are interest-free.

Billing:

Patient Statement of Charges:

- A Summary Bill of charges, formally referred to as the Uniform Summary Bill is mailed to every inpatient within 15 days of discharge from the hospital. This contains information on the insurance company billed as well as how to contact the Patient Financial Services office for questions or assistance.

- Uninsured patients receive this Summary as well.

- Each bill for outpatient services includes detail charge information on the first request for payment.

- At any time, the patient may request a copy of their detailed itemized bill.

- The HSCRC required Patient Billing Information sheet data is printed on the Uniform Summary Bill and the back of all patient billing statements.

- A representative list of services and charges is available to the public on the hospital's website and in written form. The website will be updated quarterly with the most recent average charge per case for each of the services.

- Requests and inquires for current charges for specific procedures/services will be directed to the ACP Financial Coordinator or if applicable the specific department Financial Coordinator. The Coordinator will communicate with the patient and the patient's provider of care to provide the best possible estimate of charges. Using the CPT code, service description and/or other supply/hospitalization time charge estimates are based on, a) review of the charge master for the CPT code/service description, and/or b) review of cost of similar surgical procedures/treatments/hospital stays. The patient will be informed cost quotes are estimates and could vary based on the actual procedure(s) performed, supplies used, hospital stay/OR time & changes in HSCRC rates. If the Coordinator requires guidance or additional information to provide the estimate he/she will contact the Reimbursement Department. Every effort will be made to respond to the request for charges within 2 business days depending on information needed to fulfill the patient's request.

Patient Balance Billing:

- From the point in which it is known that the patient has a balance for which they are responsible the hospital begins billing the patient to request payment.
- Each patient receives a minimum of 3 requests for payment over a 90 day period.
- Each patient bill includes contact information for financial assistance and states where to call to request a payment plan.
- Each bill informs the patient they may receive bills from physicians or other professionals.
- Short and Long term interest free payment plans are available. The hospital takes into account the balance of the bill and the patient's financial circumstances in determining the appropriate agreement.
- Should the patient contact Patient Financial Services Customer Service unit regarding inability to pay – financial assistance is offered and the financial assistance screening process begins.

Collection Agency process:

- If there is no indication from the patient or a representative that they cannot pay and no attempt at payment or reasonable payment arrangements is made, the account is referred to a collection agency.
- The collection agency referral would typically occur between 90 – 110 days from the first request to the patient to pay assuming the patient made no attempt to work out payment arrangements or indicated financial need.
- The final statement to the patient communicates the account will be referred to an external agency if the balance is not satisfied.

Collections:

- The Director of Patient Financial Services oversees the hospital's business relationship with the Collection Agency. The Patient Financial Services Department is responsible for determining that reasonable efforts have been made to determine whether an individual is eligible for financial assistance before initiating extraordinary collection actions (ECAs).
- If a financial assistance application is received within 240 days of the first post-discharge billing statement, and the account is with a collection agency, the agency will be notified to suspend all ECAs until the application and all appeal rights have been processed.
- AAMC does not utilize a credit reporting bureau.
- AAMC does not charge interest to patients.
- The collection agency performs a financial checkpoint before taking the next step to legal action including potential eligibility for financial assistance under this policy.
- AAMC staff reviews each case before being referred for legal action.
- The collection agency is educated on how to make referrals to AAMC's financial counseling department for individuals indicating they have an inability to pay.

- The collection agency will establish payment arrangements in compliance with AAMC's interest free commitment.

- As a last resort, AAMC will file suit for collection of debts.

- If the court makes judgment in the hospitals favor – a formal legal credit mark referred to as a "judgment" is placed on an individual's credit and remains intact for 10 years. Once the full payment is made the patient may request that the judgment reflects as satisfied on the credit rating.

- AAMC will file suit against estates and in some cases, when appropriate, trust funds.

- AAMC does actively enforce a lien against an individual's primary home.

References: Patient Protection and Affordable Care Act statutory section 501 (r)
Department of Treasury, Internal Revenue Service, Additional Requirements for Charitable Hospitals; Volume 77, No. 123, Part II, 26 CFR, Part 1

Cross References: None

Financial Assistance Policy
Plain Language Summary

Financial Assistance Policy

Anne Arundel Medical Center (AAMC) promotes access to all medically necessary services regardless of an individual's ability to pay. AAMC will provide Financial Assistance based on indigence or high medical expenses for patients who meet specified financial criteria and request such assistance. A patient who is eligible for financial assistance will not be charged more than the amount generally billed to other payers.

Eligibility Determination Process

1. Interview patient or a family member
2. Verify all other forms of assistance have been exhausted
3. Obtain annual gross income and supporting documentation
4. Determine eligibility (preliminary eligibility within two business days)
5. If the patient or family members do not disclose the financial information required to make a determination under this policy, standard collection efforts will apply to the patient's account. No Extraordinary Collection Actions (ECAs) will be taken for at least 120 days from the first post-discharge billing statement.
6. All applications received within 240 days of the first post-discharge billing statement will be considered. If ECAs have occurred prior to receiving an application, those ECAs will be suspended until the application for financial assistance is processed.

How to Apply

- Applications can be taken orally by calling 1-443-481-6500
- Patients may apply in person at the Financial Advocacy Office which is located in the Ambulatory Care Pavilion on the first floor of AAMC's main campus between 8:30 a.m. and 4:00 p.m., Monday through Friday
- The Financial Advocacy Office will mail a free copy of AAMC's financial assistance policy and financial assistance application to any patient who requests those documents
- Patients may apply on the internet at http://www.aahs.org/patients-visitors/billing.php
- Applications are available in English and en Español