Anne Arundel Medical Center Collaborative Care Network, LLC
MDCTO-0107
Summary Information

Maryland Primary Care Program, 2018 Application Cycle

CTO Overview

CTO Information	
Application ID Number	MDCTO-0107
Status of the Proposed CTO	The proposed CTO is owned and operated by a healthcare organization and is currently in existence.
Organization Site Name	Anne Arundel Medical Center Collaborative Care Network, LLC
DBA Name	Anne Arundel Medical Center Collaborative Care Network, LLC
Website (if applicable)	https://www.aahs.org/CCN/
Ownership & Legal Structure	
Owned by Health Care Organization	Yes
Name of Parent Organization	Anne Arundel Health System
Legal Structure	Non profit 501: LLC
Service Area	
Counties Served	Anne Arundel County; Prince George's County; Queen Anne's County; Talbot County
Partnerships	
Formal Partnerships	Regional Partnership: Bay Area Transformation Partnership LHIC: Healthy Anne Arundel Coalition HEZ: Annapolis Community Health Partnership Other formal community collaborations: Arundel Lodge Behavioral Health Home, Prince George's County Mobile Integrated Health (with EMS), Queen Anne County Mobile Integrated Health (with Health Dept) - The Coordinating Center (community health workers)
Informal Partnerships	N/A
Services Offered	
Tele-diagnosis	Planned for future
Tele-behavioral health	Planned for future
Tele-consultation	Currently in place
Remote Monitoring	Planned for future
Other	Planned for future
HIT	
CRISP Connectivity	We currently educate and support practices on the use of services from the State-Designated Health Information Exchange (CRISP).; We assist practices in establishing electronic health information exchange with CRISP or a community-based health information exchange network.; We use CRISP to view data.; We send administrative encounter data to CRISP on a regular basis.; We send clinical data (CCDAs or QRDAs) to CRISP on a regular basis.
HIT Vendor	Epic
HIT Product Name	EpicCare Ambulatory

Care Team Members

Category	Currently in place: How many?	Planned for future: How many?
Administrative Support	6	N/A
Behavioral Health Counselor	2	10
Billing/Accounting Support	1	N/A
Care Managers - RNs	1	N/A
Care Managers - Medical Assistants	3	14
Care Managers - LPN or equivalent	1	2
Community Health Workers	5	2
Data Analysts	1	N/A
Health IT Support	1	N/A
Licensed Social Workers	2	2
Nutritionist	N/A	1
Pharmacists	N/A	2
Practice Transformation Consultants	1	N/A
Psychiatrist	2	2
Psychologist	N/A	2
Disease Self-Management Educators	3	2

Vision

Vision Statement: Person-centered medical homes thriving in an integrated medical neighborhood Since 2015, Anne Arundel Medical Center's (AAMC) Collaborative Care Network (CCN) has taken care of patients and providers by supporting and maintaining a well-resourced medical neighborhood of integrated care. Beyond engaging physicians of all types as well as the hospital itself, the CCN has entered into collaborative arrangements with local public and private sector social and medical services, enabling whole-person care. The CCN's history of providing services - particularly to primary care practices - is testimony to both our commitment and expertise. In anticipation of MDPCP, the CCN in 2016 began implementing: 1. "One-Call" Care Management: The "easy button" for community practices to call with concerns about ANY patient, regardless of insurance status, with any social or behavioral health needs 2. Behavioral Health Navigator: Accessed through the "easy button" above, this resource connects patients to treatment for mental illness and/or substance use disorders 3. Community Health Advocates: These health coaches visit patients in their homes, ensuring obstacles to care are addressed and patients and families become better self-managers 4. Patient Panel Coordinators: These highly trained Medical Assistants "scrub" primary care patient and disease registries to identify patients with gaps in care, then solve these gaps collaboratively under the primary care clinicians' guidance. They also arrange for transitional care and help identify patients in need of social services. They are ideal practice-embedded care managers. 5. Practice Transformation Specialist: Sharon Cameron engages clinicians and practice personnel in practice-driven improvement efforts concerning access, quality measures, patient engagement, workflow, care plans, telehealth, and clinician and patient satisfaction 6. Embedded Psychotherapeutic Services: The CCN piloted and now is expanding to interested practices a successful, co-located and integrated behavioral health/primary care program. 7. Integrated Care Pathways: These are the CCN's evidence-based clinical algorithms that are supplemented with defined roles and responsibilities of CCN specialists and ancillary staff to support the primary care practices' patients and reduce unnecessary ED visits and hospitalizations. Six ICPs are already available, with more to come. 8. Medication Therapy Management: We piloted and now are expanding patient- and population-specific approaches to improve patient adherence and help practices meet their quality metrics 9. Chronic Disease Supports: currently for diabetes, pulmonary disease, obesity, tobacco use 10. Data Analysis: Brian McElroy's role is to consume, integrate, and report to practices native as well as externally derived information, e.g. claims, quality, and utilization data. 11. Field Support: Renee Kilroy regularly visits primary care practices to ensure their satisfaction with CCN services and keep them current on developing opportunities and new CCN offerings. Additional CCN resources and supports for our MDPCP practices are in the planning and implementation phase (The Conversation Project, curbside psychiatry consults, nutrition classes, and others). We are responding to the stated needs of our CCN primary care practices. The CCN supports the delivery of advanced primary care. Our work is informed by the practices and patients themselves, recognizing each practice's strengths and supplementing them as needed. We approach the MDPCP enthusiastically as the means to promote our local primary care community's success in driving clinical performance to improve health outcomes for the population we serve.

Approach to Care Delivery Transformation

As a local, multidisciplinary network, the CCN's approach to care delivery transformation is to share data, resources, & opportunities for success in Maryland's Model. We will serve as a CTO for our member primary care practices while we provide aligned opportunities for our member specialty care practices. This approach creates a cohesive & integrated medical community that drives clinical performance to achieve positive outcomes. Since 2016, we've been preparing to be a CTO. We expect each member primary care practice site (employed & independent) will apply this year. Our relationship with these practices is substantial: in addition to providing them necessary resources to support the delivery of advanced primary care, we have oriented them to MDPCP since late 2016, we have assisted them in getting ready for the program, & now we are preparing for their success. In our application, we have indicated numbers of existing & planned CTO personnel. The CTO-related personnel we are providing to our CCN primary care practices as of now are listed & briefly described in our Vision Statement. These EXISTING resources will be scaled up in 2019 & beyond to support all of our participant practices: "One-Call" Care Management, Behavioral Health Navigator, Community Health Advocates, Patient Panel Coordinators, Practice Transformation Specialist, Embedded Psychotherapeutic Services, Medication Therapy Management, Chronic Disease Supports, Data Analysis & IT Support, Admin & Field Support. In addition to these personnel & services, our CTO will provide: Governance (physician-led, with patient input), Integrated Care Pathways, PFAC implementation, Secure texting, CRISP integration (in place), Budget planning, financial projections, Risk stratification, Collaborative agreements with key specialists & social services, Advance care planning training & implementation, Alternative access strategies, Sharing of best practices, & Additional services to meet evolving MDPCP requirements.