STATE OF MARYLAND

Community Health Resources Commission

45 Calvert Street, Annapolis, MD 21401, Room 336

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor
John A. Hurson, Chairman - Mark Luckner, Executive Director

Health Enterprise Zones
Call for Proposals
Cover Sheet FY2013

Applicant Organization:

Name: Anne Arundel Health System

Federal Identification Number (EIN): 52-1169362

Street Address: 2001 Medical Parkway

City: Annapolis State: MD Zip Code: 21401 County: Anne Arundel County

Official Authorized to Execute Contracts:

Name: Victoria W. Bayless E-mail: vbayless@aahs.org

Title: President and Chief Executive Officer

Phone: 443-481-1307 Fax: 443-481-1313

Signature: Victoria W. Bayless Date: 11-14-12

Project Director (if different than Authorized Official)**:**

Name: Patricia Czapp E-mail: pczapp@aahs.org

Title: Chair, Clinical Integration

Phone: 443-481-1306 Fax: 443-481-4749

Signature: Date: 11/14/12

Alternate Contact Person:

Name: Larry Kushner E-mail: lkushner@aahs.org

Title: Director of Advancement, AAMC Foundation

Phone: 443-481-4747 Fax: 443-481-4749

Signature: Larry Kushner Date: 11/14/12

Grant Request:

Project Title: "Reducing Health Disparities: A Creative Dual-Clinic Approach to Improving Access"

Priority Area: X Infant Mortality ☐ Integrated Behavioral Health X New Access ☐ Pediatric Dental
X Information Technology

Amount Requested $ 2,980,718 Beginning Date 1/1/13 Ending Date 12/31/16

STATEMENT OF OBLIGATIONS, ASSURANCES, AND CONDITIONS

In submitting its grant application to the Maryland Community Health Resources Commission ("Commission") and by executing this Statement of Obligations, Assurances, and Conditions, the applicant agrees to and affirms the following:

1. All application materials, once submitted, become the property of the Maryland Community Health Resources Commission.
2. All information contained within the application submitted to the Commission is true and correct and, if true and correct, not reasonably likely to mislead or deceive.
3. The applicant, if awarded a grant, will execute and abide by the terms and conditions of the Standard Grant Agreement (attached).
4. The applicant affirms that in relation to employment and personnel practices, it does not and shall not discriminate on the basis of race, creed, color, sex or country of national origin.
5. The applicant agrees to comply with the requirements of the Americans with Disabilities Act of 1990, where applicable.
6. The applicant agrees to complete and submit the Certification Regarding Environmental Tobacco Smoke, P.L. 103-227, also known as the Pro-Children Act of 1994.
7. The applicant agrees that grant funds shall be used only in accordance with applicable state and federal law, regulations and policies, the Commission's Call

for Proposals, and the final proposal as accepted by the Commission, including Commission-agreed modifications (if any).

8. If the applicant is an entity organization under the laws of Maryland or any other state, that is in good standing and has compiled with all requirements applicable to entities organized under that law.
9. The applicant has no outstanding claims, judgments or penalties pending or assessed against it – whether administrative, civil or criminal – in any local, state or federal forum or proceeding.

AGREED TO ON BEHALF OF, Anne Arundel Health System, BY:
(Applicant Name)

VICTORIA W. BAYLESS CEO

Legally Authorized Representative Name (Please PRINT Name) Title

Legally Authorized Representative Name (Signature) Title

Reducing Health Disparities: A Creative Dual-Clinic Approach to Improving Access
Anne Arundel Health System, November 15, 2012

1. PROGRAM SUMMARY

Just blocks away from the State House in Maryland's capital city of Annapolis, well-documented health care disparities persist in a federally designated medically underserved area (MUA)[1]. Access to culturally proficient primary care is limited for our most vulnerable residents who call that neighborhood home. High rates of perinatal mortality, low birth weights, lack of prenatal care, emergency room utilization, hospital admissions and readmissions, and a high number of medical 911 calls to this MUA all stand as testimony to its unmet health care needs.

Anne Arundel Health System's (AAHS) Health Enterprise Zone (HEZ) plan addresses this MUA's needs by establishing two sites which between them will deliver full-spectrum primary care to this population. All residents of this MUA, including pregnant women, infants, children, the elderly, the disabled, and those who are uninsured, under-insured or have public coverage stand to benefit from these two community-based resources, nestled within their own neighborhood and within walking distance of each other.

The two proposed sites offer complementary services. They are 1) a patient-centered primary care medical home (PCMH) at the Morris Blum public housing building, which is a residence for the elderly and disabled, and 2) a Prenatal Care Center at what is now a free clinic at the Stanton Center, a community facility in the historically African-American Clay Street neighborhood. The sites will be designed and staffed to promote consistent, long-term patient/provider relationships in a culturally proficient manner. This will build on AAHS' earlier experience and success in providing care to the medically underserved in our service area at the Community Health Center (CHC) on Forest Drive, Annapolis. Both the Morris Blum and the Prenatal Care Centers will fully utilize the Epic electronic medical record system (EMR) of AAHS to support continuity of care across all likely service locations.

Global goals of AAHS' HEZ initiative include a) improving birth outcomes, b) improving chronic disease management outcomes, and c) decreasing preventable medical 911 calls, emergency room visits, admissions and readmissions.

2. PROGRAM PURPOSE

To address these global goals, AAHS' HEZ initiative will provide reliable, comprehensive, coordinated care in such a way that it will be accepted and sought out by the community it serves. The PCMH primary care site in the Morris Blum Center will provide care not just to the elderly and disabled residents of the building but to infants, children, and the local underserved adult population. The Prenatal Care Center will provide broad-spectrum services to pregnant women from the earliest possible point in gestation. Both sites will share consistent ancillary support from community-based resources such as social work, nutritional and WIC specialists, behavioral health specialists, dental care, case management, and domestic violence and abuse resources.

Moving away from a haphazard, fragmented, inconsistent free clinic model and establishing true primary care medical homes such as these two integrated sites is key to our success. Recruiting culturally proficient, bilingual clinical staff and employees from the same neighborhood is another essential feature. Installing integrated electronic medical records in both sites serves multiple purposes: a) sharing information among the two sites and the Forest Drive CHC, the hospital, other providers and specialists, b) capturing demographic data to identify and track disparities in care, c) measuring our success in chronic disease management and birth outcomes, and d) providing a patient portal accessible by smart phones and computers at the Stanton Center and the local library so that patients themselves or their families will have access to medical records and a way to contact providers 365 days a year.

Both centers will accept Medicaid/Medical Assistance, PAC (Primary Adult Care), and REACH (REsidents Access to a Coalition of Health) patients, and those without coverage on a sliding scale fee basis. Medicare will be accepted at the Morris Blum location. Any patient who was seen at the free clinic or otherwise is medically homeless can find a medical home at the new Morris Blum Center. Both centers are within two to six blocks of the gold, orange and green local bus routes route.

3. HEZ GEOGRAPHIC DESCRIPTION

In the City of Annapolis, numerous creeks, coves, inlets and marshes render every bit of buildable land precious. The result is a tight mix of high value single family homes and waterfront condominiums within a few blocks of public or subsidized housing, lower value

properties, and commercial strips. In Annapolis, three levels of Maryland government plus non-profits, businesses and residents can attest to this. However, publicly available data -- Census 2010, the American Community Survey, HUD data – no longer has the detail to support what most residents, workers and visitors casually observe. Statistical data may not adequately describe the level of need in zip code 21401 because of very high incomes and property values in some areas that offset low incomes in other areas, but the need is readily apparent neighborhood by neighborhood, block by block.

4. COMMUNITY NEEDS ASSESSMENT

Annapolis has the fourth highest percentage of public/subsidized housing units in Maryland. These units are tucked away in pockets of the city, segregated from and not seen by the rest of the population. Within these neighborhoods, access to nutritious food and safe streets let alone adequate health care is challenging. In the census tract block group where the prenatal care clinic is proposed, the percentage of residents classified as low to moderate income (LMI - at or below 80% of median family income) is 92.5% and 667 of the 730 residents are African American. That census tract also has been identified as having three of eight County infant health risk indicators: 1) 12.1% low birthweight births *(County 8.3%)*, 2) 4.3% late or no prenatal care *(County 2.6%)*, and 3) 18.7% at poverty *(County 5.8%)*. [3] Half the women in the census tract who gave birth in the past 12 months were below 200% of the federal poverty level.[2]

Because of the lack of affordable housing in Annapolis City, 44 to 68% of LMI residents at various income levels pay more than 30% of their meager income for housing, making health care a distant priority. Health insurance is not an option for many: 15.5% have no health insurance and 25% have public coverage. Even 19% of the employed do not have health insurance[2]. Even for those with Medicaid, the number of providers able and willing to take MA reimbursement is limited and often unrealistic given transportation issues.

The very site where we intend to establish a PCMH primary care center, the Morris Blum public housing building, is a microcosm of the community we will serve. Because it is one street address, we can measure health care utilization by the building's residents. The building is a bona fide "hot spot" whose 184 elderly and disabled residents currently experience crisis-driven, episodic, and fragmented health care. In the past twelve months, there have been 220 medically related 911 calls to the building. In **six months** alone, 73 Morris Blum residents have

experienced 175 emergency room visits with 38 of those resulting in admissions [4]. The leading primary diagnoses for admissions were related to cardiac, pulmonary, or gastrointestinal disorders. A mere nine residents accounted for 41% of those 175 emergency room visits.[5]

Such statistics from Morris Blum suggest a high likelihood that some of these costly and crisis-driven interventions could have been prevented by providing consistent, accessible, patient-centered, culturally proficient primary care directly in that building, that community, that entire neighborhood. We are confident our HEZ initiatives will do just that.

5. CORE DISEASES AND CONDITIONS TARGETED

Birth Outcomes: We seek to improve health outcomes in our targeted population for both pregnant women and their infants.

Diabetes: We seek to improve outcomes of this chronic disease.

Utilization: We seek to reduce the need for costly, crisis-driven care, e.g. 911 calls, emergency room visits, and hospital admissions and readmissions.

6. GOALS

A) Birth Outcomes Goals: We will track birth weight, trimester entry-of-care data and breastfeeding rates. Without baseline data, we cannot include length of stay for mother and/or infant in postpartum and NICU units as a comparative measure; however, we will track that information throughout the grant period as it is a valuable indicator of health incomes. Similarly, we will measure complications due to lack of prenatal care and/or maternal co-morbidities as these factors influence maternal and infant health and the cost of health care delivery. Assuming an opening date for the Prenatal Care Clinic on September 1, 2013, we propose as our targets for December 31, 2016 the following for women seen at the Clinic:

1) 10% low birthweight for babies born to African Americans newborns. This narrows the gap between whites at 8% and African Americans at 12%.

2) 87% African American mothers enter prenatal care during the first trimester. This narrows the gap between whites at 90% and African Americans at 83%.

3) 65% of all new mothers irrespective of race will breastfeed in the newborn's first hour of life

Special note regarding abuse and domestic violence (A/DV)

From 1993 to 2008, the leading cause of pregnancy-related deaths in Maryland was homicide. Those homicides were most prevalent in African American women under the age of 25, and 56% were committed by the intimate partner. Without considering homicide, 7.3% of pregnant women reported intimate partner violence/domestic violence in the year before and during pregnancy, and rates of physical abuse during pregnancy were twice as great in the Medicaid population as the non-Medicaid population.[6] As that is the target population for the prenatal clinic, A/DV staff training and screening and intervention will be taken very seriously. Since 1995, Anne Arundel Medical Center (AAMC) has had a hospital-based program for domestic violence intervention and prevention, and practices universal screening for all patients. Our A/DV unit was one of four programs highlighted in the February 2010 Governor's Family Violence Council Report on Hospital Based Domestic Violence Programs, with recognition as "a national best-practice model for response to abuse and domestic violence." In addition to routine domestic violence screening and intervention at the Prenatal Care Clinic with professional response by the A/DV staff available 24/7/365, A/DV staff will conduct staff training and refreshers and be available for on-site support groups.

B) Diabetes Outcomes Goals: Assuming an opening date of the Morris Blum site on July 1, 2013, we propose as our targets for January 1, 2015 the following, for active (still being seen by us) patients with diabetes who have been followed at Morris Blum for at least 12 months:

1) 90% have been tested in the last 12 months for nephropathy. (Stretch goal = 100%)
2) 90% have had, in the last 12 months, an A1C and an LDL cholesterol test (Stretch goal = 100%)
3) 70% have a BP 140/90 or better (Stretch goal = 80%)
4) 60% have an LDL of 100 or less (Stretch goal = 70%)
5) 60% have an A1C of 8 or less (Stretch goal = 70%)

Exclusions: patients not seen at the CHC for at least 12 months and patients who have left the CHC to seek care elsewhere.

We will provide a holistic approach to diabetes self-management with peer-to-peer guidance and support as well as field trips, e.g. exercise excursions (walking), food shopping, cooking

classes, glucometer classes, and foot care classes. Our primary care medical home will feature one full-time primary care physician and one primary care mid-level provider. The staffing model will allow for increased capacity of both of these providers, see Strategies, below.

C) Utilization Reduction Goals: We are fortunate that we can track utilization data reliably in the microcosm of Morris Blum residents, who are reflective of our targeted adult community of high-risk patients. After 12 months of opening our on-site primary care medical home, residents of Morris Blum will experience a:

1) 30% decrease in medical 911 calls.
2) 30% decrease in emergency room visits.
3) 30% decrease in hospital readmissions.

7. STRATEGIES TO ADDRESS HEALTH

A) Birth Outcomes Strategy: Staffing at the Prenatal Care Center will include one Obstetrician and one Midwife, plus two Nurses to provide case management as along with medical care. Ancillary staff will include one Medical Assistant, Office Assistants, and shared Social Worker, Translator and Financial Counselor. The AAMC Maternal Fetal Medicine Specialists will see patients as needed at this location. Staffing assumes 175 deliveries by the end of the second year of this grant.

Pregnant women will receive peer-to-peer guidance and support regarding nutrition, follow-up care, and surveillance for red flags. Infants will be enrolled for primary care at the Morris Blum site or the CHC on Forest Drive, at their caregiver's choice. The Stanton Center has classrooms and other facilities, so peer-facilitated baby care classes will be provided from the extensive list of prenatal and baby care training offered by AAMC Wellness. There will be a play area in the clinic for tagalong children.

With our partner organization, the Anne Arundel County Department of Health, a Nutritionist/WIC Coordinator will be available on site at specific times. Each eligible applicant for WIC will be counseled about proper prenatal and infant/toddler nutrition and how to use benefits. For those pregnant women identified with high risk pregnancies, DOH will work with clinic staff to coordinate their other services, e.g. home visits by a community health nurse/medical social worker.

B) Diabetes Strategy: For every new patient at the patient-centered primary care medical home in the Morris Blum building, we will collect data in AAHS' electronic medical record system, including medical history and demographic data, e.g. race, ethnicity and age but also family composition to assess supports for medical and behavioral care. We will screen patients for diabetes when medically appropriate. We will access via Epic a list of diabetic patients and highlight those patients meeting goals and those who are not. We will enlist the help of local, well-controlled diabetic patients in reaching those patients whose disease is not controlled. We will identify risk factors such as language, health literacy, general literacy and social isolation. We will identify and address barriers to care: e.g. fear of glucometers, insulin or needles. We will arrange field trips and socially engaging local classes, e.g. afternoon tea and coffee or a Super Bowl party with healthy snacks and a preparation demonstration.

C) Utilization Reduction Strategy: The key to reducing utilization of costly, crisis-driven care is to provide reliable, accessible and effective primary care that can accommodate increasing patient demand. To anticipate the community's needs for both sites, we will implement the proven Eden Model of PCMH, designed by Dr. Scott Eden, Medical Director of both the existing free clinic and the CHC on Forest Drive. The Eden Model provides for two medical assistants per provider rather than the traditional one medical assistant to one provider ratio. The medical assistants will be specially trained to work to the top of their license and will perform assessments of patients during visits to the center. Whereas traditional medical assistants simply escort a patient to the exam room, record vital signs, and then leave, in the Eden Model the medical assistants provide much more value to the patient and the provider. Their assessments include medical and psychosocial aspects of each patient's medical problems, plus an assessment of what scheduled health maintenance items (e.g. mammogram, flu shot) are due. They also receive training on culturally appropriate diet and exercise advice and tobacco use cessation. All of these data and interventions are recorded in the EMR and discussed with the providers so that targeted plans can be implemented and executed. With two MAs doing this advanced level of intake at the same time for two patients for one provider, the provider never waits to see a patient. The team-based Eden Model allows for greater capacity per provider, often allowing 30 rather than 25 patients to be seen per day for 20% greater capacity per provider. We have proven

experience with this model and can demonstrate patient, staff, and provider satisfaction data to support its use.

Whereas all patients at both sites will benefit from use of the Eden Model, we have an added strategy to address our highest-utilizing patients: those who frequently dial 911, visit the emergency room, or get admitted and readmitted. These patients will be identified by center staff as well as hospital case management and will be referred to Medical Mall Health Services for their Coleman Model intervention. This model uses community health workers, an RN, and a CRNP to provide hospital-to-home transitional services that empower patients and families to self-manage their chronic disease. The patient receives a visit from Medical Mall staff while still in the hospital or emergency room with a follow-up home visit within 72 hours of discharge. At that time, medication is reconciled, individual needs are assessed, a follow-up appointment within one week with the patient's physician is confirmed, and transportation is arranged. The patient is followed for 30 days post-discharge. The Coleman Model decreases readmissions and improves patient self-management skills. Some Morris Blum resident patients with lesser and non-medical needs can be referred to the onsite HACA Care Manager and Congregate Housing Coordinator.

Read "Brenda's Story" below to see how we accomplished this in a culturally proficient manner for one Morris Blum "hot spotter." She describes in her own words what helped her and why. As we did with "Brenda," we propose to provide guidance and support from community health workers and peers in promoting chronic disease self-management, including knowing the red flags, when to call the health center, and when to ask for help and from whom.

"Brenda," a 64 year old African American resident of the Morris Blum building, used to be seen at the AAMC Emergency Room at least every two weeks, and was very frequently admitted. She came to our attention because of our efforts in reducing preventable readmissions. Brenda suffers from congestive heart failure, diabetes, coronary artery disease, chronic obstructive pulmonary disease, hypertension, obesity, advanced osteoarthritis, aortic stenosis, anemia, depression, and anxiety.

When we met with Brenda, it became obvious that she did not understand how to take care of herself. She did not know what her medications were for or how to take them. It took a couple of visits to her apartment to realize that she could not read that well. We also found that in her tiny

apartment, there was no flat surface large enough or clear enough to allow her to sort her medications. Brenda had little social support as well.

We combined our efforts with others in the community to reach out to Brenda, literally on her own turf. With help from The Coordinating Center, the county Department of Aging and Disability, a Nurse Navigator from AAMC, and both Brenda's cardiologist and her primary care physician, we made significant progress. Interventions included home visits, coaching, coordinating appointments and transportation, frequent telephone calls, a personal health record with lots of pictures, and treatment for her anxiety and depression. In addition, we provided a pill box, a small folding table, a blood pressure cuff, and a bathroom scale. Brenda made tremendous progress. She now takes responsibility for her own care by watching what she eats, weighing herself daily, checking her blood pressure, and filling her own pill box weekly. She can say what her medications are and what they do, and when they need to be taken. She makes her own appointments and arranges for transportation. She calls the doctor rather than 911.

We interviewed Brenda and asked her what made the difference. Here is what she said: "I would not have been able to do this without the close teaching and follow-up. I felt good that people cared enough about me to take the time to come to my apartment and show me what I needed to do. I now feel comfortable knowing that I don't have to go to the hospital every time something happens. I can call my doctor. I started feeling pretty good and even started getting out of the apartment more. I even began going back to church and ushering a little. I join the ladies for luncheons. It is a good feeling. I didn't like being in the hospital very much." Brenda used to be seen in the emergency room every two weeks. Since she gained confidence in her own self-management skills 11 months ago, she has been seen in the emergency room only three times, and has been admitted twice. She continues to do well.

The Prenatal Care Center and the Morris Blum center will share a Social Worker, Translator, and Financial Counselor, this last for assistance with public health coverage applications. Based on our experience with clientele at both the existing free clinic and the Forest Drive CHC, staff at both new centers will be bilingual and racially mixed to accommodate the mix of patients. Like the CHC, the PCMH at Morris Blum will have connections to the community and will partner with non-profit organizations. For example, the existing CHC partners with Arundel Lodge, which provides psychiatric rehabilitation services to Anne Arundel County adults with serious

mental illness, by sharing providers with time in each location. Domestic violence screening and intervention will be a routine component of health care at both health centers.

Support from both the county Department of Health and state Department of Health and Mental Hygiene will be critical in quickly assessing and approving new patients for medical assistance and M-CHP. At the prenatal care clinic, we will aim for a smooth transition of newborns into either the Morris Blum Center or the Forest Drive CHC. By approaching women at the Prenatal Care Center at an opportune time, they will be more open to addressing health insurance enrollment and ongoing wellness and preventive primary care for themselves, their children, and their extended families.

In order to run the two Centers safely and effectively and to promote an environment conducive to wellness, staff will receive ongoing training in crisis prevention and interventions to diffuse potentially unsafe and/or dysfunctional situations. In house staff, DOH staff and consultants will provide this training on a regular basis.

In addition to the two initiatives above, we will continue our long association with DOH for referrals, data exchange and joint boards and committees.

Transportation for those without a car, especially those who are elderly or have health issues, is always a challenge in Annapolis, but the Morris Blum building has regular transportation services from the county Department of Aging. For non-resident patients, both centers are within six blocks of the gold, orange and green local bus routes route.

8. USE OF INCENTIVES AND BENEFITS

We are pleased at the opportunity in this Health Enterprise Zone application to request loan repayment assistance for two additional physicians, one obstetrician to staff the Prenatal Care Clinic and one primary care physician to staff Morris Blum. We intend to offer each site as a possible rotation for medical assistant, Nurse Practitioner and Physician's Assistant students, and medical students and residents in primary care programs so they can experience primary care delivery in an underserved setting. This will promote the entry of qualified personnel into this care setting.

We also will request priority entry into Maryland's PCMH program for the Morris Blum site, and have requested application funds for NCQA recognition. We are requesting funds to implement Epic EMR to the Morris Blum site. The prenatal clinic site is already scheduled for

EMR installation February 2013 because of the generosity of a longtime AAMC funder of our free clinic, the O'Neill Foundation.

Another benefit request is for leasehold improvements at the Morris Blum site to accommodate two providers. The City of Annapolis will continue to provide space at the existing free clinic to be transformed to the Prenatal Care Center rent-free, and the Housing Authority of the City of Annapolis is providing space at Morris Blum free of charge. The medical equipment request is for a used ultrasound machine, Doppler and fetal monitor for the Prenatal Care Center, especially important given the nature of the pregnancies that will be seen at the clinic. We are confident another funder will assume the balance of that cost.

9. CULTURAL, LINGUISTIC AND HEALTH LITERACY COMPETENCY

Both locations will use EMR not just for patient medical record keeping, but also for data collection on race, gender, ethnicity, language preference, and preferred mode of communication. This helps us track disparities in outcomes for populations, but also tactfully reveals other challenges for individuals such as literacy, social isolation, and generally limited resources. Equipped with such knowledge, we can design effective interventions for individuals that make sense given their social environment.

Patterning our population health measures to NCQA metrics, we will measure our effectiveness in meeting our goals and stratify our results based on race and ethnicity. This will help us identify disparities, address them, and re-measure our progress once interventions have been implemented. We already have successful experience with this at the existing Community Health Center, particularly with measures involving tobacco use cessation, weight management, and interventions for patients with ischemic vascular disease.

We will hire personnel from the community we seek to help, and have patient and family advisors help us plan interventions and strategies for our client base. AAHS has a rich history of using patient and family advisors, maintaining a list of more than 60 such patient and family advisors. We will need Spanish-speaking personnel, and will hire enough bilingual staff to ensure there is always a Spanish-speaking staff member present at both sites. Whereas bilingual staff will be available at both Centers, we anticipate the occasional need for sign language and other language interpreters. We have an interpretation service that provides

qualified interpretation service free of charge to our clients. Center staff activates the service by calling the hospital operator to access a qualified interpreter.

Health literacy encompasses aspects of individuals' lives that have a direct bearing on their health status and longevity. These include not only knowledge and awareness of health risks and disease management, but also very personal choices regarding lifestyles. With the end goal of helping individuals make better choices, not necessarily "our" choices, our strategies will center on what is important to each individual. We can then work with them to modify their approaches to better meet individual goals of care (nutrition, exercise, prevention of disease, and disease management) safely and effectively, while respecting cultural frames of reference.

Patients at both centers will be encouraged and trained to use MyChart, free and accessible via the AAHS web site, as the electronic portal to manage their own health, and, in the case of minor children, their family's health. With MyChart and an Internet connection or smartphone, patients can send and receive messages to their provider and center staff, schedule appointments, request prescription refills, review their health history, and get lab and other test results. Patients will be introduced to MyChart when they are escorted to their exam room. The Stanton Center, location of the proposed Prenatal Care Center, has a computer lab with twelve new computers as of June 2012. Basic computer instruction is offered to City residents two evenings a week, and they can use the computer laboratory free of charge. We will encourage their use for MyChart access, and will offer intermittent orientation sessions on MyChart in the computer lab.

The Anne Arundel County Department of Health will provide direct education for patients, e.g. Healthy Babies topics, the value of immunizations, and building exercise into a day.

10. APPLICANT ORGANIZATION AND KEY PERSONNEL

Anne Arundel Health System is a regional health system serving central Maryland. Our 100-acre campus outside Annapolis is the site of the Anne Arundel Medical Center, the third busiest hospital by admissions in the Baltimore metro area and, with 380 licensed beds, the fifth largest in Maryland. To our long-standing core values of trust, dedication, compassion, quality, and innovation, we added in 2009 two additional values: diversity and collaboration.

As a part of Anne Arundel Health System's Vision 2020, we seek to address local health care disparities. Vision 2020 places greater focus on providing care throughout the community so that

all our service area is "Living Healthier Together." We will do this by extending services beyond the walls of the hospital to the community where people live and work. The free clinic at Stanton Center and our Community Health Center on Forest Drive, both in Annapolis, are indicative of that commitment, and the Prenatal Care and Morris Blum Centers will expand that

Project Director Pat Czapp, MD, is the AAMC Chair of Clinical Integration. Dr. Czapp is board certified in family medicine, a physician with Annapolis Primary Care, and a past AAMC Chief and Associate Chief in the family medicine service. Dr. Czapp oversees broad projects across the entire health system, such as reduction of preventable readmissions and adoption of population health strategies. She will oversee initial implementation of these two initiatives, provide ongoing expertise, and direct the collection and interpretation of key data. She will also identify fruitful opportunities for change for patients and in health care delivery by the health system. Henry J. Sobel, MD, MBA, is AAMC Chair of Women's and Children's Services, and will act as Medical Director for the Prenatal Care Center at Stanton Center. Dr. Sobel has practiced in Annapolis since 1981, and is a past AAMC Chief of Obstetrics/Gynecology. Maura Callanan, Executive Director of Women's and Children's Services at AAMC for more than five years, oversees activities at the Rebecca Clatanoff Pavilion, the third busiest birthing center in Maryland with 5,308 births last fiscal year. Scott Eden, MD, board certified in family medicine and a physician with Annapolis Primary Care, is the current Medical Director for the Forest Drive CHC and the free clinic in Stanton, and will assume that role for the Morris Blum Center. Dr. Eden was the driving force in developing the concept and seeking approval and funding for the Community Health Center on Forest Drive, and is responsible for its success. Steve Clarke, Vice President of Physician Services, has overall management responsibility for the Forest Drive CHC and the free clinic, and will assume that role for the Morris Blum Center. Mr. Clarke reports to the Chief Medical Officer, one of the five member executive team of AAHS. The executive team has governance of and ultimate decision making authority for all these centers. Mary Jo Palmer, Director of Client Services, will direct installation and start up at the two centers. Ms. Palmer directed start up activities at the Forest Drive CHC and is responsible for the day to day operations of that facility and the free clinic, and will assume that role for the Morris Blum Center.

11. COALITION ORGANIZATIONS AND GOVERNANCE

This project brings together key community organizations with strong endorsement and support from allied organizations. Spearheading the project are the Housing Authority of the City of Annapolis, the Anne Arundel County Department of Health, the City of Annapolis, and Anne Arundel Health System with support from the Healthier Anne Arundel Coalition (HAAC) which is made up of more than 15 affiliated governmental, community and service organizations. It builds upon the State Health Improvement Process for the focus areas of Health Care Access, Chronic Disease, Healthy Social Environments, Healthy Babies, Safe Physical Environments and Infectious Disease. Together the two centers will directly address each of these six areas. The project will be governed through a coalition of the key community organizations and through cooperation with members of Healthier Anne Arundel.

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION
Health Enterprise Zones -Work Plan

Organization Name:	**Anne Arundel Medical Center and Community Partners**
HEZ Project Name:	**Reducing Health Disparities: A Creative Dual-Clinic Approach to Improving Access**
Grant Program Name:	**Prenatal Care Center and Morris Blum Center**
PROJECT PURPOSE:	**Improve birth outcomes, improve chronic disease outcomes, and decrease preventable, costly crisis-driven care for an underserved population within zipcode 21401**

Goal #1:Improve Birth Outcomes

Measure of Success:

Objective	Program Activities/Action Steps	Expected Outcome	Data Evaluation and Measurement	Organization/Person Responsible	Timeframe
Increase entry to early prenatal care	Establish a new maternity center	Halve the gap between racial and ethnic groups in prenatal care initiation	Track gestational age at first prenatal visit for target population	AAMC Women's & Children's Center; Maura Callanan and Henry Sobel, MD	From opening to conclusion of grant cycle
	Partner with government and community resources	Halve the gap between racial and ethnic groups in prenatal care initiation	Track gestational age at first prenatal visit for target population	AAMC Women's & Children's Center; Maura Callanan and Henry Sobel, MD	From opening to conclusion of grant cycle
	Increase publicity and community education and outreach	Halve the gap between racial and ethnic groups in prenatal care initiation	Track gestational age at first prenatal visit for target population	AAMC Women's & Children's Center; Maura Callanan and Henry Sobel, MD	From opening to conclusion of grant cycle
Reduce low birhtweight deliveries in target population	Earlier registration	Decreased NICU days for target population	Track NICU admissions and LOS for target population	AAMC Women's & Children's Center; Maura Callanan and Henry Sobel, MD	From opening to conclusion of grant cycle

	Improved prenatal care with counseling, case managemnent and coordination with government and community resources	Decreased NICU days for target population	Track NICU admissions and LOS for target population	AAMC Women's & Children's Center; Maura Callanan and Henry Sobel, MD	From opening to conclusion of grant cycle
Improve nutritions and decrease obesity in population by encouraging breastfeeding	Prenatal and post partum education and support for breastfeeding and lactation	65% of new mothers will breastfeed in the first hour of life	Breastfeeding during newborn first hour of life	AAMC Lactation Consultants	From opening to conclusion of grant cycle
Goal #2: Improve Diabetes Outcomes					
Measure of Success:					
Objective	**Program Activities/Action Steps**	**Expected Outcome**	**Data Evaluation and Measurement**	**Organization/Person Responsible**	**Timeframe**
Improve diabetes outcomes, measurable by January 1, 2015	1a.Screening for and tracking diabetics	Establish baseline population for study and intervention	90% screened for nephropathy and have had A1C and LDL measurements, 70% have BP 140/90 or lower, 60% have LDL less than 100 and A1C of 8 or less	AAMC IT department, Patricia Czapp, MD, Scott Eden, MD	IT software already in use at existing CHC can track these metrics. Physicians can run reports on these metrics and assess their performance in real time. Will implement at Morris Blum on its opening day.

	1b. Patient Activation activities to include social events including peers, "Walk With Me", shopping field trips, cooking and nutrition events, on-site diabetic education and group visits	Better self-awareness of the disease, better adoption of self-care	Attendance at events to be measured, patient advisors to provide feedback	Scott Eden	Events to begin soon after opening and will be ongoing.
	1c. Peer outreach to patients not meeting treatment goals	Culturally sensitive interventions will impact patient activation positively	Closely monitor (same metrics) of this subset patients not meeting goal for improvement - bring back for more frequent visits, one-on-one teaching and motivational interviews	Scott Eden	Begins with Center opening and with patient entry into care
	1d. MyChart (patient portal accessible by smartphone or computer)	Patients will have the opportunity to watch their own progress, message the doctor, etc., enhancing likelihood of engagement	Number of patients enrolled in MyChart	Scott Eden, Mary Jo Palmer	MyChart is already in use at the CHC and will be available to Morris Blum patients on opening day.

	1e. Diabetes Peer Program	An onsite peer resource for guidance and support will enhance outcomes for the most vulnerable patients	Number of diabetic peers able to provide one-on-one support as well as help lead group workshops	Scott Eden, Diabetes Center and AA County Dept of Aging and Disability	Recruit peers while Center still being remodeled. Attend self-management workshop in diabetes. Attend training for lay person leadership of self-management workshops
Goal #3: Decrease preventable, costly, crisis-driven care					
Measure of Success:					
Objective	**Program Activities/Action Steps**	**Expected Outcome**	**Data Evaluation and Measurement**	**Organization/Person Responsible**	**Timeframe**
1. Within 12 months, decrease medical 911 calls to 701 Glenwood (the address of the Morris Blum public housing building) by 30%	1a. Promote use of the Morris Blum Center by local residents. Include in these efforts our patient advisors and peers. Efforts will include social events, multi-media messaging, direct outreach by clinical staff and peers to the most frequent 911 callers	Fewer non-emergency medical 911 calls from 701 Glenwood.	Measure number of unique patients seen at Morris Blum Center, including those who live at 701 Glenwood, track medical 911 calls to that address	Mary Jo Palmer	Efforts begin as soon as remodeling begins at Morris Blum (early 2013) with posters, flyers, social events at existing free clinic and on grounds of 701 Glenwood.

	1b. Coordinate with local EMS to promote and reinforce awareness of in-house medical care to 701 Glenwood residents who call for non-emergency care.	After they are assessed by EMS personnel, non-emergency cases can be referred to the Center for rapid intervention, demonstrating to our patients a safe and effective alternative to calling 911, and helping "break the cycle" of dialing 911 for any type of medical care.	Tracking 911 calls to 701 Glenwood already in place	Scott Eden and Mr. Svoboda, Mary Jo Palmer	Coordination with EMS (protocol design and implementation) to begin one month prior to Morris Blum Center opening
	1c. Form focus group of Morris Blum residents to act as our patient advisors and help with peer-to-peer recruitment of patients	Increased acceptance and use of the Center by local residents	Numbers of new patients seen at the Center will be tracked, including those from 701 Glenwood	Mary Jo Palmer, Scott Eden	Form the patient advisory group in months prior to opening. Recruit those who have already benefited from interventions, e.g. "Brenda". Solicit their input and advice and engage them in promotion as well.

2. Within 12 months, decrease emergency room visits from 701 Glenwood by 30%	2a. Promote awareness of Morris Blum Center to 701 Glenwood residents as THEIR patient-centered medical home.	Patients have easy access to consistent and reliable medical care and a better alternative to calling 911 or going to the emergency room for non-emergency care	ED visits from 701 Glenwood easily tracked	Scott Eden, MD, Mary Jo Palmer	Peer-to-peer recruitment as soon as center opens, using patient advisors mentioned above. Open House and Grand Opening events will be held at the Center to invite residents. "Meet the Doctor" and educational events to be ongoing for residents and neighbors.
	2b. Promote and maintain "Just Say Yes" philosophy to Morris Blum Center staff to enhance patients' ready access to care.	Patients have easier time accessing care in order to prevent 911 calls, emergency room visits, and ambulatory-sensitive admissions	Monitor Center schedule for "third next available appointment" per NCQA PCMH standards	Mary Jo Palmer, Scott Eden	Begins when the Center opens
3. Within 12 months, readmissions of 701 Glenwood patients will decrease by 30%	Coleman Model - as described in narrative	Patients have better self-management skills in terms of monitoring their conditions and contacting physicians for "red flags", in-home assessments address social determinants of health.	Readmissions easily measured from 701 Glenwood	Medical Mall, AA County Dept of Aging and Disability, home health agencies	Infrastructure already in place and will begin late 2012.

12. EVALUATION PLAN

As the Coordinating Organization, AAHS will measure the implementation and success of the proposed strategies on an ongoing basis. Specific targets and milestones for our strategies are finely detailed in the Goals section of the application as well as the Work Plan. Listed broadly here, those goals are: 1) improving birth outcomes, 2) improving diabetes outcomes, and 3) reducing preventable, costly, crisis-driven care. Ultimately and more importantly, however, our success toward those goals will be measured by how well we and our partners 1) improve the care experience for individuals, 2) improve population health and 3) improve cost control. *In other words, how closely are we approaching The Triple Aim, for the MUA in zip code 21401?*

The paragraphs below, organized in Triple Aim format, will describe how we will provide ongoing assessments of our performance (and that of our partners) toward our goals and how we will be able to report our progress to the MCHRC on a regular basis.

a) Improve the care experience of individuals: *Direct patient surveys will measure our performance.* Both Centers will survey patients directly using a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tool. This survey, already in use at our Forest Drive CHC, presents the patient with 15 questions and takes about 2 minutes to complete, using an Ipad device in the Center. Questions include: "Did this doctor listen carefully to you?" "Did this doctor show respect for what you had to say?" "When you phoned this doctor's office to get an appointment for care you needed, did you get an appointment as soon as you thought you needed?" Results may be stratified by race, ethnicity, gender, age, etc. Monthly reports are generated so that actions may be taken to improve, and as surveys continue to be given on a daily basis, we can detect whether our interventions created the expected positive change. Such reports are easily exported and shared with providers and with the MCHRC. The survey can start on opening day for each of the Centers.

   Additionally, *continuous input from our patient advisors* will inform our strategies to improve patient care experience. We will ask them to report on the performance of our partners as well, including Medical Mall for care transition services, the Anne Arundel County Department of Aging and Disability for in home-assessments, chronic disease management workshops, and the DOH for WIC.

Initially we will meet with our patient advisors monthly in order to be responsive to their suggestions and cement our chances for early, sustainable success in improving the care experience for individuals.

b) Improve population health: *Our electronic medical record system will capture and report our performance on the chosen quality metrics and stratify the results by race, ethnicity, gender, and age.* Both Centers will have reporting capabilities for the metrics outlined already in the Goals section (see specific metrics, time lines, and exclusions) and in the Work Plan effective the day each Center opens. This is possible via the Epic electronic medical record platform, which will furnish on-demand performance reports for each of the measures. These reports also will be stratified by race, ethnicity, gender, age, etc.; all these data points are collected on each patient. For example, a physician will receive a quarterly report of all of his diabetic patients and their blood pressure, glucose control, cholesterol, and LDL and A1C screening metrics. There will be a drill-down on actual patient names, along with their age, race, ethnicity, etc. Patients who are not at goal as defined in the Goals section will be flagged for intervention. These reports will be reviewed with clinical staff to identify disparities, address them, and then re-measure our performance. These reports will be generated at least quarterly and can be shared without patient identifying information with the MCHRC.

To improve the health of a population, we need to have access to members of that population so a therapeutic relationship can begin. *We will be assessing our partner organizations' success in referring patients in need.* For example, we will rely on the DOH and HAAC to identify and refer at-risk pregnant girls and women. We also will rely on those same sources plus the County Department of Aging and Disability to refer potential patients to the Morris Blum Center. With that in mind, we will track the source of our referrals so we can reinforce referral strategies if needed. Our ongoing relationship and data-sharing with all of these partners will help us assess our progress and determine where additional or different resources should be deployed in order to "grow" the two Centers' patient population.

c) Improving Cost Control: *Our chosen metrics for controlling cost (reducing preventable 911 calls, emergency room visits, and readmissions) are uniquely tied to residents of the Morris Blum public housing unit itself.* This is our "captive audience" that allows us fairly reliable "before and after" measurements, because utilization metrics can be tracked by street address – in this case, 701 Glenwood. We have an existing collaborative arrangement with local emergency medical services (EMS), which provides us with 911 data. Data on emergency room visits and readmissions for residents of 701 Glenwood can be mined from our own hospital's data warehouse. Both data items can be reported quarterly.

We will decrease 911 calls and emergency room visits for residents of the Morris Blum building by providing a welcoming, reliable, consistent and accessible source of primary care to the building's residents (as well as the rest of the neighborhood). Patients will have an option other than dialing 911 for health care. We will partner with EMS staff so that after they have assessed patients, they can refer the non-emergency cases directly to the Morris Blum Center to address their urgent care needs. Morris Blum Center staff will adopt a "just say yes" philosophy about accommodating patients. We will measure the number of 701 Glenwood patients seen in that Center as well, and we will track our appointment availability following NCQA PCMH standards.

To reduce readmissions, we will rely on our partners that provide hospital-to-home transitional care services: Medical Mall and the County Department of Aging and Disability. Referrals will be made to them by our own care management team in the hospital. Both meet patients while they are still in the hospital, then arrange a follow up visit in the home 72 hours after discharge. Medication reconciliation and assessment of individual needs are carried out by qualified community health workers. Follow up appointments and transportation are arranged and the patients are followed for a month to ensure they have adequate resources and support. We will track referrals to both Medical Mall and the Department of Aging and Disability: number of referrals, number of patients accepting services, and number of readmissions among referrals.

13. SUSTAINABILITY PLAN

The cost of the current dysfunction in health care delivery is pervasive and self-sustaining; it reinforces a cycle of poor health outcomes that lead to limited socioeconomic opportunities, which in turn lead to poor health outcomes. Both social justice and business issues combine to make a compelling case for addressing disparities in care. We believe these two programs together are integral for continuity of care of frail elderly, adults, the disabled, and babies, children and families in this section of Annapolis. AAMC seeks to prepare now for Medicaid expansion slated for January 2014, and these primary care patient-centered medical homes are critical for that.

Our sustainability plan incorporates predictable changes in health care delivery, payment reform, and philanthropy. The Medicaid Bump, slated for January 1, 2013, will provide physician payment equal to Medicare rates for primary care services. The Vaccines for Children program also will offer significant increases in administration fees. Both will provide more revenue to the Centers. Medicaid Expansion, slated for January 1, 2014, will increase the number of patients eligible for coverage. We intend to facilitate Medicaid or PAC enrollment, with PAC patients automatically converted to Medicaid as of January 1, 2014. The Maryland PCMH pilot may soon include Medicaid patients for a per member per month fee to be paid to qualified PCMH practices. The Morris Blum Center will participate in the Maryland PCMH pilot.

With area independent practices, AAMC has applied for Medicare ACO status under the Medicare Shared Savings Program. This is an opportunity for greater reimbursement if savings are achieved and quality measures are met. Upon successful application, the Morris Blum Center could enroll in that ACO. Other Medicare initiatives such as CareFirst's CMMI initiative would allow for greater reimbursement for providing value in the management of Medicare patients.

AAMC has an interest in supporting care in the community that creates value -- higher quality and lower cost -- for individuals and our entire service area. Commitments by other self-sustaining entities, such as Medical Mall Health Services - and the strong partnership with the Department of Health and Healthier Anne Arundel Coalition - support our commitment. Finally, the generosity of the City of Annapolis and the Housing Authority of Annapolis for no cost space in the Stanton Center and the Morris Blum building is a significant factor in sustainability.

Footnotes and References

1. Medically Underserved Areas are designated based on four measures: ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over. Census tract 7061.01 scores 59.1 on a scale of 0 to 100; has been on the list since May 1994.

2. American Community Survey 2010 and Housing and Urban Development 2009.

3. Anne Arundel County Infant Health Risk Assessment by Census Tract, 2004-2008; also 1999 US Census data using 2000 census tract designations.
4. Of those 73 Morris Blum residents, the mean age was 64.5; 72.6% African American, 26.0% Caucasian, 1.4% other,

5. Morris Blum building has 184 residents total, of which 30 are disabled. Data in this paragraph from City of Annapolis Fire Department – Division of Emergency Management Service and Department of Planning and Zoning – Community Development, and the Housing Authority of the City of Annapolis.
6. Maryland Pregnancy Risk Assessment and Monitoring Survey (PRAMS), 2004 – 2008 data.

7. American Community Survey 5-Year Estimates, 2006-2010.

APPENDIX ITEM F - Global Budget Form

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION
Health Enterprise Zones - Global Budget Form

Organization Name: Anne Arundel Health System

HEZ Project Name: Reducing Health Disparities, A Creative Dual-Clinic Approach to Improving Access

Directions: All applicants must complete the Global Budget Template which provides the annual and total budget request by program benefit and incentive requested. Applicants should choose from the listed benefits and incentives (items 1-8). Applicants are **not** required to request funding in each benefit or incentives area. Applicants requesting CHRC Grant Funding for health programs are required to list each partnering organization and grant request amount under item 8. CHRC Grant Funding and complete the Program Budget Form for each organization. Add or remove lines for CHRC Grant Funding as needed.

Budget Request for Benefits and Incentives	Year 1 (January - December 2013)	Year 2 (January - December 2014)	Year 3 (January - December 2015)	Year 4 (January - December 2016)	Total HEZ Request
1. State Tax Credits	$0	$0	$0	$0	$0
2. Hiring Tax Credits	$0	$0	$0	$0	$0
3. Loan Repayment Assistance	$30,000	$30,000	$30,000	$30,000	$120,000
4. Participation in PCMH Program	$600	$0	$0	$600	$1,200
5. Electronic Health Records	$118,930	$31,080	$31,080	$31,080	$212,170
6. Capital or Leasehold Improvements	$125,000	$0	$0	$0	$125,000
7. Medical or Dental Equipment	$13,650	$0	$0	$0	$13,650
Subtotal for Benefits and Incentives	$288,180	$61,080	$61,080	$61,680	$472,020
8. CHRC Grant Funding*					
8a. Prenatal Care Center	$134,268	$401,039	$391,982	$386,148	$1,313,437
8b. Morris Blum Center PCMH	$238,807	$247,151	$230,471	$224,190	$940,619
10. Indirect Costs @5% of 8a and 8b	$18,654	$32,410	$31,123	$30,517	$112,703
Subtotal	$679,909	$741,680	$714,656	$702,535	$2,838,779
9. Data Collection and Evaluation @ 5% of Subtotal	$33,995	$37,084	$35,733	$35,127	$141,939
Total Request	***$713,904***	***$778,763***	***$750,388***	***$737,662***	***$2,980,718***

APPENDIX ITEM H - Program Budget Form

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

Health Enterprise Zones - Program Budget

Organization Name: Anne Arundel Health System

HEZ Project Name: Reducing Health Disparities, A Creative Dual-Clinic Approach to Improving Access

Grant Program Name: Prenatal Care Center at Stanton Center

Directions: HEZ application that include requests for CHRC Grant Funds (Line item 8 in the Global Budget Form) for health programs must complete this budget form for **each** organization requesting funds. Use the line-items below to provide the annual budget (Years 1 - 3) and the total organization's program budget request for the three-year program duration. Attached to this Program Grant Budget Template, submit a concise budget justification. In the budget justification, detail what is included in each line-item and describe how each item will support the achievement of program's goals and objectives.

Budget Request for CHRC Grant Funding Add or remove lines as needed.	**Year 1 (January - December 2013)**	**Year 2 (January - December 2014)**	**Year 3 (January - December 2015)**	**Year 4 (January - December 2016)**	**Total Organization Request**
Personnel Salary					
1.0 FTE Obstetrician (4 months in year 1)	$65,000	$195,000	$200,850	$206,876	$667,726
1.0 FTE Midwife (1/2 year in year 2)	$0	$41,600	$83,200	$85,696	$210,496
1.0 FTE Medical Assistant	$13,867	$41,600	$42,848	$44,133	$142,448
1.0 FTE Office Assistant	$12,356	$37,440	$38,563	$39,720	$128,079
2.0 FTE Nurse (w/case mgmt respon)/1.0 FTE in Year 1, 2nd nurse 1/2 yr in yr 2	$13,728	$112,320	$115,690	$119,161	$360,899
1. Personnel Subtotal	$104,951	$427,960	$481,151	$495,586	$1,509,648
2. Personnel Fringe					
Physician @ 11%	$7,150	$21,450	$22,094	$22,756	$73,450
Ancillary Medical and Other Staff @ 15%	$5,993	$34,944	$42,045	$43,307	$126,288
3. Equipment/Furniture	$900	$0	$0	$0	$900
4. Supplies	$10,000	$2,500	$2,575	$2,652	$17,727
5. Travel/Mileage/Parking	$2,500	$2,575	$2,652	$2,732	$10,459
6. Staff Trainings/Development	$3,000	$3,000	$3,000	$3,000	$12,000
7. Contractual	$35,000	$50,000	$51,530	$53,076	$189,606
8. Other Expenses	$6,000	$6,180	$6,365	$6,556	$25,101
Direct Costs Subtotal (lines 1-8)	$175,494	$548,609	$611,412	$629,665	$1,965,179
Indirect Costs @ 5%	$8,775	$27,430	$30,571	$31,483	$98,259
Totals	$184,268	$576,039	$641,982	$661,148	$2,063,438
Estimated Revenues	$50,000	$175,000	$250,000	$275,000	$750,000
Net Request	***$134,268***	***$401,039***	***$391,982***	***$386,148***	***$1,313,438***

APPENDIX ITEM H - Program Budget Form

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

Health Enterprise Zones - Program Budget

Organization Name: Anne Arundel Medical Center

HEZ Project Name: Reducing Health Disparities: A Creative Dual-Clinic Approach to Improving Access□□

Grant Program Name: Morris Blum PCMH

Directions: HEZ application that include requests for CHRC Grant Funds (Line item 8 in the Global Budget Form) for health programs must complete this budget form for **each** organization requesting funds. Use the line-items below to provide the annual budget (Years 1 - 3) and the total organization's program budget request for the three-year program duration. Attached to this Program Grant Budget Template, submit a concise budget justification. In the budget justification, detail what is included in each line-item and describe how each item will support the achievement of program's goals and objectives.

Budget Request for CHRC Grant Funding Add or remove lines as needed.	Year 1 (January - December 2013)	Year 2 (January - December 2014)	Year 3 (January - December 2015)	Year 4 (January - December 2016)	Total Organization Request
Personnel Salary					
100% FTE - 1.0 FTE Physician	$93,333	$160,000	$164,800	$169,744	$587,877
100% FTE - 2.0 FTE Medical Assistant	$41,600	$42,848	$44,133	$45,457	$174,039
100% FTE - 1.0 FTE Case Manager	$40,000	$80,000	$82,400	$84,872	$287,272
1. Personnel Subtotal	$174,933	$282,848	$291,333	$300,073	$1,049,188
Personnel Fringe					
Physician - 11%	$10,267	$17,600	$18,128	$18,672	$64,666
Other Staff - 15%	$12,240	$18,427	$18,980	$19,549	$69,197
2. Personnel Fringe Subtotal	$22,507	$36,027	$37,108	$38,221	$133,863
3. Equipment/Furniture	$27,400	$0	$0	$0	$27,400
4. Supplies	$15,000	$7,983	$8,222	$8,469	$39,673
5. Travel/Mileage/Parking	$1,250	$2,500	$2,575	$2,652	$8,977
6. Staff Trainings/Development	$1,500	$3,000	$3,000	$3,000	$10,500
7. Contractual	$40,000	$80,000	$82,400	$84,872	$287,272
8. Other Expenses	$6,750	$13,500	$13,905	$14,322	$48,477
Direct Costs Subtotal (lines 1-8)	$289,340	$425,858	$438,543	$451,609	$1,605,350
Indirect Costs @ 5%	$14,467	$21,293	$21,927	$22,580	$80,268
Totals	$303,807	$447,151	$460,471	$474,190	$1,685,618
Estimated Revenues	$65,000	$200,000	$230,000	$250,000	$745,000
Net Request	***$238,807***	***$247,151***	***$230,471***	***$224,190***	***$940,618***

Reducing Health Disparities: A Creative Dual-Clinic Approach to Improving Access
Budget Narrative Anne Arundel Health System, November 15, 2012

Note that our NET request reflects a deduction for revenues received from the two programs, Morris Blum PCMH and the Prenatal Care Center.

Incentives and Benefits

Our request includes the following incentives and benefits in our Health Enterprise Zone application:

1. Loan repayment for two providers, and Obstetrician and Family Medicine Physician.
2. Priority entry into Maryland's PCMH program for the Morris Blum site with fees for NCQA recognition and maintenance of designation.
3. Epic EMR installation at the Morris Blum site. Not necessary at the Prenatal site because of the generosity of a longtime AAMC and OC funder.
4. Leasehold improvements at the Morris Blum site. The donated office suite must be reconfigured to allow for exam rooms and private space for financial counseling (Medicaid eligibility) and case management discussions and phone calls. The existing space for the Prenatal site can be used as is with minor refreshing.
5. Medical equipment request for used ultrasound, Doppler and fetal monitor for the Prenatal site. Another funder will assume the balance of that cost.

Prenatal Care Center

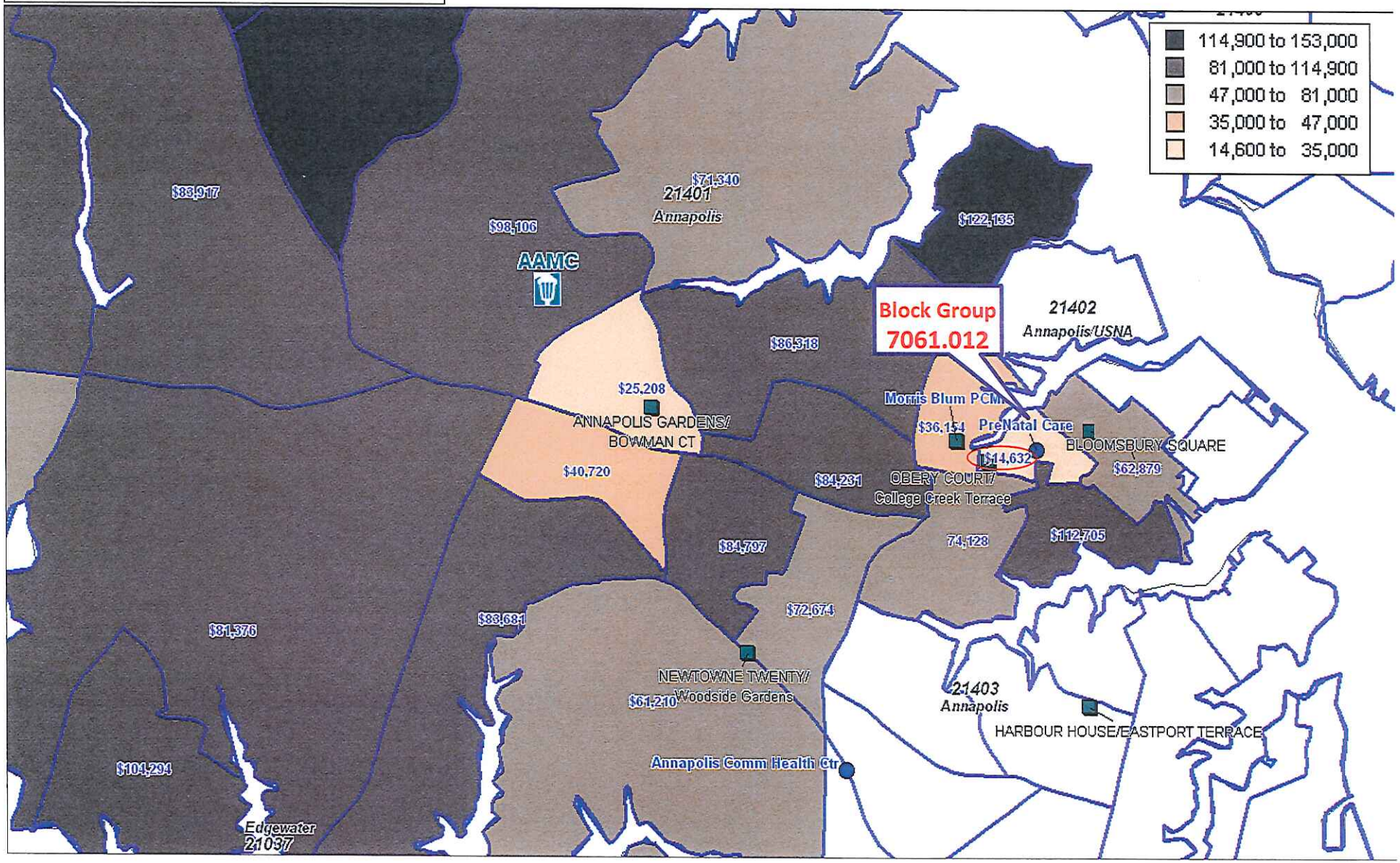
Our request includes staff salaries as required over the first two years of the grant for one Obstetrician, one Midwife, two Nurse/Case Managers, and one each Medical and Office Assistants. The request also includes 1) minimal furniture as the site is already furnished, 2) paint and carpet, 3) initial supply stock and ongoing refreshing, 4) mileage as staff travels between the site and AAMC, 5) training provided by outside consultants or DOH staff, 6) contract security, waste management, information services, couriers and maintenance, and 7) licenses and malpractice insurance. There is no cost for major equipment like exam tables as those will remain in place, and EMR equipment is provided for under a different grant received October 2012. All items are required to staff and run a quality, patient-focused prenatal care office for services that will impact the outcomes of birthweight, early prenatal care and breastfeeding.

Morris Blum Center

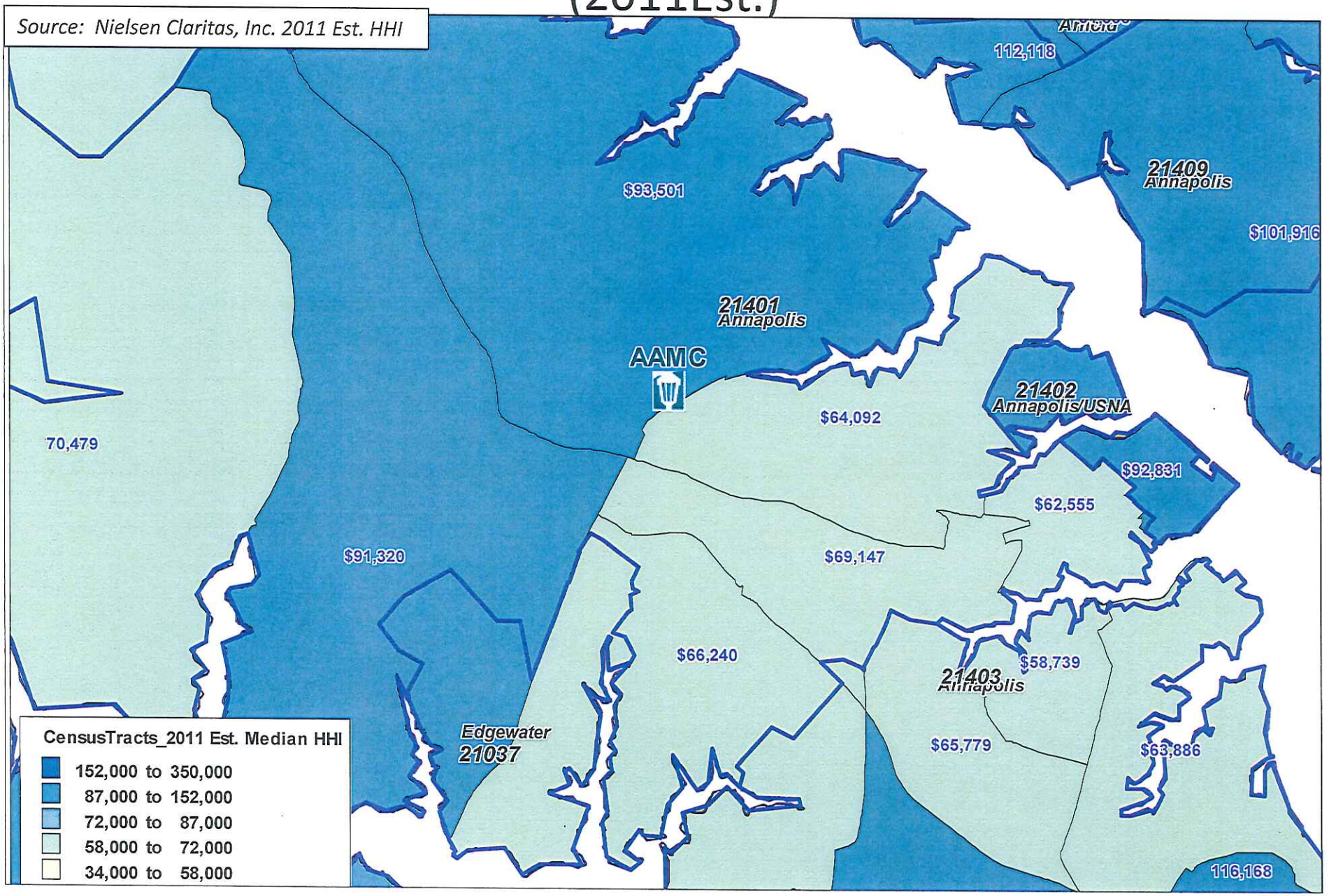
Our request includes staff salaries as required over the first two years of the grant for one Primary Care Physician, two Medical Assistants with expanded duties as noted in the grant, and a Case Manager. The request also includes 1) furnishings, 2) initial medical supply stock and ongoing refreshing, 3) office supplies and telephone, 4) mileage as staff travels between the site and AAMC, 5) training provided by outside consultants or DOH staff, 6) contract security, waste management, information services, couriers and maintenance, and 7) vaccines, licenses and malpractice insurance. All items are required to staff and run a quality, patient-centered primary care medical home for services that will impact the outcomes of diabetic improvement and reduced emergency room use and hospital admissions and readmissions.

21401 Block Group Detail with Median Household Income

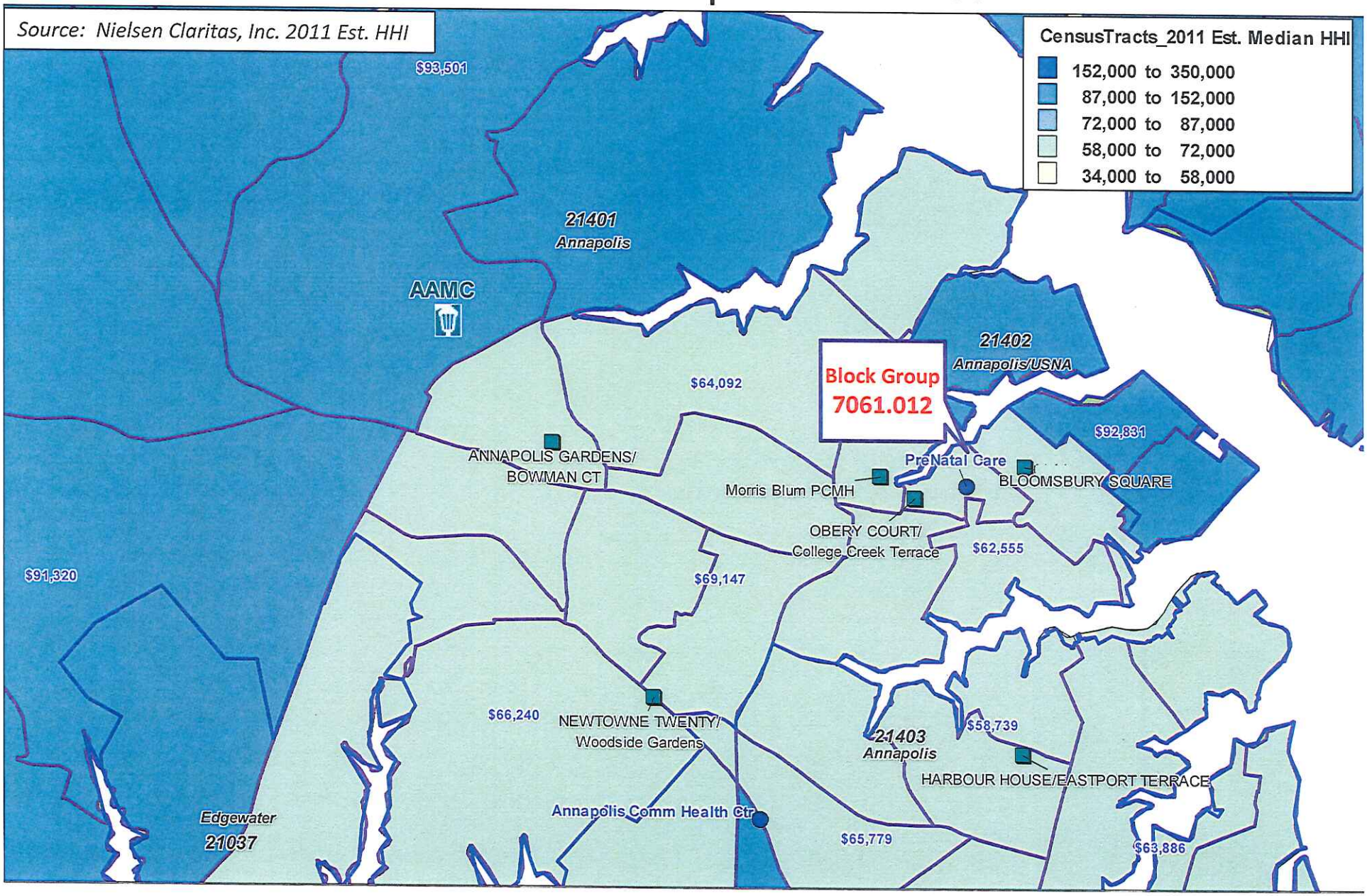
Source: Nielsen Claritas, Inc. 2011 Est. HHI



21401 Census Tracts with Median Household Income (2011Est.)



21401 Census Tracts with Median Household Income and Block Group Boundaries



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November 14, 2012

To Whom It May Concern

Re: Health Enterprise Zone Grant Application

Letter of Commitment

The Housing Authority of the City of Annapolis (HACA) is very pleased to support efforts to improve the health of our most underserved citizens under the proposed guidelines of a Health Enterprise Zone. This initiative is consistent with HACA's Pathways to Opportunity which is a health center strategy to improve the quality of life of all residents residing in our properties. Health disparities and health access are major issues for a large population of 30,000 citizens residing in the 21401 zip code. This proposal engages key partners to address these issues, including the Anne Arundel County Department of Health, members of the Healthier Anne Arundel Coalition, the City of Annapolis, the Housing Authority of the City of Annapolis and the Anne Arundel Medical Center.

The goal of this proposal is to establish two sites, within walking distance of each other, to serve our residents and the residents of 21401 who need these services. They will provide comprehensive, coordinated care for our underserved population. One site will be dedicated to prenatal and post-partum care. The other will be a patient-centered primary care medical home that provides care to infants, children and adults of all ages. Clinical staffing for each site will be chosen to promote a consistent provider-physician relationship in a culturally proficient manner. Both sites will provide care on an integrated electronic medical record that is shared by the hospital and the physician community. Additionally, the two sites will share resources designed to address adverse social determinants of health: lack of insurance, domestic violence, poor health literacy, and other factors.

The Anne Arundel County Department of Health, the City of Annapolis and the Anne Arundel Medical Center – as well as other partnering organizations and volunteers – have had a long and trusted relationship in supporting a city-based dental and medical clinic. As health care needs have changed in our City, these organizations have helped to serve our residents. In 1998 Anne Arundel Medical Center opened the Outreach Center clinic at the Stanton Center ago where our residents have received care and supportive County services. The Stanton Center is central to African American life in Annapolis.
The basic aim of this proposal is to establish a new primary care clinic in HACA's Morris H. Blum Senior/Disable Housing complex in cooperation with the City and our partners. It also will establish a prenatal and maternity clinic in the Stanton Center. These programs will provide sorely needed prenatal care, obstetrical services, and primary care right in the community.

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Phyliss A. Gibbs
Deborah A. Johnson
Jeffrey C. Henderson
Elizamae Robinson

Executive Director
Vincent O. Leggett

On behalf of HACA, we are pleased to commit 1200 Square footage of rent-free space for the duration of this grant. Further, given this new focus on improving the lives of residents in this zip code, and our past strong relationship with community partners, we hope to continue this relationship well into the future.

Sincerely,

Vincent O. Leggett
Executive Director

November 14, 2012
Date

1217 Madison Street• Annapolis, MD 21403 • Phone: 410-267-8000 • Fax: 410-267-8290
TTY/TDD: 711

Joshua J. Cohen, Mayor
City of Annapolis
160 Duke of Gloucester Street
Annapolis, Maryland 21401

Chartered 1708

November 14, 2012

To Whom It May Concern:

The City of Annapolis is pleased to support the effort to improve the health of our most underserved citizens under the proposed guidelines of a Health Enterprise Zone. Health disparities and health access are major issues for a large population of 30,000 citizens residing in the 21401 zip code. This proposal engages key partners to address these issues, including the Anne Arundel County Department of Health, the Healthy Anne Arundel Coalition, the Housing Authority of the City of Annapolis and the Anne Arundel Medical Center.

The primary aim of this proposal is to establish two sites, within walking distance of each other, and nestled within the community they seek to service. Together, they will provide comprehensive, coordinated care for this underserved population. One site will be dedicated to prenatal and post-partum care. The other will be a patient-centered primary care medical home that provides care to infants, children and adults of all ages. Clinical staffing for each site will be chosen to promote a consistent provider-physician relationship in a culturally proficient manner. Both sites will provide care on an integrated electronic medical record that is shared by the hospital and the physician community. Additionally, the two sites will share resources deigned to address adverse social determinants of health: lack of insurance, domestic violence, poor health literacy, and other factors.

The City of Annapolis has a long and fruitful relationship with the Anne Arundel County Department of Health and the Anne Arundel Medical Center, and a very close relationship with the Housing Authority of the City of Annapolis. As health care needs have changed in our City, these organizations have helped to serve our residents. In 1998 Anne Arundel Medical Center opened the Outreach Center clinic at the Stanton Center ago where area residents can receive care and supportive County services. The Stanton Center is a historic building dating from 1900, and central to African American life in this City.

The basic aim of this proposal is to establish a new primary care clinic in the City's Glenwood Senior Citizen Morris Blum Center in cooperation and with enthusiastic endorsement of the Housing Authority of the City of Annapolis. It also seeks to establish

a prenatal and maternity clinic in the Stanton Center. These programs will provide sorely needed prenatal care, obstetrical services, and primary care right in the community. On behalf of the City of Annapolis, I am pleased to commit the 1,500 square feet of space rent-free in the Stanton Center, in addition to the existing free dental clinic coordinated by Anne Arundel Medical Center, for the duration of this grant. Further, given the City's new focus on improving the lives of residents in public housing, and our past excellent relationship with community partners, I expect the City would continue this relationship well into the future.

Sincerely,

Joshua J. Cohen
Mayor

JJC:sc

ANNE ARUNDEL COUNTY
MARYLAND
County Executive John R. Leopold

Department of Health
J. Howard Beard Health Services Building
3 Harry S. Truman Parkway
Annapolis, Maryland 21401
Phone: 410-222-7375 Fax: 410-222-7294
Maryland Relay (TTY): 1-800-735-2258
www.aahealth.org

Angela M. Wakhweya, M.D., MSc.Econ.
Health Officer

November 14, 2012

Mr. Mark Luckner
Executive Director
Maryland Department of Health & Mental Hygiene
Maryland Community Health Resources Commission
45 Calvert Street, Room 336
Annapolis, MD 21401

Dear Mr. Luckner,

The Anne Arundel County Department of Health is pleased to support the effort to improve the health of our most underserved citizens under the proposed guidelines of a Health Enterprise Zone. Health disparities and health access are major issues for a large population of 30,000 citizens residing in the 21401 zip code. This proposal engages key members of our Healthy Anne Arundel Coalition to address these issues, including Anne Arundel Health System, the City of Annapolis, the Housing Authority of the City of Annapolis, and the Anne Arundel County Department of Health.

The primary aim of this proposal is to establish two care sites, within walking distance of each other, and nestled within a community with high health disparities. Together, they will provide comprehensive, coordinated care for this underserved population in the 21401 zip code. One site will be established at the Stanton Center to provide prenatal and post-partum care at the Stanton Center. The other will be a patient-centered primary care medical home to be established at the City's Glenwood Senior Citizen Morris Blum Center in cooperation and with the enthusiastic endorsement of the Housing Authority of the City of Annapolis. It will provide care to infants, children and adults of all ages. Clinical staffing for each site will be chosen to promote a consistent provider-patient relationship in a culturally proficient manner. Both sites will share an integrated electronic medical record between the hospital and the physician community. Additionally, the two sites will share resources designed to address adverse social determinants of health: lack of insurance, domestic violence, poor health literacy, and other factors.

The Anne Arundel County Department of Health, the City of Annapolis and the Anne Arundel Health System – as well as other partnering organizations and volunteers – have had a long and fruitful relationship in supporting a city-based dental and medical clinic. As health care needs have changed in Annapolis, these organizations have continued to work together to help serve our residents. In 1998 Anne Arundel Medical Center opened the Outreach Center clinic at the Stanton Center, where area residents can receive health care and supportive County services. The Stanton Center is a historic building dating from 1900, and central to African American life in Annapolis.

On behalf of the Anne Arundel County Department of Health, we are pleased to commit to working with the partners on this HEZ grant to support the proposed clinical services through linkages with important programs available through the Department of Health, including but not limited to: the Women, Infants and Children's Supplemental Nutrition Program (WIC), Healthy Start home visiting, our REACH program, and MEDICAID eligibility and enrollment programs, for the duration of this grant. Further, given this new focus on improving the lives of residents in this zip code, and our past strong relationship with community partners, we hope to continue this relationship beyond the grant period and well into the future.

Sincerely,

Angela Wakhweya, MD. MSc.Econ
Health Officer
Chair, Healthy Anne Arundel Coalition

cc: Victoria Bayless, President and CEO, Anne Arundel Health System
Lisa Hillman, Senior Vice President, Legislative Affairs, Anne Arundel Health System
Dr. Jinlene Chan, Deputy Health Officer, Healthy Families Administration
Ronna Gotthainer, Deputy Health Officer, Operations

THE MARYLAND GENERAL ASSEMBLY
ANNAPOLIS, MARYLAND 21401

November 14, 2012

Mr. Mark Luckner
Community Health Resources Commission
45 Calvert Street
Annapolis, MD 21401

Dear Mr. Luckner:

We are pleased that the Commission is moving aggressively to implement HB 493 and SB 234 - The Maryland Health Improvement and Disparities Reduction Act of 2012. The legislation provides important incentives to non-profits, community based organizations, and providers to work together to address disparities and access issues in healthcare.

The application submitted by *Anne Arundel Health Systems* and the *Housing Authority of Annapolis* is an example of a project that will have a significant impact on addressing the challenges in our local area. We are proud that our hospital system and the housing authority are collaborating to identify the needs of and contributing resources to underserved populations.

The proposal would create a new primary care health clinic at the *Morris Blum Senior Apartments* in the Clay Street community. The clinic's design will be based on medical-home principles that emphasize care coordination, patient engagement, and quality outcomes. The clinic will provide access to high-quality primary care to an underserved population. The proposal also seeks to add prenatal and maternal care resources to the clinic at the *Stanton Center* in Annapolis. The *Stanton Center* already provides needed primary care services for an underserved population. We believe that adding an additional clinic to *Glenwood* and placing more maternal health resources at *Stanton* will significantly increase access and reduce health disparities.

Again, thank you for implementing this important legislation and for considering this important application.

Sincerely,

John C. Astle
State Senate

Michael E. Busch
Speaker of the House

MEDICALMALL
HEALTH SERVICES

November 12, 2012

Patricia Czapp, MD
Anne Arundel Medical Center Foundation
2002 Medical Parkway
Sajak Pavilion, Suite 550
Annapolis, MD 21401

Dear Dr. Czapp:

Medical Mall Health Services (MMHS) is pleased to provide this letter affirming our commitment to support the Anne Arundel Medical Center Foundation's Health Enterprise Zone's Grant Application to the State of Maryland, Community Health Resources Commission. Health Disparities and health access are major issues for a large population of the 30,000 citizens residing in the 21401 zip code. This proposal engages key partners to address these issues including the Anne Arundel County Department of Health, members of the Healthier Anne Arundel Coalition, the City of Annapolis, the Housing Authority of the City of Annapolis and the Anne Arundel Medical Center (AAMC).

The primary aim of this proposal is to establish two sites, within walking distance of each other, and nestled within the community they seek to service. Together, they will provide comprehensive, coordinated care for this underserved population. One site will be dedicated to prenatal and post-partum care. The other will be a patient-centered primary care medical home that provides care to infants, children and adults of all ages. Clinical staffing for each site will be chosen to promote a consistent provider-physician relationship in a culturally proficient manner. Both sites will provide care on an integrated electronic medical record that is shared by the hospital and the physician community. Additionally, the two sites will share resources deigned to address adverse social determinants of health: lack of insurance, domestic violence, poor health literacy, and other factors.

The 21401 zip code is socioeconomically impoverished, medically underserviced and characterized by health inequity. Anne Arundel Medical Center proposes to increase medical, behavioral, and social services by establishing an integrated patient-centered medical center home in the City's Glenwood Senior Citizen Morris Blum Center in corporation with the Housing Authority of the City of Annapolis. We will also establish a prenatal and maternity clinic in the Stanton Center. These programs will provide vitally needed primary care and obstetrical services to residents that reside in a medically isolated community.

Medical Mall Health Services (MMHS) is a Maryland Corporation that provides healthcare solutions to reduce costs and improve patient outcomes for patients -- served by acute care hospitals, skilled nursing facilities, and Patient-Centered Medical Homes. Our services include community-based care transitions services, community-based intensive case management, medication management, and care coordination services.

The potential to expand the availability of primary care resources to residents of 21401 directly impacts the work that MMHS is performing at Anne Arundel Medical Center. During the past year we have been working with Anne Arundel Medical Center and the Delmarva Foundation to implement an evidence-based intervention to reduce unnecessary readmissions to AAMC. Part of our evidence-based intervention is to ensure that patients that are discharged from an acute care facility have a follow-up appointment with a primary care provider, within seven days of discharge from the hospital. Through the expanded collaboration with the AAMC, MMHS will be an active participant in the Health Enterprise Zone, providing essential care coordination services for residents of the target zip code.

Sincerely,

Timothy P. McNeill, RN, MPH
Chief Operating Officer

10110 Molecular Drive
Rockville, MD 20850
Phone: (202) 344-5465
E-Mail: tmcneill@medicalmallhs.com

Patricia Czapp, M.D.

Annapolis, Maryland
pczapp@aahs.org

Employment

2010-present, Chair of Clinical Integration, Anne Arundel Health System. Champion the integration of inpatient and outpatient care, promote population health strategies, and support health system-wide quality aims. I promote optimization of AAHS' patient-centric EMR, develop chronic disease management models, and design and implement programs to reach marginalized patient populations in the community. As a member of Health System administration I work collaboratively to implement models (e.g. ACO) to engage our physician community in mutually beneficial relationships, whether they are employed by the Health System or practice independently.

2010-present, Medical Director of Primary Care, Anne Arundel Physician Group. Recruit new medical staff, expand our primary care division, and promote quality initiatives via physician engagement and incentives. I have implemented the Patient-Centered Medical Home model of care in our ten primary care practices, designed a medical assistant enrichment program, and promoted meaningful use of our EMR.

2007-2010,Community Practice Representative, Anne Arundel Health System. Bridge the gap between outpatient and inpatient care, and represent the needs of primary care physicians to the Health System in such forums as the Medical Executive Committee, the Strategic Planning Committee, and the Board of Directors. During this period, I worked as Physician Champion of an integrated electronic medical record system and led a key work group of physician and administrative leaders in developing the vision and strategic ten-year plan for the Health System.

1999-present, Staff Physician Anne Arundel Physician Group, Annapolis, MD
1995-1999 Staff Physician, Johns Hopkins Community Physicians, Annapolis, MD
1993-1995 Staff Physician, Potomac Physicians, Severna Park, MD.

Leadership and Committee Positions

2012, Chair, Subcommittee on Health Equity, American Academy of Family Physicians.
2011-present, Member, Commission on Health of the Public and Science, American Academy of Family Physicians.
2011-present, Member, Health Delivery Reform Subcommittee, State of Maryland
2011- present, Member, Board of Directors, MidAtlantic Business Group on Health
2003-2006, Chief of Family Medicine, Anne Arundel Health System.
2000-2003 Associate Chief of Family Medicine, Anne Arundel Health System
1992-1993 Chief Resident, Family Medicine, Georgetown University.

Education

1990-1993 Georgetown University Family Medicine Residency Program, Washington DC
1988-1990 Georgetown University School of Medicine, M.D.
1986-1988 University of Michigan Medical School
1981-1985 University of Michigan, BS, Anthropology-Zoology, With Distinction

Henry J Sobel, M.D., MBA
Diplomate A.B.O.G., Fellow A.C.O.G., Fellow A.C.S.
Obstetrics and Gynecology
Annapolis, Maryland 21401

PROFESSIONAL POSITIONS

4/07 - Present	Department Chair – Women and Children's Health,
12/02 - 10/04	Chief, OB/GYN Service
2/01-12/02	Member, Maternal Child Health Committee
1/00 -12/02	Associate Chief- OB/GYN Service
1/00-11/02	Member, Credentials Committee
7/81 -11/04	Attending OB/GYN, Medical Staff Anne Arundel Medical Center, Annapolis, MD
6/05 - 1/07	Senior Health Policy Advisor, U.S. Senator Tom Coburn, M.D., Washington, D.C.
4/05 – Present	Volunteer OB/GYN Physician, Outreach Center free clinic at Stanton Center, Annapolis, MD
4/85 - 11/04	Private Practice, Annapolis, MD
7/81 - 4/85	Associate Practice, Annapolis, MD

EDUCATION, PROFESSIONAL ASSOCIATIONS, PANELS and BOARDS

2/05 - Present	M.B.A., Business of Medicine, Johns Hopkins University Carey School of Business, MD
7/77 - 6/81	Internship and OB/GYN Residency, Washington Hospital Center, Washington, D.C.
8/73 - 6/77	M.D. , Howard University, College of Medicine, Washington, D.C.
9/69 - 6/73	B.A. Biology, Lafayette College, Easton, PA
9/10 - Present	Med-Chi/ Maryland DHMH Maternity Mortality Review Committee, Baltimore, MD
6/06 - Present	Fetal & Infant Mortality Review Committee, Anne Arundel County Department of Health, Annapolis, MD
2/01-11/04	Specialty Committee Member, OB/GYN Committee, MAMSI/Mid Atlantic Medical Services, Inc.
6/04 - 9/08	Various lectures, conferences and panels about health care policy

MAURA A. CALLANAN, M.S., MBA

443.481.6967 Office **mcallanan@aahs.org**

PROFESSIONAL EXPERIENCE

ANNE ARUNDEL MEDICAL CENTER, Annapolis, MD **2007 – present**

Executive Director, Women's & Children's and Surgical Services
Ensures the provision of high quality cost effective health care for the clinical initiatives, develops clinical programs for both Women's & Children's and Surgical Services and is responsible for strategic development, physician recruitment, growth and clinical program implementation. Collaborates with physician and other clinical leaders for programmatic planning and implementation of strategic organizational department goals and objectives.

THE VALLEY HOSPITAL/VALLEY HEALTH SYSTEM, Ridgewood, NJ

Director of Children's Services **1999 – 2006**
Directed strategic and daily operations of all pediatric services including the Neonatal Intensive Care Unit, Pediatric and Pediatric Intensive Care Units and Center for child Development. Developed and managed $8.6 million annual budgets and 190 FTEs.

Manager, Family Wellness **1997 – 1998**
Managed NICU, Pediatrics and Center for Child Development.

Manager, Center for Child Development **1996 – 1997**
Managed ambulatory center.

Manager, Social Services/Discharge Planning **1993 – 1996**
Coordinated delivery of all case management and social services .

Social Worker Positions, Valley, St. Joseph's, and Barnert Hospitals, NJ **1985 – 1993**

EDUCATION

University of Maryland, University College, **Masters in Business Administration** **2012**
4.0, elected to the Honor Society of Phi Kappa Phi for excellence in academic achievement
Columbia University, New York, NY **M.S.** School of Social Work, magna cum laude
Providence College, Providence, RI **B.A.** Social Work, magna cum laude

Robert Scott Eden, M.D.
Annapolis, Maryland

Board Certified in Family Practice: 1983 to the present.

Private Practice: 1984 to the present, Annapolis Primary Care.

Employment, Anne Arundel Health System, Annapolis MD:

Medical Director, Community Health Center: January 2011 to the present.

Medical Director, Outreach Center: January 2012 to the present.

Associate Faculty Member, 1983 to 1984, Duke-Watts Family Medicine Program.

Education:

Medical School: 1976 to 1980, Duke University School of Medicine.

Residency: 1980 to 1983, Duke-Watts Family Medicine Program, Durham, N.C. Chief Resident 1982 to 1983.

College: 1971 to 1975, Duke University, BS in Zoology.

Dr. Scott Eden designed the Eden Model of PCMH, which provides for two medical assistants (MA) per provider rather than the traditional one medical assistant to one provider ratio. The medical assistants are specially trained to work to the top of their license and perform patient assessments at each visit, providing more value to the patient and the provider. Their assessments include medical and psychosocial aspects of each patient's medical problems, plus an assessment of what scheduled health maintenance items are due. They also provide wellness recommendations. These observations are recorded in the electronic medical record and discussed with the providers so that targeted plans can be implemented and executed. With two MAs doing this advanced level of intake at the same time for two patients for one provider, the provider never waits to see a patient. The team-based Eden Model allows for greater capacity per provider, often allowing 30 rather than 22 to 23 patients to be seen per day for 30% greater capacity per provider with improved patient, staff, and provider satisfaction.

Discussions and Panels about the Eden Model:

CareFirst, Maryland, 2011, panel discussion regarding Eden model for Medical Assistants
CareFirst Colloquium, Rhode Island, November of 2010, "Using Medical Assistants to Their Full Capacity"

Mary Jo Palmer
mpalmer@aahs.org or mjpalmer@verizon.net

Experience:

April 1996 – Present: Anne Arundel HealthCare Enterprises, Inc. *A subsidiary of Anne Arundel Health Systems (AAHS)*

Recent Achievements:
January 2011 - Opened AAMC Community Health Center in Annapolis, MD
March 2010 – Assumed management of the Annapolis Outreach Center, Annapolis, MD

July 2007 – Present: Director of Client Services (AAHS)
This department focuses on recruitment, start up and maintenance of physicians in the community. With high malpractice rates, cost of living and low insurance reimbursement in the state of Maryland, the Health System began providing support to physicians on staff at AAMC. My role in this department concentrates on the start-up of new physician practices, project management, market share, new technology, community benefit and public health and managing timeshare suites. I am currently responsible for the training, education and support of 350+ users on the athenahealth practice management and revenue cycle software system. During my tenure in this position, I directed the organization in implementing athenahealth in 2005. The implementation was successfully completed in 28 offices within 4 days. My team was also instrumental in the implementation of EPIC Electronic Health Record for the health system.

October 2004 – July 2007: Director of Physician Reimbursement (AAHS)
Developed and maintained support infrastructure for 100+ AAMC affiliated physicians for billing, credentialing, compliance, training, and IS issues. My duties included Fiscal Management, Operations Management, Staff Management, Planning, Problem Solving and Decision Making, Quality Management and Community Relations. I provided expertise in regulatory, financial, ICD-9 and CPT coding and IS support/helpdesk procedures.

November 1998 – October 2004: Billing Manager (AAHS)
Directed the overall operation of the Central Billing Office (CBO). Expanded the CBO from eight physicians and four employees to more than 100 physicians and 25 employees. Managed accounts receivables of more than $5 million dollars, with charges totaling $50 million and collections of $25 million annually.

November 1995 – November 1998: Practice Manager (AAHS effective April 1996)
Managed medical office of five providers with responsibilities that included accounts payables, accounts receivables, HR, daily operations and practice management.

May 1989 – November 1995: Various Office or Business Manager positions, Northern Virginia

Education:
Altoona School of Commerce, Altoona, PA, Associate in Specialized Business Degree, 1986