

A report to the Maryland
Community Health Resources Commission,
based on five promising collaborations, on
promoting the capacity and sustainability
of Maryland's safety net providers to
deliver health care services in underserved
communities.

Sustaining Community- Hospital Partnerships to Improve Population Health

Recommendations on
sustaining innovative models

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**Maryland Community
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Commission**

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Executive Summary

The Maryland Community Health Resources Commission (“the Commission”) has marked nearly a decade of support for community health resources.

This is a time of major change throughout Maryland’s health care system. These changes include a major expansion of Medicaid, creation of a state health insurance exchange, the State Health Improvement Process supported by Local Health Improvement Coalitions, multiple federal delivery and financing innovation grants, the implementation of Maryland’s All-Payer Model, and various private sector-led reforms. The Commission’s actions to enhance the effectiveness and vitality of Maryland’s safety net providers and promote access to affordable, high-quality health services in underserved communities will likely be an important contributor to the success of these reform efforts. This paper reviews the experiences of five promising Commission grants centered on collaborations between community health resources and hospitals, incorporates findings from key informant interviews with an array of grantees and summarizes recurring themes which arose during a series of four regional forums. The paper is designed to promote the long-term sustainability of successful grant projects awarded by the Commission and the ongoing efforts of Maryland’s safety net providers to deliver health care services in underserved communities.

Drawing from these sources, the paper presents two sets of recommendations for Commission consideration, those which are general and others specifically related to the sustainability of promising partnerships following the Commission’s investment. Key among those recommendations are:

- The Commission is uniquely positioned to explore the health, economic and related return on investment (ROI) of grants aimed at upstream improvements to a community’s social or economic conditions.
- In concert with its grant-making activities, the Commission could facilitate technical assistance to its constituencies in a wide range of areas including data access and analysis, financial modeling, disseminating information on successes and challenges of clinical-community partnerships.
- The Commission could explore multi-investor partnerships with hospitals, other governmental units, payers and the business sector to jointly fund projects of mutual interest.
- The Commission, with the HSCRC, could explore opportunities under the new All-Payer Model’s hospital global budgeting for ongoing, post-grant hospital support of successful partnerships.
- The Commission could partner with Medicaid and other payers to evaluate reimbursement for effective community interventions.
- The Commission could work to leverage non-profits’ Community Benefits spending toward sustainability.
- The Commission could explore emerging public-private financing innovations known as social impact bonds or pay-for-performance contracts.

The Commission enjoys three key attributes as its foundation for continued health system leadership: a unique focus on community health resources, a statutory capacity to advance its mission through investments, and an earned reputation for integrity and accountability. Through its investment activities, the Commission has strengthened community networks, advanced the practice of population health and performance monitoring and, most importantly, improved the health of underserved Marylanders. The Commission is capable and well-positioned to continue this leadership into its next decade.

Purpose

The Maryland Community Health Resources Commission (“the Commission”) has marked nearly a decade of support for community health resources. “Community health resources” are defined here as health care programs or providers that deliver health care services to low-income and uninsured individuals, regardless of the insurance status or ability of the individual to pay for these services. Examples of community health resources, also referred to as “safety net providers,” include Federally Qualified Health Centers, local health departments, behavioral health programs, school based health centers, and other programs with a historic mission of serving low-income and uninsured Marylanders.

The Commission has a unique role in the State and has important responsibilities to the general public and State elected leaders, to its community health resource constituency, and to those underserved Marylanders who rely on community health resources for their own personal health services.

This is a time of major change throughout Maryland’s health care system. Federal and State initiatives are transforming the manner in which health care is delivered and financed. Just as importantly, there are heightened consumer expectations that the experience and quality of health services both for patients and for communities will improve.

The Commission has a unique perspective and important expertise to contribute to the management and implementation of change in Maryland’s health care system. The Commission’s actions to enhance the effectiveness and vitality of Maryland’s safety net providers can be an important contributor to the success of these reform efforts.

Reflecting the various reforms currently underway, particularly those impacting hospital operations and finance, the Commission is seeking an assessment of selected community-hospitals partnership grants.

This paper reviews the experiences of five promising Commission grants centered on collaborations between community health resources and hospitals. The review is based on documentation filed by the grantees with the Commission as well as numerous key informant interviews with an array of leaders in participating hospitals, non-profit organizations and local health departments. The paper also summarizes recurring themes which arose during a series of four regional forums held across the State on the subject of community-hospital partnerships. Lastly, the paper presents recommendations for future Commission consideration and action.

Chapter One: Introduction

The Commission's Capabilities

On May 10, 2005, the Governor of Maryland, Robert L. Ehrlich, Jr., signed into law the Community Health Care Access and Safety Net Act of 2005. HB 627/SB 775 approved by the Maryland General Assembly in 2005 authorized the creation of the quasi-independent Maryland Community Health Resources Commission (“the Commission”). The purpose of the Commission, as stated in the enabling statute, includes expanding access to affordable, high quality health care services in the state’s underserved communities; supporting the adoption of health information technology by community health resources; increasing access to specialty health care services for the uninsured and low-income individuals; and promoting interconnected systems of care and partnerships among community health resources and hospitals.

With the Commission’s first eleven members appointed, regulations (COMAR Title 10, Subtitle 45) were promulgated in November 2006 detailing the Commission’s organizational structure, definitions and grant-making procedures.

Provisions of its enabling statute afford the Commission a specific role and unique capabilities. The Commission is one of three independent commissions budgeted through the Department of Health and Mental Hygiene (DHMH). While operating in close alignment with DHMH and the State’s other health-related commissions, it uniquely supports the generally under-capitalized safety net entities operating in the State’s complex health system. While enjoying strong local support and the commitment of highly dedicated volunteers, staff, local governing boards and patients, the scale and fragmented nature of these entities place them at an infrastructure disadvantage. In establishing the Commission, public health leaders in the legislative and executive branches reflected the view that such entities have both historic significance and continuing relevance in providing trusted and accessible care to difficult-to-reach people and communities across the State. Supporting such community health resources to develop the internal capabilities and external networks necessary to thrive is the Commission’s unique role.

Another unique feature of the Commission is its special, non-lapsing fund, the Community Health Resources Fund. The Fund is held separately by the Treasurer and may receive donations, grants and other contributions from additional external sources to support the mission and operation of the Commission. The Fund provides the Commission with the potential of develop and manage a portfolio of investments, subject to State audit and aimed at advancing the Commission’s mission.

In addition to its specific and unique statutory responsibilities, the Commission been distinguished by its record of performance. Over nearly a decade of public and competitive transactions, the Commission has garnered respect and credibility across an array of public and private stakeholders. The relevance, transparency and integrity of the Commissioners’ proceedings and policy decisions and the staff’s rigorous but supportive grantee performance management demonstrate accountable executive functions. The Commission has been a pioneer

in advancing the practice of outcome-based performance monitoring in the area of population health improvement. The award selection process and the grantee reporting system convey grantee requirements that include a logic model, business plan, relevant metrics and sustainability plan. By developing, refining and acting on its performance monitoring system, the Commission has, in effect, modeled and coached scores of agencies and organizations on essential elements of strategic planning, goal setting, performance management and successful operational execution.

Emerging forces are producing significant and lasting change in Maryland's health system. Accordingly, the Commission is continuing to reassess its investment priorities, practices, and areas of focus. The three features previously noted-- a unique focus on community health resources, a statutory capacity to advance its mission through investments, and an earned reputation for integrity and accountability – offer the Commission a strong foundation on which to build future success.

The Commission's Investments

The Commission's first Annual Report (2006) set forth a broad operational plan to accomplish its mission. The Report stated "Through grants, community assessments, and technical assistance, the Commission will work to increase access to care for low-income families and under- and uninsured individuals in Maryland. The Commission will help communities develop more coordinated, integrated systems of community-based care, redirect non-emergency care from hospital emergency rooms to other providers in the community, and assist individuals in establishing a medical home. The cornerstone of these efforts will be 'community health resources' that will be eligible to apply for and receive grants from the Commission."

The first Call for Proposals was released on October 4, 2006, focusing on emergency department (ED) diversion, integration of mental health, substance abuse treatment and primary care, and other projects to expand or integrate systems of care for underserved populations. In January, 2007, the first round of awards was issued, totaling \$4.6 million.

A month after the Commission's first round of awards, in February 2007, a child's tragic and preventable death signaled unacceptable system barriers to accessing dental care in Maryland. The Commission responded by issuing targeted funding of \$1.5 million to expand dental services and added improved oral health as an annual funding priority, which remains today. To date, the Commission has funded 23 dental projects for over \$5.2 million. Although oral health challenges remain, especially for low income adults, access to pediatric dental care has improved markedly throughout the state and Maryland received national recognition for this progress.

Through 2014, the Commission has awarded 143 grants totaling \$42 million, supporting programs which collectively served more than 140,000 Marylanders in every jurisdiction of the state. Initial grant funding provided by the Commission has enabled its grantees to leverage \$14.7 million in additional federal and private/non-profit resources. The Commission's annual budget has grown from \$3 to \$8 million in recent years and in 2014 the Legislature acted to

reauthorize the Commission through June 2025. Commission grants have been awarded in the following general areas:

- Addressing specific health problems (infant mortality, oral health, mental health, substance abuse, and childhood obesity);
- Expanding access to primary care for underserved populations, including ED diversion programs;
- Enhancing capacity of safety net providers, including improved information technology and business planning;
- Supporting Local Health Improvement Coalitions; and
- Supporting Health Enterprise Zones.

These grant areas reflect the Commission's response to nearly a decade of evolving health issues and public policy priorities. Enhancing the capacity of community health resources to deliver primary care and to contribute public health solutions has been central to the Commission's work since it was founded. As further public health problems and policy responses emerge, the Commission has responded with new funding priorities. For instance, recognition of the need for locally-led and data-informed community health improvement efforts led to the 2012 launch of the State Health Improvement Process and the Local Health Improvement Coalitions, toward which the Commission contributed both start-up and competitive advanced practice awards. An innovative approach to address persistent community-wide disparities in illnesses and health costs was reflected in the legislative action to create Health Enterprise Zones, with funding and fiscal oversight provided by the Commission.

The Commission's history reflects responsiveness and relevance which continues as the Commission seeks to advance its contributions in today's dynamic health system landscape.

Chapter Two: Importance of Partnerships in Today's Context

The Commission's role in strengthening Maryland's community health resources became even more important as the Affordable Care Act (ACA) was implemented in Maryland, resulting in hundreds of thousands of individuals gaining access to health coverage. In 2012, anticipating increased demand by newly insured patients and the potential for eroding federal grants to safety net providers, the Commission developed a business plan to support safety net providers' transition from relying on grant revenues to a more sustainable model based on third-party reimbursement.

In addition to authorization for a major Medicaid expansion and the launch of the State's health insurance exchange to access Qualified Health Plans, other provisions of the federal ACA are impacting community health resources. The federal government, notably the Center for Medicare and Medicaid Innovation, has funded numerous grants in Maryland, including a State Innovation Model Design grant, Health Care Innovation awards, Bundled Payment for Care and Medicare Accountable Care Organization grants, Strong Start for Mothers and Newborns, and Federally Qualified Health Center Advanced Primary Care Demonstration grants. These initiatives are introducing delivery and financing changes which impact safety net providers, and Commission grants are assisting safety net providers in their ongoing efforts to respond to these new and ongoing opportunities.

Federal grants are accelerating the design, construction and adoption of health information technology (HIT). The intent of the federal effort is to encourage meaningful use of electronic health records and inter-provider connectivity for more effective clinical practice and population health improvement. As HIT adoption advances, there is growing demand by providers, payers, governmental agencies and consumers for compatibility between systems, for more complete and integrated clinical and administrative data sets, and for specialized analytics to transform data into intelligence and effective tools for decision support. The Commission has a statutory responsibility to support IT advancements on behalf of community health resources. In the rapidly evolving arena of HIT, the Commission has encouraged grantees to act as both HIT generators and consumers, has taken steps to inform HIT developers of the needs of safety net providers and has awarded a number of grants in recent years to enable safety providers to install and utilize IT systems.

In addition to federal influences, private innovation is driving change. Examples include payer-supported advanced primary care models such as the patient-centered medical home, efforts to expand clinicians' scope of practice, retail interest in aspects of clinical care, employer interest in exploring wellness and benefit design changes, and consumer efforts to improve the quality of health information and patient experience. Separate but concurrent with federal and state policy impacts, new approaches by private sector stakeholder groups are rapidly changing the environment in which Maryland's community health resources operate.

Formation of the local health improvement coalitions (LHICs) in 2012 was supported by the Commission, along with funding from DHMH, the Maryland Hospital Association and, in some areas, local funds. LHICs, composed of local health departments, safety net and other providers,

schools, businesses, faith groups and consumers, are the local agents to achieve measurable change through the State's Health Improvement Process. In many areas of the State, LHICs have demonstrated leadership and innovation in partnering with community health resources and will continue to impact the Commission's work in the future.

A major development impacting the entire health system is Maryland's new All-Payer Model, previously known as the Hospital Medicare Waiver. Under the new Model, hospital revenues transition from a volume-driven fee-for-service model to a value-based global budget approach, rewarding prevention, quality, and avoidance of unnecessary care. As the incentives shift in response to new All-Payer Model factors, hospitals are seeking effective and efficient community-based services for residents of their service areas. The new All-Payer Model's value-based incentive structure aims to produce bottom line savings for hospitals able to implement effective alternatives to hospitalization. Improvements in overall population health may generate financial benefits that inure to hospitals. Exploring new relationship opportunities between community health resources and hospitals is the focus of several recent Commission grants. Reducing unnecessary emergency department visits, hospital admissions, and readmissions will require new partnerships and new capacities for safety net providers. The Commission's interest in monitoring and supporting high-performing partnerships which effectively improve population health is expected to continue in the future.

Chapter Three: Five Promising Partnership Grants

Partnership Grant Summaries

Between 2012 and 2014 the Commission issued seven grants, totaling \$2.4 million, explicitly designed around collaborations with hospital partners. The following are summaries of five of these community-hospital collaboration grants, four of which continue to operate at the time of this writing.

1. Community Case Management Program: Cecil County Health Department and Union Hospital of Cecil County

The Community Case Management Program (CCMP) partnership between the Cecil County Health Department (CCHD) and Union Hospital of Cecil County (UHCC) operated for just over one year, beginning in June, 2013 with the hospital's initial staffing (1 full-time nurse), later supplemented with an additional full-time nurse supported by a one-year Commission grant. The program operated until October, 2014 and was discontinued when the grant expired.

The partnership was aimed at reducing unnecessary hospital readmissions for certain chronic conditions (COPD/ respiratory diseases, heart failure/ heart disease and diabetes) through a four-six week standardized in-home intervention, using Boston University Medical Center's "Project Re-Engineered Discharge" (RED) program. <http://www.bu.edu/fammed/projectred>

Union Hospital, a voluntary participant in the Hospital Services Cost Review Commission (HSCRC) Total Patient Revenue pilot, which preceded statewide implementation of the new All-Payer Model, had been funding one full time nurse to focus on avoiding readmissions for complex patients. The caseload for the single nurse was quickly overwhelmed, so the introduction of new Commission funds allowed for a second nurse, in-home follow-up visits, various patient teaching and other administrative supports necessary for the program. Several implementation issues arose in the partnership, including (1) differing work schedules for team members comprising UHCC and CCHD employees and (2) delays due to orienting the CCHD staff to the hospital's new EMR system. Another challenge was to establish a secure, bilateral communications platform to track and share elements of patient progress between hospital and community-based staff. Ultimately a proprietary electronic system was adapted to support facility-community care management linkages, with the capacity to receive Emergency Department alerts from the State's health information exchange operated by the Chesapeake Regional Information System for Our Patients (CRISP.)

...program participants experienced a 73% reduction in emergency department visits, a 58% decline in in-patient admissions, and a 68% reduction in observation visits...with an estimated average savings of over \$4,100 per participant

Based on its own data, Union Hospital reported that the program reduced the rate of in-patient admissions, observation and emergency department visits by the observed 160 program participants when compared with the participants' pre-program utilization. Comparing utilization in the 30 days prior to the

program-triggering hospital admission with 30 days following discharge, program participants experienced a 73% reduction in emergency department visits, a 58% decline in in-patient admissions and a 68% reduction in observation visits. However, without observing the 30 day post-discharge utilization of a matched cohort, it is not known what proportion of the savings were attributable to the program's impact.

In the 15 months of program operation, savings of over \$662,000 were estimated by the hospital to have been accrued due to avoided utilization, an estimated average savings of over \$4,100 per participant. Adjusted for program expenses, the result was an estimated net savings of as much as \$460,000 over a 15 month period.

Despite early indicators of success, the program was not continued beyond the expiration of the Commission grant. Instead, Union Hospital deployed its nurse practitioner hospitalists to undertake a reduced case management effort for a smaller group of complex patients following discharge. The two program nurses, employees of the CCHD, were re-assigned within the Department. In the original proposal to the Commission, the partners stated that Union Hospital would sustain the program following the grant's term and suggested that local physicians engaged in practice innovation might also contribute to supporting community-based case management. However, inexperience with operating under the new All-Payer Model was identified by various informants as a short-term deterrent to hospitals' willingness to assume post-grant program costs, even for those programs which demonstrate early success.

2. Tri-County Health Improvement Plan (T-CHIP): Worcester County Health Department, Atlantic General Hospital and Peninsula Regional Medical Center

The Tri-County Health Improvement Coalition of Somerset, Wicomico and Worcester Counties, led by the Worcester County Health Department (WCHD), submitted a proposal to the Commission to reduce the overall rate of diabetes-related ED visits and the associated racial disparities. All three counties experienced rates of diabetes-related ED visits in excess of the State rate and significant racial disparities in these ED visits. The proposal requested \$250,000 for a 15 month period. The proposal was based on local utilization research. Specifically, a demographic, payer and geographic analysis was conducted using de-identified diabetes-related ED visit records obtained by the WCHD from Atlantic General Hospital (AGH) and Peninsula Regional Medical Center (PRMC) for a 10 month period. The hospitals agreed to continue to forward ED data quarterly for purposes of frequent-user patient selection and program evaluation.

The proposed intervention was also grounded in a literature review. The T-CHIP intervention was tailored to consist of elements shown in multiple published studies of chronic disease care management to produce cost savings. Key elements of successful chronic disease care management which the proposal identified were:

- Selection of high-cost, complex chronic disease patients;

- Multidisciplinary teams (registered nurse, social worker, community health worker and informal care giver) in close communication with the primary care provider for medication reconciliation and facilitated referrals;
- Specially trained care managers with low case loads; and
- Person-to-person encounters, including home visits, with the use of coaching.

In developing the T-CHIP proposal, the WCHD sought to leverage its strong relationships with virtually all community agencies and longstanding expertise in care management. Specifically, like most other local health departments, the WCHD employs professional staff experienced in certain care management programs for the elderly and disabled (Assessment, Referral and Evaluation Services and Medicaid Personal Care Program), and for particular populations (HIV, TB, high-risk prenatal case management programs).

Further, the WCHD had ongoing experience as a partner to Atlantic General Hospital implementing a CMS Health Care Innovation Challenge Award. Under the arrangement, the WCHD provided nursing, social work and peer health educator staff to augment the hospital's staff model patient centered medical home. For the Commission proposal, WCHD adapted the Challenge Award model to feature additional evidence-based elements so as to maximize its impact. For example, WCHD was deliberate in:

- Designing the patient selection process, including outreach to and referrals from ED physicians and targeting certain zip codes;
- Conducting care management mostly through home visits, since the patients often initially lacked a primary care provider (PCP);
- Developing agreements with the local federally qualified health center (FQHC) and other PCPs to accept referrals from the program for on-going primary care, including provisions urgent visits for assessments or lab work; and
- Designing a secure IT architecture for WCHD to share program participants' health records through agreements with CRISP for its own practitioner staff and all participating community providers. A further advance, portable telemedicine equipment, for connectivity between home visits and PCPs was considered but was not possible under the grant conditions.

In the last quarter of Year 1 funding, WCHD reported reductions in the overall rate of diabetes-related ED visits for Wicomico and Worcester Counties, and a small increase in the rate for Somerset County. Due to very small numbers and only a one year reporting period, it is not meaningful to draw inferences about the program based on fluctuation of these county rates. There were 59 patients enrolled in the program for a sufficient period of time to assess program impact. These 59 patients collectively accounted for

This group of highest utilizers collectively accounted for a total of 38 ED visits 12 months prior to enrolling in the program. Upon entering the program, these same eight patients resulted in 4 ED visits.

56 ED visits 12 months prior to enrolling in the program. These same 59 patients had only 8 ED visits during the 6-12 month period following program participation. The most notable drop in ED visits was among the highest utilizers (those with three or more ED visits in one year). This group of highest utilizers (a group of 8 patients) collectively accounted for a total of 38 ED visits 12 months prior to enrolling in the program. For the 6-12 months since entering the program, these same patients had only 4 ED visits.

As to cost savings, it was estimated that \$45,000 was saved during the observation period in averted ED visits, based on national averages for the cost of ED visits. Another \$144,000 was estimated to have been saved through 44 averted hospitalizations. These estimates were not net of program expenses or of likely increases in the cost of medications, diabetic supplies, lab and outpatient physician services attributable to improved care management.

As to sustainability, the T-CHIP proposal posits several health system transformations which might contribute to program solvency following the grant term. These include:

- Third-party reimbursement for billable care management services;
- Hospital and private physician contributions stemming from their participation in new shared savings financial models; and
- Contributions from EMS and public health reflecting reduced service demand in a healthier service area.

While each of these potential revenue streams is speculative, the proposal is very clear that the Tri-County Health Planning Board regards building a community care management infrastructure as an essential investment. The WCHD Deputy Health Officer, who is the Project Director for this grant, is leading discussions with both hospitals for continued support and expresses a commitment to ensuring T-CHIP's viability going forward.

3. Expanding Primary Care in Harford County: West Cecil Health Center, Inc. and Upper Chesapeake Health

Early in 2014 the Commission awarded a start-up contribution for West Cecil Health Center, Cecil County-based FQHC, to open the Beacon Health Center, a satellite primary care location in Harford County. The grantee documented the need for primary care based on population health data as well as patient encounter data from the HealthLink Primary Care Clinic, a safety net program operated by Upper Chesapeake Health. Without an FQHC in the County, HealthLink is Harford County's sole provider of primary care for low income uninsured adults, at full capacity of 1,400 patients. While suggesting anticipated improvements in SHIP and Prevention Quality Indicators, the proposal's goals were more general: to increase access to primary care for uninsured Harford County residents. There was not a focus on those with chronic illness nor did West Cecil specify measurable changes in particular health status or expenditures.

West Cecil proposed to open a new site, fully assume HealthLink's patient population and add an additional 100 patients per month for an expanded capacity of 2,400 patient at the end of Year 1. Transferring to the new FQHC-associated site would afford HealthLink patients and their

families access to dental, pharmacy and pediatric services unavailable through HealthLink. Upper Chesapeake Health operated HealthLink at an estimated direct and in-kind cost of approximately \$800,000 per year due to the clinic's high volume (50%) of uninsured patients. With the advent of ACA coverage expansion to largely support the FQHC clinic, the hospital system can reduce operating costs by committing a lower level of Community Benefit support to cover the new clinic's operating shortfall. The new primary care facility, like HealthLink, will accept primary care referrals from the ED Diversion Program based in County's two hospital EDs. The ED Diversion Program, begun in 2008 with Commission funding, continues to operate and reports much fewer inappropriate ED visits for patients referred to HealthLink by the Diversion Program.

West Cecil did not access new federal (HRSA) funds for the expansion, but in addition to the Commission grant, was able to leverage operating support from the hospital and in-kind capital improvements from a private foundation and other sources.

Leadership of the hospital system has committed to continuing to support the new site's operational expenses, as needed, through the hospital's Community Benefit spending.

The project's sustainability is predicated on increased insurance reimbursements as a result of the ACA's Medicaid expansion and subsidized private insurance coverage. Leadership of the hospital system has committed to continuing to support the new site's operational expenses, as needed, through the hospital's Community Benefit spending.

Since the Beacon Health Center opened in December, 2014, it is too early to examine the partnership's operations, outcomes or cost consequences. However, the project does demonstrate how a collaborative model can be mutually beneficial in advancing each partner's objectives and can generate new interest and investors.

4. ED Diversion Partnership: Health Care for the Homeless with Johns Hopkins Hospital, University of Maryland Medical Center and Mercy Hospital

Health Care for the Homeless (HCH) is an FQHC focusing on the needs of homeless people in and around Baltimore City. HCH received a one year Commission grant to develop an ED diversion program for homeless people defined as frequent ED users (3 or more hospitalizations or ED visits in the past 12 months). The grant funds a mobile community-based nurse and community health worker to transition up to 75 homeless people referred by the three participating hospitals to rely on HCH as their regular source of primary care. The project aims to reduce, among the target population, ED visits by 20% and hospitalizations by 15% in the first year of operation. Secondary goals are to improve self-reported health quality indicators and increase use of housing, social service and economic benefits.

With the Medicaid expansion and the unique demographics of their patients, HCH anticipates a major increase in clinical revenues as their uninsured case mix drops from 75% to 25% of total volume beginning in 2014. Although the project's outreach and management services are not billable, HCH expects that increased collections will be sufficient for the FQHC itself to cover

ongoing program costs. The Commission's grant, therefore, provides a jump-start to ED diversion targeting the City's homeless.

The three hospitals share data with HCH to identify homeless ED users, alert program staff when a program participant presents in the ED and provide access and interview space for program staff. HCH reports some difficulty in the timeliness and completeness of CRISP records for accessing records for the many patients who routinely use multiple City hospitals, so HCH continues to request records directly from referring hospitals. HCH also reports that the severity of psychiatric illness facing many of the frequent ED users exceeds the capability of HCH's out-patient mental health clinic or that available through other mental health providers in Baltimore City. The volume of hospital referrals to HCH's new ED Diversion Program are on target but the lack of services for severely mentally ill and those with traumatic brain injury is reported by HCH to be system failure which may diminish the Program's successful outcomes.

5. ED Diversion Partnership: Health Care Access Maryland and Sinai Hospital

Health Care Access Maryland (HCAM) was awarded a three-year Commission grant to implement an ED diversion program at Sinai Hospital, with ED-based coordinators linking frequent ED users with health benefits, primary care and behavioral health services in the community. Sinai Hospital reports an estimated 300 frequent ED users, defined for this project as those with 4 or more ED visits in a 4 month period. This model uses professionally-prepared coordinators with caseloads of 75 patients to engage patients with the program for up to 3 months. Arrangements with an FQHC and a community provider of acute and rehabilitative mental health services have been established to allow for same day or prompt referrals.

It is notable that the relationship between HCAM and Sinai Hospital is strong and that both entities were exploring a potential partnership prior to the Commission's Call for Proposals. The hospital shares medical records with HCAM on frequent ED users, including arranging for HCAM to receive CRISP alerts on patients presenting to any hospital and makes referrals to the Care Coordination program when these patients enter the ED or are discharged from a hospitalization. HCAM reports that, if successful, the hospital will be willing to contract for ED diversion services and that they will work with others on Medicaid policy changes such that some coordination services can become billable.

HCAM does not yet have sufficient experience or data to form preliminary conclusions as to program outcomes. However, it was noted that a reduction in ED visits has been observed among previously uninsured patients, presumably the result of health plan enrollment and linkage with primary care. Also, the moderately frequent ED users, those with 4-5 ED visits in the preceding 4 months, have begun to show decreased ED utilization following engagement with the project. The most resistant to change, so far, are the very frequent ED users with 6 or more ED visits in the last period. These individuals have been found to be already connected to other community service providers, including some who access the ED after-hours and who have very serious mental illnesses. Lacking close supervision and supports, these patients present to the ED as posing a possible danger to themselves or others. Thus the ED becomes the routine

provider of last resort until the less acute weekday services of a community-based mental health provider resume.

Observations from Partnership Grant Experiences

The purpose of summarizing these grants is to synthesize recurrent issues – both strengths and challenges – which emerge from analysis of these partnerships and to suggest solutions or promising practices. Another purpose to reviewing the progress of these ventures is to consider what steps the Commission might take in restructuring aspects of its grant-making processes to increase the likelihood of program success and sustainability for future programs.

The following observations are drawn from analysis of documentation submitted by the grantees and supplemental information obtained from key informant interviews with many of those directing the grant partnerships. The observations may suggest topics for the Commission to engage in further dialogue with stakeholders.

1. **Many interviewees noted the importance of nurturing strong collaborative relationships built on personal contact, frequent communications and trust.** Partnerships frequently experienced unexpected challenges with start-up personnel and logistic issues, data sharing, communications and policy integration within the respective organizations. A strong champion of the partnership and its objectives in a leadership position within each partnering organization was cited as very important to bridging different organizational cultures and successful problem-solving.
2. There were a few notable infrastructure conditions were mentioned by interviewees as being particularly helpful in fostering innovative partnerships. Infrastructure elements cited as leading to successful partnerships were certain previous Commission grants (termed “legacy contributions” by one interviewee) that provided opportunity for collaborative enhancements, the DHMH Innovations website (www.dhmf.maryland.gov/innovations), and the CMS Innovation Center’s Innovation Advisor and Health Care Innovation Award programs. **Deliberate efforts to promote leadership and infrastructure conditions within which innovation can thrive seem to pay off.** Work remains, however, in leveraging the State’s relatively rich HIT environment to advance the mission of safety net providers.
3. The very challenging health and social conditions confronting the highest cost individuals in a population require intensive and prolonged contact before behavioral change can be observed. **Several expressed the view that time and resource constraints may mean the most effective community interventions are those targeting the mid-range, not the highest utilizers.**
4. **There is general agreement that there is potential in exploring three avenues for long term sustainability for Commission-funded projects:** Hospital support made possible by the consequence of global budgeting under the new All-Payer Model; redirected hospital

Community Benefits spending; and utilizing policy levers with payers, especially Medicaid, Medicare and Qualified Health Plans, to allow for reimbursement for certain community-based services.

5. **There is interest in exploring methods to define, apportion and monetize the gains accrued to other systems, such as social services and criminal justice, that result from community interventions.** While several state and municipal pilots are operating around the country to test pay-for-performance models, sometimes called social impact bonds, the outcome and applicability of these arrangements are still largely unknown.
6. **There was concern that the full impact of the new All-Payer Model has not yet been experienced and that the anticipated consequences have not yet been observed.** Specifically, it was noted that despite promising results of the HSCRC's previous voluntary Total Patient Revenue budgeting option, hospitals have not yet experienced a year of global budgeting under the new Model. Some interviewees suggested that it is too early for most hospitals to fund or contract for new community programs under the assumption that the investment will be offset by global budget 'savings' due to averted utilization. Also, the small scale of many of these partnerships means anticipated savings are minimal compared with the high fixed costs associated with many hospital cost centers. Reducing staffing or other expenses by such a small degree may not be feasible and therefore "savings" may not be realized by the hospital.
7. **Some interviewees expressed confidence that, for certain populations and intended outcomes, there is sufficient evidence in the literature that standardized interventions for effective community-based chronic care management work.** The view expressed was that funders and payers should support such evidence-based programs and only fund "pilots" to explore implementation variations in how or to whom these standardized interventions are delivered.
8. **Every partnership encountered difficulties with the exchange of clinical records and program data between hospital and community partners.** Likewise, every partnership struggled to access and meaningfully interpret utilization and cost data so as to calculate net program impact. This challenge was compounded by a relatively brief post-intervention observation period to assess grantee outcomes.

Chapter Four: Partnership Forum Series

Four Regional Forums

To facilitate collaboration between community safety net providers and hospitals, the Commission, with support from the Maryland Hospital Association, Department of Health & Mental Hygiene, Health Services Cost Review Commission, and Chesapeake Regional Information System for our Patients, held a series of four regional forums in the fall of 2014. The regions and forum locations were Western Maryland (Cumberland), the Eastern Shore (Wye Mills), DC Metro and Southern Maryland (Waldorf), and Baltimore Metro (Elkridge). A total of 271 individuals representing 147 organizations attended the forums.

The purpose of the forums was to highlight a number of promising hospital-community partnerships and innovative interventions, to discuss with state and local participants the lessons learned and challenges confronted during implementation, and to develop strategies through which these programs could be sustained and spread.

The forums drew wide interest as they were the first opportunity, following implementation of the new Waiver, for community agencies and organizations to join with hospitals in discussing potential areas of mutual benefit given the advent of global budgeting for hospitals. Forum organizers were careful to maintain a ‘neutral’ orientation so that the agenda and presentations of promising collaborations were candid and balanced, offering bilateral perspectives of value to both hospital and community attendees. Each forum began with presentations by DHMH, HSCRC and CRISP, summarizing the status of each entity’s system transforming efforts relevant to hospital-community partnerships. Next, selected collaborations presented their goals, operating arrangements, outcomes and challenges. Lastly, a facilitated discussion was convened for all attendees to engage with the presenters, to comment on their own partnership experiences, to identify factors contributing to successful partnerships, and to describe barriers and potential solutions to accelerating meaningful and productive partnerships.

The forums were attended by representatives of virtually every acute hospital and health system, including CEOs, CFOs, and directors and staff of population health and care coordination units. Community representation included Health Officers and staff of local health departments, CEOs and staff of FQHCs, behavioral health providers, community action, advocacy, civic and other non-profit organizations as well as some local elected officials and federal representatives.

Although there was virtually no overlap between the forums’ regional participants, certain common questions and discussion themes were repeated at each meeting. The following synthesis of key themes expressed in these forums provides practical insights as the Commission evaluates current and future partnership grant-making.

Themes Arising from Regional Forums

- 1. There is genuine interest across both community and hospital sectors in exploring partnerships to improve health outcomes, improve patients' care experiences and to reduce costs.** Medical providers, community organizations and public health agencies have assimilated the goals of the Triple Aim (improved outcomes, improved experience, reduced costs) into their respective orientations. There is a growing appreciation for the relevance of improving clinical and community prevention and wellness, consumer health literacy and empowerment, and the social, economic and environmental factors impacting population health. Moreover, the perspective for 'population health' used by various types of clinical providers is widening to include families and more general populations in particular neighborhoods or communities or to include consideration of the experiences of a particular racial or ethnic group within a larger community.
- 2. The extent of change throughout the health system is universally perceived as being complex with uncertain consequences.** Leaders of organizations understand themselves to be operating within larger formal and informal systems under new rules and often untested assumptions. Developing new relationships and agreements seems desirable, but, as was expressed in several different ways, the complexity and interrelatedness of new delivery and/or financial approaches and the potential for unintended risk may make innovation seem daunting.
- 3. The major changes underway throughout the health system stemming from the ACA, the new hospital Waiver, SHIP, and new private sector and consumer initiatives are demanding new capabilities of hospitals and community organizations. Active institutional preparation is underway to gear up for partnerships in the new environment.** For instance, community providers continue to work on developing standard contracts, MOUs, data use agreements and provider credentialing. Hospitals are exploring new population health approaches beyond traditional clinically-focused home health referrals and discharge planning. Specifically, hospitals are evaluating whether to "build or buy" new ways of community care transitioning and coordination.
- 4. There is uncertainty about how Maryland's health care system will respond to the various reform influences.** Reflecting on the advent of the ACA and the new Model, forum attendees frequently commented on possible long term impacts of these transformational influences on the nature and behavior of local health care markets. There was speculation as to whether new financing incentives will ultimately cause some hospitals to close or further consolidate into health systems. There was discussion on revising traditional boundaries for hospital service areas and local health departments or LHIC jurisdictions. More immediately, there were questions as to how patients who frequently use multiple hospitals will be attributed by regulators in determining hospital readmission rates and other outcomes. Prospects for multi-hospital collaborations and regional LHD/LHIC affiliations were discussed.

5. In approximately half of the state's jurisdictions, LHICs and hospitals develop integrated community health needs assessments and implementation strategies. Such integration is needed elsewhere in order to gain efficiencies and the power of collective effort. As a practical measure, there is a need for local entities to align the timing of the ACA-mandated hospital community health needs assessments and the LHIC-led community assessments. **The Commission could be helpful in advocating for and catalyzing integrated planning partnerships in the future.**
6. Both hospitals as potential "buyers" and community organizations as possible "vendors" are working to refine their respective capabilities. The field of population health improvement is still evolving. **What is needed is a consensus knowledge base and consistent definitions and standards for specific types of interventions, matching targeted populations with specific interventions, preferred staffing models, and realistic metrics for goal-setting and performance management.**
7. Perhaps the most prominent discussion topic in every forum was the central role of data. **Improving the completeness, timeliness, granularity and accessibility of meaningful data on population health outcomes, utilization and costs is regarded as essential to advancing partnerships.** The ability to articulate measurable partnership objectives and indicators of success is fundamental to designing, operating and sustaining hospital-community partnerships. Community organizations regarded the encounter and clinical data provided through CRISP as a valuable first step. There were frequent comments as to the need for more complete data on ambulatory utilization and costs across all payers, greater accessibility to CRISP data and reports by community partners, and methods to link CRISP's clinical data with administrative claims data provided in the all-payer Medical Claims Data Base (MCDB) operated by the Maryland Health Care Commission. The MCDB was recognized as especially important in tracking utilization in all settings, including that obtained from ambulatory and long-term care providers. Forum attendees representing both hospital and community organizations expressed the lack of sufficient in-house data analysis expertise. **The Commission could explore supporting training collaboratives to provide technical assistance on accessing relevant data sets and applying analytic techniques for meaningful decision support.**
8. **Better predictive economic modeling of community-based health interventions is needed for partnerships to design effective and sustainable programming.** Like other investors faced with alternate spending decisions, hospitals and community organizations are seeking the best evidence available by which to design program models and predict likely returns on partnership investments. Whether new partnership investments are direct or in kind, new ventures carry the risk of economic loss or opportunity cost. Hospitals and community partners are seeking to minimize those risks by operating evidence-based programs targeting populations most likely to produce desired outcomes on a scale which maximizes efficiencies. There are major knowledge gaps in the application of economic modeling to community health initiatives, but considerable research is underway at the national level. **Evidence supporting the return-on-investment (ROI) for community health efforts such as ED diversion or chronic disease care management is critical to the design and sustainability of such partnerships.** ROI evidence is the essential element for

sustained program support in a number of ways. Hospitals may invest operating funds in community partnerships if confident that investments will be offset in their global budgets by saving for unnecessary utilization. Also, awareness of the ROI potential may cause hospitals to shift more of their Community Benefit spending to effective programs. Solid ROI evidence may convince payers to make certain services delivered in community settings reimbursable on either a fee-for-service or bundled basis.

9. **Despite the many significant reforms being implemented, fundamental gaps and health problems will persist.** Difficult problems such as health disparities, poor access for the undocumented and others who remain uninsured, and inadequate behavioral health services are resistant to change and will likely continue in the short-term for various social, economic and policy reasons. Safety net providers will continue to fill an important gap-filling role despite the major expansion of health coverage to over half a million previously uninsured Marylanders and those individuals that remain uninsured.
10. **Behavioral health and chronic disease co-morbidity compound to create truly complex patients who frequently are high utilizers of all types of medical services.** Dually diagnosed individuals were reported to be resistant to care coordination and require more intensive and mobile person-to-person interaction than the usual home health patient. The lack of integration between somatic and behavioral health providers complicates referrals, coordinated treatment and medication reconciliation.
11. **Addressing adverse social determinants, although considered ‘upstream’ from ED diversion and care coordination, is very important to improving outcomes and lowering utilization.** Participants endorsed projects to mitigate adverse socio-economic factors and lack of health literacy in many consumer populations. Rural participants, for instance, noted that a lack of transportation to routine health care can result in avoidable 911 calls and default hospital transports. Community care coordinators, regardless of professional background, need the knowledge, determination and tools to connect complex patients with appropriate community resources and economic benefits. This was noted to be a different skill set from that of traditional home health staff or telephonic care managers. Several partnerships reported the need to employ higher-cost licensed care coordinators in order to effectively implement care management plans for complex patients, to interact with primary care physicians and specialists and to be credentialed with insurance plans should some coordination services become reimbursable. A recurring observation of those aiming to reduce unnecessary costs was that both urban and rural high cost utilizers have a marked absence of basic health literacy or effective family and social supports. The pervasive disconnectedness of this population requires trusted, relationship-centered care.

Chapter Five: Recommendations

General Recommendations

The following recommendations were derived from the recent experiences of five hospital-community grantees and partners, as well as from participant input at the partnership forums.

1. **Commission grants should explicitly promote partnerships or networks**, such as through directly funding these arrangements or building the capacity of community health resources to develop and sustain partnerships.
2. **The Commission's Calls for Proposals could require more rigorous measurable objectives, outcome-based performance metrics and a data gathering and analytics plan clearly embedded in the proposal's design.** Anticipating more advanced data –informed proposals, the Commission could generate draft sharing agreements between grantees and relevant data set custodians such as the HSCRC, CRISP and MHCC.
3. **The Commission could consider a multi-year term to be the norm for implementation grants, with one-year grants to be exceptions.** Establishing a new partnership and implementing a new intervention is a complex undertaking and likely to require more than a year in order to show meaningful results. The Commission should continue to seek realistic timelines for deliverables. For many funding rounds, it may be worthwhile to consider segmenting RFPs for planning or implementation responses. Fewer, larger implementation grants may ultimately produce more meaningful data and generalizable success than multiple smaller investments in limited partnerships and short timelines to achieve measurable results.
4. **The Commission could consider a new funding priority directed at promoting leadership capacity among those in senior or mid-management positions in community health resources.** As several informants and forum participants expressed, there is a need to develop creative, data-informed strategic leaders who are able to design innovation, calculate risk and act accordingly in order to achieve transformational change. The Commission is uniquely suited to support safety net provider leadership, an essential element of human capital infrastructure. Such a program could be conducted as a collaborative with state, academic and private partners at modest expense.
5. **The Commission could provide technical assistance to its constituencies through an online 'partnership toolkit.'** As a collaborative effort with others, the toolkit could include, for example, templates for governance models; data sharing, gain-sharing or shared savings agreements; workforce models; health literacy resources; delivery and financing vocabulary and innovations. Further, if collaborative resources are available, the online resource might include frequently updated contact information for featured models and an interactive feature for participant comment.

6. **The Commission could actively seek avenues to regularly inform the Department and the other Commissions on policy questions arising from promising community partnerships.** For instance, the Commission could provide input to the Department as SHIP objectives and indicators are revised. Open communication between the Commission, grantees, CRISP and the MHCC on use cases for the health information exchange and the Medical Care Data Base would be useful for all parties. The Commission could foster communication between the State's health insurance exchange and safety net providers on how exchange policies and practices can improve access in underserved communities. Also, reflecting the experience of grantees, the Commission could work with other agencies on ways to promote wider adoption of tele-health technologies.
7. **The Commission could partner with DHMH to enhance the Innovations website by featuring information on promising community-based partnerships derived from the experience of grantees.** An expert advisory panel could be convened by the Commission to periodically review grantee outcomes and select partnerships for the Innovations website. There is strong interest throughout the Commission's broad stakeholder community for a reliable, neutral source of information on promising population health improvement practices which are relevant to Maryland's unique reform landscape. The Commission could be central to a collaborative aimed at identifying and disseminating such information.
8. **The Commission can contribute input as an active partner with the HSCRC in monitoring the impact that the new All-Payer Model may have on the availability and access to community services.** This information may be useful as the HSCRC considers an application for Phase II of the new All-Payer Model that shifts focus to a total cost of care model – and not just the quality and cost of hospital services.
9. **The Commission is uniquely positioned to explore the health, economic and related return on investment (ROI) of grants aimed at upstream improvements to a community's social or economic conditions.** There is a growing understanding of the critical importance of upstream social and economic determinants on health and related spending. For example, the Commission might consider projects that would implement and explicitly measure the impact of stable housing on a specific population of homeless high-cost utilizers. Or, as was mentioned in a rural forum, it would be very significant to measure change in health spending once low-income chronically ill people gain reliable transportation or a regular source of nutritious food. Funding and assessing health and economic pay-offs from community prevention work is a role to which the Commission is uniquely suited; one that could directly improve the lives of underserved Marylanders while making important contributions to the body of evidence in the field of population health improvement.
10. **The Commission could explore multi-investor partnerships to jointly fund projects of mutual interest.** Other State and federal agencies, foundations, professional associations, universities and the private sector are stakeholders in community health resource partnerships. Opportunities to join with other investors interested in population health, perhaps linked with economic development, housing, environment and education, would create synergies and extend the Commission's reach. The Commission has unique statutory authority to receive private funding and administer private funding so as to advance shared

objectives. For example, the Commission could explore partnerships with the private IT sector to pilot secure communications networks to support the integration of clinical and community health resources.

A 2014 grant from Kaiser Permanente's Mid-Atlantic States Community Benefit Program provided the Commission with experience in shared investing. The grant supplemented Commission funds aimed at bolstering safety net provider infrastructure. Through joint investing, both funding entities were able to extend their impact on a mutual priority. Kaiser Permanente derived additional benefit by accessing the Commission's knowledge of the safety net grantees and its expertise in project reporting and grants management. Replicating this experience merits further exploration.

Sustainability Recommendations

The sustainability of promising or successful projects is a key issue for the Commission and its grantees. In general, most sustainability plans submitted as a required component of Commission proposals are vague and speculative. Many suggest the possibility of a Medicaid policy change to allow for reimbursement for nonclinical services which demonstrate health improvements and/or cost savings. Many also assume that the partner hospitals will provide ongoing support for successful programs when the grant term expires. Although the concepts have merit in the new Model environment, neither of these sustainability assumptions have been demonstrated at the time of this writing.

Of the five proposals examined for this paper, only one (West Cecil) included a firm letter of support and financial commitment from the hospital CEO for continued funding following the grant term. One ongoing grant proposal (HCAM) indicated the hospital was willing to fund the program if “it is successful.” Another ongoing grantee (Health Care for the Homeless) indicated that partner hospitals may contribute when the one-year grant expires, but assumes that HCH itself will fund most of the project in the future. Leaders of the Tri-County project, currently entering its final months of the grant term, have yet to secure on-going support from the two participating hospitals. Project leadership has indicated that the program is so successful and has become so widely relied on by providers in the region that the lead agency, the Worcester County Health Department, will assume funding if necessary.

The Cecil County Health Department/Union Hospital chronic disease management project has completed its one-year grant term. Hospital data suggested a marked decrease in utilization by project participants comparing a few months pre- and post-intervention. The partnership did not re-apply for continued funding during the Commission’s next round and the project was discontinued.

The following are recommendations for managing this sustainability issue.

- 1. The Commission may wish to direct applicants to seek and present firm commitments from partners or other investors as a required proposal component. Scoring of the viability of applicants’ sustainability plans may be given more weight among selection criteria. The Commission could help link applicants and current grantees with funding opportunities (in addition to Commission grants) as they become available.**
- 2. The Commission could partner with Medicaid to jointly evaluate outcomes of partnership grants on Medicaid enrollees’ health and spending.** These reviews would develop evidence on the efficacy of certain standardized community interventions such as care coordination, chronic disease self-management and ED diversion measures. With Commission input, Medicaid could then determine the most appropriate policy steps to gain reimbursement for those services proven to be cost-effective for certain enrollees. The Commission could involve other payers in similar reviews.
3. Global budgeting for hospitals under the new Model introduces new avenues for achieving long-term sustainability of grant funded programs as well as to maximizing the impact of the

Commission's investments which are necessarily constrained by State budget realities. As the HSCRC and hospitals gain experience with implementing the new Model, the Commission could consider the following:

- a. **Effective community partnerships should produce ongoing savings for the hospital partner and therefore could be supported indefinitely through global budget revenues.** The Commission could seek HSCRC's expertise in evaluating the financing and sustainability plans of proposals submitted by hospitals or hospital partnerships.
 - b. **The Commission could explore opportunities for shared savings agreements with hospitals.** If the project successfully reduces unnecessary admissions, a portion of the hospital's resulting savings could be directed forward to maintaining the program. Another portion of the savings could be assigned back to the Commission as a return on its initial investment. In this manner, project 'dividends,' capped at an agreed level or term, could be returned to the Commission to provide revenues for future investments.
4. Federal and State Community Benefits requirements placed upon nonprofit hospitals and health plans may provide opportunities for sustainability in two ways. **The Commission could collaborate with hospitals to serve as an aggregator and administrator of Community Benefits funds derived from non-profits with shared funding goals and overlapping service areas.** For example, the Commission could establish a pooled funding account for specific hospitals seeking to invest in community-based ED diversion efforts in a multi-hospital jurisdiction. The Commission could provide the hospitals and the service-providing grantees with uniform, efficient, evidence-based grants management and fiscal oversight. The Kaiser Permanente co-investment is an example of a non-profit electing for the Commission to administer a portion of its Community Benefit funds which were aimed at the mutual priority of building safety net provider capacity.

In another action to leverage Community Benefits spending toward sustainability, the Commission could request that a hospital's Community Benefit spending profile and priorities be included with any hospital-affiliated grant proposal. The hospital's commitment to use its Community Benefit as a source of ongoing funding may be a relevant factor to consider in the Commission's competitive review process.

5. **The Commission may wish to closely explore emerging public-private financing innovations known as social impact bonds or pay-for-performance.** These are new arrangements by which private capital is invested at an agreed rate of return and term to sponsor interventions proven to yield positive outcomes and savings. These arrangements are complex and require several parties (investor, broker, service provider, independent evaluator) but they are being piloted in a number of states as vehicles to fund certain social service and public health efforts.

Chapter Six: Conclusion

The Commission has provided substantial support to community health resources over the past decade. As a result, much progress has been made in advancing the performance of these vital but often under-resourced private and governmental entities in serving their communities.

Community health resources have become more capable, with better access to improved planning, quality improvement, evaluation, networking and other tools, due in no small part to the assistance provided by the Commission. However, the environment in which they operate has become increasingly complex. Safety net providers are expected to employ fully modernized business practices in order to successfully compete in local and regional health markets. Commission grant-funding has strengthened the ability of safety net providers to effectively respond to rapid change.

The Commission's interest in assessing previous grants involving community and hospital/health system partnerships is very timely. Today's health care system is undergoing unprecedented transformation. While there is much to learn from other states, Maryland is a national leader in redesigning hospital payments so that reimbursement incentives track with population health improvement strategies. Safety net providers need to understand these reforms and build strong partnerships which leverage the potential of these reforms to improve the health of Marylanders.

These reforms are producing a watershed opportunity for the Commission to collaborate even more closely to advance its legislative mandate. The Commission's voice and actions remain centered on its fundamental goals:

- To improve the capacity of the State's community health resources;
- To expand access to affordable, high-quality health services in underserved areas of the state; and
- To support innovative community-based networks aimed at population health improvement.

Over a decade, the Commission has incubated innovation, developed networks, promoted business-ready solutions and disseminated best practices. The Commission's actions have positively impacted the accessibility, effectiveness and cost of health services for at-risk Marylanders.

With the profound and rapid change currently underway throughout Maryland's health care system, leadership toward these same goals is needed more than ever. The Commission has the capacity to deliver that leadership.

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