CHRC Business Plan:

Technical Assistance and Ongoing Support for Maryland's Safety Net Providers

Maryland Community Health Resources Commission – Health Reform Implementation (Senate Bill 514/House Bill 450)

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EXECUTIVE SUMMARY

Maryland has a dynamic safety net provider community that plays a critical role in serving uninsured and underinsured residents. Federally Qualified Health Centers (FQHC), local health departments, school-based health centers, and free clinics provide an impressive range of services at more than 150 locations. The Affordable Care Act (ACA) is expected to increase access to health insurance coverage for more than 350,000 Marylanders, but will also challenge providers to shift from providing services free of charge or on a sliding fee scale to providing services on reimbursement/insurance model. As part of this transition, providers will face pressures to implement new information technology systems and increase their capacity to contract with and bill third-party payors. These changes, compounded by fragile and lean public sector budgets, will test the ability of safety net providers to prepare effectively for this transition. There is a clear and strong policy incentive for Maryland to help guide safety providers through this inexorable transition and provide needed technical assistance and customized support through this paradigm shift brought by the ACA.

In anticipation of these challenges, the Maryland General Assembly passed and Governor O'Malley signed into law HB 450/SB 514 during the 2011 legislative session, which directed the Community Health Resource Commission (CHRC) to develop a business plan for delivering technical assistance and ongoing support to safety net providers during the implementation of health care reform. The CHRC contracted with the Mosaic Group, under the leadership of Marla Oros, to guide the Commission in this work.

Three research methodologies were conducted, and analysis from this research guided the creation of the CHRC business plan:

- ***Customized surveys*** were sent to three targeted audiences: (1) local health departments; (2) community health centers; and (3) other safety net providers. A combination of open-ended and closed-ended questions were used, while ranking questions, Likert scales and balanced rating scales captured priorities for technical assistance needs. Data was collected via Survey Monkey and responses analyzed using the software's analysis tools.
- ***Key informant interviews*** were conducted with approximately 40 key stakeholders and opinion leaders. A summary of major themes identified across all interviews supported the development of the priority needs and recommendations.
- ***CHRC's capacity to address provider needs*** was reviewed. Service and capacity enhancements at the CHRC since 2009 have included the following: new systems for grantmaking, grant management, and performance monitoring; use of GIS mapping to help providers assess unmet needs for service; and data access/analysis to support providers in program/strategic planning and fund development. The breadth and scope of Commission activities over the last three years have been impressive given limited staff and resources.

Key findings of the research included:

- More than 65% of providers indicated they are "fairly ready" for health care reform with only 8% extremely ready.
- Providers across all three respondent groups reported searching multiple sources of information in their efforts to find reliable information on health care reform.

- Needs for technical assistance were diverse. The only need common among all three respondent groups was assistance with data collection and analysis, yet many providers cited need for support with third-party contracting, credentialing, developing information systems, workforce planning, and billing.
- Only slightly more than 14% of safety net providers and 22% of health departments reported implementing electronic health record systems fully at this time.
- The majority of respondents in all groups supported a regional approach to coordinated care.
- The favored methodologies for in-depth training were learning collaboratives and other peer-to-peer initiatives.

Analysis of the surveys, interviews, and CHRC capacity yielded the following priority recommendations:

(1) **Provide technical assistance and support related to "mechanics" of health reform legislation**: Providers have a significant need for information about specific components of health reform, as well as for customized assistance with strategic and business planning to prepare for service delivery changes.

(2) **Work with DHMH, the Governor's Workforce Investment Board and other agencies to support statewide plans for workforce development**: Specific supports for safety net providers may include dissemination of local, state and national workforce plans; forums on emerging topics; access to detailed data including population variables, health indicators, and licensure; and assistance with workforce planning.

(3) **Assist community health resources providers by facilitating access to data and interpreting or translating this data to meet customized needs**: The Commission is uniquely positioned to help safety net providers clearly define data needs for program development or grant requests, identify appropriate data sources, obtain the data, analyze data for the targeted project, and report data in graphs, charts, maps and other media.

(4) **Support efforts to develop expanded systems for eligibility and enrollment of uninsured and underinsured patients**: The CHRC should assume a leadership role with public agencies and community health resources to ensure that new programs and procedures for enrolling and maintaining uninsured individuals are appropriately sited in the community and user-friendly for both patients and providers.

(5) **Catalyze innovative public-private partnerships that will leverage additional private resources**: A "Health Access Impact Fund", with financial support from foundations and corporations, would be an innovative funding mechanism to address priority needs of the safety net community in making the transition to ACA.

INTRODUCTION AND BACKGROUND

Maryland has a dynamic safety net provider community that plays a critical role in our health care system. This diverse safety net provider community is comprised of 16 Federally Qualified Health Center (FQHC) organizations operating more than 100 service delivery sites, 24 local health departments with multiple service sites, and more than 30 free clinics and school-based health centers. FQHCs, local health departments and other safety net organizations provide access to affordable, high-quality health care services for uninsured, underinsured and low-income individuals in our state. These providers offer a range of health care services including primary care, prenatal care, chronic disease management, dental care, behavioral health care, and they facilitate linkages to specialty and advanced care services for special populations.

Maryland's safety net providers are uniquely qualified to provide health care for groups that have historically been underserved by the traditional health care systems. FQHCs are located in areas of high need, many of which are designated as having physician shortages. Furthermore, safety net providers offer services at affordable or discounted rates (or free of charge), thereby removing financial barriers to care. Finally, many safety net providers also work with patients to provide case management and other enabling services to remove others barriers to accessing health care services such as transportation needs and assistance in obtaining public health insurance. Without safety net providers, many individuals wait to seek services until an illness becomes an urgent problem, resort to using the hospital emergency rooms for everyday health care needs or forgo health care services completely. The implementation of the Patient Protection and Affordable Care Act (ACA) provides Maryland with a critical opportunity to expand the capacity of our safety net infrastructure to meet the needs of the underserved populations in our state.

In recognition of this vital role of the safety net community, the Maryland General Assembly approved legislation (HB 627/SB 775) in 2005 to create the Maryland Community Health Resources Commission (CHRC), a quasi-independent agency operating within the Department of Health & Mental Hygiene whose 11 members are appointed by the Governor. In creating the Commission, the Maryland General Assembly recognized the need to support Maryland's safety net community and the special populations served by these providers. Following its statutory mandate, the CHRC develops and implements statewide policies to strengthen Maryland's vibrant network of safety net providers and address service delivery gaps in Maryland's health care marketplace.

In recent years, the CHRC has worked with multiple layers of government and regulatory agencies to develop and provide grant funding to expand access in a sustainable, efficient manner and generate the potential for systematic reform. Over the last five years, the CHRC has awarded 93 grants totaling $22.6 million, supporting programs in all 24 jurisdictions of the state. These grants have collectively served nearly 100,000 Marylanders with nearly 300,000 patient visits to date. Areas prioritized by the Commission in recent years have included efforts to help reduce infant mortality; expand access to substance use treatment; integrate behavioral health services in primary care settings; increase access to dental care; boost primary care capacity; and invest in health information technology for safety net providers.

The Affordable Care Act (ACA) presents enormous opportunities and incentives to change how Maryland's safety net providers deliver health care to thousands of Maryland residents, many of whom will now gain access to health insurance. When the ACA is fully implemented in 2014, it is projected that more than 50% of Maryland's 700,000 or more uninsured individuals will be eligible for health insurance coverage (Maryland Health Care Reform Coordinating Council, Final Report and Recommendations, January 1, 2011). This expansion of health insurance coverage and other provisions in the ACA call for an expanded and pivotal role for safety net providers, including community health centers and local health departments. It is critical that Maryland ensures that new access to health insurance results increased access to affordable, high-quality care.

Key provisions of the ACA impacting Maryland's safety net providers include the following:

- A potential of $11 billion in new federal funds for health center program expansion that includes new funding over five years to serve 20 million new patients, enhance medical, oral and behavioral health services and address capital improvement and expansion needs;
- $1.5 million over five years for the National Health Service Corps to place an estimated 15,000 primary care providers in medically underserved communities;
- Expansion of Medicaid benefits for individuals up to 133% of the Federal Poverty Level;
- Payment protections and improvements to ensure that health centers receive no less than their Medicaid PPS rate from private insurers offering plans through the new exchanges and requirements for these plans to contract with health centers;
- Addition of preventive services to the Federally Qualified Health Center Medicare payment rate and eliminates the outdated Medicare payment cap;
- Authorization and funding for new programs for health center-based residencies and payments for centers to operate provider teaching programs;
- Funding to pilot new strategies to bolster health quality and outcomes, including care coordination, early detection, home visiting and technology support to track data and manage care;
- New grants for population-based health services to promote preventive health services and evidence-based care; and
- Funding to support the expansion of school-based health centers.

It is expected that the ACA will increase health care insurance coverage and the demand for health care services. Maryland's safety net community is essential to expanding access to health insurance coverage and health care services for the newly insured and to the thousands of Marylanders who will likely remain uninsured after the ACA is fully implemented. The capacity to confront and adapt to the multitude of changes and opportunities present daunting challenges to the safety net community. Ongoing support for these organizations is critical to ensuring a smooth transition for the safety net community and critical to Maryland's overall success in implementing the ACA.

Maryland is well-positioned to implement the ACA given the leadership of Governor O'Malley and his administration. Under this leadership, Maryland has several initiatives currently underway. One day after the federal reform bill was signed into law by the President, Governor O'Malley created the Health Care Reform Coordinating Council (HCRCC) by executive order (**01.01.2010.07**). The HCRCC, co-chaired by Lieutenant Governor Anthony Brown and DHMH Secretary Joshua M. Sharfstein, M.D., provides policy recommendations to help guide the state's implementation of

the ACA. The HCRCC solicited stakeholder and public input last year through six work groups focused on the following areas: Exchange and Insurance Markets; Entry into Coverage; Education and Outreach; Public Health, Safety Net and Special Populations; Workforce; and Health Care Delivery System and issued its final report on January 1, 2011.

The HCRCC final report acknowledged the broad network of community health resources in Maryland and the important role that these providers play in the provision of vital health services for both uninsured and insured Marylanders. The HCRCC also recognized that as the ACA is implemented, some individuals will likely move in and out of Medicaid coverage and insurance products offered on the Maryland Health Insurance Exchange, and that the continuity of care for these individuals is dependent upon robust participation of safety net providers in both Medicaid and Exchange insurance products. The HCRCC final report further recognized the multitude of challenges now facing local health departments, community health centers, and other safety net providers, and that Maryland would benefit by supporting safety net providers as they respond to these challenges and expand health care access. It was noted that as more previously uninsured individuals gain access to health insurance and services previously provided to the uninsured on a sliding fee scale now become reimbursable, the traditional business model and operational practices of many community health resource providers may need to change. Implementation of information technology (IT) systems and the capacity to contract and bill third-party payors were identified by the HCRCC as key potential issues for safety net providers to address in the coming years. Capacity limitations, compounded by fragile and lean public sector budgets, will further test the ability of the existing safety net providers to be able to plan effectively and prepare for this transition on their own.

The HCRCC final report found that the CHRC was "capable and well-positioned" to lead these two activities:

(1) Provide technical assistance to safety net providers as they prepare to implement health reform; and

(2) Provide assistance to Local Health Departments as they develop their Local Health Implementation Plans as part of the State Health Improvement Process (SHIP).

Following these recommendations, Delegate James W. Hubbard and Senator Thomas "Mac" Middleton introduced legislation (HB 450/SB 514) during the 2011 session that was approved by the Maryland General Assembly and signed into law by the Governor this past May. The legislation directed the CHRC to develop a business plan outlining how the state would provide the needed technical assistance to safety net providers as Maryland implements the ACA. The CHRC contracted with the Mosaic Group, under the leadership of Marla Oros, to guide the Commission as its completes this important work and it develops and implements this business plan. As required under the legislation, the CHRC submits this business plan to the Governor and Maryland General Assembly for consideration.

After surveying Maryland's FQHCs, Local Health Departments, free clinics, school-based health centers, and other safety net providers, and conducting approximately 50 follow-up interviews, five critical recommendations were developed for action by the CHRC:

(1) Provide technical assistance and support around the "mechanics" of health reform implementation;

(2) Facilitate linkages to key public and private agencies to address anticipated workforce challenges;

(3) Provide timely access to public health, Medicaid, workforce, and other data and help "interpret" and utilize this data;

(4) Support the state's ongoing efforts around consumer outreach, eligibility, and enrollment in health insurance programs; and

(5) Provide public/CHRC resources as initial "seed" funding to catalyze private funding to support health reform implementation efforts.

The methodology for these recommendations, ability of the CHRC to provide this assistance, and specific strategies to implement these recommendations are described in this report.

METHODOLOGY

In order to identify the most appropriate and targeted set of assistance that the CHRC should provide to safety net providers, the Mosaic Group conducted a comprehensive needs assessment. The goals of the needs assessment were as follows:

- Define the baseline capacity of existing local health departments, health centers and other safety net providers across the state to plan and respond to the changes brought by implementation of the ACA;
- Identify the current and anticipated role of state agencies and supporting non-profit associations in providing planning and technical assistance support to safety net providers as they prepare for the transition;
- Identify the specific and shared needs of local health departments, health centers and other safety net providers to be prepared to plan and implement the health care reform opportunities and changes;
- Define the gaps in support and technical assistance available to providers;
- Delineate the current skill and capacity of the CHRC to address the identified needs of providers and gaps in support and technical assistance; and
- Develop a recommended set of technical assistance services that the CHRC should consider developing to respond to the needs assessment in a business plan to be presented to the Commission for consideration.

The needs assessment utilized qualitative research methods to gather data to guide this evaluation. These methods included surveys and key informant interviews. Three customized surveys for local health departments, community health centers and other safety net providers, including school-based health centers, free health clinics and mobile health service providers were developed using the software provider Survey Monkey (Copies of the survey are found in the Appendix). The objectives for the survey were the following:

- Gather baseline descriptive information about current provider scope of services and staffing;
- Understand status of current and future transition and readiness plans;
- Describe interest level and plans for participation in various new grant and program opportunities related to ACA implementation;
- Identify baseline capacity for implementation of ACA around specific key areas such as information technology, electronic medical records, participation with third party payors, data collection and reporting;
- Understand baseline knowledge and skills related to priority areas of emphasis in ACA specific to each provider group;
- Identify priority areas of interest for training and education; and
- Identify priority needs for technical assistance.

The survey contained approximately 45-50 questions. Question design consisted of a combination of open-ended and closed-ended questions, with closed-ended multiple choice questions as the majority. A number of questions were designed as ranking questions to determine priorities related to specific items of interest. Likert scales and balanced rating scales were also used to understand priorities related to various components of ACA implementation and technical assistance needs.

The sample for the surveys was provided by Commission staff leadership, with input from senior leadership at DHMH. The sample was not limited exclusively to providers within each of the groups as Commission staff leadership sought to gain input from other key opinion leaders with expertise, especially within the safety net provider group, recognizing that this could impact the response rate reflective of the actual provider group. The following groups comprise the survey sample for the three instruments:

- Health officers of every local health department in Maryland;
- Executive leadership of community health centers, including chief administrative officers and chief medical officers in some cases;
- Board or executive leadership of free clinics and mobile health units;
- Directors of school-based health centers (included in safety net survey sample);
- Directors of a selected group of substance abuse treatment providers (included in safety net survey sample); and
- Other experts and/or key opinion leaders involved with health departments, health centers or other safety net providers, such as selected departmental leaders at DHMH, within local health departments, professional associations and academic health centers.

The sample size for each of the surveys was as follows:

- Health department survey: n=24
- Community health center survey: n=23
- Safety net provider survey: n=79

The surveys were sent by email to each of the identified respondents in August, 2011. Follow-up emails and phone messages reminding those that did not respond were conducted approximately four weeks following the initial mailing.

Survey results were analyzed using the Survey Monkey analysis tools allowing for both individual item analysis and cross tabulations of specified questions. Each of the surveys was individually analyzed by item and using cross tabulations. Cross tabulations across the three surveys were also completed to understand themes and priorities common among the three groups.

In addition to the three surveys, approximately 45-50 follow-up interviews were conducted with key opinion leaders representing the interests of DHMH and the three groups (List of individuals found in Appendix). The leaders included select CHRC Commissioners, executive and senior leaders at DHMH, executives from Medicaid managed care organizations, directors of national and regional professional associations, key experts in the field, and a select group of leaders representing health departments, health centers and other safety net providers. The interviews were conducted primarily face-to-face and by phone when necessary. A standard interview guide was used to conduct the interviews. A summary of the major themes heard across the interviews was developed to support the development of the priority needs and recommendations

SUMMARY OF SURVEY RESULTS

As indicated above, the three surveys were analyzed at an individual survey level and across groups to understand themes and priority needs for technical assistance. The validity of survey methodology can be raised into question when sample sizes are low, as in this project, and response rates are moderate to low. However, the response rate for the CHRC survey was reasonably high. The health department cohort had the highest response rate at 75%, followed by the health centers at 52%, and 30% for the safety net provider group. The lower response rate for the safety net provider cohort is primarily related to lack of response by non-traditional providers, such as addiction treatment programs and school-based health centers.

"Nearly one third of health department leaders and one fifth of safety net providers indicated that they were 'not very ready'. The community health centers indicated that they were 'fairly ready,' with only 8.3% reporting they were extremely ready."

Survey respondents across the three groups were asked about levels of readiness to implement changes under health reform. As indicated in Table 1 below, health departments responded the 'least ready' of the three groups, followed closely by the safety net providers. Nearly one third of health department leaders and one fifth of safety net providers indicated that they were 'not very ready'. The bulk of community health centers indicated that they were 'fairly ready,' with only 8.3% reporting they were extremely ready.

Table 1

The Overall Level of Readiness to Implement the Various Changes Planned Under the Health Care Reform Legislation			
	Safety Net Providers	Local Health Departments	Community Health Centers
Extremely Ready	10%	5.6%	8.3%
Fairly Ready	70%	66.7%	83.3%
Not Very Ready	20%	27.8%	8.3%

Of fundamental interest to the Commission was the ability of community health resource providers to obtain information regarding health reform and changes in the health care system. This was an open-ended question and survey respondents indicated that they obtain information from many different sources, shown in Table 2 below. Safety net and community health center providers use more than 20 different sources of information, whereas health departments responded that they rely on only eight sources. This composite feedback seems to indicate that providers are searching for information and may not yet have one or two most reliable resources.

Table 2

Where Do You Usually Obtain Information Regarding Health Care Reform and Changes in the Health Care System			
	Safety Net Providers	Local Health Departments	Community Health Centers
Number of Different Sources Cited	25	8	24

A popular methodology for providing accurate information regarding health reform and other topics is a learning collaborative that can be hosted through dedicated websites and live forums. When community health resource providers were asked about topics they might learn through a new learning collaborative, they offered a number of interesting topics for which training and additional education may be needed. As Table 3 below illustrates, learning more about the reimbursement changes that are expected under health reform is a high priority across the three groups, although health departments and community health centers made it a much higher priority than safety net providers. This may be because safety net providers are reluctant to recognize or accept the need to shift from their existing grant-funded model of care to one that relies on third party reimbursement.

"…learning more about the reimbursement changes that are expected under health reform is a high priority across the three groups, although health departments and community health centers made it a much higher priority than safety net providers."

Education about new models of care precipitated by health reform and, specifically, care delivery systems that integrate behavioral health care services is considered a very high priority across the three provider groups. Learning from peers and others how to conduct community assessment and planning activities was also identified as a major topic. The high numbers of providers that responded favorably to the concept of learning collaboratives for gaining knowledge in a multitude of educational areas demonstrates that peer learning is of strong interest for the community health resource provider groups.

Table 3

If Your Organization Would Participate in a Learning Collaborative, Which Topics Would You Find Helpful?			
	Safety Net Providers	Local Health Departments	Community Health Centers
Reimbursement Charges	47.6%	83.3%	81.8%
New Models of Care	76.2%	83.3%	72.7%
Behavioral Health Care Integration	76.2%	83.3%	54.5%
Community Assessment and Planning	71.4%	66.7%	72.7%

The survey included many multiple choice questions asking providers about their needs for technical assistance in a variety of topics related to health reform implementation. Analysis of responses across the three groups revealed many areas of need. Table 4 below lists the needs for technical assistance identified by more than 50% of providers in each group. Where no value is presented (N/A), less than 50% of providers in a specific group expressed a need for technical assistance.

"All three groups identified the need for data collection and analysis as a high priority, with health departments and safety net providers responding that this was a very significant priority. Other high priorities for the same two groups were development of strategic and business plans, as well as development of billing systems."

All three groups identified the need for data collection and analysis as a high priority, with health departments and safety net providers responding that this was a very significant priority. Other high priorities for the same two groups were development of strategic and business plans, as well as development of billing systems. Health departments also identified transition planning for clinical services and help with contracting with payors as significant needs for technical assistance. Only one need for technical assistance was identified by more than 50% of community health centers: data collection and analysis.

Table 4

Areas Where 50 Percent or More of Respondent Group Indicated a Need for Technical Assistance

	Safety Net Providers	Local Health Departments	Community Health Centers
Data Collection and Analysis	85.7%	72.2%	58.3%
Development of Strategic and Business Plan	57.1%	66.7%	N/A
Qualitative Assessment	57.1%	N/A	N/A
Transition Planning	N/A	61.1%	N/A
Development of Billing Systems	50%	66.7%	N/A
Development of Systems for Contracting With Payors	N/A	72.2%	N/A
Development of Information Technology Systems	58.8%	N/A	N/A
Business Development	50%	N/A	N/A

Only safety net providers identified a priority need for assistance with development of information systems technology and electronic health records (Table 4). This was an interesting finding, given that only 22% of health departments and 19% of safety net providers (Table 5) reported that they have fully implemented electronic health systems.

Table 5

Fully Implemented Electronic Health Records			
	Safety Net Providers	Local Health Departments	Community Health Centers
Yes	18.8%	22.2%	75%
No	12.5%	50%	8.3%
In Process	68.7%	33.3%	25%

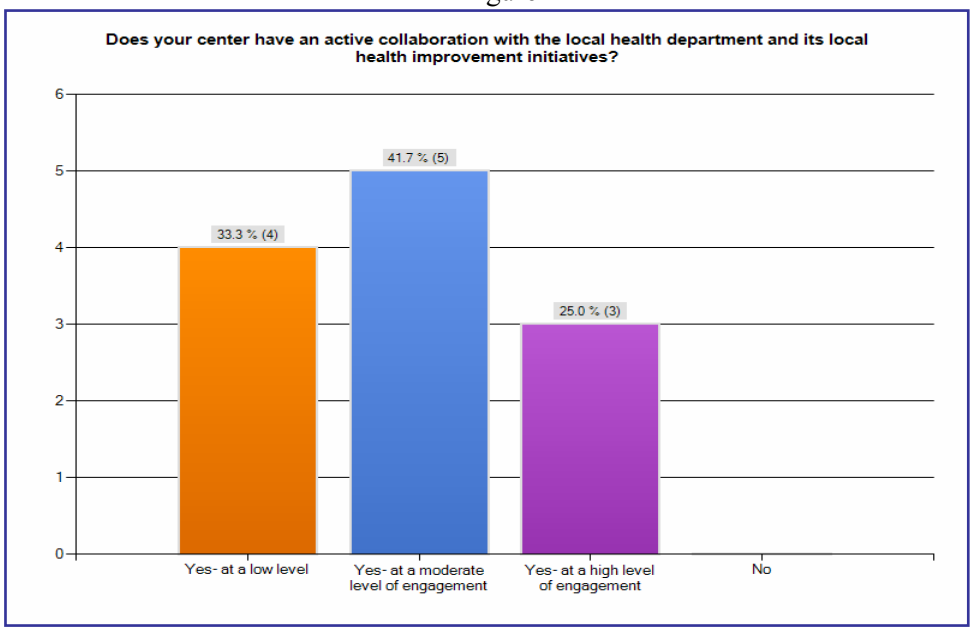
The survey revealed the need for assistance with partnership development and collaborative planning in a number of areas. When safety net providers and community health centers were asked about the need for a more regional approach to planning for future primary care needs, nearly 70% of respondents in each group answered positively (Table 6).

Table 6

Need for a More Regional Coordinated Approach to Planning for Future Primary Care Needs		
	Safety Net Providers	Community Health Centers
Yes	69.2%	72.7%
No	30.8%	27.3%

Per Figure 1 below, only 25% of health centers indicated a high level of engagement with the local health improvement initiatives in their area, and more than one third responded that they are engaged only at low levels. This survey finding further supports the interest in receiving assistance with service integration and partnership development.

Figure 1



"In general, community health resource providers are less concerned about upgrading their technology than they are with improving direct services to patients (models of care, behavioral health care integration) and developing systems for billing and third party contracting."

When all three provider groups were asked about their interest in learning more about the new Community-based Collaborative Care Network grants, they clearly were interested, as Table 7 below represents. One hundred percent of health departments indicated an interest in learning more, followed by 83.3% of health centers and 70% of safety net providers. This further validates the need for increased knowledge regarding partnership development for enhanced collaboration.

Table 7

Do You Intend to Participate in the Community-based Collaborative Care Network?			
	Safety Net Providers	**Local Health Departments**	**Community Health Centers**
Not Aware of Program or Not Sure and Would Like More Information	70%	100%	83.3%

The survey asked a number of questions related to workforce needs to address the future demands related to health reform implementation. Table 8 below shows that primary care providers, both physicians and nurse practitioners, are expected to be in greatest demand among health centers and safety net providers. Registered nurses and mental health therapists were also high priorities for future recruitment. A significant need among health centers was recruiting care coordinators and dental staff.

Table 8

Anticipated Provider Need		
	Safety Net Providers	**Community Health Centers**
Primary Care Physicians	52.4%	91.7%
Primary Care Nurse Practitioners	61.9%	75%
Registered Nurses	61.9%	66.7%
Mental Health Therapist	57.1%	57.1%
Care Coordinators	47.6%	83.3%
Dental Staff	23.8%	66.7%

Analysis of responses to all questions indicate a somewhat surprising readiness for the changes that health care reform will bring. Providers did, however, express a perceived lack of access to timely and accurate information about various aspects of the ACA. This perception may explain the prevalence survey responses indicating "not aware or not sure" responses when asked about the Community-based Collaborative Care Network. The preferred methodology for in-depth training appears to be learning collaboratives and other peer-to-peer initiatives. In general,

community health resource providers are less concerned about upgrading their technology than they are with improving direct services to patients (models of care, behavioral health care integration) and developing systems for billing and third party contracting. They also are interested in regionally coordinated approaches to planning and service delivery.

The researcher must question whether the relatively high rate of "not sure" responses and the high need for accurate information really means that some providers are unaware of how unprepared they are for the changes in health care delivery looming in the future.

SUMMARY OF INTERVIEWS

In addition to the survey instrument, approximately 45-50 follow-up interviews with key stakeholders were conducted to explore the issues raised in the survey. The following groups participated in the interview process:

- Public agencies;
- Professional associations;
- Medicaid managed care organizations;
- Health departments;
- Community health centers; and
- Other safety net providers

These interviews provided additional insight into the specific needs for technical assistance of the three groups and reinforced the priority needs identified in the survey findings.

Summary of Interviews with Public Agencies

Interviews with public agency leaders revealed that the Commission's role in supporting the state's community health resources will complement and enhance several current and future public agency efforts related to the state health planning process and implementation of the ACA. Commission staff have been participants in a number of activities related to health reform planning, such as those being led by DHMH, the Governor's Workforce Investment Board, and the Patient Centered Medical Home Steering Committee, as well as the state health reform planning process and efforts to integrate behavioral health and primary care. However, the stakeholders interviewed through this process emphasized the importance of the Commission's role in future endeavors, serving as the voice of the community providers and as liaison to these providers.

Individuals that were interviewed recommended that the CHRC form collaborations with a number of new and existing efforts across state agencies. For example, DHMH is developing a new virtual data unit to coordinate and streamline data requests across departments for both internal and external data collection projects and make valuable data more accessible to external audiences. DHMH staff involved with this work recognized that their own resource limitations and suggested the CHRC serve as a liaison with external audiences and help broker data requests from community health resources seeking to utilize this data. The leadership staff of Health Exchange acknowledged that regular communication with Commission staff would help ensure that the interests of community health resource providers are included in the future activity of the Exchange. It was also noted that the Commission could serve as liaison when provider input is needed for specific planning work.

Leadership of public agencies that are actively involved with community health resource providers, specifically local health departments and the safety net providers, expressed concern about the capacity of these organizations to participate fully with third-party payors, given their limited experience with electronic health records, provider credentialing, managed care

contracting, and billing. These organizations strongly supported a future role for the Commission in providing technical assistance to them around this set of issues.

Summary of Interviews of Professional Associations

Interviews conducted with state, regional, and national professional associations demonstrated consensus that the providers would need technical assistance to participate successfully in ACA implementation, and that enhanced methods for information distribution and education would be critical. The associations recognized that the provider groups have varying levels of management capacity and expertise to confront the many challenges presented by ACA. They also acknowledged that many of these organizations are already resource-strained and that the additional workload associated with preparing for ACA implementation would further burden their lean operations. This observation reinforced the important role that the Commission could play in supporting providers through the transition planning process.

The association leaders noted that enhanced collaboration among different sectors of the health care system will be important for future success, and that many providers will need help in facilitating these partnerships. For example, they suggested that school-based health centers might consider partnering with community health centers for service delivery under health reform, but they may lack existing relationships with those providers to initiate initial discussions. A second example of collaboration was connecting hospital emergency departments with community providers, such as health centers and other free clinics, to promote improved follow-up care and reduce inappropriate emergency room utilization.

"Acknowledging the significant need for capital and other resources required for expansion of community health centers, association leaders suggested a potential future role for the Commission in both grantmaking and in strengthening the grantseeking skills of providers."

Another need for collaboration was mentioned in workforce planning activities, to respond to anticipated growth in the insured patient population. The association representatives believe that more precise workforce projections, both by health profession category and by geographic area, are needed and that the CHRC could provide valuable assistance given its experience with data analysis and GIS mapping services. Similarly, some association representatives expressed a need for additional data analysis to target unmet primary care needs systematically across the state. It was suggested that the CHRC could offer technical assistance to providers in areas of unmet need to seek federal grants for new access points or expansion of current service delivery. Acknowledging the significant need for capital and other resources required for expansion of community health centers, association leaders suggested a potential future role for the Commission in both grantmaking and in strengthening the grantseeking skills of providers. There was general agreement across the respondents that more inclusive participation of existing safety net providers will be important to address growing need for primary care, but that many of these providers may need a high level of technical assistance. The interviews with association leadership indicated an opinion that provider groups could benefit from help with business

planning and forecasting of demand, revenue and expenses, as well as development of organizational plans to prepare for expansion.

Two specific areas of assistance were identified: (1) Support around efforts to enhance information systems capacity, including installing electronic health record systems; and (2) Preparation to participate successfully in new components of health reform, such as patient centered medical homes, integrated behavioral health and somatic care services, accountable care organizations, and systems for outreach, enrollment, eligibility and case management.

Summary of Interviews of Medicaid Managed Care Organizations (MCO)

The primary goal of these interviews was to identify the activities that the managed care organizations are currently offering or planning to providers to prepare them for health reform. The CHRC needs assessment sought a better understanding of the role of MCOs in the following areas: helping promote network adequacy; increasing capacity to participate in quality measurement; building electronic health record systems; assisting patient outreach and enrollment; and addressing limitations or barriers to contracting with health departments, health centers, and/or other safety net providers.

"Most of the MCOs expressed concern about contracting with safety net providers as they believe those network needs, the only geographic area of concern identified was on the Eastern Shore providers lack effective information systems and billing capacity."

Within the Baltimore metropolitan area, the MCOs agreed that the networks were adequate and would be sufficient in the future, even given the projection of significantly expanded coverage. Some of the MCOs that currently do not work with community health centers expressed interest in exploring new ways to partner as networks expand outside of the Baltimore metropolitan area. However, there was an uneven level of perceived value in both existing contracts and expansion, given the higher rates paid to these providers. Most of the MCOs expressed concern about contracting with safety net providers as they believe those network needs, the only geographic area of concern identified was on the Eastern Shore, providers lack effective information systems and billing capacity.

All of the MCOs expressed a strong commitment to quality and working closely with providers to monitor and improve outcomes. Some closed network organizations expressed concern about working with health centers outside of their current networks due to potential difficulties managing and controlling outcomes of care. Most of the organizations expressed concern over the capacity of health centers to meet electronic health record capacity requirements; however, they did not believe they had a role in supporting any technical assistance. All of the MCOs identified the need for enhanced systems to support outreach and enrollment of new patients under health reform. However, only one organization planned to play a role in this area. The MCOs acknowledged that development of effective systems for eligibility and enrollment at the community level was critical and they expressed hope that the centers and state would be expanding current efforts.

Summary of Interviews with Local Health Departments

The primary concern among health department leaders was the sustainability of existing clinical services in a new fee-for-service environment, given significant capacity limitations in third party contracting, billing, and information systems including electronic health records. Health officers are facing their own challenges in transitioning from a largely grant-funded business to a fee-for-service model. Those interviewed feel strongly that the Commission should play a leadership role in providing technical assistance across the spectrum of business planning and systems design needs.

Health officers also identified other needs for support, including workforce planning; training on key areas of health reform and how best to participate; partnership cultivation to continue state health plan efforts; and expanded systems for community-based outreach, eligibility and enrollment. Health officers recognized existing challenges in recruitment of some health professionals, particularly nurses and dentists, and expressed concern about their ability to recruit as demand for service expands. Health leaders were highly satisfied with the coalition building aspect of the recently completed local health planning process, and requested assistance in facilitating continued collaboration and partnership with other agencies involved in this work. They expressed a need for further education about newer components of health reform in which they might want to participate, and for opportunities to learn from peers and others in the field. Finally, one of the highest priorities expressed by all health officers was development of expanded systems for outreach, eligibility and enrollment. Most of the health departments currently provide eligibility services. However, they must significantly enhance and expand these services in order to capture as many uninsured, eligible individuals as possible.

"Health officers are facing their own challenges in transitioning from a largely grant-funded business to a fee-for-service model. Those interviewed feel strongly that the Commission should play a leadership role in providing technical assistance across the spectrum of business planning and systems design needs."

Summary of Interviews with Community Health Centers

The four primary needs of community health centers were identified as workforce planning, implementation of patient-centered medical home, achievement of meaningful use guidelines for electronic health system development, and business planning for expansion of services and new program development. Both urban and rural health center leaders expressed concern about workforce recruitment, but the concern is greatest among the rural centers where they continually confront challenges in recruitment and retention. Health centers who were interviewed raised questions about how loan repayment funds are allocated and called for advocacy to assure a more equitable distribution to areas in greatest need. There was interest in exploring innovative partnerships with academic health centers to increase the pipelines for recruitment of high-demand health professionals.

As with the professional association leaders, health center directors requested technical assistance to support full and successful participation in the patient centered medical home project. The complex changes necessary to shift models of care are challenging and time consuming, and centers would benefit from program development assistance. Similarly, the time and expertise required to move systems to achieve meaningful use were identified as challenges, and technical assistance and support in this area was identified as a priority.

Finally, health center directors interviewed reinforced the observation made by the professional association regarding the limitation on management capacity and expertise across Maryland's health centers. Technical assistance with business planning and new program development would be very helpful.

Summary of Interviews with Safety Net Providers

Safety net providers interviewed noted a significant and pressing need for technical assistance in both strategic and business planning to prepare providers for successful participation in the new health care delivery system being driven by health reform. Those interviewed expressed concern that some safety net organizations were not working with their boards to conduct the level of strategic thinking and planning required to, in some cases, dramatically change organizational missions. Like most health departments, safety net providers operate primarily in a grant-funded environment and, as such, many lack the core competencies for the systems development and business planning work required for transition to a fee-for-service environment. Interviews suggested that the Commission could play a significant role in preparing safety net providers for health reform by working with their boards and management in strategic decision-making and business planning to guide implementation.

"Like most health departments, safety net providers operate primarily in a grant-funded environment and, as such, many lack the core competencies for the systems development and business planning work required for transition to a fee-for-service environment."

CAPACITY ASSESSMENT OF CHRC

An assessment of CHRC's existing capacity was conducted to identify where additional resources would be needed to implement the activities of the business plan. The organization has undergone substantial changes in management, staffing, and funding since its creation in 2005. When it was established by the Maryland General Assembly, the CHRC was created with an annual budget of approximately $15 million, comprised of special funds (not tax-payer funds) from CareFirst. This moderately sized budget reflected the large expectation and lofty policy goals of the CHRC when it was created by the Maryland General Assembly.

During its first few years (FY 2007 and FY 2008), the Commission did not, however, award its full grant budget (approximately $15 million in special funds), and accumulated large surpluses in its budget. This budget surplus (or under-expenditure of grant funds) coincided with the downturn in the national and state economy, and the surplus funds were transferred from the CHRC's budget. In addition to this under-expenditure of funds, the CHRC also suffered from the perception in its first few years that it had failed to create a strong collaborative relationship with DHMH. In addition, grant awards made by the Commission were made without a thorough understanding of "need" as reflected in publicly available data and were not overseen by Commission staff with adequate accountability measures. As a result of the initial unspent funds, questions raised by some regarding the Commission's value and effectiveness in its first few years, and the severe budget challenges to the overall state budget since 2007, the CHRC's annual budget has been capped at approximately $3 million since FY 2010. As shown in the following table, over the last four fiscal years (FY 2009-FY 2012), more than $45 million (77.3%) has been transferred from the CHRC's budget to support other needs of the state's health care budget.

CHRC Annual Budget, FY 2009 through FY 2012					
	FY 2009	**FY 2010**	**FY 2011**	**FY 2012**	**Total**
CHRC Budget Allowance	4,092,586	2,995,705	2,996,737	3,150,000	13,235,028
Fund Transfers (out of CHRC budget)	12,100,100	10,900,000	10,500,000	11,600,000	45,100,100
Total Budget (special funds)	16,192,686	13,895,705	13,496,737	14,750,000	58,335,128
% Transferred Out	**74.7%**	**78.4%**	**77.8%**	**78.6%**	**77.3%**

These budget reductions led the CHRC Chairman to recruit a new Executive Director to lead the Commission. In October 2009, the Commission appointed a new Executive Director, the second individual to hold this position since the CHRC's creation in 2005. Following this management change, the Commission has substantially restored the confidence of DHMH leadership, the Administration, and other community leaders, by utilizing its minimal budget to support the needs of community health resource providers across the state through thoughtful and high impact grants and strong collaborative relationships. The CHRC has developed a robust system of grantee performance measurement, and utilizes the data reported by grantees to determine the impact of CHRC funded programs and communicate the work of the Commission to external audiences and key stakeholders. Vacant staffing positions were filled and the Commission has a total of three full-time staff: the Executive Director; Policy Analyst, and a Financial Officer/Administrator. As a result of these significant changes in leadership, staffing, and

performance, the Commission has been asked to participate in and/or lead a number of new priority state initiatives that are helping expand access to care and improve health outcomes.

The Commission's primary function remains centered on grant-making to build the capacity of community health resources and expand access for underserved communities. New systems for requesting, selecting, monitoring, and evaluating grants have been developed and implemented by the new staff leadership of the Commission. Stronger and more rigorous systems for grantee fiscal accountability are now in place, along with a new performance monitoring system to track outcomes of CHRC grants. As a result of these changes, the Commission is now better able to report the results and impact of its grants. These system enhancements have also allowed Commission staff to identify challenges more effectively that grantees may encounter in program implementation and to provide technical assistance and support to resolve those problems.

"Stronger and more rigorous systems for fiscal accountability are now in place, along with a new performance monitoring system to track outcomes of CHRC grants."

From FY 2007 to FY 2012, the Commission awarded 93 grants, totaling $22.7 million. These grants have collectively served nearly 100,000 Marylanders and supported programs in all 24 jurisdictions of the state. During this same time, the Commission has received 432 grant proposals, totaling more than $147 million in funding requests. This demonstrates the strong, continued need for resource support among community health resource providers, but it also indicates the significant amount of time and work required to evaluate this volume of grant proposals and monitor the performance of grant programs over a number of years. There is sufficient evidence that current Commission staff effectively and adequately addresses these needs.

In addition to its grant-making role, the Commission has increased its capacity to respond to requests for customized technical assistance from providers. The CHRC has an arrangement with Washington College that affords the Commission, its grantees, and others access to GIS mapping services and data analysis. This enables the Commission to help health centers and safety net providers produce customized maps of their service areas and assess unmet needs for primary care access points and other gaps in services. These maps have been used for board level planning, new business development, and fund initiation.

Another area of technical assistance provided by the CHRC has been helping providers access and interpret data for program planning and fund development. Commission staff, primarily the Policy Analyst, have helped providers pursue competitive grant opportunities, develop data requests involved in grant applications, analyze the data, and draw meaningful conclusions relative to the goals of specific projects. A recent example of this technical assistance was the support for providers applying for the Center for Medicare Strategies (CMS) Innovation grants. Commission staff helped providers develop data requests, acted as a liaison with DHMH to access data, assisted with analysis and in some cases helped submit the grant applications.

The Commission also has been engaged in facilitating partnerships and brokering collaborations requested by community health resource providers. In December 2010, the Commission worked with leaders in Prince George's County to provide staff support for a forum that brought together health care leaders to plan a better integrated, community-oriented health care system for the County. Commission staff helped plan the forum, invite stakeholders, and produce the summary report. More recently, the Commission brokered a relationship among a community health center, its local health department, and a non-profit organization to help develop strategies for increasing outreach and enrollment services for a large, uninsured, but potentially eligible patient population.

The Commission staff has worked hard over the last several years to re-engineer systems for their core grant-making role but have also demonstrated their value in other areas. As a result of this emerging track record of success and ability to deliver, the Administration, DHMH leadership and other state agencies have begun to turn to the CHRC to participate in a number of high priority projects, such as the Administration's Domestic Violence Screening and Referral to Treatment Initiative; the Multi-Payor Patient-Centered Medical Home (PCMH) Program; the State Health Improvement Process (SHIP); the DHMH Task Force on Regulatory Efficiency; and a new initiative of the Administration to create Health Enterprise Zones. As the responsibilities of the Commission grow, there may be a commensurate increase in the CHRC's budget to support the expanded role of the Commission.

The current breadth and scope of activities conducted by the Commission reflects the confidence of the CHRC Board in its productive and capable staff. The growing number of activities of the CHRC seems impressive, given the small number of staff and limited amount of budget resources. As a result, a thorough and thoughtful analysis of the need for additional external resource support was conducted as part of the business planning process. The results of this assessment are detailed in the Implementation Plan found later in this report.

SUMMARY OF PRIORITY NEEDS FOR TECHNICAL ASSISTANCE AND RECOMMENDATIONS

1. Providing technical assistance and support around the "mechanics" of health reform implementation

The surveys and interviews revealed a significant need for increased knowledge and information about specific components of health reform, as well as assistance with strategic and business planning to prepare for service delivery changes. Across all three groups, community health resource providers are requesting more current, reliable, and easy to access information regarding health reform implementation at both the state and national levels. Providers are currently using a multitude of sources and are unclear which are the most accurate. While information seems to be plentiful at the national level, providers feel they receive limited regular communication regarding state level planning and its impact on their work. The instability of the political and fiscal environment at the national and state levels fosters even greater uncertainty about health reform's status and whether it will survive. Providers need to be knowledgeable about the progress of implementation planning at the national and state levels in order to think strategically and effectively time their own organizational transitions.

Providers also demonstrated a lack of sufficient knowledge regarding specific components of health reform. Patient centered medical homes, accountable care organizations, meaningful use, and evidence-based practice for targeted disease areas are just a few of the topics on which providers need training and guidance. Providers acknowledge the groundbreaking and innovative work occurring among their peers and across the three groups, but they lack a formal mechanism for learning about best practices and model programs.

A high-priority for many providers is technical assistance in strategic and business planning for organizational change, service delivery expansion, and new program development. For safety net providers, especially the free clinics, deliberations about major strategic decisions are needed at the governing board to staff levels in order to plan for major shifts in organizational missions. Health departments are seeking support in considering the most appropriate future direction for specific clinical services, given a shift from a predominantly grant funded environment to a fee for service environment. Health centers lack time, capacity and, in some cases, expertise to identify systematically unmet needs for additional services and to plan for expansions. They critically need help with detailed operational planning that takes into account the range of implementation steps necessary to expand or develop new services, and/or to shift clinical services to fully participate with third party payors. Providers, particularly safety net clinics and health departments, need help with building systems for contracting with payors, credentialing providers, developing information systems, and billing.

In addition to these seemingly complex needs for education and assistance, providers also need help with simply connecting with other agencies and providers to foster greater collaboration and integrated service delivery. Lack of existing relationships and other limitations prevent many providers from different health care sectors from initiating conversations, despite acknowledging

potential opportunities. Maryland lacks a neutral agency or organization that can help facilitate and broker these types of relationships.

Recommended Action Item for CHRC: Provide technical assistance and support related to "mechanics" of health reform legislation. The Commission could play a number of roles in supporting increased education, information sharing, and technical assistance to help community resource providers understand and more fully engage in the "mechanics" of health reform implementation. One major recommendation is to increase the capacity of the Commission to provide information, education and training to providers through both web-enabled and face-to-face methodologies. The CHRC should develop a fully functional website that can support dissemination of up-to-the-minute information, educational forums, peer learning, and social networking among all three groups of providers. Commission staff could recommend the most reliable national sources for information sharing, as well as actively retrieve and share state level information on ACA implementation status, including links to state websites such as the new Health Exchange organization and the Governor's Office of Health Reform. The information would be current and factual, with Commission perspectives on implications for each of the three community resource provider groups.

The new website would support education and training opportunities through MCHRC-sponsored webinars, as well as link users to regional and national training programs that have been evaluated by the Commission for quality. Through a secure web portal, the Commission could establish peer learning collaboratives for each of the three groups to share information, questions and best practices common to their provider networks. The website also could support topic-specific learning collaboratives in high need areas, such as patient centered medical home, electronic health record implementation, and participation with third party payors.

The website could actively engage providers in understanding different types of grantmaking and technical assistance offered by MCHRC. It would announce Commission, local, and federal funding opportunities. White papers detailing best practices gleaned from prior Commission grants would also be shared through the website. An interactive help desk could be established to provide web-based support, from both internal and external resources, to community providers as they move through the transition process.

Finally, the Commission should expand its existing capacity to provide customized technical assistance to providers conducting strategic and business planning on reform-related topics as noted above. Through the development of toolkits that provide step by step "user-friendly" guidance on various high need topics and direct site delivered consultation, the Commission could help community health resource providers develop the detailed business and operating plans necessary for organizational and clinical service transition, service expansion, and new program development.

The CHRC should establish an Advisory Committee comprised of representatives from DHMH, the Governor's Office of Health Reform, and each of the three provider groups to guide all of the above education and technical assistance program design.

2. Encourage linkages of key public and private agencies to address anticipated workforce challenges

All three provider groups said they will need to expand their workforce in order to serve the increased number of patients expected by 2014. Primary care practitioners, nurses, and mental health providers are expected to be in greatest demand. Health centers and safety net providers indicated a substantial need for care coordinators and dentists. Currently, recruitment efforts utilize standard approaches such as advertising and networking among professional associations. Health centers rely on the National Health Service corps to recruit many primary care, dental, and mental health providers. However, they recognize that these methods alone will not meet future needs. Providers also are concerned that the current loan repayment program may not be equitably distributed to help providers in geographic areas most in need. A large number of safety net providers utilize a primarily volunteer provider staff and are extremely concerned about their ability to recruit and retain providers if their missions shift to caring for an insured population.

Providers also need help with workforce planning to forecast demand for providers over the next several years. Providers do not have access to detailed workforce data that specifies numbers of health professionals by job title, within in specific geographic areas consistent with their service areas. This level of analysis, in conjunction with projections of health care needs by type of service, is necessary in order for providers to recruit new staff. As indicated above, compounding the lack of data is the capacity limitations of many providers to conduct this type of sophisticated planning process.

Community health resource providers work throughout Maryland and those in rural areas are far from educational institutions that train health professionals. Even health centers in the urban centers close to the University of Maryland and Johns Hopkins University lack any substantial or formal relationships with these academic centers to assist with recruitment. Providers are interested in partnerships to increase student placements at their sites and other collaborative opportunities for more direct pipeline development and recruitment. Without any formal relationships or existing agency helping broker these partnerships, the providers are unable to initiate these discussions.

Providers are encouraged by the recent work of the Governor's Workforce Investment Board and other efforts to begin addressing the future workforce needs resulting from health reform. However, they are largely absent from the planning work. As a result, they are concerned that their "voice" may not be adequately heard in this critical planning and implementation process.

Recommended Action Item for CHRC: Work with DHMH, the Governor's Workforce Investment Board and other agencies to support statewide plans for workforce development in health departments, health centers and other community health resources. The Commission is uniquely positioned to act as a liaison between the state's workforce planning efforts and community health resource providers, given its close and collaborative working relationships with both state agencies and provider groups. MCHRC staff have been actively engaged in recent planning processes conducted by state agencies, and continuing participation will enable

the Commission to communicate the most up-to-date information on the state's plans and activities to community health resource providers. Utilizing the new web capacity recommended in Action Item One, the Commission will be able to regularly update providers on state and national plans for workforce development and direct opportunities for their involvement. The Commission should also conduct regional and statewide webinars and face to face forums on emerging workforce topics requiring more extensive explanation and training.

Through its existing GIS mapping and data analysis capacity, the Commission should assume a leadership role in assisting public agencies and providers with workforce planning projects to forecast specific needs at the community level. Communication with state agencies and providers can help produce more accurate data on existing workforce supply by type of health professional that is not routinely reported through available licensure and other data sources. This information, along with existing data on population variables and health indicators, can support more systematic and precise forecasts of future demand for specific types of health professionals by geographic area. Additional technical assistance from the Commission could help individual providers develop more customized plans for workforce development.

The Commission should work closely with public agencies to expand community-based training opportunities. Through its collaborative relationships with community health resource providers, the Commission could broker new and innovative opportunities for preceptors in underserved areas and other training initiatives. The Commission also could facilitate strategic partnerships across provider groups to develop new recruitment programs for high demand health professionals. Commission staff could communicate needs and help design and evaluate programs.

3. Facilitating access to and interpretation of data

Health reform implementation will offer a significant number of new opportunities that involve grants, reports, and competitive applications. Participation in patient-centered medical home, accountable care organizations and other components of health reform require organizations to be data-driven and data knowledgeable. Health departments will shift from a predominantly patient-centered focus to a population level perspective as they plan and develop new programs to support emerging community needs. All community health resource providers are facing critical decisions about the future direction of existing services and how best to approach expansion. These important challenges can only be met successfully through access to detailed data and the ability to interpret this data for effective decision making.

The surveys and interviews conducted for this needs assessment identified significant gaps in the capacity of providers to access and analyze data. While many local health departments have some staff with expertise in epidemiology, they may not have adequate numbers of skilled staff to meet future demands. Community health centers and other safety net providers generally operate on lean budgets with just enough staff to respond to daily operational needs, rather than dedicated resources for data collection and analysis. Even if centers have staff with skills in fundraising and grant writing, they may lack the skills needed for complex data analysis.

Capacity limitations and lack of expertise are major issues for community health resource providers trying to be data-driven. However, accessing data can be complicated even with sufficient capacity. Multiple state and federal databases contain different types of data available in different and unmatched timeframes and reporting methodologies. Data is frequently unavailable at a neighborhood or community level. Data that is publicly available varies from its level of geographic granularity being available at either zip codes or census tracts. Public and private agencies post data reports on their websites, but more detailed data required by community health resources for program planning or grants are not available in the standard reports. Navigating myriad departments of a government agency or university to find the right department with a helpful epidemiologist willing to provide more customized data is a complicating and daunting task for already resource constrained community health resource providers. DHMH is developing a "virtual data unit" to help coordinate data requests from internal and external stakeholders, yet they acknowledge that the unit will have limited resources for providing significant support to external agencies requesting assistance with a broad range of data needs.

Recommended Action Item for CHRC: Assist community health resources providers by facilitating access to data and interpreting or translating this data to meet customized needs.
The Commission has clearly demonstrated its value in providing assistance with data access and analysis to community health resource providers through its past projects. This technical assistance role and capacity should be expanded. The Commission should become the "go to" source for community health resource providers that require help with data collection and interpretation. Current availability of software for mapping and other data analysis should be evaluated for necessary enhancements, as should the need for additional technical expertise.

As DHMH implements its new "virtual data unit," the Commission should serve as liaison to community health resources that need assistance in accessing data that is maintained by the Department. The Commission can help community health resources define their data needs, identify whether DHMH is a source for this data and, if so, work with staff in the new virtual data unit to obtain the data. This process could help the resource-constrained data unit avoid becoming overwhelmed by external data requests from multiple different agencies. To achieve this goal, Commission staff will need to expand their knowledge of DHMH sources for specific types of data and to strengthen their collaborative relationships with various DHMH staff who can support enhanced data reports.

Commission staff should communicate to community health resources the scope of support that will become available through the new website and other direct venues. The scope of services should include a menu of options that meet diverse capacity needs across the spectrum of community health resource providers. CHRC services should include help in clearly defining the data needs to respond to program development or grant requests, identification of appropriate data sources from among multiple public and private sector options, obtaining the data from the selected source, analyzing data, interpreting data for the targeted project, and reporting data in graphs, charts, maps and other media.

4. Support expanded systems for outreach, eligibility and enrollment

The future success and sustainability of community health resource providers will be tied to their ability to capture new revenue streams associated with the substantially increased number of insured patients. However, many providers lack sufficient manpower to identify the new patient populations and assist them though the complicated eligibility and enrollment process. Currently, outreach and eligibility workers in most areas of the state, with the exception of Baltimore City, are funded and placed by local health departments. Health department leaders agree that current staffing levels do not adequately reach the current populations of patients, and will most definitely not support future, increased demand.

A number of community health resource providers are experiencing difficulty with revenue generation due to a lack of adequate eligibility resources in their communities. While local health departments place a small number of workers in the community to assist patients, the majority remain in health department and social service department offices that are often great distances from where patients live, work, and receive their health care services. Transportation and education barriers further prevent many individuals from accessing the eligibility assistance and, therefore, they remain uninsured. When these uninsured individuals become ill or pregnant, they present at community health centers and safety net clinics. While these providers are well-equipped to respond to the emergent health care needs of their patients, many providers lack the expertise or resources to assist the patients in determining eligibility for public health insurance programs such as Medicaid, PAC, or CHIP. Thus, the health center has a patient who contributes little if any revenue to the organization and, therefore, contributes to financial risk and loss of significant revenue that could be recouped for services rendered by the health center. A number of these centers expressed a need for having eligibility workers on site, but lack the resources to support additional staff.

The state's newly formed Health Exchange, along with DHMH, will be tasked with developing new systems to respond to forecasted increases in the insured population. Although specifics plans for the new system's operations are still being formulated, Exchange leadership expressed an interest in working closely with the Commission to ensure that the interests of community health providers are addressed.

Recommended Action Item for CHRC: Support efforts to develop expanded systems for eligibility and enrollment. Commission staff should take on a leadership role with public agencies and community health resources to ensure that new programs to enroll uninsured individuals are appropriately sited in the community to maximize new and ongoing outreach and enrollment efforts. Exchange staff have committed to working Commission leadership to provide ongoing input to these new initiatives to ensure an appropriate community level response. Exchange staff recognized the importance of the patient navigation aspect of eligibility and enrollment in the planning process, and the Commission should work to ensure that this component remains a high priority during the coming weeks and months. Commission staff should also collaborate with the Exchange so that community health resources are identified as active participants in the patient navigation, eligibility and enrollment process when requesting federal funds and other resources.

It is critical that Commission staff must serve as the "voice" of safety net providers through this process and the CHRC should thus develop clear and active communication methods to obtain the perspectives of community health resources. Through the proposed Commission website and in face-to-face discussions, CHRC staff will be in a position to track the emerging needs of community health resources and provide timely access to current information regarding the efforts of the state and local public agencies to expand systems for eligibility and enrollment.

National and state best practice models have demonstrated effective community level programs to locate hard-to-reach patient populations and help them navigate the complicated system of eligibility and enrollment to health insurance. As this need increases in 2014 with expanded health insurance choices and substantially more individuals become eligible, the Commission should provide information and training on model outreach and enrollment programs to community health resource providers. Commission staff also should provide technical assistance for providers who want to develop new programs based on best practices.

5. Provide additional resources to respond to state and community public health priorities

As indicated previously, over the last five years, the Commission has received more than 300 grant requests totaling more than $112 million. These requests far exceed the funding availability of the Commission. This needs assessment conducted to support this business plan surfaced a vast array of new resource needs facing community health resource providers as they plan for the transition involved with health reform implementation. Funding will be needed to support developing new programs, building enhanced information systems, hiring additional staff, and constructing or improving facilities. Public and private sector grants are available to community health resource provides; however, they are highly competitive and often involve national competition for a limited number of awards. This restricts the support that is available to Maryland's community health resource providers.

DHMH's launch of the State Health Improvement Process (SHIP) has identified the need for new public health intervention strategies and activities at the local level, as Local Coalitions work to improve overall public health in their communities and respond to the health needs in their regions and jurisdictions. With uncertain and dwindling state and local funding, health departments and their partners may be challenged to fund adequate implementation of these plans. The planning work has generated significant energy and momentum, but a lack of action could potentially hinder the collective commitment over the longer-term. This year's budget of the CHRC contains a new line-item ($500,000) to support the first year of the implementation of local action plans. In addition to this financial support of the SHIP and intervention strategies of the local coalitions, the CHRC should continue to collaborate closely with DHMH leadership and others at the local level to identify and recruit additional resources if resource shortfalls arise during implementation of the local action plans.

Private foundations have, in the past and again more recently, approached Commission leadership about co-investment opportunities. Several years ago, the Weinberg Foundation partnered with the Commission on a few grants to leverage Commission funding. Other

foundations have asked how they might support the Commission in providing technical assistance to providers and/or in developing new program in areas of mutual interest.

Recommended Action Item for CHRC: Catalyze innovative public-private partnerships that will leverage additional private resources. The future work of the Commission and the needs of community health resource providers to implement local health action plans and the implementation of health reform offer unprecedented opportunities to galvanize the philanthropic interests and commitment of public and private organizations to support these important efforts. Public and CHRC grant funding alone will likely be insufficient to respond to the myriad of needs of safety net providers. It is critical that the CHRC utilizes its modicum of funding to leverage additional investments from federal and private/non-profit organizations. The Commission should lead an initiative to channel the collective philanthropic support of foundations and corporations in a "Health Access Impact Fund." The first step would be to identify the priorities of community health providers with guidance from staff, community health resource provider advisors, DHMH leadership, and the Governor's Office of Health Reform. Then, through individual and group meetings with foundations and corporate giving leaders, the Commission should communicate with community health resource providers about CHRC activity and the resource needs of the safety net community. The discussions with the philanthropic organizations should identify areas of mutual interest for co-investment and mechanisms for both individual and collective support.

Commission staff should research model programs for leveraging public resources through innovative funding mechanisms. Prior efforts such as the Baltimore Safe and Sound Campaign and the Green and Healthy Homes Initiative offer examples of public-private partnerships that pooled large funds in support of a mutual high impact interest areas. Appropriate organizational vehicles for co-investing public funds with private resources should also be explored with legal counsel. Once organizational options are identified, Commission staff should work with DHMH leaders to select an appropriate organizational vehicle, identify high impact funding priorities, and create the new funding entity. A marketing plan for fund solicitation should then be developed and implemented.

IMPLEMENTATION PLAN

I. Provide technical assistance and support related to "mechanics" of health reform implementation.					
	Action	**Priority (high, medium, low)**	**Timeline**	**Capacity Evaluation**	**Fiscal Impact Low-High**
I.a.	Establish Advisory Committee comprised of public and private stakeholders to advise the CHRC on development and implementation of technical assistance and educational efforts.	High	3-6 months	Can be executed with existing CHRC resources	None
I.b.	Identify opportunities to collaborate with public and private agencies regarding implementation of the technical assistance and support.	High	3-6 months	Can be executed with existing CHRC resources	None
I.c.	Expand the capacity of the CHRC to utilize web-based technology to deliver technical assistance, peer learning, and education.	High	6-12 months	Additional external resources and expertise required	see below
I.c.i	Identify key functions required for web enhancement, including information exchange and dissemination, peer learning (expert blogs, peer postings, and questions) and exchange, webinar and other educational programming, links to other sites, interactive "help desk" around health reform implementation. (one-time)	High	6-12 months	Additional external resources and expertise required	$10,000
I.c.ii	Contract with a web design firm to develop new site. (one-time)	High	6-12 months	Additional external resources and expertise required	$11,000
I.c.iii	Develop content for new web site, including most current information about federal and state action regarding health reform implementation, post "best practices" regarding CHRC grant activities, and disseminate information about T.A. available from the CHRC to external audiences. (one-time)	High	6-12 months	Additional external resources and expertise required	$15,000
I.c.iv	Develop capacity within Commission to support ongoing site maintenance (updated content, interactive help desk staffing, site membership and security, and other functions). (on-going)	High	9-12 months	Additional external resources and expertise required	$5,000-10,000

Action		Priority (high, medium, low)	Timeline	Capacity Evaluation	Fiscal Impact Low-High
I.c.v	Hire firm for technical site maintenance. (ongoing)	High	9-12 months	Additional external resources and expertise required	$1,000
I.d	Identify priority areas of customized technical assistance to be developed and implemented in year one.	High	3-6 months	Can be executed with existing CHRC resources	None
I.d.i	Develop mechanism to notify community health resources of available technical assistance.	High	3-6 months	May be executed with existing CHRC resources	None
I.d.ii	Develop toolkits to aid in technical assistance and to distribute to interested community health resources. Initial topics may include: (1) How to Plan for Clinical Service Transition/Changes under Health Reform – one for health departments and one for the free clinics, including basics of strategic planning and business planning steps to undertake to consider overall clinic transformation or specific service transitions (2) Partnership Development – Cultivating Public Health and Health Center partnerships (this would include school-based health centers and other service opportunities for partnership with examples of models in Maryland and nationally (3) Participation with Managed Care Organizations - including all of the steps necessary to identify who to affiliate with, credentialing process, contracting and systems necessary to participate and (4) Billing Third Party Payors. (on-going)	High	12-15 months	Likely combination-some activities could be conducted with existing CHRC resources whereas other activities will likely require external resources and expertise.	$20,000
I.d.iii	Determine the specific areas of technical assistance that can be provided internally by Commission with existing resources and areas requiring external consultant support.	High	3-6 months	May be executed with existing CHRC resources	None
I.e.	Web based mechanism to facilitate peer learning among community health resource providers. (on-going)	Medium	9-12 months	Additional external resources and expertise required	$500

Action		Priority (high, medium, low)	Timeline	Capacity Evaluation	Fiscal Impact Low-High
I.e.i	Facilitate development of learning collaboratives among distinct peer groups (health departments, health centers and other community health resources) and around specific topics of interest. Utilize both web-based technology as well as live forums to foster peer sharing and communication.	Medium	9-12 months	Additional external resources and expertise required	$2,500-5,000
I.e.ii	Continue development of "white papers" on best practices/lessons learned from Commission funded projects.	Low	6-9 months	May be executed with existing CHRC resources	None
I.e.iii	Convene meetings to highlight lessons learned and best practices from past Commission grants or other priority areas to be determined.	Low	6-9 months	Can be executed with existing CHRC resources	None
I.f.	Provide opportunities for expanded education and training. (on-going)	Medium	9-12 months	Additional external resources and expertise required	$500
I.f.i	Identify priority topics for education.	Medium	6-9 months	May be executed with existing CHRC resources	None
I.f.ii	Develop a schedule and initiate program development, including engaging speakers and designing educational materials.	Medium	9-12 months	May be executed with existing CHRC resources	None
I.f.iii	Develop methodology for evaluation of educational programs.	Medium	9-12 months	May be executed with existing CHRC resources	None

II. Work with DHMH, the Governor's Workforce Investment Board and other agencies to support statewide plans for workforce development in health departments, health centers and other community health resources.					
	Action	**Priority (high, medium, low)**	**Timeline**	**Capacity Evaluation**	**Fiscal Impact Low-High**
II.a.	Continue Commission's participation in planning efforts implemented by DHMH, the Governor's Workforce Investment Board and other workforce committees.	Medium	Immediate/ Ongoing	Can be executed with existing CHRC resources	None
II.b.	Develop capacity through the web and face to face methods to provide ongoing or regular information to community health resources on key state and federal activities and opportunities for collaboration and funding around workforce planning and expansion.	Medium	6-9 months	Additional external resources and expertise required	see above
II.c.	Assist state agencies in efforts to conduct planning and analysis on the number and need of primary care providers in Maryland through targeted needs assessments of community health resources that provide data on existing primary care workers and need not currently captured through existing data sources. Assist as necessary on data analysis and projections of future supply and demand for community health resource providers.	Medium	3-6 months	Can be executed with existing CHRC resources	None
II.d.	Collaborate with the state's plans to strengthen educational and pre-training opportunities by acting as a liaison between community health resource providers and state agencies/educational institutions to develop new and expanded community-based training placements and preceptor opportunities, such as the proposed statewide CHAMP program, particularly for advanced practice nurses and physician assistants. Work with the state, educational institutions and community health resources to seek grant funding available from federal ACA implementation to support these new training and educational opportunities in the community.	Medium/Low	6-9 months	May require additional support	$5,000-10,000
II.e.	Collaborate with DHMH and other state agencies as they explore ways to expand the Maryland Loan Assistance and Repayment Program (MLARP) to communicate potential new funding streams to community health resource providers.	Medium	6-9 months	Can be executed with existing CHRC resources	None
II.f.	Provide technical assistance as requested (per above action item) to help community health resource providers develop comprehensive workforce plans.	Medium	9-12 months	Additional external resources and expertise required	$25,000-50,000

III. Assist community health resource providers by facilitating access to data and interpreting or translating this data to meet customized needs.					
	Action	**Priority (high, medium, low)**	**Timeline**	**Capacity Evaluation**	**Fiscal Impact Low-High**
III.a.	Support DHMH in its efforts to implement a new "virtual data unit" by communicating availability of the new service to community health resource providers and serving as a liaison between providers and the new unit staff, as requested by providers.	Medium	3-6 months	Can be executed with existing CHRC resources	None
III.b.	Expand Commission's technical assistance to providers to utilize data effectively for planning and fund development in the following areas: i. Formulating data needs and requests; ii. Identification of data sources; iii. Accessing data; iv. Analyzing data for the targeted need (grant or planning project); v. Interpreting data; and vi. Reporting data in various formats such as maps, graphs, charts, etc.	Medium	6-9 months	May require additional support	$30,000
III.c.	Identify need for additional staff, consultant, hardware or software resources to provide expanded assistance with data access and analysis. (on-going)	Medium	3-6 months	May be executed with existing CHRC resources	$15,000-25,000
IV. Support efforts to develop expanded systems for eligibility and enrollment.					
	Action	**Priority (high, medium, low)**	**Timeline**	**Capacity Evaluation**	**Fiscal Impact Low-High**
IV.a.	Collaborate with appropriate state agencies to understand evolving plans for expanded eligibility and enrollment and communicate specific needs of community health resource providers. Assist in communicating any new plans to community health resource providers.	Medium	9-12 months	May require additional support	None
IV.b.	Identify ways for the Commission to help the state and or local jurisdictions expand development of community-based systems for outreach, eligibility and enrollment that includes eligibility workers available in health centers and safety net provider sites. (on-going)	Medium	12-15 months	May require additional support	$15,000-25,000
IV.c.	Explore ways to potentially partner with Health Care Access Maryland, or other private partners, to expand their services to community health resources outside of Baltimore City and/or to provide program design and training assistance to community health resource providers to develop their own outreach, eligibility and enrollment services. (on-going for the next few years)	Medium	12-15 months	May require additional support	$50,000

V. Catalyze innovative public-private partnerships that will leverage additional private resources.

	Action	Priority (high, medium, low)	Timeline	Capacity Evaluation	Fiscal Impact Low-High
V.a.	Meet with foundation associations across Maryland, such as the Association of Baltimore Area Grantmakers and other individual private, family and corporate foundation leaders to discuss the Commission's business plan and priority grantmaking areas to identify interest in collaboration and potential vehicles for leveraging public-private resources.	Medium	6-9 months	May require additional support	$5,000
V.b.	Research model programs across the country for leveraging public-private resources to identify lessons learned and options for implementation, including organizational vehicles for collaborative grantmaking.	Medium	12-18 months	May require additional support	$5,000
V.c.	Research state legal requirements and restrictions associated with potential organizational options for leveraging of public-private resources.	Medium	12-18 months	Can be executed with existing CHRC resources	$10,000
V.d.	Determine ability of Commission to receive additional external funds for implementation of different aspects of this business plan.	Medium	6-9 months	Can be executed with existing CHRC resources	$10,000
V.e.	Work with DHMH leadership to identify priority areas to market for additional private resources.	Medium	12-18 months	Can be executed with existing CHRC resources	$1,000
V.f.	Develop fund development plan with supporting "marketing" materials to solicit additional private funding partners.	Medium	12-18 months	Can be executed with existing CHRC resources	$10,000-20,000
V.g.	Initiate fund solicitation.	Medium	12-18 months	Can be executed with existing CHRC resources	$15,000

TIMELINE OF KEY ACTIVITIES