MCHRC

Maryland Community Health Resources Commission

Annual Report

FY 2012, 2013, 2014

Executive Director – Mark Luckner

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MCHRC
Maryland Community Health Resources Commission

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

FY2012/2013/2014 Annual Report

I. Executive Summary

The Maryland Community Health Resources Commission (CHRC) was created by the Maryland General Assembly in 2005 to expand access to health care services in underserved communities in Maryland. The CHRC is a quasi-independent commission operating within the Maryland Department of Health & Mental Hygiene (DHMH), whose members are appointed by the Governor. Since its inception, the CHRC has awarded 142 grants totaling $41.9 million, supporting programs in every jurisdiction of the state. These programs have collectively served more than 140,000 Marylanders, and grants awarded by the CHRC have enabled grantees to leverage $14.7 million in additional federal and private/non-profit resources.

The roles and responsibilities of the CHRC have grown over the last few years in recognition of the Commission's demonstrated track record in delivering resources in an efficient and strategic basis and in recognition of the critical role that community health resources are playing as Maryland implements the Affordable Care Act (ACA). The budget of the CHRC has increased in recent years, from $3 million to $8 million, as the Maryland General Assembly voted in 2012 to amend the Budget Reconciliation and Financing Act (BRFA), approving language that ensured the CHRC's budget "shall be no less than" $8 million starting in FY 2014 and in perpetuity. The legislature also approved legislation during the 2014 session to re-authorize the Commission through June 2025. These actions by the Maryland General Assembly to increase the CHRC's budget and re-authorize the Commission demonstrate strong continued legislative support of the work of the CHRC.

The CHRC fulfills many of its statutory responsibilities by issuing annual Calls for Proposals and has aligned its grantmaking activities to support the public health priorities of the Administration and DHMH. Another major responsibility of the CHRC is implementing the Health Enterprise Zones (HEZ) Initiative jointly with DHMH. In addition, the CHRC has worked on a variety of special projects as requested by the state. This includes supporting the State Health Improvement Process created by DHMH in 2012. The CHRC has also executed a number of special projects, which include the Access to Care Program and the DDA Infrastructure Grants, and the Commission has co-chaired the DHMH Task Force of Regulatory Efficiency.

II. Background and Mission

The Maryland General Assembly created the Community Health Resources Commission in 2005 to expand access to affordable, high quality health care services in the state's underserved communities; support the adoption of health information technology in community health resources; increase access to specialty health care services for the uninsured and low-income individuals; and promote interconnected systems of care and partnerships among community health resources and hospitals. The CHRC is a quasi-independent commission

within the Maryland Department of Health & Mental Hygiene, and its 11 members are appointed by the Governor (see Appendix A). The CHRC fulfils its authorizing statutory responsibilities through its grantmaking activities, awarding 142 grants totaling $41.9 million, supporting programs in all 24 jurisdictions of the state. These programs have collectively served more than 140,000 Marylanders and enabled CHRC grantees to leverage $14.7 million in additional federal and private/non-profit resources.

In creating the CHRC, the Maryland General Assembly recognized the need to have an independent commission that focused on strengthening Maryland's diverse network of community health centers and safety net providers and addressed service delivery gaps in Maryland's dynamic health care marketplace. The role that the CHRC plays in strengthening Maryland's network of community health resources and safety net providers becomes increasingly important as Maryland implements the ACA and hundreds of thousands of individuals gain access to health insurance. The newly insured individuals will place increasing demands on Maryland's community health centers and safety net providers as they seek health care services in higher volumes. In response to legislation approved by the Maryland General Assembly in 2011, the Commission developed a business plan that outlined specific recommendations for how the state could support the work of safety net providers during ACA implementation. For a copy of this business plan, see Appendix B. The CHRC has awarded a number of grants and provided technical assistance to enable safety net providers to build capacity and expand access and to promote their transition from a grant-based revenue model to a more sustainable system of billing third-party payers. In addition, Maryland is currently implementing a new Medicare All-Payor Waiver (Waiver) which transitions the hospital revenue structure from an inpatient fee-for-service model (quantity) to a system based on total patient revenue and global budgeting that rewards quality and promotes reductions in inpatient care costs. This Waiver presents enormous challenges for Maryland's hospitals and may provide an increased focus on importance of the delivery and accessibility of services in an ambulatory care setting. This transition presents new opportunities for community health resources and safety net providers. A number of recent grants awarded by the CHRC have promoted innovative community-hospital partnerships and programs that target reductions in hospital emergency department visits, admissions, and readmissions. These types of community-hospital partnerships to reduce hospital inpatient costs and efforts to build capacity of community health resources are expected to continue.

The CHRC supports the work of community health care resources and fulfills its statutory mission in the following activities: (1) Awarding grants to expand access in underserved areas and support public health priorities; (2) Supporting the Local Health Improvement Coalitions (LHIC) and efforts to promote population health initiatives; (3) Implementing the Health Enterprise Zones Initiative jointly with DHMH; and (4) Executing additional special projects.

III. Grantmaking Activity

Since its inception, the CHRC has awarded 142 grants totaling $41.9 million through its Calls for Proposals, which have supported programs in every jurisdiction in Maryland. The CHRC has aligned its grantmaking activities to support the policy priorities of the O'Malley-Brown Administration and DHMH leadership. As shown in the table below, CHRC grants have

supported programs which have provided services for 140,644 patients, resulting in 433,692 patient visits.

Table 1:

Maryland Community Health Resources Commission				
Focus Area	# of Projects Funded	Total Award Provided	Cumulative Total	
			Patients Seen/Enrolled	Visits Provided
Expanding Access to Primary Care at Maryland's safety net providers	29	$8,562,650	57,202	194,758
Increasing Access to Dental Care for Low-income Marylanders	23	$5,275,606	42,540	93,947
Addressing Infant Mortality	15	$3,205,697	9,934	27,888
Reducing Health Care Costs through ER Diversions	6	$1,994,327	13,804	27,943
Promoting Health Information Technology at community health centers	9	$3,268,661	Health Information Technology	
Providing Access to Mental Health and Drug Treatment Services	18	$5,775,075	12,390	46,723
Addressing Health Care Needs of Co-Occurring Individuals	7	$2,230,842	4,774	42,433
Supporting Local Health Improvement Coalitions (LHICs)	24	$1,955,048		
Health Enterprise Zones	5	$7,710,000		
Safety Net Capacity Building	3	$455,000	0	0
Childhood Obesity	3	$1,560,000	0	0
Total Grant Funding Provided	**142**	**$41,992,906**	**140,644**	**433,692**
Total Funding Requested	**432**	**$147,297,981**		
Number of Patients Served/Enrolled	**140,644**			
Number of Patients Visits/Services Provided	**433,692**			
Additional federal and private resources leveraged	**51**	**$14,708,459**		

The CHRC awards grants by issuing a Call for Proposals approximately once a year. Grants are awarded in a competitive process, and priority areas and review criteria are determined by CHRC Commissioners. Grant proposals are evaluated by independent subject matter experts on a range of criteria outlined in each Call for Proposals, including the ability of the grantee to achieve stated program objectives and achieve sustainability once initial grant funds are utilized. Evaluation criteria utilized include: (1) the use of evidenced-based practices in the proposed program; (2) the ability of the program to collect and report outcomes data; (3) demonstration of a community need; (4) program sustainability; and (5) likelihood of overall program success.

Since 2012, the Commission has issued four Calls for Proposals. The most recent Call for Proposals targeted three policy objectives: (1) Building capacity as Maryland implements the ACA; (2) Reducing health disparities; and (3) Reducing hospital admissions and readmissions. Following is a summary of the grants awarded by the CHRC in recent years. For a complete list of the CHRC grants awarded in recent years, see Appendix C.

Addressing Infant Mortality

In 2008, the O'Malley-Brown Administration set the goal of reducing Maryland's infant mortality rate by 10% by 2012. The Administration announced that the state's infant mortality rate has decreased by 21%, effectively achieving the original strategic goal. The Administration subsequently announced a new goal of reducing the state's infant mortality rate by an additional 10% by 2017. To support this new goal, the CHRC has awarded 6 grants totaling $751,650 since 2012. These grants support expanding access to women's comprehensive health services in the community and have served 2,979 patients between 2012 and 2014.

Increasing Access to Integrated Behavioral Health Services

Promoting access to integrated mental health, substance abuse, and somatic health care services is a priority of the Commission as the state moves to support an integrated behavioral health care delivery system. This integration presents new challenges and opportunities to behavioral health providers. The CHRC has awarded 8 grants totaling $1.6 million since 2012 to promote overall behavioral health integration efforts. These grants support programs which provide behavioral health services in rural and urban settings to individuals with serious mental illness, co-occurring disorders, and/or significant somatic concerns and have also supported emergency department diversion/referral programs. Between 2012 and 2014, these programs have served 6,898 patients.

Expanding Access to Dental Care Services

In a recent report from The Pew Center on the States, Maryland received an "A" grade for the second consecutive year for children's dental health. However, the DHMH Office of Oral Health advised that despite recent strides to increase dental care capacity, there remain areas of the state that lack dental safety net providers. The CHRC has awarded 6 grants totaling $641,428 since 2012. These grants support programs which provide dental services and education through mobile dental clinics, school health and wellness centers, and programs that offer dental services at a discounted rate to underserved populations throughout the state. Between 2012 and 2014, these programs have served 2,707 patients.

Building Capacity of Safety Net Providers

Building on the CHRC's business plan to support the work of safety net providers as Maryland implements the ACA, the CHRC has awarded 3 grants totaling $455,000 since 2012. These grants support overall efforts of safety net providers to serve more patients and their transition from a grant-based revenue model to a more sustainable model of billing third-party payers.

Expanding Access to Primary Care Services in Underserved Communities

A core policy mission of the CHRC is to support comprehensive, interconnected systems of care in the local communities and to expand access to affordable, high-quality primary care services in underserved areas of the state. As Maryland implements the ACA, it is essential that the state expand its capacity to deliver primary care services in the community. The CHRC has awarded 7 grants totaling $1.3 million since 2012. These grants fund programs that support the opening of new access points implemented by Federally Qualified Health Centers and programs that will encourage the reduction of hospital emergency department visits, admissions, and readmissions. Between 2012 and 2014, these programs have served 10,944 patients.

Reducing Childhood Obesity

Childhood obesity is a national epidemic, with one in three children being overweight and at risk for serious chronic diseases such as diabetes. In 2010, 27.6% of Maryland's youth ages 12 to 19 were considered overweight or obese (Maryland Youth Tobacco Survey, 2010). Many early life risk factors for childhood obesity are more prevalent among the African American/Black and Hispanic populations. Because of this demonstrated health disparity, the CHRC's 2014 Call for Proposals included reducing childhood obesity, and the Commission awarded 3 grants totaling $520,000. These grants support efforts that focus on reducing obesity rates of youth through school-based programs, increasing access to healthy food options in known food deserts, and providing increased availability of physical activities in the community. These programs are expected to serve over 13,000 residents within their communities.

Grantee Performance Monitoring
The CHRC has developed and implements a robust system for grantee performance management that requires grantees to report on a series of standard and customized process and outcome measures to ensure that grant resources are utilized efficiently and that program objectives are achieved effectively. These performance measures include a core set of common data variables that all grantees are required to report, focus-area specific measures (i.e., measures specific to all infant mortality grants), as well as many grant-specific evaluation measures.

The CHRC requires data reporting as a condition of payment of Commission grant funds. At the beginning of the grant period, grantees are required to submit projected totals for the duration of the program and then report actual figures in subsequent reporting periods. CHRC staff reviews the actual data reported by the grantees and compares these figures to the grantee's projections. Grantees are held accountable for performance and progress towards meeting the goals of the programs. When programs do not achieve objectives, the Commission redirects grant funding to other successful grantees.

Supporting Sustainable Systems of Care and Leveraging Additional Resources
Promoting long-term financial sustainability of grant programs is a key priority of the Commission, and the grant funding provided by the CHRC has enabled grantees to leverage approximately $14.7 million in additional federal, private/non-profit resources, and other resources. The Commission has served as an "incubator" for innovative programs and supports the efforts of grantees to continue programs once initial CHRC grant funding has been expended. Several recent CHRC grantees that have leveraged additional funding include Community Clinic, Inc., Way Station, Inc., and Catholic Charities - Esperanza Center's Health Clinic.

Community Clinic, Inc., a Federally Qualified Health Center in the Washington D.C. metropolitan region, utilized CHRC grant funding to expand services for high-risk patients in Montgomery and Prince George's Counties and supported the integration of Community Health Workers. This program was able to expand its service delivery programming to target obesity prevention efforts and chronic conditions for patients under the age of 18. Community Clinic, Inc. leveraged CHRC grant funds to raise an additional $1.9 million in private and local funding support, including a three-year grant for $1.5 million from CareFirst. The program has served 6,168 individuals to date.

Way Station, Inc. provides comprehensive community-based mental health services to adults and children in Baltimore City, Frederick, Carroll, Howard, and Washington Counties. Way Station utilized CHRC grant funds to increase access to primary care services in their existing behavioral health clinic. The pilot program utilizes three methods to achieve its two goals of improving health and reducing medical costs: i) enhancing integration of primary care and behavioral health by imbedding primary care nurse care managers in mental health teams; ii) increasing access to primary care by co-locating primary care satellite sites in mental health facilities; and iii) enhancing patient participation in care by implementing a SAMHSA-endorsed evidence-based practice that teaches adults with mental illness the skills and motivation to manage their physical health. This program provided more than 1,500 health education sessions to assist individuals in managing chronic disease. Way Station, Inc. leveraged CHRC grant funds to raise an additional $1.7 million in private and local funding support. DHMH used the experience of the pilot to successfully secure new federal Medicaid funding available under the Affordable Care Act and to replicate the project with additional

agencies and sites through the state. The program has served 736 individuals to date, and many of these individuals have complex primary and behavioral health needs.

Catholic Charities is a 501(c)3 non-profit organization that operates the Esperanza Center's Health Clinic in Baltimore City. The CHRC grant enabled Catholic Charities to expand the successful Asociación Comunidad Saludable Project and increased access to care for this underserved population. Grant funds enabled the hiring of a bilingual nurse who tripled monthly patient visits after hiring and addresses communication barriers for this patient population. Catholic Charities leveraged CHRC grant funds to raise an additional $500,000, including a $200,000 grant from Catholic Health Initiatives. The program has served an additional 3,156 patients to date and provided 6,498 visits.

IV. Local Health Improvement Coalitions

DHMH established the State Health Improvement Process (SHIP) in 2012, which focuses on improving population health outcomes and measures in every jurisdiction based on their performance on 39 population health metrics. These metrics include reducing emergency department visits related to behavioral health; reducing diabetes-related emergency department visits; and reducing the percent of children considered obese. In support of SHIP, the CHRC has issued two Calls for Proposals in recent years and awarded 24 grants totaling $1.95 million to assist in the planning and implementation activities of Local Health Improvement Coalitions, which are led by local health departments and hospital systems. Seven grants are under current implementation.

The CHRC's most recent LHIC Call for Proposals generated a total of sixteen applications requesting $3.4 million (See Appendix D). Based on available funding, the CHRC awarded 7 LHIC grants totaling $1.3 million. The LHIC Call for Proposals was designed to support the long-term capacity of the LHICs and to support the framework for the State's future Community Integrated Medical Home model. In addition to CHRC funds, DHMH contributed $191,000 in federal funding to support the activities of these grantees. The bulk of LHIC grant funds are being utilized to support the costs of hiring new personnel, including community health workers, program administrators, and community health nurses. Non-personnel costs are being utilized by LHICs to support medical equipment in a new patient-centered medical home, purchase of computer equipment, and trainings for new personnel. A list and summary of the current LHIC grants can be found in Appendix E.

V. Implementation of the Health Enterprise Zones Initiative

During the 2012 legislative session, the Maryland General Assembly passed SB 234, the Maryland Health Improvement and Disparities Reduction Act, legislation championed by Lt. Governor Anthony G. Brown. Governor Martin O'Malley signed SB 234 into law in April 2012. This Act provides $4 million per year over the four year duration of the program and created the policy framework to create Health Enterprise Zones, which are geographically defined areas that demonstrate poor health outcomes and economic disadvantages. The HEZ Initiative provides a range of incentives, including income tax credits, hiring tax credits, loan repayment assistance, and grant funding from the CHRC, to attract new health practitioners to serve in HEZs and expand access in these underserved communities. The policy objectives of the HEZ Initiative

are to: (1) Improve health outcomes and expand access in underserved areas; (2) Reduce health disparities; and (3) Reduce health care costs and hospital admissions and readmissions. For more information about the HEZ Initiative, please visit the HEZ website and review the annual report for 2013. This information can be found at: http://dhmh.maryland.gov/healthenterprisezones/SitePages/Updates.aspx

After the Act was signed into law, a public comment period was held during the summer of 2012 to solicit feedback on the selection criteria for the HEZs, the potential uses of HEZ funding, and the outcome metrics that should be developed to monitor the progress and implementation of the HEZs. The Call for Proposals issued by the CHRC in October 2012 (see Appendix F) generated a total of 19 applications from 17 jurisdictions, representing rural, urban, and suburban areas of the state. Applications for HEZ designation were required to demonstrate health care needs and specific disparities and offer intervention strategies to improve health outcomes in the potential Zone. The HEZ applications were evaluated competitively on 13 review principles by an independent HEZ Review Committee comprised of experts in the fields of public health, health care finance, health disparities, and health care delivery. On January 24, 2013, based on recommendations from the CHRC, DHMH Secretary Sharfstein designated Maryland's first five HEZs:

(1) The Annapolis Community Health Partnership;
(2) The Caroline/Dorchester Competent Care Connections HEZ;
(3) Greater Lexington Park Zone;
(4) The Prince George's County Zone; and
(5) The West Baltimore Primary Care Access Collaboration.

These five designations involved a total funding commitment of $3.85 million in the first year of the program. A map of the designated five Zones can be found in Appendix G. Activities of the five HEZs began in earnest in March 2013, and the Zones completed their first year of implementation by April 30, 2014. A copy of the first annual HEZ report submitted to the Governor and Maryland General Assembly in January 2014 can be found in Appendix H.

The HEZ Initiative is jointly implemented by the CHRC and DHMH. The DHMH Secretary designated Health Enterprise Zones, and the CHRC administers the HEZ Reserve Fund. A shared governance model has been utilized to execute a management strategy for oversight of the five Zones and overall implementation of the HEZ Initiative in year one. Day-to-day program oversight is executed by the HEZ Project Director (hired by the CHRC in January 2014), while technical assistance and content area expertise are provided by DHMH staff. Fiscal and administrative oversight is provided by the CHRC. Overall executive direction and leadership are provided by the DHMH Secretary.

As part of the overall program management and oversight, the CHRC provides monitoring of the activities of the HEZs through site visits, conference calls, and quarterly progress reports. Each Zone is required to submit quarterly progress reports to the Commission as a condition for payment of public funds. A customized HEZ Dashboard has been developed which tracks performance towards key milestones and deliverables and overall progress towards key goals of each Zone. The Dashboards facilitate public reporting, transparency, and accountability of the Zones. Each HEZ has core clinical outcome goals, and all five Zones include a focus on diabetes. Assessment of progress towards improved clinical outcomes will be based on

standardized metrics such as those from the National Quality Forum and Uniform Data System, and these measures will be incorporated in HEZ reporting in year two of the program. Dashboards are included as Appendix I.

VI. CHRC Special Projects

In addition to its grantmaking activities, the CHRC has been tapped in recent years to support several public health initiatives and special projects. Following is an overview of these activities: (1) Access to Care Program; (2) Developmental Disabilities Administration Infrastructure Grants; and (3) DHMH Task Force on Regulatory Efficiency.

Access to Care Program

In 2011, the Maryland General Assembly approved legislation (SB 514/HB 450) that directed the CHRC to assist community health resources in their efforts to respond to the implementation of the ACA. The CHRC developed a business plan in 2012 that outlined specific recommendations for how the state could promote the readiness of safety net providers and assist in their efforts to build capacity and achieve long-term financial sustainability. As part of these efforts, the state launched the Access to Care Program, an interagency collaboration of the CHRC, DHMH, and the Maryland Health Benefit Exchange. The purpose of the Access to Care Program was to build the capacity of safety net providers to serve more patients as the newly insured individuals access primary, preventive, and specialty care services in higher volumes. The state hosted six forums in June 2013 and invited safety net providers, Medicaid Managed Care Organizations, and Quality Health Plans. These forums were designed to encourage networking opportunities and promote the participation of essential community providers in Medicaid Managed Care Organizations and commercial health insurance networks. A copy of the presentation from these forums may be found in Appendix J.

Developmental Disabilities Administration Infrastructure Grants

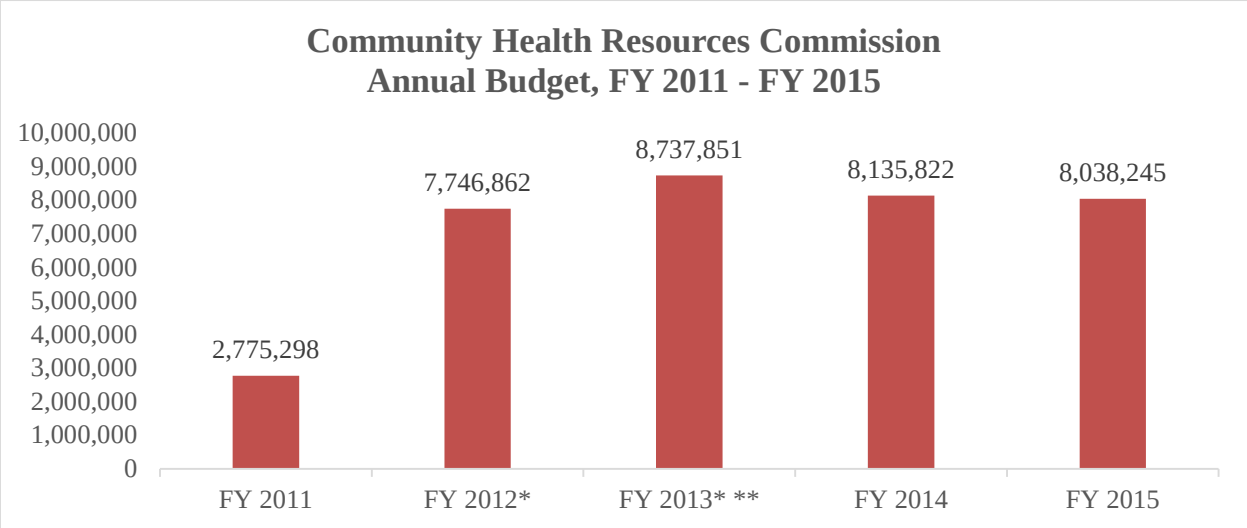
At the request of DHMH leadership, the CHRC worked with the DHMH Developmental Disabilities Administration (DDA) to issue the DDA Infrastructure Grant Call for Proposals on April 2, 2012. This Call for Proposals generated a total of 121 awards to DDA licensees, totaling $5,997,975 in one-time only infrastructure grants. The grants were supported with funds provided by the DDA (funds were transferred to the CHRC's budget) and were awarded to support projects in one of the following six categories: (1) New vehicles and other forms of transportation; (2) Adaptation of, or modification to, existing DDA licensee-owned vehicles; (3) Information technology equipment, software, or related services; (4) Adaptations, modifications, repairs, or improvements to existing provider-owned properties/programs that address critical health and safety issues or improve access or quality of life for individuals with developmental disabilities. (Programs include day, vocational, and residential services such as group homes and Assisted Living Units); (5) Start-up funds for or expansion of infrastructure for innovative programs that increase community integration or integrated employment for people with developmental disabilities; and (6) Staff training in areas directly related to working with people with developmental disabilities. Grant funds supported projects that included the purchasing of new vans for programs to provide transportation for clients to and from health care appointments and providing repairs for existing properties which provided DDA services (e.g., window replacements, updating of HVAC units, and new flooring).

DHMH Task Force on Regulatory Efficiency

At the request of DHMH leadership, the CHRC Executive Director co-chaired the DHMH Task Force on Regulatory Efficiency with the DHMH Chief-of-Staff. The Task Force was tasked with conducting a cross-agency review of DHMH regulations and soliciting public comment to promote greater transparency, efficiency, and effectiveness in regulations. An initial public comment period generated 73 proposals from the public. Following a second public comment period, the Task Force issued its final report in June 2012. Of the 73 proposals received, 42 were supported by DHMH and moved forward for implementation or further review. Proposals that were implemented include such changes as allowing patients to return unused medications to help reduce health care costs at nursing homes. For copies of the Interim and Final Reports, see Appendices K and L.

VII. Legislation and Budget

The roles and responsibilities of the CHRC have grown over the last few years in recognition of the Commission's demonstrated track record in delivering resources in an efficient and strategic basis and in recognition of the critical role that community health resources are playing as Maryland implements the Affordable Care Act. The budget of the CHRC has increased in recent years, from $3 million to $8 million, as the Maryland General Assembly voted in 2012 to amend the Budget Reconciliation and Financing Act, approving language that ensured the CHRC's budget "shall be no less than" $8 million starting in FY 2014 and in perpetuity. The legislature also approved legislation during the 2014 session to re-authorize the Commission through June 2025.



Notes:

* The budgets in FY 2012 and FY 2013 contain a one-time transfer of DDA funds to the CHRC for the DDA Infrastructure grants.

** The FY 2013 budget reflects the first year of the Health Enterprise Zone Initiative, which provides $4 million per year over the duration of the Act (FY 2013 through FY 2016).

APPENDICES

Appendix A

MCHRC
Maryland Community Health Resources Commission

Maryland Community Health Resources Commission

Commissioners, June 2014

The Hon. John A. Hurson, Chairman
Executive Vice President, Personal Care Products Association

Nelson J. Sabatini, Vice Chairman
Former Secretary, Maryland Department of Health and Mental Hygiene

Elizabeth Chung
Executive Director, Asian American Center, Frederick

Charlene Dukes
President, Prince George's Community College

Kendall Hunter
Senior Vice President, Health Insurance Exchange Operations and Federal Employees Health Benefits, Kaiser Permanente

William Jaquis, M.D.
Chief, Department of Emergency Medicine, Sinai Hospital

The Hon. P. Sue Kullen
Staff for Senator Ben Cardin

Paula McLellan
CEO, Family Health Centers of Baltimore

Meg Murray
CEO, Association for Community Affiliated Plans

Barry Ronan
President and CEO, Western Maryland Health System

Maria Tildon
Senior Vice President, Public Policy and Community Affairs, CareFirst BlueCross BlueShield

Appendix B

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)

Prepared by Marla Oros, RN, MS
February 2012

2012 COMMISSIONERS

Hon. John Adams Hurson, Chairman

Jude Boyer-Patrick, M.D., M.P.H.

Ken Hunter

Mark Li, M.D.

Paula McLellan

Meg Murray

Maria Tildon-Harris

Nelson Sabatini

Doug Wilson, Ph.D.

Acknowledgements

The Community Health Resources Commission and the Mosaic Group wish to thank everyone who participated in the analysis conducted in order to develop this business plan for technical assistance and support for Maryland's safety net providers. The Commission looks forward to working closely with the safety net provider community as Maryland implements the Affordable Care Act.

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION
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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%

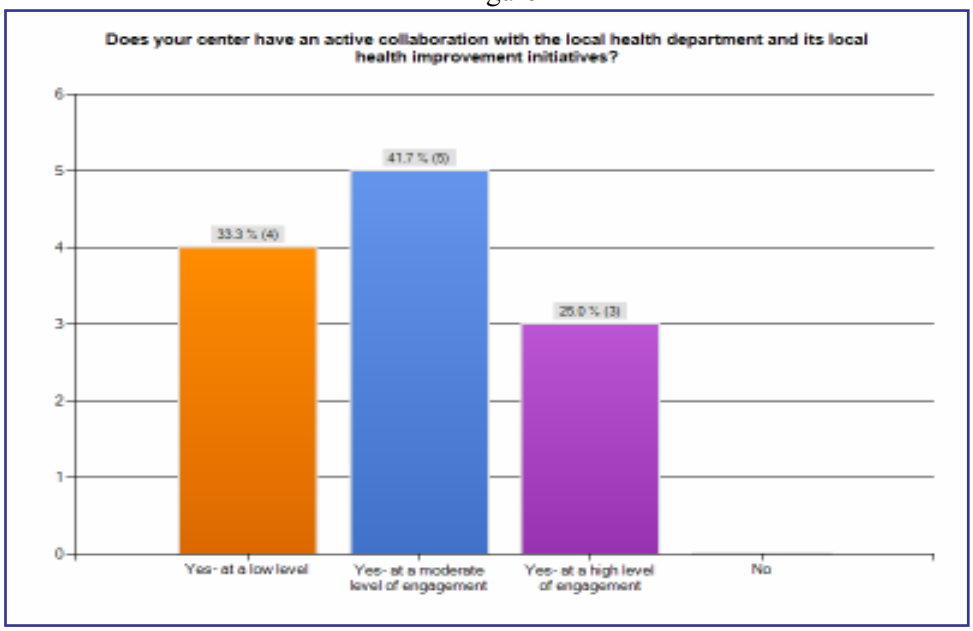
The survey revealed the need for assistance with partnership development and collaborative planning in a number of areas. When safety net providers and community health centers were asked about the need for a more regional approach to planning for future primary care needs, nearly 70% of respondents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

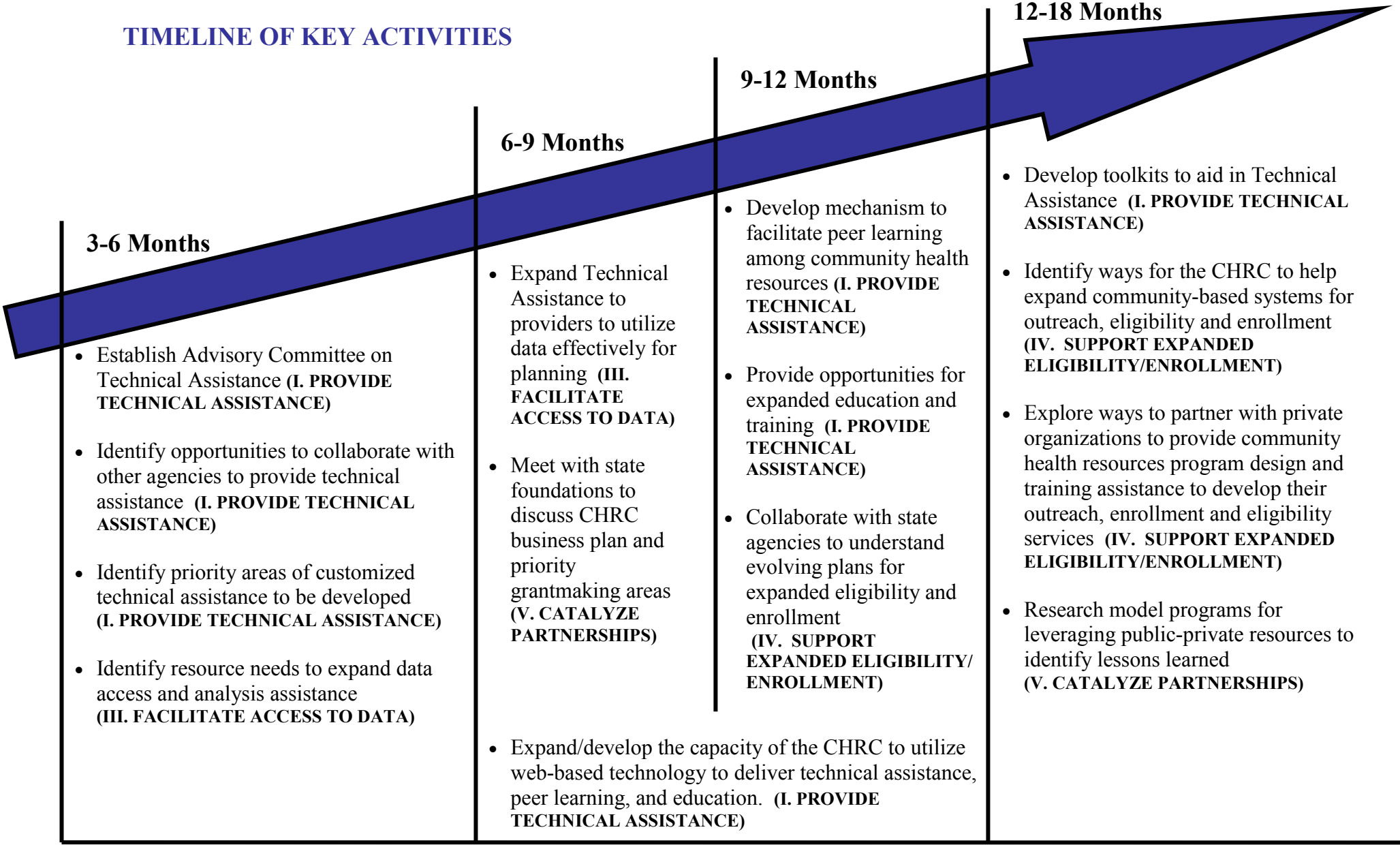
II. Work with DHMH, the Governor's Workforce Investment Board and other agencies to support statewide plans for workforce development in health departments, health centers and other community health resources.					
Action		**Priority (high, medium, low)**	**Timeline**	**Capacity Evaluation**	**Fiscal 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



HOUSE BILL 450

C3, J3 (1lr1340)

ENROLLED BILL

— Health and Government Operations/Finance —

Introduced by **Delegates Hubbard and Hammen**

Read and Examined by Proofreaders:

_____

Proofreader.

_____

Proofreader.

Sealed with the Great Seal and presented to the Governor, for his approval this

_____ day of _____ at _____ o'clock, _____M.

_____

Speaker.

CHAPTER _____

AN ACT concerning

Maryland Community Health Resources Commission – Health Care Reform – ~~Safety Net Providers~~ *Implementation*

FOR the purpose of authorizing the Maryland Community Health Resources Commission to provide certain assistance to ~~safety net providers~~ *community health resources* in preparing to implement certain health care reform; authorizing the Commission to examine certain issues and potential challenges for ~~safety net providers~~ *community health resources* in preparing to implement certain health care reform; requiring the Commission to develop a certain business plan for the provision by the State of certain assistance to ~~safety net providers~~ *community health resources*; requiring the Commission to make certain recommendations to the Governor and certain committees of the General Assembly on or before a certain date; altering a certain definition; defining certain terms; and generally relating to the Maryland Community

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**

[Brackets**]** indicate matter deleted from existing law.

Underlining indicates amendments to bill.

~~Strike out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.

Italics indicate opposite chamber/conference committee amendments.

Health Resources Commission and the implementation of health care reform ~~by safety net providers~~.

BY repealing and reenacting, with amendments,
Article – Health – General
Section 19–2101 and 19–2107(a)
Annotated Code of Maryland
(2009 Replacement Volume and 2010 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health – General

19–2101.

(a) In this subtitle the following words have the meanings indicated.

(B) "AFFORDABLE CARE ACT" MEANS THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT, AS AMENDED BY THE FEDERAL HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010, AND ANY REGULATIONS ADOPTED OR GUIDANCE ISSUED UNDER THE ACTS.

[(b)**] (C)** "Commission" means the Maryland Community Health Resources Commission.

[(c)**] (D)** (1) "Community health resource" means a nonprofit or for profit health care center or program that offers the primary health care services required by the Commission under § 19–2109(a)(2) of this subtitle to an individual on a sliding scale fee schedule and without regard to an individual's ability to pay.

(2) "Community health resource" includes:

(i) A federally qualified health center;

(ii) A federally qualified health center "look–alike";

(iii) A community health center;

(iv) A migrant health center;

(v) A health care program for the homeless;

(vi) A primary care program for a public housing project;

(vii) A local nonprofit and community–owned health care program;

(viii) A school–based health center;

(ix) A teaching clinic;

(x) A wellmobile;

(xi) A health center controlled operating network;

(xii) A historic Maryland primary care provider;

(xiii) An outpatient **[**mental health clinic**]** **BEHAVIORAL HEALTH PROGRAM**; and

(xiv) Any other center or program identified by the Commission as a community health resource.

~~**(E) "SAFETY NET PROVIDER" MEANS A PROVIDER THAT DELIVERS A SIGNIFICANT LEVEL OF HEALTH CARE TO THE UNINSURED, ENROLLEES IN THE MEDICAL ASSISTANCE PROGRAM, OR OTHER VULNERABLE PATIENTS.**~~

19–2107.

(a) In addition to the powers set forth elsewhere in this subtitle, the Commission may:

(1) Adopt regulations to carry out the provisions of this subtitle;

(2) Create committees from among its members;

(3) Appoint advisory committees, which may include individuals and representatives of interested public or private organizations;

(4) Apply for and accept any funds, property, or services from any person or government agency;

(5) Make agreements with a grantor or payor of funds, property, or services, including an agreement to make any study, plan, demonstration, or project;

(6) Publish and give out any information that relates to expanding access to health care through community health resources that is considered desirable in the public interest; **[**and**]**

(7) Subject to the limitations of this subtitle, exercise any other power that is reasonably necessary to carry out the purposes of this subtitle**; AND**

(8) ASSIST ~~SAFETY NET PROVIDERS~~ *COMMUNITY HEALTH RESOURCES* IN PREPARING TO IMPLEMENT THE AFFORDABLE CARE ACT.

SECTION 2. AND BE IT FURTHER ENACTED, That:

(a) In this section, "Affordable Care Act" and "~~safety net provider~~ *community health resource*" have the meanings stated in § 19–2101 of the Health – General Article, as enacted by Section 1 of this Act.

(b) The Maryland Community Health Resources Commission shall:

(1) examine issues and potential challenges for ~~safety net providers~~ *community health resources* in preparing to implement health care reform associated with the Affordable Care Act, including:

(i) the administrative infrastructure and information technology capacity of ~~safety net providers~~ *community health resources* and any barriers to ~~safety net providers~~ *community health resources* achieving meaningful use of the information technology;

(ii) whether common administrative and information technology systems and technical assistance would help ~~safety net providers~~ *community health resources* in contracting with managed care organizations and commercial insurers;

(iii) opportunities for ~~safety net providers~~ *community health resources* to partner to achieve efficient administrative economies of scale;

(iv) ~~methods to assist safety net providers to obtain reimbursement from~~ barriers to ~~safety net providers~~ *community health resources* contracting with and billing third–party payors;

(v) assistance in positioning ~~safety net providers~~ *community health resources* to obtain resources available under health care reform; and

(vi) barriers that may impede ~~safety net providers~~ *community health resources* from sustaining their service delivery; and

(2) develop a business plan for the State to provide ongoing assistance to ~~safety net providers~~ *community health resources* to assist the ~~providers~~ *community health resources* in~~:~~

~~(i) obtaining reimbursement from third–party payors; and~~

~~(ii)~~ sustaining and enhancing their service delivery.

(c) On or before January 1, 2012, the Maryland Community Health Resources Commission shall make recommendations for a plan to assist ~~safety net providers~~ *community health resources* in implementing health care reform associated with the Affordable Care Act to the Governor and, in accordance with § 2–1246 of the State Government Article, the Senate Finance Committee and the House Health and Government Operations Committee.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2011.

Approved:

_____

Governor.

_____

Speaker of the House of Delegates.

_____

President of the Senate.

Community Health Center Health Care Reform Readiness Survey

Exit this survey

***1. What is the name of your health center?**

2. Please identify the person(s) completing the survey:

Person 1:	
Name:	
Title:	
Email address:	
Person 2:	
Name:	
Title:	
Email address:	

3. Which statement best describes the level of readiness of your organization to implement the various changes planned under the health care reform legislation?

- Extremely ready, our organization has plans in place
- Fairly ready, our organization has some plans but may still be working on plans in certain areas
- Not very ready, our organization does not have many plans in place yet

4. Are you a teaching health center (provide training opportunities on a regular basis for health care professionals affiliated with health professional training institutions)?

- Yes
- No

If yes, please describe the role your center plays as a teaching center, If no, why not

5. What type of physicians are available at your health center?

	Family medicine	Internal medicine	Pediatrics	Obstetrics/gynecology	Psychiatry
Physicians	☐	☐	☐	☐	☐

6. What type of nurse practitioners are available at your center?

	Adult	Family practice	Women's health	Psychiatry	None
Nurse practitioners	☐	☐	☐	☐	☐

7. Do you employ physician's assistants?

- ☐ Yes
- ☐ No

8. What types of behavioral health specialists are available at your center?

	Psychologists	Psychiatrists	Licensed clinical social workers	Certified addiction specialists	Psychiatric nurse specialists	Certified counselors	Peer recovery coaches	None
Behavioral health specialists	☐	☐	☐	☐	☐	☐	☐	☐

9. What types of nurses do you have working at the center?

	Registered nurses	LPN's	None
Nurses	☐	☐	☐

10. What additional clinical support staff do you have working at the center?

	Pharmacists	Health educators	Designated care coordinators	Dentists	Dental hygienists	Dental assistants	Community health workers	None
Clinical support staff	☐	☐	☐	☐	☐	☐	☐	☐

11. Which of the following providers do you anticipate needing to recruit more of in the next two to three years?

- [ ] Primary care physicians
- [ ] Primary care nurse practitioners
- [ ] Physician's assistants
- [ ] Registered nurses
- [ ] LPNs
- [ ] Pharmacists
- [ ] Mental health therapists
- [ ] Addiction counselors
- [ ] Health educators
- [ ] Care coordinators
- [ ] Community health workers
- [ ] Dental staff
- [ ] None of the above
- [ ] All of the above
- [ ] Other (please specify)

12. Please identify the types of providers that you anticipate having the most difficulty recruiting in the next several years?

1.
2.
3.
4.
5.

13. Do you currently employ bi-lingual staff?

- [ ] Yes
- [ ] No

14. How does your center provide interpretation services for patients that are non-English speaking?

- [ ] On site staff interpreters

- [ ] Managed care organization support
- [ ] Other (please specify)

15. Please check all that apply related to diversity and language needs for your center in the future:

- [ ] I anticipate needing to hire additional bi-lingual staff
- [ ] I anticipate needing to hire more culturally diverse staff
- [ ] I believe hiring bi-lingual staff may be a challenge
- [ ] I believe hiring culturally diverse staff may be a challenge
- [ ] I have a plan for cultural diversity training
- [ ] I do not have a plan for cultural diversity training
- [ ] I do not anticipate any needs related to additional bi-lingual staff
- [ ] I do not anticipate any needs related to more culturally diverse staff

16. Please identify the priority topics that you anticipate your staff may need training and staff development to be prepared for future health care reform implementation:

1.
2.
3.
4.
5.

17. Does your center offer the following to your patients?

	Yes	No	In development	Need technical assistance to develop
An on-call provider (physician, nurse practitioner or physician assistant) directly or via a phone triage	☐	☐	☐	☐

	Yes	No	In development	Need technical assistance to develop
system 24 hours a day, 7 days a week				
Same day appointments through a pre-determined system	☐	☐	☐	☐
A protocol to determine which patients with acute care needs will be seen same-day or next day	☐	☐	☐	☐
After hours medical care	☐	☐	☐	☐
Weekend hours	☐	☐	☐	☐
Secure email for your patients to communicate with the clinic/providers	☐	☐	☐	☐
Telemedicine for your patients	☐	☐	☐	☐
Timely communication of test results to patients	☐	☐	☐	☐
A process to identify patients who are discharged from nursing home, hospital, skilled care facility and process for health center follow-up	☐	☐	☐	☐
Relationships with specialists for all care needs	☐	☐	☐	☐
Relationships with community resources for	☐	☐	☐	☐

	Yes	No	In development	Need technical assistance to develop
support needs of patients				
Systems to determine eligibility and enroll patients in health insurance	☐	☐	☐	☐

18. Do you conduct a comprehensive community needs assessment that is data-driven on a regular basis?

- ☐ Yes
- ☐ No

If yes, how often to you conduct the assessment (please attach a copy if possible)?

19. Does your center have an active collaboration with the local health department and its local health improvement initiatives:

- ☐ Yes- at a low level
- ☐ Yes- at a moderate level of engagement
- ☐ Yes- at a high level of engagement
- ☐ No

If yes, please describe the nature of the collaboration

20. Do you need technical assistance in any of the following areas to support future planning for growth and new business development (check all that apply):

- ☐ Data collection and analysis of local, state and national health and other community-level indicators
- ☐ Qualitative assessment using tools such as focus groups, surveys and interviews with my stakeholders in the community to help guide planning

- [ ] Development of strategic plans and annual business plans for future growth
- [ ] Information technology support
- [ ] Grant writing
- [ ] Development of systems to determine eligibility and help patients enroll in public health insurance programs
- [ ] No needs
- [ ] Other (please specify)

21. Does your organization have a fully implemented EHR?

- [ ] Yes
- [ ] No
- [ ] In process
- [ ] Other (please specify)

22. What possible needs for technical assistance in the future development of your EHR may you have (please identify the areas below)?

1.
2.
3.
4.
5.

23. Given the changes under health care reform, please identify what areas you anticipate the most strain on delivery capacity for your organization:

1.
2.
3.
4.
5.

24. Do you perceive any need for a more regional coordinated approach to planning for future primary care needs?

- Yes
- No
- Other (please specify)

25. Do you anticipate participating in a CMS Accountable Care Organization pilot?

- Yes- we intend to submit an application
- No, we are not going to participate
- No decision has been made - we are studying the option
- Not yet considering
- Other (please specify)

26. Would you like more information and possible technical assistance to plan for potential participation in an Accountable Care Organization pilot:

- Yes
- No
- Other (please specify)

27. Please identify the components of a patient centered medical home that you currently offer or are in the process of developing:

	Currently offer	In development	Do not offer	Need technical assistance to develop
Patient-centered care coordination at the primary care provider level that effectively addresses chronic conditions and the				

	Currently offer	In development	Do not offer	Need technical assistance to develop
unique needs of Medicaid members				
Consistent access to primary care, regardless of time of day or night	☐	☐	☐	☐
Emphasis on quality and safety, including use of information technology	☐	☐	☐	☐
Patient engagement, so patients become active partners in improving their health status and better adhere to treatment regimens	☐	☐	☐	☐
Improved communication and education, between providers and patients to address issues such as health literacy, cultural sensitivities and language barriers	☐	☐	☐	☐
Alignment of incentives for providers, such as using pay-for-performance and other tactics	☐	☐	☐	☐
Team-based care, which encourages a multidisciplinary approach to care	☐	☐	☐	☐

28. Is your center considering seeking recognition as a Patient-Centered Medical Home by the National Committee for Quality Assurance (NCQA)?

- Yes
- No
- I don't know
- If you are not, please explain why

29. Rate each of the following based on your organization's ability to meet the likely ACO and PCMH guidelines (Please also identify areas needing technical assistance):

	Yes	No	Working to implement	I don't know	Need technical assistance
Have a formal legal structure to receive and distribute shared savings					
Have a sufficient number of primary care professionals					
Have a leadership and management structure that includes clinical and administrative systems					
Have defined processes to promote evidence-based medicine and implement at the point of care					
Have defined processes to report the necessary data to evaluate quality and cost measures					

	Yes	No	Working to implement	I don't know	Need technical assistance
Have defined processes to coordinate care across the internal health center organization, community affiliates and referring providers	☐	☐	☐	☐	☐
Have implemented the ability to exchange clinical information across settings of care including unaffiliated providers	☐	☐	☐	☐	☐
Certification requirements	☐	☐	☐	☐	☐
Fully implemented EHR	☐	☐	☐	☐	☐
A patient database or registry to manage preventive care (e.g. mammography, colonoscopy, etc.)	☐	☐	☐	☐	☐
A patient database or registry to manage chronic disease (diabetes, hypertension, etc.)	☐	☐	☐	☐	☐

30. Which of the following primarily provide care coordination at your center(s) (check all that apply)?

- ☐ Physicians
- ☐ Nurse practitioners
- ☐ Nurses
- ☐ Social workers

- [ ] Health educators

Other (please specify)

31. Does your health center have the following in place (please identify areas of technical assistance need):

	Yes	No	Working to implement	I don't know	Need technical assistance
Coordination of resources to help patients/their families to achieve health care goals	☐	☐	☐	☐	☐
Referral of resources to help patients/their families to achieve health care goals	☐	☐	☐	☐	☐
A referral tracking process for specialty referrals, admissions to hospitals, or skilled nursing facilities	☐	☐	☐	☐	☐
A protocol/process used by the center with patient when it learns of emergency room use, hospitalization or other discharge plan	☐	☐	☐	☐	☐
A process to avoid unnecessary admissions to the emergency department	☐	☐	☐	☐	☐
Shared decision making with patients and/or families	☐	☐	☐	☐	☐

	Yes	No	Working to implement	I don't know	Need technical assistance
Assistance with eligibility and enrollment in health insurance	☐	☐	☐	☐	☐

32. How does your organization determine and/or assist in the eligibility and enrollment of patients for Medicaid, PAC, or other public health insurance programs?

1.
2.
3.
4.
5.

33. Does your center have/use the following (please identify areas of technical assistance need):

	Yes	No	Working to implement	I don't know	Need technical assistance
Training on quality improvement methods for staff and quality improvement team members	☐	☐	☐	☐	☐
Learning collaborative(s) with other centers to improve outcomes	☐	☐	☐	☐	☐
Standardized care guidelines or evidence-based practice guidelines	☐	☐	☐	☐	☐
EHR fully capable of capturing and reporting on the measures required to demonstrate meaningful use of	☐	☐	☐	☐	☐

	Yes	No	Working to implement	I don't know	Need technical assistance
health information technology					
EHR fully capable of capturing and reporting measures for JCAHO	☐	☐	☐	☐	☐
EHR fully capable of capturing and reporting measures for your own quality improvement plan	☐	☐	☐	☐	☐

34. What challenges do you anticipate in the future related to new requirements for quality reporting and measurement?

1.
2.
3.
4.
5.

35. What components of behavioral health integration do you currently provide (check all that apply):

	Yes	No	In development	I don't know	Need technical assistance
Mental health counselors co-located with primary care	☐	☐	☐	☐	☐
Substance abuse treatment co-located with primary care	☐	☐	☐	☐	☐
Mental health counselors integrated as part of the primary care team	☐	☐	☐	☐	☐

	Yes	No	In development	I don't know	Need technical assistance
Substance abuse counselors integrated as part of the primary care team	☐	☐	☐	☐	☐
Implementation of SBIRT (Screening, Brief intervention and referral to treatment) as part of primary care services	☐	☐	☐	☐	☐
Depression screening as part of primary care services	☐	☐	☐	☐	☐
Referral systems in place for patients identified as having mental health concerns	☐	☐	☐	☐	☐
Referral systems in place for patients identified as having substance abuse concerns	☐	☐	☐	☐	☐
Partnership with a mental health treatment provider	☐	☐	☐	☐	☐
Partnership with a substance abuse treatment provider	☐	☐	☐	☐	☐

36. If your organization would participate in a learning collaborative, which of the following topics would you find helpful?

- ☐ Reimbursement changes under health care reform
- ☐ New models of care (PCMH,ACO's, chronic disease management, etc.)
- ☐ Behavioral health care integration

- [ ] Quality improvement
- [ ] Community assessment and planning

Other (please specify)

37. Please identify how you plan to participate in the new state health insurance exchange (check all that apply):

	Yes	No	Considering	I don't know	Need technical assistance
Contracts with health plans	☐	☐	☐	☐	☐
Assist with eligibility and enrollment	☐	☐	☐	☐	☐
Provide patient navigation	☐	☐	☐	☐	☐
Offer consumer education	☐	☐	☐	☐	☐

Other (please specify)

38. Which statement below describes your center's commitment to research as an organizational priority (check all that apply)?

- [ ] We have included research as a priority area in our strategic plan
- [ ] We have designated staff to conduct research
- [ ] We have allocated funds in our budget to conduct research
- [ ] We have developed partnerships with academic institutions and other researchers to conduct research as part of our future plans
- [ ] We do not see research as a priority

39. Please indicate your capacity to obtain research grants (check all that apply):

- [ ] On staff research expertise
- [ ] On staff grantwriters to write research grants

- Have available contract staff to write research grants
- Have established partnerships with academic institutions to help with seeking research grants
- Have minimal capacity to obtain research grants
- I would like to collaborate with other centers and institutions to seek grants
- I need technical assistance to seek research grants

40. Please indicate your capacity to obtain other (non-research) grants (check all that apply):

- On staff fund development staff to write grants and cultivate funders
- Have available contract staff to write grants
- Have established partnerships with community agencies and other institutions to help write non-research grants
- Have minimal capacity to obtain other non-research public or private grants
- I would like to collaborate with other centers and institutions to seek grants
- I need technical assistance to seek grants

41. The health care reform legislation funds a new community-based Collaborative Care Network program to support consortia of providers to coordinate care for low income and underinsured populations. Do you intend to participate?

- Yes
- No
- Not aware of the program
- Not sure
- Not sure and would like more information and possible support to consider participation

42. Please indicate if you have any of the following organizational approaches established to prepare for the central provisions of health care reform (please indicate areas of need for technical assistance):

	Not in place	Under discussion	Agreed but not implemented yet	Implemented/In place	Need technical assistance
Tactical plan across the organization which specifies objectives for					

	Not in place	Under discussion	Agreed but not implemented yet	Implemented/In place	Need technical assistance
succeeding under health care reform					
Decision process across the organization which will facilitate actions related to health reform	☐	☐	☐	☐	☐
Designation of a point person to organize and orchestrate the institution's activities across clinical and operational missions	☐	☐	☐	☐	☐
Designation of a task force/committee to organize and orchestrate the institution's activities across clinical and operational missions	☐	☐	☐	☐	☐
Designation of investments necessary to address health reform and an approach to securing these funds	☐	☐	☐	☐	☐

43. What do you consider the major barriers to your organization's success under health care reform?

1.
2.

3.
4.
5.

44. What areas of potential technical assistance from the state would be most helpful to your organization in the future?

1.
2.
3.
4.
5.

Done

Local Health Department Health Care Reform Readiness Survey

Exit this survey

***1. Please indicate the jurisdiction of this health department?**

2. Please identify the person(s) completing the survey:

Person 1:	
Name:	
Title:	
Email address:	
Person 2:	
Name:	
Title:	
Email address:	

3. Which statement best describes the level of readiness of your health department to implement the various changes planned under the health care reform legislation?

- Extremely ready, our department has plans in place
- Fairly ready, our department has some plans but may still be working on plans in certain areas
- Not very ready, our department does not have many plans in place yet

4. What are the greatest opportunities for your health department or jurisdiction presented by health reform?

1.	
2.	
3.	
4.	
5.	

5. What areas of health care reform implementation are of greatest concern to your health department and/or jurisdiction?

1.	

2.
3.
4.
5.

6. Which of the following direct clinical services do you currently provide (check all that apply):

- Primary care for adults
- Primary care for children
- Specialty medical care for adults (cardiology, surgery, etc.)
- Specialty medical care for children
- Family planning services
- Pre-natal and post-natal care
- Well women care
- STD screening
- STD treatment
- TB screening
- TB treatment
- Mental health services
- Substance abuse treatment
- Dental care
- Other (please specify)

7. With the future implementation of health care reform and the expansion of coverage, are you planning to continue to provide direct clinical services?

- Yes, all services will continue
- No, all services will be transitioned
- Yes, but some services may be transitioned
- Planning process in place to decide
- I don't know and are not currently engaged in a planning process to decide
- Other (please specify)

8. Would technical assistance be helpful to your department to help plan for the decision to transition clinical services and/or to help with the transition planning (check all that apply)?

- [ ] Yes
- [ ] No
- [ ] I don't know
- [ ] If yes, please indicate the types of technical assistance that might be helpful

9. Which of the following areas of disease prevention do you currently offer to the community (check all that apply)?

- [ ] Asthma education and management
- [ ] Diabetes education and management
- [ ] Smoking cessation and tobacco control
- [ ] Nutrition education
- [ ] Physical activity programs (walking clubs, exercise programs, partnerships with parks, etc.)
- [ ] Menu labeling initiatives
- [ ] Healthy eating options (virtual supermarkets, corner store programs, gardens, etc)
- [ ] Hypertension management
- [ ] Other cardiology education and management programs (CHF, cardiac rehabilitation)
- [ ] STD prevention
- [ ] Substance abuse prevention
- [ ] Mental health awareness and screening
- [ ] Immunizations
- [ ] Violence prevention
- [ ] Other (please specify)

10. Which of the following other public health services does your department provide (check all the apply)?

- Animal licensing
- Animal control
- Childhood lead poisoning control
- Food safety
- Emergency preparedness planning
- Insect control
- Air pollution control
- Sanitation safety

Other (please specify)

11. Do you offer home visiting programs for pregnant women and young children?

- Yes
- No
- In development
- If yes, please indicate the population served and the curriculum used for the home visiting program (Healthy Families America, Parents as Teachers, HIPPY, etc.)

12. The health care reform legislation calls for new funding for evidence-based home visiting programs for pregnant women and young children. Are you planning to apply for this funding to expand services or develop new programs?

- Yes
- No
- Considering

- [ ] Considering and may need technical assistance
- [ ] I don't know
- [ ] Other (please specify)

13. Do you directly operate school-based health centers?

- [ ] Yes
- [ ] No
- [ ] No, but we partner with a provider to deliver services
- [ ] In development

14. The health care reform legislation calls for increased funding for school-based health centers. Does your department plan to develop or expand centers as part of the proposed funding?

- [ ] Yes
- [ ] No
- [ ] Considering
- [ ] Considering and may need technical assistance
- [ ] I don't know
- [ ] Other (please specify)

15. How would you rate your department's capacity to deliver evidence-based prevention and disease management programs?

- [ ] Very strong - the majority of our programs utilize evidence-based guidelines and we have internal staff expertise
- [ ] Moderate - some of our programs utilize evidence-based guidelines and there is some expertise on our staff
- [ ] Weak - not many of our programs utilize evidence-based guidelines and we have little internal expertise
- [ ] Non-existent - we do not utilize evidence-based guidelines at all and have no expertise
- [ ] Other (please specify)

16. Does your department need technical assistance to help develop greater capacity to deliver evidence-based programs and to be a community resource for evidence-based guideline development?

- Yes
- No
- Maybe
- I don't know
- If yes, please describe the type of technical assistance that might be helpful

17. The health care reform legislation calls for the establishment of a Prevention and Public Health Fund to provide grants for prevention and wellness activities. Are you planning to apply for these grants (check all that apply)?

- Yes
- No
- Considering
- Considering and may need technical assistance
- Considering and would like to partner with other community agencies
- I don't know
- Other (please specify)

18. Does your department have an active collaboration with community-based organizations and other health care providers to deliver population-based prevention and disease management programs (check all that apply)?

- Yes- at a low level
- Yes- at a moderate level of engagement

- Yes- at a high level of engagement
- No
- May need technical assistance to help increase partnerships
- Other (please specify)

19. Does your department have an active collaboration with your jurisdiction's community health centers (check all that apply)?

- Yes- at a low level
- Yes- at a moderate level of engagement
- Yes- at a high level of engagement
- No
- May need technical assistance to help increase partnerships
- Other (please specify)

20. The health care reform legislation will be funding a number of new prevention and disease management efforts in addition to those noted previously. Please indicate your plans to apply for funding for the following (check all that apply):

	Yes	No	I don't know	In development	Considering	Need technical assistance
Community transformation grants						
Epidemiology and lab capacity grants						
Healthy aging, living well (public health interventions for older adults)						
Childhood obesity demonstration program						

	Yes	No	I don't know	In development	Considering	Need technical assistance
Clinical prevention grants (immunizations, employee wellness)						

21. How would you rate your department's capacity to deliver population-based services?

- Very strong - we currently deliver many population-based programs and have internal staff expertise
- Moderate - we deliver some population-based programs and there is some expertise on our staff
- Weak - not many of our programs are population-based and we have little internal expertise
- Non-existent - we do not utilize evidence-based guidelines at all and have no expertise
- Other (please specify)

22. Does your department plan to expand population-based services in the next several years?

- Yes
- No
- In development
- Considering
- I don't know
- If answer is yes, in development or considering, what specialties are you possibly considering expanding?

23. Does your department need technical assistance to develop greater capacity to deliver population-based services?

- Yes

- [ ] No
- [ ] Maybe
- [ ] I don't know
- [ ] If yes, please indicate the type of technical assistance that might be helpful

24. Please indicate if your department employs the following types of public health professionals (check all that apply)?

	Yes	No	Will need more in future
Primary care physicians	☐	☐	☐
Specialty care physicians (infectious disease, cardiology, etc.)	☐	☐	☐
Physicians in management/program support roles	☐	☐	☐
Primary care nurse practitioners	☐	☐	☐
Nurse practitioners in management/program support roles	☐	☐	☐
Physicians assistants in direct care roles	☐	☐	☐
Physicians assistants in management/program support roles	☐	☐	☐
Nurses in direct care roles	☐	☐	☐
Nurses in management/program support roles	☐	☐	☐
Social workers in direct care roles	☐	☐	☐

	Yes	No	Will need more in future
Social workers in management/program support roles			
Psychologists			
Other mental health clinicians not listed above			
Addiction counselors			
Peer recovery coaches			
Dentists in direct care roles			
Dentists in management/support care roles			
Dental hygienists			
Dental assistants			
Health educators			
Nutritionists			
Care coordinators			
Epidemiologists			
Non clinical public health professionals in management/program support roles			

Other not listed

25. Please identify the types of providers that you anticpate having the most difficulty recruiting in the next several years?

1.

2.

3.
4.
5.

26. How does your health department conduct workforce planning?

27. Do you currently employ bi-lingual staff?

- Yes
- No

28. How does your department provide interpretation services for patients that are non-English speaking?

- On site staff interpreters
- Partnership for interpreters with community-based agencies
- Managed care organization support
- Other (please specify)

29. Please check all that apply related to diversity and language needs for your department in the future (check all that apply):

- I anticipate needing to hire additional bi-lingual staff
- I anticipate needing to hire more culturally diverse staff
- I believe hiring bi-lingual staff may be a challenge
- I believe hiring culturally diverse staff may be a challenge
- I have a plan for cultural diversity training
- I do not have a plan for cultural diversity training
- I do not anticipate any needs related to additional bi-lingual staff
- I do not anticipate any needs related to more culturally diverse staff

30. Please identify the priority topics that you anticipate your staff may need training and staff development to be prepared for future health care reform implementation:

1.
2.
3.
4.
5.

31. Do you conduct a comprehensive community needs assessment that is data-driven on a regular basis?

- Yes
- No

32. How does your health department identify the greatest gaps in service delivery for the community?

33. Have you completed your local health improvement plan within the last six months (check all that apply)?

- Yes
- No
- In development
- May need technical assistance
- Other (please specify)

34. Do you have a fully functional electronic health record (EHR) (check all that apply)?

- Yes
- No
- Not necessary (we do not provide clinical services)
- In development

- [ ] May need technical assistance
- [ ] If you indicated a need for technical assistance, what areas might be helpful?

35. How would you rate your department's capacity for data collection and reporting on the range of epidemiological indicators to determine needs and track improvements in health measures, especially to reduce health disparities (check all that apply)?

- [ ] Strong
- [ ] Moderate
- [ ] Weak
- [ ] Non-existent
- [ ] We serve as a resource to our community for data
- [ ] May need techical assistance to improve capacity

Other (please specify)

36. Do you anticipate needing technical assistance in any of the following areas to support future planning for growth and new program development (check all that apply):

- [ ] Data collection and analysis of local, state and national health and other community-level indicators
- [ ] Qualitative assessment using tools such as focus groups, surveys and interviews with my stakeholders in the community to help guide planning
- [ ] Development of strategic plans and annual business plans for future growth
- [ ] No needs
- [ ] Other (please specify)

37. Given the changes under health care reform, please identify what areas you anticipate the most strain on delivery capacity for your department:

1.
2.
3.
4.
5.

38. Do you perceive playing a role in helping coordinate a regional/local jurisdicational approach for future primary care needs?

- Yes
- No
- Maybe
- I don't know
- If yes, please indicate the type of role that you may play

39. Are any of your clinics considering seeking recognition as a Patient-Centered Medical Home by the National Committee for Quality Assurance (NCQA) (check all that apply)?

- Yes
- No
- I don't know
- Non-applicable
- Considering
- Considering and may need technical assistance
- Other (please specify)

40. Does your department have the following in place (please identify areas of technical assistance need):

	Yes	No	Working to implement	I don't know	Need technical assistance
Coordination of resources to help patients/their families to achieve health care goals	☐	☐	☐	☐	☐
Referral of resources to help patients/their families to achieve health care goals	☐	☐	☐	☐	☐
Systems to determine eligibility and help individuals enroll in health insurance	☐	☐	☐	☐	☐
Help to patients with system navigation	☐	☐	☐	☐	☐
Public education on changes/coverage options under health care reform	☐	☐	☐	☐	☐

41. If your department would participate in a learning collaborative, which of the following topics would you find helpful (check all that apply)?

- ☐ Reimbursement changes under health care reform
- ☐ New models of care (PCMH, ACO's, chronic disease management, etc.)
- ☐ Behavioral health care integration
- ☐ Prevention strategies
- ☐ Evidence-based care
- ☐ Population-based care models
- ☐ Quality improvement
- ☐ Community assessment and planning

Other (please specify)

42. Please identify how your department plans to participate in the new state health insurance exchange(check all that apply:

	Yes	No	Considering	I don't know	Need technical assistance
Contracts with health plans					
Assist with eligibility and enrollment					
Provide patient navigation					
Offer consumer education					

Other (please specify)

43. Which statement below describes your commitment to research as a departmental priority (check all that apply)?

- We have included research as a priority area in our health improvement/strategic plan
- We have designated staff to conduct research
- We have allocated funds in our budget to conduct research
- We have developed partnerships with academic institutions and other researchers to conduct research as part of our future plans
- We do not see research as a priority

44. Please indicate your capacity to obtain research and other external grants (check all that apply):

- On staff research expertise
- On staff fund development professionals to write grants and cultivate funders
- Have available contract staff for to write research grants
- Have available contract staff to write grants for other non-research public sector or private funder grants
- Have established partnerships with academic institutions to help with seeking grants

- Have minimal capacity to obtain research grants
- Have minimal capacity to obtain other public or private funder grants
- I would like to collaborate with other health departments and agencies to seek grants
- I need technical assistance to seek research and other major grants

45. The health care reform legislation funds a new community-based Collaborative Care Network program to support consortia of providers to coordinate care for low income and underinsured populations. Do you intend to participate?

- Yes
- No
- Not aware of the program
- Not sure
- Not sure and would like more information and possible support to consider participation

46. Please indicate if you have any of the following organizational approaches established to prepare for the central provisions of health care reform (please indicate areas of need for technical assistance):

	Not in place	Under discussion	Agreed but not implemented yet	Implemented/In place	Need technical assistance
Tactical plan across the department which specifies objectives for succeeding under health care reform					
Decision process across the department which will facilitate actions related to health reform					
Designation of a point person to organize and orchestrate the department's activities across clinical and					

	Not in place	Under discussion	Agreed but not implemented yet	Implemented/In place	Need technical assistance
operational missions					
Designation of a task force/committee to organize and orchestrate the department's activities across clinical and operational missions	☐	☐	☐	☐	☐
Designation of investments necessary to address health reform and an approach to securing these funds	☐	☐	☐	☐	☐

47. What do you consider the major barriers to your department's success under health care reform?

1.
2.
3.
4.
5.

Done

Safety Net Provider Health Care Reform Readiness Survey

Exit this survey

***1. What is the name of your organization?**

2. Please identify the person(s) completing the survey:

Person 1:	
Name:	
Title:	
Email address:	
Person 2:	
Name:	
Title:	
Email address:	

3. Please indicate the type of safety-net provider you are:

- Free health clinic
- School-based health clinic
- Mobile health clinic
- Infectious disease clinic
- Other
- If other indicated, please identify the type of provider or describe your clinic

4. Please indicate the services that you provide at your organization (check all that apply):

- Primary care for adults
- Primary care for children
- Specialty medical care for adults (cardiology, pulmonary, etc.)
- Specialty medical care for children

- [ ] Family planning services
- [ ] Pre-natal and post-natal care
- [ ] Well woman care
- [ ] STD screening
- [ ] STD treatment
- [ ] TB screening
- [ ] TB treatment
- [ ] Laboratory services
- [ ] Pharmacy on-site
- [ ] Mental health services
- [ ] Substance abuse treatment
- [ ] Dental care
- [ ] Home visiting and outreach
- [ ] Health education
- [ ] Social services/care coordination

Other (please specify)

5. Which statement best describes the level of readiness of your organization to implement the various changes planned under the health care reform legislation?

- [ ] Extremely ready, our organization has plans in place
- [ ] Fairly ready, our organization has some plans but may still be working on plans in certain areas
- [ ] Not very ready, our organization does not have many plans in place yet

6. With the changes anticipated under health care reform implementation, which of the following are you planning for your organization's future?

- [ ] Expand services
- [ ] Decrease services
- [ ] Eliminate some services
- [ ] Eliminate all services
- [ ] Partner with another organization for future viability and possible expansion

- [ ] I don't know
- [ ] Planning process underway currently

Other (please specify)

7. Would technical assistance be helpful to your organization to help plan for how best to position your clinic in the future?

- [ ] Yes
- [ ] No
- [ ] I don't know

8. If you answered yes to question 7, please identify which of the following areas of technical assistance would be most beneficial to your organization (check all that apply):

- [ ] Grant writing and assistance in identification of grant opportunities
- [ ] Developing systems for billing
- [ ] Developing information technology systems
- [ ] Developing collaborative relationships with other providers

Other (please specify)

9. Are you a teaching organization (provide training opportunities on a regular basis for health care professionals affiliated with health professional training institutions)?

- [ ] Yes
- [ ] No

10. What type of physicians are available at your organization?

	Family medicine	Internal medicine	Pediatrics	Obstetrics/gynecology	Psychiatry	None
Physicians	☐	☐	☐	☐	☐	☐

11. What type of nurse practitioners are available at your organization?

	Adult	Family practice	Women's health	Psychiatry	None
Nurse practitioners	☐	☐	☐	☐	☐

12. Do you utilize physician's assistants?

- ☐ Yes
- ☐ No

13. What types of behavioral health specialists are available at your organization?

	Psychologists	Psychiatrists	Licensed clinical social workers	Certified addiction specialists	Psychiatric nurse specialists	Certified counselors	Peer recovery coaches	None
Behavioral health specialists	☐	☐	☐	☐	☐	☐	☐	☐

14. What types of nurses do you have working for the organization?

	Registered nurses	LPN's	None
Nurses	☐	☐	☐

15. What additional clinical support staff do you have working for the organization?

	Pharmacists	Health educators	Designated care coordinators	Dentists	Dental hygienists	Dental assistants	Community health workers	None
Clinical support staff	☐	☐	☐	☐	☐	☐	☐	☐

16. For those providers that work with your organization, please indicate the employment relationship (check all that apply):

	Employed by center	Volunteer	Contracted through another agency	Other
Physicians	☐	☐	☐	☐
Nurse practitioners	☐	☐	☐	☐

	Employed by center	Volunteer	Contracted through another agency	Other
Physicians assistants	☐	☐	☐	☐
Dentists	☐	☐	☐	☐
Social workers	☐	☐	☐	☐
Counselors	☐	☐	☐	☐
Nutritionists	☐	☐	☐	☐
Addiction counselors	☐	☐	☐	☐
Psychologists	☐	☐	☐	☐
Community health workers	☐	☐	☐	☐
Dentists	☐	☐	☐	☐
Dental hygienists	☐	☐	☐	☐
Dental assistants	☐	☐	☐	☐
Pharmacists	☐	☐	☐	☐

If other indicated, please explain

***17. What percentage of your organization's medical provider base are volunteers?**

18. Does your organization rely on medical liability coverage for your volunteer providers under the Federal Tort Claims Act (FTCA)?

- ☐ Yes
- ☐ No
- ☐ We don't use volunteers

19. If your organization does rely on FTCA for your volunteer providers, is billing for services a "non-starter" for your organization because of requirements under FTCA that you do not bill for services?

- Yes
- No
- N/A

Other (please specify)

20. Which of the following providers do you anticipate needing to recruit more of in the next two to three years?

- Primary care physicians
- Primary care nurse practitioners
- Physician's assistants
- Registered nurses
- LPNs
- Pharmacists
- Mental health therapists
- Addiction counselors
- Health educators
- Care coordinators
- Community health workers
- Dental staff
- None of the above
- All of the above
- Other (please specify)

21. Please identify the types of providers that you anticipate having the most difficulty recruiting in the next several years?

1.

2.
3.
4.
5.

22. Do you currently employ bi-lingual staff?

- Yes
- No

23. How does your organization provide interpretation services for patients that are non-English speaking?

- On site staff interpreters
- Managed care organization support
- Other (please specify)

24. Please check all that apply related to diversity and language needs for your organization in the future:

- I anticipate needing to hire additional bi-lingual staff
- I anticipate needing to hire more culturally diverse staff
- I believe hiring bi-lingual staff may be a challenge
- I believe hiring culturally diverse staff may be a challenge
- I have a plan for cultural diversity training
- I do not have a plan for cultural diversity training
- I do not anticipate any needs related to additional bi-lingual staff
- I do not anticipate any needs related to more culturally diverse staff

25. Please identify the priority topics that you anticipate your staff may need training and staff development to be prepared for future health care reform implementation:

1.
2.

3.
4.
5.

26. Does your organization offer any of the following to your patients (check all that apply)?

	Yes	No	In development	Need assistance to develop
An on-call provider (physician, nurse practitioner or physician assistant) directly or via a phone triage system 24 hours a day, 7 days a week				
Same day appointments through a pre-determined system				
A protocol to determine which patients with acute care needs will be seen same-day or next day				
After hours medical care				
Weekend hours				
Secure email for your patients to communicate with the clinic/providers				
Telemedicine for your patients				
Timely communication of test results to patients				

	Yes	No	In development	Need assistance to develop
A process to identify patients who are discharged from nursing home, hospital, skilled care facility and process for health center follow-up	☐	☐	☐	☐
Relationships with specialists for all care needs	☐	☐	☐	☐
Relationships with community resources for support needs of patients	☐	☐	☐	☐
Systems to determine eligibility and enroll patients in health insurance	☐	☐	☐	☐

27. Do you conduct a comprehensive community needs assessment that is data-driven on a regular basis?

- ☐ Yes
- ☐ No

28. Do you anticipate needing technical assistance in any of the following areas to support future planning for growth and new business development (check all that apply):

- ☐ Data collection and analysis of local, state and national health and other community-level indicators
- ☐ Qualitative assessment using tools such as focus groups, surveys and interviews with my stakeholders in the community to help guide planning
- ☐ Development of strategic plans and annual business plans for future growth
- ☐ No needs
- ☐ Other (please specify)

29. Does your organization have an active collaboration with the local health department and its local health improvement initiatives:

- Yes- at a low level
- Yes- at a moderate level of engagement
- Yes- at a high level of engagement
- No

30. Does your organization have active collaborations with any of the following other types of organizations (check all that apply):

- Acute care hospitals
- Specialty physicians
- Community health centers
- Hospital outpatient clinics
- Infectious disease clinics
- Nursing homes
- Substance abuse treatment centers
- Mental health treatment providers
- Community social support agencies

Other (please specify)

31. What types of partner agencies are the most important to the ongoing success of your organization?

1.
2.
3.
4.
5.

32. Do you anticipate needing technical assistance in the future to help expand your organization's collaborative relationships with health care and community organizations:

- Yes
- No
- Maybe
- I don't know
- If yes, what type of technical assistance might be helpful?

33. Given the changes under health care reform, please identify what areas you anticipate the most strain on delivery capacity for your organization:

1.
2.
3.
4.
5.

34. Do you perceive any need for a more regional coordinated approach to planning for future primary care needs?

- Yes
- No
- Other (please specify)

35. Do you anticipate participating in a CMS Accountable Care Organization pilot?

- Yes- we intend to submit an application
- No, we are not going to participate
- No decision has been made - we are studying the option
- Not yet considering

- [ ] Other (please specify)

36. Would you like more information and possible technical assistance to plan for potential participation in an Accountable Care Organization pilot:

- [ ] Yes
- [ ] No
- [ ] Other (please specify)

37. Please identify the components of a patient-centered medical home that you currently offer or are in the process of developing (check all that apply):

	Currently offer	In development	Do not offer	Need technical assistance to develop
Patient-centered care coordination at the primary care provider level that effectively addresses chronic condition and the unique needs of Medicaid members	☐	☐	☐	☐
Consistent access to primary care, regardless of time of day or night	☐	☐	☐	☐
Emphasis on quality and safety, including use of information technology	☐	☐	☐	☐
Patient engagement, so patients become active partners in improving their health status and	☐	☐	☐	☐

	Currently offer	In development	Do not offer	Need technical assistance to develop
better adhere to treatment regimens				
Improved communication and education between providers and patients to address issues such as health literacy, cultural sensitivities and language barriers	☐	☐	☐	☐
Alignment of incentives for providers, such as using pay-for-performance and other tactics	☐	☐	☐	☐
Team-based care, which encourages a multidisciplinary approach to care	☐	☐	☐	☐

38. Is your organization considering seeking recognition as a Patient-Centered Medical Home by the National Committee for Quality Assurance (NCQA)?

- ☐ Yes
- ☐ No
- ☐ I don't know
- ☐ If not, please indicate the reason

39. Rate each of the following based on your organization's ability to meet the likely ACO and PCMH guidelines (Please also identify areas needing technical assistance):

	Yes	No	Working to implement	I don't know	Need technical assistance
Have a formal legal structure to receive and distribute shared savings	☐	☐	☐	☐	☐
Have a sufficient number of primary care professionals	☐	☐	☐	☐	☐
Have a leadership and management structure that includes clinical and administrative systems	☐	☐	☐	☐	☐
Have defined processes to promote evidence-based medicine and implement at the point of care	☐	☐	☐	☐	☐
Have defined processes to report the necessary data to evaluate quality and cost measures	☐	☐	☐	☐	☐
Have defined processes to coordinate care across the internal health center organization, community affiliates and referring providers	☐	☐	☐	☐	☐
Have implemented the ability to exchange clinical information across settings of care	☐	☐	☐	☐	☐

	Yes	No	Working to implement	I don't know	Need technical assistance
including unaffiliated providers					
Certification requirements	☐	☐	☐	☐	☐
Fully implemented EHR	☐	☐	☐	☐	☐
A patient database or registry to manage preventive care (e.g. mammography, colonoscopy, etc.)	☐	☐	☐	☐	☐
A patient database or registry to manage chronic disease (diabetes, hypertension, etc.)	☐	☐	☐	☐	☐

40. Which of the following primarily provide care coordination for your organization (check all that apply)?

- ☐ Physicians
- ☐ Nurse practitioners
- ☐ Nurses
- ☐ Social workers
- ☐ Health educators

Other (please specify)

41. Does your organization have any of the following in place (please identify areas of technical assistance need):

	Yes	No	Working to implement	I don't know	Need technical assistance
A system on site to help patients determine eligibility for health insurance	☐	☐	☐	☐	☐

	Yes	No	Working to implement	I don't know	Need technical assistance
and help with enrollment					
Coordination of resources to help patients/their families to achieve health care goals	☐	☐	☐	☐	☐
Referral of resources to help patients/their families to achieve health care goals	☐	☐	☐	☐	☐
A referral tracking process for specialty referrals, admissions to hospitals, or skilled nursing facilities	☐	☐	☐	☐	☐
A protocol/process used by the center with patient when it learns of emergency room use, hospitalization or other discharge plan	☐	☐	☐	☐	☐
A process to avoid unnecessary admissions to the emergency department	☐	☐	☐	☐	☐
Shared decision making with patients and/or families	☐	☐	☐	☐	☐

42. Please indicate which of the following systems are in place at your organization related to billing and financial management and those areas that you may need future technical assistance (check all that apply):

	Yes	No	In development	Need technical assistance
We bill insurance companies for our services	☐	☐	☐	☐
We have contracts with managed care organizations and other payors	☐	☐	☐	☐
We have an internal staff that processes and manages our billing systems	☐	☐	☐	☐
We have a contract with an agency to manage our billing systems	☐	☐	☐	☐
We have a sliding fee scale	☐	☐	☐	☐
We have well developed financial reporting systems to track billing, accounts payable and income/losses	☐	☐	☐	☐

43. What impact will health reform present for your organization in terms of the ability to bill for patients who gain access to health insurance under reform?

1.
2.
3.
4.
5.

44. Does your organization have/use the following (please identify areas of technical assistance need):

	Yes	No	Working to implement	I don't know	Need technical assistance
Training on quality improvement methods for staff and quality improvement team members	☐	☐	☐	☐	☐
Learning collaborative(s) with other centers to improve outcomes	☐	☐	☐	☐	☐
Standardized care guidelines or evidence-based practice guidelines	☐	☐	☐	☐	☐
EHR fully capable of capturing and reporting on the measures required to demonstrate meaningful use of health information technology	☐	☐	☐	☐	☐
EHR fully capable of capturing and reporting measures for JCAHO	☐	☐	☐	☐	☐
EHR fully capable of capturing and reporting measures for your own quality improvement plan	☐	☐	☐	☐	☐

45. What challenges do you anticipate in the future related to new requirements for quality reporting and measurement?

1.
2.
3.

4.

5.

46. Does your organization have a fully implemented EHR?

- Yes
- No
- In process
- Other (please specify)

47. I anticipate a possible need for technical assistance in the future development of our EHR in the following areas?

1.

2.

3.

4.

5.

48. If your organization would participate in a learning collaborative, which of the following topics would you find helpful?

- Reimbursement changes under health care reform
- New models of care (PCMH,ACO's, chronic disease management, etc.)
- Behavioral health care integration
- Quality improvement
- Community assessment and planning

Other (please specify)

49. Please identify how your organization plans to participate in the new state health insurance exchange (check all that apply):

	Yes	No	Considering	I don't know	Need technical assistance
Contracts with health plans	☐	☐	☐	☐	☐
Assist with eligibility and enrollment	☐	☐	☐	☐	☐
Provide patient navigation	☐	☐	☐	☐	☐
Offer consumer education	☐	☐	☐	☐	☐

Other (please specify)

50. Which statement below describes your center's commitment to research as an organizational priority (check all that apply)?

- ☐ We have included research as a priority area in our strategic plan
- ☐ We have designated staff to conduct research
- ☐ We have allocated funds in our budget to conduct research
- ☐ We have developed partnerships with academic institutions and other researchers to conduct research as part of our future plans
- ☐ We do not see research as a priority

***51. What percent of your overall organizational budget relies on grant funding?**

52. Please indicate your capacity to obtain research and other external grants (check all that apply):

- ☐ On staff research expertise
- ☐ On staff fund development staff to write grants and cultivate funders
- ☐ Have available contract staff to write research grants
- ☐ Have available contract staff to write other non-research public sector grants or private funder grants
- ☐ Have established partnerships with academic institutions to help with seeking grants

- Have minimal capacity to obtain research grants
- Have minimal capacity to obtain other public or private funder grants
- I would like to collaborate with other centers and institutions to seek grants
- I need technical assistance to seek research and other major grants

53. The health care reform legislation funds a new community-based Collaborative Care Network program to support consortia of providers to coordinate care for low income and underinsured populations. Do you intend to participate?

- Yes
- No
- Not aware of the program
- Not sure
- Not sure and would like more information and possible support to consider participation

54. The health care reform legislation calls for increased funding for school-based health centers. Do you plan to apply for this funding?

- Yes
- No
- Considering
- Considering and may need technical assistance
- I don't know
- Not applicable
- Other (please specify)

55. Please indicate if you have any of the following organizational approaches established to prepare for the central provisions of health care reform (please indicate areas of need for technical assistance):

	Not in place	Under discussion	Agreed but not implemented yet	Implemented/In place	Need technical assistance
Tactical plan across the organization which specifies objectives for					

	Not in place	Under discussion	Agreed but not implemented yet	Implemented/In place	Need technical assistance
succeeding under health care reform					
Decision process across the organization which will facilitate actions related to health reform					
Designation of a point person to organize and orchestrate the institution's activities across clinical and operational missions					
Designation of a task force/committee to organize and orchestrate the institution's activities across clinical and operational missions					
Designation of investments necessary to address health reform and an approach to securing these funds					

56. What do you consider the major barriers to your organization's success under health care reform?

1.

2.

3.
4.
5.

Done

Interview Participants

Uma S. Ahluwalia, Commissioner, Montgomery County Department of Health and Human Services
Salliann Alborn, CEO, Community Health Integrated Partnership
Donna Behrens, Immediate Past President, Maryland Assembly on School Based Health Care
Dr. Peter Beilenson, Health Officer, Howard County Health Department
Dr. George Bone, Medical Practitioner, Prince George's County
Barbara Marx Brocato, Barbara Marx Brocato & Associates
Honorable Eric Bromwell, House of Delegates, Maryland General Assembly
Dr. Barbara Brookmyer, Health Officer, Frederick County Health Department
Patrick Dooley, Chief of Staff, Office of the Secretary, DHMH
Robyn Elliott, Partner, Public Policy Partners
Steve M. Galen, President & CEO, Primary Care Coalition of Montgomery County
Ken Glover, CEO, Dimensions Health Care
Honorable Peter Hammen, House of Delegates, Maryland General Assembly
Heather Hauck, Director Infectious Disease and Environmental Health Administration, DHMH
Dan Hawkins, Senior Vice President, Public Policy and Research,
National Association of Community Health Centers
Isabelle Horon, Director Vital Statistics Administration DHMH
Kendall Hunter, Senior Vice President, Insurance Exchange Operations and Federal Employees
Line of Business, Kaiser Permanente Mid-Atlantic States
Honorable John Hurson. Chairman, Maryland Community Health Resources Commission
Dr. Sarah Leonard, CEO, Greater Baden Medical Services, Inc.
Kathleen Loughran, Vice President of Government Relations, Amerigroup
Peter Lowet, Executive Director, Mobile Medical Care, Inc.
Enrique Martinez-Vidal, Vice President for State Policy and Technical Assistance, Academy Health
Dr. Andrea Mathias, Deputy Health Officer, Worcester County Health Department
Miguel McInnis, CEO, Mid-Atlantic Association of Community Health Centers
Paula McLellan, CEO, Family Health Centers of Baltimore
Honorable Thomas Middleton, State Senate, Maryland General Assembly
Charles Milligan, Deputy Secretary Health Care Financing, DHMH
Orlee Panitch, Chief Culture Officer, Maryland Emergency Physicians
Rebecca Pearce, Executive Director, Maryland Health Benefit Exchange
Kathy Pettway, Priority Partners
Frances B. Phillips, Deputy Secretary Public Health Services, DHMH
Carolyn Quattocki, Executive Director, Governor's Office of Health Care Reform
Dr. Susan Raver, Health Officer, Allegany County Health Department
Debra Ross, Special Assistant to the County Executive, The Honorable Rushern Baker,
Prince George's County
Jai Seunarine, CEO, Jai Medical Systems, Inc.
Madeleine Shea, Director Office of Population Health Improvement, DHMH

Michael R. Spurrier, Director, Frederick Community Action Agency
Theresa Staudenmaier, Program Officer Health and Human Services, Abell Foundation
John Strube, Vice President of Marketing and Development,
Choptank Community Health System, Inc.
Jack VandenHengel, Executive Director, Shepherd's Clinic
Erik Wagner, Executive Vice President, External Affairs and Diversified Operations, MedStar Health
Lesley Wallace, AVP Regulatory Affairs, Marketing and Network Development,
MedStar Family Choice
Susan Walter, Executive Director, Tri-State Community Health Center
Jay Wolvolsky, President & CEO, Baltimore Medical Systems, Inc.

Appendix C

Appendix C:
List of Grantees

CHRC Areas of Focus for Grants during FY 2012 and 2014

Focus Area: REDUCING INFANT MORTALITY

- **Access to Wholistic and Productive Living (Year One Grant Award $50,000)**
  Jurisdiction: Prince George's County
  Grant funds support expanded services for pregnant and early postpartum women over two years in order to improve birth outcomes and rates of first trimester prenatal care in underserved communities in Prince George's County. Services include targeted case management, home visiting, linkage to prenatal care, smoking cessation services, and/or health education. Grant funds will be utilized to hire staff to increase the number of zip codes in Prince George's County served by the Bright Beginnings program.

- **Calvert County Health Department (Year One Grant Award $85,000)**
  Jurisdiction: Calvert County
  Grant funds support a program to improve overall health outcomes for reproductive age women and reduce infant mortality rates by creating a new, "one-stop shop" of integrated behavioral health and social services for substance abusing women and expectant mothers. Grant funds will be utilized to support staff to develop and implement the multi-disciplinary program, which includes intensive case management and linkage to local obstetric providers, family planning, folic acid supplements, behavioral health services, WIC, social services, dental care, health insurance enrollment, and community resources such as education and job training opportunities.

- **Mary's Center (Year One Grant Award $200,000)**
  Jurisdictions: Prince George's and Montgomery County
  Grant funds support a program which seeks to reduce health disparities and the State's infant mortality rate by expanding its current prenatal services at the Adelphi clinic to include primary health care for women of reproductive age so that if they become pregnant, they will be in good health and will give birth to healthy birth weight babies. Grant funds will be used to support the salary costs of a Primary Care Adult/Family Medical Doctor, a Certified Nurse Midwife, a Family Support Worker, and a Life Cycle Health Educator at the Adelphi health center, which targets underserved communities in Prince George's County.

- **Harford County Health Department (Grant Award: $156,052)**
  Jurisdiction: Harford County
  Grant funds launched a comprehensive women's health services program aimed at assisting women in need of subsidized clinical family planning care to receive a comprehensive set of services that include Medicaid screening/eligibility, WIC nutrition services, dental referrals, substance abuse/mental health referrals, smoking cessation services, domestic violence screening/prevention, and other prevention services. Grant funds will be utlized to support costs of personnel and case management services.

- **Planned Parenthood-Maryland (Year One Grant Award $125,000)**
  Jurisdictions: Baltimore County, Anne Arundel County and Wicomico County
  Grant funds support a program that seeks to reduce infant mortality rates by increasing access to comprehensive women's health services in Baltimore, Anne Arundel, and Wicomico Counties by building on evidenced-based strategies currently used in Baltimore City. Grant funds will be utilized to provide same-day access to Long Acting Reversible Contraception (LARC), prevent substance-exposed pregnancies by implementing use of SAMHSA's evidence-based practice of Screening, Brief Intervention, and Referral to Treatment (SBIRT) tool, and outreaching to clients to educate and connect those eligible to provisions of the Affordable Care Act.

- **Tri State Community Health Center (Grant Award: $135,598)**
  Jurisdiction: Allegany County
  Grant funds enabled the health center to create a program to increase positive pregnancy outcomes for low-income women, teens, and high risk women by integrating services available to women through Tri-State and the Allegany County Health Department in one location. Grant funds will be utilized to provide OB/GYN and postnatal care services through Tri-State providers and case-management, education, and home visiting services through the ACHD staff.

Focus Area: INCREASING ACCESS TO DENTAL CARE SERVICES

- **Allegany Health Right (Year One Grant Award $45,000)**
  Jurisdiction: Allegany County
  Grant funds support a program that targets low-income, special needs patients with low health literacy and provides access to dental care services and oral health education for underserved communities in Allegany County. Grant funds will be utilized to support a Dental Case Manager's time, to pay for discounted dental treatment, and to support collaboration with the Western Maryland Health System Emergency Department to divert dental patients to discounted urgent dental care services.

- **Baltimore City Health Department (Grant Award: $58,428)**
  Jurisdiction: Baltimore City
  Grant funds support a partnership between the Oral Health Services Program and the Immunization Program to ensure at-risk children and families receive preventative oral health education and dental care at an early juncture in the child's development. Grant funds will be utlized to support personnel costs; increase the number of children with dental homes, increase the number of children who receive fluoride varnish and sealants, and improve the oral health literacy of parents and caregivers.

- **Bel Alton Alumni Association (Grant Award: $250,000)**
  Jurisdiction: Charles County
  Grant funds enabled Bel Alton to provide comprehensive dental screenings and oral health education to children in eight elementary schools in Charles County. Grant funds will be utlized to support personnel costs of providing services in schools throughout Charles

County.

- **Charles County Health Department (Year One Grant Award $100,000)**
  Jurisdiction: Charles County
  Grant funds support a school-based dental program that screens children in the Charles County public school system and provides access to fluoride, dental sealants, and clinical services in an area of southern Maryland that is lacking in oral health safety net infrastructure. Grant funds will be utilized to support the salaries of a dentist, dental hygienist, dental assistant, and community health worker.

- **Frederick Community Action Agency (Year One Grant Award $90,000)**
  Jurisdiction: Frederick County
  Grant funds support a program which seeks to improve oral health and reduce hospital emergency department visits for non-emergent dental needs by expanding access to oral health care for underserved residents in Frederick County. Grant funds will be utilized to recruit dentists to provide non-emergent dental services and a Registered Dental Hygienist to provide fluoride varnish and oral health education to lower-income children and adults.

- **Walnut Street Community Health Center (Grant Award: $98,000)**
  Jurisdiction: Washington County
  Grant funds enabled Walnut Street to support the planning and implementation of an integrated practice management, electronic dental records, and electronic medical records system. Grant funds will be used to support the purchase of necessary systems and training for providers.

Focus Area: INTEGRATING BEHAVIORAL HEALTH IN THE COMMUNITY

- **Frederick Mental Health Association (Year One Grant Award $120,000)**
  Jurisdiction: Frederick County
  Grant funds support expanding access to behavioral health care services in the region and reducing behavioral-health related hospital emergency department visits at Frederick Memorial Hospital. Grant funds will be utilized to expand the hours of a new behavioral health urgent care/walk-in service that is available to residents regardless of ability to pay or health insurance status.

- **Lower Shore Clinic (Grant Award: $240,000)**
  Jurisdiction: Lower Shore
  Grant funds targeted individuals with behavioral health care issues who often have co-occurring somatic conditions but experience significant barriers to appropriate care. Grant funds will be utlized to support primary care services provision in existing behavioral health care services, providing regular physicals, preventative services, and chronic disease management for individuals with an exisiting mental health or substance use disorder.

- **Mary's Center for Maternal and Child Health (Grant Award: $198,318)**
  Jurisdiction: Prince George's County

Grant funds enabled Mary's Center to integrate behavioral health care at their primary care services locations in Silver Spring and Adelphi sites. Grant funds will be utlized to support program management and personnel costs for integrated care.

- **Mobile Medical (Grant Award: $136,000)**
  Jurisdiction: Montgomery County
  Grant funds enabled Mobile Medical to increase access to primary care and integrate behavioral health care services in a model that leveraged grant funding with existing County resources. Grant funds will be utlized to open a new primary care clinic in Rockville which is co-located with existing behavioral health care services provided by Montgomery County.

- **Mosaic (Year One Grant Award $300,000)**
  Jurisdiction: Baltimore City
  Grant funds promoted access to bi-directional, integrated health care by "co-locating" Mosaic behavioral health professionals and Baltimore Medical Systems (BMS) primary care services in four clinic locations. CHRC grant funding will be utilized to support two physicians and two full time care managers to implement the integrated model at two BMS locations and two Mosaic locations. Services include somatic, case management, addiction and behavioral health, which are traditionally provided across "siloed" programs.

- **Walden Sierra (Grant Award: $250,000)**
  Jurisdiction: Southern Maryland
  Grant funds enabled a pilot program co-locating behavioral health services with primary care partners serving low-income and uninsured individuals. Grant funds will be utlized to support personnel costs to provide primary care services and to support clinical space for Walden Sierra behavioral health care providers.

- **Way Station Inc. (Grant Award: $170,000)**
  Jurisdiction: Baltimore County
  Grant funds enabled Way Station to pilot a new service model which integrated three evidenced-based practices to improve the effectiveness of behavioral health care and primary care services for low income individuals with serious and persistent mental illness and co-occurring disorders. Grant funds will be utilized to support personnel costs to support the new pilot program.

- **Worcester County Health Department (Year One Grant Award $250,000)**
  Jurisdiction: Worcester County
  Grant funds developed an integrated behavioral health unit in Worcester County by adding access to primary care services in an existing behavioral health facility, providing screening and preventive services. CHRC grant funds will be utilized to support the salary costs of one nurse practitioner, one community health nurse, one health services clerk, and one community health worker. The new unit will provide team-based care and access to publicly supported psychiatrists and therapists.

Focus Area: PROMOTING CAPACITY OF SAFETY NET PROVIDERS

- **Access Carroll (Year One Grant Award $125,000)**
  Grant funds promoted the long-term financial sustainability of the grantee, a free clinic in Westminster, as it transitioned to a revenue model that involves billing third-party payers. Grant funds will be utilized to hire a full time biller/coder and consultant help to design and implement billing systems and enhance the use of its IT system.

- **Allegany County Health Department (Year One Grant Award $30,000)**
  Jurisdiction: Allegany County
  Grant funds addressed workforce challenges in this rural area of the state by supporting a "behavioral health learning collaborative" that provided training and technical assistance to providers in the region. Grant funds will be utilized to support the start-up costs of the collaborative, which will provide access to training and technical assistance and enable behavioral health providers to participate in Maryland's ongoing efforts to promote functional behavioral health integration.

- **Health Partners (Year One Grant Award $110,000)**
  Jurisdiction: Charles County
  Grant funds promoted the long-term financial sustainability of the grantee, a free clinic in Waldorf, as it transitions to a revenue model that involves billing third-party payers. Grant funds will be utilized to support the salary costs of four new health clinicians in a patient-centered medical home model.

- **Omini House Behavioral Health System (Grant Award: $150,000)**
  Jurisdiction: Anne Arundel County
  Grant funds supported the implementation of an electronic medical records system at Omni House's Day Program, Residential Program, and clinic. Grant funds will be utilized to provide technology training for data migration, staff training, and installation of new hardware and software systems.

- **Prince George's Health Department (Grant Award: $75,000)**
  Jurisdiction: Prince George's County
  Grant funds supported a comprehensive plan to implement electronic health records and associated functionality in the health department's nine clinics. The overall goal of the program is to facilitate EHR adoption that will increase the health department's efficiency, capacity, and quality in the county's communicable disease and maternal and child health clinics.

Focus Area: EXPANDING ACCESS TO PRIMARY CARE IN UNDERSERVED AREAS

- **Catholic Charities- Esperenza Center (Grant Award: $219,400)**
  Jurisdiciton: Baltimore City
  Grant funds enabled Catholic Charities to expand the successful Asociación Comunidad Saludable (ACS) Project that increased access to care for underserved populations. Grant

funds will be utilized to hire a full-time nurse practitioner who provides primary care visits to children and adults.

- **Community Clinic Inc. (Grant Award: $280,000)**
  Jurisdictions: Montgomery and Prince George's County
  Grant funds enabled Community Clinic to expand services for high-risk patients in Montgomery and Prince George's Counties by supporting the integration of Community Health Workers and other staff into its primary care clinical program. Grant funds will be utilized to support the new Community Health Worker program.

- **West Cecil Community Health Center (Year One Grant Award $180,000)**
  Jurisdiction: Cecil County
  Grant funds supported expanding access in a Medically Underserved Area in Harford County. Grant funds will be utilized to support the start-up operational costs of opening a new Federally Qualified Health Center site that will serve residents of Cecil and Harford Counties.

- **Health Care Access Maryland (Year One Grant Award $200,000)**
  Jurisdiction: Baltimore City
  Grant funds helped target individuals with chronic disease conditions who frequently utilize hospital departments and promoted access to primary and preventative care services in the community. Grant funds will be utilized to support new ED diversion teams deployed in one Baltimore City hospital (Sinai).

- **Health Care for the Homeless (HCH) (Year One Grant Award $140,000)**
  Jurisdiction: Baltimore City
  Grant funds supported an emergency department diversion/referral program that will target homeless individuals in Baltimore City who utilize hospital emergency departments at high rates and establish a "medical home" for these individuals. CHRC grant funds will be utilized to enable the grantee to implement an emergency room diversion team, partner with three Baltimore hospitals, facilitate access to comprehensive primary and preventative care services, and promote health insurance enrollment for homeless individuals in Baltimore.

- **Mobile Medical Care Aspen Hill Multicultural Clinic (Year One Grant Award $180,000)**
  Jurisdiction: Montgomery County
  Grant funds supported the opening of a multicultural, safety net health clinic in Aspen Hill, a Medically Underserved Area of Montgomery County. Grant funds will be utilized to open the new clinic and expand access for a highly diverse and underserved area of Montgomery County.

- **Shepherds Clinic (Grant Award: $160,000)**
  Jurisdiction: Baltimore City
  Grant funds supported a nonprofit that targeted the medical needs of the uninsured by offering afforable primary and diagnostic health care services to low-income adults without

any health care coverage. Grant funds were utilized to fund part-time clincial staff and I.T./EHR Specialist to oversee the organization's transition to electronic health records.

Focus Area: ADDRESSING CHILDHOOD OBESITY

- **University of Maryland-Baltimore Department of Pediatrics (Year One Grant Award $195,000)**
  Jurisdiction: Baltimore City
  Grant funds reduced rates of childhood obesity by engaging three public schools in the Promise Heights neighborhood of West Baltimore. Grant funding will be utilized to support efforts to promote adoption of healthy lifestyle choices and increase physical activity, including the development of home and school environments that support those healthy choices. A secondary goal of the program is to develop an inter-professional pediatric obesity prevention training program for future leaders in medicine, nursing, and social work. CHRC grant funding will support the salary costs for a full-time program manager, partial clinical coordinator, research assistant, and minimal funding for Community School Coordinators.

- **Baltimore City Health Department (Year One Grant Award $275,000)**
  Jurisdiction: Baltimore City
  Grant funds supported efforts to reduce childhood obesity by addressing food insecurity for residents in known food deserts throughout the city. Grant funds will build on the current Virtual Supermarkets Program, a national, award-winning program that uses online grocery ordering and delivery, to bring food to community sites in food desert neighborhoods. The program will engage corner stores to provide retail options for affordable, healthy food options.

- **Somerset County Health Department (Year One Grant Award $50,000)**
  Jurisdiction: Somerset County Grant funds support a public outreach campaign that will build community awareness and support for healthy lifestyle choices to reduce rates of childhood obesity. Grant funds will be utilized to create new after-school opportunities for physical activity, expanded access to affordable healthy food options, and provide home visitation and health coaching for youths between the ages of 4 and 18 deemed at highest risk of obesity by their health care provider.

Appendix D

STATE OF MARYLAND
Community Health Resources Commission
45 Calvert Street, Annapolis, MD 21401, Room 336
Office (410) 260-6290 Fax No. (410) 626-0304

State Health Improvement Process:

Supporting Local Health Improvement Coalitions to Fuel Local Action and Improve Community Health

Call for Proposals

May 1, 2013

I. Overview

The Maryland Community Health Resources Commission (CHRC) was created by the Maryland General Assembly to expand access to affordable, high-quality health care services for every Marylander and help address the unmet health care needs of underserved communities. Since its inception in 2005, the CHRC has awarded 115 grants, totaling $29.6 million, supporting programs in all 24 jurisdictions of the state. These grants have collectively provided health care services for approximately 110,000 Marylanders. The grant funding provided by the Commission has enabled its grantees to leverage $10.1 million in additional federal and private/non-profit resources. Grants awarded by the Commission have expanded access to comprehensive women's health services to support the Governor's goal of reducing infant mortality rates; have increased access to dental services for low-income children; have promoted the integration of behavioral health services in the community; have expanded primary care capacity in underserved areas; and have promoted the adoption of health information technology by Maryland's safety net providers.

The CHRC is working with the Maryland Department of Health and Mental Hygiene (DHMH) to implement the Maryland Health Improvement and Disparities Reduction Act of 2012, legislation that created the Health Enterprise Zones Initiative. Five Zones designated by the state earlier this year will help expand access to health care services in communities facing tremendous health care challenges, will help address persistent health care disparities, and will help reduce health care costs by reducing preventable hospital admissions and re-admissions.

The statutory mission of the CHRC and its work to build capacity in Maryland's safety net infrastructure gains greater importance as Maryland prepares to implement the Affordable Care Act (ACA). The CHRC will be working very closely with DHMH, Maryland's Health Benefit Exchange (MHBE), local health departments, and safety net providers to build capacity and meet the expected demand for primary, preventative, and specialty care services by the estimated 250,000 Marylanders who will become eligible for health insurance in 2014.

Improving the health of Marylanders through local action and partnerships with community health resources is a mutual goal of the CHRC and DHMH. In support of the State Health Improvement Process (SHIP), which was launched by DHMH last year, the CHRC awarded 17 grants in FY 2012, totaling $600,000, to support the work of Local Health Improvement Coalitions (LHICs). The grants supported targeted population health interventions and fueled innovative LHIC partnerships with community health resources.

In the 2013 LHIC Call for Proposals, the CHRC will be making available a potential total of $1,200,000 (funding across FY 2013 and FY 2014) to continue to support the efforts of LHICs to improve population health in their communities, support continuous quality improvement activities, and build on innovative partnerships with community health resources. Unlike last year's LHIC Call for Proposals, the CHRC will be awarding grants exclusively on a **competitive** basis this year. Please see page 4 of this Call for Proposals for the review criteria that will be utilized by the Commission this year. Based on available funding, grant awards issued by the CHRC are expected to range from $150,000 to $250,000 each, and LHIC applicants are encouraged to develop and submit proposals for projects or programs to be implemented over a 12-16 month period, beginning this summer (2013). Funding requests below $150,000 will also be considered by the CHRC.

In the 2013 Call for Proposals, the CHRC will provide special consideration for projects that continue to support LHIC capacity in the following areas: (1) Facilitate the development of interconnected, comprehensive, patient-centered systems of care; (2) Promote LHIC collaboration and data sharing across multiple types of community health resources and efforts to use this data to improve community health outcomes; (3) Encourage innovative partnerships and programs that will expand access for underserved communities and address health disparities in the region/jurisdiction; (4) Identify potential cost savings or a return on investment (ROI) and suggest methods where these cost savings could be re-invested to support sustainability; and (5) Align with the Community Integrated Medical Home (CIMH) concept, as articulated in DHMH's proposal for the State Innovation Model (SIM) grant recently awarded to Maryland. Suggested areas of focus or specific types of projects for consideration by LHIC applicants are provided on pages 3-4 of this Call for Proposals.

II. Key Dates to Remember

The following are the dates and deadlines for this Call for Proposals.

May 1, 2013	**Release Call for Proposals**
May 9, 2013 9:30 a.m.	**Question & Answer Conference Call** **Dial in number: 1.866.247.6034** **Conference code: 4102607046**
May 30, 2013 5:00 p.m.	**Deadline for submission of Proposals to CHRC**
June 26, 2013	**A select number of applicants invited to present to CHRC; awards will be made following presentations**

II. Grant Eligibility

What is a Community Health Resource?

Pursuant to Health-General §19-2102 *et seq*. and its implementing regulations, the Commission may only award grants to an entity that meets the definition of a "community health resource." "Community health resource" is defined in Maryland Health-General §19-2102 (d)(1) to include specific examples of entities or programs meeting this definition, as well as "any other center or program identified by the Commission as a community health resource." The Commission has explicitly recognized a local health department as a "community health resource" in its regulations found at COMAR 10.45.05.

Given that each LHIC by its nature includes at least one local health department, the statutory definition of "community health resource" found at COMAR 10.45.05 is met. Similar to last year's Call for Proposals, **only Local Health Improvement Coalitions are eligible to respond to the 2013 Call for Proposals.** While the Commission typically requires an entity submitting a proposal to provide documentation showing that it meets the "community health resource" definition, such documentation is ***not necessary*** as part of the response to the 2013 Call for Proposals.

III. Requirements in the 2013 Call for Proposals

In keeping with the CHRC's overall support of the State Health Improvement Process (SHIP), LHIC applicants will be required to provide a copy of their updated Local Health Action Plan and provide documentation demonstrating how the activities in this year's grant proposal will facilitate the achievement of the measurable core goals identified in the Local Health Improvement Plan.

In addition, LHIC applicants will be **required** to identify a **10% local match** in their proposal this year by providing a letter of commitment confirming that at least 10% of the overall grant request will be supported with local backing such as a contribution by a hospital, foundation, or other resource (in addition to the CHRC grant). For example, if the overall LHIC grant request is $200,000, then at least 10% ($20,000) of the $200,000 (making a total budget of $220,000) must be provided in a local match. The CHRC may consider in-kind contributions to count towards this 10% matching requirement, but these requests by LHICs will be evaluated on a case-by-case basis by the Commission.

IV. The Grants Program- Specific Types of Projects

Following are examples of types of projects that the CHRC is looking to support in this year's Call for Proposals. LHIC applicants may utilize one or several of the following types of projects in this year's Call for Proposals.

- ***Projects that will support specific population health/community health interventions and reflect the main goals of the LHIC and its local health improvement plan.*** These efforts would support new activities of the LHIC (beyond activities currently implemented by the LHIC), reflect priority areas identified by the LHIC based on SHIP data, and demonstrate the ability to improve LHIC performance in areas where the region/jurisdiction shows the potential for improvement in community health.

- ***Projects that will build the capacity of LHICs for continuous quality improvement efforts through important primary (e.g., care coordination) and secondary (e.g., performance monitoring) uses of health data.*** The efforts could include establishing innovative partnerships or programs involving multiple types of providers (such as community health resources, hospitals, and others), facilitating data sharing and data integration across multiple types of providers, and/or utilizing data provided by CRISP to drive continuous quality improvement efforts and support population health improvement.

- ***Projects that will facilitate the integration of public health, social services, and other community health resources with the health care delivery system to address social determinants of health***. These efforts could include using grant funds to hire non-traditional professionals like community health workers by the LHIC or other community health resources to integrate schools and public housing as potential sites of care delivery and to support comprehensive case management services in the region/jurisdiction. These efforts might also include innovative partnerships among health care providers, Patient Centered Medical Homes (PCMHs), social services organizations and other local partners to help address social determinants of health. These partnerships might incorporate comprehensive care management service models and identify methods to capture cost savings through reductions in hospital admissions/re-admissions and re-deploying these savings to promote long-term sustainability of the model. One example of such a partnership

can be found in the Camden Coalition in New Jersey, which identifies individuals with complex health and social service needs, coordinates and ensures the delivery of the full array of health and other social needs, and helps achieve cost savings by removing barriers in accessing health care services in the community. The Camden Coalition of Healthcare Providers website can be found at http://www.camdenhealth.org/. Additional information about the work of the Camden Coalition and other organizations integrating public health, social services, and community health resources to address social determinants of health can be found in an article in *The New Yorker* entitled "The Hot Spotters," which can be found at http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande?currentPage=all.

V. Review Criteria

As stated previously, the CHRC will be awarding grants on a **competitive** basis this year. LHIC proposals will be evaluated on the following review criteria, and a select number of the highest-scoring applicants will be invited to present to the CHRC on June 26, 2013 in Annapolis.

1. The proposal clearly indicates what the areas of greatest population health need are within the geographic area, provides data to support those claims, and puts forth evidence-based or innovative interventions that are likely to address those needs;
2. The proposal leverages community health resources (in addition to local health departments) and facilitates innovative partnerships among multiple providers, especially among partners that may not have been part of the LHIC previously;
3. The proposal includes a post-CHRC award sustainability plan for maintaining LHIC activities and has a high degree of enabling the LHIC or providers in the region/jurisdiction to participate in the future Community Integrated Medical Home (CIMH) Initiative;
4. The proposal includes strategies that will assist in building a collaborative, interconnected, and efficient health care system at the local/regional level;
5. The proposal supports continuous quality improvement efforts, clearly indicates what the core goals are, articulates the core goals as measurable outcomes, and includes a statement defining baseline performance on those measures. The proposal should also include a clear evaluation plan to ensure that the goals of the proposal are met;
6. The proposal includes specific strategies to address unmet health needs of low-income, uninsured, and underinsured populations;
7. The proposal helps reduce health disparities in the region/jurisdiction and advances the overall concept of health equity; and
8. The proposal assists the state's overall implementation of the Affordable Care Act by expanding access for Marylanders who will become eligible for health insurance in 2014.

VI. Evaluation and Monitoring

As a condition of receiving any grant funds, LHIC grantees must agree to participate in an ongoing evaluation of the grants program, which will be discussed with successful LHIC applicants post-award. Compliance with these reporting requirements will be considered in future LHIC grant opportunities provided by the CHRC.

VII. Use of Grant Funds

CHRC funds must be used to help LHICs implement Local Health Action Plans, in part or in their entirety. **Requests for CHRC grant funds that are not directly supported/evidenced by**

the Local Health Action Plans will not be considered. CHRC grant funds may be used for project staff salaries and fringe benefits, consultant fees, data collection and analysis, conference calls and meetings, and office supplies and expenses. **Indirect costs are limited to 10% of the total direct costs of the proposed actions**. CHRC grant funds may also be expended for a limited amount of essential equipment and supplies required by the LHIC. CHRC grantees may subcontract with other organizations as appropriate to accomplish the goals of the LHIC proposal. Any one LHIC subcontract for more than $10,000 requires **prior** approval of the Commission (post-award). If the services in the proposal will be delivered by a contractor agency rather than directly by the LHIC, the LHIC may **not** take a fee for passing through the funds to the contractor entity. CHRC grant funds may **not** be used for major equipment or new construction projects, to support clinical trials, or for lobbying or political activity.

VIII. How to Apply

The deadline for submitting proposals is **5:00 p.m. EDT on May 30, 2013**. The CHRC will review the materials to determine if all necessary items are provided.

Please review the Table **CHRC FY2013 LHIC Application Check List** on page 9 and include all required items/materials for the funding in one proposal package. Information on each of the required documents and materials for the funding proposals is detailed below.

A. Required Proposal Items

All LHICs must submit the following items to be eligible for the funding awards (please submit these documents/items in the order listed below):

(1) Grant Application Cover Sheet: This form is located in the Appendix section of this Call for Proposals and also can be accessed by visiting the Maryland Community Health Resources website (http://www.dhmh.maryland.gov/mchrc) and clicking on "Forms" on the left side menu.

(2) The LHIC Local Health Action Plan: Include a copy of the most recent Local Health Action Plan and a clear demonstration of how requested grant funds from the CHRC will support the core goals of the latest Plan.

(3) Project Narrative: The Project Narrative should be succinctly written and be approximately 10 to 12 pages in length (not including attachments such as the Local Health Action Plan, budget, or key staff involved with the project). The proposal should clearly state specific action items in the LHIC Local Health Action Plan that will be implemented, in part or in its entirety, using CHRC grant funds. This proposal should focus on the key action steps that will be supported with CHRC grant funding and will be undertaken over the next 12-16 months and should address priority areas or action steps in the Local Health Action Plan. An applicant is encouraged to address the 8 review criteria (listed on page 4 of this Call for Proposals). In addition, this proposal must include evaluation measures that will assess whether the LHIC's funding proposal's objectives and milestones have been achieved.

(4) Post-CHRC Funding Sustainability Plan: LHICs must include information on how the coalition will sustain actions initially supported by CHRC grant funds once these grant funds have been expended. The Sustainability Plan should be one page or less.

(5) Project Budget: LHICs must provide a budget and budget for the total grant request. LHICs must use the Project Budget Form provided in the Appendix section of the 2013 Call for Proposals followed by a line-item budget justification detailing the purpose of each budget item (the line-item budget justification is a simple list of expenditures and a one-sentence description for each expenditure). The budget request should be between $150,000 and $250,000 and support a program to be implemented over a 12-16 month period. The amount of the grant awards will be determined by the CHRC following presentations on June 26, 2013. Funding requests below $150,000 will also be considered by the CHRC.

The CHRC Project Budget Form includes the following line item areas:

a) *Personnel:* Include the percent effort (FTE) and title of the individual.
b) *Personnel Fringe*: Fringe benefits should be shown at the LHIC lead LHD's standard rate.
c) *Equipment/Furniture:* Small equipment and furniture costs.
d) *Supplies*
e) *Travel/Mileage/Parking*
f) *Staff Trainings/Development*
g) *Contractual:* Contracts for more than $10,000 require prior approval of the Commission.
h) *Other Expenses:* Other miscellaneous expenses or other program expenses that do not fit the other categories should be placed here. Detail each different expense in this area in the budget justification narrative.
i) *Indirect Costs:* Indirect costs may not exceed 10% of direct proposal costs.
j) *Matching funds:* The LHIC is required to confirm that at least 10% of the overall CHRC grant request is provided in matching funds. **LHICs must provide a copy of a signed letter of commitment from the organization(s) contributing the matching funds.**

(6) Key staff. The proposal should indicate the key staff who will be involved in implementing and evaluating the proposal. If the LHIC engages outside consultants or participating partners (external to the LHIC), these staff should be identified in the proposal. The specific roles, duties, and responsibilities should be provided in the proposal. Accompanying biographies or C.V.s may be included as well.

B. Additional Information

Proposals must be single spaced on standard 8 ½" x 11" paper with one-inch margins and using 12-point Times New Roman or Arial font. Tables and charts may use a 10-point font or larger. All pages of the proposal must be numbered.

The CHRC requires:

(1) Five original applications, including all required materials for the request funding application in one package. The hard copy original should be bound with two-prong report fasteners or with clips. If two-prong fasteners are used, cardboard or plastic covers and backs can be used. Do not send three ring binders or spiral bound proposals. Please send the hard copy original to:

Mark Luckner, Executive Director
Maryland Community Health Resources Commission
45 Calvert Street, Room 336
Annapolis, MD 21401

(2) One electronic copy of all the application materials should be emailed to edith.budd@maryland.gov. In the subject line of the email, please state the coalition's full name and the following reference: "LHIC 2013 Call for Proposals".

Grant proposals, both original hard copy and electronic copy, are due at the Commission's offices by 5:00 p.m. on Thursday, May 30, 2013.

IX. Inquiries

Conference Call for Applicants: The CHRC will host a conference call on May 9, 2013 at 9:30 am for interested applicants to provide information on the grants program and assistance with the application process. The dial in number for the conference call is 1.866.247.6034. The conference code is 4102607046. Participation in this conference call is ***optional.***

Questions from Applicants: Applicants may also submit written questions about the grants program. Send questions to Mark Luckner (mark.luckner@maryland.gov). Questions may be submitted at any time.

The Maryland Community Health Resources Commission

The *Community Health Care Access and Safety Net Act of 2005* became law on May 10, 2005. The law authorized establishment of the 11-member Maryland Community Health Resources Commission to help communities in Maryland improve access to care for low-income families and under- and uninsured individuals. The Commissioners are appointed by Governor Martin O'Malley.

Commissioners

John A. Hurson, Chairman
Charlene M. Dukes, Ed.D.
Kendall D. Hunter
Sue Kullen
Paula McLellan
Nelson Sabatini, Vice Chairman
Maria Harris-Tildon
William Jaquis, M.D.
Mark Li, M.D.
Margaret Murray, M.P.A.

CHRC Staff:

Mark Luckner, Executive Director
E-mail: mark.luckner@maryland.gov

Edith Budd, Administrator
E-mail: edith.budd@maryland.gov

Telephone: (410) 260-6290
Fax: (410) 626-0304
Website: http://www.dhmh.maryland.gov/mchrc

CHRC FY13 LHIC Application Check-List

Required Items

1. **Grant Application Cover Sheet – required.**

2. **Copy of updated Local Health Action Plan – required.**
   The LHIC should include a copy of the most recent Local Health Action Plan (it may be the same document supplied to DHMH). The grant proposal should include a clear demonstration of how requested grant funds from the CHRC will support the core goals of the latest Plan.

3. **Project Narrative – required.**
   The Project Narrative should clearly and succinctly describe how requested grant funds will be utilized by the LHIC and how the activities supported with CHRC grant funds will enable the LHIC to achieve the core goals of the Local Health Action Plan. The Project Narrative should be no more than 10-12 pages. The Project Narrative must also include evaluation measures and address the eight criteria listed on page 4 of the Call for Proposals. The page limit requirement only pertains to the Project Narrative; it does not include the Application Cover Sheet, Local Health Action Plan, Sustainability Funding Plan, or Project Budget Form and Budget Justification.

4. **Post-CHRC Funding Sustainability Plan – required.**
   LHICs must include information on how the coalition will sustain actions initially supported by CHRC grant funds once these grant funds have been expended. The Sustainability Plan should be no more than one page.

5. **Project Budget Form and Budget Justification – required.**
   This budget must reflect action strategy/ies that the CHRC's funding will support. The amount and source of matching funds must be included in the Project Budget Form. Please note the 10% matching funds requirement.

6. **Letter of Commitment for Matching Funds - required.**
   LHICs must provide a copy of signed letter of commitment from the organization(s) contributing the matching funds.

Additional items that may be included (optional)

7. **Key Staff – optional.**
   Biographies or C.V.s of key staff may be included. The inclusion of these materials will not be counted towards the overall page limit for the Project Narrative.

STATE OF MARYLAND
Community Health Resources Commission
45 Calvert Street, Annapolis, MD 21401, Room 336
Office (410) 260-6290 Fax No. (410) 626-0304

LHIC Grant Application Cover Sheet FY 2013-FY 2014

State Health Improvement Process: Supporting Local Health Improvement Coalitions (LHICs) to Fuel Local Action and Improve Community Health

LHIC Designated Applicant Organization:

Name of Organization: _____

Federal Identification Number (EIN): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

LHIC Official Authorized to Execute Grants/Contracts:

Name: _____

Title: _____ E-mail: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____

LHIC Project Director (if different than the official authorized to execute contracts)

Name: _____

Title: _____ E-mail: _____

Phone: _____ Fax: _____

Overall LHIC Grant Funding Request:

(Range of $150,000 to $250,000 may be provided by CHRC on a <u>competitive</u> basis; funding requests below $150,000 will also be received and considered).

Project Budget Form for LHIC Grant Funding Request	
MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION	
State Health Improvement Process: ***Supporting Local Health Improvement Coalitions (LHICs) to Fuel Local Action and Improve Community Health***	
LHIC/Organization Name:	
Project Name:	
Budget Request for CHRC Grant Funding	**Amount of Request**
Personnel Salary	
% FTE - Title	
% FTE - Title	
% FTE - Title	
Personnel Subtotal	
Personnel Fringe (% - Rate)	
Equipment/Furniture	
Supplies	
Travel/Mileage/Parking	
Staff Trainings/Development	
Contractual	
Other Expenses	
Indirect Costs (no more than 10% of direct costs)	
Matching Funds – at least 10% of the overall CHRC grant request must be provided in matching funds	
Total	

Appendix E

Appendix E:

Local Health Improvement Coalition FY 2013 Grantees

- **Allegany County Health Department (Grant award: $185,048)**
  This proposal seeks to reduce health disparities and address social determinants of health by deploying community health workers to link patients to community resources. Grant funds will be utilized to create a community resource guide, to support cultural competency provider training, and to provide access to subsidized transportation services.

- **Cecil County Health Department for Cecil County Community Health Advisory Committee (Grant Award: $189,659)**
  This proposal seeks to reduce behavioral health-related visits to Union Hospital by embedding a nursing case management program in the hospital to link patients with services in the community. The grant also supports a mobile mental health crisis program in Cecil County, which is supported by Cecil County Government (in addition to CHRC grant funding).

- **The Partnerships for a Healthier Charles County (Grant award: $159,756)**
  This proposal seeks to expand access to primary care services in an underserved area in western Charles County and utilizes CHRC grant funds to establish a new Patient-Centered Medical Home (PCMH) in Nanjemoy.

- **Harford County Health Department (Grant award: $250,000)**
  This proposal seeks to improve overall health outcomes for high-risk residents by providing comprehensive coordinated care and preventative mental health services to decrease ED utilization. Grant funds will be utilized to hire three clinical nurse social workers and to expand the Comprehensive Women's Health Project care coordination model to 3 additional sites.

- **Howard County Local Health Improvement Coalition (Grant award: $250,000)**
  This proposal seeks to increase access to health care and enhance chronic disease prevention by utilizing "hotspotting" data analysis and targeting resources to address the complex health needs of individuals identified in this analysis. Grant funds will be utilized to establish a community health worker program; increase the number of PCMHs in the community; and create shared savings blueprint.

- **Montgomery County Department of Health and Human Services (Grant award: $236,672)**
  This proposal seeks to promote obesity prevention efforts and reduce behavioral health-related ED visits. Grant funds will be utilized to promote comprehensive care coordination efforts.

- **Tri-County / Worcester County Health Department (Grant award: $250,000)**
  This proposals targets diabetes-related hospital ED visits and develops a comprehensive care coordination model to link frequent ED users with access to primary care services in the

community. The model leverages community partnerships and addresses social determinants of health in the Lower Shore. Grant funds will be utilized to develop and implement regional diabetes care management teams to assist diabetic patients in gaining access to a range of health care and social support resources.

Appendix F

STATE OF MARYLAND
Community Health Resources Commission
45 Calvert Street, Annapolis, MD 21401, Room 336

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

Health Enterprise Zones

Call for Proposals

October 5, 2012

Table of Contents

I. Executive Summary

The state of Maryland has numerous advantages for its residents to enjoy good health care, such as the 3rd highest median household income; the 2nd highest number of primary care physicians per capita; the 10th lowest rate of smoking; and outstanding medical schools. Despite these advantages, Maryland continues to lag behind other states on a number of key health indicators, such as ranking 43rd in infant mortality, 31st in early prenatal care, 28th in obesity prevalence, 31st in diabetes prevalence, 35th in cardiovascular deaths, 32nd in cancer deaths, and 33rd for geographic health disparities.

In recognition of these unacceptable disparities, Lieutenant Governor Anthony G. Brown, as Chair of the Maryland Health Quality and Cost Council, established the Health Disparities Work Group, led by Dean E. Albert Reece, M.D, Ph.D., M.B.A. of the University of Maryland School of Medicine. The Work Group issued its final report in January 2012, which provided several recommendations for best practices, monitoring, and financial incentives for the reduction of disparities in Maryland's health care system. The Work Group developed bold recommendations, including the concept of utilizing enterprise zones typically used to drive economic development, and applied this principle in the field of public health and health disparities. The Work Group concluded that improvement in overall health in communities and reductions in health care costs may be achieved by saturating underserved communities with primary care providers and other essential health care services.

The recommendations of the Maryland Health Quality and Cost Council provided the structure for legislation, The Maryland Health Improvement and Disparities Reduction Act of 2012 (SB 234/Chapter 3 of 2012), which was approved by the Maryland General Assembly and signed into law on April 10 by the Governor. The Act combats continued health disparities and attempts to improve public health in underserved communities by creating the framework for the establishment of Health Enterprise Zones (HEZ), contiguous geographic areas that demonstrate measurable and documented health disparities and poor health outcomes and that are small enough for the incentives in this program to have a significant impact on improving health outcomes and reducing health disparities. The purpose of the HEZ Initiative is to target state resources to:

- Reduce health disparities among racial and ethnic minority populations and among geographic areas;
- Improve health care access and health outcomes in underserved communities; and
- Reduce health care costs and hospital admissions and re-admissions.

The HEZ Initiative is a new, four-year pilot program, and the FY 2013 budget provides $4 million in new funding to the Community Health Resources Commission (CHRC) to support the activities of HEZs. Through this Call for Proposals, communities may apply for HEZ designation, which will enable access to a range of incentives which include state income tax credits; hiring tax credits; loan repayment assistance; priority entrance into the state's Patient Centered Medical Home Program; priority for available state electronic health record (EHR) grant funding; additional grant funding from the CHRC; and capital grant support. Applicants seeking HEZ designation may draw upon any or all of these incentives when developing their

intervention strategies to address health disparities, to expand access, and to help attract needed health care practitioners into the area. The application for HEZ designation will be a combination of **both** demonstrated need and intervention strategies to improve health outcomes in the potential HEZ.

The HEZ Initiative will be jointly administered by the Maryland Department of Health & Mental Hygiene (DHMH) and the CHRC. The Commission is issuing this HEZ Call for Proposals, will evaluate applications requesting HEZ designation, and will provide recommendations to the DHMH Secretary. Final HEZ designation decisions will be made by the Secretary by the end of calendar year 2012. It is anticipated that the state will award between two to four Zones in this first year of the program.

An internal steering committee led by DHMH Secretary Joshua M. Sharfstein, M.D., comprised of DHMH, Lt. Governor, and CHRC staff, was established to help guide implementation of the HEZ Initiative. The committee received guidance and input from several external sources including the Health Disparities Collaborative, which included more than 175 Marylanders participating in five committees.

In addition, a public comment period was launched in the summer of 2012, and the following three documents were distributed in draft form to solicit public feedback:
1. Threshold eligibility criteria for communities seeking HEZ designation;
2. Additional benefits that could be provided by the state to assist HEZ awardees; and
3. Principles that will be used to review HEZ applications.

The committee received more than 150 comments which led to a range of changes in the implementation plan and are summarized in a Joint Chairmen's Report submitted in August to the Maryland General Assembly (this report is available at http://dhmh.maryland.gov/healthenterprisezones/SitePages/Updates.aspx). In addition, public forums were held earlier this year in Baltimore City, Montgomery, Prince George's, and Charles Counties, the Eastern Shore, and western Maryland. The public comment period and these public forums informed the development of this Call for Proposals.

Key Dates

October 11, 2:30 PM	Proposal Question & Answer Conference Call Dial-In Number: (866) 233-3852 Participant Access Code: 267478
October 19, 5:00 p.m.	Initial Letters of Interest are due to the CHRC
November 13, 12:00 p.m.	HEZ Proposals due to the CHRC
December 11	Select applicants invited to present at CHRC meeting
December 21	DHMH Secretary makes HEZ designations

Overview of the CHRC
The Maryland Community Health Resources Commission (CHRC) was created by the Maryland General Assembly when it approved the *Community Health Care Access and Safety Net Act of 2005* legislation to expand access to health care for low-income Marylanders and underserved communities in the state and bolster Maryland's health care safety net infrastructure. The CHRC is a quasi-independent commission operating within the DHMH, and its 11 members are appointed by the Governor. In creating the Commission, the Maryland General Assembly recognized the need for having an independent commission that focused on strengthening the state's diverse network of community health centers and safety net providers and addressed service delivery gaps in Maryland's dynamic health care marketplace.

Over the last seven years, the Commission has awarded 110 grants totaling approximately $26.3 million, supporting programs in every jurisdiction of the state. These 110 programs have collectively served more than 105,000 underserved Marylanders. The CHRC has awarded grants 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. Program sustainability is a top priority of the Commission, and CHRC grantees have used initial grant funds to leverage more than $10 million in additional federal and private funding sources to support their programs.

II. Information for Health Enterprise Zone Applicants

The designation of HEZ status will enable access to a range of incentives to support strategies to address health disparities, to expand access, and to help attract needed health care practitioners into the HEZ. Incentives and benefits include state income tax credits; hiring tax credits; loan repayment assistance; priority entrance into the state's Patient Centered Medical Home Program; priority for state EHR grant funding; additional grant funding from the CHRC; and capital grant support. These benefits and incentives are described in greater detail on page six. The purpose of the HEZ Initiative is to target state resources to:

- Reduce health disparities among racial and ethnic minority populations, and among geographic areas;
- Improve health care access and health outcomes in underserved communities; and
- Reduce health care costs and hospital admissions and re-admissions.

HEZ applicants are expected to submit applications which demonstrate the needs of the community, provide a comprehensive plan to address these needs, and achieve the overall policy goals of the HEZ Initiative. Eligible applicants should develop strategies using the benefits and incentives available to designated HEZs described in this Call for Proposals.

Community Eligibility
An HEZ is a community or a cluster of contiguous communities that are comprised of one or more zip codes. In order to be designated an HEZ, the proposed zip code(s) within a potential HEZ area must meet <u>each</u> of the following four criteria:

1. An HEZ must be a community, or a contiguous cluster of communities, defined by zip code boundaries (one or multiple zip codes);
2. An HEZ must have a resident population of at least 5,000 people;
3. An HEZ must demonstrate economic disadvantage by having either:
   a) a Medicaid enrollment rate above the median value for all Maryland zip codes; or
   b) a WIC participation rate above the median value for all Maryland zip codes.
4. An HEZ must demonstrate poor health outcomes by having either:
   a) a life expectancy below the median value for all Maryland zip codes, or
   b) a percentage of low birth weight infants above the median value for all Maryland zip codes.

A proposed HEZ made up of multiple zip codes must meet these criteria in each zip code if the values are known. ***Applicants are permitted to propose an alternative approach in eligibility determinations, using sub-zip code geographic bounds*** *(e.g. Census Tracts, Public Use Microdata Areas),* ***if the following criteria are met****:*

1. The area proposed is contiguous geographically;
2. The population in the proposed area is at least 5,000; and
3. The zip code(s) where the sub-zip code geographic bounds are located must meet the criteria for demonstrating economic disadvantage and poor health outcomes.

Data regarding the economic disadvantage and poor health outcomes, by zip code, has been compiled by DHMH and is available at: http://eh.dhmh.md.gov/hez/index.html. ***Applicants seeking designation status for sub-zip code geographic bounds will be required to provide data confirming eligibility for economic disadvantage and poor health outcomes.***

Letters of Interest are due to the CHRC no later than 5:00 p.m., October 19, 2012, but will be accepted and reviewed on a **rolling basis**. Applicants are encouraged to submit the Letter of Interest as soon as it ready, and not wait until October 19. The CHRC will review the Letters of Interest and Eligibility Worksheets (see Appendix Item A) as soon as is possible, certify each applicant's eligibility, and contact eligible applicants to submit the full application, hopefully within 48 hours of submission of LOI. Once eligibility is certified and applicants are notified, LOIs will be posted on the HEZ website. The full grant application is due to the CHRC no later than 12:00 p.m., November 13, 2012. For a more detailed description of the LOI, please see page 11 of this Call for Proposals.

Organizations Eligible to Apply for HEZ Designation on Behalf of a Community
An applicant for this Call for Proposals must be either a local government entity or a non-profit community-based organization. Applications should be submitted by one organization, the Coordinating Organization (local government entity or local non-profit entity), on behalf of a coalition of key community stakeholders and proposed HEZ geographic area. The community coalition should include a combination of health and community partners with specific roles and demonstrated historical experience working in the proposed zone. Applicants will be required to provide evidence validating that genuine efforts were made to include members of the target populations and minority groups in the HEZ application, and in the planning and program implementation, post-designation award.

Health Care Provider/Practices Eligibility
Individual health care providers and practices providing services within a Zone are eligible to receive state tax credits against their income, loan repayment assistance, funding for electronic health records, capital improvements and equipment in accordance with the HEZ Initiative and regulations to be proposed and adopted regarding tax credits. In addition, providers and practices may only receive incentives and benefits under the HEZ Initiative for the duration of their service/employment in a designated HEZ.

HEZ Benefits and Incentives
The HEZ Initiative provides a range of benefits and incentives to address health disparities and expand access to health care services. These benefits and incentives are available to non-profit organizations, local government entities, and eligible health care providers to achieve the HEZ's program goals at the community level. Following are examples of benefits and incentives that HEZ applicants may include in their application. If these benefits and incentives are included, then their cost must be included in the overall budget request of the HEZ application. Successful applicants will finalize the specific benefits and incentives utilized in the Zone in a post-designation conference.

- Tax credits against the State income tax: State income tax credits are available to eligible health care providers as part of an overall HEZ strategy to increase health care capacity and access to services. An eligible practitioner may claim a credit against the state income tax in an amount equal to 100% of the amount of the state income tax derived from income received from practice in the HEZ. Based on the language of the HEZ Act, tax credits are available for calendar years 2013, 2014, and 2015. Tax credits may become available for calendar year 2016, pending legislative approval and budget appropriation.

- Hiring Tax credits: Hiring tax credits are available to eligible health care provider practices as part of an overall HEZ strategy to increase health care capacity and access to services. An eligible practitioner may claim a refundable credit of $10,000 against the state income tax for hiring a qualified position in the Health Enterprise Zone. Based on the language of the HEZ Act, tax credits are available for calendar years 2013, 2014, and 2015. Tax credits may become available for calendar year 2016, pending legislative approval and budget appropriation.

- Loan repayment assistance: Loan repayment assistance is available to eligible health care providers for qualified education loan repayments.

- Priority to enter the state's Patient Centered Medical Home Program (PCMH): Priority entry into Maryland's PCMH program may be available to eligible health care providers and practices who meet the standards developed by the Maryland Health Care Commission for entry into the PCMH Program.

- Grant funds for electronic health records: Grants for obtaining and/or implementing electronic health records systems are available to eligible health care providers and

practices.

- Grants to defray the costs of capital or leasehold improvements**:** Grants for capital/leasehold improvements are available to eligible health care providers and practices to improve or expand capacity for the delivery of primary healthcare, behavioral, or dental services in the HEZ.

- Grants to defray the costs of medical or dental equipment**:** Grants for medical or dental equipment are available to eligible health care providers and practices for equipment which must be used to provide medical or dental services in the HEZ. Grants are not to exceed the lesser of $25,000 or 50% of the cost of the equipment. Providers/Practitioners must leave working medical and dental equipment in the designated Zone for continued community use, should the providers/practitioners choose to leave the Zone.

- Grant funding for innovative public health strategies: Grant funding is available to non-profit organizations and local government entities to facilitate innovative public health strategies and other incentives to help address the goals of the HEZ Initiative. Examples of fundable innovative public health strategies could include (but are not limited to) the following:
  a) Internship and volunteer programs for students in an HEZ;
  b) Funding for improvements to the environment in an HEZ, including improvements intended to increase access to recreation, healthy food, and quality housing;
  c) Grants to integrate behavioral health care into existing primary care practices in an HEZ;
  d) Funding for better health information technology tools for providers in an HEZ; and
  e) Funding for resources to enhance provider capacity to serve non-English speakers in an HEZ.

In addition to these incentives and benefits, CHRC and DHMH will provide the following types of assistance and support to HEZ designees, which do not need to be included in the application's budget.

- General support for program planning, implementation, and evaluation;
- Working with HEZ grantees and coalition members to provide access to DHMH data resources for approved HEZs;
- Invitation to participate in appropriate collaboratives and work groups;
- Assistance in connecting to existing grant-writing resources;
- Opportunity to apply for J-1 Visa Waiver primary care placements in HEZ sites that are located in federally designated Health Professional Shortage Areas and Medically Underserved Areas or Populations; and
- Priority assistance in achieving Health Information Exchange connectivity at the individual practice level.

Program Duration

HEZ designation will be for a four-year period and applications for HEZ designation should reflect a four-year period of activities. Designations made by the Secretary will be for the duration of the four-year program. Applicants should submit a detailed work-plan and evaluation plan with specific activities, objectives, milestones, and deliverables for each year of

the potential four-year program. In order to receive funding in years two, three, and four of the designation, HEZ Coordinating Organizations will need to meet the terms and conditions of the designation award, namely submitting the required reporting documents on a quarterly basis. In addition, Coordinating Organizations must demonstrate progress in terms of meeting performance measures developed by the Coordinating Organization and CHRC. HEZs that fail to comply with the reporting requirements or do not demonstrate performance in year one may be subject to revocation of designation status, and would no longer have access to benefits and incentives under the HEZ Act. The CHRC retains the right to "claw-back" funds distributed to the Zones or revoke the designation award if the Coordinating Organization is not compliant under the terms and conditions of the designation or does not meet performance measures during implementation.

Program Budget and Use of Funds

HEZ funding requests should be between $500,000 and $2 million per year for the duration of the four-year program. Annual budgets should be based on the calendar year (January – December). The Secretary and the CHRC, post-designation decisions (in January 2013), will meet with grantees to finalize the distribution of benefits and incentives to each designated Zone.

Overall or Global Budget

Applicants will be required to submit an overall or global budget requested, per year, for the duration of the four-year program. The global budget should include the total dollar amount allocated to **each** of the above benefit and incentive areas in the budget, per year. (see Appendix Item F). For example, if the HEZ applicant is requesting a total of $1 million in year one (calendar year 2013), the sum of each incentive or benefit requested should total $1 million. Please refer to Appendix Item G for a sample global budget. In the global budget, applicants are not expected to include/list the specific/actual provider names or practices that will receive each of the incentives or benefits. The global budget simply requires sub-totals for each incentive or benefit utilized in the Zone for each year of the program duration. In the months following the HEZ designation, the Coordinating Organizations will work to identify the individual providers and practices that will receive these benefits and incentives, and the CHRC will work with the Coordinating Organization to develop a mechanism to distribute these benefits and incentives.

Grant Program Budget (by Implementing Organization)

In addition to submitting the global budget, applicants may also be required to submit in their HEZ application a program-specific budget, if they request CHRC grant funding for innovative public health strategies. Applicants are required to provide the total grant funding amount requested for **each** participating partner organization that may receive CHRC grant funding and an accompanying line-item budget, by organization, showing precisely how each organization will utilize CHRC grant funding. Please refer to Appendix Item I for a sample line-item budget. In addition to the Grant Program Budget form, applicants must also provide an accompanying budget justification which details how each line item of grant funding will support the overall objectives of the HEZ. Funding amounts to partners should be appropriate to their responsibilities in the implementation of the HEZ programs and strategies. Applicants are expected at the time of the application to indicate in their application which organizations are committed to partnering in the implementation of the program's strategies by providing either an executed Memorandum of Understanding or Letter of Commitment.

Depending on the distribution mechanism agreed upon by the HEZ Coordinating Organization and CHRC, grant funding and certain incentives will be made directly by the CHRC to the partnering organization or providers who will be implementing the program and/or receiving the benefit. Coalition organizations and providers receiving funding under the HEZ program are expected to work with the CHRC and Coordinating Organizations to ensure all HEZ program reporting and evaluation guidelines are followed.

Incentives and benefits must be used for the purposes indicated in the HEZ Call for Proposals. As required in previous CHRC Call for Proposals, grant funds for innovative public health strategies may be used for program staff salaries and fringe benefits, consultant fees, data collection and analysis, in-state program-related travel, conference calls and meetings, and office supplies and expenses. Indirect costs are limited to 10% of the total grant funds requested (not 10% of the overall HEZ budget). If the services in an application will be delivered by a contractor agency or sub-grantee, and not directly by the applicant, the applicant may not take a fee for passing through the funds to the contractor agency. Funding under the HEZ program may not be used to support clinical trials, for lobbying, or for political activity.

III. Review Principles

Applications will be evaluated by a Review Committee, which will be comprised of experts in the fields of public health, health disparities, chronic diseases, social determinants of health and program management, and economic development. Individuals volunteering on the Review Committee may not be involved in any of the HEZ applications. The Review Committee will be asked to review and score each application on the following 13 review criteria:

1. Purpose. The application addresses the core statutory goals of the HEZ Initiative of reducing health disparities, including racial/ethnic and geographic health disparities, in Maryland.

2. Description of need. The application demonstrates the health and health services needs of the proposed HEZ resident population. The application demonstrates that the needs of the community exceed existing health resources and that the community's health and socio-economic outcomes are worse than/below the State's average and/or comparable communities. Applicants are permitted to draw on the data submitted in the Letter of Interest (the economic disadvantage or poor health outcomes) for threshold eligibility consideration or draw on other data metrics or factors demonstrating the need of the proposed Zone.

3. Core disease targets and conditions. The application identifies at least one or more specific diseases and/or conditions for improvement, and the data provided in the description of need supports the targeted disease(s) and/or conditions(s).

4. Goals. The applicant provides goals for health improvement by January 2016 in the HEZ that are achievable and measurable. The goals reflect the disparities being addressed (in terms of racial, ethnic and/or geographic) and reflect each of the following areas:
   a. Improved risk factor prevalence or health outcomes (Maryland State Health Improvement Process or Local Health Improvement Coalition measures, or others);
   b. Expanded primary care workforce ;

c. Increased community health workforce (including public health and outreach workers);
d. Increased community resources for health (housing, built environment, food access, etc.);
e. Reduced preventable emergency department visits and hospitalizations; and
f. Reduced unnecessary costs in health care (costs that would not have accrued if preventive services and adequate primary care had been provided).

5. Strategies. The strategies and interventions proposed in the application have a high degree of achieving success or achieving the goals stated in the application.

6. Cultural, linguistic and health literacy competence. The application explains how the strategies will be implemented in a culturally competent manner and designed to be accessible to the target population. This includes addressing translation and interpretation issues for non-English speakers and issues of low health literacy in the target population. The application describes the efforts that will be undertaken to recruit a racially, ethnically, and linguistically diverse workforce for the HEZ.

7. Balance. The proposed strategies are balanced between community-based approaches and primary care provider-based incentives. The strategies combine grants for public health and community services with the provider credits and incentives to expand health care capacity/services.

8. Contributions from local partners. Explicit financial or in-kind contributions from local partners and stakeholders are part of the strategic resource mix in order to amplify the impact of the State-provided pilot funding and incentives.

9. Coalition. The application demonstrates that the coalition includes a diverse array of health and community partners, with specific roles and historical experience working in the HEZ. A potential coalition could be led by the Coordinating Organization (the entity submitting the HEZ application and ultimately responsible for reporting requirements and Zone performance) and be comprised of participating partners that are delivering services in the Zone and community advisory groups involved in assisting overall implementation of the activities in the Zone. The application demonstrates inclusion of members of the target populations and minority groups in planning and ongoing oversight of the program. The application describes the coalition team members and participating partners and what assets, experience, knowledge, etc., are brought to the HEZ. There should be a clear governance structure of the coalition with a point of accountability for the Coordinating Organization and each key coalition member. There should be an advisory and oversight entity composed primarily of community members or residents of the designated Zone to provide advice and input to the coalition and the Coordinating Organization. This advisory/oversight entity should reflect experience in serving minority communities or populations.

10. Work-plan. The application provides a detailed work-plan that provides a clear understanding of how the program will be implemented over a four-year period and includes a detailed list of program activities, measurable outcomes, timelines, responsible entities and other logistics that enable tracking of effort; describes roles of the listed partners; includes interim milestones and deliverables; and supports appropriate data collection and reporting. See Appendix E for a sample work-plan.

11. Program management and guidance. The application provides a plan for quarterly reporting to the CHRC regarding progress and challenges regarding implementation of the HEZ work-plan and interim values for the evaluation metrics. The application includes a plan of quarterly reporting that meets the criteria in this Call for Proposal (see section V. Evaluation and Implementation, page 18) and that make sense given the core disease targets and conditions of the HEZ as well as the goals of the HEZ.

12. Sustainability. The application provides a feasible short-term and long-term sustainability strategy and acquisition of resources beyond state funding. Explicit financial or in-kind contributions from local partners and stakeholders should be part of the strategic resource mix and can be described here either as pledges or potential contributions to be pursued by the Coordinating Organization. Investments from insurers who stand to gain from cost savings in the HEZ are a potential component of a sustainability plan.

13. Internal evaluation and progress monitoring. The application provides a draft internal evaluation plan which tracks its progress in meeting each of the goals within the HEZ. The evaluation plan should include implementation and process metrics and performance measures with time-specific milestones and targets to allow assessment of the deployment of the interventions in the work-plan.

A Review Committee will evaluate applications on these review principles and will provide the CHRC with recommendations for selected organizations to present their applications before the full Community Health Resources Commission. Applicants not invited to present will be notified that they are not eligible to receive HEZ designation in this Call for Proposal opportunity. Recommendations by the CHRC to the Secretary will be based upon the recommendations of the Review Committee and presentations before the Commission. The Secretary will issue final HEZ designation awards in late December, 2012.

IV. Submitting an Application for Health Enterprise Zone Designation

The HEZ designation application has three steps:
Step 1: Submit a Letter of Interest, due no later than October 19, 2012, 5:00 p.m.
Step 2: Submit full Application, due no later than November 13, 2012, 12:00 p.m.
Step 3: Present Applications before the CHRC, December 11 (invited applicants only)

Step 1: Letter of Interest
The Letter of Interest should include the following items:
1. Name of the applicant organization (the Coordinating Organization);
2. Name, title, address, telephone number, and e-mail for the Chief Executive Officer and the proposed program director (if different) of the Coordinating Organization;
3. Documentation that shows the Coordinating Organization is either a community-based non-profit organization or local government entity;
4. Name of organizations partnering in the coalition;
5. A description of the location/geographic area of the proposed Health Enterprise Zone (i.e., community/neighborhood names); and

6. HEZ Eligibility Worksheet (Appendix Item A).

Letters of Interest are due to the CHRC no later than 5:00 p.m., October 19, 2012, but will be accepted and reviewed on a **rolling basis**. Applicants are encouraged to submit the Letter of Interest as soon as it is ready, and not wait until October 19. Letters of Interest should be submitted as a PDF or Word Document attachment, sent via email to dhmh.hez@maryland.gov. Please save file attachments using the following format: Organization Name, HEZ Letter of Interest, Date.

The CHRC will review the Letters of Interest and Eligibility Worksheets (see Appendix Item A) as soon as is possible, certify each applicant's eligibility, and contact eligible applicants to submit the full application, hopefully within 48 hours of submission of LOI. Once eligibility is certified and applicants are notified, LOIs will be posted on the HEZ website.

Only applicants whose proposed HEZ meets the eligibility criteria (see page 4) will be invited to proceed in submitting a full application (Step 2). CHRC staff will review the Letters of Interest, certify applicants' eligibility, and will invite eligible applicants to submit a formal application for HEZ designation. The CHRC will notify applicants of their eligibility as soon as is possible, hopefully within a 48-hour period of submission of the Letter of Interest.

Step 2: Submission of Applications
Following are guidelines and the requested structure of the HEZ application. The overall length of the HEZ application should be no more than 25 pages and will contain Standard Forms located in the Appendices of this Call for Proposals and narrative written sections. The HEZ application should be structured using these topic headings and forms, in the following order:

Topic Heading and Forms	Narrative versus Standard Form	Included in Page Limit
Table of Contents	Narrative	Not included
1. Grant Application Cover Sheet	Standard Form – CFP Appendix Item B	Not included
2. Contractual Obligations, Assurances, and Certifications	Standard Form – CFP Appendix Item C	Not included
3. Program Summary	Narrative	Included
4. Program Purpose	Narrative	Included
5. HEZ Geographic Description (HEZ map)	Narrative	Included (map not included)
6. Community Needs Assessment	Narrative	Included
7. Core Disease(s) and Condition(s) Targeted	Narrative	Included
8. Goals	Narrative	Included
9. Strategy to Address Health Disparities	Narrative	Included
10. Use of Incentives and Benefits	Narrative	Included

11. Cultural, linguistic and health literacy competency	Narrative	Included
12. Applicant Organization and Key Personnel	Narrative	Included
13. Coalition Organizations and Governance	Narrative	Included
14. Work-plan	Standard Form – CFP Appendix Items D and E	Not included
15. Evaluation Plan	Narrative	Included
16. Sustainability Plan	Narrative	Included
17. Program Budget and Justification	Standard Form – CFP Appendix Items F - I	Not included
18. Financial Audit		Not included
Appendices		Not included

The suggested content of each of these sections is provided below. Appendices should be limited to only the material necessary to support the application.

1. Grant Application Cover Sheet: The form should be completed and signed by the program director(s) and either the chief executive officer or the individual responsible for conducting the affairs of the applicant and legally authorized to execute contracts on behalf of the applicant organization. This form is attached as Appendix Item B and also can be accessed at the Maryland Community Health Resources website (http://dhmh.maryland.gov/mchrc/ - click on "Forms" on the left hand side menu) and the DHMH HEZ website (http://dhmh.maryland.gov/healthenterprisezones/).

2. Contractual Obligations, Assurances, and Certifications**:** The agreement should be completed and signed by either the Chief Executive Officer or the individual responsible for conducting the affairs of the applicant and authorized to execute contracts on behalf of the applicant organization. This document is attached as Appendix Item C and also can be accessed at the Maryland Community Health Resources website (http://dhmh.maryland.gov/mchrc/ - click on "Forms" on the left hand side menu) and the DHMH HEZ website (http://dhmh.maryland.gov/healthenterprisezones/).

3. Program Summary: The program summary is a concise, one-page overview of the proposed HEZ community(ies), the community needs, and the overall strategies that will be implemented to achieve the HEZ program's goals.

4. Program Purpose: The application should describe how the activities in the application will address the core goals of HEZ Initiative.

5. HEZ Geographic Description: The application should provide a brief description of the geographic location of the proposed HEZ, including the zip code(s) or sub-zip code geographic units that will be part of the HEZ. Applications should provide names of the community(ies) or

neighborhood(s) that are participating as part of the HEZ and any other relevant details that help to describe the physical location of the proposed HEZ. Applications should include a map of the proposed HEZ area that delineates the geographic units that are the boundaries of the zone (i.e., zip code, Census Tracts, etc). This can be the same map provided as part of the Letter of Interest.

6. Community Needs Assessment: The application should describe the health and health service needs of the population in the proposed HEZ. Examples of metrics to describe community need include (but are not limited to) indicators of health status, risk factor prevalence, health insurance status, primary care access, Medically Underserved Area or Medically Underserved Population designations, and other needs that impact the health of the community. This data should be presented, where possible, by racial groups and by Hispanic ethnicity. The application should also discuss other socio-economic factors that contribute to poor health in the community, such as data regarding education, employment, income, housing, physical environment, and other community factors that impact health.

7. Core Disease Targets and Conditions. Based upon the community need, the application should identify specific disease(s) and/or condition(s) that will be targeted for improvement. Applications are encouraged to target at least one of the following conditions identified by the Health Disparities Workgroup of the Maryland Health Quality and Cost Council: cardiovascular disease, diabetes, and asthma. Applications may address other major conditions where the community experiences poor health outcomes, such as behavioral health, dental health, birth outcomes, or related co-morbid conditions.

8. Goals: The application should propose ***measurable*** goals for health improvement in the HEZ by January 2016. The goals should reflect the disparities being addressed. Each goal should be included in the work-plan (see item 16, page 17). Goals should cover each of the following areas:

- Improved risk factor prevalence or health outcomes (e.g., SHIP or LHIP measures, or others);
- Expanded primary care workforce;
- Increased community health workforce (including public health and outreach workers);
- Increased community resources for health (e.g., housing, built environment, food access, etc.);
- Reduced preventable emergency department visits and hospitalizations; and
- Reduced unnecessary costs in health care (costs that would not have accrued if preventive services and adequate primary care had been provided).

9. Strategies. The application should provide a clear description of each strategy, including the key programmatic components, implementation steps, and partnering organizations who will assist in the implementation of the proposed strategy. The application should reference the key action steps included in the work-plan (see item 16, page 17). The evidence and rationale for each of the strategies and interventions should be presented. Examples of potential strategies could include:

- A strategy to increase provider capacity by a specified percentage;
- A strategy to improve the quality of service delivery as indicated by HEDIS measures;
- A strategy to address community barriers to healthy lifestyles;
- A strategy to improve health outcomes through the use of community health workers;

- A plan to strengthen community and environmental policies to support good health in schools, day care, recreation centers, senior centers, and workplaces;
- A strategy to provide better access to healthy foods or facilities for physical activities;
- A strategy to engage underserved racial and ethnic minority persons in the Health Enterprise Zone;
- A strategy to improve the built environment in an HEZ, including improvements intended to increase access to recreation, healthy food, and quality housing;
- A strategy to integrate behavioral health care into existing primary care practices in an HEZ;
- A strategy to improve health information technology tools for providers in an HEZ; and
- A strategy to enhance provider capacity to serve non-English speakers in an HEZ.

Applicants are encouraged where possible to adopt strategies that are evidence-based, generally accepted as promising practices, or new/innovative ideas. Applicants are encouraged to bring health information technology (electronic medical records and health information exchange) and the patient-centered medical home model to their strategic approaches.

10. Use of Incentives and Benefits. The applications should describe which incentives and benefits will be utilized as part of its strategies. The proposed strategies should be balanced between community-based approaches and provider-based incentives, and it should combine grants for public health and community services with the provider credits and incentives that are available to HEZs. The application must include a proposal to use funding available under this Initiative to provide for loan repayment incentives to induce health enterprise zone practitioners to practice in the HEZ.

11. Cultural, linguistic and health literacy competency. The application should explain how the strategies will be implemented in a culturally competent manner and designed to be accessible to the target population. This includes addressing translation and interpretation issues for non-English speakers, and issues of low health literacy in the target population. The application should describe the efforts that will be undertaken to recruit a racially, ethnically, and linguistically diverse workforce for the HEZ.

12. Applicant Organization and Key Personnel: The application should provide a description of the Coordinating Organization (applicant organization) and the organization's capacity to implement and lead the HEZ program. This can include any relevant experience in leading a coalition of organizations, community-based work, and implementation of multi-year programs. The application should identify the program director and describe his/her role within the Coordinating Organization, qualifications to lead the program, and responsibilities in carrying out the program. The application should also identify other essential staff, their roles in the program, and their relevant qualifications. Résumés for all key personnel should be included as appendices, and do not count as part of the overall page limit of the application. The application should describe any positions for which the organization that will need to hire new/additional staff.

13. Coalition Governance and Participating Partners: The application should provide a list of all HEZ coalition members (this list may be included as an appendix item if needed [not included in

the overall page limit]). The application should describe the coalition team members and what assets, experience, knowledge, etc. each brings to the proposed HEZ. The application should also describe the roles and responsibilities (if any) of coalition members in the implementation of any of the proposed strategies and intervention. The application should describe the governance structure that will be used by the Coordinating Organization, which provides a point of accountability for each core coalition member and participating partner. The application should describe plans to include members of the target populations and minority groups in planning and ongoing oversight of the program.

14. Work-Plan (Chart): The application should include a work-plan for implementing the HEZ program across each goal and strategies. The work-plan is a comprehensive program management tool for HEZ performance (see Appendix E for a sample chart) that describes the key strategies, activities, and evaluation measures and links these with the overall goals of the HEZ. The work-plan should provide a "step-by-step" understanding of the key actions, the timing to implement these actions, and who (which participating partners or personnel) is responsible for implementing these actions. In addition, the work-plan will describe the time-specific milestones or deliverables that will be used to evaluate the success of the activities in the HEZ. The work-plan should be in a chart format which provides a clear understanding of how the program's goals will be achieved over the four-year program duration and should include the following components:

a. Goals;
b. Objectives;
c. Key program activities/action steps;
d. Data evaluation and measurement;
e. Responsible organization/entity; and
f. Timeline for implementation.

Some information presented in the other parts of the application, such as goals, specific strategies, activities, and the evaluation plan, will be repeated in the work-plan. A template (blank) work-plan chart and sample work-plan are included in this Call for Proposals (see Appendix Items D and E).

15. Evaluation Plan: The evaluation plan should include implementation and process metrics and performance measures with time-specific milestones and targets to assess the deployment of the interventions and strategies in the work-plan. Whereas the work-plan is in chart format (see Appendix D), the evaluation plan is in narrative (written prose) form. The primary purpose of the evaluation plan is to describe how the Coordinating Organization will measure the implementation and success of the proposed strategies on an ongoing basis to achieve the goals of the HEZ and report this information to the CHRC on a regular basis. This evaluation plan should include the specific activities/methods the Coordinating Organization (and sub-grantees/participating partners, where applicable) will undertake to capture needed information (e.g., health outcome data) and how the Coordinating Organization will evaluate the success of the activities within the HEZ on a regular basis. The evaluation plan should also include the health outcome metrics that will be tracked/reported to demonstrate that the HEZ is achieving its health improvement goals. Time-specific milestones for the health outcome metrics should be included. Methods for collecting the health outcome data within the HEZ or assembling data from external sources should be discussed. The metrics of reach (deployment) and impact

(health outcomes) should be analyzed in categories of race and ethnicity to assess the impact on minority health and health disparities.

In addition, the internal evaluation plan should describe how the Coordinating Organization plans to monitor the activities and progress of sub-grantees/participating partners in the implementation of specific program activities. This could include any information/data the Coordinating Organization will require from sub-grantees, how sub-grantees will be held accountable for program achievement, and how this information will be reported to the CHRC. The information gathered by the Coordinating Organization should be linked to specific milestones, data measures, and/or other metrics that evaluate the progress on key activities, objectives, and program goals. Applications should reference the data and evaluation measures included in the Work-Plan (see item 16, page 17).

Applications should show a budgeted line-item between 5% and 10% of the overall HEZ global budget for data collection and evaluation efforts. If the applicant organization plans to utilize external organizations or other tools/resources to assist to evaluation of the program, this should be described here (e.g., hiring an external organization to administer a survey or group interviews, purchasing software to capture particular data).

16. Sustainability: The application should describe a plan for sustainability and acquisition of resources beyond State funding, including partnership with entities in the health care system that have the financial incentive for better outcomes. The application should include a specific plan for developing and implementing a short-term and long-term sustainability strategy.

17. Program Budget and Justification (Standard form): The HEZ funding request should be between $500,000 to $2 million per year for the duration of the four-year program. All applicants must complete the Global Budget Form which provides the annual and total budget request by program benefit and incentive requested (see Appendix Item F for a template (blank) global budget form and Appendix Item G for a sample global budget form).

Applicants requesting CHRC grant funding for innovative health programs may also be required to complete a separate Grant Program Budget Form, which is a line-item budget for each organization that will be partnering in the implementation of the public health grant program (see Appendix Item H for a template (blank) organization program budget form and Appendix Item I for a sample organization program budget). For example, if the application requests CHRC grant support for the salaries of five community health workers to be hired by a participating partner, then the Line-Item Grant Budget Form is required in addition to the Global Budget.

The budget justification should detail what is included in each line-item and describe how each item will support the achievement of the program's goals and objectives. Funding levels to implementing organizations should be appropriate to their roles and responsibilities in the work-plan.

18. Financial Audits: Non-profit Coordinating Organizations must submit a copy of their most recent financial audit of the organization. As in previous CHRC Call for Proposals, financial audits are not required for local government entities.

Application Formatting
Applications should be approximately 20 to 25 pages single-spaced on standard 8 ½" x 11" paper with one-inch margins and using 12-point Times New Roman or Arial font. Tables and charts may use a 10-point font or larger. Please number pages. The hard copy of the application documents should be bound with prong report fasteners or clips. Please do not use spiral binding or three ring binders.

Applications are due to the CHRC no later than 12:00 p.m., November 13, 2012 by email **and** hand delivery, U.S. Postal Service, or private courier.

Electronic versions of applications should be submitted in one PDF or Word Document attachment, sent via email to dhmh.hez@maryland.gov. Please save file attachments using the following format: Organization Name, HEZ Proposal, Date.

In addition to electronic application submission, the following must be received by November 13, 2012, 12:00 p.m. to be considered a complete application package:

(1) One original application, labeled "original"; and

(2) Eight bound copies of the application.

Send hard copies of applications to:

Mark Luckner
Executive Director
Maryland Community Health Resources Commission
45 Calvert Street, Room 336
Annapolis, MD 21401

Step 3: Presentation before the CHRC (invited applicants only)
A selected number of applicants will be invited to present their proposal at a Community Health Resources Commission meeting. This meeting will be held on December 11, Additional information regarding time and location of this meeting will be forthcoming. Invited applicants will be provided presentation instructions upon notification of invitation to present.

V. Program Evaluation and Implementation

The CHRC implements a robust system of grantee performance management that holds grantees accountable for performance and is designed to ensure that finite grant resources are utilized wisely and efficiently. The CHRC will work with each HEZ Coordinating Organization and its participating partners to develop standard and customized performance measures that will be reported by the grantees on a quarterly basis. These performance measures will reflect the four-year duration of the program and will be a combination of interim and longer-term measures.

Internal Evaluation
At the beginning of the grant period (January 2013), CHRC staff and the HEZ Coordinating Organization will meet to finalize the internal evaluation plans, which will be developed from the work-plan and proposed internal evaluation plan submitted in the original HEZ application. As part of this internal evaluation, HEZ Coordinating Organizations will be required to submit the following three deliverables on a quarterly basis. CHRC staff will make sample reports available to HEZ Coordinating Organizations after HEZ designations are made.

1. **Milestone & Deliverable Report (M&D)**. Quantitative report (excel file) which reports on a core set of common measures for all HEZ programs and specific measures that are unique to each HEZ program. These measures will be developed from the work-plan and proposed evaluation measures provided in the HEZ application. Grantees will be expected to provide baseline data/projections on evaluation measures and subsequent data will be compared to baseline data/projected outcomes;

2. **Narrative reports**. Qualitative report (word document) summarizing the status of implementation of key strategies of the HEZ proposal. The narrative reports should be based on the key time-specific milestones and deliverables in the M&D report (above), and the work-plan and proposed evaluation plan that were provided in the HEZ application. These reports provide details about each grant program including any major events or activities that took place as part of the implementation; any problems or barriers encountered during the reporting period and how these barriers were resolved or will be addressed; and details about why the grantee has not achieved program goals to date. Any successes or unexpected outcomes from the program activities should be highlighted in the narrative report; and

3. **Expenditure reports.** A line-item budget detail (excel file) showing exactly how HEZ resources were expended and utilized. Activities or expenditures by participating partners should be included. Recipients of HEZ funds are expected to retain all documentation of the use of grant funds and provide these to the CHRC upon request.

HEZ grantees will provide these reports throughout the program's four-year duration. Compliance will be required as a condition of receipt of funding in years two, three, and four of the program.

External Evaluation
Under the Maryland Health Improvement and Disparities Reduction Act, the CHRC and DHMH are required to submit an annual report to the Maryland General Assembly and Governor documenting the impact of the activities in the Health Enterprise Zones. To fulfill this reporting requirement, the CHRC will solicit proposals to contract with an outside entity to perform an independent, external evaluation of the program. This evaluator will not only analyze the periodic reports submitted by the HEZ Coordinating Organizations, but will also perform additional data collection and analysis to assess the impact of the activities of the HEZs on the outcomes specified in the Act and the proposals. The external evaluation activities will be coordinated and funded through the CHRC and DHMH, and, as such, do not need to be included as part of budget requests submitted by HEZ Coordinating Organizations. As a condition of receiving HEZ grant funds, however, HEZ grantees will be required to participate in this external evaluation. This may include the Coordinating Organization and participating partners assisting

with any data collection and information gathering required, such as participation in surveys, focus groups, site visits, meetings, and key informant interviews with the evaluators.

Program Implementation and Benefits Distribution
The HEZ program period will begin in January 2013, and reporting requirements will be organized around a calendar year. Once HEZ designations are made by the Secretary, CHRC staff and HEZ Coordinating Organizations will develop and finalize program budgets, internal evaluation plans, and periodic reports submitted to the CHRC. Once these documents are finalized, it is expected that the Coordinating Organization and partnering entities will begin implementing the HEZ strategies immediately. In addition, the HEZ Coordinating Organization and CHRC will determine the mechanics of distributing incentives or benefits. In some cases, the Coordinating Organization will receive funds from the CHRC to distribute the benefits to participating partners, and in other cases, the CHRC will distribute benefits directly to the individual participating partners.

Providers and practices who wish to receive benefits and incentives in the HEZ strategies (income and hiring tax credits, loan repayment assistance, EHR, capital and equipment funding) must apply to the Coordinating Organization. Within six months of designation (July 2013), the Coordinating Organization must evaluate the applications of providers and practices, certify their eligibility, and provide the CHRC with the specific/actual providers and practices that will receive the benefits and incentives budgeted for year one of the program. The CHRC and DHMH will distribute funding and incentives directly to each provider/practice.

Grant Modifications
HEZ Coordinating Organizations are permitted to request changes to their approved HEZ proposal/programs by submitting a formal Grant Modification Form (see Appendix Item H), and when required, an updated Global or Program Budget to the CHRC. Grantees may be asked to present their grant modification request before the CHRC.

VI. Inquiries and Other Information

Conference Call for Applicants
The program office will host a conference call for interested applicants to provide information on the HEZ program and assistance with the application process. This conference call, on **October 11, 2:30 p.m.,** is ***optional***. This call will be available on a first come, first serve basis. Multiple participants from the same organization are encouraged to use one phone line when calling into the conference call. The call in information is:

Dial-In Number: (866) 233-3852
Participant Access Code: 267478

Questions from Applicants
Applicants may also submit written questions at any time to dhmh.hez@maryland.gov.

COMMUNITY HEALTH RESOURCES COMMISSION
2012 Commissioners
John A. Hurson, Chairman
Nelson Sabatini, Vice Chairman
Dr. Charlene Dukes
Maria Harris-Tildon
Kendall D. Hunter
P. Sue Kullen
Dr. Mark Li
Paula McLellan
Margaret Murray, M.P.A.

CHRC Staff and Contact Information
The Maryland Community Health Resources Commission is located at:

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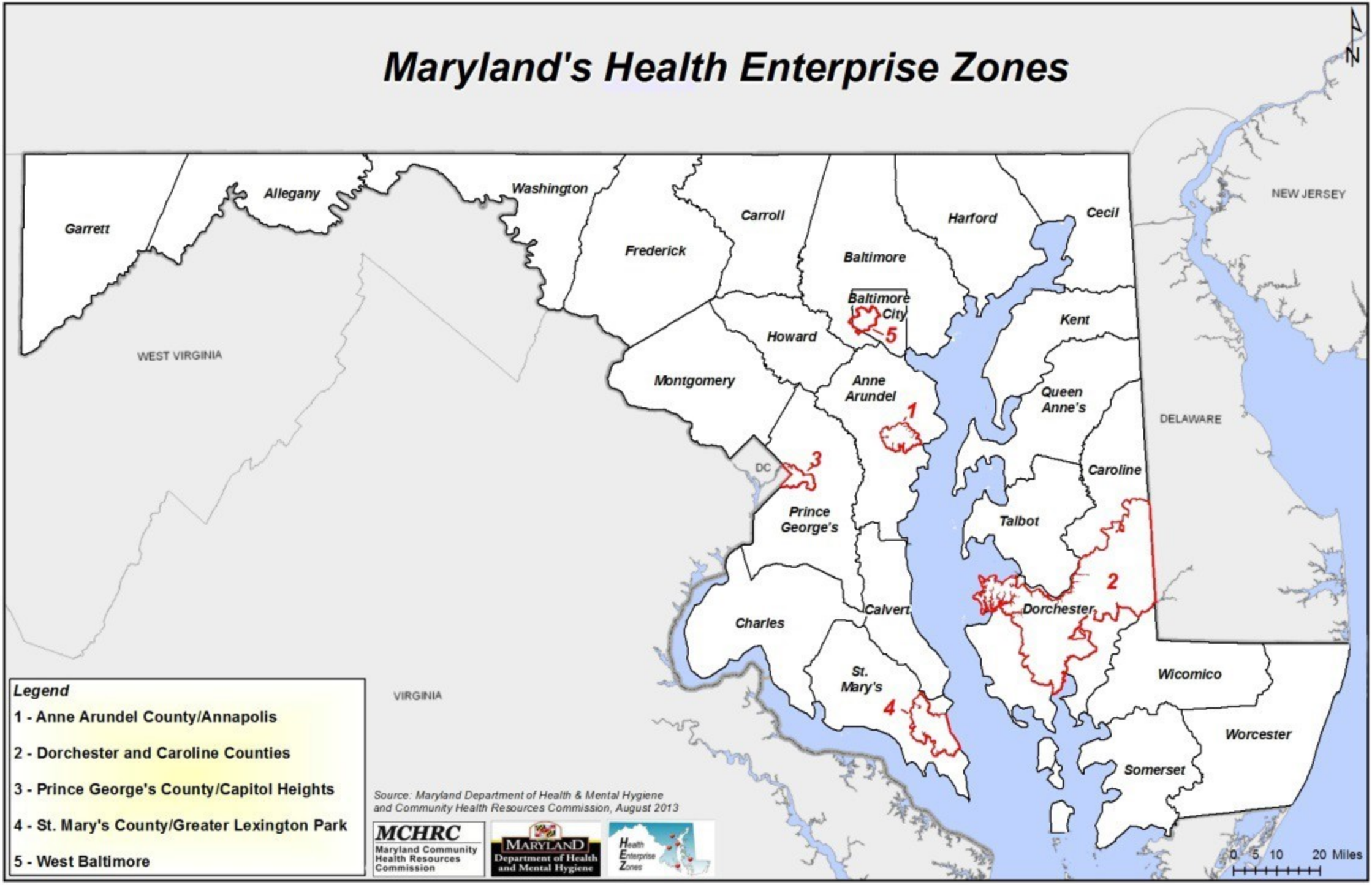
Appendix G

Maryland's Health Enterprise Zones



Legend

1 - Anne Arundel County/Annapolis

2 - Dorchester and Caroline Counties

3 - Prince George's County/Capitol Heights

4 - St. Mary's County/Greater Lexington Park

5 - West Baltimore

Source: Maryland Department of Health & Mental Hygiene and Community Health Resources Commission, August 2013

MCHRC Maryland Community Health Resources Commission

MARYLAND Department of Health and Mental Hygiene

Health Enterprise Zones

Appendix H

STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

January 13, 2014

The Honorable Martin O'Malley
Governor
State of Maryland
Annapolis, MD 21401-1991

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
H-107 State House
Annapolis, MD 21401-1991

The Honorable Michael E. Busch
Speaker of the House
H-101 State House
Annapolis, MD 21401-1991

Re: Health-General Article § 20-1407-2013 Annual Report
Report of Health Enterprise Zones Implementation Year One

Dear Governor O'Malley, President Miller, and Speaker Busch:

Pursuant to Maryland Health-General Article, Section 20-1407, the Department of Health and Mental Hygiene (the Department) and the Community Health Resources Commission (the Commission) submit this 2013 Report of the first year of the Maryland Health Enterprise Zones (HEZ) implementation, including incentives granted. The Report describes a variety of start-up activities by both the Department and the Commission. Under Health-General Article, Section 20-1402, the purposes of the HEZs are to reduce health disparities, improve health outcomes, reduce health costs, and to reduce hospital admissions and readmissions in specific areas of the State.

Calendar year 2013 was the first year of HEZ operations and was largely dedicated to start-up activities to launch this innovative and collaborative community-based public health intervention in communities with high poverty and persistent health disparities. The enclosed Report describes these start-up activities and initial results, including successes and challenges.

If you have questions concerning this Report, please contact Christi Megna, Assistant Director of Governmental Affairs, at (410) 767-6509, Mark Luckner, Executive Director, Community Health Resources Commission, at (410) 260-7046 or Carlessia Hussein, Director, Office of Minority Health and Health Disparities at (410) 767-0094.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

Sincerely,

John Hurson
Chairman, Community Health Resources Commission

Enclosure

cc: Patrick Dooley
Christi Megna, J.D.
Carlessia A. Hussein, R.N., Dr. P.H.
Sarah Albert, MSAR#9344
Mark Luckner, M.A.

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

and

COMMUNITY HEALTH RESOURCES COMMISSION

Health General Article § 20-1407
Annotated Code of Maryland

HEALTH ENTERPRISE ZONES

2013 REPORT

January 2014

Martin O'Malley
Governor

Anthony G. Brown
Lieutenant Governor

Joshua M. Sharfstein, M.D.
Secretary
Department of Health and Mental Hygiene

The Honorable John Hurson
Chairman
Community Health Resources Commission

Maryland Health Enterprise Zone Program (HEZ)
2013 Annual Report

Table of Contents

I. Executive Summary

Maryland has a number of advantages that allow its citizens to access quality health care. Despite these advantages, Maryland lags behind other states in several health indicators. Health disparities by race/ethnicity and by place of residence are seen throughout the State. In response to these persistent health disparities, Maryland Lieutenant Governor Anthony G. Brown convened the Maryland Health Quality and Cost Council's Health Disparities Workgroup charged with investigating strategies to reduce and eliminate health disparities. The Workgroup led by Dean E. Albert Reece, MD, PhD, MBA, of the University of Maryland School of Medicine, articulated the concept of applying principles of economic development and revitalization to public health and healthcare delivery.

The recommendations of the Workgroup led to the introduction of SB 234, the Maryland Health Improvement and Disparities Reduction Act of 2012 (the "Act"), championed by Lt. Governor Anthony G. Brown. The purpose of the Act is to target state resources to: (1) Reduce health disparities; (2) Improve health outcomes; and (3) Reduce health costs and hospital admissions and readmissions in specific areas of the state. The Act created the policy framework to establish and implement the Health Enterprise Zones (HEZs) Initiative. In its wisdom, the Maryland General Assembly authorized the Maryland Department of Health and Mental Hygiene (DHMH) and the Maryland Community Health Resources Commission (CHRC) to collaborate in implementing provisions of the Act.

Solicitation for HEZ proposals took place in late 2012 with designations being made by DHMH Secretary Sharfstein in January 2013 based on recommendations from CHRC. Under the Act, non-profit community-based organizations or local government agencies were eligible to apply for HEZ designation status on behalf of a local community. The Call for Proposals generated a total of 19 applications from 17 jurisdictions, representing rural, urban, and suburban areas of the state. The five HEZs are located in Anne Arundel, Dorchester/Caroline, Prince George's, and St. Mary's Counties and Baltimore City. These Zones exhibited measurable and documented economic disadvantages and poor health outcomes and proposed creative and sustainable plans for targeted investments in community health. These designations involved local coordinating organizations/coalitions led by three hospital systems and two local health departments, and result in two rural, one urban, and two suburban HEZs.

Technical assistance and guidance was provided to the HEZs by the HEZ Team's program directors from CHRC and DHMH, with lead responsibility in Health Systems and Infrastructure, Prevention and Health Promotions, Minority Health and Health Disparities, Behavioral Health and the Community Health Resources Commission. A variety of assistance was provided by these programs through written guidelines, on-site consultation, and conference calls.

The HEZs articulated a collective recruitment goal for Year One of recruiting 38 new health care practitioners. As of this Report, 43 new practitioners have been added, including physicians, nurse practitioners, registered nurses, social workers and a psychiatrist. Four of the HEZs have achieved their Year-One practitioner recruitment goals. Though the HEZs achieved their overall Year-One practitioner recruitment goals, several of the Zones, especially in rural areas, reported challenges in recruiting primary care physicians. The Zones are confronting the challenges

involved with collecting and reporting individual patient clinical outcome data and aggregating this data across multiple different EMR systems and paper-based systems.

Loan repayment assistance was provided in the HEZ Statute as an incentive to recruit and retain providers to HEZs. Two types of tax credits are offered as incentives by the Act: (1) hiring tax credits and (2) income tax credits. For full use of these two incentives, submitted Health Care Practitioner Income Tax Credit regulations and Employer Hiring Tax Credit amendments need to be executed. Both actions are expected by summer of 2014.

The impact of the HEZ programs and incentives on disparities, admissions, health outcomes and cost cannot be measured at the end of Year One. The first year has been dedicated to hiring, establishing protocols, training and recruitment of practitioners. While activity data are being collected, sufficient data will not be available for analysis due to the lag time in collecting hospital admission data and state mortality and morbidity data for the respective HEZs.

The HEZ Team members from DHMH and CHRC provided public health guidelines, operational technical assistance, budget/fiscal guidance, and in-person consultation to the HEZs as a collective and individually throughout start up efforts during this first year. The technical assistance included advice on accessing incentives, measuring performance and outcomes, cultural competency standards, chronic disease interventions, behavioral health support, reporting, and evaluation.

The individual HEZs are conducting their own internal evaluation by tracking start up and program intervention tasks as outlined in their approved proposals. An external evaluation, to be conducted by an outside entity, will utilize the internal program tracking information and employ a quantitative evaluation model to measure overall outcomes and impact on the established goals of reducing health disparities, improving health outcomes, and reducing health costs, admissions and readmissions in the HEZs.

In Year Two, calendar year 2014, the HEZ Team in partnership with the HEZs will ensure that all start-up activities are complete, operations are modified based on lessons learned, and ongoing oversight focuses on achievement of the stated objectives for each HEZ. Additional resources will be provided in the form of federal grants, data analyst experts, training and other support to strengthen each HEZ's capacity to revitalize public health with community partnerships at the local level.

II. Authorizing Legislation, Funding and Joint Management

A. Maryland Health Improvement and Disparities Reduction Act

Maryland has a number of advantages that allow its citizens to access quality health care. Maryland has outstanding medical schools, and among the 50 states, it has the highest median household income and the fifth highest number of primary care physicians. Despite these advantages, Maryland lags behind other states in several health indicators. In America's Health Rankings, a ranking system where 1st is best, Maryland ranked 36th in infant mortality, 31st in cardiovascular deaths, 26th in cancer deaths, and 25th in obesity prevalence in the 2013 edition. For these and for other key health indicators, important and persistent health disparities by race/ethnicity and by place of residence are seen in Maryland.

In response to these persistent health disparities, Maryland Lt. Governor Anthony G. Brown convened the Maryland Health Quality and Cost Council's Health Disparities Workgroup, composed of public health experts, research scholars, and community health leaders, and charged this group with investigating strategies to reduce and eliminate health disparities. The Workgroup was led by Dean E. Albert Reece, MD, PhD, MBA, of the University of Maryland School of Medicine. The Workgroup articulated the concept of applying principles of economic development and revitalization to public health and healthcare delivery, recommending a range of incentives including tax credits, loan repayment assistance, and grant funding to expand access in underserved areas, reduce health disparities, and improve health outcomes. These incentives would serve to attract primary care clinicians to expand or open practices and would support community-level interventions such as community health workers and other strategies to address social determinants of health. The key recommendation of the Workgroup was the creation of "Health Enterprise Zones," which are contiguous geographic areas where the population experiences poor health outcomes that contribute to racial/ethnic and geographic health disparities and are small enough for incentives to have a measurable impact.

The recommendations of the Workgroup led to the introduction of SB 234, the Maryland Health Improvement and Disparities Reduction Act of 2012 (the "Act") (Appendix A), which was championed by Lieutenant Governor Anthony G. Brown. The Maryland General Assembly passed SB 234 during the 2012 session, and Governor Martin O'Malley signed the bill into law in April 2012. The purpose of the Act is to target state resources to: (1) Reduce health disparities; (2) Improve health outcomes; and (3) Reduce health costs and hospital admissions and readmissions in specific areas of the state. The Act created the policy framework to establish and implement the Health Enterprise Zones (HEZs) Initiative. Funding for this initiative was placed in the budget of the Maryland Community Health Resources Commission (CHRC) consistent with their charge to direct resources to communities where poor health persists despite ongoing services provided by the public and private sectors. The Department of Health and Mental Hygiene (DHMH) was charged to apply their public health expertise in Core Public Health Services and their State authority to ensure *assessment, policy development, and assurance* that quality, safe and effective health services are delivered. In its wisdom, the Maryland General Assembly authorized the two organizations (DHMH and CHRC) to collaborate in implementing provisions of the Act. Nine of the Act's provisions are the sole responsibility of DHMH, seven are jointly shared, and one provision is the sole responsibility of CHRC.

B. Funding and Resources

The Act provides $4 million per year over the four-year duration of the program and creates the Health Enterprise Zone Reserve Fund, a special, non-lapsing fund which is administered by the Community Health Resources Commission. The Act provides access to a range of incentives and resources to Health Enterprise Zones, including: (1) Income tax credits; (2) Hiring tax credits; (3) Loan repayment assistance; (4) Priority participation in the Maryland Patient-Centered Medical Home Program; and (5) Grant funding provided by the CHRC. In addition to these incentives and resources, the state also supports the Zones with specific technical assistance and program guidance [which is detailed in the report in section IV].

C. DHMH and CHRC Shared Management

Secretary Joshua M. Sharfstein (DHMH) and Chairman John A. Hurson (CHRC) established an HEZ Team under the direction of the DHMH Secretary. Members of the Team include staff from CHRC and leaders in DHMH from Health Systems Infrastructure Administration (HSIA), Prevention and Health Promotion Administration (PHPA), the Office of Minority Health and Health Disparities (MHHD), Behavioral Health and Disabilities (BHD), and the DHMH Virtual Data Unit (VDU). The HEZ Team met frequently, working together to establish guidelines for implementation, chronic disease metrics and measures, periodic reporting, budget expenditure guidance, and technical assistance on health equity.

A shared management model is being used, with leadership of the overall HEZ Team's work guided by CHRC and DHMH, and with each program area expert providing guidance and technical assistance. The HSIA guided the Loan Repayment project, the PHPA provided chronic disease guidance, the MHHD provided principles for cultural competency assessment and training, the BHD provided behavioral health guidance, and the VDU along with the entire HEZ team assisted with identifying performance metrics for base-line, final tracking, and evaluation.

III. Health Enterprise Zone Implementation

A. Solicitation and Designation

After the Act was signed into law, DHMH and the CHRC held a public comment period to solicit feedback on the selection criteria for the HEZs, the potential uses of HEZ funding, and the outcome metrics that should be developed to monitor the progress and implementation of the HEZs. This public comment was summarized in a Joint Chairmen's Report submitted to the legislature in August 2012 (Appendix B). Public comments were incorporated into the Call for Proposals issued by CHRC which can be found in Appendix C. Under the Act, non-profit community-based organizations or local government agencies were eligible to apply for HEZ designation status on behalf of a local community. Applicants were encouraged to reflect inclusion, community participation, and collaboration and to support the priorities identified in the Local Health Improvement Process. Applications for HEZ designation were required to have demonstrated need and intervention strategies to improve health outcomes in the potential Zone. The Call for Proposals generated a total of 19 applications (Appendix D) from 17 jurisdictions, representing rural, urban, and suburban areas of the state. These applications were evaluated competitively on 13 review principles by an independent HEZ Review Committee comprised of experts in the fields of public health, health care finance, health disparities, and health care delivery.

On January 24, 2013, based on recommendations from CHRC, DHMH Secretary Sharfstein designated Maryland's first five HEZs:

- Jurisdiction: Anne Arundel County
  Community: Annapolis, Morris Blum Public Housing Building (zip code 21401)
  Coordinating Organization: Anne Arundel Medical Center
  Project Title: Anne Arundel Health System's Health Enterprise Zone

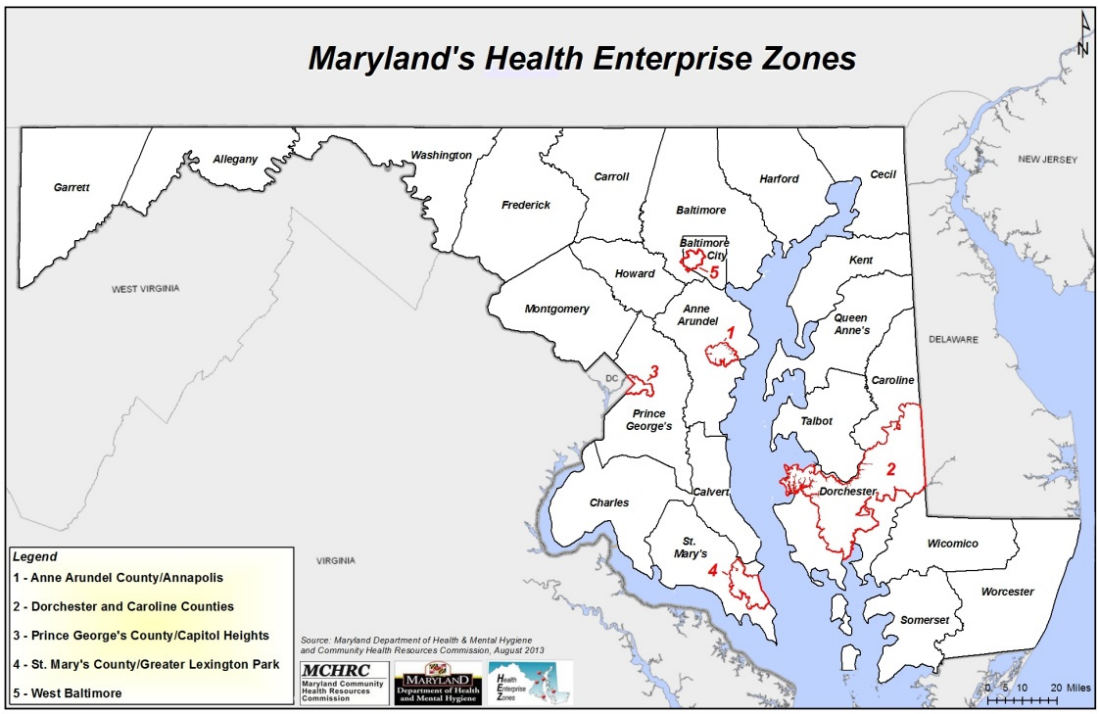
- Jurisdiction: Dorchester and Caroline Counties
  Community: Mid-Shore Region (zip codes 21613, 21631, 21643, 21835, 21659, 21664, 21632)
  Coordinating Organization: Dorchester County Health Department
  Project Title: Competent Care Connection

- Jurisdiction: Prince George's County
  Community: Capitol Heights (zip code 20743)
  Coordinating Organization: Prince George's County Health Department
  Project Title: Prince George's County Health Enterprise Zone

- Jurisdiction: St. Mary's County
  Community: Greater Lexington Park (zip codes 20653, 20634, 20667)
  Coordinating Organization: MedStar St. Mary's Hospital
  Project Title: St. Mary's County Health Enterprise Zone Consortium

- Jurisdiction: Baltimore City
  Community: West Baltimore (zip codes 21216, 21217, 21223, 21229)
  Coordinating Organization: Bon Secours Baltimore Health System
  Project Title: West Baltimore Primary Care Access Collaborative

Map of the first five HEZs



These Zones exhibited measurable and documented economic disadvantages and poor health outcomes and proposed creative and sustainable plans for targeted investments in community health. These designations involve local coordinating organizations/coalitions led by three hospital systems and two local health departments, and will develop two rural, one urban, and two suburban HEZs.

Brief Overview of 5 HEZs

Annapolis/Morris Blum (Suburban), Year One Budget: $200,000. This Zone is utilizing HEZ funds to establish a new primary care health center based in the Morris Blum public housing building. The goals of this HEZ include a reduction in diabetes-related and smoking illnesses, obesity, and cardiovascular disease of the Morris Blum residents.

Dorchester/Caroline Counties (Rural), Year One Budget: $755,000. The Zone targets primary care and behavioral health issues and is utilizing funds to support health care services teams that include peer recovery support specialists, community health outreach workers, mobile health care crisis teams, and school-based wellness programs. The goals of this HEZ include a reduction in behavioral health emergency department (ED) visits and hospitalization rates for hypertension, and obesity prevention.

Prince George's County Health Department/Capitol Heights (Suburban), Year One Budget: $1,100,000. This Zone focuses on Capitol Heights and is utilizing resources to expand primary care access and recruit providers to establish five patient-centered medical homes to serve a minimum of 10,000 residents. The goals of this HEZ are to reduce hospitalization rates for asthma, diabetes, and hypertension.

St. Mary's County/Greater Lexington Park. (Rural), Year One Budget: $750,000. The Zone is utilizing funds to expand access to primary and behavioral health services. The goals of this HEZ are to reduce emergency department and hospital admissions for behavioral health conditions and for key chronic conditions such as hypertension, asthma, pulmonary disease, heart failure, and diabetes.

West Baltimore Primary Care Collaborative (Urban), Year One Budget: $1,050,000. This Zone targets reducing cardiovascular disease and utilizes HEZ resources to support recruitment of primary care providers, deploy community health workers, and increase access to community health resources such as gyms and healthy food retailers. The goals of this HEZ are to reduce hospitalization rates for cardiovascular disease, diabetes, and hypertension.

B. Technical Assistance and Guidance

The HEZ Team organized its responsibilities consistent with the assigned provisions in the Act to identify CHRC and DHMH programs that had direct responsibility and authority to implement, manage, and provide technical assistance and consultation during the four year cycle of this Initiative. Six domains were identified wherein State program directors had lead responsibility and oversight. The following are the domains and the types of assistance that was provided:

Cultural Competency: Minority Health and Health Disparities (MHHD) in DHMH

Resources and Assistance:

- Cultural Competency Standards published 2012 by MHHD: Group train-the-trainer guide for presentations to HEZ Coordinating Organizations and partners
- Cultural Competency Primer published 2013 by MHHD: Resource Guide for academic institutions partnering with the HEZ, to support development of training programs
- Upon Request: Response to Disparities-related inquiries to enhance program intervention
- TA Methodology: Web-based information, scheduled trainings, and site visit meetings

Health Data**:** Virtual Data Unit (VDU) in DHMH

Resources and Assistance**:**

- Quarterly report of HEZ Client utilization data and other performance metrics
- Quarterly analysis and review of HEZ Dash Board
- Extensive exploration of best and available outcome metrics for use by the HEZs was conducted by the HEZ Team as a whole
- Access to Cross Industry Standard Process (CRISP) data resources and services: (1) Reporting/ Geographic Information System (GIS) services; (2) Encounter Notification Services; and (3) Query Portal

Public Health: Prevention and Health Promotion Administration (PHPA) in DHMH

Resources and Assistance:

Maternal & Child Health

- Provide quarterly review of Fetal Infant Mortality Team data and trends with Maternal and Child Health Bureau Analyst, Fetal and Infant Mortality Review Coordinator, and Epidemiologist to address trends by partnering with other programs
- Provide on-site training to Family Planning Programs to implement evidence-based tool for assessing alcohol/drug use, smoking, and risk for domestic violence
- Provide training on what to do when a woman screens positive and how Family Planning Program can establish warm referrals
- Provide on-site training on the importance of improving the health of women & children to WIC, family planning, and home visiting programs
- Provide technical assistance to substance abuse treatment programs to provide family planning services on-site to assist in reducing unintended pregnancies and improved birth outcomes (not currently being done). A needs assessment would proceed this TA
- TA Methodology: conference call, site visits, webinars, and staff trainings

Cancer & Chronic Disease

- Engaging partners to protect residents from second-hand smoke exposure in outdoor areas
- Support employers in implementing worksite wellness initiatives as part of the Healthiest Maryland Businesses
- Provide guidance on chronic disease self-management programs
- Provide training on Million Hearts implementation guide
- TA Methodology: conference call, site visits, webinars, staff trainings, and/or best practices resource guides

Behavioral Health: Behavioral Health and Disabilities (BHD) in DHMH

Resources and Assistance:

- Provide review of behavioral health data submitted by Mid-Shore Mental Health Systems (MSMHS)
- Provide review of program management by MSMHS

Delivery Reform: Health Systems and Infrastructure Administration (HSIA) in DHMH

Resources and Assistance**:**

- Workforce Loan Assistance Repayment Program in collaboration with MHEC
- Tax Credit support and processing
- Community Integrated Medical Home framework overview and integration

- Centers for Medicare and Medicaid Services (CMS) Challenge Grant proposal development and submission:
    - Payment Model
    - Data Integration and Quality Improvement – Local Health Improvement Coalition support and capacity building

HEZ Administration and Safety-net Support**:** Community Health Resources Commission (CHRC)

Resources and Assistance:

- Provide administrative coordination of initial HEZ Call for Proposals, review of proposals, and designation of HEZs
- Manage the HEZ Reserve Fund and individual HEZ grant awards and provided fiscal oversight for program
- Collaborate with individual DHMH program directors and the Secretary to achieve seamless oversight and management of HEZ program implementation
- Direct and coordinate the day-to-day work of the HEZ Team members to assist the designated HEZs to start up their respective programs
- Work with the Maryland Comptroller's Office and the Maryland Department of Business and Economic Development to coordinate implementation of the financial incentives built in the legislation
- Access to capacity-building grant opportunities. In addition to funding made available under the Act, the CHRC released its annual Call for Proposals in October 2013, providing potential grant support for the following types of programs: (1) Reducing infant mortality; (2) Increasing dental care services; (3) Supporting new access point and expanding primary care access; (4) Integrating behavioral health services in the community; (5) Promoting administrative capacity-building; and (6) Reducing childhood obesity. This Call for Proposals generated 66 proposals with direct funding requests of $27.1 million. At the time of the submission of this report, the proposals are under evaluation by independent "subject matters" experts who will issue their recommendations to the CHRC Board in early January 2014. A select number of top-scoring applicants will be invited to present to the CHRC Board on January 30, and funding decisions will be made immediately following these presentations. The CHRC is in a position to award approximately $2.85 million this fiscal year (FY 2014).

C. Start-Up Successes and Challenges

Following the designations made in January 2013, implementation of the Zones began in earnest this past spring. At the time of this report, the Zones have approximately six months of program implementation. Following is a synopsis of some of the initial successes and early challenges experienced by the Zones.

Initial Successes

Expanding capacity to deliver services. Across all five zones, a total of eight care delivery sites have been opened or expanded. All five Zones are now providing clinical and other support services supported with resources provided under the Act.

Meeting first year recruitment goals. The Zones articulated a collective Year-One goal of recruiting 38 new health care practitioners, and report the addition of 43 new practitioners, which include physicians, nurse practitioners, and registered nurses to deliver primary care services and licensed clinical social workers and a psychiatrist to deliver behavioral health services. Four of the five HEZs have achieved their Year-One practitioner recruitment goals.

Promoting job creation. The Zones reported the creation of a collective total of 87 jobs during their first six months of operations. This total includes HEZ practitioners, community health workers, and other staff that will deliver care and support the goals of each HEZ.

Early Challenges

Practitioner recruitment challenges. Though the HEZs achieved their overall Year-One practitioner recruitment goals, several of the Zones, especially in rural areas, reported challenges in recruiting primary care physicians. Though loan repayment assistance is available to help with practitioner recruitment efforts, requirements surrounding these incentives created difficulties for the Zones to utilize the assistance fully. Reasons for underutilization by the Zones vary. For example, one nurse practitioner could not access loan repayment assistance because of current statutory requirements that the applicant attend a Maryland school. Challenges to identify and recruit practitioners are not unique to HEZs, as they exist for all health care entities in the state.

Collecting individual patient outcome data across multiple provider sites. Most of the HEZs involve multiple care delivery sites and practitioners, some of whom currently have electronic medical record (EMR) systems while some do not. The Zones are confronting the challenges involved with collecting and reporting individual patient clinical outcome data and aggregating this data across multiple different EMR systems and paper-based systems. The state plans to provide technical assistance with the Zones in Year-Two to help address this data collection and reporting challenge.

IV. Measuring Progress

A. Incentives Available to the HEZs

Loan Repayment

Loan Repayment Assistance was provided in the Health Enterprise Zone Statute as an incentive to recruit and retain providers to HEZs. DHMH is collaborating with the Maryland Higher Education Commission to offer loan repayment to the HEZs through two existing State programs; the Maryland Loan Assistance Repayment Program for Physicians and the Janet L. Hoffman Loan Assistance Repayment Program. The State programs are being utilized to maximize current HEZ dollars. The Maryland Loan Assistance Repayment Program for Physicians (state and federal funds) offers loan repayment to primary care physicians. The Janet L. Hoffman Loan Assistance Repayment Program offers loan repayment to nurses, nurse practitioners, physician's assistants, and social workers.

Tax Credits

Two types of tax credits are offered as incentives by the Act: (1) hiring tax credits and (2) income tax credits. To date, all tax credit materials for both types of tax incentives have been developed. They have not at this time, however, been executed for use in the HEZ. The regulations for the Health Care Practitioner Income Tax Credit have been submitted to the legislature for approval. DHMH and CHRC hope to have the materials for the Health Care Practitioner Income tax credit available in February 2014 once the final regulations are approved. Practitioners who worked in the zone in 2013 will be able to utilize this tax credit once it is posted.

The Employer Hiring Tax Credit requires some statutory amendments to include for-profit and non-profit entities. DHMH and CHRC hope to have the employer hiring tax credit materials available to the HEZs in early summer of 2014 depending on the outcome of the 2014 legislative session. The delay will not have great impact on the HEZs, as they must have an employee working in the zone for at least 12 months before they can claim the hiring tax credit.

A letter of support will be required by the HEZ for all health care practitioner or entities that are applying for tax credit. This letter of support was added to ensure that the practitioners or entities applying for tax credits are directly supporting the HEZ effort. The Zones requested a total of $264,145 in tax credits for Year-One.

B. Impact of Incentives in Attracting HEZ Practitioners to the Zone

The Zones report hiring a total of 43 HEZ practitioners (defined in the Act as licensed primary care providers who offer medical, behavioral health or dental services). This number surpassed the practitioner recruitment goal of 38 originally proposed by the HEZs. In all, 87 jobs have been created by the HEZs. Sixty-one of these jobs were direct hires (defined as those jobs that are supported by HEZ funds or were recruited by the use of HEZ incentives), and 26 were indirect hires (defined as jobs created by the HEZ for their activities but not supported by HEZ funds or hired with the use of HEZ incentives).

Anne Arundel – In 2013, no practitioners from Anne Arundel applied for or received loan payment assistance, nor did they request any tax credits. The HEZ met their goal of hiring two

practitioners for the year, as well as two additional direct hires and three indirect hires. Total jobs created in this Zone in Year One were seven (four direct and three indirect);

Dorchester/Caroline – One practitioner from Dorchester/Caroline applied for the loan repayment program but was found to be ineligible. The HEZ has requested $60,000 in tax incentives for the first year on the program. The practitioner goal for the HEZ was nine for the first year, and the HEZ hired seven. Total jobs created in this Zone in Year One were 16 (16 direct and no indirect).

Prince George's – No practitioners applied for the loan repayment program from Prince George's County, but this Zone requested $64,145 in tax credits. The hiring goal for Prince George's in 2013 was seven practitioners and the Zone was successful in hiring seven practitioners. Total jobs created in this Zone in Year One were 14 (13 direct jobs and one indirect).

St. Mary's – No practitioners from St. Mary's applied for the loan assistance program but the Zone requested $50,000 in tax assistance funds. St. Mary's was successful in reaching their goal of attracting four new practitioners to the Zone. Total jobs created in this Zone in Year One were 12 (eight direct and four indirect).

West Baltimore – Five practitioners from West Baltimore applied for the loan repayment program, with four being found to be eligible for this incentive. Additionally, West Baltimore requested $90,000 in tax credits. The Zone attracted 23 new practitioners, surpassing their goal of 16. Total jobs created in this Zone in Year One are 38 (20 direct and 18 indirect).

C. Impact on Disparities, Health Outcomes, Admissions, Readmissions, and Costs

The ultimate goals of the HEZ program are to improve health outcomes within the HEZs generally, to improve health outcomes in racial and ethnic minority populations within the HEZs in particular, and thereby contribute to reductions in racial/ethnic and geographic health disparities in Maryland. Important outcome measures by which to assess this improvement, explicitly mentioned in the legislation, are hospital admission rates, readmission rates, and hospital costs.

The hospital admission data has about a nine month lag time between the end of a calendar quarter and the availability of the data. As a result, data on hospital admission rates after HEZ inception are still pending. Progress in reporting impact on Disparities, Health Outcomes, Admissions, Readmissions, and Costs in the first year of the HEZ program is to be found in two areas:

- Defining the metrics and data sets to be used for assessment of those impacts, and
- Computing the 2012 baseline values for those metrics.

Metrics that will be used for impact assessment will be the hospital admission rate and the percent of hospital admissions that are readmissions. The data source for these metrics will be the Health Services Cost Review Commission (HSCRC) and the Chesapeake Regional Information System for our patients. Baseline data for all-cause admission rates for each quarter of 2012 have been determined and are summarized in the table below. Baseline values for all-cause admission rates and for disease-specific admission rates (for conditions such as diabetes, high blood pressure, asthma, etc.) are currently being finalized.

V. Program Guidance and Accomplishments

The HEZ Team members from the DHMH and the CHRC provided public health guidelines, operational technical assistance, and in-person consultation to the HEZs as a collective and individually throughout start up efforts during this first year. The following sections describe selected assistance that was provided.

A. Loan Repayment and Tax Credits

The HEZ Initiative provides a range of public incentives and resources to help attract private health care practitioners to serve in underserved communities. These incentives include tax credits and loan repayment. Tax credits and loan repayment were included in the HEZ statute as incentives for recruiting and retaining providers in these underserved areas.

As mentioned in previous sections, Tax Credits have not been launched at this time. CHRC and DHMH anticipate that both tax credits will be launched by spring 2014 and will be utilized to the fullest extent.

DHMH has been working closely with the Maryland Higher Education Commission (MHEC) to align the current available loan repayment programs Maryland Loan Assistance Repayment Program for Physicians (MLARP), and Janet L. Hoffman Loan Assistance Repayment Program with the HEZ initiative to maximize HEZ dollars. Through utilization of existing loan repayment programs, DHMH and CHRC, have been able to provide an additional $510,000 for loan repayment through non-HEZ funding sources thus increasing available HEZ dollars by 12.5%.

In July 2013, one loan repayment recipient was awarded loan repayment through MLARP. DHMH and CHRC anticipate that three more recipients (pending MHEC review) will be awarded loan repayment funding in early 2014. DHMH has increased marketing efforts for loan repayment programs. This includes presentations, webinars, and social media. The increased marketing has brought in more applications for loan repayment but very few applications from the HEZs.

In utilizing the available State programs as a mechanism for funding, DHMH and CHRC have discovered some barriers which may be affecting the utilization of loan repayment programs by the HEZ. The statutory guidelines for MLARP may be too restrictive to accommodate all providers who are interested in loan repayment through the HEZ. Some barriers identified were the numbers hours the provider is required to work per week and their specific work location (i.e. inpatient vs. outpatient). The same is true for the State funded program, the Janet L. Hoffman Loan Assistance Repayment Program which has a maximum salary cap, and the provider must have graduated from a State of Maryland institution to be eligible. DHMH is working closely with MHEC to see if the identified barriers have a possible solution to make the programs more accessible to the HEZs.

B. Performance Measures and Tracking

The activities of each of the five Zones are closely monitored by its coordinating organization (the designee) and by the State. The Zones have developed work plans with key milestones and deliverables and monitor program execution internally with key partners of the Zone. These work plans are made available to the State.

Monitoring by the State occurs through site visits, conference calls, and quarterly progress grant reports. Each Zone is required to submit the quarterly progress reports to the State as a condition for payment of public funds. In addition, the State has developed an "HEZ Dashboard" to assess performance towards key milestones and deliverables and overall progress towards key goals of each Zone. The Dashboards facilitate public reporting, accountability of the Zones, and fiscal stewardship of public resources. In addition, clinical outcome metrics based on national standards such as National Quality Forum and Uniform Data System measures will be incorporated in year two of the program. Zones are required to develop annual performance goals, such as the number of primary care providers hired or number of residents assisted by community health workers. Progress towards reaching these goals is then tracked on a quarterly basis by the State.

There will also be independent evaluation of the HEZ Initiative. In July 2013, the Department of Health and Mental Hygiene and the Community Health Resources Commission issued a call for public comment on how best to evaluate both the impact of individual HEZs and the success of the overall initiative on improving the health of the populations of the HEZs. The evaluation is expected to begin in the first quarter of 2014 and will conclude after the duration of the program (end of calendar year 2016).

C. Cultural Competency Guidelines

The Cultural and Linguistic Competency Workgroup of the Maryland Health Disparities Collaborative is a panel of experts affiliated with community-based organizations, statewide health advocacy organizations, health systems and health plans, health licensing boards, local health departments, and academic institutions. In June 2012, the group submitted a report which included recommendations for assessing the level of cultural and linguistic competence of Health Enterprise Zone applicants.

In 2013, the assessment criteria recommended by the group were used to development an assessment tool for organizations requesting tax incentives as part of the HEZ program. The HEZ tax incentive program has reporting requirements for organizations which include an assessment of cultural competency and submission of the results to DHMH. The tool, MHHD's Cultural Competency Assessment Survey, has been made available online to the HEZs.

Additional cultural competency reporting requirements have been developed by MHHD for healthcare providers seeking loan repayments or tax incentives through the HEZ program. Each provider is required to complete 6 continuing education credits in cultural competency within 12 months of the initial application, with proof of completion to be sent to DHMH.

In fall 2013, DHMH, CHRC, and the HEZs held conference calls to discuss the technical assistance that would be provided by DHMH to each HEZ. MHHD is offering the HEZs cultural competency training to be held in the first half of 2014. A standard curriculum has been

developed for these training sessions which include separate sessions for the HEZ leadership and staff.

D. Behavioral Health Program Resources and Assistance

Mid-Shore Mental Health Systems, Inc. (MSMHS) has been an integral partner in the HEZ project since the planning stage for submitting an application. Behavioral Health is a major component of the Dorchester-Caroline project known locally as Competent Care Connections. Funding has allowed for the expansion of Eastern Shore Mobile Crisis Services (ESMCS) for a team to specifically serve Dorchester and Caroline Counties. MSMHS contracted with Affiliated Santé Group to provide the additional team with program oversight provided by MSMHS on an ongoing basis. MSMHS is a member of the Dorchester-Caroline HEZ Advisory Committee and attends quarterly meetings for the project in preparation for submission of quarterly reports. MSMHS participated in a meeting held at AHEC on November 15th with CHRC to review outcomes for the project. Review of data submitted specific to the Caroline/Dorchester team is conducted on a monthly basis to ensure compliance with DHMH requests. Through the month of November, there have been 143 dispatches of the new team.

Monthly case reviews with ESMCS are held with MSMHS as well as monthly administrative meetings with MSMHS Community Programs Administrator, the ESMCS Director and Eastern Shore Operations Center (ESOC-Crisis Call Center) Coordinator to ensure the quality of operations between the call center and mobile crisis teams.

E. Chronic Disease Guidelines and Assistance

The Prevention and Health Promotion Administration (PHPA) has taken an active interest in providing guidance and technical assistance to the HEZs. PHPA was an active participant in discussions regarding the criteria for including geographic areas to apply to be an HEZ, providing data and maps, as well as staff to help organize this effort. Once the HEZs were selected, PHPA participated in five technical assistance calls with the HEZs and offered Maternal and Child Health and Cancer and Chronic Disease resources and assistance found in the HEZ: Technical Assistance and Guidance section of this report.

As many of the program HEZ outcome goals were chronic disease related, the Center for Chronic Disease Prevention and Control (CCDPC) provided expertise and technical assistance on an individual basis.

The following list shows specific examples of technical assistance provided by CCDPC:

- Prince George's HEZ - offered Healthiest Maryland Businesses (HMB) training to Prince George's County Health Department and three Mayors (Fairmont Heights, Seat Pleasant, and Capital Heights) so they may outreach to local businesses to join their efforts to improve health outcomes.
- St. Mary's HEZ - CCDPC responded to a request for evidence-based faith-based nutrition initiatives with detailed information for three programs: Healthy Bodies, Healthy Souls, ADA's Project Power, and Body and Soul, a program used by the Mid-Shore LHIC. Links to these programs, along with evidence that supports these programs were also provided.

- West Baltimore HEZ/PCMH Maryland Learning Collaborative - CCDPC met with Dr. Khanna to discuss the Patient Centered Medical Homes' role in the West Baltimore HEZ and the quality metrics to be utilized in the HEZ. Team-based care models and available Million Hearts resources can be incorporated into private practices, Federally Qualified Health Centers, and State and Local Health Departments.
- CCDPC provided uniform data measures to align chronic disease and associated risk factor outcomes in primary care from care provided by practices and FQHCs in each HEZ.

CCDPC also identified funding to support Maryland Million Hearts Coordinators in four jurisdictions in Maryland, including two jurisdictions that contain HEZs (St. Mary's County - $110,500 and Baltimore City - $123,000). These coordinators will focus on improving hypertension control through clinical quality improvement efforts in alignment with the expanded chronic care model by implementing the following activities:

- Engaging community partners
- Identifying community resources for patients with hypertension
- Developing a hypertension response plan in each jurisdiction to address obesity, nutrition, and social determinants of health to comprehensively treat patients with hypertension
- Collaborating with public and private health care providers on meaningful data use and aggregating NQF 18 (hypertension control) data where possible
- Reducing emergency department visits for hypertension through care coordination, use of Community Health Workers, and community pharmacists

F. Evaluation

Evaluation is the term that describes a formal process for assessing the success of a program across all of its aspects: establishment and set-up, ongoing operations, and impact on targeted outcomes. External evaluation by an outside party is considered to be the best way to obtain an unbiased assessment of a project. The HEZ program plan calls for an external evaluation. The accomplishments to date regarding evaluation of the HEZ program are development of a quantitative evaluation framework, and drafting the Request for Proposals for the external evaluation.

Quantitative evaluation of the HEZ program will follow the Donabedian model of health services assessment, which divides the analysis into Structure, Process, and Outcome components:

Structure: Evaluation of structure focuses on the degree to which **service capacity** and/or **service quality** has been enhanced in the HEZs as a result of new physical plant, new personnel, and/or new skills developed in training programs. Structural metrics will measure new sites opened, FTE's of new personnel hired, new care encounter capacity added to the zones, and training rates for zone employees.

Process: Evaluation of process is evaluation of **operations:** here it focuses the **utilization rate** of the new service capacity within the HEZs, and the degree of **quality of those services** as compared to national benchmarks. Utilization rate process metrics assess the productivity of the newly deployed capacity, indicate the value for dollar in terms of service delivery, define the reach of the HEZ program, and are critical for understanding the long term solvency and sustainability of the newly-established HEZ providers. Process metrics will measure provider productivity, reach to persons previously without a provider, productivity and reach of community health workers, and how well provider care follows national guidelines.

Outcome: Evaluation of outcomes focuses on whether the enhancements to capacity and the operations using that capacity have made an **impact on the health** of the people served, and on the health of the HEZ more generally. Outcome assessment is the ultimate determination of success or failure of the HEZ program. Outcome metrics which reflect population health will include hospitalization rates and emergency department visit rates (for all causes and for specific conditions) and measures of chronic disease control (taken from national standards).

Several of these metrics are being reported quarterly as a part of Performance Tracking and Management. Some of the above metrics are still under development.

The HEZ program will undergo external evaluation, which is expected to begin in 2014, as the solicitation for this vendor is the in the final stages of development and is expected to be released in the first quarter of the year. The external evaluation will independently review and evaluate the quantitative data described above. In addition, the external evaluation contractor will collect qualitative data by surveys, focus groups, and key informant interviews with HEZ residents, patients, providers, administrators and staff. This will provide important insights into the levels of awareness of and satisfaction with the HEZ from the perspective of these various kinds of stakeholders.

VI. Year Two - 2014 Plans

In year two, calendar year 2014, the HEZ Team in partnership with the HEZs will ensure that all start up activities are complete, operations are modified based on lessons learned, and ongoing oversight focuses on achievement of the stated objectives for each HEZ.

The program impact metrics will be explored and refined within each HEZ and across HEZs where disease reduction and interventions are similar. One such exploration will be to examine whether removing admissions for childbirth from the all-cause admission metric gives a clearer picture of potential HEZ impact. The HEZ team will also be working collaboratively with each of the Zones to encourage their collection of individual clinical outcome metrics, which will be based on national standards.

In addition to admissions, readmissions, and cost, another set of useful outcomes for HEZ impact assessment may be emergency department (ED) visit rates and emergency department costs. In Year Two of the program, CHRC and DHMH staff will assess the feasibility and value of adding these ED visit rate and ED cost metrics to the set of performance measures for HEZ tracking.

Cultural competency and Culturally and Linguistically Appropriate Services (CLAS) Standards training will be offered to the HEZ leadership and front line staff to aid in increasing diverse population's understanding and acceptability of services and messages provided.

Additional resources will be provided in the form of federal grants, data analyst experts, training and other support to strengthen each HEZ's capacity to revitalize public health with community partnerships at the local level.

An HEZ Conference is planned for the spring with funds from the Robert Wood Johnson Foundation (RWJF) for the purpose of bringing national experts to Maryland who can share their knowledge and experience implementing enterprise movements in communities with poverty. At this Conference, the Maryland HEZs will have an opportunity to share their experiences and increase collaboration throughout the State.

VII. Appendices

A. Maryland Health Improvement and Disparities Reduction Act of 2012
B. 2012 Joint Chairmen's Report, Page 79, M00R01.03 – Maryland Community Health Commission – Health Enterprise Zones
C. HEZ Call for Proposals (October 2012)
D. Health Enterprise Zone Applications (19)

Chapter 3

(Senate Bill 234)

AN ACT concerning

Maryland Health Improvement and Disparities Reduction Act of 2012

FOR the purpose of requiring the Secretary of Health and Mental Hygiene to designate certain areas as Health Enterprise Zones in a certain manner; specifying the purpose of establishing Health Enterprise Zones; ~~requiring~~ authorizing the ~~Department~~ Secretary, in consultation with the Community Health Resources Commission, to adopt certain regulations; requiring the Secretary to consult with the Office of Minority Health and Health Disparities in implementing this Act; authorizing certain nonprofit community–based organizations or local government agencies to apply to the ~~Commission~~ Secretary on behalf of certain areas for designation as Health Enterprise Zones; establishing certain procedures and requirements in connection with the application process; requiring the Commission to make certain recommendations to the Secretary; requiring the Secretary to consider certain factors when designating areas as health enterprise zones and authorizing the Secretary to direct the Commission to conduct certain outreach efforts; requiring the Commission to report to certain committees of the General Assembly on certain information after certain applications are received by the Commission; authorizing the Secretary to limit the number of areas designated as Health Enterprise Zones; requiring the Commission and Secretary to give priority to applications in a certain manner; requiring the Commission to provide funding in accordance with the designation of the Secretary of a Health Enterprise Zone; authorizing certain licensed health care providers who practice in the Health Enterprise Zones to receive certain benefits, including certain grants; authorizing certain nonprofit community–based organizations or local government agencies to receive certain grants; establishing a Health Enterprise Zone Reserve Fund; requiring the Commission and the ~~Department~~ Secretary to submit certain annual reports; allowing a credit against the State income tax for certain health care providers who practice in Health Enterprise Zones under certain circumstances; ~~allowing certain nonprofit community–based organizations or local government agencies to assign certain tax credits~~ allowing a refundable State income tax credit in certain circumstances for certain health care providers who practice in, and hire certain health care providers to practice in, a Health Enterprise Zone; requiring the Department to certify to the Comptroller the applicability of the credit for each health care provider and the amount of each credit assigned; limiting the amount of the credits allowed for a fiscal year; requiring the Department, in consultation with the Comptroller, to adopt certain regulations; requiring a certain evaluation system to establish and incorporate a certain set of measures regarding racial

and ethnic variations in quality and outcomes and include certain information on certain actions taken relating to health disparities; requiring a certain community benefit report to include certain information relating to health disparities; requiring certain institutions of higher education to make a certain annual report to the Governor and the General Assembly relating to health disparities; requiring the Health Services Cost Review Commission and the Maryland Health Care Commission to conduct a certain study, develop certain regulations, and report to the Governor and General Assembly on or before a certain date; requiring the Maryland Health Quality and Cost Council to convene a certain workgroup and issue a certain report on or before a certain date; defining certain terms; providing for the application of certain provisions of this Act; providing for the termination of certain provisions of this Act; and generally relating to health improvement and the reduction of health disparities.

BY adding to
Article – Health – General
Section 20–904; and 20–1401 through ~~20–1406~~ 20–1407 to be under the new subtitle "Subtitle 14. Health Enterprise Zones"
Annotated Code of Maryland
(2009 Replacement Volume and 2011 Supplement)

BY adding to
Article – Tax – General
Section 10–731
Annotated Code of Maryland
(2010 Replacement Volume and 2011 Supplement)

BY repealing and reenacting, with amendments,
Article – Health – General
Section 19–134(c) and 19–303(c)
Annotated Code of Maryland
(2009 Replacement Volume and 2011 Supplement)

Preamble

WHEREAS, The State of Maryland has numerous advantages for its residents to enjoy good health care, such as the 3rd highest median household income, the 2nd highest number of primary care physicians per capita, the 10th lowest rate of smoking, and outstanding medical schools; and

WHEREAS, Despite these advantages, the State continues to lag behind other states on a number of key health indicators, such as ranking 43rd in infant mortality, 31st in early prenatal care, 28th in obesity prevalence, 31st in diabetes prevalence, 35th in cardiovascular deaths, 32nd in cancer deaths, and 33rd for geographic health disparities; and

WHEREAS, The State also demonstrates significant disparities in health care and health outcomes; and

WHEREAS, Examples of these disparities include a Black or African American death rate from HIV/AIDS that is 15 times higher than the White rate; an American Indian or Alaska Native end–stage kidney disease rate that is 3 times the White rate; an Asian or Pacific Islander death rate from tuberculosis that is 9 times higher than the White ~~rate, and~~ rate; a Hispanic rate of lack of health insurance that is 4.4 times the White rate; and a White rate of completion of advance directives that is 2 times the Minority rate; and

WHEREAS, Health disparities exist in urban, suburban, and rural communities in the State; and

WHEREAS, Communities where significant health disparities exist also often face shortages in the primary health care workforce, including nurses; and

WHEREAS, Health disparities are the result of modifiable health care system factors, community factors, and individual factors; and

WHEREAS, Key strategies for reducing and eliminating health disparities include collection and analysis of racial and ethnic data; inclusion of minority communities in health planning and outreach to those communities with health education and health services; cultural and linguistic health competency among service providers; diversity in the health care and public health workforce; access to primary care practitioners; and attention to the social determinants of health; and

WHEREAS, Health disparities present a serious fiscal challenge for our State and nation and result in significant costs; a 2009 report titled "The Economic Burden of Health and Equalities in the United States" released by the Joint Center for Political and Economic Studies found that between 2003 and 2006, the U.S. could have saved nearly $230 billion in direct medical care costs if racial and ethnic health disparities did not exist; and

WHEREAS, By 2045, over one–half of the U.S. population will be persons of color, and in order to reach health equity and stem the tide of rising health care costs, the State must take advantage of the tools provided by the federal Affordable Care Act to expand access, eliminate disparities, and make Maryland the healthiest state in the nation; and

WHEREAS, The Maryland Health Quality and Cost Council formed a workgroup to examine ways to reduce health disparities in the State; and

WHEREAS, The workgroup noted significant disparities between blacks and whites in Maryland in hospital admission rates measured by the federal Agency for Healthcare Research and Quality; and

WHEREAS, The workgroup found that these admission disparities were especially high for lung disease, cardiovascular disease, and diabetes; and

WHEREAS, The workgroup and the Maryland Health Quality and Cost Council recommended taking aggressive action to reduce health disparities in Maryland and improve the health of all Marylanders; now, therefore,

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health – General

SUBTITLE 14. HEALTH ENTERPRISE ZONES.

20–1401.

(A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(B) "AREA" MEANS A CONTIGUOUS GEOGRAPHIC AREA THAT:

(1) DEMONSTRATES MEASURABLE AND DOCUMENTED HEALTH DISPARITIES AND POOR HEALTH OUTCOMES; AND

(2) IS SMALL ENOUGH TO ALLOW FOR THE INCENTIVES OFFERED UNDER THIS SUBTITLE TO HAVE A SIGNIFICANT IMPACT ON IMPROVING HEALTH OUTCOMES AND REDUCING HEALTH DISPARITIES, INCLUDING RACIAL, ETHNIC, AND GEOGRAPHIC HEALTH DISPARITIES.

(C) "COMMISSION" MEANS THE COMMUNITY HEALTH RESOURCES COMMISSION.

(D) "FUND" MEANS THE HEALTH ENTERPRISE ZONE RESERVE FUND ESTABLISHED UNDER § 20–1406 OF THIS SUBTITLE.

~~(D)~~ (E) "HEALTH ENTERPRISE ZONE" MEANS A CONTIGUOUS GEOGRAPHIC AREA THAT:

(1) DEMONSTRATES MEASURABLE AND DOCUMENTED HEALTH DISPARITIES AND POOR HEALTH OUTCOMES;

(2) IS SMALL ENOUGH TO ALLOW FOR THE INCENTIVES OFFERED UNDER THIS SUBTITLE TO HAVE A SIGNIFICANT IMPACT ON IMPROVING HEALTH OUTCOMES AND REDUCING HEALTH DISPARITIES, INCLUDING RACIAL, ETHNIC, AND GEOGRAPHIC HEALTH DISPARITIES; AND

(3) IS DESIGNATED AS A HEALTH ENTERPRISE ZONE BY THE COMMISSION AND THE SECRETARY IN ACCORDANCE WITH THE PROVISIONS OF THIS SUBTITLE.

~~(E)~~ (F) "HEALTH ENTERPRISE ZONE PRACTITIONER" MEANS A ~~LICENSED HEALTH CARE PROVIDER WHO PRACTICES AS A FAMILY PHYSICIAN, AN INTERNIST, A PEDIATRICIAN, AN OBSTETRICIAN, A GYNECOLOGIST, A GERIATRICIAN, A PSYCHIATRIST, A DENTIST, OR A PRIMARY CARE NURSE PRACTITIONER~~ HEALTH CARE PRACTITIONER WHO IS LICENSED OR CERTIFIED UNDER THE HEALTH OCCUPATIONS ARTICLE AND WHO PROVIDES:

(1) PRIMARY CARE, INCLUDING OBSTETRICS, GYNECOLOGICAL SERVICES, PEDIATRIC SERVICES, OR GERIATRIC SERVICES;

(2) BEHAVIORAL HEALTH SERVICES, INCLUDING MENTAL HEALTH OR ALCOHOL AND SUBSTANCE ABUSE SERVICES; OR

(3) DENTAL SERVICES.

20–1402.

(A) THE PURPOSE OF ESTABLISHING HEALTH ENTERPRISE ZONES IS TO TARGET STATE RESOURCES TO REDUCE HEALTH DISPARITIES, IMPROVE HEALTH OUTCOMES, AND REDUCE HEALTH COSTS AND HOSPITAL ADMISSIONS AND READMISSIONS IN SPECIFIC AREAS OF THE STATE.

(B) (1) THE ~~DEPARTMENT~~ SECRETARY, IN CONSULTATION WITH THE COMMISSION, ~~SHALL~~ MAY ADOPT REGULATIONS TO CARRY OUT THE PROVISIONS OF THIS SUBTITLE AND TO SPECIFY ELIGIBILITY CRITERIA AND APPLICATION, APPROVAL, AND MONITORING PROCESSES FOR THE BENEFITS UNDER THIS SUBTITLE.

(2) THE SECRETARY SHALL CONSULT WITH THE OFFICE OF MINORITY HEALTH AND HEALTH DISPARITIES IN IMPLEMENTING THE PROVISIONS OF THIS SUBTITLE.

20–1403.

(A) IN ORDER FOR AN AREA TO RECEIVE DESIGNATION AS A HEALTH ENTERPRISE ZONE, A NONPROFIT COMMUNITY–BASED ORGANIZATION OR A LOCAL GOVERNMENT AGENCY SHALL APPLY TO THE ~~COMMISSION~~ SECRETARY ON BEHALF OF THE AREA TO RECEIVE DESIGNATION.

(B) THE APPLICATION SHALL BE IN THE FORM AND MANNER AND CONTAIN THE INFORMATION THAT THE COMMISSION AND THE SECRETARY REQUIRE.

(C) THE APPLICATION SHALL CONTAIN AN EFFECTIVE AND SUSTAINABLE PLAN TO REDUCE HEALTH DISPARITIES, REDUCE COSTS OR PRODUCE SAVINGS TO THE HEALTH CARE SYSTEM, AND IMPROVE HEALTH OUTCOMES, INCLUDING:

(1) A DESCRIPTION OF THE PLAN OF THE NONPROFIT COMMUNITY–BASED ORGANIZATION OR LOCAL GOVERNMENT AGENCY TO UTILIZE FUNDING AVAILABLE UNDER THIS SUBTITLE TO ADDRESS HEALTH CARE PROVIDER CAPACITY, IMPROVE HEALTH SERVICES DELIVERY, EFFECTUATE COMMUNITY IMPROVEMENTS, OR CONDUCT OUTREACH AND EDUCATION EFFORTS; AND

(2) A PROPOSAL TO USE FUNDING AVAILABLE UNDER THIS SUBTITLE TO PROVIDE FOR LOAN REPAYMENT INCENTIVES TO INDUCE HEALTH ENTERPRISE ZONE PRACTITIONERS TO PRACTICE IN THE AREA.

(D) THE APPLICATION MAY ALSO CONTAIN A PLAN TO UTILIZE OTHER BENEFITS, INCLUDING:

(1) TAX CREDITS AVAILABLE UNDER THIS SUBTITLE AND § 10–731 OF THE TAX – GENERAL ARTICLE TO ENCOURAGE HEALTH ENTERPRISE ZONE PRACTITIONERS TO ESTABLISH OR EXPAND HEALTH CARE PRACTICES IN THE AREA; ~~AND~~

(2) A PROPOSAL TO USE INNOVATIVE PUBLIC HEALTH STRATEGIES TO REDUCE HEALTH DISPARITIES IN THE AREA, SUCH AS THE USE OF COMMUNITY HEALTH WORKERS, HEALTH COACHES, REGISTERED DIETICIANS, OPTOMETRISTS, PEER LEARNING, AND COMMUNITY–BASED DISEASE MANAGEMENT ACTIVITIES, THAT COULD BE SUPPORTED BY GRANTS AWARDED UNDER THIS SUBTITLE; AND

~~(2)~~ (3) A PROPOSAL TO USE OTHER INCENTIVES OR MECHANISMS TO ADDRESS HEALTH DISPARITIES THAT FOCUS ON WAYS TO EXPAND ACCESS TO CARE, EXPAND ACCESS TO FRESH PRODUCE THROUGH

GROCERY STORES AND FARMER'S MARKETS, PROMOTE HIRING, AND REDUCE COSTS TO THE HEALTH CARE SYSTEM.

20–1404.

(A) THE COMMISSION SHALL MAKE RECOMMENDATIONS TO THE SECRETARY ON THE DESIGNATION OF HEALTH ENTERPRISE ZONES UNDER THIS SUBTITLE.

(B) (1) THE SECRETARY SHALL DESIGNATE AREAS AS HEALTH ENTERPRISE ZONES IN ACCORDANCE WITH THIS SUBTITLE.

(2) THE SECRETARY SHALL CONSIDER GEOGRAPHIC DIVERSITY, AMONG OTHER FACTORS, WHEN DESIGNATING AREAS AS HEALTH ENTERPRISE ZONES AND MAY DIRECT THE COMMISSION TO CONDUCT OUTREACH EFFORTS TO FACILITATE A GEOGRAPHICALLY DIVERSE POOL OF APPLICANTS, INCLUDING PROMOTING APPLICATIONS FROM RURAL AREAS.

(3) AFTER RECEIVING ALL APPLICATIONS SUBMITTED TO THE COMMISSION, THE COMMISSION SHALL REPORT, IN ACCORDANCE WITH § 2–1246 OF THE STATE GOVERNMENT ARTICLE, TO THE SENATE FINANCE COMMITTEE AND THE HOUSE HEALTH AND GOVERNMENT OPERATIONS COMMITTEE ON THE NAMES OF APPLICANTS AND GEOGRAPHIC AREAS IN WHICH APPLICANTS ARE LOCATED.

(C) THE SECRETARY MAY LIMIT THE NUMBER OF AREAS DESIGNATED AS HEALTH ENTERPRISE ZONES IN ACCORDANCE WITH THE STATE BUDGET.

(D) THE COMMISSION AND THE SECRETARY SHALL GIVE PRIORITY TO APPLICATIONS THAT DEMONSTRATE THE FOLLOWING:

(1) SUPPORT FROM AND PARTICIPATION OF KEY STAKEHOLDERS IN THE PUBLIC AND PRIVATE SECTORS, INCLUDING RESIDENTS OF THE AREA AND LOCAL GOVERNMENT;

(2) A PLAN FOR LONG–TERM FUNDING AND SUSTAINABILITY;

(3) INCLUSION OF SUPPORTING FUNDS FROM THE PRIVATE SECTOR;

(4) ~~THE SUPPORT~~ INTEGRATION WITH THE STATE HEALTH IMPROVEMENT PROCESS AND THE GOALS SET OUT IN THE STRATEGIC PLAN OF THE LOCAL HEALTH IMPROVEMENT COALITION;

(5) A PLAN FOR EVALUATION OF THE IMPACT OF DESIGNATION OF THE PROPOSED AREA AS A HEALTH ENTERPRISE ZONE; AND

(6) OTHER FACTORS THAT THE COMMISSION AND THE SECRETARY DETERMINE ARE APPROPRIATE TO DEMONSTRATE A COMMITMENT TO REDUCE DISPARITIES AND IMPROVE HEALTH OUTCOMES.

(E) THE DECISION OF THE SECRETARY TO DESIGNATE AN AREA AS A HEALTH ENTERPRISE ZONE IS FINAL.

20–1405.

(A) HEALTH ENTERPRISE ZONE PRACTITIONERS THAT PRACTICE IN A HEALTH ENTERPRISE ZONE MAY RECEIVE:

(1) TAX CREDITS AGAINST THE STATE INCOME TAX AS PROVIDED IN § 10–731 OF THE TAX – GENERAL ARTICLE;

(2) LOAN REPAYMENT ASSISTANCE, AS PROVIDED FOR IN THE APPLICATION FOR DESIGNATION FOR THE HEALTH ENTERPRISE ZONE AND APPROVED BY THE SECRETARY AND THE COMMISSION UNDER THIS SUBTITLE;

(3) PRIORITY TO ENTER THE MARYLAND PATIENT CENTERED MEDICAL HOME PROGRAM, IF THE HEALTH ENTERPRISE ZONE PRACTITIONER MEETS THE STANDARDS DEVELOPED BY THE MARYLAND HEALTH CARE COMMISSION FOR ENTRY INTO THE PROGRAM; AND

(4) PRIORITY FOR THE RECEIPT OF ANY STATE FUNDING AVAILABLE FOR ELECTRONIC HEALTH RECORDS, IF FEASIBLE AND IF OTHER STANDARDS FOR RECEIPT OF THE FUNDING ARE MET.

(B) A NONPROFIT COMMUNITY–BASED ORGANIZATION OR A LOCAL GOVERNMENT AGENCY THAT APPLIES ON BEHALF OF AN AREA FOR DESIGNATION AS A HEALTH ENTERPRISE ZONE MAY RECEIVE GRANTS, AS DETERMINED BY THE COMMISSION AND THE SECRETARY, TO IMPLEMENT ACTIONS OUTLINED IN THE ORGANIZATION'S OR AGENCY'S APPLICATION TO IMPROVE HEALTH OUTCOMES AND REDUCE HEALTH DISPARITIES IN THE HEALTH ENTERPRISE ZONE.

(C) (1) A HEALTH ENTERPRISE ZONE PRACTITIONER MAY APPLY TO THE SECRETARY FOR A GRANT TO DEFRAY THE COSTS OF CAPITAL OR LEASEHOLD IMPROVEMENTS TO, OR MEDICAL OR DENTAL EQUIPMENT TO BE USED IN, A HEALTH ENTERPRISE ZONE.

(2) TO QUALIFY FOR A GRANT UNDER PARAGRAPH (1) OF THIS SUBSECTION, A HEALTH ENTERPRISE ZONE PRACTITIONER SHALL:

(I) OWN OR LEASE THE HEALTH CARE FACILITY; AND

(II) PROVIDE HEALTH CARE FROM THAT FACILITY.

(3) (I) A GRANT TO DEFRAY THE COST OF MEDICAL OR DENTAL EQUIPMENT MAY NOT EXCEED THE LESSER OF $25,000 OR 50% OF THE COST OF THE EQUIPMENT.

(II) GRANTS FOR CAPITAL OR LEASEHOLD IMPROVEMENTS SHALL BE FOR THE PURPOSES OF IMPROVING OR EXPANDING THE DELIVERY OF HEALTH CARE IN THE HEALTH ENTERPRISE ZONE.

20–1406.

(A) THERE IS A HEALTH ENTERPRISE ZONE RESERVE FUND.

(B) THE FUND IS A SPECIAL, NONLAPSING FUND THAT IS NOT SUBJECT TO § 7–302 OF THE STATE FINANCE AND PROCUREMENT ARTICLE.

(C) (1) THE STATE TREASURER SHALL INVEST THE MONEY OF THE FUND IN THE SAME MANNER AS OTHER STATE MONEY MAY BE INVESTED.

(2) ANY INVESTMENT EARNINGS OF THE FUND SHALL BE CREDITED TO THE GENERAL FUND OF THE STATE.

(D) THE MONEY IN THE FUND SHALL BE USED FOR:

(1) ANY ACTIVITY AUTHORIZED UNDER THIS SUBTITLE; AND

(2) THE STATE INCOME TAX CREDIT AUTHORIZED UNDER § 10–731 OF THE TAX – GENERAL ARTICLE.

(E) THE COMMISSION SHALL ADMINISTER THE FUND AND PROVIDE FUNDING IN ACCORDANCE WITH THE DESIGNATION BY THE SECRETARY OF A HEALTH ENTERPRISE ZONE UNDER THIS SUBTITLE.

20–1407.

ON OR BEFORE DECEMBER 15 OF EACH YEAR, THE COMMISSION AND THE ~~DEPARTMENT~~ SECRETARY SHALL SUBMIT TO THE GOVERNOR AND, IN

ACCORDANCE WITH § 2–1246 OF THE STATE GOVERNMENT ARTICLE, THE GENERAL ASSEMBLY, A REPORT THAT INCLUDES:

(1) THE NUMBER AND TYPES OF INCENTIVES GRANTED IN EACH HEALTH ENTERPRISE ZONE;

(2) ~~ANY EVIDENCE~~ EVIDENCE OF THE ~~SUCCESS~~ IMPACT OF THE TAX AND LOAN REPAYMENT INCENTIVES IN ATTRACTING HEALTH ENTERPRISE ZONE PRACTITIONERS TO HEALTH ENTERPRISE ZONES;

(3) ~~ANY EVIDENCE~~ EVIDENCE OF THE ~~SUCCESS~~ IMPACT OF THE INCENTIVES OFFERED IN HEALTH ENTERPRISE ZONES IN REDUCING HEALTH DISPARITIES AND IMPROVING HEALTH OUTCOMES; AND

(4) ~~ANY EVIDENCE~~ EVIDENCE OF THE ~~SUCCESS~~ PROGRESS IN REDUCING HEALTH COSTS AND HOSPITAL ADMISSIONS AND READMISSIONS IN HEALTH ENTERPRISE ZONES.

Article – Tax – General

10–731.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "DEPARTMENT" MEANS THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE.

(3) "FUND" MEANS THE HEALTH ENTERPRISE ZONE RESERVE FUND ESTABLISHED UNDER § 20–1406 OF THE HEALTH – GENERAL ARTICLE.

~~(3)~~ (4) "HEALTH ENTERPRISE ZONE" HAS THE MEANING STATED IN § 20–1401 OF THE HEALTH – GENERAL ARTICLE.

~~(4)~~ (5) "HEALTH ENTERPRISE ZONE PRACTITIONER" HAS THE MEANING STATED IN § 20–1401 OF THE HEALTH – GENERAL ARTICLE.

(6) "QUALIFIED EMPLOYEE" MEANS A HEALTH ENTERPRISE ZONE PRACTITIONER, COMMUNITY HEALTH WORKER, OR INTERPRETER WHO:

(I) PROVIDES DIRECT SUPPORT TO A HEALTH ENTERPRISE ZONE PRACTITIONER; AND

(II) EXPANDS ACCESS TO SERVICES IN A HEALTH ENTERPRISE ZONE.

(7) (I) "QUALIFIED POSITION" MEANS A QUALIFIED EMPLOYEE POSITION THAT:

1. PAYS AT LEAST 150% OF THE FEDERAL MINIMUM WAGE;

2. IS FULL TIME AND OF INDEFINITE DURATION;

3. IS LOCATED IN A HEALTH ENTERPRISE ZONE;

4. IS NEWLY CREATED AS A RESULT OF THE ESTABLISHMENT OF, OR EXPANSION OF SERVICES IN, A HEALTH ENTERPRISE ZONE; AND

5. IS FILLED.

(II) "QUALIFIED POSITION" DOES NOT INCLUDE A POSITION THAT IS FILLED FOR A PERIOD OF LESS THAN 12 MONTHS.

(B) A HEALTH ENTERPRISE ZONE PRACTITIONER WHO PRACTICES HEALTH CARE IN A HEALTH ENTERPRISE ZONE MAY BE ELIGIBLE FOR A TAX CREDIT AGAINST THE STATE INCOME TAX IN ACCORDANCE WITH A PROPOSAL APPROVED BY THE SECRETARY OF HEALTH AND MENTAL HYGIENE, IF THE INDIVIDUAL:

(1) DEMONSTRATES COMPETENCY IN CULTURAL, LINGUISTIC, AND HEALTH LITERACY IN A MANNER DETERMINED BY THE DEPARTMENT;

(2) ACCEPTS AND PROVIDES CARE FOR PATIENTS ENROLLED IN THE MARYLAND MEDICAL ASSISTANCE PROGRAM AND FOR UNINSURED PATIENTS; AND

(3) MEETS ANY OTHER CRITERIA ESTABLISHED BY THE DEPARTMENT.

(C) (1) A NONPROFIT COMMUNITY–BASED ORGANIZATION OR A LOCAL GOVERNMENT AGENCY ~~MAY SUBMIT~~ THAT SUBMITS A PROPOSAL TO THE DEPARTMENT AND THE COMMUNITY HEALTH RESOURCES COMMISSION UNDER TITLE 20, SUBTITLE 14 OF THE HEALTH – GENERAL ARTICLE ~~REQUESTING AN ALLOCATION OF TAX CREDITS AGAINST THE STATE INCOME TAX FOR USE BY~~ MAY ALSO SUBMIT TO THE DEPARTMENT A REQUEST FOR

CERTIFICATION OF ELIGIBILITY FOR CERTAIN INCOME TAX CREDITS ON BEHALF OF A HEALTH ENTERPRISE ZONE ~~PRACTITIONERS~~ PRACTITIONER PRACTICING OR SEEKING TO PRACTICE IN A HEALTH ENTERPRISE ZONE.

(2) THE PROPOSAL SHALL MEET THE REQUIREMENTS SPECIFIED UNDER TITLE 20, SUBTITLE 14 OF THE HEALTH – GENERAL ARTICLE.

(D) ~~IF THE DEPARTMENT APPROVES A PROPOSAL SUBMITTED UNDER THIS SECTION AND UNDER TITLE 20, SUBTITLE 14 OF THE HEALTH – GENERAL ARTICLE, THE NONPROFIT COMMUNITY–BASED ORGANIZATION OR LOCAL GOVERNMENT AGENCY THAT SUBMITTED THE PROPOSAL MAY ASSIGN THE TAX CREDIT AMOUNTS ALLOCATED TO THE HEALTH ENTERPRISE ZONE FOR A TAXABLE YEAR TO HEALTH ENTERPRISE ZONE PRACTITIONERS THAT ESTABLISH, EXPAND, OR MAINTAIN HEALTH CARE PRACTICES IN THE HEALTH ENTERPRISE ZONE DURING THE TAXABLE YEAR AND MEET THE REQUIREMENTS OF THIS SECTION.~~

~~(E) A HEALTH ENTERPRISE ZONE PRACTITIONER MAY CLAIM A CREDIT AGAINST THE STATE INCOME TAX IN AN AMOUNT EQUAL TO THE AMOUNT OF THE TAX CREDIT ASSIGNED BY THE NONPROFIT COMMUNITY–BASED ORGANIZATION OR LOCAL GOVERNMENT AGENCY, AS CERTIFIED BY THE DEPARTMENT, FOR THE TAXABLE YEAR~~

(1) IF THE DEPARTMENT APPROVES A REQUEST FOR CERTIFICATION SUBMITTED UNDER THIS SECTION, A HEALTH ENTERPRISE ZONE PRACTITIONER MAY CLAIM A CREDIT AGAINST THE STATE INCOME TAX IN AN AMOUNT EQUAL TO 100% OF THE AMOUNT OF THE STATE INCOME TAX EXPECTED TO BE DUE FROM THE HEALTH ENTERPRISE ZONE PRACTITIONER FROM INCOME TO BE DERIVED FROM PRACTICE IN THE HEALTH ENTERPRISE ZONE, AS CERTIFIED BY THE DEPARTMENT FOR THE TAXABLE YEAR.

(2) (I) IN ADDITION TO THE STATE INCOME TAX CREDIT PROVIDED UNDER PARAGRAPH (1) OF THIS SUBSECTION, A HEALTH ENTERPRISE ZONE PRACTITIONER MAY CLAIM A REFUNDABLE CREDIT OF $10,000 AGAINST THE STATE INCOME TAX FOR HIRING FOR A QUALIFIED POSITION IN THE HEALTH ENTERPRISE ZONE, AS CERTIFIED BY THE DEPARTMENT FOR THE TAXABLE YEAR.

(II) TO BE ELIGIBLE FOR THE CREDIT PROVIDED UNDER THIS PARAGRAPH, A HEALTH ENTERPRISE ZONE PRACTITIONER MAY CREATE ONE OR MORE QUALIFIED POSITIONS DURING ANY 24–MONTH PERIOD.

(III) THE CREDIT EARNED UNDER THIS PARAGRAPH SHALL BE TAKEN OVER A 24–MONTH PERIOD, WITH ONE–HALF FOR THE CREDIT AMOUNT ALLOWED EACH YEAR BEGINNING WITH THE FIRST TAXABLE YEAR IN WHICH THE CREDIT IS CERTIFIED.

(IV) IF THE QUALIFIED POSITION IS FILLED FOR A PERIOD OF LESS THAN 24 MONTHS, THE TAX CREDIT SHALL BE RECAPTURED AS FOLLOWS:

1. THE TAX CREDIT SHALL BE RECOMPUTED AND REDUCED ON A PRORATED BASIS, BASED ON THE PERIOD OF TIME THE POSITION WAS FILLED, AS DETERMINED BY THE DEPARTMENT AND REPORTED TO THE COMPTROLLER; AND

2. THE HEALTH ENTERPRISE ZONE PRACTITIONER WHO RECEIVED THE TAX CREDIT SHALL REPAY ANY AMOUNT OF THE CREDIT THAT MAY HAVE ALREADY BEEN REFUNDED TO THE PRACTITIONER THAT EXCEEDS THE AMOUNT RECOMPUTED BY THE DEPARTMENT IN ACCORDANCE WITH ITEM 1 OF THIS SUBPARAGRAPH.

(3) (I) TO BE CERTIFIED AS ELIGIBLE FOR THE CREDITS PROVIDED UNDER THIS SECTION, A HEALTH ENTERPRISE ZONE PRACTITIONER MAY APPLY FOR CERTIFICATION THROUGH THE NONPROFIT COMMUNITY–BASED ORGANIZATION OR LOCAL GOVERNMENT THAT SUBMITS AN APPROVED PROPOSAL UNDER TITLE 20, SUBTITLE 14 OF THE HEALTH – GENERAL ARTICLE.

(II) 1. ELIGIBILITY FOR THE CERTIFICATION FOR THE CREDITS PROVIDED UNDER THIS SECTION IS LIMITED BY AVAILABILITY OF BUDGETED FUNDS FOR THAT PURPOSE, AS DETERMINED BY THE DEPARTMENT.

2. CERTIFICATES OF ELIGIBILITY SHALL BE SUBJECT TO APPROVAL BY THE DEPARTMENT ON A FIRST–COME, FIRST–SERVED BASIS, AS DETERMINED BY THE DEPARTMENT IN ITS SOLE DISCRETION.

~~(F)~~ (E) THE DEPARTMENT SHALL CERTIFY TO THE COMPTROLLER THE APPLICABILITY OF THE CREDIT PROVIDED UNDER THIS SECTION FOR EACH HEALTH ENTERPRISE ZONE PRACTITIONER AND THE AMOUNT OF EACH CREDIT ASSIGNED TO A HEALTH ENTERPRISE ZONE PRACTITIONER, FOR EACH TAXABLE YEAR.

~~(G)~~ (F) THE CREDITS ALLOWED UNDER THIS SECTION FOR A FISCAL YEAR MAY NOT EXCEED THE AMOUNT PROVIDED FOR IN THE STATE BUDGET FOR THAT FISCAL YEAR.

~~(H)~~ (G) THE DEPARTMENT, IN CONSULTATION WITH THE COMPTROLLER, SHALL ADOPT REGULATIONS TO IMPLEMENT THE TAX CREDIT UNDER THIS SECTION.

SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article – Health – General

19–134.

(c) (1) The Commission shall:

(i) Establish and implement a system to comparatively evaluate the quality of care and performance of categories of health benefit plans as determined by the Commission on an objective basis; and

(ii) Annually publish the summary findings of the evaluation.

(2) The purpose of the evaluation system established under this subsection is to assist carriers to improve care by establishing a common set of quality and performance measurements and disseminating the findings to carriers and other interested parties.

(3) The system, where appropriate, shall:

(i) Solicit performance information from enrollees of health benefit plans; **[**and**]**

(ii) **[**On or before October 1, 2007, to the extent feasible, incorporate racial and ethnic variations**]** **ESTABLISH AND INCORPORATE A STANDARD SET OF MEASURES REGARDING RACIAL AND ETHNIC VARIATIONS IN QUALITY AND OUTCOMES; AND**

(III) INCLUDE INFORMATION ON THE ACTIONS TAKEN BY CARRIERS TO TRACK AND REDUCE HEALTH DISPARITIES, INCLUDING WHETHER THE HEALTH BENEFIT PLAN PROVIDES CULTURALLY APPROPRIATE EDUCATIONAL MATERIALS FOR ITS MEMBERS.

(4) (i) The Commission shall adopt regulations to establish the system of evaluation provided under this subsection.

(ii) Before adopting regulations to implement an evaluation system under this subsection, the Commission shall consider recommendations of nationally recognized organizations that are involved in quality of care and performance measurement.

(III) IN IMPLEMENTING PARAGRAPH (3)(II) AND (III) OF THIS SUBSECTION, THE COMMISSION SHALL CONSULT WITH APPROPRIATE STAKEHOLDERS, INCLUDING AT LEAST ONE REPRESENTATIVE OF A CARRIER THAT DOES BUSINESS PREDOMINANTLY IN THE STATE AND A CARRIER THAT DOES BUSINESS IN THE STATE AND NATIONALLY, TO DETERMINE NATIONAL STANDARDS FOR EVALUATING THE EFFECTIVENESS OF CARRIERS IN ADDRESSING HEALTH DISPARITIES AND TO FULFILL THE PURPOSES OF PARAGRAPH (3)(II) AND (III) OF THIS SUBSECTION IN A MANNER THAT CAN BE EASILY REPLICATED IN OTHER STATES.

(5) The Commission may contract with a private, nonprofit entity to implement the system required under this subsection provided that the entity is not an insurer.

(6) The annual evaluation summary required under paragraph (1) of this subsection shall include to the extent feasible information on racial and ethnic variations.

19–303.

(c) (1) Each nonprofit hospital shall submit an annual community benefit report to the Health Services Cost Review Commission detailing the community benefits provided by the hospital during the preceding year.

(2) The community benefit report shall include:

(i) The mission statement of the hospital;

(ii) A list of the initiatives that were undertaken by the hospital;

(iii) The cost to the hospital of each community benefit initiative;

(iv) The objectives of each community benefit initiative;

(v) A description of efforts taken to evaluate the effectiveness of each community benefit initiative; **[**and**]**

(vi) A description of gaps in the availability of specialist providers to serve the uninsured in the hospital**; AND**

(VII) A DESCRIPTION OF THE HOSPITAL'S EFFORTS TO TRACK AND REDUCE HEALTH DISPARITIES IN THE COMMUNITY THAT THE HOSPITAL SERVES~~, IN THE FORM SET BY THE DEPARTMENT BY REGULATION~~.

20–904.

(A) ON OR BEFORE DECEMBER 1 OF EACH YEAR, EACH INSTITUTION OF HIGHER EDUCATION IN THE STATE THAT ~~INCLUDES IN THE CURRICULUM COURSES~~ OFFERS A PROGRAM NECESSARY FOR THE LICENSING OF HEALTH CARE PROFESSIONALS IN THE STATE SHALL REPORT TO THE GOVERNOR AND, IN ACCORDANCE WITH § 2–1246 OF THE STATE GOVERNMENT ARTICLE, THE GENERAL ASSEMBLY ON THE ACTIONS TAKEN BY THE INSTITUTION TO REDUCE HEALTH DISPARITIES.

(B) THE ~~DEPARTMENT~~ SECRETARY MAY SET STANDARDS FOR THE FORM OF THE REPORT REQUIRED UNDER THIS SECTION.

SECTION 3. AND BE IT FURTHER ENACTED, That the Health Services Cost Review Commission and the Maryland Health Care Commission shall:

(1) Study the feasibility of including racial and ethnic performance data tracking in quality incentive programs;

(2) In coordination with the evaluation of the Maryland Patient Centered Medical Home, develop recommendations for criteria and standards to measure the impact of the Maryland Patient Centered Medical Home on eliminating disparities in health care outcomes;

~~(2)~~ (3) Report to the General Assembly on or before January 1, 2013, data by race and ethnicity in quality incentive programs where feasible and recommendations for criteria and standards to measure the impact of the Maryland Patient Centered Medical Home on eliminating disparities in health care outcomes; and

~~(3)~~ (4) Submit a report on or before January 1, 2013, to the Governor and, in accordance with § 2–1246 of the State Government Article, the General Assembly that explains when data cannot be reported by race and ethnicity and describes any necessary changes to overcome those limitations.

SECTION 4. AND BE IT FURTHER ENACTED, That:

(1) ~~the~~ The Maryland Health Quality and Cost Council shall:

~~(1)~~ (i) Convene a workgroup to examine appropriate standards for cultural and linguistic competency for medical and behavioral health treatment and

the feasibility and desirability of incorporating these standards into reporting by health care providers and tiering of reimbursement rates by payors; ~~and~~

(ii) Assess the feasibility of and develop recommendations for criteria and standards establishing multicultural health care equity and assessment programs for the Maryland Patient Centered Medical Home program and other health care settings; and

(iii) Recommend criteria for health care providers in the State to receive continuing education in multicultural health care, including cultural competency and health literacy training.

(2) The workgroup established under this section may include representatives from:

(i) The Maryland Health Care Commission;

(ii) The Maryland Office of Minority Health and Health Disparities;

(iii) Academic centers of health literacy and academic centers for health disparities research;

(iv) The Department of Health and Mental Hygiene;

(v) Health Occupations Boards in the State;

(vi) A wide range of health care professionals and providers;

(vii) Experts on health disparities and health literacy;

(viii) Accreditation entities, including the National Committee for Quality Assurance and URAC;

(ix) Members of the Maryland Patient Centered Medical Home Program Learning Collaborative; and

(x) The Maryland Advisory Council on Mental Hygiene/Cultural Competence Advisory Group.

(3) The academic centers of health literacy and the academic centers for health disparities research shall assist the Maryland Health Care Commission and the Department of Health and Mental Hygiene in staffing and leading the workgroup.

~~(2)~~ (4) ~~Submit~~ The workgroup shall submit a report to the ~~Governor and, in accordance with § 2–1246 of the State Government Article, the~~

~~General Assembly~~ Maryland Quality and Cost Council on or before ~~January~~ December 1, 2013, on its findings and recommendations.

SECTION 5. AND BE IT FURTHER ENACTED, That Section 1 of this Act shall be applicable to all taxable years beginning after December 31, 2012, but before January 1, 2016.

SECTION 6. AND BE IT FURTHER ENACTED, That Section 1 of this Act shall take effect July 1, 2012. It shall remain effective for a period of 4 years and, at the end of June 30, 2016, with no further action required by the General Assembly, Section 1 of this Act shall be abrogated and of no further force and effect.

SECTION 7. AND BE IT FURTHER ENACTED, That Section 2 of this Act shall take effect on October 1, 2012.

SECTION 8. AND BE IT FURTHER ENACTED, That, except as provided in Sections 6 and 7 of this Act, this Act shall take effect July 1, 2012.

Approved by the Governor, April 10, 2012.

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

AUG 15 2012

The Honorable Edward J. Kasemeyer
Chair
Senate Budget and Taxation Committee
3 West Miller Senate Building
Annapolis, MD 21401-1991

The Honorable Norman H. Conway
Chair
House Appropriations Committee
121 House Office Building
Annapolis, MD 21401-1991

The Honorable Thomas M. Middleton
Chair
Senate Finance Committee
3 East Miller Senate Building
Annapolis, MD 21401-1991

The Honorable Peter A. Hammen
Chair
House Health and Government
Operations Committee
241 House Office Building
Annapolis, MD 21401-1991

RE: 2012 Joint Chairmen's Report, Page 79, M00R01.03- Maryland Community Health Resources Commission – Health Enterprise Zones

Dear Chairmen Kasemeyer, Middleton, Conway and Hammen:

Pursuant to page 79 of the Joint Chairmen's Report of 2012, the Department of Health and Mental Hygiene respectfully submits this report on the implementation of provisions of Senate Bill 234 of the Acts of 2012 relating to Health Enterprise Zones. Specifically, the Joint Chairmen's Report requested that the report contain specifics as to the criteria used in selecting Health Enterprise Zones, how funding is to be allocated, and what outcome measures and/or measurement system will be developed to monitor the progress in the Health Enterprise Zones, as well as other details about the funding. The Fiscal 2013 budget restricts $3.75 million until the report is submitted, and gives the committees 45 days to review and comment on the report.

This report responds to this requirement, and contains general information about our plan for implementation of Senate Bill 234.

I. Introduction

a. Overview of the Maryland Health Improvement and Disparities Reduction Act of 2012

The Maryland Health Improvement and Disparities Reduction Act of 2012 (Senate Bill 234/Chapter 3 of 2012) seeks to combat unacceptable health disparities and improve health in

underserved communities. The legislation created a framework for the establishment of Health Enterprise Zones (HEZs) in Maryland.

The purpose of establishing HEZs is to target State resources to:

- Reduce health disparities among racial and ethnic groups and geographic areas;
- Improve health care access and health outcomes in underserved communities; and
- Reduce healthcare costs and hospital admissions and readmissions.

The legislation enables local governments and non-profit community-based organizations to submit a plan for addressing disparities and improving health outcomes in their communities. Approved HEZs can receive funding for innovative strategies to reduce disparities and improve health outcomes, as well as for tax and capital incentives to attract needed health care providers to the HEZ. The FY 2013 budget provides for $4 million for HEZs.

b. Restricted Funds and Requested Report

Page 79, M00R01.03, of the 2012 Joint Chairmen's Report requests the Community Health Resources Commission to submit a report to the House Health and Government Operations Committee, the Senate Finance Committee, and the budget committees detailing how the funding for HEZs will be spent. $3.75 million in funding is made contingent on the receipt of the report.

This report will describe the process that the Maryland Department of Health and Mental Hygiene (DHMH) and the Community Health Resources Commission (CHRC) used to develop our approach to implementation for HEZs, as well as provide details about our approach to implementation.

II. Process Used to Develop Approach to Implementation

An internal steering committee led by Lieutenant Governor Anthony Brown and Secretary Sharfstein, and comprised of DHMH and CHRC staff, has been established to lead implementation of the HEZs. This committee received guidance from the Health Disparities Collaborative, with more than 175 Marylanders participating in 5 committees.

On June 15, DHMH and the CHRC published the following drafts on the HEZ website, http://dhmh.maryland.gov/healthenterprisezones, for public comment:

- Threshold eligibility criteria for HEZ applicants;
- Additional benefits that could be provided by the State to assist HEZ awardees; and
- Principles that will be used to review HEZ applications.

The official public comment period ended July 20. We received more than 150 comments from Marylanders across the state. These comments led to a range of changes in the proposals. The summary of our responses to comments is included as **Attachment 4**.

In addition, we are holding public forums to educate the public about the HEZ implementation process. Events have been held in Charles County, Baltimore City, and Montgomery County. Events are also being planned for Prince George's County, the Eastern Shore, and Western Maryland.

III. Approach To Implementation

a. General Threshold Eligibility Criteria

DHMH and CHRC are proposing that HEZ applicants meet basic threshold eligibility criteria, as set out in **Attachment 1**. These general threshold eligibility criteria aim to cast a wide net and allow many communities to apply to become an HEZ.

The selection process will be the point at which more stringent criteria are used and communities have the opportunity to further demonstrate the existence of health disparities and poor health outcomes in their communities. It is expected that communities with large racial and ethnic minority populations and rural communities that experience poor health and health disparities will be adequately represented in the set of communities that meet these proposed eligibility criteria.

b. Benefits Included in the Maryland Health Improvement and Disparities Reduction Act of 2012

HEZs are eligible to receive a wide range of benefits to address health disparities as approved in the HEZ plan, including funding for innovative public health strategies and other incentives or mechanisms to address health disparities and improve access to care. A summary of the benefits in various categories can be found in **Attachment 2.**

c. Principles for Review of Applications

Several principles were developed for the review of applications for HEZs. These principles will inform the Request for Proposals and reflect how the funding will be allocated. These Principles -- which cover the purpose, description of need, core disease targets and conditions, strategies, evaluations, and other key topics -- are set out in **Attachment 3**.

IV. Next Steps

Following review of comments from the General Assembly, DHMH and CHRC plan to release a Request for Proposals (RFP) for the HEZ Application Process. The RFP will be based on the threshold eligibility criteria and principles for review of HEZ applications contained in this report. The CHRC will use its process to fairly review the applications and make recommendations for awards to the DHMH Secretary.

On this timeline, HEZ awards will be made in December. It is anticipated that two to four HEZs will be selected, depending on the number of applications and their scale. We will provide the General Assembly with information on the specific grants when the awards are made. We greatly appreciate the support that the General Assembly has given for this exciting initiative.

We hope this information is useful. We respectfully request that the restricted funding be released. If you have any questions regarding this report, please contact Ms. Marie Grant, Director of the Office of Governmental Affairs, at (410) 767-6481.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

John A. Hurson
Chair, Community Health Resources Commission

Enclosures - 4

cc: The Honorable Anthony G. Brown
Carlessia Hussein, RN, DrPH
Mark Luckner
Marie L. Grant, J.D.
Frances Phillips, RN, MHA

Attachment 1

HEZ Threshold Eligibility Criteria

In general, the below table summarizes HEZ threshold eligibility criteria that an applicant should demonstrate. Potential applicants will also be allowed to use an alternative approach, as outlined after the table.

HEZ Eligibility Criteria	Rationale	Data Source
1. An HEZ must be a community, or a contiguous cluster of communities, defined by zip code boundaries (one or multiple zip codes).	The law requires that an HEZ be a contiguous geographic area. In addition, there needs to be a cohesive sense of place held by residents and community leaders, who will actively participate in the governance of the HEZ project. Zip codes were selected because of the data available to measure need and outcomes (ex. utilization rates).	MD Department of Planning zip code maps
2. An HEZ must have a resident population of at least 5,000 people.	The HEZ population should be large enough to model community change for application statewide. An upper limit was not placed on the HEZ population size to allow applicants flexibility to determine what population size is appropriate for their selected interventions.	2010 Census, population by zip code tabulation areas
3. An HEZ must demonstrate economic disadvantage by having either: a) a Medicaid enrollment rate above the median value for all Maryland zip codes, or b) a WIC participation rate above the median value for all Maryland zip codes. An HEZ made up of multiple zip codes must meet this criterion in each zip code if the values are known.	Medicaid enrollment data provides information on the number of low-income individuals in a community. WIC participation can be used to identify communities with a large number of low-income families and can capture high need populations that are ineligible for Medicaid. We expect this criterion to identify communities with disadvantaged racial/ethnic minority populations.	Medicaid enrollment data, Number of people enrolled per population, 2006-2010 Maryland WIC Program, Number of people enrolled per population, 2006-2010
4. An HEZ must demonstrate poor health outcomes by having either: a) a life expectancy below the median value for all Maryland zip codes, or b) a percentage of low birth weight infants above the median value for all Maryland zip codes. An HEZ made up of multiple zip codes must meet this criterion in each zip code if the values are known.	Life expectancy is a meaningful measure of how health and wellbeing in a community compare to other areas of the state. This metric is easy for the public to interpret and data are available by zip code. Low birth weight is associated with infant mortality, which is an excellent indicator of the overall health of a population.	Maryland Vital Statistics, Life expectancy by zip code, 2006-2010 Maryland Vital Statistics, Low birth weight infants, age-adjusted, 2006-2010

DHMH and CHRC will permit applications to propose an alternative HEZ approach using sub-zip code geographic boundaries offered by an applicant, if:

- the proposal includes equivalent data to demonstrate ***both*** economic and health status eligibility,
- the area proposed is contiguous geographically, and
- the population in the proposed area is at least 5,000.

Attachment 2

Benefits for Health Enterprise Zones

Benefits Included in the Maryland Health Improvement and Disparities Reduction Act of 2012
HEZs are eligible to receive benefits to address health disparities as approved in the HEZ plan, including funding for innovative public health strategies and other incentives or mechanisms to address health disparities and improve access to care.

Examples of funding for innovative public health strategies and other incentives could include the following suggestions received during the public comment period, if requested in an approved application and linked to targeted diseases and outcomes:

- Internship and volunteer programs for students in an HEZ;
- Discounted gym memberships for families as a benefit of an HEZ;
- Funding for improvements to the built environment in an HEZ, including improvements intended to increase access to recreation, healthy food, and quality housing;
- Grants to integrate behavioral health care into existing primary care practices in an HEZ;
- Funding for better health information technology tools for providers in an HEZ; and
- Funding for resources to enhance provider capacity to serve non-English speakers in an HEZ.

As is provided in the enabling legislation, practitioners that provide primary care, behavioral health services, or dental services in an approved HEZ are eligible for:

- Tax credits against the State income tax, in accordance with the approved HEZ plan;
- Loan repayment assistance, in accordance with the approved HEZ plan;
- Priority to enter the state's Patient Centered Medical Home Program, if the practitioner meets the standards developed by the Maryland Health Care Commission for entry into the Program;
- Priority for the receipt of any State funding available for electronic health records; if feasible and if other standards for receipt of the funding are met;
- Additional grant funding from the Community Health Resources Commission;
- Grants to defray the costs of capital or leasehold improvements for the purposes of improving or expanding the delivery of healthcare in the HEZ; and
- Grants to defray the costs of medical or dental equipment to be used in the HEZ, not to exceed the lesser of $25,000 or 50% of the cost of the equipment.

Additional Benefits for HEZs
In addition to the benefits listed above, DHMH plans to provide assistance and support to approved HEZs, including the following:

- General support for program planning, implementation, and evaluation;
- Working with awardees to provide access to DHMH data resources about approved HEZs;
- Invitations to participate in appropriate collaboratives and workgroups;
- Assistance in connecting to existing grant-writing resources; and

- Opportunity to apply for J-1 Visa Waiver primary care placements in HEZ sites that are located in federally designated Health Professional Shortage Areas and Medically Underserved Areas or Populations.

DHMH can also provide assistance with benefits that do not need to be budgeted for, but that should be specifically requested by an HEZ in an approved application. These benefits include working with federal agencies to enable an HEZ to be considered for new FQHC sites, working to promote incentives for care to take place in the appropriate venue in the HEZ, and assisting in identifying funding opportunities for cultural competency trainings.

Attachment 3

Principles for Review of Applications for HEZs

The following are proposed principles for the review of applications for HEZs. These principles will inform the Request for Proposals and will be used in the final selection of the Health Enterprise Zones.

Principles

1. Purpose. The application must describe how the proposal will address the core statutory goal of Health Enterprise Zones of reducing health disparities, including racial/ethnic and geographic health disparities, in Maryland.

2. Description of need. The application should describe the health and health service needs of the population. Examples of metrics to describe community need include metrics of health status, risk factor prevalence, health un-insurance, primary care access (for example, Medically Underserved Area or Medically Underserved Population designations), and other health needs specific to the community. These metrics should be presented where possible by racial groups and by Hispanic ethnicity. The application should also discuss other factors that contribute to poor health in the community (such as education, employment, income, housing, physical environment, and other community factors that impact health).

3. Core disease targets and conditions. The application should identify specific diseases for improvement. Applications are encouraged to target at least one of the following conditions identified by the Health Disparities Workgroup of the Maryland Health Quality and Cost Council: cardiovascular disease, diabetes, and asthma. Applicants may address other major conditions where the community experiences poor health outcomes, such as behavioral health, dental health, birth outcomes, or related and co-morbid conditions.

4. Goals. The application should propose measurable goals for health improvement in the HEZ by January 2016. Goals should cover each of the following areas:

    a. Improved risk factor prevalence or health outcomes (SHIP or LHIP measures, or others);
    b. Expanded primary care workforce ;
    c. Increased community health workforce (including public health and outreach workers);
    d. Increased community resources for health (housing, built environment, food access, etc.);
    e. Reduced preventable emergency department visits and hospitalizations ; and
    f. Reduced unnecessary costs in health care (costs that would not have accrued if preventive services and adequate primary care had been provided).

    The goals should reflect the disparities being addressed. For example, if the disparity being targeted is diabetes admissions for African-Americans, the goal should be stated as a specific value for diabetes admissions for African-Americans.

5. Strategies. The application should propose strategies and interventions to meet the goals. Investments in prevention, community outreach, and improved self-management of chronic disease are encouraged. The evidence and rationale for the strategies and interventions should be presented.

Examples of such strategies could include:

- A strategy to increase provider capacity by a specified percentage;
- A strategy to improve the quality of service delivery as indicated by tracking metrics such as those used by HEDIS ;
- A strategy to increase access to behavioral health and improve integration with primary care;
- A strategy to address community barriers to healthy lifestyles through public health involvement;
- A strategy to improve health outcomes through the use of community health workers;
- A plan to strengthen community and environmental policies to support good health in schools, day care, recreation centers, senior centers, and workplaces;
- A strategy to apply the Community-Centered Health Home model to the HEZ;
- A strategy to provide better access to healthy foods or facilities for physical activities; or
- A strategy to reach underserved racial and ethnic minority persons in the Health Enterprise Zone including approaches to increase capacity to reach non-English speakers.

Applicants are encouraged where possible to adopt strategies that are evidence-based, generally accepted as promising practices, or new/innovative ideas. Applicants are encouraged to bring health information technology (electronic medical records and health information exchange) and the patient-centered medical home model to their strategic approaches.

6. Cultural, linguistic and health literacy competence. The application should explain how the strategies will be implemented in a culturally competent manner and designed to be accessible to the target population. This includes addressing translation and interpretation issues for non-English speakers, and issues of low health literacy in the population. The application should describe the efforts that will be undertaken to recruit a racially ethnically and linguistically diverse workforce for the HEZ.

7. Balance. The proposed strategies should be balanced between community-based approaches with primary care provider based incentives; it should combine grants for public health and community services with the provider credits and incentives that are available to HEZs.

8. Contributions from local partners. Explicit financial or in-kind contributions from local partners and stakeholders should be part of the strategic resource mix, in order to amplify the impact of the State-provided pilot funding and incentives.

9. Coalition. The applying coalition should include a diverse array of health and community partners, with specific roles and deep historical experience working in the HEZ. Efforts should be made to include members of the target populations and minority groups in planning and ongoing oversight of the program. The proposal should describe the coalition team and what assets, experience, knowledge, etc., it brings to the proposed HEZ. There should be a clear governance structure with a point of accountability. There should be an advisory and oversight entity composed primarily of community members to provide advice and input to the coalition and the governing body.

10. Work-plan. The application should include a detailed list of program activities, measurable outputs, timelines, responsible entities and other logistics that enable tracking of effort; describe roles of the listed partners, include interim milestones and deliverables; and support appropriate data collection

and reporting. Funding levels to partners should be appropriate to their responsibilities in the work-plan.

11. Program management and guidance. The application should include a plan for periodic reporting to the State regarding progress and challenges on implementation of the HEZ work-plan and interim values for the evaluation metrics. Applicants should propose a plan of periodic reporting that meets any criteria in the Request for Proposals issued by the CHRC and that contains periodic reporting requirements that make sense given the core disease targets and conditions of the HEZ as well as the goals of the HEZ.

12. Sustainability. The application should describe a plan for sustainability and acquisition of resources beyond State funding, including partnership with entities in the health care system that have the financial incentive for better outcomes. The application should include a specific plan for developing and implementing a short-term and long-term sustainability strategy. Investments from insurers who stand to gain from cost savings in the HEZ are a potential component of a sustainability plan.

13. Internal evaluation and progress monitoring. The application should propose a draft internal evaluation plan (to be finalized with DHMH and CHRC input after award) which tracks progress in meeting the health goals within the HEZ. This is separate from the external program evaluation that will be performed statewide and funded separately. As discussed in 4 above, the draft internal evaluation should include goals in each of these areas:

    a. Improved risk factor prevalence or health outcomes (SHIP or LHIP measures, or others);
    b. Expanded primary care workforce ;
    c. Increased community health workforce (including public health and outreach workers);
    d. Increased community resources for health (housing, built environment, food access, etc.);
    e. Reduced preventable emergency department visits and hospitalizations ; and
    f. Reduced unnecessary costs in health care (costs that would not have accrued if preventive services and adequate primary care had been provided).

    In addition, the evaluation plan should propose assessing the process used to achieve these goals. For example, the plan should track the use of proposed incentives, the implementation of the plan on cultural competency, the broad-based participation of the community coalition, and the status of progress on sustainability.

    Data collection and monitoring should be an ongoing effort, so that productivity metrics, program implementation milestones, and values for the goal outcome metrics can be monitored at baseline and throughout the HEZ lifespan. Data collection and monitoring budget is expected to range between 5% and 10% of the total HEZ budget.

Attachment 4

Responses to Public Comment on Implementation of Health Enterprise Zones

Threshold Eligibility, Benefits, and Principles for Review of Applications

Background

On June 15, the Department of Health and Mental Hygiene (DHMH) and the Community Health Resources Commission (CHRC) released draft threshold eligibility criteria for health enterprise zones (HEZs), draft benefits for approved HEZs, and draft principles for the review of applications for HEZs for public comment. The public comment period closed July 20. DHMH and CHRC received over 150 comments on these three topics. Below is a summary of how DHMH and CHRC responded to the comments. For additional information on specific comments, please email hez@dhmh.state.md.us.

Threshold Eligibility for HEZs

We received numerous comments related to eligibility criteria for the HEZs, summarized below. Generally, these comments addressed one of three topics:

1. The geographic unit of measurement/data that should be used to determine eligibility;
2. The selection of an appropriate cutoff to determine eligibility; or
3. Different or additional criteria that should be applied to determine eligibility.

We appreciated all of the comments and have made several changes as a result.

To understand where we did not make changes, it will be helpful to recognize that the purpose of the eligibility criteria is solely to consider areas eligible to be designated a HEZ. The specific criteria for eligibility have no bearing on whether an organization will be selected; it is the application review that determines selection. As we originally stated, "the selection process will be the point at which more stringent criteria are used and communities have the opportunity to further demonstrate the existence of health disparities and poor health outcomes in their communities."

Selection of the Appropriate Geographic Unit of Measurement/Data to Determine Eligibility

Several commentators suggested that in place of zip codes, it would be better to use census tracts or other units, such as Public Use Microdata Sample Areas (PUMAs), census tracts, community statistical areas (CSAs), or urban renewal zone designations. Several commentators also suggested that the initial screening could be done using zip code level data, but that the subsequent evaluation of applications should involve explicit criteria, and could involve different levels of geographic detail and different ("more descriptive") data such as census tracts.

Response: The Department selected zip codes as the unit of analysis so that as much of the state could be included as possible, with as complete and uniform a set of data as possible. We looked at other potential units of analysis, and noted significant limitations for all of them:

- We determined, based on a review of the literature, that average life expectancy should only be calculated for geographic units containing at least 5,000 individuals. Of the 1,406 census tracts

in Maryland in the 2010 census, 1,012 census tracts have a population less than 5,000. However, these smaller census tracts contain 3.3 million (57%) of the state's 5.8 million people.

- There are no standardized state-wide data sources or designations for any of the other geographic units (PUMAs, CSAs, Urban Renewal Zones).
- People recognize zip codes and identify them readily, unlike many other geographic units.
- There are data readily available for calculations of many measures using zip codes and zip code tabulation areas (ZCTAs). Significantly, health outcomes data from the Health Services Cost Review Commission (HSCRC) are only available at the zip code or county level.

The Department recognizes that zip codes have many limitations, as pointed out by several commentators. The Department agrees with the comments that suggested that applications could address geographic units at a sub-zip code level. Therefore, the Department is providing the following guidance regarding the unit of measure for HEZ eligibility:

- The area proposed for an HEZ must be contiguous and have a population of at least 5000.
- Zip code boundaries will be the benchmark unit of measure for HEZ proposals for the reasons noted above.

An alternative HEZ approach using sub-zip code geographic boundaries will be considered, provided the proposal submits equivalent data to demonstrate both economic and health status eligibility.

1. Selection of Appropriate Cutoffs to Determine Eligibility

A few comments suggested cutoff points other than the median value of the four eligibility criteria. Some of these comments suggested lower cutoffs, which would have the effect of decreasing the number of eligible zip codes; a number also suggested cutoffs higher than the median value, which would have the effect of increasing the number of eligible zip codes.

Response: No specific rationale or evidence was presented to justify alternative cutoff points. The Department is comfortable that its proposal, which has the advantage of simplicity of calculation and interpretation, is appropriate as a screening measure.

By using the median value as the eligibility cutoff point for economic and health measures, the Department is intentionally adopting a permissive screen for HEZ proposals. A proposal representing a geographic area that does not meet the median cutoff would be required to have a special and compelling justification to be considered.

Selection of Different/Additional Criteria to Determine Eligibility

A number of commentators suggested additional or different criteria to determine eligibility, other than average life expectancy, percentage of low birth weight infants, Medicaid enrollment rate, or WIC participation rate. Some of the suggested criteria included:

- Social determinants of health
- Income
- Title I school status
- Unemployment
- Number of families up to X% of the poverty level who use emergency room for services
- Women with no prenatal care during pregnancy

- Asthma emergency room visits
- Child abuse and neglect cases
- Children who drop out of school before the 10th grade
- Environmental contaminants, industrial pollution and toxic exposures
- Obesity and overweight in youth and adults
- Chronic diseases
- HIV infection rates
- Competency in cultural, linguistic, and health literacy

There were also specific comments regarding the challenge of applying criteria uniformly for both urban and rural areas. Several comments suggested that applicants should be free to add their own criteria to demonstrate disadvantage.

Response: These are all important metrics of health and economic well-being. In setting eligibility criteria, we looked for a few basic criteria where data would be available for the entire state, with the idea to cast a wide net. Once the basic criteria are met, the focus shifts to the application. The above metrics are more appropriate for inclusion in specific applications, where organizations will make the case about the challenges in their specific areas and their solutions.

Benefits for Health Enterprise Zones

The Maryland Health Improvement and Disparities Reduction Act of 2012 provides that Health Enterprise Zones (HEZs) are eligible to receive benefits to address health disparities as approved in the HEZ plan, including funding for innovative public health strategies and other incentives or mechanisms to address health disparities and improve access to care. Practitioners in an HEZ are also eligible for a variety of incentives if included in an approved HEZ plan, as well as other incentives specifically provided for in the legislation.

DHMH posted for comment questions relating to the benefits that the State could provide to an approved HEZ. Specifically, DHMH requested comments on the following questions:

1. What other types of benefits could the state provide in a HEZ?
2. What specific existing programs, i.e. public health grant programs, might be prioritized for applicants in a HEZ?

DHMH requested that comments take into account fiscal and legal parameters when responding, as well as the overall mission of the HEZ program.

DHMH received a number of thoughtful comments regarding benefits that would be helpful to be provided in an HEZ.

The comments can be divided into five categories:

1. Benefits that DHMH will provide to approved HEZs that do not need to be budgeted for in specific applications;

2. Benefits that DHMH will provide, on request, to approved HEZs that do not need to be budgeted for in specific applications;
3. Benefits that DHMH and the CHRC will provide to approved HEZs as budgeted for in an approved application;
4. Benefits that approved HEZs may work with other local entities to achieve; and
5. Benefits that are outside the scope of the HEZ program.

A description of the comments, by each category, is below.

1. *Benefits that DHMH will Provide to Approved Health Enterprise Zones And That Do Not Need to Requested or Budgeted For*

Some of the benefits that were suggested through public comment are benefits that DHMH plans to provide to approved HEZs automatically. These benefits do not need to be budgeted for in an application and do not need to be specifically identified in an application.

These benefits include:

- General support for program planning, implementation, and evaluation;
- Working with awardees to provide access to DHMH data resources about approved HEZs;
- Invitations to participate in appropriate collaboratives and workgroups;
- Assistance in connecting to existing grant-writing resources; and
- Opportunity to apply for J-1 Visa Waiver primary care placements in HEZ sites that are located in federally designated Health Professional Shortage Areas and Medically Underserved Areas or Populations.

2. *Benefits that the State will Provide to Approved Health Enterprise Zones That Do Not Need to Be Budgeted For, But Need to Be Requested in An Application*

Several comments suggested benefits that DHMH can offer to HEZs that do not need to be budgeted for, but that would need to be specifically requested by an HEZ in an approved application. These benefits include working with federal agencies to enable an HEZ to be considered for new FQHC sites, working to promote incentives for care to take place in the appropriate venue in the HEZ, and assisting in identifying outside funding opportunities for cultural competency trainings (the application can also budget for such trainings).

3. *Benefits that Can Be Provided As Part of An Approved Application, and Must Be Requested and Budgeted For*

Many of the comments suggested benefits that an HEZ could pursue as part of an approved application, but that should be requested in as well as budgeted for in the HEZ application. These benefits could be part of an approved funding package for an approved HEZ, if funding for these types of expenses was part of the application and linked to the applicable targeted diseases and outcomes.

Examples of these benefits that can be requested in and budgeted for in an application include:

- Internship and volunteer programs for students in an HEZ;

- Discounted gym memberships for families as a benefit of an HEZ;
- Funding for improvements to the built environment in an HEZ;
- Grants to integrate behavioral health care into existing primary care practices in an HEZ;
- Funding for better health information technology tools for providers in an HEZ; and
- Funding for resources to enhance provider capacity to serve non-English speaking individuals in an HEZ.

4. *Benefits That Approved HEZs May Work with Other Local Entities to Achieve*

Some benefits suggested in comments are not benefits that DHMH can offer, but may be benefits that an approved HEZ could work with other local entities on achieving. Examples of these types of benefits could include access to school buildings for education and health screenings and use of municipality-owned land for community gardens. In such cases, the applicants should engage the school or municipality during the application process and include the plan as part of the application.

5. *Benefits That DHMH Cannot Provide As Part of The Program*

Some suggested benefits that were provided during the public comment period are outside of the scope of the program as envisioned by Senate Bill 234. Benefits that cannot be provided by DHMH as part of the program, whether for fiscal, administrative, or legal reasons, include:

- Forgiving the costs of an employer's share of workers compensation or unemployment insurance;
- Increasing Medicaid reimbursement for particular providers as part of the HEZ program; and
- Providing enhanced medical liability protections for mid-level practitioners and community health workers.

Principles for Review of Applications of Health Enterprise Zones

The principles for review of applications for HEZs were drafted to capture values that would lead to use of innovative and promising public health practices, focus on reducing health disparities, support existing and stimulate new partnerships within communities, and ensure a results and outcome orientation.

The comments received regarding the principles for review fell in 6 categories. A majority of the comments were accepted and integrated into the draft.

The following is a brief summary of how comments were incorporated into the principles for review of applications:

- in the *NEED* section race, income, ethnicity, MUA and MUP were added;

- in the *TARGETS* section the title was changed to add conditions that will include dental, behavioral, and co-morbidities, as eligible to be addressed;

- in the *GOALS* section clarification was provided to include public health and outreach workers and social determinants of health;

- in the *STRATEGY* section the use of HEDIS measures, specifically mentioning behavioral health, applying a 'Community-Centered Health Home' model to the HEZ, and adopt models that are Promising Practices, new or innovative and evidence-based; integrate Information technology, health information exchange and patient-centered medical home to HEZ strategic approaches;

- in the *CULTURAL COMPETENCY* section promote cultural and linguistic competency in the provider workforce;

- in the *COALITION* section include members of the target populations in planning and ongoing oversight, involve and partner with existing organizations with history in the community, place greater emphasis on the Coalition as an entity that can keep the HEZ responsive to the community and keep the partners connected to each other;

- in the *EVALUATION* section clarification on evaluation expectations was asked along with adequate resources to do evaluation, and concern was raised about HEZ goals whose metrics cannot show change for many months or years; and

- in the *DATA RESOURCES* section clarification is provided regarding the internal evaluation by the HEZ organization and an external evaluation conducted by the State including the need for an evaluation budget between 5 and 10 percent of the base award.

STATE OF MARYLAND
Community Health Resources Commission
45 Calvert Street, Annapolis, MD 21401, Room 336

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

Health Enterprise Zones

Call for Proposals

October 5, 2012

Table of Contents

I. Executive Summary

The state of Maryland has numerous advantages for its residents to enjoy good health care, such as the 3rd highest median household income; the 2nd highest number of primary care physicians per capita; the 10th lowest rate of smoking; and outstanding medical schools. Despite these advantages, Maryland continues to lag behind other states on a number of key health indicators, such as ranking 43rd in infant mortality, 31st in early prenatal care, 28th in obesity prevalence, 31st in diabetes prevalence, 35th in cardiovascular deaths, 32nd in cancer deaths, and 33rd for geographic health disparities.

In recognition of these unacceptable disparities, Lieutenant Governor Anthony G. Brown, as Chair of the Maryland Health Quality and Cost Council, established the Health Disparities Work Group, led by Dean E. Albert Reece, M.D, Ph.D., M.B.A. of the University of Maryland School of Medicine. The Work Group issued its final report in January 2012, which provided several recommendations for best practices, monitoring, and financial incentives for the reduction of disparities in Maryland's health care system. The Work Group developed bold recommendations, including the concept of utilizing enterprise zones typically used to drive economic development, and applied this principle in the field of public health and health disparities. The Work Group concluded that improvement in overall health in communities and reductions in health care costs may be achieved by saturating underserved communities with primary care providers and other essential health care services.

The recommendations of the Maryland Health Quality and Cost Council provided the structure for legislation, The Maryland Health Improvement and Disparities Reduction Act of 2012 (SB 234/Chapter 3 of 2012), which was approved by the Maryland General Assembly and signed into law on April 10 by the Governor. The Act combats continued health disparities and attempts to improve public health in underserved communities by creating the framework for the establishment of Health Enterprise Zones (HEZ), contiguous geographic areas that demonstrate measurable and documented health disparities and poor health outcomes and that are small enough for the incentives in this program to have a significant impact on improving health outcomes and reducing health disparities. The purpose of the HEZ Initiative is to target state resources to:

- Reduce health disparities among racial and ethnic minority populations and among geographic areas;
- Improve health care access and health outcomes in underserved communities; and
- Reduce health care costs and hospital admissions and re-admissions.

The HEZ Initiative is a new, four-year pilot program, and the FY 2013 budget provides $4 million in new funding to the Community Health Resources Commission (CHRC) to support the activities of HEZs. Through this Call for Proposals, communities may apply for HEZ designation, which will enable access to a range of incentives which include state income tax credits; hiring tax credits; loan repayment assistance; priority entrance into the state's Patient Centered Medical Home Program; priority for available state electronic health record (EHR) grant funding; additional grant funding from the CHRC; and capital grant support. Applicants seeking HEZ designation may draw upon any or all of these incentives when developing their

intervention strategies to address health disparities, to expand access, and to help attract needed health care practitioners into the area. The application for HEZ designation will be a combination of **both** demonstrated need and intervention strategies to improve health outcomes in the potential HEZ.

The HEZ Initiative will be jointly administered by the Maryland Department of Health & Mental Hygiene (DHMH) and the CHRC. The Commission is issuing this HEZ Call for Proposals, will evaluate applications requesting HEZ designation, and will provide recommendations to the DHMH Secretary. Final HEZ designation decisions will be made by the Secretary by the end of calendar year 2012. It is anticipated that the state will award between two to four Zones in this first year of the program.

An internal steering committee led by DHMH Secretary Joshua M. Sharfstein, M.D., comprised of DHMH, Lt. Governor, and CHRC staff, was established to help guide implementation of the HEZ Initiative. The committee received guidance and input from several external sources including the Health Disparities Collaborative, which included more than 175 Marylanders participating in five committees.

In addition, a public comment period was launched in the summer of 2012, and the following three documents were distributed in draft form to solicit public feedback:
1. Threshold eligibility criteria for communities seeking HEZ designation;
2. Additional benefits that could be provided by the state to assist HEZ awardees; and
3. Principles that will be used to review HEZ applications.

The committee received more than 150 comments which led to a range of changes in the implementation plan and are summarized in a Joint Chairmen's Report submitted in August to the Maryland General Assembly (this report is available at http://dhmh.maryland.gov/healthenterprisezones/SitePages/Updates.aspx). In addition, public forums were held earlier this year in Baltimore City, Montgomery, Prince George's, and Charles Counties, the Eastern Shore, and western Maryland. The public comment period and these public forums informed the development of this Call for Proposals.

Key Dates

October 11, 2:30 PM	Proposal Question & Answer Conference Call Dial-In Number: (866) 233-3852 Participant Access Code: 267478
October 19, 5:00 p.m.	Initial Letters of Interest are due to the CHRC
November 13, 12:00 p.m.	HEZ Proposals due to the CHRC
December 11	Select applicants invited to present at CHRC meeting
December 21	DHMH Secretary makes HEZ designations

Overview of the CHRC
The Maryland Community Health Resources Commission (CHRC) was created by the Maryland General Assembly when it approved the *Community Health Care Access and Safety Net Act of 2005* legislation to expand access to health care for low-income Marylanders and underserved communities in the state and bolster Maryland's health care safety net infrastructure. The CHRC is a quasi-independent commission operating within the DHMH, and its 11 members are appointed by the Governor. In creating the Commission, the Maryland General Assembly recognized the need for having an independent commission that focused on strengthening the state's diverse network of community health centers and safety net providers and addressed service delivery gaps in Maryland's dynamic health care marketplace.

Over the last seven years, the Commission has awarded 110 grants totaling approximately $26.3 million, supporting programs in every jurisdiction of the state. These 110 programs have collectively served more than 105,000 underserved Marylanders. The CHRC has awarded grants 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. Program sustainability is a top priority of the Commission, and CHRC grantees have used initial grant funds to leverage more than $10 million in additional federal and private funding sources to support their programs.

II. Information for Health Enterprise Zone Applicants

The designation of HEZ status will enable access to a range of incentives to support strategies to address health disparities, to expand access, and to help attract needed health care practitioners into the HEZ. Incentives and benefits include state income tax credits; hiring tax credits; loan repayment assistance; priority entrance into the state's Patient Centered Medical Home Program; priority for state EHR grant funding; additional grant funding from the CHRC; and capital grant support. These benefits and incentives are described in greater detail on page six. The purpose of the HEZ Initiative is to target state resources to:

- Reduce health disparities among racial and ethnic minority populations, and among geographic areas;
- Improve health care access and health outcomes in underserved communities; and
- Reduce health care costs and hospital admissions and re-admissions.

HEZ applicants are expected to submit applications which demonstrate the needs of the community, provide a comprehensive plan to address these needs, and achieve the overall policy goals of the HEZ Initiative. Eligible applicants should develop strategies using the benefits and incentives available to designated HEZs described in this Call for Proposals.

Community Eligibility
An HEZ is a community or a cluster of contiguous communities that are comprised of one or more zip codes. In order to be designated an HEZ, the proposed zip code(s) within a potential HEZ area must meet <u>each</u> of the following four criteria:

1. An HEZ must be a community, or a contiguous cluster of communities, defined by zip code boundaries (one or multiple zip codes);
2. An HEZ must have a resident population of at least 5,000 people;
3. An HEZ must demonstrate economic disadvantage by having either:
   a) a Medicaid enrollment rate above the median value for all Maryland zip codes; or
   b) a WIC participation rate above the median value for all Maryland zip codes.
4. An HEZ must demonstrate poor health outcomes by having either:
   a) a life expectancy below the median value for all Maryland zip codes, or
   b) a percentage of low birth weight infants above the median value for all Maryland zip codes.

A proposed HEZ made up of multiple zip codes must meet these criteria in each zip code if the values are known. ***Applicants are permitted to propose an alternative approach in eligibility determinations, using sub-zip code geographic bounds*** *(e.g. Census Tracts, Public Use Microdata Areas),* ***if the following criteria are met****:*

1. The area proposed is contiguous geographically;
2. The population in the proposed area is at least 5,000; and
3. The zip code(s) where the sub-zip code geographic bounds are located must meet the criteria for demonstrating economic disadvantage and poor health outcomes.

Data regarding the economic disadvantage and poor health outcomes, by zip code, has been compiled by DHMH and is available at: http://eh.dhmh.md.gov/hez/index.html. ***Applicants seeking designation status for sub-zip code geographic bounds will be required to provide data confirming eligibility for economic disadvantage and poor health outcomes.***

Letters of Interest are due to the CHRC no later than 5:00 p.m., October 19, 2012, but will be accepted and reviewed on a **rolling basis**. Applicants are encouraged to submit the Letter of Interest as soon as it ready, and not wait until October 19. The CHRC will review the Letters of Interest and Eligibility Worksheets (see Appendix Item A) as soon as is possible, certify each applicant's eligibility, and contact eligible applicants to submit the full application, hopefully within 48 hours of submission of LOI. Once eligibility is certified and applicants are notified, LOIs will be posted on the HEZ website. The full grant application is due to the CHRC no later than 12:00 p.m., November 13, 2012. For a more detailed description of the LOI, please see page 11 of this Call for Proposals.

Organizations Eligible to Apply for HEZ Designation on Behalf of a Community
An applicant for this Call for Proposals must be either a local government entity or a non-profit community-based organization. Applications should be submitted by one organization, the Coordinating Organization (local government entity or local non-profit entity), on behalf of a coalition of key community stakeholders and proposed HEZ geographic area. The community coalition should include a combination of health and community partners with specific roles and demonstrated historical experience working in the proposed zone. Applicants will be required to provide evidence validating that genuine efforts were made to include members of the target populations and minority groups in the HEZ application, and in the planning and program implementation, post-designation award.

Health Care Provider/Practices Eligibility
Individual health care providers and practices providing services within a Zone are eligible to receive state tax credits against their income, loan repayment assistance, funding for electronic health records, capital improvements and equipment in accordance with the HEZ Initiative and regulations to be proposed and adopted regarding tax credits. In addition, providers and practices may only receive incentives and benefits under the HEZ Initiative for the duration of their service/employment in a designated HEZ.

HEZ Benefits and Incentives
The HEZ Initiative provides a range of benefits and incentives to address health disparities and expand access to health care services. These benefits and incentives are available to non-profit organizations, local government entities, and eligible health care providers to achieve the HEZ's program goals at the community level. Following are examples of benefits and incentives that HEZ applicants may include in their application. If these benefits and incentives are included, then their cost must be included in the overall budget request of the HEZ application. Successful applicants will finalize the specific benefits and incentives utilized in the Zone in a post-designation conference.

- Tax credits against the State income tax: State income tax credits are available to eligible health care providers as part of an overall HEZ strategy to increase health care capacity and access to services. An eligible practitioner may claim a credit against the state income tax in an amount equal to 100% of the amount of the state income tax derived from income received from practice in the HEZ. Based on the language of the HEZ Act, tax credits are available for calendar years 2013, 2014, and 2015. Tax credits may become available for calendar year 2016, pending legislative approval and budget appropriation.

- Hiring Tax credits: Hiring tax credits are available to eligible health care provider practices as part of an overall HEZ strategy to increase health care capacity and access to services. An eligible practitioner may claim a refundable credit of $10,000 against the state income tax for hiring a qualified position in the Health Enterprise Zone. Based on the language of the HEZ Act, tax credits are available for calendar years 2013, 2014, and 2015. Tax credits may become available for calendar year 2016, pending legislative approval and budget appropriation.

- Loan repayment assistance: Loan repayment assistance is available to eligible health care providers for qualified education loan repayments.

- Priority to enter the state's Patient Centered Medical Home Program (PCMH): Priority entry into Maryland's PCMH program may be available to eligible health care providers and practices who meet the standards developed by the Maryland Health Care Commission for entry into the PCMH Program.

- Grant funds for electronic health records: Grants for obtaining and/or implementing electronic health records systems are available to eligible health care providers and

practices.

- Grants to defray the costs of capital or leasehold improvements**:** Grants for capital/leasehold improvements are available to eligible health care providers and practices to improve or expand capacity for the delivery of primary healthcare, behavioral, or dental services in the HEZ.

- Grants to defray the costs of medical or dental equipment**:** Grants for medical or dental equipment are available to eligible health care providers and practices for equipment which must be used to provide medical or dental services in the HEZ. Grants are not to exceed the lesser of $25,000 or 50% of the cost of the equipment. Providers/Practitioners must leave working medical and dental equipment in the designated Zone for continued community use, should the providers/practitioners choose to leave the Zone.

- Grant funding for innovative public health strategies: Grant funding is available to non-profit organizations and local government entities to facilitate innovative public health strategies and other incentives to help address the goals of the HEZ Initiative. Examples of fundable innovative public health strategies could include (but are not limited to) the following:
  a) Internship and volunteer programs for students in an HEZ;
  b) Funding for improvements to the environment in an HEZ, including improvements intended to increase access to recreation, healthy food, and quality housing;
  c) Grants to integrate behavioral health care into existing primary care practices in an HEZ;
  d) Funding for better health information technology tools for providers in an HEZ; and
  e) Funding for resources to enhance provider capacity to serve non-English speakers in an HEZ.

In addition to these incentives and benefits, CHRC and DHMH will provide the following types of assistance and support to HEZ designees, which do not need to be included in the application's budget.

- General support for program planning, implementation, and evaluation;
- Working with HEZ grantees and coalition members to provide access to DHMH data resources for approved HEZs;
- Invitation to participate in appropriate collaboratives and work groups;
- Assistance in connecting to existing grant-writing resources;
- Opportunity to apply for J-1 Visa Waiver primary care placements in HEZ sites that are located in federally designated Health Professional Shortage Areas and Medically Underserved Areas or Populations; and
- Priority assistance in achieving Health Information Exchange connectivity at the individual practice level.

Program Duration

HEZ designation will be for a four-year period and applications for HEZ designation should reflect a four-year period of activities. Designations made by the Secretary will be for the duration of the four-year program. Applicants should submit a detailed work-plan and evaluation plan with specific activities, objectives, milestones, and deliverables for each year of

the potential four-year program. In order to receive funding in years two, three, and four of the designation, HEZ Coordinating Organizations will need to meet the terms and conditions of the designation award, namely submitting the required reporting documents on a quarterly basis. In addition, Coordinating Organizations must demonstrate progress in terms of meeting performance measures developed by the Coordinating Organization and CHRC. HEZs that fail to comply with the reporting requirements or do not demonstrate performance in year one may be subject to revocation of designation status, and would no longer have access to benefits and incentives under the HEZ Act. The CHRC retains the right to "claw-back" funds distributed to the Zones or revoke the designation award if the Coordinating Organization is not compliant under the terms and conditions of the designation or does not meet performance measures during implementation.

Program Budget and Use of Funds

HEZ funding requests should be between $500,000 and $2 million per year for the duration of the four-year program. Annual budgets should be based on the calendar year (January – December). The Secretary and the CHRC, post-designation decisions (in January 2013), will meet with grantees to finalize the distribution of benefits and incentives to each designated Zone.

Overall or Global Budget

Applicants will be required to submit an overall or global budget requested, per year, for the duration of the four-year program. The global budget should include the total dollar amount allocated to **each** of the above benefit and incentive areas in the budget, per year. (see Appendix Item F). For example, if the HEZ applicant is requesting a total of $1 million in year one (calendar year 2013), the sum of each incentive or benefit requested should total $1 million. Please refer to Appendix Item G for a sample global budget. In the global budget, applicants are not expected to include/list the specific/actual provider names or practices that will receive each of the incentives or benefits. The global budget simply requires sub-totals for each incentive or benefit utilized in the Zone for each year of the program duration. In the months following the HEZ designation, the Coordinating Organizations will work to identify the individual providers and practices that will receive these benefits and incentives, and the CHRC will work with the Coordinating Organization to develop a mechanism to distribute these benefits and incentives.

Grant Program Budget (by Implementing Organization)

In addition to submitting the global budget, applicants may also be required to submit in their HEZ application a program-specific budget, if they request CHRC grant funding for innovative public health strategies. Applicants are required to provide the total grant funding amount requested for **each** participating partner organization that may receive CHRC grant funding and an accompanying line-item budget, by organization, showing precisely how each organization will utilize CHRC grant funding. Please refer to Appendix Item I for a sample line-item budget. In addition to the Grant Program Budget form, applicants must also provide an accompanying budget justification which details how each line item of grant funding will support the overall objectives of the HEZ. Funding amounts to partners should be appropriate to their responsibilities in the implementation of the HEZ programs and strategies. Applicants are expected at the time of the application to indicate in their application which organizations are committed to partnering in the implementation of the program's strategies by providing either an executed Memorandum of Understanding or Letter of Commitment.

Depending on the distribution mechanism agreed upon by the HEZ Coordinating Organization and CHRC, grant funding and certain incentives will be made directly by the CHRC to the partnering organization or providers who will be implementing the program and/or receiving the benefit. Coalition organizations and providers receiving funding under the HEZ program are expected to work with the CHRC and Coordinating Organizations to ensure all HEZ program reporting and evaluation guidelines are followed.

Incentives and benefits must be used for the purposes indicated in the HEZ Call for Proposals. As required in previous CHRC Call for Proposals, grant funds for innovative public health strategies may be used for program staff salaries and fringe benefits, consultant fees, data collection and analysis, in-state program-related travel, conference calls and meetings, and office supplies and expenses. Indirect costs are limited to 10% of the total grant funds requested (not 10% of the overall HEZ budget). If the services in an application will be delivered by a contractor agency or sub-grantee, and not directly by the applicant, the applicant may not take a fee for passing through the funds to the contractor agency. Funding under the HEZ program may not be used to support clinical trials, for lobbying, or for political activity.

III. Review Principles

Applications will be evaluated by a Review Committee, which will be comprised of experts in the fields of public health, health disparities, chronic diseases, social determinants of health and program management, and economic development. Individuals volunteering on the Review Committee may not be involved in any of the HEZ applications. The Review Committee will be asked to review and score each application on the following 13 review criteria:

1. Purpose. The application addresses the core statutory goals of the HEZ Initiative of reducing health disparities, including racial/ethnic and geographic health disparities, in Maryland.

2. Description of need. The application demonstrates the health and health services needs of the proposed HEZ resident population. The application demonstrates that the needs of the community exceed existing health resources and that the community's health and socio-economic outcomes are worse than/below the State's average and/or comparable communities. Applicants are permitted to draw on the data submitted in the Letter of Interest (the economic disadvantage or poor health outcomes) for threshold eligibility consideration or draw on other data metrics or factors demonstrating the need of the proposed Zone.

3. Core disease targets and conditions. The application identifies at least one or more specific diseases and/or conditions for improvement, and the data provided in the description of need supports the targeted disease(s) and/or conditions(s).

4. Goals. The applicant provides goals for health improvement by January 2016 in the HEZ that are achievable and measurable. The goals reflect the disparities being addressed (in terms of racial, ethnic and/or geographic) and reflect each of the following areas:
   a. Improved risk factor prevalence or health outcomes (Maryland State Health Improvement Process or Local Health Improvement Coalition measures, or others);
   b. Expanded primary care workforce ;

c. Increased community health workforce (including public health and outreach workers);
d. Increased community resources for health (housing, built environment, food access, etc.);
e. Reduced preventable emergency department visits and hospitalizations; and
f. Reduced unnecessary costs in health care (costs that would not have accrued if preventive services and adequate primary care had been provided).

5. Strategies. The strategies and interventions proposed in the application have a high degree of achieving success or achieving the goals stated in the application.

6. Cultural, linguistic and health literacy competence. The application explains how the strategies will be implemented in a culturally competent manner and designed to be accessible to the target population. This includes addressing translation and interpretation issues for non-English speakers and issues of low health literacy in the target population. The application describes the efforts that will be undertaken to recruit a racially, ethnically, and linguistically diverse workforce for the HEZ.

7. Balance. The proposed strategies are balanced between community-based approaches and primary care provider-based incentives. The strategies combine grants for public health and community services with the provider credits and incentives to expand health care capacity/services.

8. Contributions from local partners. Explicit financial or in-kind contributions from local partners and stakeholders are part of the strategic resource mix in order to amplify the impact of the State-provided pilot funding and incentives.

9. Coalition. The application demonstrates that the coalition includes a diverse array of health and community partners, with specific roles and historical experience working in the HEZ. A potential coalition could be led by the Coordinating Organization (the entity submitting the HEZ application and ultimately responsible for reporting requirements and Zone performance) and be comprised of participating partners that are delivering services in the Zone and community advisory groups involved in assisting overall implementation of the activities in the Zone. The application demonstrates inclusion of members of the target populations and minority groups in planning and ongoing oversight of the program. The application describes the coalition team members and participating partners and what assets, experience, knowledge, etc., are brought to the HEZ. There should be a clear governance structure of the coalition with a point of accountability for the Coordinating Organization and each key coalition member. There should be an advisory and oversight entity composed primarily of community members or residents of the designated Zone to provide advice and input to the coalition and the Coordinating Organization. This advisory/oversight entity should reflect experience in serving minority communities or populations.

10. Work-plan. The application provides a detailed work-plan that provides a clear understanding of how the program will be implemented over a four-year period and includes a detailed list of program activities, measurable outcomes, timelines, responsible entities and other logistics that enable tracking of effort; describes roles of the listed partners; includes interim milestones and deliverables; and supports appropriate data collection and reporting. See Appendix E for a sample work-plan.

11. Program management and guidance. The application provides a plan for quarterly reporting to the CHRC regarding progress and challenges regarding implementation of the HEZ work-plan and interim values for the evaluation metrics. The application includes a plan of quarterly reporting that meets the criteria in this Call for Proposal (see section V. Evaluation and Implementation, page 18) and that make sense given the core disease targets and conditions of the HEZ as well as the goals of the HEZ.

12. Sustainability. The application provides a feasible short-term and long-term sustainability strategy and acquisition of resources beyond state funding. Explicit financial or in-kind contributions from local partners and stakeholders should be part of the strategic resource mix and can be described here either as pledges or potential contributions to be pursued by the Coordinating Organization. Investments from insurers who stand to gain from cost savings in the HEZ are a potential component of a sustainability plan.

13. Internal evaluation and progress monitoring. The application provides a draft internal evaluation plan which tracks its progress in meeting each of the goals within the HEZ. The evaluation plan should include implementation and process metrics and performance measures with time-specific milestones and targets to allow assessment of the deployment of the interventions in the work-plan.

A Review Committee will evaluate applications on these review principles and will provide the CHRC with recommendations for selected organizations to present their applications before the full Community Health Resources Commission. Applicants not invited to present will be notified that they are not eligible to receive HEZ designation in this Call for Proposal opportunity. Recommendations by the CHRC to the Secretary will be based upon the recommendations of the Review Committee and presentations before the Commission. The Secretary will issue final HEZ designation awards in late December, 2012.

IV. Submitting an Application for Health Enterprise Zone Designation

The HEZ designation application has three steps:
Step 1: Submit a Letter of Interest, due no later than October 19, 2012, 5:00 p.m.
Step 2: Submit full Application, due no later than November 13, 2012, 12:00 p.m.
Step 3: Present Applications before the CHRC, December 11 (invited applicants only)

Step 1: Letter of Interest
The Letter of Interest should include the following items:
1. Name of the applicant organization (the Coordinating Organization);
2. Name, title, address, telephone number, and e-mail for the Chief Executive Officer and the proposed program director (if different) of the Coordinating Organization;
3. Documentation that shows the Coordinating Organization is either a community-based non-profit organization or local government entity;
4. Name of organizations partnering in the coalition;
5. A description of the location/geographic area of the proposed Health Enterprise Zone (i.e., community/neighborhood names); and

6. HEZ Eligibility Worksheet (Appendix Item A).

Letters of Interest are due to the CHRC no later than 5:00 p.m., October 19, 2012, but will be accepted and reviewed on a **rolling basis**. Applicants are encouraged to submit the Letter of Interest as soon as it is ready, and not wait until October 19. Letters of Interest should be submitted as a PDF or Word Document attachment, sent via email to dhmh.hez@maryland.gov. Please save file attachments using the following format: Organization Name, HEZ Letter of Interest, Date.

The CHRC will review the Letters of Interest and Eligibility Worksheets (see Appendix Item A) as soon as is possible, certify each applicant's eligibility, and contact eligible applicants to submit the full application, hopefully within 48 hours of submission of LOI. Once eligibility is certified and applicants are notified, LOIs will be posted on the HEZ website.

Only applicants whose proposed HEZ meets the eligibility criteria (see page 4) will be invited to proceed in submitting a full application (Step 2). CHRC staff will review the Letters of Interest, certify applicants' eligibility, and will invite eligible applicants to submit a formal application for HEZ designation. The CHRC will notify applicants of their eligibility as soon as is possible, hopefully within a 48-hour period of submission of the Letter of Interest.

Step 2: Submission of Applications
Following are guidelines and the requested structure of the HEZ application. The overall length of the HEZ application should be no more than 25 pages and will contain Standard Forms located in the Appendices of this Call for Proposals and narrative written sections. The HEZ application should be structured using these topic headings and forms, in the following order:

Topic Heading and Forms	Narrative versus Standard Form	Included in Page Limit
Table of Contents	Narrative	Not included
1. Grant Application Cover Sheet	Standard Form – CFP Appendix Item B	Not included
2. Contractual Obligations, Assurances, and Certifications	Standard Form – CFP Appendix Item C	Not included
3. Program Summary	Narrative	Included
4. Program Purpose	Narrative	Included
5. HEZ Geographic Description (HEZ map)	Narrative	Included (map not included)
6. Community Needs Assessment	Narrative	Included
7. Core Disease(s) and Condition(s) Targeted	Narrative	Included
8. Goals	Narrative	Included
9. Strategy to Address Health Disparities	Narrative	Included
10. Use of Incentives and Benefits	Narrative	Included

11. Cultural, linguistic and health literacy competency	Narrative	Included
12. Applicant Organization and Key Personnel	Narrative	Included
13. Coalition Organizations and Governance	Narrative	Included
14. Work-plan	Standard Form – CFP Appendix Items D and E	Not included
15. Evaluation Plan	Narrative	Included
16. Sustainability Plan	Narrative	Included
17. Program Budget and Justification	Standard Form – CFP Appendix Items F - I	Not included
18. Financial Audit		Not included
Appendices		Not included

The suggested content of each of these sections is provided below. Appendices should be limited to only the material necessary to support the application.

1. Grant Application Cover Sheet: The form should be completed and signed by the program director(s) and either the chief executive officer or the individual responsible for conducting the affairs of the applicant and legally authorized to execute contracts on behalf of the applicant organization. This form is attached as Appendix Item B and also can be accessed at the Maryland Community Health Resources website (http://dhmh.maryland.gov/mchrc/ - click on "Forms" on the left hand side menu) and the DHMH HEZ website (http://dhmh.maryland.gov/healthenterprisezones/).

2. Contractual Obligations, Assurances, and Certifications**:** The agreement should be completed and signed by either the Chief Executive Officer or the individual responsible for conducting the affairs of the applicant and authorized to execute contracts on behalf of the applicant organization. This document is attached as Appendix Item C and also can be accessed at the Maryland Community Health Resources website (http://dhmh.maryland.gov/mchrc/ - click on "Forms" on the left hand side menu) and the DHMH HEZ website (http://dhmh.maryland.gov/healthenterprisezones/).

3. Program Summary: The program summary is a concise, one-page overview of the proposed HEZ community(ies), the community needs, and the overall strategies that will be implemented to achieve the HEZ program's goals.

4. Program Purpose: The application should describe how the activities in the application will address the core goals of HEZ Initiative.

5. HEZ Geographic Description: The application should provide a brief description of the geographic location of the proposed HEZ, including the zip code(s) or sub-zip code geographic units that will be part of the HEZ. Applications should provide names of the community(ies) or

neighborhood(s) that are participating as part of the HEZ and any other relevant details that help to describe the physical location of the proposed HEZ. Applications should include a map of the proposed HEZ area that delineates the geographic units that are the boundaries of the zone (i.e., zip code, Census Tracts, etc). This can be the same map provided as part of the Letter of Interest.

6. Community Needs Assessment: The application should describe the health and health service needs of the population in the proposed HEZ. Examples of metrics to describe community need include (but are not limited to) indicators of health status, risk factor prevalence, health insurance status, primary care access, Medically Underserved Area or Medically Underserved Population designations, and other needs that impact the health of the community. This data should be presented, where possible, by racial groups and by Hispanic ethnicity. The application should also discuss other socio-economic factors that contribute to poor health in the community, such as data regarding education, employment, income, housing, physical environment, and other community factors that impact health.

7. Core Disease Targets and Conditions. Based upon the community need, the application should identify specific disease(s) and/or condition(s) that will be targeted for improvement. Applications are encouraged to target at least one of the following conditions identified by the Health Disparities Workgroup of the Maryland Health Quality and Cost Council: cardiovascular disease, diabetes, and asthma. Applications may address other major conditions where the community experiences poor health outcomes, such as behavioral health, dental health, birth outcomes, or related co-morbid conditions.

8. Goals: The application should propose ***measurable*** goals for health improvement in the HEZ by January 2016. The goals should reflect the disparities being addressed. Each goal should be included in the work-plan (see item 16, page 17). Goals should cover each of the following areas:

- Improved risk factor prevalence or health outcomes (e.g., SHIP or LHIP measures, or others);
- Expanded primary care workforce;
- Increased community health workforce (including public health and outreach workers);
- Increased community resources for health (e.g., housing, built environment, food access, etc.);
- Reduced preventable emergency department visits and hospitalizations; and
- Reduced unnecessary costs in health care (costs that would not have accrued if preventive services and adequate primary care had been provided).

9. Strategies. The application should provide a clear description of each strategy, including the key programmatic components, implementation steps, and partnering organizations who will assist in the implementation of the proposed strategy. The application should reference the key action steps included in the work-plan (see item 16, page 17). The evidence and rationale for each of the strategies and interventions should be presented. Examples of potential strategies could include:

- A strategy to increase provider capacity by a specified percentage;
- A strategy to improve the quality of service delivery as indicated by HEDIS measures;
- A strategy to address community barriers to healthy lifestyles;
- A strategy to improve health outcomes through the use of community health workers;

- A plan to strengthen community and environmental policies to support good health in schools, day care, recreation centers, senior centers, and workplaces;
- A strategy to provide better access to healthy foods or facilities for physical activities;
- A strategy to engage underserved racial and ethnic minority persons in the Health Enterprise Zone;
- A strategy to improve the built environment in an HEZ, including improvements intended to increase access to recreation, healthy food, and quality housing;
- A strategy to integrate behavioral health care into existing primary care practices in an HEZ;
- A strategy to improve health information technology tools for providers in an HEZ; and
- A strategy to enhance provider capacity to serve non-English speakers in an HEZ.

Applicants are encouraged where possible to adopt strategies that are evidence-based, generally accepted as promising practices, or new/innovative ideas. Applicants are encouraged to bring health information technology (electronic medical records and health information exchange) and the patient-centered medical home model to their strategic approaches.

10. Use of Incentives and Benefits. The applications should describe which incentives and benefits will be utilized as part of its strategies. The proposed strategies should be balanced between community-based approaches and provider-based incentives, and it should combine grants for public health and community services with the provider credits and incentives that are available to HEZs. The application must include a proposal to use funding available under this Initiative to provide for loan repayment incentives to induce health enterprise zone practitioners to practice in the HEZ.

11. Cultural, linguistic and health literacy competency. The application should explain how the strategies will be implemented in a culturally competent manner and designed to be accessible to the target population. This includes addressing translation and interpretation issues for non-English speakers, and issues of low health literacy in the target population. The application should describe the efforts that will be undertaken to recruit a racially, ethnically, and linguistically diverse workforce for the HEZ.

12. Applicant Organization and Key Personnel: The application should provide a description of the Coordinating Organization (applicant organization) and the organization's capacity to implement and lead the HEZ program. This can include any relevant experience in leading a coalition of organizations, community-based work, and implementation of multi-year programs. The application should identify the program director and describe his/her role within the Coordinating Organization, qualifications to lead the program, and responsibilities in carrying out the program. The application should also identify other essential staff, their roles in the program, and their relevant qualifications. Résumés for all key personnel should be included as appendices, and do not count as part of the overall page limit of the application. The application should describe any positions for which the organization that will need to hire new/additional staff.

13. Coalition Governance and Participating Partners: The application should provide a list of all HEZ coalition members (this list may be included as an appendix item if needed [not included in

the overall page limit]). The application should describe the coalition team members and what assets, experience, knowledge, etc. each brings to the proposed HEZ. The application should also describe the roles and responsibilities (if any) of coalition members in the implementation of any of the proposed strategies and intervention. The application should describe the governance structure that will be used by the Coordinating Organization, which provides a point of accountability for each core coalition member and participating partner. The application should describe plans to include members of the target populations and minority groups in planning and ongoing oversight of the program.

14. Work-Plan (Chart): The application should include a work-plan for implementing the HEZ program across each goal and strategies. The work-plan is a comprehensive program management tool for HEZ performance (see Appendix E for a sample chart) that describes the key strategies, activities, and evaluation measures and links these with the overall goals of the HEZ. The work-plan should provide a "step-by-step" understanding of the key actions, the timing to implement these actions, and who (which participating partners or personnel) is responsible for implementing these actions. In addition, the work-plan will describe the time-specific milestones or deliverables that will be used to evaluate the success of the activities in the HEZ. The work-plan should be in a chart format which provides a clear understanding of how the program's goals will be achieved over the four-year program duration and should include the following components:

a. Goals;
b. Objectives;
c. Key program activities/action steps;
d. Data evaluation and measurement;
e. Responsible organization/entity; and
f. Timeline for implementation.

Some information presented in the other parts of the application, such as goals, specific strategies, activities, and the evaluation plan, will be repeated in the work-plan. A template (blank) work-plan chart and sample work-plan are included in this Call for Proposals (see Appendix Items D and E).

15. Evaluation Plan: The evaluation plan should include implementation and process metrics and performance measures with time-specific milestones and targets to assess the deployment of the interventions and strategies in the work-plan. Whereas the work-plan is in chart format (see Appendix D), the evaluation plan is in narrative (written prose) form. The primary purpose of the evaluation plan is to describe how the Coordinating Organization will measure the implementation and success of the proposed strategies on an ongoing basis to achieve the goals of the HEZ and report this information to the CHRC on a regular basis. This evaluation plan should include the specific activities/methods the Coordinating Organization (and sub-grantees/participating partners, where applicable) will undertake to capture needed information (e.g., health outcome data) and how the Coordinating Organization will evaluate the success of the activities within the HEZ on a regular basis. The evaluation plan should also include the health outcome metrics that will be tracked/reported to demonstrate that the HEZ is achieving its health improvement goals. Time-specific milestones for the health outcome metrics should be included. Methods for collecting the health outcome data within the HEZ or assembling data from external sources should be discussed. The metrics of reach (deployment) and impact

(health outcomes) should be analyzed in categories of race and ethnicity to assess the impact on minority health and health disparities.

In addition, the internal evaluation plan should describe how the Coordinating Organization plans to monitor the activities and progress of sub-grantees/participating partners in the implementation of specific program activities. This could include any information/data the Coordinating Organization will require from sub-grantees, how sub-grantees will be held accountable for program achievement, and how this information will be reported to the CHRC. The information gathered by the Coordinating Organization should be linked to specific milestones, data measures, and/or other metrics that evaluate the progress on key activities, objectives, and program goals. Applications should reference the data and evaluation measures included in the Work-Plan (see item 16, page 17).

Applications should show a budgeted line-item between 5% and 10% of the overall HEZ global budget for data collection and evaluation efforts. If the applicant organization plans to utilize external organizations or other tools/resources to assist to evaluation of the program, this should be described here (e.g., hiring an external organization to administer a survey or group interviews, purchasing software to capture particular data).

16. Sustainability: The application should describe a plan for sustainability and acquisition of resources beyond State funding, including partnership with entities in the health care system that have the financial incentive for better outcomes. The application should include a specific plan for developing and implementing a short-term and long-term sustainability strategy.

17. Program Budget and Justification (Standard form): The HEZ funding request should be between $500,000 to $2 million per year for the duration of the four-year program. All applicants must complete the Global Budget Form which provides the annual and total budget request by program benefit and incentive requested (see Appendix Item F for a template (blank) global budget form and Appendix Item G for a sample global budget form).

Applicants requesting CHRC grant funding for innovative health programs may also be required to complete a separate Grant Program Budget Form, which is a line-item budget for each organization that will be partnering in the implementation of the public health grant program (see Appendix Item H for a template (blank) organization program budget form and Appendix Item I for a sample organization program budget). For example, if the application requests CHRC grant support for the salaries of five community health workers to be hired by a participating partner, then the Line-Item Grant Budget Form is required in addition to the Global Budget.

The budget justification should detail what is included in each line-item and describe how each item will support the achievement of the program's goals and objectives. Funding levels to implementing organizations should be appropriate to their roles and responsibilities in the work-plan.

18. Financial Audits: Non-profit Coordinating Organizations must submit a copy of their most recent financial audit of the organization. As in previous CHRC Call for Proposals, financial audits are not required for local government entities.

Application Formatting
Applications should be approximately 20 to 25 pages single-spaced on standard 8 ½" x 11" paper with one-inch margins and using 12-point Times New Roman or Arial font. Tables and charts may use a 10-point font or larger. Please number pages. The hard copy of the application documents should be bound with prong report fasteners or clips. Please do not use spiral binding or three ring binders.

Applications are due to the CHRC no later than 12:00 p.m., November 13, 2012 by email **and** hand delivery, U.S. Postal Service, or private courier.

Electronic versions of applications should be submitted in one PDF or Word Document attachment, sent via email to dhmh.hez@maryland.gov. Please save file attachments using the following format: Organization Name, HEZ Proposal, Date.

In addition to electronic application submission, the following must be received by November 13, 2012, 12:00 p.m. to be considered a complete application package:

(1) One original application, labeled "original"; and

(2) Eight bound copies of the application.

Send hard copies of applications to:

Mark Luckner
Executive Director
Maryland Community Health Resources Commission
45 Calvert Street, Room 336
Annapolis, MD 21401

Step 3: Presentation before the CHRC (invited applicants only)
A selected number of applicants will be invited to present their proposal at a Community Health Resources Commission meeting. This meeting will be held on December 11, Additional information regarding time and location of this meeting will be forthcoming. Invited applicants will be provided presentation instructions upon notification of invitation to present.

V. Program Evaluation and Implementation

The CHRC implements a robust system of grantee performance management that holds grantees accountable for performance and is designed to ensure that finite grant resources are utilized wisely and efficiently. The CHRC will work with each HEZ Coordinating Organization and its participating partners to develop standard and customized performance measures that will be reported by the grantees on a quarterly basis. These performance measures will reflect the four-year duration of the program and will be a combination of interim and longer-term measures.

Internal Evaluation
At the beginning of the grant period (January 2013), CHRC staff and the HEZ Coordinating Organization will meet to finalize the internal evaluation plans, which will be developed from the work-plan and proposed internal evaluation plan submitted in the original HEZ application. As part of this internal evaluation, HEZ Coordinating Organizations will be required to submit the following three deliverables on a quarterly basis. CHRC staff will make sample reports available to HEZ Coordinating Organizations after HEZ designations are made.

1. **Milestone & Deliverable Report (M&D)**. Quantitative report (excel file) which reports on a core set of common measures for all HEZ programs and specific measures that are unique to each HEZ program. These measures will be developed from the work-plan and proposed evaluation measures provided in the HEZ application. Grantees will be expected to provide baseline data/projections on evaluation measures and subsequent data will be compared to baseline data/projected outcomes;

2. **Narrative reports**. Qualitative report (word document) summarizing the status of implementation of key strategies of the HEZ proposal. The narrative reports should be based on the key time-specific milestones and deliverables in the M&D report (above), and the work-plan and proposed evaluation plan that were provided in the HEZ application. These reports provide details about each grant program including any major events or activities that took place as part of the implementation; any problems or barriers encountered during the reporting period and how these barriers were resolved or will be addressed; and details about why the grantee has not achieved program goals to date. Any successes or unexpected outcomes from the program activities should be highlighted in the narrative report; and

3. **Expenditure reports.** A line-item budget detail (excel file) showing exactly how HEZ resources were expended and utilized. Activities or expenditures by participating partners should be included. Recipients of HEZ funds are expected to retain all documentation of the use of grant funds and provide these to the CHRC upon request.

HEZ grantees will provide these reports throughout the program's four-year duration. Compliance will be required as a condition of receipt of funding in years two, three, and four of the program.

External Evaluation
Under the Maryland Health Improvement and Disparities Reduction Act, the CHRC and DHMH are required to submit an annual report to the Maryland General Assembly and Governor documenting the impact of the activities in the Health Enterprise Zones. To fulfill this reporting requirement, the CHRC will solicit proposals to contract with an outside entity to perform an independent, external evaluation of the program. This evaluator will not only analyze the periodic reports submitted by the HEZ Coordinating Organizations, but will also perform additional data collection and analysis to assess the impact of the activities of the HEZs on the outcomes specified in the Act and the proposals. The external evaluation activities will be coordinated and funded through the CHRC and DHMH, and, as such, do not need to be included as part of budget requests submitted by HEZ Coordinating Organizations. As a condition of receiving HEZ grant funds, however, HEZ grantees will be required to participate in this external evaluation. This may include the Coordinating Organization and participating partners assisting

with any data collection and information gathering required, such as participation in surveys, focus groups, site visits, meetings, and key informant interviews with the evaluators.

Program Implementation and Benefits Distribution
The HEZ program period will begin in January 2013, and reporting requirements will be organized around a calendar year. Once HEZ designations are made by the Secretary, CHRC staff and HEZ Coordinating Organizations will develop and finalize program budgets, internal evaluation plans, and periodic reports submitted to the CHRC. Once these documents are finalized, it is expected that the Coordinating Organization and partnering entities will begin implementing the HEZ strategies immediately. In addition, the HEZ Coordinating Organization and CHRC will determine the mechanics of distributing incentives or benefits. In some cases, the Coordinating Organization will receive funds from the CHRC to distribute the benefits to participating partners, and in other cases, the CHRC will distribute benefits directly to the individual participating partners.

Providers and practices who wish to receive benefits and incentives in the HEZ strategies (income and hiring tax credits, loan repayment assistance, EHR, capital and equipment funding) must apply to the Coordinating Organization. Within six months of designation (July 2013), the Coordinating Organization must evaluate the applications of providers and practices, certify their eligibility, and provide the CHRC with the specific/actual providers and practices that will receive the benefits and incentives budgeted for year one of the program. The CHRC and DHMH will distribute funding and incentives directly to each provider/practice.

Grant Modifications
HEZ Coordinating Organizations are permitted to request changes to their approved HEZ proposal/programs by submitting a formal Grant Modification Form (see Appendix Item H), and when required, an updated Global or Program Budget to the CHRC. Grantees may be asked to present their grant modification request before the CHRC.

VI. Inquiries and Other Information

Conference Call for Applicants
The program office will host a conference call for interested applicants to provide information on the HEZ program and assistance with the application process. This conference call, on **October 11, 2:30 p.m.,** is ***optional***. This call will be available on a first come, first serve basis. Multiple participants from the same organization are encouraged to use one phone line when calling into the conference call. The call in information is:

Dial-In Number: (866) 233-3852
Participant Access Code: 267478

Questions from Applicants
Applicants may also submit written questions at any time to dhmh.hez@maryland.gov.

COMMUNITY HEALTH RESOURCES COMMISSION
2012 Commissioners
John A. Hurson, Chairman
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Dr. Charlene Dukes
Maria Harris-Tildon
Kendall D. Hunter
P. Sue Kullen
Dr. Mark Li
Paula McLellan
Margaret Murray, M.P.A.

CHRC Staff and Contact Information
The Maryland Community Health Resources Commission is located at:

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MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION
Health Enterprise Zone Applications
Applicant
Allegany County Health Department
Anne Arundel Medical Center
Asian American Center of Frederick/ L.I.F.E. & Discovery, Inc.
Baltimore County Department of Health
Bon Secours Baltimore Health System
Calvert Memorial Hospital
Care for your Health
Cecil County Health Department
Charles County Department of Health
Dorchester County Health Department
GOSPEL/Allen Chapel AME
Laurel Regional Hospital/Dimensions Healthcare System
Lower Shore Clinic
MedChi - Chestertown
Primary Care Coalition of Montgomery County
Prince George's County Health Department
Sisters Together And Reaching - East Baltimore HEZ Collaborative
Somerset County Health Department
St. Mary's Hospital of St. Mary's County

Appendix I

Zone: Prince George's County

Total Population of Zone: 38,626

Date: January – March 2014 (Q4)

Health Enterprise Zones Dashboard

Prince George's County Health Department
Greater Baden Medical Services
Sister Circles, Inc.
Concentra Urgent Care
Global Vision Community Health Center
Medical Mall Health Services
Dimensions Hospital
Doctors Community Hospital
Gerald Family Care
University of Maryland School of Public Health
Prince George's County Dept. of Social Services
Prince George's County Dept. of Family Services

Hospital Utilization		Annual Rates		2014			
		CY 2012	CY 2013	Q1	Q2	Q3	Year
Capitol Heights	Hospitalization Rate*	99.3	92.1				
	Readmission Rate	14.4%	14.3%				
Maryland	Hospitalization Rate*	110.1	105.0				
	Readmission Rate	13.3%	13.8%				

*Rate per 1,000 residents.
Maryland residents hospitalized out of state are not included in data.

Process Measures	Year One Goals	Year One Cumulative Totals			
		Q1	Q2	Q3	Q4
# of HEZ practitioners added* (FTE)	7	0	0	2.5	8.3
# of CHWs added (FTE)	5	0	0	3.0	5.0
# of patients (unduplicated) across Zone		Opened Q4			925
# of patient visits across Zone					3,251
# of CHW outreach encounters					6,000

Clinical Measures	Baseline	Year Two			
		Q1	Q2	Q3	Q4
# of sites reporting					
# of primary care providers reporting					
# of patients receiving services across sites					
Asthma					
Use of appropriate medications **(NQF 36)**					
Behavioral Health					
Screening for clinical depression and follow up plan **(NQF 418)**					
Antidepression medication management **(NQF 105)**					
Diabetes					
Diabetes: HbA1c Control **(NQF 575)**					
Diabetes: LDL Management **(NQF 64)**					
Diabetes: BP Management **(NQF 61)**					
Hypertension					
Hypertension: BP Control **(NQF 18)**					
Smoking					
Smoking Screening & Counseling **(NQF 28)**					
Obesity					
BMI Screening & Follow-Up **(NQF 421)**					

Key Milestones	Year One			
	Q1	Q2	Q3	Q4
Goal 1: Increase access to primary care services				
Open and/or expand 2 new PCMH sites in the Zone (in Year 1)				
Develop and Initiate Community Health Worker program				
Goal 2: Increase community health resources				
Develop a Health Information Exchange (HIE) and connect various electronic medical records to the HIE				
Develop and implement care coordination software application				
Establish post discharge care coordination protocols				
Develop and implement electronic Healthy Eating Active Living Wellness Plan Template				
Conduct health literacy surveys				
Goal 3: Promote Cultural Competency				
Develop comprehensive cultural competency training curriculum				

Completed **On-Task** **Delayed**

Completed Milestones

√	Open and staff Global Visions PCMH site
√	Expand services at Greater Baden PCMH site
√	Identify additional services provided by Prince George's County Health Department (to complement PCMH-related services in the Zone)

*Includes direct and indirect licensed health care providers who provide primary care, behavioral health or dental services in the Zone (physicians, NPs, PAs, psychiatrists, psychologists, dentists, RNs, dental hygienists, LCSWs, licensed clinical professional counselors, and licensed substance abuse service providers).

Zone: Caroline/Dorchester
Total Population of Zone: 36,123
Date: January – March 3014 (Q4)

Health Enterprise Zones Dashboard

Associated Black Charities
Eastern Shore Area Health Education Center
Dorchester County Health Department

Maryland State Medical Society
Chesapeake Voyagers, Inc./DRI Dock
Affiliated Sante Group

Shore Wellness Partners
Maryland Healthy Weighs
Caroline County Health Department

Hospital Utilization		Annual Rates		2014			
		CY 2012	CY 2013	Q1	Q2	Q3	Year
Dorchester/ Caroline	Hospitalization Rate*	143.0	134.5				
	Readmission Rate	12.2%	12.0%				
Maryland	Hospitalization Rate*	110.1	105.0				
	Readmission Rate	13.3%	13.8%				

*Rate per 1,000 residents.
Maryland residents hospitalized out of state are not included in data.

Process Measures	Year One Goals	Year One Cumulative Totals			
		Q1	Q2	Q3	Q4
# of HEZ practitioners added* (FTE)	**9**	3.5	5.7	5.7	10.3
# of unduplicated patients seen across Zone	**687**	29	200	440	591
Average response time to calls for the mobile crisis team	**<60 mins**	NA	45 mins	16 mins	10 mins
# of patient visits (unduplicated) across Zone		NA	580	1630	3,267
# of students (unduplicated) served in school based wellness centers		NA	60	150	196
# of individuals (unduplicated) participating in Maryland Healthy Weighs		12	23	33	46

Clinical Measures	Baseline	Year Two			
		Q1	Q2	Q3	Q4
# of sites reporting					
# of primary care providers reporting					
# of patients receiving services across sites					
Asthma					
Use of appropriate medications **(NQF 36)**					
Behavioral Health					
Screening for clinical depression and follow up plan **(NQF 418)**					
Antidepression medication management **(NQF 105)**					
Diabetes					
Diabetes: HbA1c Control **(NQF 575)**					
Diabetes: LDL Management **(NQF 64)**					
Diabetes: BP Management **(NQF 61)**					
Hypertension					
Hypertension: BP Control **(NQF 18)**					
Smoking					
Smoking Screening & Counseling **(NQF 28)**					
Obesity					
BMI Screening & Follow-Up **(NQF 421)**					

Key Milestones	Year One			
	Q1	Q2	Q3	Q4
Goal 1: Increase access to primary care services				
Develop and implement SBWC in Caroline County				
Open Federalsburg adult mental health clinic				
Expand primary care services at Chesapeake Women's Health				
Goal 2: Increase community health resources				
Implement Community Health Outreach Teams				
Implement peer substance abuse recovery program				
Implement Shore Wellness home visiting program				
Goal 3: Promote Cultural Competency				
Provide cultural competency training to collaborative partners				

Completed **On-Task** **Delayed**

Completed Milestones	
√	Develop and implement SBWC in Dorchester County
√	Initiate new mobile health crisis team
√	Initiate Maryland Healthy Weighs program

*Includes direct and indirect licensed health care providers who provide primary care, behavioral health or dental services in the Zone (physicians, NPs, PAs, psychiatrists, psychologists, dentists, RNs, dental hygienists, LCSWs, licensed clinical professional counselors, and licensed substance abuse service providers).

Zone: Greater Lexington Park

Total Population of Zone: 34,035

Date: January – March 2014 (Q4)

Health Enterprise Zones Dashboard

MedStar Health Research Institute
St. Mary's County Government Agencies
Community Development Corporation
Southern Maryland Center for Independent Living
The Healthy St. Mary's Partnership LHIC
The Minority Outreach Coalition
Greater Baden Medical Service
MedStar St. Mary's Hospital
Walden Sierra Inc.

Hospital Utilization		Annual Rates		2014			
		CY 2012	CY 2013	Q1	Q2	Q3	Year
Greater Lexington Park	Hospitalization Rate*	93.8	88.4				
	Readmission Rate	9.6%	9.0%				
Maryland	Hospitalization Rate*	110.1	105.0				
	Readmission Rate	13.3%	13.8%				

*Rate per 1,000 residents.
Maryland residents hospitalized out of state are not included in data.

Process Measures	Year One Goals	Year One Cumulative Totals			
		Q1	Q2	Q3	Q4
# of HEZ practitioners added* (FTE)	**3**	0.0	1.2	4.3	4.8
# of CHWs added (FTE)	**3**	0	1.0	2.0	2.0
# of residents who use mobile medical route	**200**	0	0	0	387
# residents who are assisted by CHWs		0	0	13	85
# of patients (unduplicated) receiving primary care services		N/A	135	310	490
Number of visits across the Zone		N/A	280	545	791

Clinical Measures	Baseline	Year Two			
		Q1	Q2	Q3	Q4
# of sites reporting					
# of primary care providers reporting					
# of patients receiving services across sites					
Asthma					
Use of appropriate medications **(NQF 36)**					
Behavioral Health					
Screening for clinical depression and follow up plan **(NQF 418)**					
Antidepression medication management **(NQF 105)**					
Diabetes					
Diabetes: HbA1c Control **(NQF 575)**					
Diabetes: LDL Management **(NQF 64)**					
Diabetes: BP Management **(NQF 61)**					
Hypertension					
Hypertension: BP Control **(NQF 18)**					
Smoking					
Smoking Screening & Counseling **(NQF 28)**					
Obesity					
BMI Screening & Follow-Up **(NQF 421)**					

Key Milestones	Year One			
	Q1	Q2	Q3	Q4
Goal 1: Increase access to primary care services				
Develop and implement Care Coordination program targeting eligible residents who utilized ED or were inpatients				
Initiate mobile dental program				
Open Community Health Center in target zip code(s)				
Goal 2: Increase community health resources				
Hire/place CHWs throughout the Zone				
Implement Hair, Heart and Health program*				
Goal 3: Promote Cultural Competency				
Provide cultural competency training				

Completed **On-Task** **Delayed**

Completed Milestones	
√	Initiate and implement mobile medical route
√	Integrate primary care services with behavioral health services at Walden Sierra
√	Expand behavioral health services at Walden Sierra

*Includes direct and indirect licensed health care providers who provide primary care, behavioral health or dental services in the Zone (physicians, NPs, PAs, psychiatrists, psychologists, dentists, RNs, dental hygienists, LCSWs, licensed clinical professional counselors, and licensed substance abuse service providers).

Zone: Annapolis / Morris Blum

Total Population of Zone: 36,805 / 184

Date: January – March 2014 (Q4)

Health Enterprise Zones Dashboard

Anne Arundel County Health Department
Housing Authority, City of Annapolis

Anne Arundel Health System
Anne Arundel County Department of Aging and Disabilities

Hospital Utilization		Annual Rates		2014			
		CY 2012	CY 2013	Q1	Q2	Q3	Year
Morris Blum	Hospitalization Rate*	138.5	121.8				
	Readmission Rate	13.6%	12.3%				
Maryland	Hospitalization Rate*	110.1	105.0				
	Readmission Rate	13.3%	13.8%				

*Rate per 1,000 residents.
Maryland residents hospitalized out of state are not included in data.

Process Measures	Year One Goals	Year One Cumulative Totals			
		Q1	Q2	Q3	Q4
# of HEZ practitioners added* (FTE)	2	N/A	2.0	2.0	2.0
# of 911 calls from Morris Blum Center		N/A	39	87	144
# of ED visits from Morris Blum residents		N/A	56	103	152
# of Morris Blum residents (unduplicated) who receive services at new PCMH		Opened Oct. 9th		45	81
# of additional residents (outside Morris Blum) who receive services (unduplicated)		Opened Oct. 9th		252	470
# of patients (unduplicated) with diabetes seen for primary care		Opened Oct. 9th		33	70

Clinical Measures	Baseline	Year Two			
		Q1	Q2	Q3	Q4
# of sites reporting					
# of primary care providers reporting					
# of patients receiving services across sites					
Asthma					
Use of appropriate medications **(NQF 36)**					
Behavioral Health					
Screening for clinical depression and follow up plan **(NQF 418)**					
Antidepression medication management **(NQF 105)**					
Diabetes					
Diabetes: HbA1c Control **(NQF 575)**					
Diabetes: LDL Management **(NQF 64)**					
Diabetes: BP Management **(NQF 61)**					
Hypertension					
Hypertension: BP Control **(NQF 18)**					
Smoking					
Smoking Screening & Counseling **(NQF 28)**					
Obesity					
BMI Screening & Follow-Up **(NQF 421)**					

Key Milestones	Year One			
	Q1	Q2	Q3	Q4
Goal 1: Increase access to primary care services				
Begin providing primary care services to Morris Blum residents				
Inform greater Annapolis area about new PCMH				
Goal 2: Increase community health resources				
Develop diabetes management program for residents				
Implement self-management support activities (e.g., shopping field trips, cooking and nutrition events)				
Goal 3: Promote Cultural Competency				
Provide cultural competency training				

Completed **On-Task** **Delayed**

Completed Milestones	
√	Hire new providers for PCMH at Morris Blum
√	Make capital improvements to new PCMH
√	Open new PCMH at Morris Blum

*Includes direct and indirect licensed health care providers who provide primary care, behavioral health or dental services in the Zone (physicians, NPs, PAs, psychiatrists, psychologists, dentists, RNs, dental hygienists, LCSWs, licensed clinical professional counselors, and licensed substance abuse service providers).

Zone: West Baltimore

Total Population of Zone: 137,823

Date: January – March 2014 (Q4)

Health Enterprise Zones Dashboard

Baltimore Medical Center
University Maryland Medical Centers
Mosaic Community Services
Park West Health System
Bon Secours Baltimore Health System
Total Health Care
People's Community Health Centers
Saint Agnes Hospital
Coppin State University
Light Health and Wellness Comprehensive Services
National Council on Alcohol and Drug Dependence
Sinai Hospital, Baltimore

Hospital Utilization		Annual Rates		2014			
		CY 2012	CY 2013	Q1	Q2	Q3	Year
West Baltimore	Hospitalization Rate*	222.0	206.3				
	Readmission Rate	17.7%	16.9%				
Maryland	Hospitalization Rate*	110.1	105.0				
	Readmission Rate	13.3%	13.8%				

*Rate per 1,000 residents.
Maryland residents hospitalized out of state are not included in data.

Process Measures	Year One Goals	Year One Cumulative Totals			
		Q1	Q2	Q3	Q4
# of HEZ practitioners added* (FTE)	**16**	12.0	24.0	24.0	26.0
# of CHWs added (FTE)	**11**	0	10.5	10.5	10.5
# of community "mini-grants" awarded by HEZ	**4**	0	7	7	7
# new community health resources created for HEZ residents	**5**	8	10	15	25

Clinical Measures	Baseline	Year Two			
		Q1	Q2	Q3	Q4
# of sites reporting					
# of primary care providers reporting					
# of patients receiving services across sites					
Asthma					
Use of appropriate medications **(NQF 36)**					
Behavioral Health					
Screening for clinical depression and follow up plan **(NQF 418)**					
Antidepression medication management **(NQF 105)**					
Diabetes					
Diabetes: HbA1c Control **(NQF 575)**					
Diabetes: LDL Management **(NQF 64)**					
Diabetes: BP Management **(NQF 61)**					
Hypertension					
Hypertension: BP Control **(NQF 18)**					
Smoking					
Smoking Screening & Counseling **(NQF 28)**					
Obesity					
BMI Screening & Follow-Up **(NQF 421)**					

Key Milestones	Year One			
	Q1	Q2	Q3	Q4
Goal 1: Increase access to primary care services				
Establish and implement Community Health Worker Team linked to HEZ primary care providers				
Establish and implement Care Coordination Programs with HEZ primary care providers				
Goal 2: Increase community health resources				
Initiate health education and fitness classes				
Develop scholarship program for Zone residents				
Expand Virtual Supermarket Program				
Goal 3: Promote Cultural Competency				
Provide cultural competency training to collaborative partners				

Completed **On-Task** **Delayed**

Completed Milestones

√	Recruit and place Primary Care Providers in the Zone for year one
√	Recruit and hire Community Health Workers
√	Create healthy food options in the community
√	Develop and implement Chronic Disease Management classes
√	Award Partnership Mini-grants

*Includes direct and indirect licensed health care providers who provide primary care, behavioral health or dental services in the Zone (physicians, NPs, PAs, psychiatrists, psychologists, dentists, RNs, dental hygienists, LCSWs, licensed clinical professional counselors, and licensed substance abuse service providers).

Appendix J

Health Care Reform Coordinating Council

October 16, 2013

Access to Care

Mark Luckner
Executive Director
Community Health Resources Commission
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Supporting Safety Net Provider Capacity

- CHRC business plan in February 2012 – specific recommendations to bolster capacity of safety net providers:

1. Transition from grant-based revenue models to billing third-party payers (more sustainable);
2. Promoting IT/EMR adoption and administrative efficiencies;
3. Supporting workforce development; and
4. Leverage public-private partnerships.

Access to Care Regional Forums

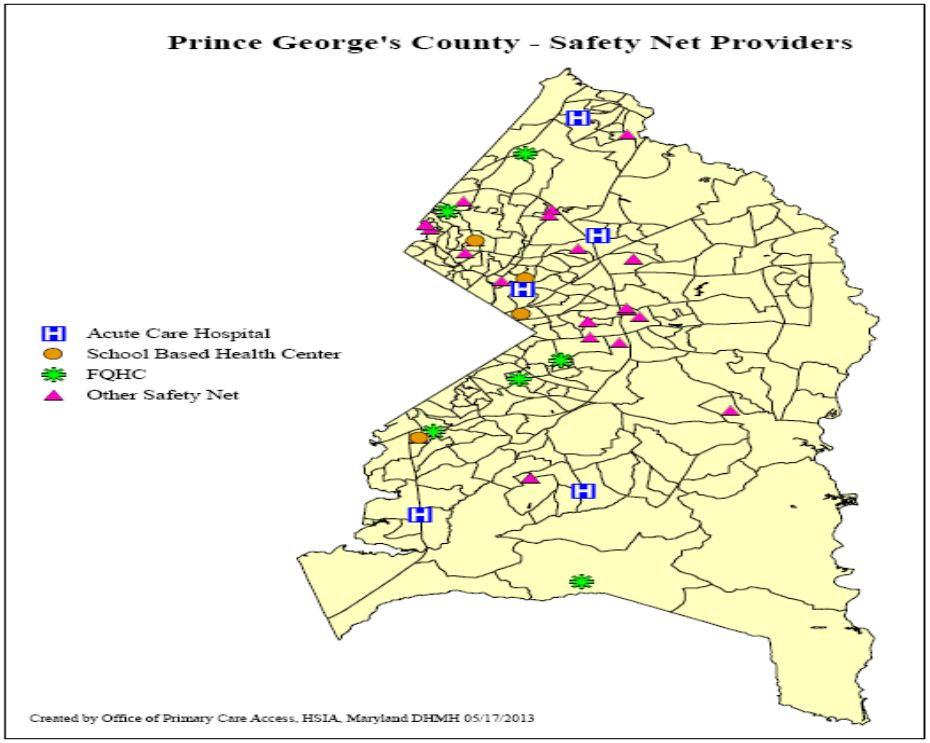
- Launched in early 2013, Access to Care Program is designed to help promote robust participation of safety net providers (history of serving low-income/uninsured) in new health insurance options made available under Affordable Care Act
- Promote continuity of care for newly insured
- Prepare to meet the expected demand for new health services by Maryland's newly insured (estimated to be 250,000)
- Interagency program of DHMH, Maryland Health Benefit Exchange, and CHRC

Access to Care Regional Forums

- Invited safety net provider organizations, Medicaid Managed Care Organizations, and commercial carriers to attend six regional networking forums held earlier this summer:
  - **Southern Maryland**: June 6
  - **Eastern Shore**: June 10
  - **Central Maryland**: June 12
  - **Western Maryland**: June 18
  - **Washington Metro region**: June 20
  - **Baltimore Metro region**: June 25
- A total of 363 individuals, representing 191 organizations, attended the forums.

Access to Care Regional Forums

- Encourage providers to establish contacts with MCOs and carriers participating in their regions
- Provide information about safety net providers to MCOs and carriers
- Promote network development



Safety Net Capacity-building Efforts

- The CHRC is scheduled to release its Call for Proposals later this month to solicit grant applications. There is just under $3M to award in new grant funding this fiscal year.
- The Call for Proposals is expected to include efforts to provide technical assistance and support safety net capacity-building efforts.
- The CHRC was recently awarded a $50,000 grant from Kaiser Permanente to support Maryland's safety net capacity building.