Regional Partnership for Health System Transformation

Regional Transformation Plan – Final Report

Due: December 7, 2015

Regional Partner: West Baltimore Collaborative

Goals, Strategies and Outcomes

Articulate the goals, strategies and outcomes that will be pursued and measured by the regional partnership.

In order to better improve healthcare access and outcomes for patients with chronic conditions identified as high utilizers of hospital services, the four hospitals located in West Baltimore: Bon Secours, St. Agnes, University of Maryland Medical Center and University of Maryland-Midtown have collaborated to create the West Baltimore Collaborative ("WBC"). The WBC will contract with the Population Service Health Organization ("PHSO"), operated by the University of Maryland Medical System, to address the health and social concerns of individual patients who receive care from WBC member hospitals, PCPs, and other affiliated entities. The PHSO will hire and manage care team members and support staff, provide human resource functions to include record and schedule maintenance, and centralize IT infrastructure.

- The WBC will focus on a targeted patient population as defined by the criteria described below. While program participation will not be limited by a patient's domicile, a portion of these patients who will be provided access to and benefit from the program are concentrated within West Baltimore, as defined by zip code;
- The goal of the WBC is to provide comprehensive, robust health management services to a targeted patient population of high utilizers of hospital services;
- Strategies include the development of care teams made up of an RN/Care Manager, a Social Worker, and a Community Health Worker. These teams will be responsible for the care of approximately 100 patients. Additionally, ancillary staff to include a Clinical Pharmacist would carry a caseload of 150 patients;
- Successful outcomes will be determined by patients' ability to achieve goals established in their individualized care plans and to avoid hospital readmission and reduce utilization of hospital services.

Describe the target population that will be monitored and measured, including the number of people and geographical location.

- The targeted patient population will be comprised of patients from WBC member hospitals that meet the following criteria:
  - Medicare or Dual Eligible patients
  - In CY 2014, the patient had 3 or more bedded hospital encounters of greater than 24 hours in the following settings:
    - Inpatient

        - Inpatient Observation
        - ED
    - The patient suffers from 2 or more chronic conditions
    - The patient does not suffer from a Major Mental Health Diagnosis
        - Including Bipolarity, Schizophrenia, other Psychotic disorders
        - This criterion would ***not*** exclude mental health diagnoses of depression, anxiety, etc. Patients with these diagnoses who meet additional criteria would be eligible for the program.
- Based upon CY 2014 data of WBC members, there were approximately 1,500 patients that met the listed criteria. Future program iterations, expanding criteria to all payers, will capture approximately 3,600 patients
- Geographic consideration: patient domicile will not disqualify a patient from program participation, but each WBC member is located in and provides service to the West Baltimore community. The institutional collaboration manifested in the WBC formation will positively benefit the patient population of West Baltimore.

Describe specific metrics that will be used to measure progress including patient satisfaction, quality, outcomes metrics, process metrics and cost metrics. Describe how the selected metrics draw from or relate to the State of Maryland's requirements under the new model.

To ensure accuracy in the measurement of program success, the WBC will evaluate utilization of the balance of identified outcome, process and ROI metrics provided in the application as the program proceeds through rollout to full functionality and beyond. Understanding that the HSCRC and others, including CRISP, are still refining the recommended set of metrics, the WBC will make any necessary adjustments as the process evolves.

Programmatic Metrics will include:

- Does the patient have an appointment with a primary care provider prior to discharge and within 7 days of discharge?
- Did the patient connect with the scheduled primary care provider?
- Reduce emergency room visit rates
- Reduce readmission rates
- Was medication reconciliation completed prior to discharge?
- Was a follow-up call by the transitions team completed within 72 hours?
- Home visits within 30 days are completed
- Care Plans will be completed on all patients in care management
- HEDIS and MU measures for program
- Total hospital cost per capita
- Total hospital admits per capita
- Total healthcare cost per person
- ED visits per capita

These metrics, while focused on programs also lend to the overarching outcome metrics captured in the Core Outcomes Measures listed in Table A of the Implementation Grant Request for Proposals. Measures germane to the program, including reduction of PAU's, readmissions, and avoidable utilization of the emergency department will be captured.

Currently, based on CY 2014 WBC data, the baseline for the targeted patient population (TPP) reflects the following:

- WBC TPP
  - 1,491 Unique Patients
  - 8, 216 Total Visits
  - $130,740,898M Total Charges
- WBC TPP Revisit Information
  - Inpatient Readmissions
    - 1,540 Cases
    - $31,583,989 Charges
  - Observation Revisits
    - 346 Cases
    - $2,076,385 Charges
  - ER Revisits
    - 575 Cases
    - $680,763 Charges
- WBC TPP Prevention Quality Indicators
  - 677 Cases
  - $11,115,755M Charges

Additionally, there are efforts underway to identify and align with metrics across institutions citywide. These efforts will be further explained in the grant application. See Note (1), below.

Describe the regional partnership's current performance (target population) against the stated metrics.

In the first year, the West Baltimore Collaborative's targeted patient population is focused on approximately 1,500 patients; this is a combination of Medicare high utilizers and Dual Eligibles age 50 years and above. This target patient population has had 3 or more bedded encounters within the past 12 months. Patients are medically complex and without a major mental health diagnosis. The metrics which have been outlined above are geared towards care coordination and care management activities which will impact the utilization of the acute care setting.

Define the data collection and analytics capabilities that will be used to measure goals and outcomes.

Please see Data and Analytics section, in the subsection describing the regional partnership's plan for

capturing CRISP data. It is located on page 7 of this report.

List the major areas of focus for year one. (For the completion of this plan, if various areas of focus require different descriptions, please identify each area under the following sections of the plan.)

Within the first several months of funded operation, the WBC will bring organizational infrastructure online and begin program operations, endeavoring to meet the following schedule:

- Upon grant award,
  - Patients identified as eligible will be contacted
  - Securing program's physical space will occur
  - A refresh of inter-hospital data to confirm accuracy of metrics and patient capture
  - If necessary, program scalability will occur
  - Model implementation for Medicare and Dual Eligible Patients will commence at the member institutions
  - Candidate evaluations based upon prior position publication will commence
  - WBC appoints interim program Director to provide day-to-day leadership during recruitment process
- Within 30 days of grant award
  - Participating hospitals will execute a Memoranda of Understanding, which will dictate member association and organizational structure
  - FQHCs, hospital-affiliated practices and community-based physicians will begin to execute Participation Agreements
  - Vetting of potential hires will continue, and the beginning of the hiring process will commence
- Within 60 days of grant award
  - Initiation of practice assessments to identify practice needs and provide appropriate resources and support
- Within 90 days of grant award
  - Enrollment of patients into the program will begin
- Within 6 months of grant award
  - Analysis of captured data metrics will begin
  - Patient and Provider surveys will begin
- Within 9 months of grant award
  - It is anticipated that 75% of the target population will be enrolled
- Within 12 months of grant award
  - Evaluation of program performance will begin
  - Considerations will be made regarding expansion of the targeted patient population
  - Finalize budget for year 2

Formal Relationships and Governance

List the participants of the regional partnership such as hospitals, physicians, nursing homes, post-acute facilities, behavioral health providers, community-based organizations, etc. Specify names and titles where possible.

WBC primary participants will be the four hospitals located in West Baltimore, collaborating via executed Memoranda of Understanding.

- University of Maryland Medical Center (University and Midtown campuses))
  - Dana Farrakhan, SVP, Strategy, Community and Business Development
- Saint Agnes Hospitals-
  - F. Joseph Meyers, CSO
- Bon Secours Hospital
  - Katie Eckert, Director of Operations Finance

Additional participants and collaborators, many of whom have submitted letters of intent to participate in the WBC's mission include:

- Mercy Medical Center
  - Christopher Thomaskutty, Chief of Staff & SVP, Clinical Programs
  - Michael Mullane, Senior Advisor to the President & CEO
- St. Agnes Medical Group
  - Patrick Mutch, Interim President and CEO
- Total Healthcare
  - Faye Royale-Larkins, CEO
- Baltimore Medical System (BMS)
  - Shirley Sutton, President/CEO
- Chase Brexton
  - Richard Larson, CEO
- University of Maryland Rehabilitation & Orthopedic Institute
  - Cindy Kelleher, CEO
- University of Maryland, Faculty Physicians, Family Medicine
  - David Stewart, M.D., Chair
- Bon Secours affiliated physicians
  - Arsalan Sheikh, D.O., Chair, BSHS Department of Medicine
- University of Maryland, Faculty Physicians, Community Psychiatry
  - Jill RachBeisel, MD
- B'more Clubhouse
  - Jason Woody, Executive Director

Describe the governance structure or process through which decisions will be made for the regional partnership. List the participants of the structure/process.

The WBC will utilize the following governance structure

- West Baltimore Governing Council
  - Core membership will be CEOs, CFOs, CMOs and CIOs from Saint Agnes, Bon Secours, and UMMC (University and Midtown campuses)
  - Providing advisory resources and stakeholder perspectives to the Governing Council will be 2 panels:

        - Community Advisory Committee
        - Medical Advisory Committee
    - Management Committee
        - Committee will directly manage activities of the WBC as it provides for patients
        - Committee will consist of 6 members (finance, care management and strategy) from the participating hospitals/health systems plus the WBC Director
        - The Committee will also manage the contract with the Population Health Services Organization ("PHSO")
            - The PHSO will provide patient services through the following mechanisms
                - Care management teams
                - Manage relationships with PCPs
                - Oversee network of providers
                - Collect patient data, review analytics and program performance

Identify the types of decisions that will be made by the regional partnership.

Decisions made by the WBC, through its governance structure will include

- Decisions regarding the scope of partners' and participant involvement
- Monitoring programmatic design to achieve targeted patient and financial outcomes
- Monitoring funds flow
- Directing decisions regarding program management
- Directing decisions on vendor contracts
- Decisions affecting savings management

Describe the patient consent process for the purpose of sharing data among regional partnership members.

- Upon determination of program eligibility by Collaboration member and WBC staff, identified patients will be enrolled during hospitalization, or shortly after discharge. Patients may also be identified by participating PCPs.
- There will be a standard enrollment form used by WBC staff advising patients of the program's data collection and sharing among the regional partners.
- Any sharing of data will be for the express purpose of patient care coordination and management

Describe the processes that will be used by the regional partnership to improve care and the MOUs or other agreements that will be used to facilitate the legal and appropriate sharing of care plans, alerts and other data as described in the process.

Data-sharing procedures among Collaborative members will be contained in executed MOUs. The WBC will also enter into an agreement with CRISP to capture and maintain data for enrolled patients.

Attach the list of HIPAA compliance rules that will be implemented by the regional partnership.

The sharing of patient level data will be governed by BAAs that will be executed among all parties participating in the WBC. Further HIPAA compliance rules regarding data collection, storage and security protection are currently covered by the existing policies and procedures of the WBC member organizations. A complete review of these policies and procedures will be complete to ensure

compliance within the operations of the WBC. Similar to the operations in the WBC member organizations, access to patient level data will be provisioned based on a staff member's roles and responsibilities in the patient care and/or program evaluation.

Data and Analytics

Define the data collection and analytics capabilities that will be used to measure goals and outcomes, including specific metrics and measures.

Data collection and analytics will be completed by analysts hired by the West Baltimore Collaborative via the PHSO. This will be an effort that combines CRISP, the West Baltimore medical records, publically available data, and data collected by care teams and PCPs.

Describe with specificity the regional partnership's plan for use of CRISP data.

Once MOUs have been signed between the participating entities, CRISP will provide a consolidated PATH report to the WBC. This will be used to support the WBC's targeted care management efforts. Additionally, the WBC will provide a panel of patients to CRISP in order to track the utilization of patients enrolled in the WBC program. This will enable the WBC to track utilization (including readmissions and other PAU metrics) and savings across the four hospitals of the collaborative and across the state of Maryland for enrolled patients. This will also enable the WBC and participating care providers to receive ENS alerts for WBC patients. The WBC is also working closing with CRISP to develop Care Profiles and Care Plans in CRISP. The WBC plans to communicate critical care management information via this new CRISP capability.

Risk Stratification, Health Risk Assessments, Care Profiles and Care Plans

Describe any plans for use of risk stratification, HRAs, care profiles, or care plans. Describe how these draw from or complement the standardized models being developed.

- Care profiles will be utilized via CRISP on all patients
- Care plans will be created by the primary care provider/care team and uploaded into CRISP
- Expectation that efforts to standardize ambulatory care plans across the WBC will continue
- HRA's will be completed by care managers and/or the transitions of care team
- Risk stratification will be completed by the health system
- Each of these tools will draw upon CRISP which is in the process of standardization across the state

For risk stratification, include the types of patients, risk levels, data sources, accountabilities (who is accountable to do what?)

- Assessments will be conducted on the identified high utilizer patients
- Risk stratification will be conducted by an RN Care Manager, and stored in CRISP or an

informatics and workflow program available to the WBC.

Data will be pulled from the EMR, where applicable. The accountable party will be the analyst who will be pulling data

For HRAs, include the types of screenings, who is accountable for completing, and where information is recorded.

- HRAs will be completed and recorded in the patient's medical record
- The RN/Care Manager and other members of the care management team are responsible for completing the HRA during the initial visit with the patient following program enrollment

For care profiles and/or care plans, include the key elements that will be included, the systems through which they will be accessible, the people who will have access. Standardized care profiles are anticipated to be developed by the state-level integrated care coordination infrastructure.

- Comprehensive, individualized care plans for WBC patients, in consultation with PCPs, will incorporate and contain the following elements:
    - Patient assessment and identification of health concerns
    - Tasks
    - Treatment goals
    - Timelines
    - Responsibilities of patient
    - Barriers
    - Disease management guidelines
    - Identified Providers and services
- Care profiles will include information regarding the patient's:
    - Lifestyle
    - Clinical history
    - Psychosocial Issues
    - Patient and family education and engagement
- Care Plans will be accessible by WBC team members responsible for the patient, and PCPs providing treatment. Parties will continually monitor the plan's efficacy
- Care plans will be accessible via CRISP

Identify the training plan for any new tool identified in this section.

All training will come through the PHSO, any new tools that are utilized by the West Baltimore Collaborative will be produced and implemented by the PHSO and training will be given on those tools.

Care Coordination

Describe any new care coordination capabilities that will be deployed by the regional partnership.

The WBC will contract with the University of Maryland Population Health Services Organization ("PHSO") to provide comprehensive care management services to enrolled participants. The PHSO will hire staff to provide services exclusively to WBC participants. These staff members, consisting of RN/Care Managers, Social Workers and Community Health Workers will be joined as teams, tasked with managing the care of about 100 patients. Teams will:

- assist the patient in obtaining a PCP
- complete HRAs
- coordinate care for those patients already seen by a PCP,
- perform medication reconciliation, HRA, risk stratification
- provide health education services,
- maintain a calendar of scheduled appointments and document results,
- follow the patient into the community to address social welfare needs

Team members will engage patients:

- While hospitalized
- By embedding in PCP practices, where appropriate
- At the patients' residences
- Via telephonic contact

The WBC will also maintain an information hub allowing remote contact by patients, providers and team members. The hub will employ a clinical pharmacist to complete medication reconciliation, an IT manager and Analysts to support evaluation and data analysis.

Identify the types of patients that will be eligible for care coordination and how they will be identified and by whom.

Patients eligible for care coordination will be those individuals identified by the WBC's target patient population criteria. These patients will be identified by:

- WBC member staff while admitted to the hospital;
- By WBC team members:
  - Engaging patients at the hospital
  - Embedded in participating PCPs
  - Via telephonic health services

Define accountability of each person in the care coordination process.

Each member of the care team will be responsible for assisting patients in coordinating their care. Tasks will include:

- Obtaining appointments for patients with their primary care physicians when needed

- Assisting patients in establishing obtainable patient goals, to manage their symptoms and disease process
- Making appropriate referrals for services including substance abuse and mental health

Programmatic metrics will be established to monitor productivity of the care team and their progress with their patients.

Describe staffing models, if applicable.

The following staff members will be hired by the UMMS PHSO as employees dedicated to the activities of the WBC.

Care Management Team

RN/Care Manager

- Licensed individual who does the following:
  - Assesses and enrolls patients into the program
  - Conducts and/or telephonic follow-up or home visits to educate patients on medications, chronic illness and sign and symptoms
  - Use teach-back method and motivational interviewing
  - Works with patients to establish a care plan and establishes goals with patient to engage patient in their own plan of care
- Requires clinical assessment skills, advocacy, joint care planning with other providers and the use of motivational and teach-back skills
- In a primary care setting (under the auspices of a PCP)
  - can assist patients and review with them their illness
  - help to identify patient needs
- In a community setting:
  - can be called upon by patient to discuss illness signs and symptoms
  - help patients get into the PCP for urgent visit
  - work with physicians to have patient take an urgent dose of medication
  - Educate patients on diet and lifestyle changes
- Work with other team members to bring needed resources to the patient
  - Social workers
  - Behavioral health professionals
  - Community health workers

Social Worker (SW)

- Works to aid patients to obtain financing for medications, health care or other social needs
- Works to provide other community resources such as meals on wheels, or senior housing
- Helps with placement in post-acute care facilities (if needed)
- Helps to obtain behavioral health resources
- Serves as a behavioral coach or as a behavioral health resource
  - A portion of the SW team members will be trained and certified in Behavioral Health

Community Health Worker

- Assists the RN and or SS worker to help patients get to appointments
- Assists care team in ensuring patients are adhering to medications
- Visits patient in community in between visits of RN or SW
- Assist the care team in reinforcing patient engagement and care plan goals
- Promotes nutrition and personal care
- Some healthcare screening

WBC Staff

WBC Senior Director

- Oversees all care coordination or care management activities
- Accountable to WBC Governance Council and hospital members for overall program performance
- Helps to assign patients
- Ensures work load are distributed appropriately
- Ensures team quality and training
- Measures team productivity

Clinical Pharmacist

- Works to ensure medication reconciliation is completed on all patients
- Advises physicians of correct dosing, other drug interactions and supervision of drug usage and dosing in therapeutic procedures
- Works with the care team in renewal of prescriptions
- Helps with providing education for patients
- Helps high risk patients with obtaining generics or other prescription options

Practice Transformation Experts

- Use of data, registries, quality data, cost data, etc. to assess practices
- Assuring availability of practice to patients (hours, urgent care, call center, etc.)
- Imbedding of practice guidelines for chronic diseases and other common conditions
- Expanding span of in-office procedures
- Patient and family engagement
- Shared decision making and advanced care planning
- Getting the most out of specialist care
- Managing transitions of care
- Creating teams and getting all staff "to practice at the top of their license."

IT Team/Analysts

- Provide phone and computer connectivity
- Manage software used to attribute patients to Care Management teams
- Maintain central data resource of patients' records and appointments

- Conduct data analytics and tracks and publishes performance dashboards which include identified program metrics

Describe any patient engagement techniques that will be deployed.

Care team members, including community health workers, will engage in:

- Extensive education and training focused on addressing needs of diverse patient population to effectuate change in health behavior
- Motivational interviewing
- Development of teach-back method

Physician Alignment

Describe the methods by which physician alignment will be created.

Physician alignment in the WBC will be created via collaborative requirements conditioned on participation, including:

- Sharing patient data with WBC members and CRISP
- Participation in quality improvement activities
- Meeting HIPAA requirements
- Utilizing CRISP tools and reports
- Providing availability to targeted patients
- Collaborating and partnering with care coordination team and complex care practice guidelines

Further efforts undertaken by the WBC will include:

- Assisting physicians to work to the top of their license
- Developing of clinical protocols
- Investigating the availability of the Chronic Care Management fee based on HSCRC research
- Assessing practice needs
- Providing additional staff and services, as needed

Describe any new processes, procedures and accountabilities that will be used to connect community physicians, behavioral health and other providers in the regional partnership and the supporting tools, technologies and data that will assist providers in the activities associated with improved care, cost containment, quality and satisfaction.

The WBC will seek input from the Medical Advisory Committee, which provides advisory services to the WBC Governance Committee. Made of PCP representatives from FQHCs, hospital-employed physicians, UM Faculty Practices and UM Rehab and Orthopedics, and Independent PCPs, the committee will suggest additional methods of creating and strengthening alignment, in addition to those listed above.

Describe any new value-based payment models that will be employed in the regional partnerships

Similar to the HSCRC's evaluation of the permissibility of using Value Based Payments, the WBC is currently evaluating ways to successfully engage PCPs by way of value-based payments for program participation and looks forward to working with the HSCRC to achieve shared goals.

Organizational Effectiveness Tools

Attach the implementation plan for each major area of focus (with timelines and task accountabilities)

The implementation plan for the WBC is currently under development and will be included in the WBC implementation grant application.

Describe the continuous improvement methods that will be used by the regional partnership.

The WBC is uniquely positioned to engage in constant, direct patient monitoring from the hospital to the community. Methods for program improvement are built directly into the entity structure:

- Team members will be able to directly evaluate patients in a variety of environments and adjust treatment plans in real time to maximize effectiveness
- The information hub component will allow for programmatic outcomes of patient data, enabling comparison to program metrics to established benchmarks and targets
- The Medical and Community Advisory Committees will provide clinical and communal expertise, ensuring successful process refinement
- The governance structure will allow collaborators to address variances to goals rapidly and directly
- Performance dashboard will be developed for monitoring metrics

Attach a copy of the metrics dashboard that will be used to manage performance over time with an explanation of associated processes that will be used to monitor and improved performance.

When the HSCRC finalizes performance metrics, the WBC will develop specific outcome, programmatic and financial measures as listed above. A performance dashboard will be operational at the time of program start-up. The dashboard will be subject to monthly review by the WBC Program Director and Management Committee, with specific input on metric evaluation from the Community and Medical Advisory Councils.

Describe the work that will be done to affect a patient-centered culture.

The WBC is implementing a complex care management program centered around the medical and social needs of patients. Care Management teams will integrate with PCPs to assist patients achieve the highest health and quality of life.

New Care Delivery Models

Describe any new delivery models that will be used to support the care coordination outcomes. (For instance, tele-visits, behavioral health integration or home monitoring.)

- The care team will bring together health and community social resources to provide comprehensive care services to patients outside of the hospital. The mobility of the care team allows for continual patient contact and assessment, and reduces travel burden on the patient
- Contact will be maintained through team home visits
- If a home visit is not practicable, the WBC central information hub will permit telephonic services by care team members if a personal visit with the patient is not practicable
- The data collection services and the IT infrastructure

Identify how the regional partnership will identify patients, new processes, new technology and sharing of information.

Patients will have eligibility determined by evaluations based upon the target patient population criteria. This screening will be specific to the location of the patient:

- For hospitalized patients, high-level screens will be conducted by hospital staff. A referral will then be made to a WBC team member, who will conduct a comprehensive patient evaluation, provide program information, and secure patient enrollment
- For patients at PCPs that have a high volume of eligible patients in the practice, embedded WBC care management members will assist in enrolling eligible patients at the practices
- The central information hub will allow providers to contact staff members, who will assign potential patients to care teams, who will conduct full evaluations
- The WBC will endeavor to have all PCPs within the WBC enroll with CRISP thus enabling data-sharing within the WBC. We note, however, that we may need to prioritize enrolling key PCPs within WBC with CRISP based on resources available to CRISP.

Financial Sustainability Plan

Describe the financial sustainability plan for implementation of these models.

- Detailed financial and budget analysis will be contained in final grant application
- Current financial analyses yield anticipated savings within 3-5 years that may enable expansion of services beyond Medicare and Dual Eligibles to all-payers
- With a reduction in PAUs, it is anticipated there will be savings to be reinvested in the Collaborative's efforts
- Per the estimated Return on Investment calculation, we are expecting to reinvest savings into model expansion, to eventually capture high utilizers in all payers

Describe the specific financial arrangements that will incent provider participation.

- Physicians who participate with the WBC in the care of chronic care Medicare patients would be eligible for Medicare's Chronic Care Management reimbursement amount
- The WBC is actively seeking mechanisms to reward providers for successful patient outcomes e.g. pay for performance within the limits of financial and legal feasibility
- Detailed financials will be provided in the final grant application

Population Health Improvement Plan

Provide detailed description of strategies to improve the health of the entire region over the long term, beyond just the target populations of new care delivery models. Describe how this plan aligns with the state's vision, including how delivery model concepts will contribute and align with the improvement plan, as well as how it aligns with priorities and action plans of the Local Health Improvement Coalitions in the region.

The WBC is working with the hospitals across Baltimore City to devise compatible systems of care to attend to the medical and social needs of patients. The hospitals are collaborating in several important areas including care profiles, metrics and patient assignment for care management. Further, the Baltimore City Hospitals Community Benefit Collaborative is another important forum that seeks to improve the health of residents of Baltimore City. Representatives of the Community Benefits programs of most of the city hospitals meet once a month to discuss how the hospitals can work together to maximize the impact of our collective community health improvement efforts. This collaborative is considering whether it is possible to effectively combine and capitalize on efforts related to their Community Health Needs Assessments and Community Health Implementation Plans. The group prioritizes social determinants of health, and for the coming year has committed to focus on health literacy, and specifically on messages encouraging positive engagement with the healthcare system by establishing a relationship with a primary care provider. The goal is to help people understand how to

use the healthcare system effectively, which will reduce ED and inpatient utilization.

NOTES:

(1) The University of Maryland Medical Center was the lead applicant for this planning grant proposal and Johns Hopkins Hospital was the lead applicant on another. Since the time of the initial award, and in fact during the development of the proposals, the two partnerships have been committed to working together, knowing that many high-cost, high-use patients visit multiple hospitals across the City, and that the goals of the partnership cannot be achieved without improving health and lowering costs for all City residents. One of the goals of the planning process—and a charge to us by the HSCRC/DHMH staff when the planning grants were awarded—was to identify the areas that most lend themselves to being developed jointly. This was explored during meetings of the Alignment Committee, with participants from both partnerships. The Committee identified Patient Attribution, Care Profiles, and Quality Measures as priority areas for joint development. The results of the work of the subcommittees addressing these areas will be described in the Implementation Grant Application.

(2) The information contained in this text reflects current analyses, processes and thinking of the WBC. Minor changes to the proposed operation may be reflected in the final implementation grant submission.