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

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

Health Enterprise Zones
Call for Proposals
Cover Sheet FY2013

Applicant Organization:

Name: Bon Secours Hospital Baltimore Inc.

Federal Identification Number (EIN): 52-0591555

Street Address: 2000 West Baltimore Street

City: Baltimore State: Maryland Zip Code: 21223 County: Baltimore City

Official Authorized to Execute Contracts:

Name: Samuel L. Ross, MD, MS E-mail: Samuel_Ross@bshsi.org

Title: Chief Executive Officer

Phone: 410-362-3011 Fax: 410-362-3117

Signature: Date: November 14, 2012

Project Director (if different than Authorized Official):

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Signature: Date: November 14, 2012

Alternate Contact Person:

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HEZ Project Name:

West Baltimore Primary Care Access Collaborative

STATEMENT OF OBLIGATIONS, ASSURANCES, AND CONDITIONS

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

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

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

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

AGREED TO ON BEHALF OF, Bon Secours Hospital Baltimore, Inc., BY:

Samuel L. Ross, M.D., M.S. Chief Executive Officer

BON SECOURS BALTIMORE HEALTH SYSTEM

November 15, 2012

Mark Luckner
Community Health Resources Commission
45 Calvert St., Room 336
Annapolis, MD 21401

Dear Mr. Luckner,

On behalf of the West Baltimore Primary Care Access Collaborative (WBPCAC), it is my pleasure to submit our application to be designated as a Health Enterprise Zone (HEZ). You will find that our proposal to create a sustainable infrastructure to reduce morbidity and mortality of cardiovascular disease is West Baltimore perfectly aligns with the HEZ purpose and goals.

The combined West Baltimore zip codes of 21216, 21217, 21223, and 21229 have the highest disease burden and worst indicators of social determinants of health than most any other community in Maryland. These neighborhoods establish the lower extremes for health disparities in the City and the State across all major chronic illnesses. Further contributing to the poor health outcomes is the compromised access to health care services, earning the community's unfortunate designation by HRSA as a medically-underserved area (MUA) and medically-underserved population (MUP).

We look forward to applying HEZ resources to address these issues in a manner that may be replicated in other disadvantaged communities. We are excited to have this opportunity to be designated as an HEZ and look forward to hearing from you. Should you have any questions regarding our proposal, please contact me at 410-362-3011 or Samuel_Ross@bshsi.org.

Sincerely,

Samuel L. Ross, M.D., M.S.
Chief Executive Officer

West Baltimore Primary Care Access Collaborative HEZ Application

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3. PROGRAM SUMMARY

Every year, the equivalent of twenty-four jumbo jets carrying passengers with chronic diseases crashes in West Baltimore. In the wreckage: hundreds of premature deaths, hundreds more permanently disabled, and tens of thousands of bystanders who realize that, at any time, they or a loved one might be counted among the casualties. Highly-treatable, preventable chronic illnesses like diabetes, hypertension, and cardiovascular disease kill and disable more men and women in West Baltimore than in any other area in Baltimore City and the State. Conditions that are even more challenging to treat--like HIV, cancer, and behavioral health issues--impact this community at similarly alarming rates.

The combined West Baltimore zip codes of 21216, 21217, 21223, and 21229 have the highest disease burden and worst indicators of social determinants of health than most any other community in Maryland. These neighborhoods establish the lower extremes for health disparities in the City and the State across all major chronic illnesses. Further contributing to poor health outcomes is the compromised access to health care services, earning the community's unfortunate designation by HRSA as a medically-underserved area (MUA) and medically-underserved population (MUP).

The West Baltimore Primary Care Access Collaborative (WBPCAC) is a group of sixteen organizations with tremendous individual capacity that realized extraordinary coordination and cooperation would be required to make a meaningful, sustained impact on the incidence and impact of chronic diseases in their community.

The WBPCAC will employ principles of innovation in partnerships to build a sustainable, replicable infrastructure to serve as the foundation for clinic- and community-based interventions aimed at reducing cardiovascular disease.

To accomplish the goals described below, the Collaborative will launch multiple culturally-competent, evidence-based, innovative, and promising interventions through dual overarching strategies: (1) development of an infrastructure to foster enduring system change and (2) implementation of a community-wide, patient-centered medical home approach to caring for patients with CVD. Collective Impact theory supports this tack, maintaining that the actual intervention in such efforts should be establishment of an infrastructure to serve as the foundation of concerted strategies that, over time, foster significant, sustainable systemic change.

WBPCAC Goal
A. By 2016, reduce by 15% cardiovascular disease risk factor prevalence among West Baltimore residents.
B. By June 2015, increase by 48 the number of primary care professionals represented on WBPCAC members' care teams.
C. By December 2013, increase by 11 the number of community health workers serving West Baltimore.
D. By 2014, create a mechanism to identify and implement interventions to increase community resources for health.
E1. By 2016, reduce by 15% the number of preventable emergency department visits of West Baltimore residents with cardiovascular disease. E2. By 2016, reduce by 10% the number of preventable hospitalizations of West Baltimore residents with cardiovascular disease.
F. By 2016, reduce by 10% unnecessary costs of caring for West Baltimore residents with cardiovascular disease.

4. PROGRAM PURPOSE

Late in the nineteenth century, a group of French nuns traveled to America endeavoring to extend to this country their mission of caring for the sick and dying. They settled in West Baltimore and began a community-based nursing practice that combined medical care and social work. These visionaries recognized that an individual's physical condition was just one component of overall health status. Employing what was then a novel approach, they treated the entire person, providing food to the hungry, arranging housing for those in transition, and assisting people in finding employment so they could care for themselves and their families.

During a period when resources were scarce and ethnic and class discrimination was commonplace, the nuns mobilized community assets to care for those in need, regardless of race, nationality, or ability to pay. Eventually, they garnered enough support through an informal coalition--comprised of concerned citizens, area businesses, and their diocese--to build a hospital and, later, a school of nursing.

Today, more than a century after the Sisters' journey to the US, the leading illnesses of their time—typhoid and scarlet fever, diphtheria, and tuberculosis--have been supplanted by contemporary diseases like diabetes, cardiovascular disease, mental illness, substance abuse, and HIV/AIDS. What remains are similar levels of poverty, homelessness, and unemployment the nuns encountered when they arrived in this community so long ago.

This HEZ project, the West Baltimore Community Assets and Resources Exchange (CARE), is an outgrowth of the West Baltimore Primary Care Access Collaborative (WBPCAC) that recalls the spirit of the coalition that advanced the concept of community-based, holistic care in this area in the nineteenth century. Formed in 2010, the WBPCAC is comprised of sixteen partnership-oriented organizations, including federally-qualified health centers, community-based organizations, private physicians, hospitals, and academic institutions that operate in or serve the residents of West Baltimore. (Attachment A)

Through this unprecedented effort, CARE will create a sustainable, replicable system of care to reduce health disparities, improve access to health care, reduce costs, and expand the primary care and community health workforce. The network will be accessible through Community Health Workers and at least sixteen points of entry, all of which serve as a portal to the comprehensive array of primary care services the WBPCAC envisioned when they assembled more than two years ago.

The infrastructure that will be established through Health Enterprise Zone (HEZ) grant funding will increase the primary care workforce in West Baltimore by at least 59. The HEZ benefits and incentives of loan repayment, tax credits, and hiring credits will be used to attract qualified primary care professionals to the area and encourage WBPCAC members to hire primary care professionals. Additionally, the WBPCAC will provide annual subsidies to further support members' expansion of their primary care teams.

The project will increase the community health workforce by adding eleven compensated community health workers and dozens of volunteer community health workers to support clinical teams in the community and throughout member facilities. These individuals will work together

to implement a culturally-competent, patient-centered approach across all points of care. The care coordination and team approach that are the cornerstones of this model will promote expanded access to and utilization of primary care—factors that are highly associated with improved health outcomes and reductions in health care costs, emergency department visits, hospitalizations, and readmissions.

A critical component of the enduring nature of this project will be building significant, lasting capacity in the community. Residents of West Baltimore—including high school students and seniors--will be trained to serve as volunteer outreach workers. An additional thirty West Baltimore residents will receive scholarships to pursue technical or professional credentials in health careers. These individuals will be encouraged to return to the community and share their skills in the concerted effort to improve the health status of the chronically ill and prevent disease among those at risk. These newly-skilled community members will join other primary care professionals in providing their neighbors patient-centered medical care, disease-management education, physical activity opportunities, and assistance in addressing the social determinants of health.

An important byproduct of this project will be development of a replicable model that can be shared across the state and beyond for sustainable systems to amplify collective impact in the area of chronic disease prevention.

5. HEZ GEOGRAPHIC DESCRIPTION

WBPCAC's HEZ project will be implemented in the contiguous neighborhoods of West Baltimore that comprise zip codes: 21216, 21217, 21223, and 21229. Covering just over fourteen square miles, the targeted area contains as unofficial boundaries several of Baltimore's famous landmarks, tourist attractions, and access points. Near the northern-most tip of the HEZ is the Baltimore Zoo and Druid Hill Park, the most southern neighborhoods are home to M & T "Ravens" Stadium, Carroll Park Golf Course, and the Washington Boulevard entrance to I-95 South. The eastern and western portions of the area span between Interstate 83 and the Baltimore County line, respectively.

The targeted area fully or partially includes the following sixteen neighborhoods: Allendale/Irvington/South Hilton, Beechfield/Ten Hills/West Hills, Dorchester/Ashburton*, Edmonson Village, Forest Park/Walbrook, Greater Mondawmin*, Greater Rosemont*, Medfield/Hampden/Woodberry, Midtown*, Morrell Park/Violetville*, Penn North/Reservoir Hill, Poppleton/The Terraces/Hollins Market, Sandtown-Winchester/Harlem Park, Southwest Baltimore, Upton/Druid Heights, and Washington Village. Note that asterisks denote neighborhoods that do not fall completely within the stated zip codes.

6. COMMUNITY NEEDS ASSESSMENT

Every year, the equivalent of twenty-four jumbo jets carrying passengers with chronic diseases crashes in West Baltimore. In the wreckage: hundreds of premature deaths, hundreds more permanently disabled, and tens of thousands of bystanders who realize that, at any time, they or a loved one might be counted among the casualties. Highly-treatable, preventable chronic illnesses like diabetes, hypertension, and cardiovascular disease kill and disable more men and women in West Baltimore than in any other area in Baltimore City and the state. Conditions that

are even more challenging to treat--like HIV, cancer, and behavioral health issues--impact this community at similarly alarming rates. (Table 1)

Table 1. Prevalence of Select Chronic Disease Mortality, Risk Factors, and Social Determinants						
	W Balto.	**MD**	**City**	**W Balto.**	**MD**	**City**
Percent families below poverty	19.94%	6.1	17.0	Obesity	27.9%	30.9%
Diabetes Mortality Per 10,000	4.23		3.7	Smoking	15.2%	25.5%
Heart disease mortality per 10,000	31.01		28.9	Asthma	8.4%	11.5%
HIV/AIDS per 10,000	6.03		5.2	Poor Mental Health	12.4%	13.5%
				Physical Activity	76.9%	68.3%

The combined West Baltimore zip codes of 21216, 21217, 21223, and 21229 have the highest disease burden and worst indicators of social determinants of health than most any other community in Maryland. These neighborhoods establish the lower extremes for health disparities in the City and the State across all major chronic illnesses. Further contributing to poor health outcomes is compromised access to health care services, earning the community's unfortunate designation by HRSA as a medically-underserved area (MUA) and medically-underserved population (MUP).

When compared to the state and Baltimore City, West Baltimore largely is homogenous with respect to indicators for health and social determinants of health. African-Americans make up more than 81% of the population, compared to 30% and 63% in Maryland and Baltimore City, respectively. The high percentage of African-American and low-income residents contributes to the disproportionate prevalence of ethnically- and socioeconomically-linked health conditions such as diabetes, obesity, asthma, and low birth weight. (Appendix B)

Hospital discharge data stratified by ZIP codes reveal rates of chronic illness in West Baltimore that, in some instances, are more than three times that of Maryland. (Table 2) At 847/100,000, the prevalence of asthma in some parts of the target area is as much as five times higher than Maryland's rate of 166/100,000 and twice as high as in Baltimore City. Similarly, the rates of diabetes, major cardiovascular disease, and chronic obstructive pulmonary disease (COPD) in West Baltimore are double or triple that of the City and the state.

Table 2. Prevalence Per Hospital Discharge Rate (per 100,00)						
	21216	**21217**	**21223**	**21229**	**MD**	**Balto. City**
% Preventable ED visits	55%	55%	54%	55%	48	53
Asthma	582	722	847	382	166	419
Cancer	976	944	1067	1007	608	886
Diabetes	845	869	911	666	240	558
Major CVD	4501	4945	5618	3973	2284	3773
Cerebrovascular	869	839	872	744	430	651
COPD	1048	1267	1870	826	427	506
Hypertension	238	261	349	147	66	168

Preventable, ambulatory care-sensitive emergency department visits in the targeted communities are about 12% higher than the state average. Ranging between 54 and 55%, the four combined ZIP codes exceed the City average and almost all other communities in Baltimore City.

The West Baltimore communities selected also suffer from poorer social determinants of health. They substantially exceed the minimum eligibility requirements to apply for HEZ designation. (Table 3) The rates of Medicaid and WIC enrollment in the targeted area are two to three times higher than in Maryland. Moreover, the life expectancy in these neighborhoods is five to twelve years shorter than Maryland and lower than Baltimore City's in all but one ZIP code.

Table 3. HEZ Economic Disadvantage and Poor Health Outcome Criteria (Per 1,000 residents)					
	21216	**21217**	**21223**	**21229**	**Maryland**
Medicaid	376.5	463.09	478.88	285.2	109
WIC Enrollment	50.51	52.26	60.66	42.8	17.9
Life Expectancy	70.2	68.2	67	74.1	79.2
% Low Birth Weight	12.3%	13.1%	12.7%	11.3%	6.3%

The average median income in these ZIP codes is roughly $26,150—more than $13,000 lower than Baltimore City's and almost $45,000 less than the state of Maryland. The rates of unemployment, uninsured, poverty, and high school completion are substantially worse than the state, Baltimore City as a whole, and almost every individual Baltimore City neighborhood.[1]

7. CORE DISEASE TARGETS AND CONDITIONS

The primary disease target for this application is cardiovascular disease (CVD), which affects residents of the HEZ area at a rate twice that of Maryland.

[1] Baltimore City Neighborhood Report

This application proposes a two-part approach, emphasizing: 1) increased care coordination through the patient-centered medical home for patients with cardiovascular disease at high risk of hospitalization and emergency department (ED) use; and 2) community-based risk factor reduction for patients at risk of developing cardiovascular disease. These strategies are designed to be mutually reinforcing to improve cardiovascular outcomes.

This project will target approximately 86,000 West Baltimore residents through primary care, care coordination, disease management education, and a multi-media community education campaign. This includes 43,000 people who are obese, 36,000 smokers, and 6,500 people with CVD who are excessively high users of the emergency department.

This HEZ project offers enhancements to existing community health resources and addition of new programs and services to support improved health among the target population. WBPCAC members who provide outpatient care collectively serve approximately 51,000 patients with CVD. It is anticipated that all existing CVD patients of Collaborative members will experience the enhanced care coordination that results from this project as well as be referred for other HEZ project programs and services. An additional 15,500 individuals who previously have not been served by the Collaborative will receive primary care and other services. This equates to provision of new services to approximately 66,000 individuals, including 51,000 existing patients who benefit from the enhanced services and 15,000 individuals who previously had not received any services from Collaborative members.

A standardized process and schedule for data collection and reporting will be established by the Evaluation Team. These data will allow minimal to extensive tracking of (1) patient referral source (eg. ED, CHW outreach); (2) the number of new patients served by Collaborative members and/or CARE; (3) the number of Collaborative members' existing patients who receive new or enhanced services from the HEZ project; and (4) patients' frequency of use of primary care and CARE programs and services. Minimally, these data will be reported semiannually.

8. GOALS

HEZ Goal	WBPCAC Goal
A. Improved risk factor prevalence or health outcomes. *(e.g., SHIP or LHIP measures, or others)*	A. By 2016, reduce by 15% cardiovascular disease risk factor prevalence among West Baltimore residents.
B. Expanded primary care workforce.	B. By June 2015, increase by 48 the number of primary care professionals represented on WBPCAC members' care teams.
C. Increased community health workforce. *(including public health and outreach workers)*	C. By December 2013, increase by 11 the number of community health workers serving West Baltimore.
D. Increased community resources for health. *(e.g., housing, built environment, food access, etc.)*	D. By 2014, create a mechanism to identify and implement interventions to increase community resources for health.
E. Reduced preventable emergency department visits and hospitalizations.	E1. By 2016, reduce by 15% the number of preventable emergency department visits of West Baltimore residents with cardiovascular disease. E2. By 2016, reduce by 10% the number of preventable

	hospitalizations of West Baltimore residents with cardiovascular disease.
F. Reduced unnecessary costs in health care. *(costs that would not have accrued if preventive services and adequate primary care had been provided)*	F. By 2016, reduce by 10% unnecessary costs of caring for West Baltimore residents with cardiovascular disease.

9. STRATEGIES

The WBPCAC will employ principles of innovation in partnerships to build a sustainable, replicable infrastructure to serve as the foundation for clinic- and community-based interventions aimed at reducing cardiovascular disease. *Collective Impact* is an emerging trend that asserts that sustainable improvements in complex, population-based issues requires systemic change that most likely can be achieved when stakeholders abandon their individual agendas in favor of a formalized, collective approach.

In their article, *Collective Impact*[2], Kania and Kramer maintain that "large-scale social change requires broad, cross-sector coordination" and summarize the five conditions of collective success: (1) Common Agenda, (2) Shared Measurement Systems, (3) Mutually-Reinforcing Activities, (4) Continuous Communication, and (5) a "Backbone" Organization. The WBPCAC will satisfy these tenets through the creation of West Baltimore Health CARE (Community Asset and Resource Exchange), an entity that will become the hub for a constellation of evidence-based activities designed to improve health outcomes and contain health care costs by building capacity of primary care teams and chronically ill patients.

The Collaborative will launch multiple culturally-competent, evidence-based, innovative, and promising interventions through dual overarching strategies: (1) development of an infrastructure to foster enduring system change and (2) implementation of a community-wide, patient-centered medical home approach to caring for patients with CVD. Collective Impact theory supports this tack, maintaining that the actual intervention in such efforts should be establishment of an infrastructure to serve as the foundation of concerted strategies that, over time, foster significant, sustainable systemic change.

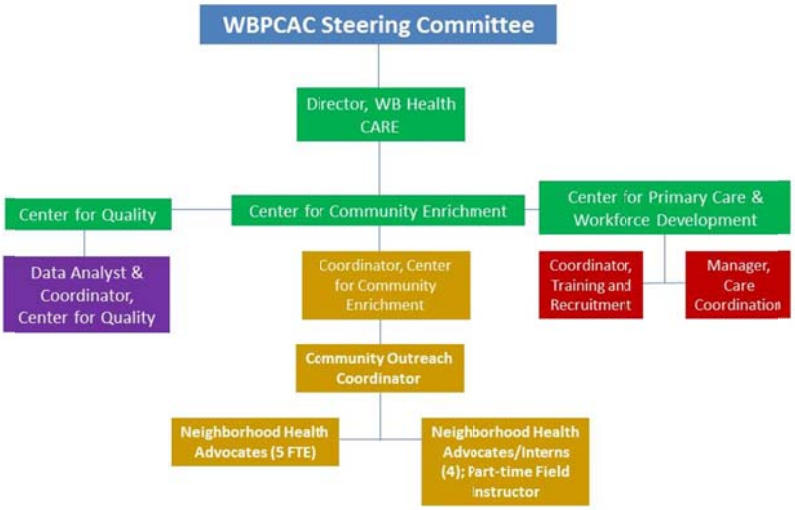
Overarching Strategy #1 – Establishment of West Baltimore Health CARE ("CARE")

The WBPCAC's shared agenda of reducing the incidence and impact of CVD will be pursued through CARE, a newly-formed, 501c3 organization that will be the headquarters and "backbone organization" of the HEZ project. CARE will be the site of highly-coordinated interventions implemented by WBPCAC member organizations to fulfill the HEZ purpose and goals.

CARE will be staffed by dedicated personnel and compensated and volunteer community health workers. It will consist of three Centers: Community Enrichment, Primary Care and Workforce Development (PCWD), and Quality. (Figure 1) The current WBPCAC infrastructure detailed in the Coalition Governance and Participating Partners section of this proposal will recompose into the leadership for CARE. (Appendix C) The existing WBPCAC Steering Committee will serve as the governing body of CARE and each Center will receive guidance from a designated advisory board comprised of community members and health, social service, and business professionals.

[2] Kania, J , Kramer, M. Stanford Social Innovation Review, Winter 2011.

Figure 1.
CARE Organizational Structure



Collectively, CARE Centers' core activities will expand the primary care and community health workforce and build capacity of both the community and primary care teams of member organizations, ultimately improving health outcomes and reducing health care costs.

The **Center for Community Enrichment** will administer programs that directly serve and benefit the patient and community. The **Center for Primary Care and Workforce Development** will provide training and technical assistance to members of primary care and community health teams and coordinate programs that expand the workforce through HEZ benefits and incentives, hiring subsidies, scholarships, and internships. The **Center for Quality** will implement and provide technical assistance for a comprehensive reporting and quality improvement structure that will monitor and support members' progress towards achieving HEZ and Collaborative goals. (Figure 2)

Figure 2.
CARE Programs and Services

Overarching Strategy #2 – Collaborative-Wide Adoption of Patient-Centered Medical Home Approach

The WBPCAC's second overarching strategy will be to lead collaborative-wide adoption and implementation of a patient-centered approach to delivering primary care. The patient-centered medical home (PCMH) model is an evidence-based innovation in primary care that improves quality, health outcomes, and the patient-provider experience while reducing overall health care costs.

The hallmarks of the PCMH model are ongoing relationships between providers and patients, care coordination, and an emphasis on high-quality care and prevention. Successful PCMHs undergo a culture change that involves a deepened understanding of the symbiotic role patients and providers play in comprehensively addressing the medical and social needs of the individual.

In recent years, the term "PCMH" has become synonymous with a recognition that is offered by various health care accrediting bodies to certify practices as patient-centered. The health care providers in the WBPCAC have yet to meet full (Level 4) requirements of a patient-centered medical home and are at varying stages of pursuing recognition. While members' attainment of National Committee on Quality Assurance (NCQA) PCMH recognition is not an explicit goal of this project, the trainings, resources, and technical assistance provided through CARE's Center for Primary Care and Workforce Development will build capacity to function as true medical homes, thereby facilitating NCQA PCMH eligibility. It also will qualify them for Maryland's PCMH project.

The Center for Primary Care and Workforce Development will coordinate training and technical assistance to enhance and build WBPCAC members' PCMH capacity in three specific areas: 1) *improving team-based care that directly relates to CVD risk factor reduction*; *2) care coordination;* and *3) promoting patient-centered interactions.* The anticipated impact will be reductions in: CVD risk factors, preventable emergency department visits, avoidable hospitalizations, and healthcare costs.

Use of Team-Based Care to Improve Health Outcomes

Tailored to the needs of the population to be served, PCMH care teams may be composed of a combination of physician, nurse practitioner, nurse care coordinator, social worker, pharmacist, health educator, receptionist, and community health worker. A meta-analysis on the impact of this model of care found that care teams were the most effective intervention at reducing hemoglobin A1C values for patients with diabetes. (Shojania KG 2006).

A growing body of evidence supports the concept of ***practice facilitation*** as an effective strategy to enhance team care functioning and improve primary care processes. CARE will engage the Maryland Learning Collaborative (MLC), the educational and training arm of the Maryland Multi-payer PCMH pilot, to provide practice facilitation to WBPCAC members. MLC's Practice Facilitators successfully have promoted PCMH re-design in 52 primary care practices in Maryland that achieved NCQA recognition.

Care Coordination

Care coordination of high risk chronically ill patients in primary care reduces hospital admissions, emergency room visits, and costs while producing high patient and provider satisfaction. Effective care coordination is responsive to the person-specific needs, preferences, and resources of individuals within the context of their families, communities, and "social determinants of health." [3]

To improve care coordination processes within HEZ practices, the Center for Primary Care and Workforce Development will conduct workshops and trainings to help define care coordination needs and specify procedures and workflows that facilitate integrated care. Practice Facilitators from the MLC will work with individual practices to develop these tailored coordination strategies.

WBPCAC members will receive extensive training on culturally-competent application of a standardized care planning tool to coordinate the care of multi-morbid CVD patients. Members utilize at least seven different information systems that can track their respective care coordination activities and outcomes. Because there is no interoperability between these organizations' systems, the evaluation team will assess WBPCAC members' individual IT resources to identify common care coordination data elements that will be reported by each collaborative member. These data will be compiled quarterly to produce reports on the individual and collective care coordination activities and impact.

In addition to reporting these data to satisfy HEZ requirements, reports on the Collaborative's care coordination efforts will be reviewed during monthly meetings of Care Coordinators from Collaborative member organizations. These meetings will include information-sharing, training, and peer-review of care plans. In the absence of system interoperability, this forum will allow some discovery of patient overlap and enhance coordination across Collaborative sites.

An IT Integration Workgroup will be convened regularly to explore opportunities for improving the exchange of information within the collaborative and among other providers in the community. This group will be facilitated by a WBPCAC member with expertise in health information technology. The workgroup will have subcommittees related to specific areas of the delivery of primary care. One subcommittee will be devoted to improving tracking and outcomes of care coordination and identifying mechanisms to improve the transfer of care management information between the various partners.

Patient-Centered Interactions

Effective PCMH teams communicate with patients using culturally- and linguistically-appropriate techniques that acknowledge an individual's positive health behaviors, promote adoption of healthier behaviors, and involve them in decisions about care. WBPCAC care team members will receive ongoing training through CARE's Center for Primary Care and Workforce

[3] Kobb, R., Hoffmann, N., Lodge, R., & Kline, S. (2003). Enhancing Elder Chronic Care through Technology and Care Coordination: Report from a Pilot. *Telemedicine Journal and eHealth, 9*(2), 189-195.

Steiner BD, Denham AC, Ashkin E, Newton WP, Wroth T, Dovson LA. Community Care of North Carolina: Improving care through community health networks. Annals of Family Medicine. 2008;6(4):361-367.

Development and technical assistance from the Maryland Learning Collaborative on patient-centered communication strategies.

A major component of the team training will be on the SBIRT (Screening, Brief Intervention, Referral to Treatment) Program, a comprehensive, integrated, evidence-based, public health approach to the delivery of early intervention and treatment services. While SBIRT traditionally is used for identifying and treating substance abuse issues, certain aspects—including motivational interviewing, promotion of self-care, patient tracking, and delegation within care teams--have practical applications in the PCMH setting to influence positive behavior change (eg. improving medication adherence and increasing exercise).

Fulfillment of HEZ Goals

Through the creation of the WBPCAC CARE, culturally-competent, evidence-based, innovative, and promising interventions will be implemented to address the six HEZ goals and CVD-related objectives in the State Health Improvement Process and Healthy Baltimore 2015. Described in detail in this section, the goals and strategies are summarized in Table 4. Two scenarios of a patient experience in CARE are shown in Appendix D.

Table 4. Summary of Goals and Strategies for West Baltimore Health CARE

HEZ Goal	Corresponding Strategies
Improved Risk Factor Prevalence	• Enhanced care coordination resulting from implementation of patient-centered medical home approach will target improving rates of obesity, tobacco use, and physical activity among individuals with CVD. • Free disease self-management courses offered to WBPCAC patients and the community will build capacity to adopt healthier behaviors. • Deployment of Community Health Workers will identify and bring into primary care and care coordination more people with CVD. • A community education campaign, consisting of billboard, print, radio, and television advertising will educate and raise awareness about CVD. • $40,000 will be reserved to implement evidence-based interventions that have been selected through a collaborative process with members of the community.
Expanded (and Enhanced) Primary Care Workforce	• HEZ benefits will be combined with grant funds to attract primary care professionals to West Baltimore. • Scholarships will be awarded to community members to support pursuit of a health career. As a result of these two efforts, 59 health professionals will be added to the community, including at least 30 who reside in the community. • CARE will offer free ongoing training and technical assistance to all staff of WBPCAC members. • A Care Coordination Manager will organize activities, technologies, and trainings to improve the quality of care coordination delivered in WBPCAC practices.
Increased Community Health Workforce	• A Community Health Outreach Coordinator hired by CARE will oversee and participate in execution of the WBPCAC Community Outreach Plan. • Five members from the community will be recruited and trained to be community health workers. Four graduate level social work students--led by a Field Instructor—also will function as community health workers. • Additional community members along with high school, college, and graduate students will be recruited and trained to be volunteer NHAs.

Increased Community Resource for Health	• A contract with the YMCA will raise the number of fitness venues in West Baltimore to increase options for physical fitness. • A partnership with Coppin State University will allow WBPCAC patients discounted memberships to the college's fitness center. Additionally, these patients will be authorized to use Coppin's walking track. • CARE will coordinate patients' participation in the City's Virtual Supermarket Program to increase access to healthier food options.
Reduced Preventable Emergency Department Visits and Hospitalizations	• System-wide implementation of PCMHs will facilitate reductions in preventable emergency department visits and hospitalizations. • Hospital-based Care Coordinators will join clinic-based Care Coordinators in trainings and meetings that will promote alignment in approaches to reduce preventable ED visits.
Reduced unnecessary costs in health care.	• Implementation of patient-centered medical homes and care coordination will promote a reduction in overall health care costs.

HEZ Goal A – Improved Risk Factor Prevalence

Strategy A.1 Implementation of Patient-Centered Medical Home Approach

The WBPCAC's collaborative-wide implementation of PCMH will facilitate diagnosis and treatment of comorbidities (e.g., depression, COPD) that can exacerbate cardiovascular disease and complicate the management of cardiovascular risk factors. Better care coordination and the integration of community health workers support medication adherence and behavior change, which are key elements of management of cardiovascular disease and contributors to cardiovascular health disparities.

Strategy A.2 Disease Self-Management Courses

Disease self-management courses--which subscribe to the notion that patients who are empowered to have a more active role in their care are more successful—largely have replaced traditional "health education" courses that focus more on sharing information than building capacity. The Center for Community Enrichment will coordinate disease self-management courses aimed at reinforcing guidance provided by the care team and equipping patients with the knowledge and skills to fulfill their role on the team, thereby increasing their ability to independently address risk factors for CVD.

The Center also will offer CVD disease prevention courses to the entire community to inspire treatment and healthy behaviors among residents with CVD. Courses on nutrition, physical activity, smoking cessation, and stress relief will be offered for free and held in venues conveniently located around the community. A special series targeting children also will be offered.

In partnership with the Baltimore City Health Department, American Diabetes Association, and American Heart Association, the WBPCAC will identify and regularly assess for relevance and currency the curricula for the disease management and prevention programs. All curricula will be culturally and linguistically-competent and age-appropriate and taught in-kind by staff from the collaborative. A master training calendar will be produced and distributed throughout the

community on a regular basis. With the exception of training supplies and the purchase of curriculum, the cost of this intervention will be free and, therefore, sustainable.

Strategy A.3 Increased Identification of Individuals With CVD or at risk for CVD

The WBPCAC Steering Committee, advisory boards, and CARE center leads collaboratively will develop the overall Community Health Outreach Plan for CARE. The plan will detail the project's annual outreach goals and strategies for achieving metrics that have been established for targeted populations and areas, volunteer and student Community Health Worker recruitment, and community partnerships.

The force of Community Health Workers detailed under HEZ #C will target 86,000 people with CVD for connection to a primary care provider. This will be accomplished in alignment with Baltimore's participation in the national *Million Hearts* initiative by conducting non-invasive assessments (eg. blood pressure screening, calculating BMIs, and administering a CVD screening tool) in community settings like churches, barber shops, schools, businesses, and health fairs.

Strategy A.4 Community Education Campaign

The Coordinator of the Center for Community Enrichment will work with all Centers, the Steering Committee, and advisory boards to plan and implement the multi-media component of the outreach plan. The campaign will endeavor to raise community-wide awareness about CVD, bring into care those who have CVD, and prevent the disease in those at risk. The campaign, also in alignment with the *Million Hearts* initiative, will disseminate these messages through billboards displayed throughout the service areas, written materials distributed through members and community partners, radio and television advertisements, and participation in health fairs and community events.

Community members from the advisory boards and cultural competency and health literacy experts from the University of Maryland's College Park and Baltimore campuses will be engaged to ensure the messaging is culturally-competent and at the appropriate reading level. Some materials will be printed in Spanish. See the Cultural, Linguistic, and Health Literacy Competency section for additional information on methods that will be employed to assure cultural competency in these interventions.

A.5 Targeted Interventions

The Center for Community Enrichment will be the headquarters of targeted interventions implemented by Collaborative members. This grant will provide seed money of $40,000 to fund evidence-based, innovative, and promising strategies that will be selected by the advisory boards—comprised of community members and health and business professionals--and evaluated by the Center for Quality.

HEZ Goal #B – Expanded [and Enhanced] Primary Care Workforce

Strategy B.1 Recruitment of Primary Care Professionals and Paraprofessionals
The Center for Primary Care and Workforce Development will collaborate with WBPCAC members in recruitment efforts to fill primary care and community health vacancies within their organizations. The Center will have a more active role in the search for primary care professionals who are eligible for HEZ benefits and incentives. Up to eight eligible primary care professionals will receive $25,000 annually for student loan repayment and up to $5,000 annually in state tax credits.

Over the course of the project, CARE will extend to ten WBPCAC members a $10,000 HEZ hiring tax credit for adding or retaining qualifying personnel to their care team. In addition, CARE will offer ten annual $5,000 primary care expansion subsidies to allow member practices to hire personnel to augment existing staff.

To supplement the primary care teams, CARE will identify community members and secondary, undergraduate, and graduate students to serve as volunteer Community Health Workers (a.k.a Neighborhood Health Advocates) and interns in member offices.

Strategy B.2 Scholarships to Expand Care Teams with Community Members
To further expand the primary care workforce and contribute to the sustainability of the patient-centered approach to care, scholarships will be offered to community members to support enrollment in technical or professional programs for health or social service careers. Beginning in Year 2, ten $8,000 scholarships will be awarded annually to complete Nursing Assistant, Medical Assistant, or other entry-level training programs.

Recipients will be selected by a committee of the Centers' advisory boards that will be comprised of community members and other health and business professionals. Once appropriately certified or degreed, these individuals will complete internships in the offices of WBPCAC members and be strongly encouraged to permanently contribute to the West Baltimore effort to reduce CVD. WBPCAC members who employ these scholarship recipients will provide mentorship to encourage advancement in health careers.

Strategy B.3 Training and Technical Assistance
Ongoing training and technical assistance will be coordinated by the Center for Primary Care and Workforce Development and provided for free to all members of WBPCAC care teams. See Appendix E for a listing and description of training topics.

Strategy B.4 Enhanced Care Coordination
Care Coordinators working in members' offices will receive ongoing technical assistance, continuing education, and quality improvement feedback organized by the Care Coordination Manager. The Care Coordination Manager will convene the group on a monthly basis to conduct peer-reviewed care plans as a quality improvement measure. In these sessions, care coordinators will offer colleagues insight and advice on addressing and meeting the needs of multi-morbid patients. Additionally, they will share with resources and suggestions for addressing social

determinants of health. All WBPCAC members will have access to a database of community resources that will be maintained by the Care Coordination Manager.

Eventually, the care coordination activities across the collaborative will be recorded in a common software program that will be managed by the Center for Quality.

HEZ GOAL #C – INCREASED COMMUNITY HEALTH WORKFORCE

The Center for Community Enrichment will deploy a cadre of at least eleven community health workers to (1) implement CARE's Community Health Outreach Plan, (2) identify and bring into care people identified in the community who have CVD or are at risk for the disease, and (3) serve on members' clinic-based primary care teams.

The community health outreach team will consist of a Community Health Outreach Coordinator, five full-time Neighborhood Health Advocates (NHAs), four compensated, part-time graduate student interns from the University of Maryland School of Social Work, and a part-time Field Instructor to oversee the activities of the interns. The NHAs will be employees of the HEZ project and compensated at a competitive rate, including fringe benefits. The interns will receive stipends. The Field Instructor's compensation will be in-kind from the University of Maryland.

Additional volunteers will be recruited from area high schools and colleges and universities to serve as uncompensated NHAs. After being trained by the Center for Primary Care and Workforce Development, all NHAs will operate under the Center for Community Enrichment and be deployed throughout the community.

The Coordinator of the Center for Community Enrichment will collect and synthesize data on the activities of the outreach team for reporting to the Center for Quality.

HEZ GOAL #D – INCREASED COMMUNITY RESOURCES FOR HEALTH

The Center for Community Enrichment will pursue and maintain partnerships with community organizations and businesses that can participate in achieving the HEZ goals. One such partnership will be with the area YMCA to increase fitness venues in the community. CARE will enter into a four-year contract with the YMCA to work with community organizations and businesses to provide additional exercise opportunities in the community. This may entail providing funding and guidance to these entities to purchase and maintain fitness equipment. These new partners will make available fitness classes and exercise facilities to patients being served by WBPCAC members.

A partnership with Coppin State University will provide discounted gym memberships and free use of the campus track to individuals who have been referred by WBPCAC members. Similarly, the early morning walking program at Mondawmin Mall will be expanded to accommodate targeted patients. Physicians will be able to "prescribe" walking in the Mall for patients who need to increase their physical activity.

The area targeted for this HEZ application meets many of the criteria to be designated a "food desert." A leading risk factor for CVD is the disparity in access to healthy food choices.[4] Baltimore City's Virtual Supermarkets Program is a community-based, self-sustaining model that enables residents to place grocery orders at local library, school, senior housing site, or any internet-enabled device. Along with the Baltimore City Health Department, an ex-officio member of WBPCAC and supporter of this proposal (see Letters of Support section in Appendix), CARE will promote the use of Baltimore City's Virtual Supermarket to facilitate residents' access to competitively priced, healthy foods. The food-ordering locations within the HEZ will be selected based on cardiovascular disease prevalence, food environment, poverty level, and residents' access to a personal vehicle.

Additional partnerships will be pursued with food retailers to increase the availability of healthier food options. These retailers will be invited to join one of the advisory boards and enlisted in discussions to identify ways to promote healthier eating and access to such foods.

HEZ Goal #E – Reduced Preventable Emergency Department Visits and Hospitalizations

Strategy E.1 Patient-Centered Medical Home

A study by the Patient-Centered Primary Care Collaborative[5] that summarized the health and cost outcomes of PCMH interventions across the country found a 15% to 50% reduction in emergency department visits and 10% to 40% reduction in hospitalizations. Through system-wide implementation of the PCMH approach, the WBPCAC anticipates a 15% reduction in preventable emergency department visits and 10% reduction in preventable hospitalizations.

Strategy E.2 Hospital-Based Care Coordination

Care Coordinators employed by WBPCAC's five participating hospitals will participate in ongoing care coordination training offered by CARE's Center for Primary Care and Workforce Development. In addition, they will participate in Care Coordinator's Roundtables, held regularly to share insight and information about caring for high-risk populations and strengthen care coordination networks across care settings. These shared trainings and regular meetings will promote alignment between hospital-based and PCMH Care Coordinators to prevent inappropriate use of the emergency department.

HEZ GOAL #F – REDUCED UNNECESSARY COSTS IN HEALTH CARE

The Patient-Centered Primary Care Collaborative study referenced in Strategy E.1 revealed significant costs savings from improved health outcomes and reductions in preventable emergency department visits and hospitalizations. In implementing patient-centered care across the Collaborative, a 10% reduction in the cost of care is anticipated.

10. USE OF INCENTIVES AND BENEFITS / BALANCE

As discussed in the Strategies section of this proposal, a balance of HEZ benefits and incentives is critical to the sustainable system of care that will be established through the creation of the

[4] http://www.letsmove.gov/sites/letsmove.gov/files/TFCO_Access_to_Healthy_Affordable_Food.pdf

[5] Grumback, Bodenheimer, Grundy, The Outcomes of Implementing Patient-Centered Medical Home Interventions. Patient-Centered Primary Care Collaborative.

West Baltimore Community Asset and Resources Exchange. Central to CARE model is the expansion and enrichment of the primary care workforce in West Baltimore. HEZ benefits will be used to repay $25,000 annually in student loans for up to eight qualifying primary care professionals. These individuals also will receive $5,000 tax credits. Combining HEZ benefits and incentives with existing federal loan repayment programs might bolster the appeal of working in the HEZ.

To support WBPCAC providers' hiring of primary care professionals, CARE will extend ten $10,000 hiring tax credits to members. Incidentally, CARE will offer ten annual $5,000 primary care expansion subsidies to allow five member practices and five member hospitals to hire personnel to augment existing care teams. A description of how recipients of these benefits will be applied is detailed on page 14 in Section 9, HEZ Goal #B.

The provider-based incentives detailed above are complementary to planned community-based approaches, including use of grant funds to engage community members as entry-level health professionals and community health workers (on stipend), providing grant based funds to offset the cost of gym memberships, and offering grant based funds to evidence based community partners to deliver fitness and/or food programs for the community. This balance is consistent with the overall approach, which is human-resource rich, placing the highest value on assuring a culturally-competent system of care that builds enduring capacity among community members and providers. (See Appendix i. Flow of Resources)

11. CULTURAL, LINGUISTIC AND HEALTH LITERACY COMPETENCY

The Primary Care Workforce and Development center will partner with the Cultural Competency in Healthcare Training Center at the University of Maryland's to assist members' practices in assessing their National Standards on Culturally and Linguistically Appropriate Services (CLAS) capabilities and resources and develop new capacities and workflows to ensure cultural competence.

A range of approaches, tailored to practices' diverse needs, will be used to enhance cultural competency within the PCMHs, including online provider and staff learning, reflective exercises linked with motivational interviewing trainings, development of health education materials for patients with low literacy, provider training in how to work with medical interpreters, and creation of specific workflows to meet patients' needs for medical interpretation services.

WBPCAC and CARE's organizational structures both were created with cultural competence in mind. During the preparation of this HEZ application, members of the community were engaged in the WBPCAC subgroups to assist in developing strategies to address cardiovascular disease in a culturally-competent manner that would resonate with community members. Once the CARE infrastructure is formalized, these individuals and members of the community will be invited to serve on the three CARE advisory boards, which will guide the programming and activities of CARE. Their involvement will assure a balanced perspective.

This project entails recruiting nearly sixty new primary care professionals and paraprofessionals in West Baltimore. During the recruiting process, efforts will be made to identify qualified candidates who have a resemblance to or a demonstrated ability in providing culturally-competent care to the residents of West Baltimore. These may include enlisting the assistance of professional associations with large minority membership and posting positions in publications with a high African-American readership.

Community health workers promote culturally-competent care and can educate providers about community health needs and cultural relevance of care, leveraging opportunities and resources that can reduce barriers to care and improve health outcomes directly. (Margolis 2001; Barr 2003). The project features the addition of at least thirteen community members to serve on care teams and community health worker team. Over the course of the HEZ funding period, forty community members will receive scholarships to pursue health careers with the anticipation that they will return to work in primary care practices in West Baltimore.

12. APPLICANT ORGANIZATION AND KEY PERSONNEL

Bon Secours Baltimore Health System ("Bon Secours") is part of a national health corporation sponsored by Bon Secours Ministries with a mission to "help people and communities to health and wholeness by providing compassionate, quality healthcare and being good help to all in need with special concern for the poor and dying". The Bon Secours Hospital opened in 1919 and was the first hospital established by the Sisters of Bon Secours. Its corporate parent, Bon Secours Health System, Inc. was incorporated in 1983 and currently has eighteen acute-care facilitates, one psychiatric hospital, five assist-living facilities, several ambulatory care sites, home health and hospice services and five nursing care facilities in the United States.

Bon Secours serves the Southwest/West Baltimore community with 801 full-time-equivalent employees, providing an array of health care and community-based services. Bon Secours established its subsidiary, Bon Secours Community Works, in 1991 as a 501 (c) 3 to provide quality community-based programs with a continuum of services to improve the quality of life for the residents of Southwest Baltimore. Community Works provides a wide range of community and individual development programs including family support services, employment, financial and asset management, youth development, housing and neighborhood revitalization.

Bon Secours is experienced in the management of multi-year projects. The Baltimore Cardiovascular Partnership to Reduce Health Disparities with a Focus on Diabetes and Hypertension, funded by the NIH from 2004 – 2010, utilized a community based participatory research model between Bon Secours and the University of Maryland, Baltimore and the University of Maryland Medical Center. The overall purpose of the project was to reduce health disparities related to diabetes and hypertension. Bon Secours exceeded the patient recruitment and retention goals for the project, with over 800 participants and a 95% retention rate during the course of the study.

Bon Secours Hospital founded and launched *Operation ReachOut Southwest* OROSW, a community-driven coalition taking a comprehensive and multi-dimensional approach to neighborhood revitalization in 1997. In 2000, OROSW created a 20-year comprehensive

community plan, focused on social, economic and physical revitalization and outlining a long-range vision for the community.

Bon Secours' experience with the OROSW community planning process and results yielded institutional knowledge that successful initiatives are resident led and community driven. Through the OROSW coalition, a decision-making infrastructure is in place that ensures meaningful resident participation in planning and implementation. One of OROSW's major roles is to attract resources and leverage these investments to attract additional resources needed by the community. OROSW and Bon Secours accomplishments since 1997 include creation of a Strategic Neighborhood Action Plan, The Working Families Initiative, including a Career Center that has placed over 500 people in jobs, a Garden Club, the Clean and Green Program which has transformed over 600 vacant lots into green space and a Housing Program which has created 559 units of affordable housing.

The Collaborative has identified internal resources that will transition into key positions in CARE to allow immediate implementation of this HEZ project. The Interim Project Director will be Gregory Kearns and the Implementation Coordination position will be filled by Novella Tascoe Hunter, both of Bon Secours. Additionally, Dr. E. Albert Reece, Dean of University of Maryland's School of Medicine, will serve as a Special Consultant throughout the project. While Dr. Reece was not involved in the preparation of this proposal, he will join the project immediately after the funding award.

13. COALITION GOVERNANCE AND PARTICIPATING PARTNERS

Perhaps the most illustrative way to describe the WBPCAC's infrastructure, responsibilities, and decision-making is to chronicle its two-year evolution and process for responding to this HEZ designation opportunity. Coincidentally, the WBPCAC's formation and subsequent activities, which commenced independent of the related state-initiated effort, has resulted in a mission that almost perfectly aligns with Maryland's HEZ goals and State Health Improvement Process (SHIP) and Healthy Baltimore 2015 objectives.

In January 2010, Senator Verna Jones-Rodwell and Bon Secours Baltimore Hospital convened the *West Baltimore Health Care Summit* to discuss the health status and health care access issues of the citizens of the State's 44th District.

An outcome of the 2010 Summit was formation of the West Baltimore Primary Care Access Collaborative, a group of sixteen organizations with tremendous individual capacity (Appendix A and F) that realized extraordinary coordination and cooperation would be required to make a meaningful, sustained impact on the incidence and impact of chronic diseases in their community. In alphabetic order, the current members are Baltimore Medical System; Bon Secours Baltimore Health System; Coppin State University; Equity Matters; Light Health and Wellness Comprehensive Services, Inc.; Maryland General Hospital; Mosaic Community Services; National Council on Alcohol and Drug Dependence, Maryland; Park West Health System, Inc.; People's Community Health Centers; Saint Agnes Hospital; Senator Verna Jones Rodwell; Sinai Hospital of Baltimore; Total Health Care, Inc.; University of Maryland Medical Center; and University of Maryland, Baltimore.

The Collaborative commissioned a qualitative and quantitative needs assessment to determine the full scope of the challenges in the areas primary and preventive care system. Completed by John Snow, Inc., the assessment revealed the major barriers to optimal health status and health care delivery and offered a strategic approach for addressing them. In the interval between the 2010 formation the WBPCAC and the announcement of the HEZ opportunity, the Collaborative agreed that creating an independent, 501(c)3 organization would be an ideal venue to implement the recommendations of the plan.

A leadership structure that included a Steering Committee, Governance Committee, and Programs and Services Committee was established to guide the activities of and make decisions on behalf of the Collaborative. To explore the salient issues astutely and efficiently, the Collaborative members organized into three workgroups: Primary Care Access, Care Coordination, and Community Outreach and Education. All three executive committees were populated by representatives of the member organizations.

The announcement of Maryland's HEZ opportunity coincided with the initiation of the WBPCAC's pursuit of non-profit status and presented an opportunity for seed money to implement an expanded vision for CARE. To promote appeal and culturally-competent strategies, the Collaborative invited members from the community who would be potential beneficiaries of resulting interventions to serve on the three workgroups.

The WBPCAC's three workgroups met weekly to review existing resources and gaps in primary care services and offer strategies to address barriers to care. The Collaborative's Steering and Governance Committees met in alternating weeks to review the results of the workgroup meetings, offer suggestions and resources, and facilitate recommended next steps. It is estimated that hundreds of man-hours have been contributed by the members during the process detailed above.

A 501(c)3 organization that will be created by WBPCAC, will administer the HEZ project. The WBPCAC Steering Committee will serve as the single governing body of CARE, overseeing the work of the organization. The Collaborative's three workgroups will become three advisory boards populated by WBPCAC members, including members of the community. The Quality Advisory Board, Community Enrichment Advisory Board, and the Workforce Development Advisory Boards will inform and support the programs and activities of their respective Center within CARE. This organizational structure is shown in Figure 1 on page 8.

14. WORK PLAN

West Baltimore CARE Work Plan

Project Purpose: To reduce cardiovascular disease (CVD) morbidity and mortality in West Baltimore through patient-centered care.

* Objectives from State Health Improvement Process ** Objectives from Healthy Baltimore 2015

WBPCAC Goal A: By 2016, reduce by 15% cardiovascular disease risk factor prevalence among West Baltimore residents. **Corresponding HEZ Goal A:** Improved risk factor prevalence or health outcomes.					
Objectives	**Program Activities/Action Steps**	**Expected Outcome**	**Data and Evaluation Measures**	**Organization/Person Responsible**	**Timeframe**
Measure of success: 86,000 West Baltimore residents will be screened for CVD and CVD risk factors by WBPCAC members and Community Health Workers or be informed about CVD risk factors and treatment through a multi-media campaign.					
• By 2016, reduce by 5% the proportion of [Baltimore City] adults who are current smokers.* • Decrease by 20% the percentage of [Baltimore City] adults who smoke.** • By 2016, increase by 20% the physical activity rate of West Baltimore residents.** • By 2016, decrease by 15% percent of adults who are obese.** • By 2016, increase by 15% the percentage of WBPCAC tobacco-using patients who receive smoking cessation advice. • By 2016, increase by 20% the percentage of overweight child and adult WBPCAC patients who receive counseling on nutrition and physical activity. • By 2016, increase by 30%	• Facilitate collaborative-wide implementation of PCMH approach, including care coordination that addresses disease self-management, medication management, smoking cessation, social determinants, nutrition, physical activity, and behavioral health issues.	• Increased screening, counseling, and referral for CVD. • Enhanced quality of care, education, and support provided to patients with CVD or at risk for CVD. • Improved patient skills and knowledge to self-manage illness. • Increased patient participation in managing disease. • Reduced CVD risk factors/improved health outcomes.	• Number of WBPCAC practices that participate in CARE's patient-centered medical home training. • Number of patients referred by WBPCAC members for disease management and health promotion courses. • Number and percentage of patients who experience improved biometric indicators.	WBPCAC members,	March 2013 – Formally engage Maryland Learning Collaborative to provide WBPCAC members technical assistance. April 2013 – Begin curriculum development/purchase and identification of faculty for PCMH trainings May 2013 – Institute Care Coordination meetings
	• Outreach to 1,300 West Baltimore residents monthly for referrals into primary care.	• Increased number of CVD patients connected to primary care provider.	• Number of monthly outreach encounters • Number of new patients identified by Community Health Workers/Neighborhood	Community Health Outreach team/Center for Community Enrichment	March 2013 – Begin search for Community Health Outreach Coordinators May 2013 –

the percentage of WBPCAC hypertensive adult patients with blood pressures lower than 140/90. • By 2016, increase by 30% the percentage of WBPCAC hypertensive adult patients with blood pressures lower than 140/90. • By 2016, increase by 30% the percentage of WBPCAC diabetic adult patients with HbA1c under 9%. • Increase proportion of adults who are at a healthy weight.* ***Note that objectives followed by asterisks are adopted from the State Health Improvement Process (and) and Healthy Baltimore 2015.***			Health Advocates		WBPCAC's/CARE's Finalize Community Outreach Plan
	• Offer at least five monthly disease self-management classes that reinforce accessing care, medication management, physical activity, nutrition, smoking cessation • Offer at least five monthly health promotion course for all West Baltimore residents to learn about CVD prevention and treatment.	• Improved patient skills and knowledge to self-manage illness.	• Number of disease management courses offered • Number of patients referred by WBPCAC members for disease management and health promotion courses. • Number of patients who complete disease management and health promotion courses.	CARE's Center for Community Enrichment CARE's Center for Primary Care and Workforce Development	April 2013 – Develop/identify curriculum for courses May 2013 – Begin offering disease management courses.
	• Offer WBPCAC patients discounted use of Coppin State University's fitness facility • Extend WBPCAC patients authorized use of Coppin State University's walking track • Facilitate WBPCAC patients participation in Mondawmin Mall walking program • Increased fitness venues in West Baltimore through YMCA partnership • Facilitate WBPCAC patients' participation in Virtual Supermarket program • Text4Health	• Increase in frequency of physical activity for patients with CVD. • Reduction in CVD risk factors.	• Number of WBPCAC patients who use discounted fitness club membership at least two times with two months of initiation. • Number of patients who report enrollment in Virtual Supermarket		March 2013 – Finalize partnerships with Coppin, Mondawnim Mall, and YMCA April 2013 – Finalize Virtual Supermarket participation support.

WBPCAC Goal B. By June 2015, increase by 48 the number of highly-skilled primary care professionals on WBPCAC members' care teams. **Corresponding HEZ Goal B.** Expanded primary care workforce.					
Objectives	**Program Activities/Action Steps**	**Expected Outcome**	**Data and Evaluation Measures**	**Organization/Person Responsible**	**Timeframe**
Measure of success: Attainment of recommended caseload for patient-centered medical home care coordination for target population.					
• Conduct an annual assessment of primary care workforce needs among WBPCAC members.	• Ongoing assessment of workforce status, composition	• Quantitative understanding of primary care needs in West Baltimore.	• Completion of assessment.	CARE's Center for Quality, Center for Primary Care and Workforce Development, Evaluation Team	March 2013 – Establish metrics and methodology April 2013 – Begin assessment
• By 2014, recruit eight primary care professionals to WBPCAC member practices.	• Provider recruitment using HEZ benefits and incentives	• Addition of new primary care physicians to West Baltimore.	• Number of new providers added	WBPCAC members	January 2013 – Begin offering HEZ benefits and project subsidies to WBPCAC members April 2013 – Begin recruitment offering HEZ benefits
• By 2016, support addition of a minimum of ten primary care professionals to WBPCAC member practices.	• Provide ten $10,000 HEZ hiring tax credits to WBPCAC members • Provide ten $5,000 primary care expansion subsidies to WBPCAC members	• Addition of up to ten new primary care professionals. • Improved access to primary care services.	• Number of hiring credits extended • Number of primary care expansion subsidies awarded	WBPCAC members, Center for Primary Care and Workforce Development	January 2013 – Begin offering HEZ benefits and project subsidies to WBPCAC members.
• By 2016, increase by 30 the number of community members who are trained as healthcare paraprofessional training.	• Identify ten community members to annually to receive a scholarship for primary care paraprofessional training program.	• Increase the diversity of healthcare professionals in West Baltimore. • Increase in culturally-competent care delivered to West Baltimore residents.	• Number of community members awarded scholarships. • Number of community members who complete paraprofessional training program. • Number of community members who accept employment in West Baltimore following completion of program.	CARE's Center for Primary Care and Workforce Development, WBPCAC Steering Committee	November 2013 – Begin advertising scholarship opportunity April 2014 – Award first scholarships Annually

• Train 90% WBPCAC primary care professionals and paraprofessionals on PCMH approach.	• Develop and offer training to all WBPCAC professionals, paraprofessionals, volunteers, and interns on PCMH approach.	• Standardized, unified approach to delivery of care to chronically ill patients.	• Number of WBPCAC professionals, paraprofessionals, volunteers, and interns who complete training versus overall number.	WBPCAC members, Center for Primary Care and Workforce Development	March 2013 – Develop/purchase curriculum Annually – Review curriculum June 2013; Ongoing – Offer training
• By 2016, increase by 20 the number of high school and college students who pursue a career in healthcare.	• Annually recruit and train five high school or college students to serve as interns in WBPCAC practices. • Offer scholarships to students who pursue degrees or certificates to become primary care professionals.	• Increase in the number of students who pursue health careers.	• Number of students targeted. • Number of venues enlisted in promoting student opportunities. • Number of students recruited.	CARE's Center for Primary Care and Workforce Development, WBPCAC Steering Committee	July 2013 – Advertise opportunity September 2013 – Select students Annually
WBPCAC Goal C. By December 2013, increase by at least 11 the number of Community Health Workers serving West Baltimore. **Corresponding HEZ Goal C.** Increased community health workforce (including public health and outreach workers).					
Objectives	**Program Activities/Action Steps**	**Expected Outcome**	**Data and Evaluation Measures**	**Organization/Person Responsible**	**Timeframe**
Measure of success: Addition of thirteen Community Health Workers to support WBPCAC members.					
• By June 2013, hire a Community Health Outreach Coordinator.	• Recruit for position.	• Enhanced ability to implement CARE's Community Outreach Plan. • Enhanced ability to manage Neighborhood Health Advocates (community outreach volunteers)	• Hiring of Coordinator	Coordinator, Center for Community Enrichment	February 2013 – Begin recruitment for position April 2013 – Hire Community Health Outreach Coordinator.
• Recruit and/or retain five West Baltimore residents as Neighborhood Health Advocates (aka NHAs or Community Health Workers).	• Recruit for five full-time NHA positions.	• Increased culturally-competent community health outreach	• Number of community members targeted. • Number of venues enlisted in promoting opportunity. • Number of community members recruited.	Coordinator, Center for Community Enrichment, Coordinator, Center for Primary Care and Workforce Development	April 2013 – Begin recruiting June 2013 – Train NHAs. Annually

• Install four graduate students interns as part-time NHAs (to be supervised by a part-time Field Instructor)	• Identify four students to serve as part-time NHA positions.	• Increased culturally-competent community health outreach	• Number of community members targeted. • Number of venues enlisted in promoting opportunity. • Number of community members recruited.	University of Maryland School of Social Work, Coordinator, Center for Community Enrichment, Coordinator, Center for Primary Care and Workforce Development	April 2013 – Begin recruiting June 2013 – Train NHAs. Annually
• Annually recruit ten uncompensated Neighborhood Health Advocates.	Recruit for ten NHA uncompensated positions.	• Increased culturally-competent community health outreach	• Number of community members targeted. • Number of venues enlisted in promoting opportunity. • Number of community members recruited.	Coordinator, Center for Community Enrichment, Coordinator, Center for Primary Care and Workforce Development	April 2013 – Begin recruiting June 2013 – Train NHAs. Annually
WBPCAC Goal D. By 2014, create an infrastructure to identify and implement interventions to increase community resources for health. **Corresponding HEZ Goal D.** Increased community resources for health (e.g., housing, built environment, food access, etc.).					
Objectives	**Program Activities/Action Steps**	**Expected Outcome**	**Data and Evaluation Measures**	**Organization/Person Responsible**	**Timeframe**
Measure of success: Satisfactory achievement of desired caseload for 86,000 West Baltimore residents will be screened for CVD by WBPCAC members and Community Health Workers.					
• By 2014, establish partnerships with two food retailers. • By 2013, formalize support of programs to increase access to healthier foods.	• Invite food retailers to join collaborative. • Facilitate patients' participation in Baltimore City Health Department's Virtual Supermarkets	• Increased access to healthy food options	• Number of invitations extended to food retailers • Number of food retailers represented on Collaborative • Number of healthy food-related initiatives implemented by food retailers	Center for Community Enrichment	March 2013 – Begin effort to identify potential food retailers for WBPCAC membership. Ongoing
WBPCAC Goal E1. By 2016, reduce by 15% the number of preventable emergency department visits of West Baltimore residents with CVD. **WBPCAC Goal E2.** By 2016, reduce by 10% the number of preventable hospitalizations of West Baltimore residents with CVD. **Corresponding HEZ Goal E.** Reduced preventable emergency department visits and hospitalizations.					
Objectives	**Program Activities/Action Steps**	**Expected Outcome**	**Data and Evaluation Measures**	**Organization/Person Responsible**	**Timeframe**
Measure of success: Reduction in the percentage of preventable ED visits and hospitalizations in targeted ZIP codes.					
• By 2016, reduce [by 15%]	• Facilitate	• Enhanced quality of	• Number and percentage	Center for Quality,	June 2013 – Develop

diabetes-related ED visits.* • By 2016, reduce [by 15%] hypertension-related ED visits.* • By 2016, reduce by 15% the percentage of CVD-related, preventable ED visits. • By 2016, reduce by 15% the percentage of CVD-related, preventable hospitalizations.	collaborative-wide implementation of PCMH approach, including care coordination that addresses disease self-management, medication management, smoking cessation, social determinants, nutrition, physical activity, and behavioral health issues.	care, education, and support provided to patients with CVD or at risk for CVD. • Improved patient skills and knowledge to self-manage illness. • Increased patient participation in managing disease. • Reduced CVD risk factors/improved health outcomes.	of diabetes-related ED visits in ZIP codes. • Number and percentage of hypertension-related ED visits in ZIP codes. • Number and percentage of CVD-related preventable ED visits. • Number and percentage of CVD-related preventable hospitalizations.	Evaluation Team	process to measure reductions. Annually
WBPCAC Goal F. By 2016, reduce by 10% unnecessary costs of caring for West Baltimore residents with cardiovascular disease. **Corresponding HEZ Goal F.** Reduced unnecessary costs in health care (costs that would not have accrued if preventive services and adequate primary care had been provided).					
Objectives	**Program Activities/Action Steps**	**Expected Outcome**	**Data and Evaluation Measures**	**Organization/Person Responsible**	**Timeframe**
Measure of success: Reduction in the estimated overall cost of care for CVD patients served by WBPCAC members.					
• By 2016, reduce [by 15%] diabetes-related ED visits.* • By 2016, reduce [by 15%] hypertension-related ED visits.* • By 2016, reduce by 15% the percentage of CVD-related, preventable ED visits. • By 2016, reduce by 15% the percentage of CVD-related, preventable hospitalizations.	• Facilitate collaborative-wide implementation of PCMH approach, including care coordination that addresses disease self-management, medication management, smoking cessation, social determinants, nutrition, physical activity, and behavioral health issues.	• Reduction in overall cost of caring for people with CVD.	• Number and percentage of diabetes-related ED visits in ZIP codes. • Number and percentage of hypertension-related ED visits in ZIP codes. • Number and percentage of CVD-related preventable ED visits. • Number and percentage of CVD-related preventable hospitalizations.	Center for Quality, Evaluation Team	June 2013 – Develop process to measure reductions. Annually

15. EVALUATION PLAN

This section describes the project's **Internal Evaluation, Progress Monitoring, Program Management and Guidance** (as defined in HEZ Review Principles). The WBPCAC combined HEZ Internal Evaluation and Progress Monitoring Plan ("the Evaluation Plan") will be completed by a team led by University of Maryland Professor C. Daniel Mullins, PhD, a nationally-recognized expert in community-based program evaluation, health disparities, patient-centered research, and health economics. Prof. Mullins will work closely with the Center for Quality's Coordinator and Data Analyst, a research nurse (Aurelia Laird), and Project Director to implement and provide technical assistance for a comprehensive reporting and quality improvement structure that will monitor and support members' progress towards achieving HEZ goals and internal targets

Implementation of the evaluation plan will be rigorous, culturally-sensitive, and engaging to support a learning health care system environment, as described by the Institute of Medicine. Regular evaluation and feedback to WBPCAC members will promote continuous quality improvement, maximize effectiveness and translational impact into community-based practice, and minimize the time to impact health disparities. Data will track both individual patients who participate in the WBPCAC HEZ as well as population-level statistics for the 4 targeted zip codes. Stratification of data will reflect race/ethnicity.

The Evaluation Plan will include both quantitative and qualitative components with the overarching aim to perform a self-assessment that measures and reports to both the CHRC and the WBPCAC the progress toward achieving the project goals.

The following activities will occur to evaluate the impact, effectiveness, and efficiency of the HEZ efforts aimed at reducing health disparities, improving access, and health outcomes of individuals living in the catchment area and:

- Evaluate and enrich data captured by the Baltimore City Health Department and HRSA (for FQHCs) to determine implementation, process, and health outcomes associated with the WBPCAC HEZ initiative;
- Capture and analyze data in categories of race and ethnicity to assess the impact on minority health and health disparities among the targeted population;
- Supplement quantitative data with qualitative assessment and feedback from community members, including healthcare providers, patients, community leaders, partners, and other stakeholders; and
- Create an infrastructure that promotes ongoing dissemination of findings to both the CHRC and WBPCAC to support a "learning healthcare system" and motivate continued progress toward achievement of targets.

IMPLEMENTATION AND PROCESS METRICS AND ASSOCIATED TIME-SPECIFIC MILESTONES

Following is a summary of the approaches to evaluating progress towards the HEZ goals:

HEZ Goal A: Improved Risk Factor Prevalence

Several key risk factors will be targeted (Table 5) and changes in the proportion of patients with hypertension and diabetes whose conditions are controlled will be evaluated.

HEZ Goals B and C: Expanded Primary Care Workforce and Increased Community Health Workforce

To facilitate monitoring and reporting of progress towards this goal, an analysis of the dynamic structure of the HEZ in West Baltimore and number and types of providers and utilization of health care services by race/ethnicity will be conducted. In addition to the metrics provided in the Table below, the number of individuals whose "regular source of care" is a primary care provider versus the emergency department or "no regular source of care" will be tracked. Process metrics will document access and use of services and facilities.

In addition to tracking recruitment and retention of primary care providers, the recruitment and activities of community health workers and other ancillary personnel will be tracked to monitor progress on achieving the goal of expanding the community health workforce.

Table 5. Evaluation Metrics and Milestones

HEZ GOALS and Associated Metrics	Reporting Frequency	Targeted Milestones	Partner Responsible for Reporting Metrics Data
1. IMPROVED RISK FACTOR PREVALENCE OR HEALTH OUTCOMES			
a. Annual check-ups, well visits, preventive care	Quarterly to CHRC; tracked monthly	By 2013 – 5%, 2014 – 10%, 2015 – 15%, 2016 – 20% increase in percentage (annual check-ups) or number *Interim performance measures: Appointment system in place, tracking scheduling of visits and cancelations/missed appointments*	Patient Centered Medical Homes
b. Smoking • % of Adults Assessed for Tobacco Use • % of Tobacco Users who Received Cessation Advice	Quarterly to CHRC; tracked monthly	By 2013 – 3%, 2014 – 8%, 2015 – 12%, 2016 –15%, increase in the percentage of WBPCAC tobacco-using patients who receive smoking cessation advice *Interim performance measures: Training program in place, tracking scheduling of sessions*	Patient Centered Medical Homes, community-based organizations
c. Obesity • BMI grouped according to Normal weight (BMI </= 24.9); Overweight (BMI 25.0 - 29.9); or Obese (BMI 30.0 - 99.8) • % of Children and Adolescents with BMI Percentile and Counseling on Nutrition and Physical Activity Documented	Quarterly to CHRC; tracked monthly	By 2013 – 3%, 2014 – 8%, 2015 – 12%, 2016 –15%, decrease in the percentage of child and adult WBPCAC patients who are obese *Interim performance measures: Tracking and reporting system in place, Counseling program in place*	Patient Centered Medical Homes, supplemented by Baltimore City Health Department data

Table 5. Evaluation Metrics and Milestones			
HEZ GOALS and Associated Metrics	**Reporting Frequency**	**Targeted Milestones**	**Partner Responsible for Reporting Metrics Data**
d. Hypertension • % of adults with hypertension who have their blood pressure under control, defined as under 140/90	Quarterly to CHRC; tracked monthly	By 2013 – 5%, 2014 – 10%, 2015 – 20%, 2016 –30%, increase in the percentage of WBPCAC hypertensive adult patients with blood pressures lower than 140/90 *Interim performance measures: Tracking and reporting system in place*	Patient Centered Medical Homes, supplemented by Baltimore City Health Department data
e. Diabetes • % of adults with diabetes who have their blood sugar under control, defined as a HbA1c under 9 percent	Quarterly to CHRC; tracked monthly	By 2013 – 5%, 2014 – 10%, 2015 – 20%, 2016 –30%, increase in the percentage of WBPCAC diabetic adult patients with HbA1c under 9%. *Interim performance measures: Tracking and reporting system in place*	Patient Centered Medical Homes, supplemented by Baltimore City Health Department data
f. Improved level of physical activity • At least 30 minutes of exercise 3-5 times/week	Quarterly to CHRC; tracked monthly	By 2013 – 5%, 2014 – 10%, 2015 – 15%, 2016 – 20% increase in the physical activity rate of West Baltimore residents *Interim performance measures: Tracking and reporting system in place, training program (e.g. YMCA) in place*	Patient Centered Medical Homes, supplemented by Baltimore City Health Department data
g. Diet • Reduced salt intake (no more than 2.3g/day for non-hypertensive patients, </= 1.5g for hypertensive patients) • Targeted average daily calorie intake: 2,200-2,500cal/day (men) 1,500-1,800cal/day (women)	Quarterly to CHRC; tracked monthly	By 2013 – 5%, 2014 – 10%, 2015 – 15%, 2016 – 20% increase in the percentage of overweight child and adult WBPCAC patients who receive counseling on nutrition *Interim performance measures: Tracking and reporting system in place, Counseling program in place*	Patient Centered Medical Homes supplemented by Baltimore City Health Department data
2. EXPANDED PRIMARY CARE WORKFORCE			
• New providers, including % using each type of incentive (e.g. % using loan repayment) • Expansion in the coalition of partners within the Baltimore HEZ initiative	Monthly to CHRC	By the end of 2013, eight (8) new providers within the WBPCAC HEZ; Thirty (30) new (scholarships) by the end of the project *Interim performance measures: Outreach program in place, Dissemination of HEZ benefits to potential new providers*	Patient Centered Medical Homes, supplemented by WBPCAC Steering Committee
3. INCREASED COMMUNITY HEALTH WORKFORCE			

Table 5. Evaluation Metrics and Milestones			
HEZ GOALS and Associated Metrics	**Reporting Frequency**	**Targeted Milestones**	**Partner Responsible for Reporting Metrics Data**
• New health-related ancillary personnel (e.g. community health workers)	Quarterly to CHRC; tracked monthly	By the end of 2013, create 11 new community health worker positions and paraprofessionals within the WBPCAC HEZ *Interim performance measures: Outreach program in place, Contract in place with UM School of Social Work; CHWs hired.*	Patient Centered Medical Homes, community-based organizations, hospitals supplemented by Baltimore City Health Department data
4. INCREASED COMMUNITY RESOURCES FOR HEALTH			
• Local farmers markets • Medical, dental and visions services • Substance abuse services • Enabling services • Housing facilities for the homeless	Quarterly to CHRC; tracked monthly	By 2014, add two additional community resource outlets for health within WBPCAC and increase to three outlets by 2015 and to four outlets by 2016; increase annually by 5% the number of individuals who access outlets (e.g. dental or substance abuse services) and number who use them routinely *Interim performance measures: Meetings with potential outlets, Review of community needs assessment*	Patient Centered Medical Homes, community-based organizations, hospitals, supplemented by WBPCAC Steering Committee
5. REDUCED PREVENTABLE EMERGENCY DEPARTMENT VISITS/ HOSPITALIZATIONS			
a. Heart Attacks • % with chest pain confirmed to be heart attack by ECG and laboratory results b. Stroke (Hemorrhagic or Thromboembolic) • % of neurologic symptoms diagnosed by physical examination or/and MRI	Quarterly to CHRC; tracked monthly	By 2013 – 3%, 2014 – 8%, 2015 – 12%, 2016 –15%, decrease in the percentage of HTN and CVD-related, preventable ED visits/hospitalizations *Interim performance measures: Tracking and reporting system in place, New hospital-based initiatives targeting reduction in avoidable readmissions*	Patient Centered Medical Homes, community-based organizations, hospitals, supplemented by Baltimore City Health Department data

Table 5. Evaluation Metrics and Milestones			
HEZ GOALS and Associated Metrics	**Reporting Frequency**	**Targeted Milestones**	**Partner Responsible for Reporting Metrics Data**
c. Diabetic Emergencies • % with Diabetic Ketoacidosis, confirmed by blood and urine laboratory tests • % with Hyperglycemic Hyperosmolar Nonketotic Syndrome, confirmed by blood and urine laboratory tests	Quarterly to CHRC; tracked monthly	By 2013 – 3%, 2014 – 8%, 2015 – 12%, 2016 –15%, decrease in the percentage of diabetes-related ED visits *Interim performance measures: Tracking and reporting system in place, New hospital-based initiatives targeting reduction in avoidable diabetes-related ED visits*	Patient Centered Medical Homes, community-based organizations, hospitals, supplemented by Baltimore City Health Department data
6. REDUCED UNNECESSARY COSTS IN HEALTH CARE			
• Dollars saved by preventing avoidable hospitalizations and ED visits	Quarterly to CHRC; tracked monthly	Savings of 5% in year 1, rising to 10% for years 2-4 *Interim performance measures: Baseline measures in the first 6-12 months, from which progress will be tracked by Bon Secours and demonstrated over time; Co-development of actuarial models for estimating cost savings with the State (and possibly other HEZ designees)*	Hospitals and academic institution (UMB) for calculations

HEZ Goal D: Increased Community Resources for Health

After conducting a gap analysis, process metrics will document increases in community resources for delivering health care for the underserved in the West Baltimore community through distribution of health education teaching materials as well as health preventive screening tools.

The above implementation and process metrics will be assessed annually and biannually based on measurable and **time-specific milestones** including biannual evaluation of the functionality and physical inspection of the condition and servicing logs of all existing health resource and facilities.

A key component of assessing the deployment of interventions within the HEZ involves:

- Reduction in "food deserts" and increase in the availability of healthy foods
- Number of referrals by care managers in our program to PCMH
- Number of patients that are involved in any of the risk reduction/education programs

PERFORMANCE MEASURES AND ASSOCIATED TIME-SPECIFIC MILESTONES

Performance measure will include reduction in both cardiovascular disease risk factors and improvement in health outcomes among patients with established cardiovascular disease. Performance measures will include indicators outlined in Healthy Baltimore 2015 initiative.

Health outcomes hat reflect improvements in HEZ patient health and reductions in avoidable emergency department visits/hospitalizations and their associated costs will be assessed. A starting point will be data and reports produced by the Baltimore City Health Department, such as data presented in "Neighborhood Health Profiles".

HEZ Goal #E: Reducing Preventable Emergency Department Visits and Hospitalizations The WBPCAC HEZ will align targeted indicators for this goal with Health Baltimore 2015. As one example, the Baltimore citywide rate of hospitalization and emergency department visits for hypertension are 95.5 and 404.2 per 100,000 people, respectively. By 2015, the goal is to decrease rates of hospitalizations and emergency department visits for ambulatory care sensitive conditions by 10% and 15%, respectively.

HEZ Goal #F : Reduced Unnecessary Costs in Health Care
The ability to "bend the cost curve" is greatest with the proposed focus on greater patient activation and involvement in PCMHs and provider expansion within the WBPCAC HEZThe evaluators will apply actuarial principles to estimate potential cost savings due to avoidable hospitalizations and ED visits.

EVALUATING FIDELITY OF PROGRAM AND PARTNERS' ACTIVITIES AND PROGRESS

Key groups involved in this HEZ project include (1) CARE, the coordinating organization; (2) Community Members; (3) Hospitals; (4) Behavioral Health Providers; (5) Community-Based Organizations; (6) Patient-Centered Medical Homes; and (7) Academic Institutions. Each group possesses distinct responsibilities, eligibility for HEZ and CARE benefits, and accountability.

The roles and accountability of each member are summarized in Tables 5 and 6. The standards for Collaborative participants are detailed in Attachment F, the WBPCAC Participant Agreement.

The WBPCAC Steering Committee will monitor the activities and progress of participating partners within the WBPCAC to assure fidelity of implementation of protocols and provision of supplemental data for internal and external program evaluations. Integrity of data capture and reporting will be included within the evaluation process.

Results of this process evaluation will be summarized and reported to the WBPCAC Steering Committee and CHRC on a semiannual basis. In cases where targets are not achieved, partners will be required to develop a corrective action plan within 30 days that will be reviewed and approved by the WBPCAC Steering Committee and, if requested, by CHRC. The corrective action plan will be monitored and assessed at 90 and 180 days. Partners that do not meet the requirements of the corrective action plan will no longer be eligible for benefits from the HEZ.

Table 6. Summary of WBPCAC Members' Responsibilities and Accountability

Member Type	Role and Responsibilities in HEZ Project	HEZ & CARE Benefits Eligibility	Reporting/Accountability
West Baltimore CARE	• Coordinating body for all Collaborative activities • Daily operation of three	• Administration of HEZ funds	• Ultimate responsibility for monitoring HEZ project activities

	Centers: Center for Primary Care and Workforce Development, Center for Community Enrichment, Center for Quality •		• Ultimate responsibility for collecting and reporting HEZ project data • Accountable to WBPCAC Steering Committee
Community Members	• If a PCMH patient, actively participate on care team • Engage in activities to improve health • Participate in CARE decision-making through membership on CARE Advisory Boards • Possibly serve as a compensated or volunteer Neighborhood Health Advocate (aka Community Health Worker)	• Enhanced care coordination through PCMHs • Disease management classes • Training to become compensated or uncompensated Neighborhood Health Advocate • Use of expanded Community Health Resources (eg. gym memberships, BCHD virtual supermarket, walking track, etc.) • Scholarships for entry-level health professional training programs	• NHAs: complete training program and fulfill position responsibilities • Scholarship recipients: complete training program, complete internship in HEZ, seek employment in HEZ
Hospitals - Bon Secours Baltimore Health System - Maryland General Hospital - Sinai Hospital - St. Agnes Hospital - University of Maryland Medical Center	• Care Coordinators connect patients to PCMHs from ED and inpatient discharge • Connect patients to Center for Community Enrichment • Refer care team members to Center for Primary Care and Workforce Development for training • Provide faculty for disease management courses • Provide faculty for health professional training courses	• Trainings for care team members • Grants to fund targeted interventions	• Collect and report HEZ evaluation metrics (see Table 2) • Utilization of professional development • Provide in-kind faculty for disease management and professional development classes • Referrals to CARE programs and services • Participation in WBPCAC governance
Behavioral Health Providers - Mosaic Community Services - NCADD Maryland	• Provide Behavioral Health and Social Services • Refer patients to PCMHs • Connect care team members to Center for Primary Care and Workforce Development for training • Refer patients to Community Resources for Health (eg. YMCA, Coppin, Mondawmin	• Grants to fund targeted interventions • Training for care team members	• Collect and report HEZ evaluation metrics (see Table 2) • Utilization of professional development • Provide in-kind faculty for disease management and professional development classes • Referrals to CARE programs and services • Participation in WBPCAC governance

	Mall, partnership, Virtual Food Supermarket)		
Community-Based Organizations - Equity Matters - Light Health & Wellness	• Provide social services • Host Community Health Workers to recruit clients into PCMHs and CARE • Refer constituents to PCMHs and CARE • Refer patients to Community Resources for Health (eg. YMCA, Coppin, Mondawmin Mall, partnership, Virtual Food Supermarket) • Connect Care Team Members to Center for Primary Care and Workforce Development	• Grants to fund targeted interventions	• Collect and report HEZ evaluation metrics (see Table 2) • Utilization of professional development • Provide in-kind faculty for disease management and professional development classes • Referrals to CARE programs and services • Participation in WBPCAC governance
Patient Centered Medical Homes - Baltimore Medical Systems - Park West Medical Center - People's Community Health Centers - Total Health Care *Hospital-affiliated primary care practices of:* - Maryland General Hospital - Sinai Hospital - St. Agnes Hospital - University of Maryland Medical Center	• Provide primary and acute care to targeted population • Manage long term care coordination • Deploy and co-manage Community Health Workers • Refer patients to Center for Community Enrichment for disease management and social services • Refer patients to Community Resources for Health (eg. YMCA, Coppin, Mondawmin Mall, partnership, Virtual Food Supermarket) • Connect care team members to Center for Primary Care and Workforce Development • Provide faculty for disease management course • Provide faculty for health professional training courses	• Hiring tax credits • Stipends for hiring primary care professionals • Trainings for care team members • Ability to offer LARP and income tax credits to attract primary care professionals • Grants to fund targeted interventions	• Collect and report HEZ evaluation metrics (see Table 2) • Utilization of professional development • Provide in-kind faculty for disease management and professional development classes • Referrals to CARE programs and services • Participation in WBPCAC governance
Academic Institutions - Coppin State University - University of Maryland	• Provide curriculum and training for Center for Primary Care and Workforce Development and Center for Community Enrichment • Offer facilities for use (meeting space, gym, walking track at Coppin) • Connect Students to Center for Primary Care	• Grants to fund targeted interventions • Trainings staff and students affiliated with HEZ activities	• Collect and report HEZ evaluation metrics Utilization of professional development • Provide in-kind faculty for disease management and professional development classes • Referrals to CARE programs and services • Participation in WBPCAC

	and Workforce Development • Provide faculty for disease management and health professional training courses		governance

QUALITATIVE IMPACT EVALUATION PLAN

The WBPCAC recognizes that stakeholder engagement and feedback is a critical component of the Internal Evaluation and Progress Monitoring Plan Evaluation Plan. A qualitative evaluation of the HEZ will promote transparency and guide dissemination and translational activities to WBPCAC participants and beyond. I also will provide an important self-assessment component for the external evaluation.

To generate the evidence base to sustain this project, guide future HEZs, and assure that investment in WBPCAC produces dividends, an impact evaluation with key stakeholders will be conducted. Working in partnership with all members of WBPCAC, the evaluation team will collect, analyze, synthesize, and disseminate assessments, information, tools, and resources that are useful to WBPCAC providers and partners. The broad aims of the impact evaluation are to:

- Identify the needs of WBPCAC partners, healthcare delivery systems, providers, and patients;
- Assess participants' understanding of the purpose and perceived success of the WBPCAC HEZ, particularly as they relate to strategies, interventions and information flow;
- Document the resource requirements and lessons learned according to stakeholder category;
- Gauge the extent to which the WBPCAC HEZ operates in a culturally competent manner that addresses the health literacy of the WBPCAC HEZ population;
- Determine the extent to which WBPCAC members feel there is a balance between community-based approaches and primary care provider-based incentives; and
- Obtain feedback on how best to address continuous quality improvement and support the sustainability of the WBPCAC HEZ. Sample topics and questions for qualitative impact evaluation are detailed in Appendix G.

Data Collection: We will utilize existing University of Maryland protocols for conducting and analyzing focus group/key informant interviews. We will follow ethical standard operating procedures for participant recruitment, enrollment, consent, data collection, and data handling. In addition, we will work diligently to assure that all processes are culturally appropriate and designed to maximize participation across the broad array of stakeholders. The evaluation team will submit the protocol, data collection instruments, and other materials (e.g., screeners, scripts) to the University of Maryland IRB (and to other IRBs as needed) for review and approval.

Data Analysis: Given the complexities of evaluating the WBPCAC HEZ, we propose a mixed-methods approach; triangulation of quantitative and qualitative data maximizes the strengths and reduces the limitations inherent in research involving only one type of data.

Qualitative Data: We will analyze data at 4-month intervals so that early insights and findings can be shared with WBPCAC members, community partners, and the State. Qualitative evaluation will use notes and audio recordings to organize and clean interview/focus group notes. Confidentiality of qualitative data will be maintained by removing all personal information. Transcripts from interviews/focus groups will be imported into NVivo 9 to easily code data, as well as organize and manage codes. Based on the general principles of grounded theory, the evaluation team will conduct three phases of coding: open, axial and selective coding. In open coding, we will broadly code text relevant to evaluation questions, such as text that indicates participants' expectations, challenges and facilitators for providing care, promoting health and reducing health disparities. During axial coding, we will refine the broad codes, delete extraneous categories, and merge categories that are redundant. During selective coding, we will further refine categories through deliberate selection and the relationships among them.

Quantitative Data: The evaluation team will analyze survey data available from the Baltimore City and State of Maryland Health Departments as well as prospectively collected and retrospective data available from WBPCAC members.

Reporting and Dissemination: Findings from each wave of analysis will be written up into brief reports and submitted to both the State and to the WBPCAC Steering Committee. The purpose of continuous analysis and sharing of findings will demonstrate achievement of milestones and stimulate learning across WBPCAC and beyond. Interim findings will be presented along with recommendations for improving WBPCAC HEZ activities and plans to address barriers. As the evaluation activities take place at 4-month intervals, we propose the use of feedback loops to encourage the WBPCAC partnership to function as a learning community and to inform subsequent WBPCAC actions for more effective and efficient provision of care. At the end of each year, a larger, annual report will be developed that incorporates each smaller wave of data collection and analysis. The annual report will be presented for feedback and used to develop targeted expansion strategies as well as solutions to address concerns. The reports will be revised based on feedback from WBPCAC and the State and will be used to inform the subsequent year's evaluation activities (i.e., we will revise the evaluation plan so that it is tailored to current WBPCAC needs). No reports will contain any identifying information.

16. SUSTAINABILITY

The main premise of this project is that sustainable, population-wide change can be achieved when a broad group of stakeholders combines and directs resources towards creating a system to address a common goal. The WBPCAC created CARE to collectively reduce cardiovascular disease morbidity and mortality. The programs and services offered through CARE will result in a standardized, comprehensive approach to patient-centered care that should inspire an enduring culture change in health care and social services delivery and utilization in West Baltimore.

Inherent to CARE are several components that were designed to assure short- and long-term sustainability. With the cautious understanding that funds may not extend beyond the HEZ period, the project will be implemented in four stages that culminate in sustainability of the core functions of the Collaborative. All project activities will occur within or across the following four stages: Developing, Strengthening, Positioning, and Sustaining. (Appendix H)

Short- and Long-Term Sustainability: "Developing and Strengthening":
Many of the major ongoing expenses typically associated with efforts of this type are and will remain in-kind. Office space for all CARE staff will be provided in-kind indefinitely by WBPCAC members. Training expenses—including locations and faculty—will remain an in-kind contribution from WBPCAC members. Curricula developed and purchased with HEZ funds will be used until they have been determined irrelevant. Updates and replacements to curricula will be purchased with funds secured through long-term sustainability activities.

Because this project builds capacity among primary care and community health professionals, future healthcare professionals, and the community, the knowledge, skills, and expertise that have been added to West Baltimore's primary care system will endure at no additional cost.

It is anticipated that the eight primary care professionals recruited using HEZ benefits and incentives, thirty community members who received scholarships to pursue entry-level health careers, and undetermined number of compensated and uncompensated Community Health Workers (aka Neighborhood Health Advocates) will continue to work in WBPCAC primary care settings and throughout the community, thus preserving the increases in the workforce that resulted from HEZ funding. Human Resources experts from the Collaborative and the literature will be consulted to identify methods to increase the likelihood of retention.

Further, HEZ Members who achieve NCQA PCMH recognition and/or join the Maryland pilot as a result of CARE's support will be better positioned to fund the continuation of these positions through the enhanced compensation and cost savings facilitated by these programs. The Neighborhood Health Advocates' continued stipends will be funded through the long-term sustainability activities described below.

Other aspects of the project that will continue in the foreseeable future at no additional costs are the expanded fitness venues that result from the YMCA initiative.

Funds to expand services during the HEZ period and continue programming beyond the project period will be sought through partnerships with the Collaborative's hospital members. WBPCAC will pursue agreements with these hospitals to share cost-savings that have been realized as a result of the Collaborative's coordinated efforts to (1) increase access to primary care in West Baltimore; (2) bring into primary care more difficult-to-reach populations; and (3) provide care coordination that improves outcomes, ultimately, reducing hospitalizations, readmissions, and unnecessary ED use.

The evaluation team will conduct an assessment of Collaborative members' information systems and data collection processes to ascertain the availability of information that will allow evaluation of cost savings. It is anticipated that this early review will yield metrics that allow preliminary calculation of HEZ project-related cost savings and development of a formula for cost-sharing within eighteen months of project implementation.

As information systems in the HEZ become more sophisticated and integrated, cost savings calculations and the formula for sharing these savings will be refined. Eventually, cost savings will be evaluated and shared savings will be disbursed annually. WBPCAC's portion of these

funds will be reinvested into the HEZ project with a pre-determined percentage disseminated to eligible WBPCAC members.

Regardless of continued funding, CARE will aim to permanently employ a Coordinator of Community and Strategic Partnerships to recruit additional members to the Collaborative who can contribute in-kind, material, or financial resources towards expanding and sustaining CARE's programs. This position will be deemed essential in the event of a reduction in force due to lack of funding.

Long-Term Sustainability: "Positioning and Sustaining":
During the initial stages of implementation, insurers will be invited to join the Collaborative. As members, they will learn the culture, concepts, and philosophy of the effort. As the project approaches the Sustainability phase, the Collaborative will work with insurers and the Center for Quality to determine a methodology for tracking and isolating cost savings as a foundation for sharing such savings. These savings will be shared with the Collaborative members using a pre-determined division between members and future operations of CARE.

At the outset of the grant preparation process, WBPCAC members formalized their commitment to collaboratively reduce CVD in West Baltimore by signing Memoranda of Understanding. (Appendix I) These pledges inspired a concerted search for local, state, federal, and foundation funding opportunities that partially or fully can support CARE. A detailed list of these opportunities and the status of WBPCAC's pursuit are detailed in Appendix J.

If strategies for attaining long-term success are unsuccessful, the Collaborative has created a plan for minimal operations that includes cross-training of staff, identification of essential programs and services, and a reduction in force. In the unfortunate event of this scenario, every effort will be made to absorb into WBPCAC members' organization any CARE personnel affected by the reduction in force.

During the Positioning phase, staff training will transition into a train-the-trainer model to allow continuation of this programming. Similarly, the Center for Quality will offer trainings on advanced data collection procedures to increase members' capacity to function without its support in the event of decreased or lost funding.

17. PROGRAM BUDGET AND JUSTIFICATION

Global Budget Form

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

Coordinating Organization Name: Bon Secours Baltimore Health System

HEZ Project Name: West Baltimore Primary Care Access Collaborative

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

Budget Request for Benefits and Incentives Applicants should choose from the listed benefits and incentives (items 1-8) and do **not** need to request funding from each benefit or incentives.	**Year 1 (January - December 2013)**	**Year 2 (January - December 2014)**	**Year 3 (January - December 2015)**	**Year 4 (January - December 2016)**	**Total HEZ Request**
1. State Tax Credits	$ 40,000	$ 40,000	$ 40,000	$ 40,000	$ 160,000
2. Hiring Tax Credits	$ 50,000	$ 50,000	$ -	$ -	$ 100,000
3. Loan Repayment Assistance	$ 200,000	$ 200,000	$ 200,000	$ 200,000	$ 800,000
4. Participation in the Patient Centered Medical Home Program					$ -
5. Electronic Health Records					$ -
6. Capital or Leasehold Improvements					$ -
7. Medical or Dental Equipment					$ -
8. CHRC Grant Funding*					$ -
8a. Bon Secours Baltimore Health System	$ 827,585	$ 838,360	$ 853,478	$ 844,081	$ 3,363,504
8d. Insert Organization 2					$ -
8d. Insert Organization 3					$ -
8d. Insert Organization 4					$ -
Subtotal for Benefits and Incentives	$ 1,117,585	$ 1,128,360	$ 1,093,478	$ 1,084,081	$ 4,423,504
9. Data Collection and Evaluation** (see exhibit)	$91,000	$102,930	$105,735	$108,617	$ 408,282
10. Indirect Costs***	$ 41,379	$ 41,918	$ 42,674	$ 42,204	$ 168,175
Totals	$ 1,249,964	$ 1,273,208	$ 1,241,887	$ 1,234,902	$ 4,999,961

*Applicants requesting CHRC Grant Funding must also complete Program Budget Form
** Data collection and evaluation should be between 5-10% of the subtotal for benefits and incentives.
*** Indirect Costs may be no more than 10% of the subtotal for benefits and incentives.

EVALUATION BUDGET	Year 1 (January - December 2013)	Year 2 (January - December 2014)	Year 3 (January - December 2015)	Year 4 (January - December 2016)	Total Organization Request
Personnel Salary					
80% FTE - TBH, Coordinator, Ctr.for Quality	$40,000	$49,200	$50,430	$51,691	$191,321
Fringe (15%)	$6,000	$7,380	$7,565	$7,754	$28,698
Contract with UMB Staff for Evaluation	$45,000	$46,350	$47,741	$49,173	$188,263
Totals	$91,000	$102,930	$105,735	$108,617	$408,282

Program Budget Form

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION
Health Enterprise Zones - Program Budget Template

Organization Name: Bon Secours Baltimore Health System

HEZ Project Name: West Baltimore Primary Care Access Collaborative

Grant Program Name: West Baltimore CARE

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

Budget Request for CHRC Grant Funding Add or remove lines as needed.	**Year 1 (January - December 2013)**	**Year 2 (January - December 2014)**	**Year 3 (January - December 2015)**	**Year 4 (January - December 2016)**	**Total Organization Request**
Personnel Salary (Year 1 Prorated - see exhibit)					
100 % FTE - [redacted], Project Director	$80,000	$82,000	$84,050	$86,151	$332,201
100% FTE - TBH, Coordinator, Ctr. Comm. Enrich.	$55,833	$68,675	$70,392	$72,152	$267,052
20% FTE - TBH, Coordinator, Ctr. Quality	$10,000	$12,300	$12,608	$12,923	$47,830
100% FTE - TBH, Comm Outreach Coordinator 1	$33,333	$41,000	$42,025	$43,076	$159,434
100% FTE - TBH, Coordinator, Training and Recruitment	$50,000	$61,500	$63,038	$64,613	$239,151
100% FTE - TBH, Mgr., Care Coordination	$58,333	$71,750	$73,544	$75,382	$279,009
100% FTE - TBH, Neighborhood Health Advocate 1	$18,200	$31,980	$32,780	$33,599	$116,558
100% FTE - TBH, Neighborhood Health Advocate 2	$18,200	$31,980	$32,780	$33,599	$116,558
100% FTE - TBH, Neighborhood Health Advocate 3	$18,200	$31,980	$32,780	$33,599	$116,558
100% FTE - TBH, Neighborhood Health Advocate 4	$18,200	$31,980	$32,780	$33,599	$116,558
100% FTE - TBH, Neighborhood Health Advocate 5	$18,200	$31,980	$32,780	$33,599	$116,558
see contractual Agreement for Additional Community Health Outreach Resources from University Of Maryland School of Social Work					
1. Personnel Subtotal	$378,500	$497,125	$509,553	$522,292	$1,907,470
2. Personnel Fringe (15% - Rate)	$56,775	$74,569	$76,433	$78,344	$286,121
3. Equipment/Furniture (see exhibit)	$28,550	$0	$0	$0	$28,550
4. Supplies	$12,000	$12,360	$12,731	$13,113	$50,204
5. Travel/Mileage/Parking	$12,000	$13,500	$13,905	$14,322	$53,727
6. Staff Trainings/Development	$5,000	$5,000	$5,000	$5,000	$20,000
7. Contractual (see exhibit)	$215,000	$65,000	$65,000	$40,000	$385,000
8. Other Expenses (see exhibit)	$119,760	$170,806	$170,856	$171,011	$632,432
Direct Costs Subtotal (lines 1-8)	$827,585	$838,360	$853,478	$844,081	$3,363,504
Indirect Costs (no more than 10% of direct costs)					$0
Totals	$827,585	$838,360	$853,478	$844,081	$3,363,504

Equipment Needs	Computer (one time)	Office Phone (one time)	Office Furniture (one time)	Printer (one time)	Cell Phone (Annual)	Land Line Phone (Annual)
Cost Per Item	*$ 1,600*	*$ 75*	*$ 1,000*	*various*	*$ 720*	*$ 600*
Personnel requiring equipment						
100 % FTE - [redacted], Project Director	$1,600		$ 1,000	$500	$720	$600
100% FTE - TBH, Coordinator, Ctr.for Quality	$1,600	$75	$ 1,000	$500	$720	$600
100% FTE - TBH, Coordinator, Ctr. Comm. Enrich.	$1,600	$75	$ 1,000	$1,400	$720	$600
100% FTE - TBH, Comm Outreach Coordinator 1	$1,600		$ 1,000	$500	$720	
100% FTE - TBH, Coordinator, Training and Recruitment	$1,600		$ 1,000	$1,400	$720	
100% FTE - TBH, Mgr., Care Coordination	$1,600		$ 1,000	$500	$720	
5 x 100% FTE- TBH, Neighborhood Health Advocates	$8,000				$3,600	
Subtotal	$17,600	$150	$6,000	$4,800	$7,920	$1,800
One Time Costs	$28,550					
Annual Costs	$9,720					

Contractual Expenses	Year 1	Year 2	Year 3	Year 4	Total
Contract					
YMCA Grant	$40,000	$0	$0	$0	$40,000
Curriculum Development / Delivery	$70,000	$10,000	$10,000	$10,000	$100,000
Targeted Interventions	$40,000	$20,000	$20,000	$0	$80,000
Community Partnership Grants	$45,000	$15,000	$15,000	$10,000	$85,000
University of Maryland School of Social Work - Stipends for four (4) MSW field placements to conduct outreach ($5K each); overseen by half time Field Instructor (In-Kind)	$20,000	$20,000	$20,000	$20,000	$80,000
Implementation Coordinator (to be provided IN-KIND)	$0	$0	$0	$0	$0
Subtotal	$215,000	$65,000	$65,000	$40,000	$385,000

Other Expenses	Year 1	Year 2	Year 3	Year 4	Total
Expense					
Cellular and Landline Phone Operating expense (50% subsidy)	$4,860	$5,006	$5,156	$5,311	$20,332
Scholarships to Community for health career programs (10 x $8,000 beginning Year 2)		$80,000	$80,000	$80,000	$240,000
PCMH Grants for Care Team Member subsidies (10 x $5,000)	$ 50,000	$ 50,000	$ 50,000	$ 50,000	$200,000
Meeting Expenses	$5,500	$5,000	$5,000	$5,000	$20,500
Printing / Reproduction Education Materials	$3,500	$3,400	$3,300	$3,300	$13,500
Multimedia Campaign	$55,900	$27,400	$27,400	$27,400	$138,100
Subtotal	$119,760	$170,806	$170,856	$171,011	$632,432

Personnel Salary - YEAR 1 Prorated	Annual Salary Year 1	# Months in service Year 1	Pro-Rated Salary Year 1
100 % FTE - [redacted], Project Director	$80,000	12	$80,000
100% FTE - TBH, Coordinator, Ctr. Comm. Enrich.	$67,000	10	$55,833
20% FTE - TBH, Coordinator, Ctr. Quality	$12,000	10	$10,000
100% FTE - TBH, Comm Outreach Coordinator 1	$40,000	10	$33,333
100% FTE - TBH, Neighborhood Health Advocate 1	$31,200	7	$18,200
100% FTE - TBH, Neighborhood Health Advocate 2	$31,200	7	$18,200
100% FTE - TBH, Neighborhood Health Advocate 3	$31,200	7	$18,200
100% FTE - TBH, Neighborhood Health Advocate 4	$31,200	7	$18,200
100% FTE - TBH, Neighborhood Health Advocate 5	$31,200	7	$18,200
100% FTE - TBH, Coordinator, Training and Recruitment	$60,000	10	$50,000
100% FTE - TBH, Mgr., Care Coordination	$70,000	10	$58,333

17. PROGRAM BUDGET AND JUSTIFICATION

Global Budget Justification:

The Global Budget for the West Baltimore Primary Care Access Collaborative – approximating $1.25 million annually- is made up of the following components:

- *State Tax Credits* and *Loan Repayment Assistance:* In an effort to fill vacancies and expand and enhance the Primary Care Work Force, eight (8) Primary Care Professionals will be recruited to practice at Collaborative member sites located within the HEZ. These professionals will be eligible for:
    - *State Income Tax Credits:* Assumed $5,000 of State Income Tax credits per provider annually ($40,000 total annually for 8 professionals)
    - *Loan Repayment Assistance*: $25,000 per provider annually ($200,000 total annually for 8 professionals)

- *Hiring Tax Credits:* In an effort to support PCMH collaborative members in adding qualified personnel to their care teams, CARE will extend ten (10) $10,000 hiring tax credits – for total cost of $100,000 spread over the first two years of the project ($50,000 annually). These hiring tax credits will be combined with stipend grants to PCMH members as identified below in the Program Budget Justification to support the annual salary of qualified personnel.

- *CHRC Grant Funding:* Grant funding will be awarded to Bon Secours Baltimore Health System (BSBHS) for implementation and operation of West Baltimore CARE and the various associated strategies identified throughout the HEZ application. Annual funding to BSBHS will be as follows:

    - Year 1: $827,585
    - Year 2: $838,360
    - Year 3: $853,478
    - Year 4: $844,081

    Justification detail for the annual grant allocations can be found in the Program Budget Justification below.

- *Data Collection and Evaluation:* Costs for the data collection and evaluation process described in the application range between 8% and 10% of the subtotal for benefits and incentives annually and are made up of the following costs:

    - Contract with University of Maryland at Baltimore for Professor Daniel Mullins and staff member totaling $45,000 in Year 1 with a 3% annual inflation in years 2-4.

    - 80% of the cost (salary and benefits) of the FTE to be hired as the Coordinator of the Center for Quality ($60,000 annual salary and fringe)

- Note: Center for Quality Coordinator is estimated as:
  - 10 months of salary in Year 1 assuming 60 days to recruit
  - Full Salary and Annual inflation rate of 2.5% applied in years 2-4
  - Fringe rate of 15%

- *Indirect costs:* Indirect costs are assumed at 5% of Total Grant Costs (approximately $42,000 annually) and will be utilized to cover such expenses as: legal, human resources / recruiting, finance / accounting, insurance, and other general overhead costs for the administration of the West Baltimore Primary Care Access Collaborative HEZ.

Program Budget Justification:

The West Baltimore Primary Care Access Collaborative has identified Bon Secours Baltimore Health System as the Coordinating Agency of the HEZ application and as such BSBHS will serve as the principal administrator of the Grant funds to support West Baltimore CARE and its associated strategies. As outlined in the Global Budget, Total CHRC Grant funding to BSBHS by year is:

- Year 1: $827,585
- Year 2: $838,360
- Year 3: $853,478
- Year 4: $844,081

The detailed costs are as follows:

- *Personnel:* The costs for Personnel that will staff West Baltimore CARE and its three Centers (The Center for Quality, The Center for Community Enrichment and The Center for Primary Care and Workforce Development) include the following 11 positions:

  - Project Director

  - Coordinator, Center for Community Enrichment

  - Coordinator, Center for Quality (80% of salary and fringe dedicated to evaluation and data collection budget)

  - Community Outreach Coordinator

  - Coordinator, Training and Recruitment

  - Manager, Care Coordination

- Five (5) Neighborhood Health Advocates

- Detailed responsibilities for each position can be found in the position descriptions outlined in the Appendices.

- NOTE: CARE will seek to raise additional resources to fund additional positions including:

    - Up to 2 Additional Community Outreach Coordinators
    - Up to 5 Additional Neighborhood Health Advocates
    - One Coordinator for Community and Strategic Partnerships
    - One Administrative Assistant
    - One Data Analyst in the Center for Quality

- NOTE: Personnel costs include the following assumptions.
    - Salary costs assume all positions will be hired within 60 days and on payroll for 10 months in Year 1. (NOTE: exception for Project Director who will be on payroll for 12 months and Neighborhood Health Advocates who will be on payroll for 7 months in Year 1).
    - Inflation factor of 2.5% is applied in Years 2-4 for salaries.

- *Personnel Fringe:*

    - Fringe costs are budgeted at 15% of total salary costs.

- *Equipment / Furniture:* Equipment and Furniture costs are budgeted at $30,150 in Year 1. One- time costs in Year 1 include:

    - 11 Laptop Computers for personnel and neighborhood health advocates @ $1,600 each ($17,600 total)
    - 2 Landline telephones to support Center for Quality and Center for Community Enrichment @ $75 each ($150 total)
    - 6 sets of desks / chairs for personnel offices @ $1,000 each ($6,000 total)
    - 2 Office Printers @ $1,400 each; 4 Desk Printers @ $500 each ($4,800 total)

- *Supplies:* General office supplies are budgeted at $1,000 per month to support CARE and the three (3) centers. Total Cost in Year 1 is $12,000 with a 3% inflation factor applied in Years 2-4.

- *Travel / Mileage / Parking:* Budgeted at $1,000 per month in Year 1 (annual cost $12,000), growing to $13,500 annual cost by Year 2 once Neighborhood Health Advocates are in full operation. An inflation factor of 3% is applied in Years 3 and 4.

- *Staff Training and Development:* Participation in one annual conference-including travel – is budgeted at $1,250 for each of the following positions:

    - Project Director
    - Coordinator, Center for Community Enrichment
    - Coordinator, Center for Quality
    - Coordinator, Training and Recruitment

- *Contractual:* CARE will partner with various community members, institutions, and community organizations to implement the following strategies included in the HEZ application:

    - YMCA Grant (Total Cost: $40,000): CARE will enter into a contract with the YMCA to work with community organizations and businesses to provide additional exercise opportunities in the community. This may entail providing funding and guidance to these entities to purchase and maintain fitness equipment. These new facilities will make available fitness classes and exercise facilities to patients being served by WBPCAC members. Funding is budgeted as $40,000 in Year 1.

    - Curriculum Development / Delivery (Total Cost: $100,000): CARE has budgeted $70,000 in Year 1, and $10,000 in years 2-4 to support the acquisition, development, and delivery of specialized curriculum to be provided in the Center for Primary Care and Workforce Development. Training will be administered to Care Coordinators, Neighborhood Health Advocates, and other members of partner care teams.

    - Targeted Interventions (Total Cost: $80,000): CARE has budgeted $40,000 in Year 1 and $20,000 in Years 2-3 which will be used to fund evidence based programs that advance the goals of the HEZ. Population-based approaches will emphasize communication, education and empowerment, and policy / environmental change. Community-based interventions will focus on promoting physical activity, improved nutrition, and smoking cessation.

    - Community Partnership Grants (Total Cost: $85,000): CARE has budgeted $45,000 in Year 1, $15,000 in Years 2-3, and $10,000 in Year 4 which will be used as grants to support the efforts of various community based partners that align with the goals and strategies outlined in the HEZ application. Examples of partners that may be eligible include churches, neighborhood associations, and other community based organizations that are not yet part of the Collaborative. Review and awarding of the grants will be completed by the Advisory Board of the Center for Community

Enrichment and overseen by the Coordinator of Community and Strategic Partnerships.

- University of Maryland School of Social Work ($20,000 annually): CARE will enter into a contract with the University of Maryland School of Social Work to fund stipends for four (4) Master of Social Work (MSW) students to conduct outreach in the community. Stipends will be $5,000 per student annually. The students will be overseen by a half time field instructor provided IN-KIND by the School of Social Work.

- Implementation Coordinator ($40,000; IN-KIND): The implementation coordinator will assist in implementing the project / executing the work plan for a specified engagement in the first year of operation. See position description in Appendices for specific responsibilities. This fee will be fully subsidized by the WBPCAC members.

- *Other Expenses:* CARE has budgeted the following Other Expenses

  - **50% subsidy using HEZ funds** to cover monthly expenses for cellular and landline telephones:
    - Cellular Telephones: 11 phones at $720 each ($7,920 total with a 3% inflation factor in Years 2-4)
    - Land Line Telephones: 3 phones at $600 each ($1,800 total in Year 1 with a 3% inflation factor in Years 2-4)

    - Total Cost Year 1: $9,720
    - *HALF (for HEZ Subsidy): $4,860; 3% inflation factor Years 2-4*

  - Health Career Scholarships ($80,000 annually beginning Year 2): Beginning in Year 2, CARE will distribute thirty (30) $8,000 scholarships (10 per year in Years 2-4) to community members so they may pursue health careers. The intention is that recipients will return to work in primary care practices in West Baltimore. Eligibility criteria and selection will be determined by the Advisory Board for the Center for Primary Care and Workforce Development, and administration

  - Grants to Collaborative PCMH members to support Care Team personnel ($50,000 annually): In an effort to support PCMH collaborative members in adding qualified personnel to their care teams, CARE will extend ten (10) $5,000 subsidies – for a total cost of $50,000 annually. These stipends will be combined with the Hiring Tax Credits as identified above in the Global Budget Justification to support the annual salary of qualified personnel.

- Meeting Expenses ($20,500 Total Costs): CARE has budgeted $5,500 in Year 1 and $5,000 in Years 2-4 to cover the costs of meetings with external stakeholders (food / beverage, material preparation, etc.)

- Printing / Reproduction of Education Materials ($13,500 Total Costs): CARE has budgeted $3,500 in Year 1, $3,400 in Year 2 and $3,300 in Years 3 and 4 for printing and reproduction of education materials to be distributed through The Center for Community Enrichment and its staff of Community Health Workers and Neighborhood Health Advocates.

- Multimedia Campaign ($138,100 Total Cost): Through the Center for Community Enrichment, CARE will plan and implement a multi-media community outreach plan. The campaign will endeavor to raise community-wide awareness about CVD, bring into care those who have CVD, and prevent CVD in at risk patients. The campaign will disseminate messages through:

    - billboards displayed throughout the HEZ service area
    - written materials distributed through Collaborative members and community partners
    - radio and television advertisements, and
    - participation in health fairs and community events

  Costs are budgeted at $55,900 in Year 1, decreasing to $27,400 in Years 2-4 with the intention that Collaborative Partners will contribute additional funds / pool their existing marketing resources to support the campaign needs.

Appendix

WBPCAC HEZ Project Resource Allocation (Average Year)

Member Training, Support, and Accountability - $389,000

Resources directed to **all Collaborative Members**. All activities result in new or enhanced direct services.

Programs and Services:

- HCP Recruitment
- PCMH Practice Training
- Care Coordination Mgt.
- Care Coordination Training
- Care Team Training
- CHW Training
- Data Mgt. Guidance
- Data Collection/Reporting
- Member Monitoring and Accountability
- Quality Improvement

Direct Services -- $413,000

Resources directed to community members, Park West Medical Center, People's Community Health, Total Health Care, Bon Secours Baltimore, Maryland General, Sinai Hospital, St. Agnes Hospital, and University of Maryland Medical Center.

Programs and Services:

- New MDs or NPs (8)
- New Primary Care Professionals (10)
- New Entry-Level Health Care Personnel (30)
- New CHWs (11)
- Disease Management Courses
- Medical/Social Svc Referrals
- Multimedia Community Education Campaign
- Enhanced Delivery of Primary Care and Care Coordination

HEZ Goals

1. #1 Reduce CVD
2. #2 Increase Primary Care Professionals
3. #3 Increase CHWs
4. #4 Increase Community Resources for Health
5. #5 Reduce preventable ED visits
6. #6 Reduce preventable hospitalizations
7. #7 Reduce HC costs

Community Partnerships $125,000

Resources directed to community members, Park West Medical Center, People's Community Health, Total Health Care, Equity Matters, Light Health and Wellness, Mosaic Community Services, NCADD Maryland, Bon Secours Baltimore, Maryland General, Sinai Hospital, St. Agnes Hospital, University of Maryland Medical Center, YMCA, and other community partners.

- Targeted Interventions Community Partnership Grants
- YMCA Partnership

HEZ Benefits - $290,000

Resources directed to community members, Park West Medical Center, People's Community Health, Total Health Care, Bon Secours Baltimore, Maryland General, Sinai Hospital, St. Agnes Hospital, and University of Maryland Medical Center.

Programs and Services:

- Loan Repayment Assistance
- State Tax Credits
- Hiring Tax Credits

Admin. $113,000

Legend for Administration of Programs and Services

- Center for Primary Care & Workforce Development
- Center for Quality
- Center for Community Enrichment

Summary WBPCAC Dashboard

Community Resource and Asset Exchange

For The One Month Ending June 2013

A = Annual Update, M = Monthly , ML = Month Lag, M2L = Two Month Lag, M3L = Three Month Lag

Variance Shading Index				
Type	>=	<=	>=	<=
Favorable	0.0%	0.0%	-2.8%	-2.9%
Favorable	2.9%	2.8%	0.0%	0.0%

	Indicator Description	Timing	Prior Yr YTD	Current Yr MTD	Current Yr YTD	Target	% Var to Tgt	% Var to PY	Type
Improved CVD Screening and Risk Factor Prevalence									
1	Primary Care Visit Volume	M	Being Evaluated						Favorable
2	% of Patients Assessed for Tobacco Use	M	Being Evaluated						Favorable
3	% of Tobacco Users Who Received Cessation Advice	M	Being Evaluated						Favorable
4	Proportion of Patients Who Are Current Smokers	M3L	Being Evaluated						Favorable
5	% of Patients with BMI Percentile and Counseling on Nutrition and Physical Activity	M	Being Evaluated						Favorable
6	% of Obese Patients	M3L	Being Evaluated						Favorable
7	% of Obese Patients Who Received Counseling on Nutrition and Physical Activity	M	Being Evaluated						Favorable
8	% of Hypertensive Adult Patients With Controlled Blood Pressures Lower Than 140/90	M	Being Evaluated						Favorable
9	% of Patients With Diabetic Screening	M	Being Evaluated						Favorable
10	% of Diabetic Adult Patients With Controlled HbA1c under 9%.	M	Being Evaluated						Favorable
11	% of Patients Reporting At least 30 Minutes of Exercise 3-5 Times/Week	M2L	Being Evaluated						Favorable
Reduced CVD Related ED Visits/Hospitalizations									
12	% of HTN Related ED Visits	M	Being Evaluated						Favorable
13	% of HTN Related Hospitalizations	M	Being Evaluated						Favorable
14	% of CVD Related ED Visits	M	Being Evaluated						Favorable
15	% of CVD Related Hospitalizations	M	Being Evaluated						Favorable
16	% of Diabetic Related ED Visits	M	Being Evaluated						Favorable
17	% of Diabetic Related Hospitalizations	M	Being Evaluated						Favorable
Reduced Overall Cost of Care for CVD Patients									
18	CVD LOS Ratio	M	Being Evaluated						Favorable
19	CVD Related Readmissions	M	Being Evaluated						Favorable
20	Total Cost per Case for Patients With CVD Primary Diagnosis	M	Being Evaluated						Favorable
21	% of HTN Related Preventable ED Visits	M	Being Evaluated						Favorable
22	% of HTN Related Preventable Hospitalizations	M	Being Evaluated						Favorable
23	% of CVD Related Preventable ED Visits	M	Being Evaluated						Favorable
24	% of CVD Related Preventable Hospitalizations	M	Being Evaluated						Favorable
25	% of Diabetic Related Preventable ED Visits	M	Being Evaluated						Favorable
26	% of Diabetic Related Preventable Hospitalizations	M	Being Evaluated						Favorable

Summary WBPCAC Dashboard

[Organization Name]

For The One Month Ending June 2013

A = Annual Update, M = Monthly , ML = Month Lag, M2L = Two Month Lag, M3L = Three Month Lag

Variance Shading Index				
Type	>=	<=	>=	<=
Favorable	0.0%	0.0%	-2.8%	-2.9%
Favorable	2.9%	2.8%	0.0%	0.0%

	Indicator Description	Timing	Prior Yr YTD	Current Yr MTD	Current Yr YTD	Target	% Var to Tgt	% Var to PY	Type
Improved CVD Screening and Risk Factor Prevalence									
1	Primary Care Visit Volume	M	Being Evaluated						Favorable
2	% of Patients Assessed for Tobacco Use	M	Being Evaluated						Favorable
3	% of Tobacco Users Who Received Cessation Advice	M	Being Evaluated						Favorable
4	Proportion of Patients Who Are Current Smokers	M3L	Being Evaluated						Favorable
5	% of Patients with BMI Percentile and Counseling on Nutrition and Physical Activity	M	Being Evaluated						Favorable
6	% of Obese Patients	M3L	Being Evaluated						Favorable
7	% of Obese Patients Who Received Counseling on Nutrition and Physical Activity	M	Being Evaluated						Favorable
8	% of Hypertensive Adult Patients With Controlled Blood Pressures Lower Than 140/90	M	Being Evaluated						Favorable
9	% of Patients With Diabetic Screening	M	Being Evaluated						Favorable
10	% of Diabetic Adult Patients With Controlled HbA1c under 9%.	M	Being Evaluated						Favorable
11	% of Patients Reporting At least 30 Minutes of Exercise 3-5 Times/Week	M2L	Being Evaluated						Favorable
Reduced CVD Related ED Visits/Hospitalizations									
12	% of HTN Related ED Visits	M	Being Evaluated						Favorable
13	% of HTN Related Hospitalizations	M	Being Evaluated						Favorable
14	% of CVD Related ED Visits	M	Being Evaluated						Favorable
15	% of CVD Related Hospitalizations	M	Being Evaluated						Favorable
16	% of Diabetic Related ED Visits	M	Being Evaluated						Favorable
17	% of Diabetic Related Hospitalizations	M	Being Evaluated						Favorable
Reduced Overall Cost of Care for CVD Patients									
18	CVD LOS Ratio	M	Being Evaluated						Favorable
19	CVD Related Readmissions	M	Being Evaluated						Favorable
20	Total Cost per Case for Patients With CVD Primary Diagnosis	M	Being Evaluated						Favorable
21	% of HTN Related Preventable ED Visits	M	Being Evaluated						Favorable
22	% of HTN Related Preventable Hospitalizations	M	Being Evaluated						Favorable
23	% of CVD Related Preventable ED Visits	M	Being Evaluated						Favorable
24	% of CVD Related Preventable Hospitalizations	M	Being Evaluated						Favorable
25	% of Diabetic Related Preventable ED Visits	M	Being Evaluated						Favorable
26	% of Diabetic Related Preventable Hospitalizations	M	Being Evaluated						Favorable
Improved Access, Care Capacity, and Health Delivery									
	Expanded Primary Care Workforce								
27	# of New Primary Care Providers Added Using HEZ Incentives/Benefits	M	N/A						Favorable
28	Total # of New Primary Care Providers Added	M	N/A						Favorable

Appendix A

West Baltimore Primary Care Access Collaborative Members

The sixteen members of the West Baltimore Primary Care Access Collaborative (WBPCAC) have expressed their support of and commitment to the Collaborative by signing a Memorandum of Understanding. A sample of the MOU follows this page.

Collectively, the WBPCAC has donated more than 12,000 man hours to establishing the Collaborative and preparing the HEZ grant proposal. Current members are listed below.

- Baltimore Medical System
- Bon Secours Baltimore Health System
- Coppin State University
- Equity Matters
- Light Health and Wellness Comprehensive Services, Inc.
- Maryland General Hospital
- Mosaic Community Services
- National Council on Alcohol and Drug Dependence, Maryland
- Park West Health System, Inc.
- People's Community Health Centers.
- Saint Agnes Hospital
- Senator Verna Jones Rodwell
- Sinai Hospital of Baltimore
- Total Health Care, Inc.
- University of Maryland Medical Center
- University of Maryland, Baltimore

Appendix B

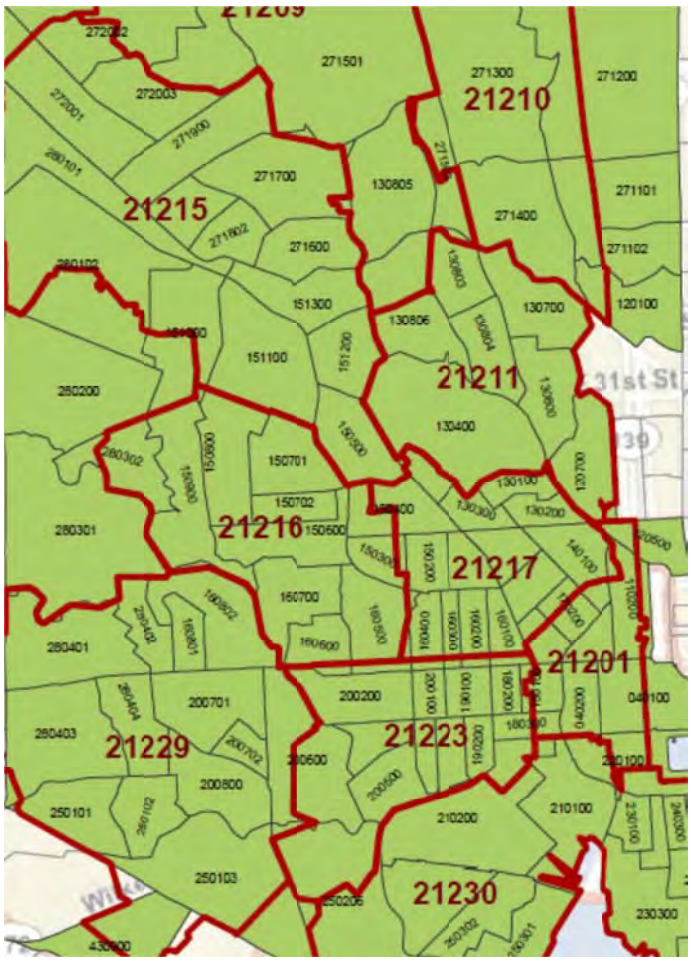
Additional Data Tables for West Baltimore

	21216		21217		21223		21229		All	
	Total	**%**	**Total**	**%**	**Total**	**%**	**Total**	**%**		
Total population	32071	100%	37111	100%	26366	100%	45213	100%	140761	
Race										
White	415	1.30%	3624	9.80%	5039	19.10%	8422	18.60%	17500	12.21
Black or African American	30992	96.60%	32255	86.90%	19821	75.20%	34253	75.80%	117321	81.89
American Indian and Alaska Native	69	0.20%	89	0.20%	129	0.50%	137	0.30%	424	
Asian	55	0.20%	369	1%	338	1.30%	1257	2.80%	2019	
Some Other Race	86	0.30%	131	0.40%	444	1.70%	280	0.60%	941	
Hispanic or Latino (of any race)	341	1.10%	501	1.40%	816	3.10%	891	2%	2549	

Prevalence per hospital discharge rate						
	21216	**21217**	**21223**	**21229**	**MD**	**Balto. City**
% Preventable ED visits	55%	55%	54%	55%	48	53
Asthma per 100,000	582	722	847	382	166	419
Cancer per 100,000	976	944	1067	1007	608	886
Diabetes per 100,000	845	869	911	666	240	558
Major CVD per 100,000	4501	4945	5618	3973	2284	3773
Cerebrovascular per 100,000	869	839	872	744	430	651
COPD per 100,000	1048	1267	1870	826	427	506
Hypertension per 100,000	238	261	349	147	66	168

West Baltimore Primary Care Access Collaborative Target Area

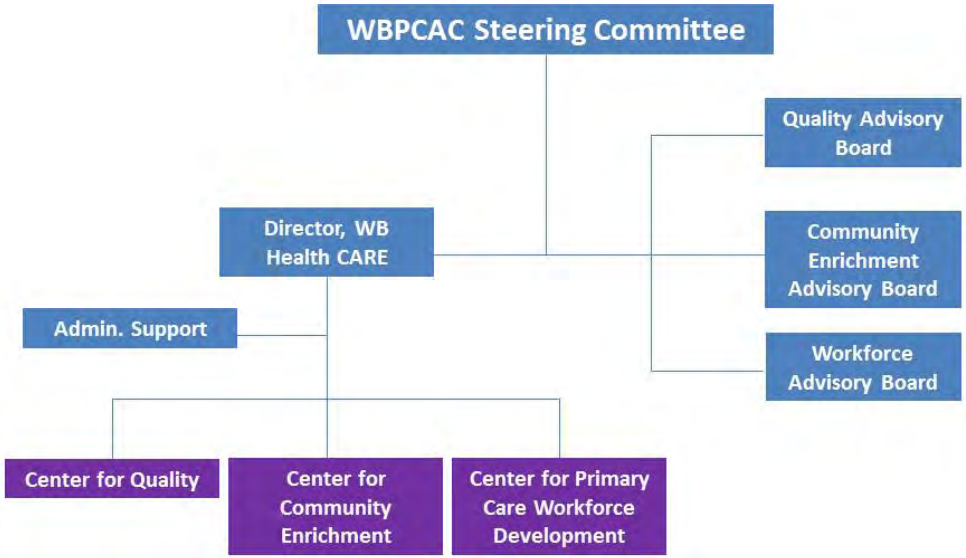
Zip Codes 21216, 21217, 21223, 21229



Appendix C

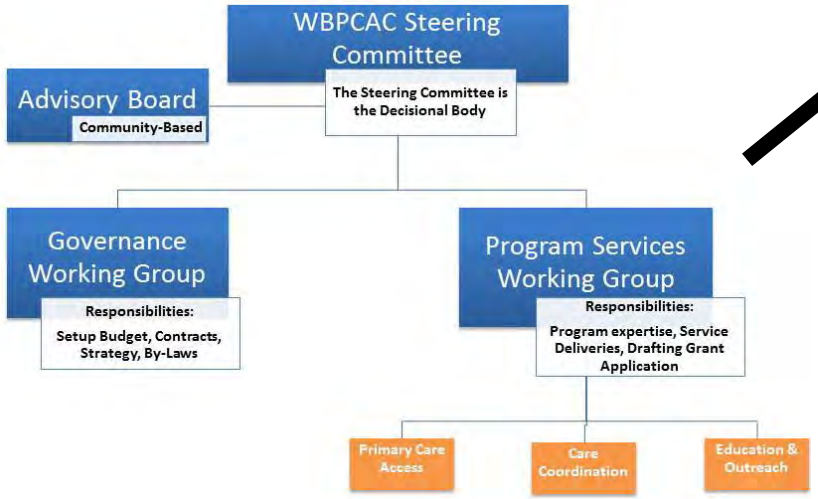
West Baltimore Health CARE

(HEZ Project)



WBPCAC Current Structure

(Prior to HEZ Funding)



Appendix D

West Baltimore CARE

Patient Experience Scenarios

West Baltimore CARE Patient Experience #2: Emergency Department Care Coordination

ED Care Coordination Nurse refers patient to primary care provider

Patient

Pt. sees primary care provider; PCP treats patient and refers to Care Team

PCMH Care Team assesses , treats, and refers patient

RN **Pt.** **CHW**

Patient continues to see PCP and Care Team

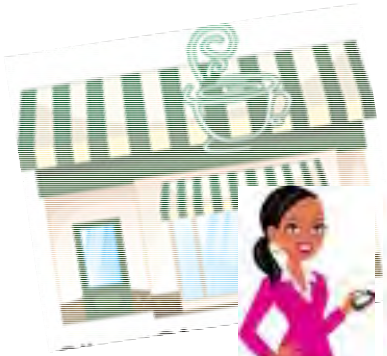
Patient becomes a Medical Assistant and joins a PCMH Care Team

CARE gives patient $10,000 scholarship to Medical Assisting Program

CARE teaches Disease Management Course; provides Discounted Fitness Membership

Social Services and Program to address Social Determinants

West Baltimore CARE Patient Experience #1: Community Outreach



Community Health Worker encounters patient at coffee shop

Pt. sees primary care provider; PCP treats patient and refers to Care Team

PCMH Care Team assesses , treats, and refers patient

CHW **Pt.** **RN**

Patient

CHW visits patient's home. Assists patient in rescheduling and keeping appointments

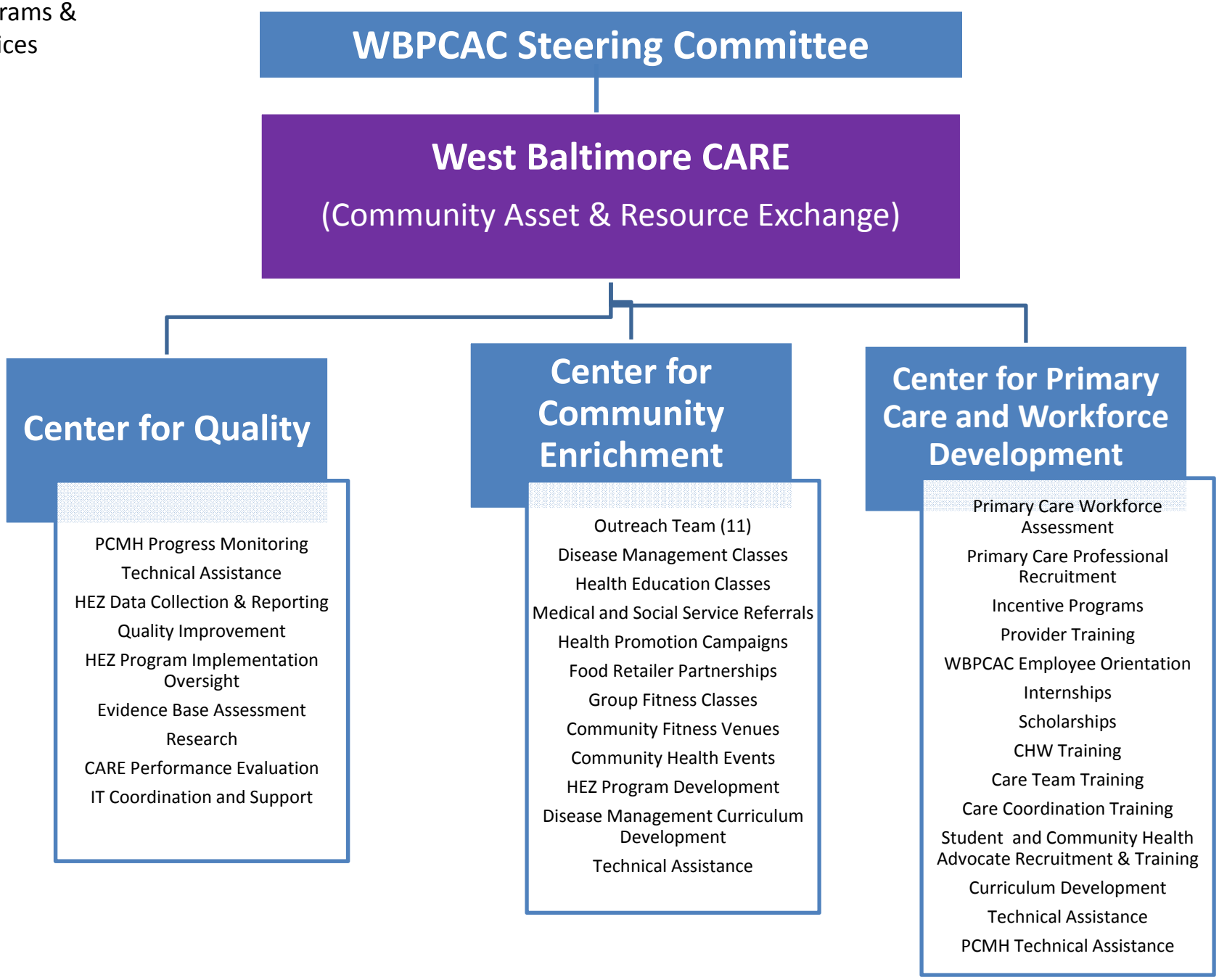
Patient **does not** go to CARE for classes and referrals

X X

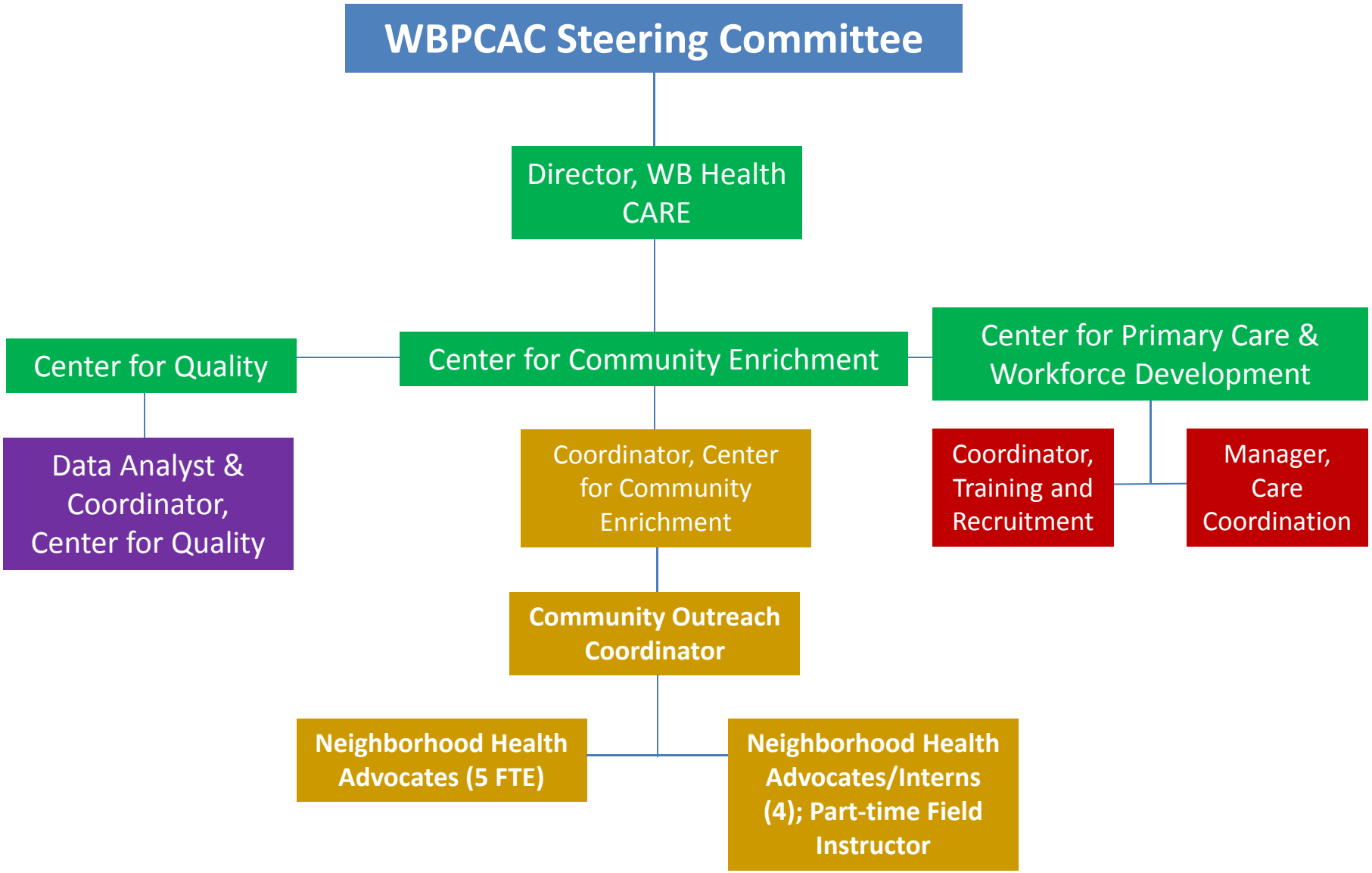
Patient **does not** go to Pharmacist for medication counseling

Social Services and Program to address Social Determinants

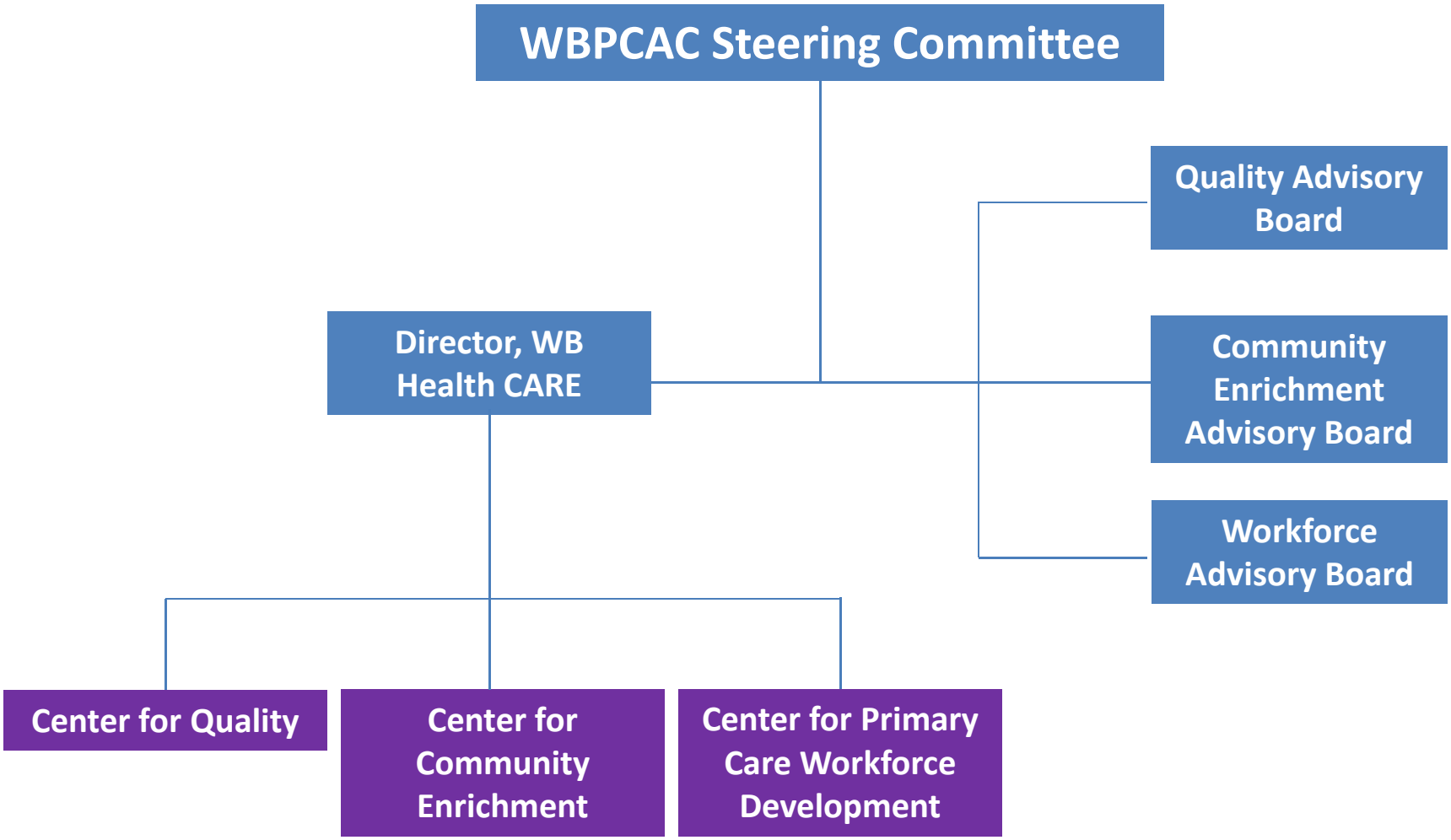
Programs & Services



West Baltimore CARE Organizational Structure



West Baltimore CARE Organizational Structure



Appendix E

WBPCAC Sample Training Schedule and Descriptions

- **Practice Facilitators to Promote Team Care -** Train the Trainer Program – Developed by Maryland Learning Collaborative –Core Curriculum Developed enabling key staff in each PCMH to help practices operationalize effective teams and support practices to define and specify roles of team members and workflows, as facilitate team development and capacity.

- **Screening, Brief Intervention, and Referral Treatment (SBIRT) Training** This will be an evidence based program assisted by Behavioral Health Experts and Faculty and Staff from the University of Maryland's School of Social Work. Care Coordination Team members will be trained in over 34 randomized trials in primary care and ER settings that demonstrate effectiveness of SBIRT in reducing substance abuse. The courses in SBIRT Training will include: defining roles, distributing risks among care team members, and developing capacity through electronic or paper records to monitor which patients have been reached.

- **Motivational Interviewing Course I** begins with an Introduction to Motivational Interviewing with the Spirit of MI (Evocation, Collaboration and Autonomy/Support) through experiential activities, didactic lecture with Power Point and podcast, the use of audio/video MI sessions of several different fields including Healthcare, Mental Health/Substance Misuse, Criminal Justice settings, Public Health and others. This course will include both audio and video demonstrations of MI, identifying and eliciting Change Talk, integrating the micro-skills of Questions, Affirmations, Reflections and Summaries. Forming therapeutic alliance, rolling with resistance (Sustain Talk) and "following the path of Change Talk" will be addressed.

  There will be emphasis on the development and use of Support and Autonomy Statements. We will focus on developing Active Listening skills, where the practitioner hears the "message within the message." We also demonstrate the use of Higher Level Affirmations.

- **Course II MI** continues with Change Talk, and focusing on reinforcing Change Talk in strategic ways that allow the practitioner to continue to move towards the goal (target behavior) while maintaining a collaborative spirit. The focus is "guide on the side, not sage on the stage." The movement of Phase 1 (Building Alliance) to Phase 2 (Negotiating Change Plans) will be the primary focus, and techniques specific to that will be demonstrated and practiced. This highly interactive course will include "real time" interaction whenever possible. Brief Motivational Interviewing will be introduced, and the learner will complete development of the use of Pocket Guides for each learner's setting. Continued work on accurate complex reflections, evocative questions, Elicit/Provide/Elicit and Agenda Setting will be acquired.

- **Course III MI** will include focus on strength of Change and Commitment Talk,

the Development of Action Plans, coaching focusing on Autonomy language, higher level affirmations, reflections, supports and continued focus on "what might be" rather than "what was done in the past". Difficulties such as non-verbal clients, mandated clients, patients who appear to be choosing paths that may lead to extremely negative consequences, and the potential use of MI in groups as well as couple/family therapy will be demonstrated and practiced. The use of MI in Feedback and Coaching will complete the course with the practitioners using their best MI skills to practice feedback/coaching with their peers in the course.

- **Cultural Competence and Diversity Training –** Will discuss overall organizational cultural competence as well as focus on the specific population groups and/or health issues that are relevant to this HEZ community. It will address the linguistic access needs of patients with limited English proficiency, as outlined in the National Standards on Culturally and Linguistically Appropriate Services (CLAS) in health care, developed by the Office of Minority Health (OMH) in 2000.

  The course in Cultural Competency will start with broad overview of the African American population, its historical development in this area and an in depth understanding of the cultural and health disparities plaguing this community. This program will address three themes of the CLAS standards: organizational, clinical and linguistic competence. Prior to the development of the CLAS guidelines, most cultural competency training focused on organizational issues of cultural diversity. But a well-rounded program also should help clinicians with diagnostic issues, such as identifying health conditions specific to certain ethnic patient populations or conducting skin assessments for patients with skin of color.

Care Coordination and Care Coordinator Training

- Courses will include:
- Assuming accountability for care coordination;
- Providing patient support for completing patient referrals;
- Developing relationships and agreements with key outside providers
- Establishing connectivity that assures appropriate information transfer.

  This program will cover the work-flow within practices and between practice and referral communities (e.g. specialists, ERs, community based resources) to ensure that patients understand how everything fits together, exercise appropriate engagement in their care decision-making, and experience whole person care that addresses their needs.

Community Health Worker Training

The Core Curriculum will be developed around the following topics:

- CHW role and history
- Communication Skills
- Interpersonal Skills
- Informal Counseling
- Service Coordination Skills
- Capacity Building Skills
- Advocacy Skills
- Technical Skills
- Organizational Skills
- Research Skills
- Disease and Illness Skills

Improving Patient-centered Interactions and Cultural Competency

This course will focus on the following:

- Implementing a process for all practice teams to learn about patient and family centered care
- Appoint a patient and family centered steering committee comprised of patients and families, and formal and informal leaders of the practice – findings from this effort will shape a part of the curriculum
- Develop assessment models to determine compliance within PCMHs with the principles and concepts.
- Trained in developing action plans to better meet the PCMH needs
- Develop community strategies to keep families and other community members involved in the process
- Learn Training and Teaching techniques that will better serve the needs of the community

Community Education and Enrichment Course Offerings

- Conducting media and education campaigns to raise community awareness.
- Conducting community-based cardiovascular health screening, referral, and follow-up services using a mobile screening unit and health fairs.
- Conducting nutrition education (including shopping tours, cooking schools, and healthy eating classes) and physical activity classes.
- Training community health advocates to conduct comprehensive heart health awareness activities to increase the adoption of heart-healthy lifestyles.
- Conducting professional education training.

The proposed strategies will focus on all four NHLBI performance goals:

- Prevent development of risk factors.
- Detect and treat risk factors.
- Recognize and treat acute coronary syndromes early.
- Prevent recurrence and complications of CVD

The Community Based Education will achieve the following:

- Increase awareness of and action to control CVD risk factors.
- Increase adoption of heart-healthy lifestyle behaviors through implementation of community-based exercise, nutrition and weight management, smoking cessation, and blood pressure control interventions.
- Increase physicians' awareness and application of the latest NHLBI CVD "best practice" interventions.

Other related courses include:

- **General Overview of Patient Centered Medical Homes – how they function, and matching appropriate resources with community member needs.** This course will provide an introduction and welcome to community members on a regular basis to ask questions and spend time with representatives from various PCMHs operation around this HEZ area. The doctors leading this program will outline the course offerings that will be available to the community over the next 6-12 weeks and encourage people to sign up.

Appendix F

WBPCAC Existing Cardiovascular Disease Targeted Resources

Collaborative Partner	Existing CVD Related Programs and Services	Existing CVD Community Risk Reduction Efforts
St. Agnes	CHF self-monitoring and symptom management program; Education on cardiac and stroke signs and symptoms and importance of 911, and use of designated stroke and cardiac intervention centers; Heart Failure Center provides on-going support for coronary disease; Cardiovascular/Diabetes dedicated staff include: Nurse Practitioners; certified diabetic educators; cardiac rehab nurses, exercise physiologists, dieticians, preventive cardiology nurse, and lifestyle management coaches.	Public seminars on Bariatric Surgery and wellness via Well4life, diabetes training classes, vascular screenings, Women's Heart Check, speaker series throughout Baltimore City on CVD; Red Dress Sunday: outreach, education, and assessment program designed to raise awareness of the devastating effects of heart disease among women, that reaches 130 churches in the Baltimore area, with an emphasis on underserved communities; Women's Heart Health Symposium: provides education on heart health to our faith-based partners and the community-at-large.
Bon Secours Baltimore	CVD Specific Distress Zone Alert literature and teaching to ensure that the patient can verbalize understanding of when to visit primary care vs. ED for disease management; Dedicated CVD Parish Nurse Outreach Program.	Staff participate in medication review and provide smoking cessation education at assisted living facilities; Conducts COPD and CVD targeted community health fairs and outreach.
Total Health Care	CVD related education including: Diabetic and Nutrition, Weight Management, Healthy Meals, Exercise, Smoking Cessation, Medication Management, Diabetic Clinic, and Healthy Heart Education Programs; Materials used: Health Related brochures and audio visual tools.	Conducts community outreach activities that include: Distribution of patient health education materials, community resource information, sponsorship/participation in community events, health screenings (BP, Diabetes, HIV education, testing and counseling), door-to-door canvasing, and linkage to care via phone appointment scheduling.
Coppin		Conducts Healthy Me program, which is designed to teach a healthy lifestyle for all students, and to evaluate effect on overweight and obese adolescents. Program includes nutritional education and exercise periods.
UMMC	Social worker and nurse care coordinator provides home visit as needed to aid in the management of chronic disease; Social worker and nurse care coordinator coordinates follow up visits post hospitalization for chronic disease prevention, including Obesity/CVD/Diabetes, and addressing barriers to	Conducts 3-4 large major community events and over 60 smaller health fairs/events annually – including CVD screenings, education, walks and fitness events, and cooking demos; Partnership with school of nursing to address childhood

	care access; Dedicated diabetic nurse educator.	obesity;
Maryland General		Partners with the American Diabetes Association to provide community education on diabetes and will soon begin offering free smoking cessation courses to the community; Provides free screenings for blood pressure, cholesterol and glucose levels, at off-site community health events.
Baltimore Medical System	Provides education materials on CVD, nutrition, and chronic disease management; Contracts with a company which does automated outreach for current patients who need preventive services or chronic care follow-up.	Provides 4 outreach workers that target smoking cessation and 3 community health workers targeting chronic disease management programs; Houses a site of Health Leads which is staffed with Student volunteers to address social determinants of health, amongst other things.

Appendix G

Sample Topics and Questions for Qualitative Impact Evaluation

Capitalizing upon the evaluation team's strengths and expertise from prior strategies used for community-based assessment of health-improving and health disparities-reducing programs, we propose to conduct focus group and key informant interviews. These interviews will enhance the quantitative assessment. Interviews will address topics and utilize questions similar to those shown below, yet be modified to reflect topics that are mutually agreed upon between the WBPCAC and the CHRC.

Community needs assessment and quality of community engagement: How has the WBPCAC understood (probe: valued? addressed?) the needs of patients, providers, and community members from the West Baltimore HEZ? Are all relevant stakeholders engaged in the WBPCAC? (probe: if not, what types of individuals are missing? how can they be engaged?) How are key stakeholders informed of progress and any changes to the WBPCAC? (probe: are there better ways to provide updates?) Do WBPCAC activities address patients' cultural and linguistic needs? (if not, what's missing?) What are community members' views (positive and negative) about the WBPCAC and how the community is engaged in HEZ activities?

Implementation, quality improvement, and sustainability: What are/were the barriers and facilitators to incentivizing health care providers to participate in the WBPCAC HEZ? (probe: are there other incentives that should be considered in the future)? What practices worked/did not work for engaging and activating patients? (probe: what are the best mechanisms for referring patients to PCMHs)? What is/would be required to guarantee sustainability of the WBPCAC HEZ? (probe: what is your institution willing to provide to enhance sustainability?) What are the "lessons learned" and suggestions for continuous quality improvement? (probe: what implementation issues or alterations would be required to extend the HEZ outside of West Baltimore?)

Appendix H

WBPCAC CARE Sustainability Plan

Phase 1	Phase 2	Phase 3	Phase 4
Developing	**Strengthening**	**Positioning**	**Sustaining**
• Recruit CARE Staff • Finalize PCMH model and curriculum • Finalize community health training curricula • Refine Advisory Boards • Recruit Community Health Team • Train staff and volunteers	• Deploy staff and volunteers • Hire primary care professionals • Initiate relationships with potential funders • Initiate relationships with insurers	• Strengthen relationships with potential funders • Establish cost-sharing relationships with insurers • Cross train staff	• Continue activities previously funded by HEZ • Fund CARE through grant funds, member contributions, shared cost savings with insurers

Appendix I

WEST BALTIMORE PRIMARY CARE ACCESS COLLABORATIVE
Memorandum of Understanding

As a result of the Maryland Health Improvement and Disparities Reduction Act of 2012 with a focus on Health Enterprise Zones and the possibility of creating a qualitative change in the health and wellness of the Citizens of West Baltimore the Principal Organizations identified below agree to work together in developing a winning grant application and creating an organizational structure that will meet the needs of the community and the participating members of the collaborative.

The West Baltimore Primary Care Collaborative (WBPCAC) Mission is:

The West Baltimore Health Care Collaborative is a community partnership of health care providers, local officials, and community organizations. We commit to improving the health outcomes and well-being of underserved residents in Central-West and Southwest Baltimore by developing sustainable models that incorporate innovative care coordination and community engagement.

The Vision is:

The Collaborative's innovative care coordination, chronic disease management, and community engagement methods will result in Central-West and Southwest Baltimore becoming a vital, healthy community and will be held as a national model for health improvement. The collaborative envisions a future where residents of our community will be empowered to take ownership of their health, and will have the expectation of living full, healthy lives.

The WBPCAC has identified its three principle areas of focus as being:

1. Developing a robust care coordination service plan that ensures coordination among the participating members of the collaborative.
2. Develop strong communications and integrated services into the community through state of the art technology.
3. Transform the health care workforce so access, coordination, and patient engagement are vastly improved.

A. Purpose

The purpose of this Memorandum is to specify the agreement of the individual Principal Organizations, as participants in the "West Baltimore Primary Care Access Collaborative," hereinafter referred to as the "WBPCAC." The parties to this memorandum agree to participate in this health care quality improvement project. The goal of the project is to improve the quality of cardiovascular care in a cost effective manner through partnerships and collaborations using innovative solutions, and proven, evidence-based practices.

B. Project Scope

The WBPCAC Scope of Work entails all participating organizations working together to develop a successful proposal in response to the HEZ Grant Request for Proposals. This effort will entail developing detailed plans in the areas of Primary Care Capacity, Care Coordination and Case Management, Medical Home Development, Service Integration, Better Use of Hospital Emergency Rooms, and Collaboration and Partnership Models. This effort will entail careful coordination with each member organization, identifying the resource capabilities and possible business models that will work with each entity. The Collaborative will be responsible for developing a corporate non-profit structure, a governance program that will focus on collaborative decision-making, securing additional funding sources, establishing formal partnering relationships with community members, developing operating budgets, and overseeing the business model being established for this effort. In addition, in order to further the purpose of improving the quality of health in West Baltimore, the WBPCAC agrees to work to achieve a long-lasting, sustainable Care Collaborative.

C. Commitment and Expectations

Each participating organization in the WBPCAC is expected to provide the necessary resources including staff time and expertise, funding and overall support to accomplish the Project Scope. It is understood that each entity will participate in all the Working Group and Steering Group meetings to the extent feasible either through their principal representative or an alternate. Each participating organization shall pay its share of the costs of developing the proposal. This may include but not be limited to a Grant Writer, a Health Care Consultant, or other requirements that the Steering Committee/Governance may require.

Each signatory organization agrees that it will participate only in this Health Enterprise Zone proposal under the auspices of the WBPCAC. Member organizations agree to disclose any known or anticipated conflicts with the Governance Working Group upon knowing of any such conflict. The WBPCAC recognizes that each member organization will be pursuing other grant applications and will provide updates if there are opportunities that might exist for the WBPCAC to participate.

Each participating organization will have an opportunity to recommit to the Collaborative prior to filing the grant application. It is expected that a separate set of legal documents will be developed that will provide the obligations and commitments for Member organizations going forward.

D. Schedule

The anticipated proposal schedule is June 26, 2012 with the commencement of the Steering Committee and will conclude on or around November 15, 2012 with submission of the HEZ Grant Application.

Working Group and Steering Committee Meetings will be scheduled regularly during this timeframe in order to develop an effective and winning proposal.

E. Good Faith and Trust

The participating organizations targeting the communities located in the Central and Southwest sections of Baltimore (covering the zip codes of 21216, 21217, 21223 and 21229), agree to work towards entering into a long term collaborative agreement that establishes the necessary organizational and business planning models that will sustain and carry out its Mission and Vision. The first phase of this effort entails each member organization providing the necessary staff and to share equitably in providing the resources to produce a successful and winning grant proposal that secures the Maryland Health Enterprise Zone Grant plus positions itself for other long term funding opportunities.

It is anticipated that organizations in the future will want to become part of the WBPCAC albeit as a full member or as an Advisory Board Member. The WBPCAC

members desire to be inclusive and work with all community based organizations throughout this process. During the grant application process the WBPCAC will maintain a list of all organizations interested in joining the collaborative and will establish decision-making criteria that can be used to determine which of these applicants ought to be invited to join the collaborative.

The following organizations hereby commit to participating and supporting a successful grant application and any other grant applications that are submitted consistent with the overall purpose of the WBPCAC Vision and Mission.

_____

Signature Date

_____

Printed
Member Organization Name

Appendix J

HEZ GRANT PROPOSAL – SUSTAINABILITY SUPPLEMENT

The WBPCAC will continue discussions and negotiations with our foundational, state and federal partners as we proceed after grant award. In finalizing these agreements the WBPCAC will identify direct benefits and cost savings with our private insurers (MCOs and Care First) and the Center for Medicare and Medicaid Services. The WBPCAC will work with each of our Partner Development Offices to identify and establish joint projects for new grants coming into the community.

A. The WBPCAC Coordination and Training/Work Force Development Center Trains Hundreds of Staff and Impacts Potentially Thousands from the Local Community

- The HEZ Grant will enable the WBPCAC to direct attention to **Federal Programs such as the Departments of Education, Labor and HHS,** for community based education and work force development projects.
- The HEZ Grant establishes the **Training and Workforce Development Center at Maryland General Hospital Center and positions it for greater access and support through various University programs.** The University partners in collaboration with the WBPCAC are developing pathways to include students and faculty in multi-disciplinary forms of learning at the Training Center and in the Center for Community Enrichment. The President of the University (Dr. Perman), its Dean and Faculty at the Schools of Social Work Pharmacy, Nursing, and Medicine commit themselves in full to this effort.

B. WBPCAC Will Increase Staffing Capacity at the PCMH – With Lasting Impacts Beyond the HEZ

- **The WBPCAC has begun working with its foundation partners and other philanthropic centers.** With support from our partner foundations, the WBPCAC will access funding opportunities to expand the programs outlined in this grant proposal. These areas may include development work, staffing capacity, and other areas that are of importance to the particular foundation. These foundations may include:
    - Harry and Jeanette Weinberg Foundation, Inc.
    - The Abell Foundation
    - Goldseker Foundation
    - Saint Agnes Foundation
    - Bon Secours Health Systems Foundation, and national entities such as the Robert Woods Johnson Foundation and the Bill and Melinda Gates Foundations. A few immediate examples include:

Sinai Hospital Center will provide a Medical Fellows Program: The goal of the Urban Medicine Fellowship is to provide a strong educational and clinical foundation for primary care physicians who will remain dedicated to the clinical practice and teaching of primary care medicine in medically underserved communities. The Fellowship experience is structured to provide Fellows with skills in working in multidisciplinary clinical and non-clinical teams that emphasizes longitudinal relationships with parents

and their families, chronic disease management, health promotion and disease prevention, cultural competence and the medical home model.

The Fellowship Program Director will assign weekly lectures for the Fellow to attend at either the home institution, or the University of Maryland Medical Center, St. Agnes and other partners in the West Baltimore Collaborative. Fellows will gain teaching experience by pre-accepting residents in continuity clinics from their home institution and other residency programs in the Collaborative. In addition, Fellows will make presentations in the home institution's grand rounds and resident didactic series. Fellows will receive feedback from their program director and faculty on their teaching and presentation skills.

C. Emergency Department Cultural Change - Nurse Navigation Teams Providing Moving Patients Appropriately to PCMHs

- The WBPCAC has begun discussions with Senior Leadership at the **Substance Abuse and Mental Health Services Administration (SAMSA)** to create new vehicles to work with Centers for Medicare and Medicaid Services funds. See CMS Pilot Project establishing PCMH around substance abuse patients in Rhode Island.. The WBPCAC are in process of working on grant funding applications through our partners Mosaic and Light Health and Wellness.
- **Expanded use of hand-held devices and telephones at the PCMH for patient use**. Additional grant funds will be acquired through the University of Maryland's programs that track increase in compliance with medication and diabetic testing protocols. This model enables the WBPCAC to develop and implement a pilot project in one or more PCMHs, track results and receive additional funding.
- WBPCAC Partners have begun **negotiations with associated Managed Care Organizations** to clarify the incentives that can be provided by improved Value Based Purchasing models in conjunction with the State Department of Health and Mental Hygiene (DHMH). This will provide ongoing subsidies for increased staffing at the PCMH level. This effort will position the WBPCAC to lower the cost of care, improve the overall quality of care delivery and ultimately to improve the patient's experience. As the WBPCAC establishes itself as an Accountable Care Organization, documents reduction in Intensive Care Unit visits, Emergency Room and other hospital use there are economic benefits that will flow to all parties.
- The University of Maryland School of Nursing has identified a **Medical Van unit** that can move into operation and be used to provide additional staff resources to the various PCMH Centers. Discussions are in place to secure this resource fort the WBPCAC.
- The WBPCAC has begun negotiations and discussions with Care First for future funding sources. The collaborative will work with Baltimore Medical Systems, Park West and Total who are already establishing reimbursements with the largest health insurance provider in the State.
- The WBPCAC will continue working directly with its Hospital Partners, Bon Secours, Sinai Hospital of Baltimore, Saint Agnes, and Maryland General to identify State Hospital and Benefits Grants that can go directly to support the community

enrichment efforts planned under this effort.

D. The Community Enrichment Programs Providing Essential Education and Empowerment Health Programs Survive the HEZ

- **Saint Agnes Hospital Heart-to-Heart Program**: Identifies and assesses underserved, low-income African-American women at high risk for cardiovascular disease (CVD) and provides a community-based church intervention program including nutrition, physical activity and healthy lifestyle education to reduce their risk for heart disease as measured by clinically significant improvements in laboratory and CVD risk profiles at four and ten month intervals after program initiation. Secured Funding: $344,500.

  -Saint Agnes Hospital Pre-Diabetes Education Program: The WBPCAC will work with Saint Agnes to identify people in the targeted zip code area with pre-diabetes and deliver lifestyle interventions through the implementation of a Pre-Diabetes Education program to reduce their risk of developing type 2 diabetes. **Secured Funding: $90,000**

- The WBPCAC has identified and begun preliminary discussions with **Information Technology partners** including the IBM Foundation and others to work with our existing assets and IT infrastructure developing an E-Medical System that is state of the art, supports our partners in achieving PCMH certifications, and serves our patients so there is one patient record being utilized across the collaborative that respects and abides by all privacy laws.

  -The University of Maryland's Institute for Clinical and Translational Sciences has just issued an RFP for two $75,000 pilot studies that are intended to be submitted to address issues of community health that involve university investigators and community partners. The goals of this program are consistent with those of the proposed HEZ and members of the WBPCAC are able to apply for these resources.

  - The WBPCAC is preliminary exploring options with the Joint Center who has committed up to a $50,000 matching grant and an additional $100,000 of in-kind support upon receipt of the HEZ Grant. These funds are being offered by the Pew Foundation, the Annie E. Casey Foundation, the Open Society Institute, the W.K. Kellogg Foundation, and Kaiser Permanente of the mid-Atlantic States.

  - The WBPCAC Project Team have begun discussions with mdLogix an IT firm that is developing a commercial portfolio of innovative health science informatics solutions, including its flagship Clinical Research Management System (CRMS) integrated product suite. The CRMS is an enterprise scale, web based, end-to-end clinical research management solution, the largest CRMS deployment current has over 6,000 studies (over 1,500 active) and over 90,000 research subjects.

  -The WBPCAC has begun discussions with the YMCA about expanding the YMCA's role in managing physical activity programs in West Baltimore through the **30x30 Healthy Communities Coalition Initiative** of the National Forum for Black Public Administrators. The YMCA USA has received substantial federal funding for programs of this nature and is supporting the **30x30 Initiative** to improve the health of key communities across the United States.

- The University of Maryland also is submitting an application to the National Institutes of Health for a Clinical and Translational Science Center award of greater than $35 million over a five year period. The leaders of this initiative are Drs.

Stephen Davis and Alan Shuldiner. If awarded, the program will feature the WBPCAC HEZ as one of the areas that will be emphasized for the conduct of transnational research that is intended to benefit the health of the community.

- Capital Investments that will establish improved community centers for fitness, nutrition and relevant programs for the community to enjoy and benefit from are contemplated as part of this longer term effort. The WBPCAC will seek capital funds to develop **feasibility studies, identify anchor tenants, develop capital campaigns and fund drives, hire design and architect teams, and begin construction or renovations.** Possible project sites that have been identified include:

  -Coppin State University is currently working to develop the Hebrew Orphanage as an Emergency WBPCAC Center. There is also a prospect of having a community based education and outreach component. The WBPCAC may choose to partner with Coppin State in this effort and have this as a needed resource for the community.

  -Bon Secours Baltimore Health Systems working with Baltimore City's Department of Economic Development have identified certain possible project sites that are being considered for Community Centers.

- The Baltimore City Health Department has numerous programs that the WBPCAC is planning on working together on throughout the course of this initial grant period. The future programming anticipated by the Health Department will be a continued source of technical excellence and resources that we hope to leverage.
- Baltimore City Block Grants will be a key source of funding during this initial period to launch the WBPCAC. With $14-$16M awarded in annual grants for organizations that are focused on improving the overall quality of health and welfare for members of the community.

The WBPCAC has already accomplished what has never before been done in this City – organize 16 key partners working together to solve and bring about a healthy population in West Baltimore. The Collaborative has the necessary resources to dramatically reduce Cardio Vascular Disease and other underlying risk factors occurring in the four zip codes that form this HEZ. We have identified some projects that will serve as additional doorways for members of the community to enter into a comprehensive health care program. One other program, worthy of mention is the **Saint Agnes Hospital Cardinal Gibbons project as a cross-sector collaboration.** Saint Agnes Hospital has invested $9M in the Cardinal Gibbons property to develop an innovative plan merging health and community development in collaboration with partners across multiple sectors building a stronger and healthier community, while preserving the rich history of Cardinal Gibbons. Best practices and innovative projects have demonstrated that the intersection between health and our environment with a focus on housing, transportation, recreation and other environmental factors, can transform the health of neighborhoods creating safer, healthier and more vibrant communities.

Appendix K

Position Descriptions and Resumes

West Baltimore Health CARE (WBHC)

Position Descriptions

Director, WBHC

Under the direction of the WBPCAC Steering Committee, the Director of WBHC will oversee all activities of West Baltimore Health CARE, including:

- Coordinate activities of the Center for Primary Care and Workforce Development
- Manage the Coordinators of the Center for Community Enrichment and Center for Quality
- Manage the Coordinator of Training and Recruitment
- Manage the Manager of Care Coordination
- Along with their respective Chairs, coordinate the meetings and agendas of the three advisory boards
- Identify and pursue funding opportunities to support CARE's activities
- Recruit additional members into Collaborative
- Represent CARE in community and beyond
- Assess overall programming

Qualifications and Experience

- Master's degree in public health, public administration, or a related field or equivalent experience
- Minimum five years experience in community health, public health, health care
- Minimum five years experience managing at the executive level
- Experience managing and participating in coalitions, collaboratives, or multiple partnerships
- Knowledge of health care, health insurance,
- Clinical experience
- Qualitative and quantitative data analysis

Coordinator, Center for Community Enrichment

Under the direction of the Director of CARE, the Coordinator for Community Enrichment will oversee all activities and programs within the Center, including:

- Lead curriculum development for disease management and health promotion courses
- Identify and coordinate faculty for disease management and health promotion course
- Create schedule for and promote disease management and health promotion courses
- Directly manage Community Outreach Manager
- Develop with the Outreach Manager the outreach plan for the overall initiative
- Oversee activities of entire outreach team
- Develop and implement community education campaign
- Organize and execute community events related to health
- Collect and report data on activities occurring through Center for Community Enrichment

- Develop plan for recruiting and retaining Neighborhood Health Advocates

Qualifications and Experience

- Master's degree in public health, community health, public administration or equivalent experience
- Experience with outreach
- Experience with health promotion campaigns
- Health literacy, cultural competency
- Curriculum development

Coordinator, Training and Recruitment

Under the direction of the Director of CARE, the Coordinator of Training and Recruitment will:

- Coordinate development of curriculum for trainings and orientation for all primary care disciplines
- Develop and promote training schedule
- Plan and manage the volunteer recruitment process/program
- Coordinate internships
- Coordinate scholarship program
- Coordinate/administer primary care provider incentive program

Qualifications and Experience

- Master's degree in related field
- Experience working with clinical practitioners
- Experience in curriculum development
- Experience with volunteer management
- Data collection and reporting

Coordinator, Center for Quality

Under the direction of the Director of CARE, the Coordinator for the Center for Quality will:

- Collect and compile all data related to HEZ and Collaborative activities
- Prepare and submit HEZ grant reports
- Establish data collection and reporting system for the Collaborative
- Oversee implementation of patient-centered approach to care across Collaborative
- Assess proposed programs for evidence base, innovation, or promise
- Provide technical assistance to Collaborative members
- Manage Data Analyst

- Prepare and submit reports to Steering Committee on progress of Collaborative and HEZ programs
- Ensure fulfillment of/adherence to HEZ principles and requirements
- Regularly assess data collection instruments and systems utilized by the Collaborative

Qualifications and Experience

- Master's degree in related field or clinical degree
- Experience coordinating data collection for large project
- Preparing grant reports

Data Analyst

Under the direction of the Coordinator of the Center for Quality, the Data Analyst will:

- Receive and synthesize all data related to the Collaborative
- Make recommendations for IT systems and software to facilitate data collection
- Respond to data requests
- Develop data collection instruments
- Provide technical assistance to Collaborative members in data collection efforts

Qualifications and Experience

- Master's degree in related field
- Experience coordinating data collection for large project

Implementation Coordinator

In assisting the Steering Committee and their designees in implementing the project/executing the work plan, the Implementation Coordinator will have the following qualifications and experience:

- Master's Degree in a related field
- Implementing and working in grant-funded projects
- Developing or overseeing development of data collection instruments and systems
- Data collection and reporting
- Assessing IT systems
- Developing or coordinating identification of curricula
- Working in community health, health care, and/or public health setting
- Developing or coordinating development of policy and procedures
- Developing or coordinating development of contracts and Memoranda of Understanding
- Recruiting, interviewing, and hiring staff; developing job descriptions

Outreach Coordinators

Under the direction of the Coordinator of the Center for Community Enrichment, Outreach Coordinators will:

- Supervise Neighborhood Health Advocates
- Support Outreach Manager
- Staff community events and activities
- Work with NHAs in the community
- Partner with Collaborative members
- Address and lead NHAs in addressing social determinants of health

Qualifications and Experience

- Bachelors degree or equivalent years experience
- Knowledge of neighborhoods served by WBHC
- Supervisory experience
- Excellent interpersonal and communications skills

Neighborhood Health Advocates

Based in the offices and clinics of Collaborative members, and under the direction of the Outreach Coordinator, the Neighborhood Health Advocates will:

- Support primary care team and share information based on community contact
- Make home visits in collaboration with the Outreach Coordinator
- Facilitate community-based education and identification of persons at high-risk or living with disease
- Report and work with Coordinator to address social determinants
- With training, perform routine, non-invasive health assessments (eg. BP)
- Staff community events and activities
- Assist in identifying venues for community events and activities

Qualifications and Experience

- Knowledge of neighborhoods served by WBHC
- Excellent inter-personal and communications skills

GREGORY SCOTT KEARNS

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Gregory_Kearns@bshsi.org

PROFILE

Dynamic Health Care Administrator with eight years of progressive experience in a $3.2 billion not-for-profit Catholic health system with numerous hospitals and other facilities. Diverse experience includes providing project management support to CEO for strategic planning initiatives, leading of a major real estate divestiture, and managing $150 million in annual capital expenditures. Strong analytical, verbal and written communication skills. Experience breaking down complex issues to identify creative solutions to problems. Able to handle multiple projects at the same time and exhibit a high degree of flexibility when presented with shifting priorities. Considerable experience interacting with senior leadership, boards of directors, and external stakeholders with a high degree of respect and professionalism.

EXPERIENCE

Bon Secours Baltimore Health System, Baltimore, MD March 2011-Present

Director, Strategic Management

- Lead the project team for a 16 member collaborative including 5 hospitals, 4 FQHCs, mental health providers and community based organizations to develop a request to the State of Maryland for designation of West Baltimore as a Health Enterprise Zone; lead development of meeting materials, work plans, and facilitate all communication amongst collaborative members, consultants, and grant writers.
- Served as system liaison for a Primary Care Access Study to identify gaps in supply and demand for primary care services, potential barriers to access, and a plan for expanded access in West Baltimore.
- Served as system lead on a multi-provider collaborative to achieve funding from the CMS Innovation Center for a Care Transitions grant to reduce inter and intra hospital readmissions amongst Medicare fee-for-service patients.
- Complete comprehensive current state assessments on an array of clinical, community support, and education/outreach programs to better coordinate care and set priorities for growth and expansion.
- Participate in a Community Engagement task force responsible for engaging community residents in the health system's strategic planning process.
- Provide project management support to Chief Executive Officer of Baltimore Health System for strategic planning initiatives.
- Prepare presentations for the CEO in meetings with internal and external stakeholders including the Board of Directors, legislators, city and state health departments, potential partners, and the philanthropic community.

Bon Secours Health System, Inc., Marriottsville, MD June 2004-March 2011
(System includes 18 acute-care hospitals, five skilled nursing facilities, four assisted living facilities, multiple home care and hospice programs, outpatient centers and a growing network of employed physicians)

Senior Manager, Strategic Performance (December 2009-March 2011)

- Led a $6.8 million real estate divestiture: negotiated purchase agreement, coordinated buyer due diligence, managed communication with all stakeholders, and led negotiations to achieve forgiveness of $5 million of State and City loans.

- Partnered with a Maryland State Senator to organize a West Baltimore Health Care Summit bringing together over 100 participants representing hospitals, federally qualified health centers, physicians, philanthropic organizations, higher education, and community members to focus on improving access to primary care.
- Led the overhaul and streamlining of the review and approval process for 15 types of transactions.

Manager, Strategic Performance (July 2006 – December 2009)

- Provided staff support in negotiations with State legislators and the Governor to achieve a one-time $5 million operating grant from the Maryland Family Health Administration.
- Designed and managed process for submission, review and allocation of $100-150 million in capital funds annually.
- Prepared senior management presentations to rating agencies and bond insurers in preparation for a $265 million debt issue.
- Coordinated Chief Operating Officer's staff support to achieve divestiture of a two hospital local system; participated in presentations to bidders and conducted reverse due diligence**.**
- Managed strategic relationships with vendors and banks to lease $10 million of medical equipment annually.
- Managed review process to obtain senior management and board approvals for capital, real estate, joint venture, and physician related transactions.

Analyst, Strategic Projects (April 2005 – July 2006)

- Analyzed business plans and pro-forma financial statements of projects prior to CEO's approval.
- Led system-wide implementation of a web-based system for submission of strategic business plans and financial pro-formas.
- Led development of a balanced dashboard for use by management and the board of directors to monitor performance on key financial, quality, and patient, physician and employee satisfaction indicators.
- Prepared various presentations for use by the COO in meetings with the board and health system leadership.

Administrative Resident (June 2004 – April 2005)

- Led task force to recommend priorities for growth of ambulatory services to the board of directors.
- Coordinated task force to recommend improvements to health system's corporate responsibility program.
- Organized Tsunami relief donation and employee gift matching program that resulted in a gift of $295,000 to Catholic Relief Services.

EDUCATION

Master of Health Administration, Virginia Commonwealth University, Richmond, VA, May 2005
Bon Secours Scholar (prestigious scholarship which included tuition, monthly stipend and a paid internship)

Bachelor of Science, *cum laude,* Spring Hill College, Mobile, AL, May 2002
Biology Major, Honors Program, Alpha Sigma Nu Jesuit Honor Society, Dean's List

OTHER

American College of Healthcare Executives, Member	2002-present
Maryland Association of Health Care Executives, Member	2004-present
Healthcare Leaders of New York	2011-present
Catholic Health Association *Tomorrow's Leaders* Honoree	2012

Novella Tascoe Hunter, RRT, MSHA, JD

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SUMMARY OF QUALIFICATIONS

- 10 years of health care clinical experience as a Registered Respiratory Therapist.
- Knowledge of health care laws, regulations, and operations.
- Experience in health legislation and policy analysis.
- Skilled in writing, communication, research, strategic management, and community organizing.

EDUCATION

Georgia State University, J. Mack Robinson College of Business Atlanta, Georgia
Master of Science, Health Administration May 2012

- G.P.A.: 3.61/4.0
- R. J. Knobel Scholarship Recipient: Academic Performance, Professional and Community Service Distinction
- NAHSE Case Competition Participant

Georgia State University, College of Law Atlanta, Georgia
Doctor of Jurisprudence May 2012

- G.P.A.: 3.23/4.0
- Member, Student Health Law Association
- **Health Law Partnership Clinic** Conducted Client Intake and Representation, Conducted Client Counseling, Reviewed Medical Records to Establish Claims, Filed Motions, Drafted Letter Briefs, Amicus Documentation, Represented Clients in Hearings to Establish State and Federal Entitlements

John Marshall Law School Atlanta, Georgia
Candidate for Juris Doctor August 2009-July 2010

- G.P.A.: 3.30/4.0, Top 5% (6/141)
- Vice President, Corporate Law Society; Chair of Community Service, Black Law Student Association
- Solomon Scholarship Recipient: Awarded to Top 15 Full Time Students; Association of Corporate Counsel, Internship & Scholarship Recipient; CALI Award Recipient: Legal Writing, Research, and Analysis

Armstrong Atlantic State University Savannah, Georgia
Bachelor of Science, Respiratory Therapy May 2002

- Dean's List; Kappa Alpha Psi Scholarship Recipient: Outstanding Mentorship and Community Involvement; Recognized by Office of Minority Affairs: Outstanding Academic Achievement and Community Service

EXPERIENCE

Current

Bon Secours Baltimore Health System Baltimore, Maryland
Administrative Fellow June 2012-Present

- Assisting in managing multi-collaborative group for Health Enterprise Zone Legislative Initiative, including, drafting letters and briefs, assisting in developing strategic and tactical approach for response to RFP, assisting in convening multi-stakeholder group, and analyzing and communicating key legislative points; assisting CEO in meeting facilitation and strategic planning; managing special hospital operational and stewardship initiatives.

Legal

Fulton County, Office of the Solicitor General Atlanta, Georgia
Legal Intern January 2012- April 2012

- Prosecuting misdemeanor crimes, conducting negotiations, interviewing law enforcement personnel and victims, engaging in settlement agreements, examining witnesses and defendants, conducting legal research.

United States Department of Health and Human Services, Office of the Regional Director Atlanta, Georgia
Policy Intern July 2011- October 2011

- Advised the Regional Director on health legislation and policy; conducted community town halls regarding the Affordable Care Act and health care advocacy; attended congressional briefings and senior staff meetings, conducted briefings on Medicare, Medicaid, and the Affordable Care Act.

Health Legislation and Advocacy Clinical Practicum Atlanta, Georgia
Legal Extern August 2010- May 2011

- Drafted health care legislation for implementation of the ACA in Georgia, conducted client counseling and consultation, conducted grassroots organizing, drafted letters to legislators, created community education materials on health policy and legislation, tracked legislation and drafted floor testimony, briefed legislators and community advocates on health policy and the Affordable Care Act.

United States Department of the Interior, Office of the Regional Solicitor Atlanta, Georgia
Legal Intern September 2010-July 2011

- Drafted legal memoranda; conducted discovery and responded to discovery requests; represented the Agency in Equal Employment Opportunity Commission proceedings; reviewed EEOC complaints; researched environmental legal issues; reviewed contracts and affiliation agreements for governmental agencies; counseled governmental agencies on employment practices and procedures; engaged in settlement negotiations

Association of Corporate Counsel Atlanta, Georgia
Summer Legal Intern: Scholarship Recipient June 2010-August 2010

- **American Cancer Society, Inc.**: Drafted legal memoranda, conducted legal research, client consultation, redlined contracts, responded to permission requests (3 weeks)
- **Pre Visor Inc.**: Drafted legal memorandum, conducted legal research, reviewed contracts, attended weekly operational meetings (3 weeks)
- **Delta Airlines, Inc.**: Drafted legal memoranda, legal research, reviewed of EEOC charges, reviewed position statements, reviewed briefs prepared by outside counsel, attended weekly Human Resources' meetings. (1 month)

Grady Health System Atlanta, Georgia
Legal Intern May 2010

- Performed initial review of contracts and affiliation agreements drafted and negotiated contracts, employee dispute resolution, patient dispute resolution, drafted legal memoranda and motions, conducted legal research, and attended meetings under the direct supervision of Grady In-house Associate General Counsel.

Clinical

South Fulton Medical Center East Point, Georgia
Registered Respiratory Therapist December 2002 – January 2004, May 2011- May 2012

- Oriented new therapists, supervised students during clinical rotations, therapist driven ventilator management, arterial puncture and analysis, neonatal and adult intubation, clinically managed patients in critical care and intensive care units.

Emory Eastside Medical Center Snellville, Georgia
Registered Respiratory Therapist January 2009 – March 2011

- Administered care as the primary Neonatal Therapist, mechanical ventilation management, arterial blood gas analysis, capillary blood gas analysis, surfactant administration, high frequency oscillator management, continuous positive airway pressure administration and management, trained neonatal therapists, oriented new therapists, cardio pulmonary resuscitation, hand held nebulizer administration, metered dose inhaler administration, assisted in initiating therapist driven patient protocols.

Northside Hospital Atlanta, Georgia
Registered Respiratory Therapist October 2004 – January 2009

- Trained and oriented new employees, mechanical ventilator management, surfactant administration, riboviran therapy, high frequency oscillator management, jet ventilation management, arterial blood gas draws and analysis, hand held nebulizer therapy, metered dose inhaler administration, protocol initiation and evaluation.

ACTIVITIES

- American College of Healthcare Executives, National Association of Health Service Executives, Future Healthcare Executives
- Atlanta Bar Association, Georgia Association of Black Women Attorneys, Gate City Bar Association, American Bar Association

C. DANIEL MULLINS, PHD

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EDUCATION

Ph.D.	Economics, Duke University, 1994	
B.S.	Economics, M.I.T., 1986	

EMPLOYMENT

UNIVERSITY OF MARYLAND SCHOOL OF PHARMACY

Professor *July 2003 - present*
Chair, Pharmaceutical Health Services Research Department *April 2003 – July 2008*
Associate Director, Center on Drugs & Public Policy *December 2000 - present*
Associate Professor/Graduate Program Director *July 1999 - June 2003*
Assistant Professor *July 1995 - June 1999*

Research and teaching focuses on pharmacoeconomics, pharmaceutical/health outcomes research, health disparities, pharmaceutical pricing, and economic analysis of the pharmaceutical industry. Teaching responsibilities include a PhD/PharmD course on *Pharmaceutical Economics* and a PharmD course on *Context of Health Care* and lectures in various other classes.

UNIVERSITY OF NORTH CAROLINA SCHOOL OF PHARMACY

Director of Graduate Studies *July 1994 - July 1995*
Assistant Professor *July 1993 - July 1995*

Awards

2008 International Society For Pharmacoeconomics and Outcomes Research (ISPOR) Service Award
2007 Dr. Patricia Sokolove Outstanding Mentor Award (University of Maryland Baltimore Graduate Student Association campus-wide Award)
2006 International Society For Pharmacoeconomics and Outcomes Research (ISPOR) Service Award
2002 ISPOR 5th Annual European Congress Best Podium Presentation
2002 Drug Information Association (DIA) Outstanding Service Award
1998 Faculty Development Award in Pharmacoeconomics. Provides $40,000/year for 2 years Source: Pharmaceutical Research and Manufacturers of America (PhRMA) Foundation

Grants

"Heterogeneous Treatment Effects: DNA vs. MSA." Source: National Pharmaceutical Council 2012; $151,109 (Principal Investigator).

"Cancer Related Bone Metastasis." Source: Amgen Inc. 2011; $433,950 (Co-Principal Investigator; Principal Investigator = Arif Hussain, MD).

"Interviews to Identify Evidence for Eliciting the Hard to Reach Patient's Perspective in PCOR." Source: PCORI (contract PCORI-SOL-PCWG-002) 2011; $125,000 (Principal Investigator).

"Modifying Contact Precautions for MRSA in Extended Care." Source: **AHRQ (R18HS019979-01A1)** 2011; (Economist; Principal Investigator = Mary-Claire Roghmann, MD, MS).

"Colon Cancer SEER-Medicare CER: HEOR." Source: Bayer HealthCare Pharmaceuticals 2011; $398,700 (Principal Investigator).

"Prostate Cancer SEER-Medicare CER: HEOR." Source: Bayer HealthCare Pharmaceuticals 2011; $393,300 (Co-Principal Investigator; Principal Investigator = Eberechukwu Onukwugha, PhD).

"Treatment Selection and CER of Liver Cancer Treatment." Source: Bayer HealthCare Pharmaceuticals 2010; $399,999 (Co-Principal Investigator; Principal Investigator = Fadia T. Shaya, PhD, MPH).

"Interpreting IV Estimates with Treatment Effect Heterogeneity: ACE/ARBs & Race." Source: **NIH/NIA (1RC4AG038635-01)** 2010; $1,458,033 (co-Investigator; Principal Investigator = John M. Brooks, PhD).

"Do Bayesian Adaptive Trials Offer Advantages for CER?" Source: **NIH/NHLBI (1RC4HL106363-01)** 2010; $1,499,866 (Principal Investigator).

"The Value of Atorvastatin over the Product Life Cycle." Source: Pfizer 2010; $84,000 (Principal Investigator).

"Cost Study of Linezolid versus Vancomycin among Hospitalized Patients." Source: Pfizer 2010; $235,224 (Principal Investigator).

"FDA/CDER University of Maryland Basic Topics in Statistics: ANOVA, ANCOVA, Linear Regression, Logistics Regression and Survival Analysis." Source: Food and Drug Administration (FDA) 2010; $30,000 (Principal Investigator).

"Patient Flow and VTE Incidence among Colon Cancer Patients." Source: Sanofi-Aventis 2009; $237,600 (Principal Investigator).

"Analysis of the Baltimore Community Health Partnership (CHP): Feasibility and Effectiveness of Baltimore Community-based Engagement in MTM Adherence." Source: Sanofi-Aventis 2009; $244,026 (Multiple Principal Investigators = C. Daniel Mullins, PhD and Fadia T. Shaya, PhD, MPH).

"The Comparative Effectiveness of Tiotropium Plus Long-Acting β2-agonist in the Treatment of Chronic Obstructive Pulmonary Disease at the Veterans Affairs Maryland Health Care System." Source: Novartis 2009; $132,384 (Co-Investigator; Principal Investigator = Ebere Onukwugha, PhD).

"Treatment and Survival among Men Diagnosed with Prostate Cancer: An examination of newer management strategies and therapies." Source: Sanofi-Aventis 2009; $421,809 (Multiple Principal Investigators = C. Daniel Mullins, PhD and Ebere Onukwugha, PhD).

"Treatment Patterns, Outcomes, and Costs Related to Colon Cancer." Source: Sanofi-Aventis 2009; $319,337 (Multiple Principal Investigators = C. Daniel Mullins, PhD and Ebere Onukwugha, PhD).

"The Economic Burden of Overactive Bladder Symptoms." Source: Pfizer, Inc 2008; $113,605 (Co-Investigator; Principal Investigator = Ebere Onukwugha, PhD).

"FDA/CDER University of Maryland Basic Topics in Statistics: ANOVA, ANCOVA, Linear Regression, Logistics Regression and Survival Analysis." Source: Food and Drug Administration (FDA) 2008; $30,000 (Principal Investigator).

"Response to Medicare Reimbursement Policy Change by Minority and All ESRD Patients." Source: **NIH/NIA (R21AG033791)** 2008; $325,433 (Principal Investigator).

"Computerized Decision Support at the Time of a Prescription." Source: Department of Veterans Affairs Health Services Research and Development Service (HSR&D) 2008; $110,810 (Co-Investigator; Principal Investigator = Sylvain DeLisle, MD, MBA).
"Maryland Men's CardioVascular Health Promotion Program (MVP)." Source: CareFirst BlueCross BlueShield 2008; $1,000,000 (Co-Investigator; Principal Investigator = Fadia T. Shaya, PhD, MPH).
"Treatment Patterns, Costs, and Outcomes across Various Cancer Sites." Source: Sanofi-Aventis 2007; $690,000 (Principal Investigator).
"Improving Quality through Health IT: Testing the Feasibility and Assessing the Impact of Using Existing Health IT Infrastructure for Better Care Delivery." Source: **AHRQ HHSA290200600022, Task Order #3** 2007; $393,457 (Consultant; Principal Investigator = Romana Hasnain-Wynia, PhD).
"Antithrombotic Therapy Outcomes Research Compendium." Source: Pfizer 2007; $129,357 (Principal Investigator).
"Linezolid vs. Vancomycin Outcomes among MRSA Patients." Source: Pfizer 2007; $322,676 (Principal Investigator).
"White Paper on Cost/QALY Threshold." Source: GlaxoSmithKline 2007; $55,000 (Principal Investigator).
"Health care utilization and spending among a commercially-insured population using antipsychotics: the influence of drug characteristics." Source: Bristol-Myers Squibb 2007; $144,160 (Co-Investigator; Principal Investigator = Linda Simoni-Wastila, RPh, PhD).
"Barriers to Preemptive Kidney Transplantation." Source National Kidney Foundation 2007; $25,000 (Co-Investigator; Principal Investigator = Françoise G. Pradel, PhD).
"Adverse Event Costs in Osteoarthritis NSAID Users." Source: Novartis 2007; $124,314 (Principal Investigator).
"Sutent Budget Impact Model and Dossier." Source: Pfizer 2006; $80,711 (Principal Investigator).
"Interface for Sutent Budget Impact Model." Source: Pfizer 2006; $29,383 (Principal Investigator).
"White Paper on Access to Drugs in the Medicare Part D era." Source: Pfizer 2006; $18,000 (Principal Investigator).
"Treatment Patterns, Costs, and Outcomes of Chemotherapy in Prostate and Lung Cancers." Source: Sanofi-Aventis 2006; $488,464 (Principal Investigator).
"Use and Outcomes of Novel Chemotherapeutic Agents in Colorectal Cancer" Source: Sanofi-Aventis 2006; $650,514 (Principal Investigator).
"Pharmacy Dispensing Cost Analysis." Source: Maryland Department of Health and Mental Hygiene (DHMH) 2006; $24,395 (Principal Investigator).
"Pharmaceutical Health Policy Seminar Series." Source: Pfizer 2006; $50,000 (Principal Investigator).
"Cost-effectiveness Analysis of Sutent versus Interferon-α as First-line Treatment for Metastatic Renal Cell Carcinoma." Source: Pfizer 2006; $60,000 (Principal Investigator).
"Cost Per Successfully Treated Patient (CPSTP) Estimates for Medicaid Patients." Source: Pfizer 2006; $45,578 (Principal Investigator).
"Formulary Tier Placement for Commonly Prescribed Drugs: Benchmarking and Creation of an Accessibility Index." Source: Pfizer 2005; $40,000 (Principal Investigator).
"Specialty Injectables Benchmarking Study Part 2." Source: BlueCross BlueShield Association (BCBSA) 2004-2005; $140,090 (Principal Investigator).
"Center Effects Influence on Anemia and Mortality." Source: **NIH/NIDDK (R21DK064126)** 2004; $62,766=subcontract amount (Co-Investigator; Principal Investigator = Jeffrey C. Fink, MD).
"Baltimore Partnership Program to Reduce Cardiovascular Disparities." Source: **NIH/NHLBI (5U01HL079151)** 2004; $6,000,000 (Co-Investigator; Principal Investigator = Elijah T. Saunders, MD).

"Hypertension Telemanagement in African Americans." Source: **NIH/NHLBI (R01HL078579)** 2004; $2,376,489 (Co-Investigator; Principal Investigator = Joseph Finkelstein, MD).
"Starting Dose and Persistence of Geodon® Among Medicaid Patients." Source: Pfizer 2004; $240,850 (Principal Investigator).
"Evaluation of an Early Educational Program to Increase Live Kidney Donations." Source: **HRSA R39OT03408** 2004; $372,706 (Co-Investigator; Principal Investigator = Stephen T. Bartlett, MD).
"Schizophrenia/Bipolar Outcomes Research Compendium." Source: Pfizer 2004; $55,000 (Principal Investigator).
"Antifungal Outcomes Research Compendium." Source: Pfizer 2004; $45,205 (Principal Investigator).
"Injectables Expenditure Variations/Benchmarking Study." Source: BlueCross BlueShield Association (BCBSA) 2003; $68,000 (Principal Investigator).
"University of Maryland Center for Health Disparities Research, Training, and Outreach" Source: **NIH (P60MD000532)** 2003; $4,282,056 (Shared Resources Core Director; Principal Investigator = Donald Wilson, MD).
"Evaluation of MedBank Demonstration Project." Source: MedBank of Maryland, Inc. 2003; $50,000 (Principal Investigator).
"MRSA Outcomes Research Compendium." Source: Pfizer 2003; $45,205 (Co-Principal Investigator; Principal Investigator = Françoise G. Pradel, PhD).
"Overactive Bladder and urge urinary incontinence Outcomes Research Compendium." Source: Pfizer 2003; $45,205 (Principal Investigator).
"Switching and Discontinuation of SSRI Therapy." Source: Pfizer 2003; $139,570 (Principal Investigator).
"Determinants of Acceptability for Migraine Therapy." Source: Pfizer 2002; $50,000 (Principal Investigator).
"Migraine Budget Impact Model Interface." Source: Pfizer 2002; $40,000 (Principal Investigator).
"White Paper on the Value of Specialty Certification in Pharmacy." Source: APhA/Board of Pharmaceutical Specialties 2002; $29,497 (Investigator; Principal Investigator = Françoise G. Pradel, PhD).
"Combination Therapy Supplement to Eplerenone CEA Grant." Source: Pharmacia 2002; $39,704 (Principal Investigator).
"Migraine Treatment Outcomes Compendium." Source: Pfizer 2002; $40,000 (Principal Investigator).
"Compilation of SOURCE Document." Source: Pharmacia 2002; $20,384 (Co-Principal Investigator; Principal Investigator = Françoise G. Pradel, PhD).
"Variations in the Cost of Cardiovascular events by Country." Source: Pharmacia 2001; $28,306 (Principal Investigator).
"Economic Impact of Uncontrolled Hypertension among chronic arthritis patients: Implications for African Americans." Source: Pharmacia 2001; $135,368 (Principal Investigator).
"White Paper on Direct-To-Consumer Advertising." Source: Kaiser Family Foundation 2000; $22,930 (Co-Principal Investigator; Principal Investigator = Francis B. Palumbo, PhD, JD).
"Annotated Bibliography for Treatment of Congestive Heart Failure (CHF)." Source: USP 2000; $66,700 (Principal Investigator).
"Eplerenone CEA." Source: Searle 2000; $347,300. (Principal Investigator).
"Living Donation & Laparoscopic Nephrectomy." Source: Roche Laboratories 2000; $130,000 (Co-Principal Investigator; Principal Investigator = Stephen T. Bartlett, MD).
"Impact of Pipeline Drugs on Future Pharmacy Costs." Source: HIAA/BCBSA 2000; $50,012 (Principal Investigator).
"Prescription Costs for Medicare Beneficiaries: What We Know and What We Need to Know." Source: DHHS, Assistant Secretary for Policy and Evaluation. Contract No. SA-00-0064 2000; $24,598 (Co-Investigator; Principal Investigator = Bruce Stuart, PhD).

"Adult Medicaid Patients' Dental Visits in EDs." Source: AHCPR (1 R01 HS10129-01) 1999; $139,853 (Co-Investigator; Principal Investigator = Len Cohen, DDS).
"Alpha 1-Antitrypsin Deficiency Cost of Illness Model." Source: Alpha One Foundation 1998; $32,956 (Principal Investigator).
"Cost of IVIG Therapy for PIDDs by Site of Care." Source: Immune Deficiency Foundation 1998; $16,100 (Principal Investigator).
"An Economic Analysis of Alternative Treatment Regimens for Acromegaly." Source: Novartis Pharmaceutical Corp. 1998; $27,000 (Co-Investigator; Principal Investigator = Bruce Stuart, PhD).
"ZEBRA and EORTC Economic Evaluation." Source: Zeneca Pharmaceuticals 1998; $15,000 (Principal Investigator).
"Abciximab Outcomes/Cost Analysis." Source: School of Pharmacy DRIF Award 1998; $9,865 (Principal Investigator).
"Utilization and Cost of IVIG Therapy for PIDDs." Source: Immune Deficiency Foundation 1998; $16,675 (Principal Investigator).
"Econometric Model of Annual Expenditures for Cancer." Source: School of Medicine DRIF Award 1998; $15,000 (Co-Investigator; Principal Investigator = Sandra Brooks, MD).
"Pharmacoeconomic Analysis of CAP Program." Source: Pharmacia & Upjohn (In conjunction with BCBS of MD, BCBS of the National Capital Area, MAMSI, and NYLCare) 1997; $41,254 (Principal Investigator).
"Evaluation of Emergency Medical Systems (EMS) Triage of Elderly Trauma Patients." Source: UMAB Geriatrics and Gerontology Education and Research (GGEAR) Program 1997; $25,000 (Co-Principal Investigator; Principal Investigator = Jane Scott, ScD).
"Pharmaceutical Research Monitoring Project." Sources: Merck, Novartis, Pfizer, Pharmacia-Upjohn, and Wyeth-Ayerst 1997; $25,000/firm = $125,000 (Principal Investigator on two; Co-Investigator on three).
"Update of Pharmacoeconomic Guidelines/Principle List." Source: Health Outcomes Work Group at PhRMA 1997; $14,500 (Principal Investigator).
"Unrestricted educational grant for development of economic models." Source: Wyeth-Ayerst Research 1996; $15,000 (Principal Investigator).
"Cost-Benefit Analysis of the Community Health Worker Initiative." Source: UMAB Geriatrics and Gerontology Education and Research (GGEAR) Program 1996; $19,499 (Principal Investigator).
"Pharmaceutical Care Outcomes in a Well-Elderly and Frail-Elderly Continuing Care Retirement Community Population Using Multiple Medications." Source: UMAB Geriatrics and Gerontology Education and Research (GGEAR) Program 1996; $18,886 (Co-Principal Investigator; Principal Investigator = Maddie Feinberg, PharmD).
"Medicaid Drug Rebates, Pharmaceutical Prices and Unintended Consequences of Health Policy Reform." Source: Duke University Center for Aging Studies/The Glaxo Award in Long Term Care Research (Doctoral Dissertation Grant) 1992; $2,000.

Funded Grants as Mentor

"Value of Information: The Contribution of the PSA Screening Test to Prostate Cancer Diagnosis" Predoctoral Fellowship in Health Outcomes. Source: Pharmaceutical Research and Manufacturers of America Foundation 07/01/05-06/30/06; (Predoctoral mentee = Emily Reese).
"Discharges against Medical Advice among Cardiovascular Disease Patients" Source: **NIH (1K12RR023250-01)** 07/01/06-06/30/11; (Principal Investigator = Alan Shuldiner, MD; Faculty mentee = Ebere Onukwugha, PhD).
"Assessing Anticoagulation Therapy Management services" Source: **AHRQ (5F32HS016275-01)** 02/01/06-6/30/07; (Postdoctoral mentee = Danielle Chauncey, PharmD).
"The Application of the Probabilistic Reduction Approach to Health Econometric Model Specification and Testing." Postdoctoral Fellowship in Health Outcomes. Source:

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Funded Fellowship Contracts

"Pharmacoeconomics/Formulary Management Postdoctoral Fellowship between the University Of Maryland School of Pharmacy and the Baltimore Veterans Administration." Sources: Elan, Sanofi-Aventis; $75,000 (Principal Investigator). ***Funded for 4 years 2005-2009.***

"Pharmacoeconomics/Formulary Management Postdoctoral Fellowship between the University Of Maryland School of Pharmacy and CareFirst BlueCross BlueShield (BCBS)." Sources: Pharmacia, Pfizer, Takeda; $75,000 (Principal Investigator). ***Funded for 7 consecutive years 2001-2008.***

"Pharmacoeconomics/Pain Management Postdoctoral Fellowship." Source: Alpharma; $75,000 (Principal Investigator). ***Funded for 1 year 2007-2008.***

"Pharmacoeconomics and Medicaid Formulary Management Postdoctoral Fellowship between the University Of Maryland School of Pharmacy and various Medicaid Plans." Sources: Novartis, Pharmacia, Pfizer; $75,000 (Co-Principal Investigator; Principal Investigator = Fadia T. Shaya, PhD, MPH). ***Funded for 5 consecutive years 2002-2007.***

"Pharmacoeconomics/Formulary Management Postdoctoral Fellowship between the University Of Maryland School of Pharmacy and the Mid Atlantic Medical Services, Inc. (MAMSI)." Sources: Pharmacia, Eli Lilly; Pfizer; $65,000 (Principal Investigator). ***Funded for 5 consecutive years 2000-2005.***

"Pharmacoeconomics/ Formulary Management Postdoctoral Fellowship between the University Of Maryland School of Pharmacy and the Maryland Health Services Cost Review Commission (HSCRC)." Source: MedBank of Maryland, Inc; $55,000 (Principal Investigator). ***Funded for 1 year 2004.***

"Pfizer Predoctoral Fellowship in Pharmacoeconomics and Outcomes Research." Source: Pfizer; $43,200 (Principal Investigator). ***Funded for 1 year 2003.***

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Reports

Stuart B, Brandt N, Briesacher B, Fahlman C, Mullins D, Palumbo F, Pizarro J, Stuart L. Issues in Prescription Drug Coverage, Pricing, Utilization, and Spending: What We Know and Need to Know. *A report for the US Department of Health and Human Services (HHS), Office of the Assistant Secretary for Policy and Evaluation, Office of Health Policy*, February 18, 2000.

Mullins CD, Palumbo F, Stuart B. Projections of Drug Approvals, Patent Expirations, and Generic Entry from 2000 to 2004. *A background report for the US Department of Health and Human Services (HHS) conference on: What is known and what needs to be known about prescription drug costs and pricing practices*. August 8-9, 2000, Georgetown University, Washington, DC.

Book Reviews

Mullins CD. *Review of Peter J. Neumann's Using Cost-Effectiveness Analysis to Improve Health Care: Opportunities and Barriers* in *Value in Health* 2006; 9(2):140.

Mullins CD. *Review of Robert M. Sloane, et al.'s Introduction to Healthcare Delivery Organizations: Functions and Management, Fourth edition* in *American Journal of Pharmaceutical Education* Spring 2000; 64:106.

Mullins CD. *Review of Stuart O. Schweitzer's Pharmaceutical Economics and Policy* in *American Journal of Pharmaceutical Education* Spring 1998; 62:104-5.

Presentations

"Cost Estimation and Assessing Financial (Budget) Impact of New Health Care Technologies" Workshop presented at the ISPOR 15th Annual European Congress, Berlin, Germany, November 2012.

"Frequency of Second and Third Line Treatment among Elderly Medicare Stage 4 Colon Cancer Patients" (poster) presented at the 37th European Society of Medical Oncology (ESMO) Conference, Vienna, Austria, October 2012.

"Patient-Centered Outcomes Research (PCOR) with Hard-to-Reach Patients and Consumers" presented at the University of Florida, Gainesville, FL, October 2012.

"Comparative Effectiveness Research (CER) for Health Intervention Assessments and Improving Health" presented at the National Taiwan University, Taipei, Taiwan, September 2012.

"Conducting Oncology Health Services Research and Comparative Effectiveness Research Using Large Claims Databases: Taiwanese and United States Experiences" workshop presented at the ISPOR 5th Asia-Pacific Conference, Taipei, Taiwan, September 2012.

"Ensuring input from hard-to-reach consumers" presented at the Consumers United for Evidence-based Healthcare (CUE) Annual Meeting, Washington, DC, June 2012.
"Rehospitalization and Costs among Patients Treated with Linezolid versus Vancomycin following Hospitalization for Pneumonia in the Real-World Setting" (poster) presented at the ISPOR 17th Annual International Meeting, Washington, DC, June 2012.
"Comparative Effectiveness Research: Methods and Applications" workshop presented at the ISPOR 17th Annual International Meeting, Washington, DC, June 2012.
"Financial Impact/Cost of Illness" Workshop presented at the ISPOR 17th Annual International Meeting, Washington, DC, June 2012.
"Integrating patients' voices in study design elements with a focus on hard-to-reach populations" presented at the PCORI Workshop on Incorporating the Patient Perspective into Patient Centered Outcomes Research, Baltimore, MD, March 2012.
"Cost Estimation and Assessing Financial (Budget) Impact of New Health Care Technologies" Workshop presented at the ISPOR 14th Annual European Congress, Madrid, Spain, November 2011.
"Re-hospitalization and Direct Medical Costs Among Patients Treated with Linezolid (LZD) versus Vancomycin (VAN) Following Hospitalization for Complicated Skin and Skin Structure Infections (cSSSI)" (poster) presented at the Infectious Diseases Society of America 49th Annual Meeting, Boston, MA, October 2011.
"Bayesian Clinical Trials: Using Priors and Planning for Post-Regulatory Translation" Session Chair at the 9th International Conference on Health Policy Statistics, Cleveland, OH, October 2011.
"Budget Impact Analysis" Workshop presented at the ISPOR 3rd Latin America Conference, Mexico City, Mexico, September 2011.
"Cost-Effectiveness Analysis with and Without the QALY," presented at the Center for medical Technology Policy (CMTP) CER Institute, Santa Fe, NM, July 2011.
"Introduction and Overview: Reflections on the Importance of CER Methods Training – The Academic Perspective," presented at the Center for medical Technology Policy (CMTP) CER Institute, Santa Fe, NM, July 2011.
"Impact of VTE on Mortality" (poster) presented at the American Society of Clinical Oncology (ASCO) 47th Annual Meeting, Chicago, IL, June 2011.
"Experimental vs. Observational Studies: Which should have a Higher Rank in Health Care Decisions" Issue Panel presented at the ISPOR 16th Annual International Meeting, Baltimore, MD May 2011.
"How Can Patient-Reported Outcomes become a Part of Comparative Effectiveness Research" Issue Panel Chair presented at the ISPOR 16th Annual International Meeting, Baltimore, MD May 2011.
"Financial Impact/Cost of Illness" Workshop presented at the ISPOR 16th Annual International Meeting, Baltimore, MD May 2011.
"Webinar and Report on Comparative Effectiveness Research Aimed at Research Advocates" webinar presented to the Research Advocacy Network, February 2011.
"PROs in CER: A Case Study in Oncology" presented at CBI's 4th Annual Comparative Effectiveness Research Summit & CBI's 7th Patient Reported Outcomes Conference, Prague, Czech Republic, November 2010.
"Cost Estimation and Assessing Financial (Budget) Impact of New Health Care Technologies" Workshop presented at the ISPOR 13th Annual European Congress, Prague, Czech Republic, November 2010.
"Pharmacoeconomics and Value Assessments of Drugs and Biomarkers" presented at the 8th annual CMOD Biomarkers meeting on Science, Economics and the Globalization of Healthcare, Bethesda, MD, September 2010.
"Baltimore Community Health Partnership: A Model for Local Empowerment" presented at the ISHIB 25th Annual International Interdisciplinary Conference, Washington, DC, July 2010.

"Incidence of diagnosed VTE among elderly Americans in the year following stage III or IV colon cancer diagnosis" (poster) presented at the American Society of Clinical Oncology (ASCO) 46th Annual Meeting, Chicago, IL, June 2010.

"Pragmatic Clinical Trials - How Broad is Too Broad and How Early if Too Early?" Moderator for Issue Panel presented at the ISPOR 15th Annual International Meeting, Atlanta, GA May 2010.

"Selecting Comparators and Outcomes for Comparative Effectiveness Studies in Oncology" Workshop presented at the ISPOR 15th Annual International Meeting, Atlanta, GA May 2010.

"Financial Impact/Cost of Illness" Workshop presented at the ISPOR 15th Annual International Meeting, Atlanta, GA May 2010.

"Community Health Partnership: A Model for Local Empowerment" presented at the National Minority Quality Forum's 7th Annual Leadership Summit, Washington, DC, April 2010.

"Evidence-based Medicine & Health Technology Assessment: Moving from Separate Appraisals to Synergistic Communications," Program Chair for Drug Information Association Workshop, Washington, DC, March 2010.

"Evidence Based Medicine: Trials and Tribulations," Tutorial at the Drug Information Association 21st Annual Workshop on Medical Communications, Phoenix, AZ, March 2010.

"Comparative effectiveness of FOLFOX and FOLFIRI versus 5FU/LV among elderly stage IV colon cancer patients" (poster) presented at the ASCO 2010 Gastrointestinal Cancers Symposium, Orlando, FL, January 2010.

"How Comparative Effectiveness Research is Transforming Pharmaceutical and Device R&D and promotion," Webinar Moderator for the Drug Information Association sponsored webinar, November 2009.

"Linezolid vs. Vancomycin: Re-hospitalization Rates among Patients with Pneumonia, Staphylococcal Infection, and Skin and Soft Tissue Infection" (poster) presented at the IDSA 47th Annual Meeting, Philadelphia, PA, October 2009.

"Cost Estimation and Assessing Financial (Budget) Impact of New Health Care Technologies" Workshop presented at the ISPOR 12th Annual European Congress, Paris, France, October 2009.

"The Policy Perspective: The subtle and not-so-subtle influences on physician prescribing – impact of insurance and payers through formularies, guidelines, and quality measures" lecture provide at Johns Hopkins Medical School, Baltimore, MD, October 2009.

"Financial Impact/Cost of Illness" Workshop presented at the ISPOR 14th Annual International Meeting, Orlando, FL May 2009.

"Assessing Costs of New Drugs and Health Technologies: The Importance of Budgetary Impact In Addition to Cost-Effectiveness Analysis" presented at the Colegio Mexicano de Famacoeconomía e Investgación, A. C. V Reunion de Farmacoeconomía, Juriquilla, Querétaro, Mexico, April, 2009.

"Describing and Researching Health Disparities – The Role of Communities and Partnerships: Health Disparities and the Role of Services Research in the Community" presented at the Third Annual Health Disparities Conference, New Orleans, LA, April 2009.

"Pharmacoeconomics Fulbright Senior Specialist Program" presented at the University of Galway, Galway, Ireland, March 2009.

"Trends in Health Disparities in Staging of Prostate cancer Patients" (poster) presented at the ASCO 2009 Genitourinary Cancers Symposium, Orlando, FL, February 2009.

"Medical Decision-Making: The Payer Perspective" lecture provide at Johns Hopkins Medical School, Baltimore, MD, February 2009.

"Budget Impact Analysis: An Overview" presented at the ISPOR Mexico Chapter Annual Meeting, Mexico City, Mexico, December 2008.

"Trends in Health Disparities in Staging of Prostate cancer Patients" guest seminar presented at the University of Rhode Island, Kingston, RI, November 2008; also presented at the University of Southern California, Los Angeles, CA, December 2008.

"Cost Estimation and Assessing Financial (Budget) Impact of New Health Care Technologies" Workshop presented at the ISPOR 11th Annual European Congress, Athens, Greece, November 2008.
"Trends in Health Disparities in Staging of Prostate cancer Patients" presented at the Association for Academic Minority Physicians Annual Meeting, Naples, FL, October 2008.
"Evidence-Based Medicine and Health Technology Assessment: Can We Find Common Ground," Conference Chair for the Drug Information Association, Alexandria, VA, September 2008.
"Unequal Health Burden," presented at the American Cancer Society Cervical Cancer Conference: Tipping the Scales, Better Health for Generations of Women, Research Triangle Park, NC, August 2008.
"Disparities and Trends in Prostate Cancer Screening Over Time" (poster) presented at the American Society of Clinical Oncology (ASCO) 44th Annual Meeting, Chicago, IL, May 2008.
Conference co-Chair for the ISPOR 13th Annual International Meeting, Toronto, ON, Canada, May 2008.
"Financial Impact/Cost of Illness" Workshop presented at the ISPOR 13th Annual International Meeting, Toronto, ON, Canada, May 2008.
"Building a Research Agenda: A Case Study in Health Disparities in End Stage Renal Disease (ESRD)" presented at the University of Tennessee School of Pharmacy, Memphis, TN, April 2008.
"The Future of Pharmacoeconomic Analyses: How Can We Best Evaluate Advanced Therapeutic and Preventive Options" presented at an AMCP Satellite Symposium, San Francisco, CA, April 2008.
"Cost Estimation and Assessing Financial (Budget) Impact of New Health Care Technologies" Workshop presented at the ISPOR 10th Annual European Congress, Dublin, Ireland, October 2007.
"Debate: The Pros and Cons of ePROs" presented at the DIA Annual Meeting, Atlanta, GA, June 2007.
"The Economic Implications of New Episodes of MDD for Non-stable Versus Stable Depression" (poster) presented at the American Psychiatric Association's 160th Annual Meeting, San Diego, CA May 2007.
"Probability of Increase in Healthcare Costs in Non-Stable Depressed Individuals Compared to Stable Patients" (poster) presented at the American Psychiatric Association's 160th Annual Meeting, San Diego, CA May 2007.
"Predicting the Budgetary Impact of New Drugs: Applying Microeconomic Theory and Case Studies" Workshop presented at the ISPOR 12th Annual International Meeting, Crystal City, VA, May 2007.
"Quality Issues Related to the Use of Patient Level Databases" Workshop presented at the ISPOR 12th Annual International Meeting, Crystal City, VA, May 2007.
"Formulary Applications in Translational Medicine" Workshop presented at the ISPOR 12th Annual International Meeting, Crystal City, VA, May 2007.
"Manuscript Writing and the Peer-Review Process" Forum presented at the ISPOR 12th Annual International Meeting, Crystal City, VA, May 2007.
"Financial Impact/Cost of Illness" Workshop presented at the ISPOR 12th Annual International Meeting, Crystal City, VA, May 2007.
"Value-based Decision Making: US Perspectives" presented at the Alzheimer's Association Research Roundtable: Health Economics and Real World Value of Therapy in Alzheimer's Disease Conference, Washington, DC, November 2006.
"Introduction to Global Health Economics" presented at the Alzheimer's Association Research Roundtable: Health Economics and Real World Value of Therapy in Alzheimer's Disease Conference, Washington, DC, November 2006.
"Cost Estimation and Assessing Financial (Budget) Impact of New Health Care Technologies" Workshop presented at the ISPOR 9th Annual European Congress, Copenhagen, Denmark, October 2006.

"Health Disparities in the 21st Century" Keynote Address presented at the ACCP Annual Meeting, St. Louis, MO, October 2006.
"Pharmacoeconomics Fulbright Senior Scholar Program – Part 2" presented at the Universidad de Montevideo, Montevideo, Uruguay, October 2006.
"Case Studies of New and Specialty Pharmaceuticals" presented at the Society of Actuaries' "Maximizing the Value of the Pharmacy Benefit" Seminar, Chicago, IL, July 2006.
"Rapid Cycle Research Based in Organized Health Care Delivery Systems" presented at the AcademyHealth 2006 Annual Research Meeting, Seattle, WA, June 2006.
"Initial Dose and Persistence for Five Major Atypical Antipsychotic Agents in Medicaid Enrollees" (poster) presented at the American Psychiatric Association's 159th Annual Meeting, Toronto, Canada, May 2006.
"Continuous Enrollment and the Incomplete Information Tradeoff" Workshop presented at the ISPOR 11th Annual International Meeting, Philadelphia, PA, May 2006.
"Formulary Decisions for Medicare Part D" Workshop presented at the ISPOR 11th Annual International Meeting, Philadelphia, PA, May 2006.
"Incorporating Compliance Measures in Retrospective Cost Studies" Workshop presented at the ISPOR 11th Annual International Meeting, Philadelphia, PA, May 2006.
"Financial Impact/Cost of Illness" Workshop presented at the ISPOR 11th Annual International Meeting, Philadelphia, PA, May 2006.
"Starting Dose and Persistence for Ziprasidone Users in Medicaid" (poster) presented at the Association of European Psychiatrists' 14th European Congress of Psychiatry, Nice, France, March 2006.
"Budget Impact Modeling: Appropriateness and Determining Quality Input," presentation to ISPOR Student Chapters" as an ISPOR educational teleconference, February, 2006.
"Factors Influencing Ziprasidone Prescribed Doses among Medicaid Patients with Schizophrenia" (poster) presented at the ISPOR 8th Annual European Congress, Florence, Italy, November 2005.
"Cost estimation and Assessing Financial (Budget) Impact of New Health Care Technologies" Workshop presented at the ISPOR 8th Annual European Congress, Florence, Italy, November 2005.
"Major GI Events among Cox-2 Inhibitor, NSAID, and Aspirin Users" (poster) presented at the American College of Gastroenterology Meeting, Honolulu, HI, October 2005.
"Pharmacoeconomics Fulbright Senior Scholar Program – Part 1" presented at the Universidad de Montevideo, Montevideo, Uruguay, October 2005.
"Pharmacoeconomics" at the Johns Hopkins Bloomberg School of Public Health's Twenty-Third Annual Graduate Summer Institute of Epidemiology and Biostatistics: Pharmacoepidemiology summer course" at the, Baltimore, MD, June 2005.
"Starting Dose and Persistence for Ziprasidone Users in Medicaid" (poster) presented at the American Psychiatric Association's 158th Annual Meeting, Atlanta, GA May 2005.
"Assessment of the Impact of Valdecoxib on Systolic Blood Pressure in Clinical Practice" (poster) presented at the American Society of Hypertension Twentieth Annual Scientific Meeting, San Francisco, CA May 2005.
"Formulary Decisions: Assessing Harm, Showing Benefit, Proving Value, From Managed Care Data" Workshop presented at the ISPOR 10th Annual International Meeting, Washington, DC, May 2005.
"The Peer Review Process: How Editors Draw the Line Between Science and Advertising" Issues Panel presented at the ISPOR 10th Annual International Meeting, Washington, DC, May 2005.
"Starting Dose and Persistence for Ziprasidone Users in Medicaid" (poster) presented at the ISPOR 10th Annual International Meeting, Washington, DC, May 2005.
"Triptans for Migraine Therapy: A Comparison Based on Number Needed to Treat and Doses Needed to Treat" (poster) presented at the ISPOR 10th Annual International Meeting, Washington, DC, May 2005.

"Cost-Effectiveness of Eletriptan versus Zolmitriptan: results from a Randomized Controlled Trial" (poster) presented at the ISPOR 10th Annual International Meeting, Washington, DC, May 2005.
"Financial Impact/Cost of Illness" Workshop presented at the ISPOR 10th Annual International Meeting, Washington, DC, May 2005.
"Science or Advertising: How Editors Draw the Line" Issues Panel presented at the ISPOR 7th Annual European Congress, Hamburg, Germany, November 2004.
"Disparities in Medicaid Cancer Expenditures" (poster) presented at the ISPOR 7th Annual European Congress, Hamburg, Germany, November 2004.
"Cost estimation and Assessing Financial (Budget) Impact of New Health Care Technologies" Workshop presented at the ISPOR 7th Annual European Congress, Hamburg, Germany, November 2004.
"Pharmacoeconomics/Outcomes Research Mini Course" presented at the Universidad de Montevideo, Montevideo, Uruguay, October, 2004.
"The Economic Impact of Laparoscopic Kidney Retrieval on the Medicare Program" presented at a Congressional Staff briefing on *Organ Transplant Issues*, Washington, DC June 2004.
"Cost Effectiveness of Kidney Transplantation" presented at the University of Cincinnati School of Pharmacy Graduate Research Seminar Series, Cincinnati, OH, May 2004.
"The Formulary Decision Process: What Kind of Information is Truly Helpful?" Workshop presented at the ISPOR 9th Annual International Meeting, Arlington, VA, May 2004.
"Managed Care Data: Tools and Metrics for Formulary Development" Workshop presented at the ISPOR 9th Annual International Meeting, Arlington, VA, May 2004.
"Economic Analysis - Financial Impact/Cost of Illness" Workshop presented at the ISPOR 9th Annual International Meeting, Arlington, VA, May 2004.
"Comparison of First Refill Rates Among Branded SSRI Users" (poster) presented at the American Psychiatric Association's 157th Annual Meeting, New York, NY May 2004.
"Translating Clinical Outcomes into Economic Outcomes" presented at the University of Iowa School of Pharmacy Graduate Research Day, Iowa City, IA, April 2004.
"Translating Clinical Outcomes into Economic Outcomes" presented at IIR's 2nd Annual Outcomes Research Conference on *Closing the Gap between Drug Manufacturers and Customers,* Washington, DC, February 2004.
"Cost estimation and Assessing Financial (Budget) Impact of New Health Care Technologies" Workshop presented at the ISPOR 6th Annual European Congress, Barcelona, Spain, November 2003.
"The Impact of Pharmacogenomics on the Cost-Effectiveness Ratio," presented at the Southern Economic Association 73rd Annual Meeting, San Antonio, TX, November 2003.
"The Changing Landscape of Dyslipidemia: Emerging Approaches to Achieving Lower Lipoprotein Targets - Pharmacoeconomic Outcomes for Treating Dyslipidemia" presented at the Academy of Managed Care Pharmacy's 2003 Educational Conference, Montreal, Canada, October 2003.
"The AMCP Format for Formulary Submissions: Collecting and Evaluating Cost-Effectiveness and Budget Impact Information" presented at the Academy of Managed Care Pharmacy's 2003 Educational Conference, Montreal, Canada, October 2003.
"Demystifying Pharmacoeconomics for the Practitioner" presented at the Academy of Managed Care Pharmacy's 2003 Educational Conference, Montreal, Canada, October 2003.
"Racial Disparities in Smoking and Clinical Trials Knowledge and Participation" presented at Howard University College of Pharmacy Graduate Seminar, Washington, DC, October 2003.
"Pharmacoeconomics/Outcomes Research Mini Course" presented at Chulalongkorn University, Bangkok, Thailand, August 4 - 14, 2003.
"Outcomes Research for Everyone Else: A Primer for the Non Outcomes Researcher" Tutorial at the DIA 39th Annual Meeting, San Antonio, TX, June 2003.
"From Good to Blockbuster: Successes in Outcomes Research" Session Chair at the DIA 39th Annual Meeting, San Antonio, TX, June 2003.

"Demystifying Pharmacoeconomics for the Practitioner" presented at the American Society of Health-System Pharmacists' 2003 Summer Meeting, San Diego, CA, June 2003.
"Cost estimation and Assessing Financial (Budget) Impact of New Health Care Technologies" Workshop presented at the ISPOR 8th Annual International Meeting, Arlington, VA, May 2003.
"Risk Management: Implications for Formulary Decision-Making from Risk-Benefit to Cost Effectiveness" Workshop presented at the ISPOR 8th Annual International Meeting, Arlington, VA, May 2003.
"The Societal Benefits and Costs of the 4th Hurdle: The European Experience - Evidence of the Impact on the Pharmaceutical Industry" Plenary Talk presented at the ISPOR 5th Annual European Conference, Rotterdam, The Netherlands, November 2002.
"Multi-Country Comparison of Hypertension Costs from Hospitalizations and Ambulatory Care" presented at the ISPOR 5th Annual European Conference, Rotterdam, The Netherlands, November 2002.
"Sinusitis-Related Provider and Patient Burden" presented at the DIA 4th Annual Pharmaceutical Outcomes Research Meeting, Newport, RI, October 2002.
"Pharmacoeconomics and Outcomes Research: Issues in Study Design, Analysis and Interpretation" presented at Howard University College of Pharmacy Preceptor Recognition Event, Washington, DC, September 2002.
"Outcomes Research for Everyone Else: A Primer for the Non Outcomes Researcher" Tutorial at the DIA 38th Annual Meeting, Chicago, IL, June 2002.
"From Good to Blockbuster: Successes in Outcomes Research" Session Chair at the DIA 38th Annual Meeting, Chicago, IL, June 2002.
"Communicating Pharmaceutical Value" presented at the DIA 38th Annual Meeting, Chicago, IL, June 2002.
"Pharmaceutical Costs, Expenditures, and Policy Implications" Breakfast with the Experts presented at the ISPOR 7th Annual International Meeting, Crystal City, VA, May 2002.
"Careers in Academia, Consulting, Government and Industry: A View from the Ivory Towers" ISPOR Student Forum presented at the ISPOR 7th Annual International Meeting, Crystal City, VA, May 2002.
"Incidence or Prevalence: Implications for Formulary Decision-Making" Workshop presented at the ISPOR 7th Annual International Meeting, Crystal City, VA, May 2002.
"Healthcare Financing in the 21st Century: Cost Implications for Employers, Insurers, and Policy Makers" CDPP Conference Chair, Washington, DC, April 2002.
"A Comparison of Flow of Funds for Treatment of ESRD by Treatment Modalities" (poster) presented at the American Transplant Congress 2002 Meeting, Washington, DC, April 2002.
"Communicating Pharmaceutical Value" presented at the DIA 13th Annual Workshop for Medical Communications, Tampa, FL, March 2002.
"Arthritis Economic Decision-Making for Drug Therapies" presented at The Maryland Academy of Family Physicians conference on *The Arthritis Connection: Promising Trends and Perspectives*, Baltimore, MD, February 2002.
"Regulation of Drug Prices" presented at the University of Arizona's 10th Annual Invitational Conference - Pharmaceutical Costs: The Debate Continues, Tucson, AZ, January 2002.
"The Impact of Pipeline Drugs on United States Drug Expenditure Growth Trends" presented at the ISPOR 4th Annual European Conference, Cannes, France, November 2001.
"Pharmacoeconomic and Quality of Life Labeling and Promotional Claims: A Global Update" DIA Workshop Chair, Philadelphia, PA, October 2001.
"Outcomes Issues for Regulatory Professionals" Tutorial at the DIA workshop on Pharmacoeconomic and Quality of Life Labeling and Promotional Claims: A Global Update, Philadelphia, PA, October 2001.
"The Cost on the Healthcare System" presented at The MediMedia Managed Care conference on *Best Practice Guidelines & Current Treatment Trends for Improving Hypercholesterolemia Risk Reduction*, St. Louis, MO, August 2001.

"Arthritis Economic Decision-Making for Drug Therapies" presented at The Arthritis Foundation/NAMCP/ACMCM conference on *The Arthritis Connection: Promising Trends and Perspectives*, Virginia Beach, VA, July 2001.

"Outcomes Research for Everyone Else: A Primer for the Non Outcomes Researcher" Tutorial at the DIA Annual Meeting, Denver, CO, July 2001.

"From Good to Blockbuster: Successes in Outcomes Research" Session Chair at the DIA Annual Meeting, Denver, CO, July 2001.

"Cost of Treatment for AAT-Deficiency" presented at the Alpha-1 Foundation 3rd International Scientific Conference, Warrenton, VA, June 2001.

"Challenges in Performing Meta Analysis in Heart failure Outcomes Research" Workshop presented at the ISPOR 6th Annual International Meeting, Crystal City, VA, May 2001.

"Comparability of Published Studies on Cost-Effectiveness of Antihypertensive Therapy: Do the Results Help the Decision-Making Process?" (poster) presented at the ISPOR 6th Annual International Meeting, Crystal City, VA, May 2001.

"Pharmacoeconomics: Optimizing the Use of Data" Institute for International Research Conference Chair Philadelphia, PA, March 2001.

"Building Pharmacoeconomic Models that Address Decision-Makers' Concerns" presented at IIR's Conference on *Pharmacoeconomics: Optimizing the Use of Data,* Philadelphia, PA, March 2001.

"Exploring Decisions about Formulary Adoption and Clinical Pathways/Guidelines" presented at IIR's Conference on *Pharmacoeconomics: Optimizing the Use of Data,* Philadelphia, PA, March 2001.

"Merging Marketing and Clinical Development" DIA Workshop Program Committee, Philadelphia, PA, March 2001.

"Pharmaceutical Market Impact of the Early 1990s Health Care Debate" presented at the Midwest Business Administration Association/Business & Health Administration Association Annual Meeting, Chicago, IL, March 2001.

"Predicting Future Drug Expenditures: Where Are We Headed and Can We Do Anything About It?" presented at IIR's 2nd Annual National Forum on *Controlling Escalating Pharmacy Benefit Costs*, Atlanta, GA February 2001.

"Pharmacogenomics: Methodological Considerations for Evaluating Outcomes and Cost Effectiveness" presented at the University of Arizona's 9th Annual Invitational Conference - Pharmacogenomics: Implications for Patients, Providers, Policy and Payers, Tucson, AZ, January 2002.

"Analysis of an Osteoporosis Model" presented at the Department of Obstetrics and Gynecology at UCLA and the UCLA/Harbor OB/GYN Collegium Conference on *A Pharmacoeconomic Approach to Clinical Decision-Making for the Menopause*, Los Angeles, CA December 2000.

"Modeling the Annual Cost of Postmenopausal Osteoporosis Treatment Using Raloxifene, Bisphosphonates, or Calcitonin" (poster) presented at the 35th Annual ASHP Midyear Clinical Meeting, Las Vegas, NV, December 2000.

"Justifying Product Value with Indirect Costs: An Application to Migraine" Workshop presented at the ISPOR 3rd Annual European Conference, Antwerp, Belgium, November 2000.

"Integrated Health Systems Delivery I: Understanding, Developing, and Documenting Integrated Patient (Pharmaceutical) Care" presented at the Thunderbird Executive Education Conference on *Leadership in Healthcare Administration for Pharmacists*, Glendale, AZ, October 2000.

"Integrated Health Systems Delivery II: The Role of Outcomes Research" presented at the Thunderbird Executive Education Conference on *Leadership in Healthcare Administration for Pharmacists*, Glendale, AZ, October 2000.

"Case Study: Analysis of an Osteoporosis Model" presented at a session on "A Turn-Key Approach to Utilizing Valuable Economic Models" at the AMCP 2000 Educational Conference, San Diego, CA, October 2000.

"Pharmacoeconomic and Quality of Life Labeling and Marketing Claims" DIA Workshop Chair, New Orleans, LA, October 2000.

"Presidential Race: Costly Pills" broadcast appearance on *The Marc Steiner Show* - 88.1 FM WJHU (local Public Radio station) Baltimore, MD, September 2000.
"Outcomes Research for Everyone Else: A Primer for the Non Outcomes Researcher" Tutorial at the DIA Annual Meeting, San Diego, CA, June 2000.
"From Good to Blockbuster: Successes in Outcomes Research" Session Chair at the DIA Annual Meeting, San Diego, CA, June 2000.
"Study Design Issues in Health Economics" Session Chair at the DIA Annual Meeting, San Diego, CA, June 2000.
"Cost-Effectiveness/Cost-Benefit Analyses (Session 2)" Session Chair at the ISPOR Annual Meeting, Arlington, VA, May 2000.
"Employer Costs of Diabetes" presented at the BMS Employer Diabetes Health Panel, Carlsbad, CA May 2000.
"The Impact of Pipeline Drugs on Pharmaceutical Expenditures" presented at the HIAA/BCBSA Pipeline Pharmaceuticals Symposium, Washington, DC, April 2000.
"The Impact of Pipeline Drugs on Pharmaceutical Expenditures" presented at the HIAA/BCBSA Pipeline Pharmaceuticals Symposium, New York, NY, April 2000.
"Outcomes Collected in Randomised Clinical Trials and Retrospective Database Studies" presented at the DIA EuroMeeting, Nice, France, March 2000.
"Estimates of the Indirect Cost of HIV and AIDS in the United Kingdom" (poster) presented at the ISPOR EuroMeeting, Edinburgh, Scotland, November 1999.
"Government's Role in Pharmaceutical Pricing" presented at the Drug Pricing Policy Forum, Kunming, China, October 1999.
"Pharmaceutical Pricing and International Practice" presented at the Drug Pricing Policy Forum, Kunming, China, October 1999.
"Cancer Screening in Maryland: A Review of the Cancer Insurance Study and Cost Related Aspects" presented at the Maryland State Council on Cancer Control: Cancer Roundtable Meeting at Johns Hopkins School of Hygiene & Public Health, Baltimore, MD, October 1999.
"Applied Pharmacoeconomics for Formulary Decision Making" presented at the 7th Annual ASCP Mid-Atlantic Conference, Cumberland, MD, August 1999.
"Outcomes Research for Everyone Else: A Primer for the Non Outcomes Researcher" Tutorial at the DIA Annual Meeting, Baltimore, MD, June 1999.
"Recent Successful Launches: The Role of Outcomes Research" Session Chair at the DIA Annual Meeting, Baltimore, MD, June 1999.
"Pharmacoeconomic Decision-Making: Observations from the Real World" presented at the DIA Annual Meeting, Baltimore, MD, June 1999.
"Outcomes Data on Osteoporosis for Formulary Decisions" presented at the Lilly Centre for Women's Health Outcomes Symposium, Indianapolis, IN May 1999.
"Cost-of-Treatment vs. Cost-of-Illness Analysis" presented at The Wintergreen Conference V, Wintergreen, VA, May 1999.
"Pharmacoeconomic Evaluation of a Community Acquired Pneumonia Program" presented at the Academy of Managed Care Pharmacy's Annual Meeting, Minneapolis, MN, April 1999.
"Impact of Community Acquired Pneumonia (CAP) Guidelines on Treatment Costs" presented at the DIA's Pharmaceutical Outcomes Research: Past, Present and Future Workshop, Seattle, WA, April 1999.
"Alpha 1-Antitrypsin Deficiency Cost of Illness Analysis" presented at the American Thoracic Society Annual Meeting, San Diego, CA, April 1999.
"Cost-of-Treatment Models: Tools for Comparative Cost Analyses" (poster) presented at the PhRMA Foundation Annual Awardee Meeting, New York, NY, April 1999.
"Practical Overview of Pharmacoeconomic Research" presented at ASCP's Generating and Analyzing Data for Clinical and Business Applications Workshop, Seattle, WA, November 1998.
"Pharmacoeconomics - A Practical Approach" presented at the Maryland Society of Health-System Pharmacists 33rd Annual Seminar, Deep Creek Lake, MD, October 1998.

"Cost of Treatment vs. Cost of Illness Analysis: Managing Annual Budgets vs Projecting Lifetime Expenditures for your Patients" presented at the Zitter Group's 5th Annual Congress on Health Outcomes & Accountability, San Diego, CA, October 1998.
"Pharmacoeconomics/Outcomes Research Mini Course" presented at the Clínic Barcelona, Hospital Universitari, Barcelona, Spain, September 28 - October 4, 1998.
"Pharmacoeconomics/Outcomes Research" presented at the Regulatory Affairs Professional Society Conference on "International Clinical Trials," Newark, NJ, August 1998.
"International Pharmacoeconomics Guidelines: Areas of Consensus and Disagreement" presented at the Regulatory Affairs Professional Society Conference on "International Clinical Trials," Newark, NJ, August 1998.
"Outcomes Research for Everyone Else: A Primer for the Non Outcomes Researcher" Tutorial at the DIA Annual Meeting, Boston, MA, June 1998.
"Case Study: The Health Care System Focus" presented at Howard University's "Pharmacoeconomics, Clinical Outcomes and Patient Care Seminar" Greenbelt, MD, June 1998.
"Issues in Developing Economic Models for Managed Care: The Case of Osteoporosis Prevention" workshop presented at ISPOR's Third Annual International Meeting, Philadelphia, PA, May 1998.
"Practical Overview of Pharmacoeconomics" presented at ASCP's "Data...Your Competitive Edge" Workshop, Baltimore, MD, April 1998.
"Decision Modeling in Pharmacoeconomics" presented as a roundtable discussion at the APhA Annual Meeting, Miami, FL, March 1998.
"Outcomes Research for Everyone Else...Introduction to the History, Jargon and Definitions" presented at the DIA Conference on Outcomes Research for the Non Outcomes Researcher, Baltimore, MD, March 1998.
"Pharmacoeconomic Guidelines: Areas of Consensus and Disagreement" presented at the ISPOR Conference on Pharmacoeconomics: Identifying the Issues, Crystal City, VA, February 1998.
"Pharmacoeconomics of NSAIDs: Beyond Bleeds" presented at the APhA Annual Meeting, Los Angeles, CA, March 1997.
"Economic Model of NSAID Use and Upper Gastrointestinal Symptoms" presented at the Association of Rheumatology Health Professionals National Scientific Meeting, Orlando, FL, October 1996.
"Outcomes Research Assessment" presented at a USP Mini-Symposium, Rockville, MD, July 1996.
"Strategic Drug Pricing in the Presence of Managed Care Competition" presented at The Wintergreen Conference IV, Wintergreen, VA, May 1996.
"Strategic Drug Pricing in the Presence of Managed Care Competition" presented at the Southern Economic Association Annual Meeting, New Orleans, LA, November 1995.
"Unintended Consequences of Medicaid Rebates" presented at the DIA Annual Meeting, Orlando, FL, June 1995.
"The Appropriate Setting for Measurements in Pharmacoeconomic Evaluations" presented at CePOR Conference, Chapel Hill, NC, April 1995.
"Medicaid Drug Rebates, Pharmaceutical Prices and Unintended Consequences of Health Policy Reform" presented at the Glaxo Career Development Awards Convocation, Durham, NC, March 1995.
"Medicaid Drug Rebates, Pharmaceutical Prices, and Unintended Consequences of OBRA 1990" presented at The Wintergreen Conference III, Wintergreen, VA, October 1994.
"The Interface of Methodologies from Epidemiology and Economics," presented at the American Association of Colleges of Pharmacy Annual Meeting, Albuquerque, NM, July 1994.
"Pharmaceutical Managed Care: A Penny Saved is a Penny Earned," poster presentation at the American Pharmaceutical Association Annual Meeting, Seattle, WA, March 1994.
"Most-Favored-Customer Protection and Medicaid Rebates under OBRA 1990," presented at the Southern Economic Association Annual Meeting, New Orleans, LA, November 1993.

Service Activities - University Of Maryland (UMB) School of Pharmacy

ASCP Student Chapter Faculty Advisor	1998 – 2001
Admissions Committee - PharmD	2011 - present
ISPOR Student Chapter Faculty Advisor	2002 - present
UMB A Bridge to Academic Excellence Tutor	2001
UMB Assessment Focus Group	1995, 1996
UMB Community Outreach Partnership Centers Committee	1997
UMB Computer Working Group	2000-2003
UMB Curriculum Committee	1996, 1997, 2008
UMB ELP Committee	2008
UMB Faculty Affairs Committee	1999-2001
UMB Faculty Development Committee	1997
UMB Faculty Senator	1997 - 1999
UMB PHSR Graduate Program Director	1998 - 2003
UMB PPS Research Committee	1998 - 2003
UMB Professional Reimbursement Committee	1998
UMB Research and Graduate Education Committee (ad hoc)	1998 - 2002
UMB Research and Graduate Education Committee Chair	2002 - 2003
UMB Various Faculty Search Committees	1997 - present

Service Activities - External

AHRQ Ad hoc Reviewer	2004, 2008 to 2009
AHRQ Health Systems Research (HSR) Study Section	2005 – 2007
AHRQ Expert Meeting on Evidence Evaluation for Assignment of HCPCS Codes	2007
APHA Annual Meeting Abstract Reviewer	1997
APhA Annual Meeting Abstract Reviewer	1996, 1999, 2000, 2002
ASCP Pharmacoeconomic Fellowship Selection Panel	1996
ASCP Advisory Panel for ASCP Fleetwood Project	1995 – 1999
Cancer Care Ontario Grant Reviewer	2011
DIA Annual Meeting Planning Committee - EBM Section Chair	2006-2009
DIA - IMPACT SIAC Chair	2008-2010
DIA Research Grant Award Program Committee Member	2001
DIA Steering Committee of the Americas Vice Chair	2000-2001
DIA Steering Committee of the Americas Programming Chair	2002-2004
ISPOR Awards Committee Chair	2004-2006
ISPOR BIA Task Force Committee Member	2006
ISPOR Real World Data Task Force Sub-Committee Chair	2006
ISPOR Drug Costs in Pharmacoeconomic Studies Sub-Committee Chair	2007 - 2008
ISPOR 13th Annual International Meeting co-Chair	2008
ISPOR Student Chapter Faculty Advisor Council Chair	2009-2011
Maryland Public Health Association (MPHA) Board Member	1996 - 2001
MPHA Treasurer	1998 - 2000
NIH/NCI Ad hoc Reviewer	2008 - present
NIH/NCI Study Section J Committee Member	2011 - 2015
NIH/NHLBI Ad hoc Reviewer	1997, 1998
Maryland Health Care Commission Hospital and Ambulatory Surgical Facility Report Card Steering Committee Member	2000- 2002
Maryland Health Care Commission Hospital Performance Guide Steering Committee Member	2002- 2006
PhRMA Foundation Health Outcomes Research Grants Committee Member	2008 - present

Journal Reviews

American Journal of Geriatric Pharmacotherapy, Reviewer	2005
American Journal of Hypertension, Reviewer	2004
American Journal of Pharmaceutical Education, Reviewer	1997 – 2002
American Journal of Pharmacy Benefits, Reviewer	2010 – present
American Journal of Transplantation, Reviewer	2004
American Journal of Managed Care, Reviewer	1999 - present
Annals of Internal Medicine, Reviewer	2011
Arthritis Care & Research, Reviewer	2006
Cancer Investigation, Reviewer	2008
Cancer, Reviewer	2010 - present
Chest, Reviewer	2007 - present
Clinical Therapeutics, Section Editor	2000 - 2010
Clinical Therapeutics, Reviewer	1999 - present
Clinical Drug Investigation, Reviewer	2000, 2004
Contemporary Economic Policy, Reviewer	2002
Current Therapeutic Research, Reviewer	2002 - 2011
Disease Management & Health Outcomes, Reviewer	2001 - 2003
Drugs & Aging, Reviewer	2002
Health Affairs, Reviewer	1997 - present
Health Economics, Reviewer	2003, 2010
Health Policy, Reviewer	2007
Health Services Research, Reviewer	1998
Inquiry, Reviewer	2001
Journal of Health Politics, Policy and Law, Reviewer	1997, 2003, 2004
Journal of Managed Care Pharmacy, Reviewer	2002 - present
Journal of Managed Care Medicine, Genomics & Biotech, Reviewer	2008, 2009
Journal of the National Medical Association, Reviewer	2003 - 2008
Journal of Pharmacy Teaching, Reviewer	1994 - 2002
Medical Care, Supplemental Issue Reviewer	1995, 2008
Milbank Quarterly, Reviewer	2007- present
Nature Clinical Practice Oncology, Reviewer	2007
Osteoporosis International, Reviewer	2002
PharmacoEconomics, Reviewer	1995 - present
PharmacoEconomics, Editorial Advisory Board	2002 - 2011
Research in Social & Administrative Pharmacy, Reviewer	2011
Science, Reviewer	2000
Social Science & Medicine, Reviewer	2004
Treatments in Respiratory Medicine, Reviewer	2004
Value in Health, Editorial Board	1998 - 2001
Value in Health, co-Editor	2002 - 2010
Value in Health, co-Editor-in-Chief	2010 to present

Consulting/Advisory Boards *(within last 2 year)*

Amgen
Bayer Pharmaceuticals
Bristol-Myers Squibb
Celgene
Genentech
GlaxoSmithKline
Janssen/J&J
Lilly
Merck
Mitsubishi
Novartis
Otsuka
Pfizer
Sanofi-Aventis

Ebenezer O. Oloyede, MD, MPH, MBA(Candidate)
ooloyede@jhsph.edu
(443-813-8767)

Education

- **College of Medicine, University of Ilorin (W.H.O. Collaborating Centre): MD, April 2003**

- **Johns Hopkins School of Public Health: MPH, May 2009**
  Thesis: Cost-effectiveness Analysis of Tuberculosis Outbreak Screening Program in Baltimore Homeless Shelters

- **Robert Smith Business School, University of Maryland: MBA Candidate**

Certificates/Trainings:

- Citation Management Software: Reworks, Endnote (August, 2010)
- Grants Writing, Application and Submission (July, 2010)
- e-IRB Application and Submission (June, 2010)
- HIPAA and Research (February 2010)
- HIPAA: General Issues (February 2010)
- Good Clinical Practice and Clinical Vaccine Trials (May 2009)
- CITI Collaborative: Human Subjects Research/Responsible Conduct of Research (May 2009)
- Vaccine Science and Policy (May 2009)
- Strategic Leadership Principles &Tools for Health Systems Transformation (January 2009)
- Reducing Maternal Mortality and Morbidity through Active Management of Third Stage of labor (AMTSL) & Judicious Use of Misoprostol for Treatment of Post Partum Hemorrhage (PPH) (October 2007)

Special Skills:

- Proficient in Microsoft Office applications – Word, Access, Excel and Power point
- Experience with formula-based spreadsheets creation
- Working Knowledge of STATA statistical analysis package
- Personal Attributes: passion for excellence; resilience and multi-tasking skills; keen understanding and practical application of standard operating procedures and best practices concepts; excellent project management, written and verbal communication skills; reliability; integrity; assiduousness; and team spirit.

WORK EXPERIENCE

Research Project Coordinator: University of Maryland (August 2012 - Present)

- Assist Principal Investigator in drafting and editing annual reports, updates to study sponsors and collaborators, and other required reporting.
- Assist Principal Investigator in development and management of proposals.
- Develop and/or produce reports of study data. May have a role in publications or grant applications.
- Perform or schedule appointments, interviews, or similar meetings with patients, clinicians and other stakeholders.
- Recruit and screen participants. Develop recruitment streams through doctors' offices, community clinics, and other sources. May advise participants of risks and benefits and gain their consent.
- As appropriate, file forms and reports for Human protections, the Office of Research and Development, or other campus entities.

Clinical Research/Data Assistant: Johns Hopkins University (April 2010 - May2010. Volunteer: May 2010 – October 2011)
(Study of Thromboxane Production in Acute Coronary Syndrome Patients):

- Dutifully assists with study design and writing of research manuscripts
- Performs literature searches and reviews
- Screens eligible patients for enrollment into study according to IRB-approved guide lines
- Diligently obtains informed consent, recruits eligible patients in accordance with study protocol eligibility criteria using case report forms (CRFs)
- Schedules study visits and follow-up appointments and maintains detailed regulatory binder
- Conducts study interviews on eligible patients
- Assists in sample collection for laboratory analysis and specimen banking
- Carefully collects data and inputs in the GCRC central Access database
- Uses Microsoft Excel functions and export data from Access to Excel
- Maintains data accuracy and data quality assurance
- Abstracts patients' data from clinical charts and EPR
- Analyzes data and performs data queries
- Conscientiously verifies data for quality control
- Works with the IRB on monitoring and regulatory issues

Program Associate: Prince George's County Health Department (March 2010 – May 2010)

- Provided expert clinical oversight for assessing eligibility for various types of medical assistance transportation
- Collaborated with the department leadership on quality improvement strategies
- Critically examined clients' requests for medical assistance transportation and makes appropriate recommendations based on clients' complaints and physicians' certifications
- Coordinated physicians' certifications for change of medical assistance transportation mode and out-of-area clinic appointment requests
- Effectively coordinated in-house training of staff as well as clients on the state health department's medical assistance transportation policies
- Ensured strict adherence to state policies and regulations for transporting clients with medical needs
- Played an active role on the medical assistance transportation advisory committee

Program Research Intern (MAI): Management Sciences for Health, Arlington, VA (Jan. 2010-April 2010)

- Provided support to the MSH HIV & AIDS Initiative (MAI) by analyzing HIV&AIDS-related priorities of recipient countries
- Provided assistance to the Global Technical Lead and the MAI Manager in compiling this background information
- Analyzed HIV-AIDS related priorities of recipient country governments
- Categorized HIV& AIDS-related priorities
- Identified technical areas that are key priorities across countries and regions, including gaps
- Provided technical support for the MSH TB/HIV Technical Exchange Network
- Provided additional support to MAI as needed

Program Manager: Global Resource Services Inc. (July 2009 – March 2010)

- Reading and editing all grant proposals, ensuring that they meet expected program objectives/standards and are of excellent quality
- Monitored recruitment activities of underserved minority youth into the Youth Build community program that provides educational and vocational training for unemployed youth
- Provided strategic oversight, planning and implementing operating strategies for proposed programs within and outside the U.S
- Managed and coordinated the activities of the organization's core operations and work force

Public Health Research Fellow: Baltimore City Health Department (December 2008-May 2009)

- Cost-Effectiveness Analysis of Tuberculosis Screening Program in Baltimore Homeless Shelters
- Collaboration with clinical services leadership team on cost analyses for STD, TB and HIV programs
- Participation in meetings/discussions about strategic directions for decisions based on cost analysis

Senior Medical Officer/ Lead Clinical Coordinator: Lagoon Hospital/Hygeia HMO, Nigeria (2005-2008)

- Successfully attended to a wide range of emergency/critical cases (medical and pediatric resuscitation, obstetric emergencies, trauma, etc), including cardiovascular and respiratory diseases
- Active participation as member of Infectious diseases prevention and management team
- Successfully coordinated and supervised activities of over 60 medical and paramedical staff within the hospital
- Good understanding and practical application of standard operating procedures and best practices
- Supervised HCT and PMCTC programs and provided treatment for HIV patients
- Efficiently managed various pediatric infectious diseases
- Successfully managed birth asphyxia and neonatal hyperbilirubinemia
- Administered screening and treatment services to cardiovascular out-patients
- Excellently managed patient data base and sent monthly official patient case summaries to relevant corporate organizations and HMOs within the hospital's retainership network
- Preparation and approval of medical reports, including certification of medical documents
- Dutifully developed, organized and coordinated clinical activities and agenda, conference calls, monthly physicians meetings, weekly clinical meetings, hospital seminars and presentations of pharmaceutical products

Medical Officer: Doren Specialist Hospital (2004-2005)

- Actively participated in resuscitation and critical care of neonates
- Inpatient and outpatient management of medical, pediatric, O&G and orthopedic patients
- Successfully provided reproductive health, maternal and child health services
- Empathically provided supportive care for patients with end-stage diseases (e.g. cancer, AIDS and end-stage renal disease patients on life support)
- Implemented and monitored immunization programs
- Successfully coordinated the activities of other medical and paramedical staff

House Officer: University of Ilorin Teaching Hospital (2003-2004)

- Managed patients in a tertiary care setting, conducted periodic morbidity and mortality audits and facilitated update courses among clinical staff
- Provided emergency and critical care to patients in the accident and emergency ward and the intensive care unit
- Actively managed cancer patients
- Managed patients under supervision in the Medical, Surgical, Obstetric/Gynecology and Pediatric departments
- Followed established departmental policies and procedures, including continuously achieving quality improvement objectives of safety, environmental, and infection control standards
- Actively involved in specified health promotion, education and prevention programs – e.g. health education of parents and caregivers of people living with HIV/AIDS
- Participated in the collation of clinical information (laboratory results, patients' clinical data) for research purposes
- Coordinated the presentation of clinical cases during clinical meetings, academic and radiological seminars. Actively participated in teaching conferences, grand rounds and seminars as scheduled

Public Health Service:

NGO: NCCMDS – Ilorin, Nigeria; Lagoon Hospital Friends - Lagos, Nigeria (1995-2008)

- Facilitated training workshops on Malaria
- Served as a role model and trained secondary school students as peer educators
- Provided free medical care and reproductive health services to medically underserved communities
- Organized periodic health education and health promotion programs for adolescents (Sex education, disease prevention including personal and environmental hygiene)
- Coordinated Tuberculosis screening programs
- Successfully organized HIV/AIDS awareness campaigns as well as facilitated training workshops on HIV/AIDS prevention strategies (e.g. PMTCT)
- HIV/AIDS counseling and referrals to treatment and support centers
- Coordination of annual workshop on key health issues
- Public Health Educator (e.g. food and water hygiene, home care for children with mild dehydration and nutritional support for undernourished children)

Award: Best Clinical Coordinator - 2008 (Matron's Award)

Professional Affiliations: - African Public Health Network, Johns Hopkins School of Public Health
- Johns Hopkins University Alumni
- Health Care Business Association, Robert Smith Business School, UMD

Articles, Projects, Seminars, Abstracts and Pending Publications:

1. Oloyede E.O, MD, MPH. Author: **Cost Effectiveness Analysis of Tuberculosis Outbreak Screening Program in a Homeless Shelter**
2. Oloyede E. O, MD, MPH. Co-Author: **Aspirin-insensitive Thromboxane Generation and Coronary Thrombosis in Acute Coronary Syndrome ("Heart Attack") Patients: A Study of Atherothrombosis in Acute Coronary Syndrome (ACS) Patients Despite Adequate Aspirin therapy (Publication manuscript presented at American Heart Association conference)**
3. Oloyede E. O, MD, MPH**. Gender Differences in Colorectal Cancer Screening, Incidence and Mortality in the United States of America (Applied Epidemiology Research Seminar)**
4. Sarah Preston, Oloyede E.O. **Program Planning for Health Behavior Change: Needs Assessment**
5. Oloyede E. O, MD, MPH. **Emergency Preparedness: Ready? Set? Good Project Review**
6. Oloyede E. O, MD, MPH. **Deterrents of Polio Vaccination Initiative In Nigeria: The Way Forward**
7. Oloyede E. O, MD, MPH. **Levels of Maternal Delay and Obstetric Complications in a Nigerian Tertiary Health Institution**
8. Oloyede E. O, MD, MPH. **An Overview of the Nigerian Population Dynamics and Health Structure**
9. Oloyede E. O, MD, MPH. **Program Planning and Evaluation: Process Evaluation**
10. Reubeena Shaheen, Ebenezer Oloyede, et al.**The Effects of Directly Observed Therapy** (**DOT**) **on The Rates of Drug Resistance and Relapse in Tuberculosis**
11. Oloyede E. O, MD, MPH. **Effects of Routine Isoniazid (INH) on Tuberculosis Incidence Among HIV-Infected Men in South Africa**

12. Anuli Ajeni, Heather Awsumb, Ebenezer Oloyede, et al. **Case Study: Improving HIV Prevention of Mother –To-Child Transmission (PMTC) Testing Rates in Kweneng District, Botswana**
13. Oloyede E. O, MD, MPH. **Contacts of Cases of Active Pulmonary Tuberculosis**
14. Anuli Ajeni, Heather Awsumb, Ebenezer Oloyede, et al. **Case Study: District Supportive Supervision Following Health Sector Reform In Tanzania**
15. Oloyede E. O, MD, MPH. **Transmission of Tuberculosis in a High Incidence Urban Community in South Africa**
16. Ebenezer Oloyede, Robin Harrison, Chris Hardy, Christian Hague. **Cervical Cancer Screening Rates Among Foreign-Born New York City Residents**
17. Oloyede E. O, MD, MPH. **Ethics of Public Health Practice in Developing Countries - Case Study: Enrolling Patients to receive Antiretroviral Treatment for HIV/AIDS in South Africa**

References

1. Professor Daniel Mullins (PhD)
   Pharmaceutical Health Services Research Department
   University of Maryland School of Pharmacy
   220 Arch Street, 12th Floor
   Baltimore, MD 21201
   E-mail: dmullins@rx.umaryland.edu
   Tel: 410-706-0879
   (Relationship: Supervisor)

2. Dr. Andrew DeFilippis, MD, MSc
   Director, Advanced Cardiac Support Center
   Division of Cardiology, University of Louisville
   Rudd Heart & Lung Center
   Louisville, KY 40202
   E-mail: apdefi01@louisville.edu
   Tel: 410-310-0311
   (Relationship: Supervisor, Johns Hopkins University School of Medicine)

3. Professor Kevin Frick (PhD)
   Professor, Department of Health Policy and Management
   Johns Hopkins University School of Public Health
   624 N. Broadway, Rm. 606, Baltimore, MD 21205
   E-mail: kfrick@jhsph.edu
   Tel: 410-340-9314, 443-956-1174
   (Relationship: Project Supervisor)

BIOGRAPHICAL SKETCH

Provide the following information for the Senior/key personnel and other significant contributors in the order listed on Form Page 2.
Follow this format for each person. **DO NOT EXCEED FOUR PAGES.**

NAME	POSITION TITLE
Laird, Aurelia L.	Research Project Administrator
eRA COMMONS USER NAME (credential, e.g., agency login)	

EDUCATION/TRAINING *(Begin with baccalaureate or other initial professional education, such as nursing, include postdoctoral training and residency training if applicable.)*

INSTITUTION AND LOCATION	DEGREE *(if applicable)*	MM/YY	FIELD OF STUDY
Walden University	BSN	2009	Nursing
Brooklyn-Jewish School of Nursing, Brooklyn, New York	AA / RN	1974	Nursing
College Abel Bravo, Colon, Panama	BS	1969	Science

A. Personal Statement.

My extensive clinical and supervisory nursing experience makes me a valuable part of the research team. My experience includes creating and implementing research protocols and program evaluation. I have also been extremely successful in recruiting large numbers of underserved, minority patients for research studies within a narrow time-frame for research purposes. My understanding of chronic disease prevention and treatment, and experience in educating English- and Spanish-speaking patient population on topics in healthcare, are also part of my value-added to this research team.

B. Positions and Honors.

Positions:

1973 - 1984	Staff Nurse, Brooklyn Jewish Hospital, Brooklyn, N.Y.
1984 - 1985	Assistant Head Nurse, Ambulatory Care Satellite Facility, Woodhull Hospital
1986 - 1990	Head Nurse, Ambulatory Care Satellite Facility, Woodhull Hospital
1991 - 1993	Clinical Nurse II, Operating Room, Bon Secours Health System, Baltimore, MD
1993 - 1994	Home Health Nurse Case 'Manager, Bon. Secours Health System
1994 - 1996	Quality Improvement Nurse, Bon Secours Health System
1996 - 1997	Clinical Manager, Bay Area Health Care, Baltimore, MD
1997 - 1999	Community Education Nurse, Bon Secours Health System
1998 - 2004	Home Care Coordinator, Visiting Nurses Association, Baltimore, MD
1997 - 2005	Administrative Coordinator, Bon Secours Baltimore Health System
2005 - 2007	Research Nurse, Bon Secours Baltimore Health System
2007 - 2011	Research Project Administrator, Bon Secours Baltimore Health System
2011 - 2012	Patient Centered Outcomes Research Program Director, Bon Secours Baltimore Health System
2012 – Present	Research Projects Administrator

Memberships:

- American Association of Diabetic Educators (AADE).
- Association Clinical Research Professionals (ACRP).

- National Association of Hispanics Nurses (NAHN).
- International Society for Hypertension in Blacks
- Honor Society of Nursing Sigma, Theta Tau International

C. Publication List

Abstracts

- **Laird A**, Larkins F, Winston R, Shaya FT, Samant N, Saunders E, Weaver B, Johnson W. (2008). The Impact of Patient Education on Hemoglobin A1C Value Reduction in Patients with Diabetes. Abstract presentation at the American Association of Diabetes Educators (AADE) 35th Annual Meeting and Exhibition in Washington, DC, August 7, 2008.
- Winston R, Saunders E, Shaya FT, **Laird A**, Zhiqiang KL, Jolly S, Larkins F, Johnson W, Weaver B. (2009). The Impact of Different Patient Education Modules on Hemoglobin A1c Control and Patient Awareness/Management in Diabetic People. Abstract presentation at the American Heart Association (AHA) Quality of Care and Outcomes Research in Cardiovascular Disease and Stroke 2009 Scientific Sessions in Washington, DC, April 24, 2009.
- Winston R, Saunders E, Shaya FT, **Laird A**, Zhiqiang KL, Jolly S, Larkins F, Johnson W, Weaver B. (2009). The Impact of Different Patient Education Modules on Hemoglobin A1c Control and Patient Awareness/Management in Diabetic People with Hypertension. Abstract presentation at the American Society of Hypertension (ASH) 24th Annual Scientific Meeting and Exposition in San Francisco, California, May 7, 2009.
- Winston R, Shaya FT, **Laird A,** Saunders E. (2009). Diabetes Management and Knowledge Improvements as a Result of Patient Education: A Community-Based, Randomized Clinical Trial. Abstract presentation at the International Society for Pharmacoeconomics and Outcomes Research (ISPOR) 14th Annual International Meeting in Orlando, Florida, May 18, 2009.
- Winston R, Saunders E, Shaya FT, **Laird A**, Zhiqiang KL, Larkins F, Mullins CD, Jolly S, Johnson W, Weaver B. (2009). The Improvement of Diabetes Control and Disease Process Awareness as a Result of Face-to-Face vs. Mail Intervention among Patients with Diabetes Mellitus. Abstract presentation at the International Society on Hypertension (ISHIB) 23rd Annual International Interdisciplinary Conference on Hypertension and Related Risk Factors in Ethnic Populations in Chicago, Illinois, July 11, 2009.

Manuscripts

- Shaya FT, Gbarayor CM, **Laird A**, Winston R, Saunders E. (2011) Diabetes knowledge in a high risk urban population. Ethn Dis, 21(4), 485-9. PMCID: PMC22428355
- Onwudiwe NC, Mullins CD, Winston RA, Shaya FT, Pradel FG, **Laird A**, Saunders E. (2011) Barriers to self-management of diabetes: a qualitative study among low-income minority diabetics. , Ethn Dis, 21(1), 27-32. PMCID: PMC21462726
- Ezeugwu CO, **Laird A**, Mullins CD, Saluja DS, Winston RA. (2011)Lessons learned from community-based minority health care serving system participation in an NIH clinical trial. J Natl Med Assoc, 103(9-10), 839-44. PMCID: PMC22364051
- Shaya F, Gbarayor CM**, Laird A**, Winston R, Saunders E. What is the change in Diabetes Knowledge by group? Completed. Ethnicity & Disease

D. Research Support

Completed Research Support

Project Number U01 HL079150-01 Winston (PI) NIH/NHLBI 10/01/04 – 08/31/10
Baltimore Partnership Program to Reduce Cardiovascular Disparities

This project is based on a collaborative partnership between the University of Maryland, Baltimore (UMB) and the Bon Secours Baltimore Health System (BSBHS). The research specific aims at UMB and BSBHS are

complementary and seek to improve provider and patient approaches to treatment of hypertension and Diabetes respectively. UMB also aims to modify physician related barriers to minority enrollment in clinical trials, and BSBHS to improve patient adherence to treatment plans. Through didactic training, UMB aims to build a sustainable research program at BSBHS; through cultural sensitivity training, BSBHS expects to enhance the disparities program at UMB.
Role: Research Project Administrator.

Dr D.Mullins (P.I). Patient-Centered Outcomes Research Institute (PCORI).
Interview to identify Evidence for Eliciting the hard to reach Patient's Perspective in PCOR

This project was based on a collaborative partnership between the University of Maryland, Baltimore (UMB) and the Bon Secours Baltimore health System (BSBHS). The research specific aims at UMB and BSBHS are complimentary and goal was to collaborate together along with other partners in enhancing methods for engaging hard to reach patients in patient –centered outcomes research (PCOR). Other aims included establishing permanent partnerships with local, national, and international communities of diverse patients and health care systems to improve PCOR and, ultimately, health outcomes. Expand PCOR in partnership with patients and health care delivery systems that will better inform patient-centered health care decision making and health care systems design; and promote translation and dissemination of PCOR findings for patients, health care providers, and health care systems to implement evidence-based interventions.

Role: Research Program Director

Appendix L

Letters of Support

STEPHANIE RAWLINGS-BLAKE
Mayor
250 City Hall
Baltimore, Maryland 21202

November 14, 2012

The Honorable John A. Hurson, Chairman
Community Health Resources Commission
45 Calvert Street, Room 336
Annapolis, MD 21401

Dr. Joshua Sharfstein, M.D., Secretary
Maryland Department of Health and Mental Hygiene
201 W. Preston Street
Baltimore, MD 21201

Dear Chairman Hurson and Secretary Sharfstein:

I am pleased to support the newly-formed West Baltimore Primary Care Access Collaborative and urge your consideration of its application to be recognized as a Health Enterprise Zone.

The residents of Central-West and Southwest Baltimore long have been underserved by the health care delivery system. Many families lack a primary care physician and suffer from chronic conditions such as cardiovascular disease, diabetes, and asthma. The formation of the West Baltimore Primary Care Access Collaborative (WBPCAC) offers a realistic approach to addressing these problems.

The WBPCAC has brought together 16 health, wellness, education, and community-based organizations and completed a comprehensive health assessment of West Baltimore. In addition, to ensure timely, appropriate strategies to address community needs, the WBPCAC acquires input and guidance from the grass-roots perspective. The WBPCAC has established three areas of focus: care coordination; education and outreach, and the improvement and expansion of primary care capacity.

The WBPCAC offers an approach that can make West Baltimore a healthy community. It already represents an unprecedented level of cooperation among providers, federally qualified health centers, community organizations, as well as others. These participants have made the long-term commitment to transform our community. Therefore, it is our hope that you will favorably review and fund this application.

Sincerely,

Stephanie Rawlings-Blake
Mayor
City of Baltimore

cc: *The Honorable, Verna Jones-Rodwell, Senator, 44th Legislative District*
Dr. Oxiris Barbot, Baltimore City Health Commissioner
Tom Stosur, Baltimore City Department of Planning
Kim Washington, Deputy Chief for Government and Community Affairs, Office of the Mayor
Kaliope Parthemos, Deputy Chief for Economic and Neighborhood Develop., Office of the Mayor
Kym Nelson, Deputy Chief of Staff, Office of the Mayor
Mary Pat Fannon, Senior Policy Advisor, Mayor's Office of Government Relations
Andrew Smullian, Deputy Director, Mayor's Office of Government Relations

CITY OF BALTIMORE
STEPHANIE RAWLINGS-BLAKE, Mayor

HEALTH DEPARTMENT
OXIRIS BARBOT, M.D., Commissioner
1001 E. Fayette Street
Baltimore, Maryland 21202

November 13, 2012

The Honorable John A. Hurson, Chairman
Community Health Resources Commission
45 Calvert Street, Room 336
Annapolis, MD 21401

Joshua Sharfstein, M.D., Secretary
Maryland Department of Health and Mental Hygiene
201 W. Preston Street
Baltimore, MD 21201

Dear Chairman Hurson and Secretary Sharfstein:

The Baltimore City Health Department is pleased to support the newly-formed West Baltimore Primary Care Access Collaborative and to urge your consideration of its application to be recognized as a Health Enterprise Zone.

The residents of Central-West and Southwest Baltimore long have been underserved by the health care delivery system. Many families lack a primary care physician and suffer from chronic conditions such as cardiovascular disease, diabetes, and asthma. The formation of the West Baltimore Primary Care Access Collaborative (WBPCAC) offers a realistic approach to addressing these problems.

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Sincerely,

Oxiris Barbot, M.D.
Commissioner of Health

ELIJAH E. CUMMINGS
7TH DISTRICT, MARYLAND

RANKING MEMBER, COMMITTEE ON
OVERSIGHT AND GOVERNMENT REFORM

COMMITTEE ON
TRANSPORTATION AND INFRASTRUCTURE
SUBCOMMITTEE ON COAST
GUARD AND MARITIME TRANSPORTATION
SUBCOMMITTEE ON
HIGHWAYS AND TRANSIT

JOINT ECONOMIC COMMITTEE

Congress of the United States
House of Representatives
Washington, DC 20515

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☐ 8267 MAIN STREET
ROOM 102
ELLICOTT CITY, MD 21043-9903
(410) 465-8259
FAX: (410) 465-8740

www.house.gov/cummings

November 13, 2012

Dr. Joshua Sharfstein, Secretary
Maryland Department of Health and Mental Hygiene
Mr. John A. Hurson, Chair
Maryland Community Health Resources Commission

Dear Gentlemen:

I am writing today in strong support of the newly formed West Baltimore Primary Care Access Collaborative (WBPCAC) application to be designated as a Health Enterprise Zone in Maryland.

The State of Maryland now has the opportunity to demonstrate to the nation a new approach to eliminating health disparities among racial and ethnic groups and between geographic areas.

The passage earlier this year of the Maryland Health Disparities and Reduction Act set the framework for an approach built around designated Health Enterprise Zones. The creation of the WBPCAC offers real, tangible proof of what can be accomplished.

I understand that prior to even applying for state support, the WBPCAC has brought together 17 health, wellness, education and community-based organizations and established three areas of focus for the residents of Central-West and Southwest Baltimore: care coordination; education and outreach, and the improvement and expansion of primary care capacity.

I am confident you will discover the WBPCAC's approach can make West Baltimore a healthy community. The WBPCAC is well-positioned to receive the State's support as a Health Enterprise Zone, which in turn will demonstrate to the nation the progressive leadership of Maryland's government leaders to make a difference in the lives of our residents.

I hope that you will give every reasonable consideration to WBPCAC's application to be designated as a Health Enterprise Zone in Maryland.

Sincerely,

Elijah E. Cummings
Member of Congress

EEC/dg

VERNA JONES-RODWELL
44th Legislative District
Baltimore City

Budget and Taxation Committee
Chair, Pensions Subcommittee

Senate Chair, Joint Committee on the Management of Public Funds

Chair, Baltimore City Senate Delegation
Secretary, Women Legislators of Maryland, Inc.

The Senate of Maryland
ANNAPOLIS, MARYLAND 21401

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Verna.Jones@senate.state.md.us

District Office
1701 Madison Avenue, Suite 510
Baltimore, Maryland 21217
410-669-6355 · *Fax* 410-669-6801

November 14, 2012

Dr. Joshua Sharfstein,
Secretary, Maryland Department of Health and Mental Hygiene
And
John A. Hurson,
Chair, Maryland Community Health Resources Commission

Gentlemen,

I am writing today in strong support of the newly formed West Baltimore Primary Care Access Collaborative application to be recognized as a Health Enterprise Zone.

As state senator for this community, I am well aware of the fact that the residents of Central-West and Southwest Baltimore are underserved by the city's health delivery system. A health profile produced by the city's health department in 2008 found that residents of Southwest Baltimore had a higher jobless rate, a lower median household income and a higher infant mortality rate than the city as a whole.

The profile found that people living in Southwest Baltimore had an average lifespan almost seven years shorter than the average life expectancy of Baltimore City residents. And the communities served by Bon Secours Hospital have higher death rates from heart disease, cancer, HIV, stroke and diabetes than residents of the city overall.

The formation of the West Baltimore Primary Care Access Collaborative (WBPCAC) offers a realistic approach to addressing these problems. The WBPCAC has brought together 17 health, wellness, education and community-based organizations and established three areas of focus for the residents of Central-West and Southwest Baltimore: care coordination; education and outreach, and the improvement and expansion of primary care capacity. It has been a great pleasure to have worked on such a collaborative effort with these talented and committed individuals; this level of cooperation has not been seen in Baltimore in a very long time.

Now, the WBPCAC is preparing an application for a grant under Maryland's new Health Improvement and Disparities Reduction Act to support West Baltimore as a Health Enterprise Zone. This application deserves a serious and positive review.

I am confident you will discover the WBPCAC offers an approach that can make West Baltimore a healthy community and can serve as a city and statewide model. The WBPCAC already represents an unprecedented level of cooperation among providers, federally qualified health centers, community organizations and others, and the participants have made the long-term commitment necessary to transform our community. The WBPCAC deserves the State's support.

If there are any questions or concerns please feel free to contact my office by email at verna.jones@senate.state.md.us or phone at 410-841-3612.

Sincerely,

Verna Jones-Rodwell
State Senator

CATHERINE E. PUGH
40th Legislative District
Baltimore City

DEPUTY MAJORITY LEADER

Finance Committee

Chair
Transportation Subcommittee

Chair
Special Committee on Substance Abuse

Joint Audit Committee

Joint Committee on Health Care
Delivery and Financing

Joint Committee on Investigation

The Senate of Maryland
ANNAPOLIS, MARYLAND 21401

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Catherine.Pugh@senate.state.md.us

District Office
2901 Druid Park Drive, Suite 200C
Baltimore, Maryland 21215-8102
410-383-1500
Fax 410-383-0902

October 29, 2012

Dr. Joshua Sharfstein,
Secretary, Maryland Department of Health and Mental Hygiene
And John A. Hurson,
Chair, Maryland Community Health Resources Commission

Dear Secretary Sharfstein and Mr. Hurson:

I write this letter in strong support of the newly formed West Baltimore Primary Care Access Collaborative application to be recognized as a Health Enterprise Zone.

Most everyone knows that the residents of Central-West and Southwest Baltimore are underserved by the city's health delivery system. A health profile produced by the city's health department in 2008 found that residents of Southwest Baltimore had a higher jobless rate, a lower median household income and a higher infant mortality rate than the city as a whole.

The profile found that people living in Southwest Baltimore had an average lifespan almost seven years shorter than the average life expectancy of Baltimore City residents. And the communities served by Bon Secours Hospital have higher death rates from heart disease, cancer, HIV, stroke and diabetes than residents of the city overall.

The formation of the West Baltimore Primary Care Access Collaborative (WBPCAC) offers a realistic approach to addressing these problems. The WBPCAC has brought together 17 health, wellness, education and community-based organizations and established three areas of focus for the residents of Central-West and Southwest Baltimore: care coordination; education and outreach, and the improvement and expansion of primary care capacity.

Now, the WBPCAC is preparing an application for a grant under Maryland's new Health Improvement and Disparities Reduction Act to support West Baltimore as a Health Enterprise Zone. This application deserves a serious and positive review.

I am confident you will discover the WBPCAC offers an approach that can make West Baltimore a healthy community. This WBPCAC already represents an unprecedented level of cooperation among providers, federally qualified health centers, community organizations and others, and the participants have made the long-term commitment necessary to transform our community. The WBPCAC deserves the State's support.

Sincerely,

Catherine E. Pugh

Senator Catherine E. Pugh

KEIFFER J. MITCHELL, JR.
44th Legislative District
Baltimore City

Judiciary Committee

The Maryland House of Delegates
6 Bladen Street, Room 316
Annapolis, Maryland 21401
410-841-3802 · 301-858-3802
800-492-7122 *Ext.* 3802
Keiffer.Mitchell@house.state.md.us

THE MARYLAND HOUSE OF DELEGATES
ANNAPOLIS, MARYLAND 21401

November 2, 2011

Dr. Joshua Sharfstein,
Secretary, Maryland Department of Health and Mental Hygiene
And John A. Hurson,
Chair, Maryland Community Health Resources Commission

Gentlemen,

I am writing today in strong support of the newly formed West Baltimore Primary Care Access Collaborative's application to be recognized as a Health Enterprise Zone.

It is not news that the residents of Central-West and Southwest Baltimore are underserved by the city's health delivery system. A health profile produced by the city's health department in 2008 found that residents of Southwest Baltimore had a higher jobless rate, a lower median household income and a higher infant mortality rate than the city as a whole.

The profile found that people living in Southwest Baltimore had an average lifespan almost seven years shorter than the average life expectancy of Baltimore City residents. And the communities served by Bon Secours Hospital have higher death rates from heart disease, cancer, HIV, stroke and diabetes than residents of the city overall.

The formation of the West Baltimore Primary Care Access Collaborative (WBPCAC) offers a realistic approach to addressing these problems. The WBPCAC has brought together 17 health, wellness, education and community-based organizations and established three areas of focus for the residents of Central-West and Southwest Baltimore: care coordination; education and outreach, and the improvement and expansion of primary care capacity.

Now, the WBPCAC is preparing an application for a grant under Maryland's new Health Improvement and Disparities Reduction Act to support West Baltimore as a Health Enterprise Zone. This application deserves a serious and positive review.

KEIFFER J. MITCHELL, JR.
44th Legislative District
Baltimore City

Judiciary Committee

The Maryland House of Delegates
6 Bladen Street, Room 316
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800-492-7122 *Ext.* 3802
Keiffer.Mitchell@house.state.md.us

THE MARYLAND HOUSE OF DELEGATES
ANNAPOLIS, MARYLAND 21401

I am confident you will discover the WBPCAC offers an approach that can make West Baltimore a healthy community. This WBPCAC already represents an unprecedented level of cooperation among providers, federally qualified health centers, community organizations and others, and the participants have made the long-term commitment necessary to transform our community. The WBPCAC deserves the State's support.

Sincerely,

Delegate Keiffer J. Mitchell Jr.

SHAWN Z. TARRANT
40th Legislative District
Baltimore City

DEPUTY MAJORITY WHIP

Health and Government
Operations Committee

Subcommittees
Insurance
Government Operations

THE MARYLAND HOUSE OF DELEGATES
ANNAPOLIS, MARYLAND 21401

Annapolis Office
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6 Bladen Street, Room 411
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Shawn.Tarrant@house.state.md.us

District Office
2901 Druid Park Drive, Suite 200E
Baltimore, Maryland 21215
410-728-0361
Fax 410-728-6949

November 1, 2012

Dr. Joshua Sharfstein,
Secretary
Maryland Department of Health and Mental Hygiene
201 West Preston St.
Baltimore, Maryland 21201-2399
And
John A. Hurson, Chair
Maryland Community Health Resources Commission
45 Calvert St, Room #336
Annapolis, Maryland 21401

Gentlemen,

I am writing today to endorse the efforts of the newly formed West Baltimore Primary Care Access Collaborative and to urge your serious consideration of the group's application to be recognized as a Health Enterprise Zone.

As you both are aware, the residents of Central-West and Southwest Baltimore long have been underserved by the city's health delivery system. Many families lack a primary care physician and suffer from chronic conditions such as cardiovascular disease, diabetes and asthma. The formation of the West Baltimore Primary Care Access Collaborative (WBPCAC) offers a realistic approach to addressing these problems and the state of Maryland can play a significant role.

The WBPCAC already has brought together 16 health, wellness, education and community-based organizations, and a comprehensive health assessment of West Baltimore was completed this summer. In addition, in order to ensure timely, appropriate strategies to address the needs of our community, the WBPCAC has, and continues to seek input and guidance from the grass-roots perspective. That assessment, in turn, has helped the WBPCAC establish three areas of focus: care coordination; education and outreach, and the improvement and expansion of primary care capacity.

Now, the WBPCAC is preparing an application for a grant under Maryland's new Health Improvement and Disparities Reduction Act to support West Baltimore as a Health Enterprise Zone. This application deserves a serious and positive review.

I am confident you will discover the WBPCAC offers an approach that can make West Baltimore a healthy community. This WBPCAC already represents an unprecedented level of cooperation among providers, federally qualified health centers, community organizations and others, and the participants have made the long-term commitment necessary to transform our community. The WBPCAC deserves the State's support. Please contact my District Office if additional information is needed and I can be reached at 410-728-0361.

Sincerely,

Shawn Z. Tarrant

Shawn Z. Tarrant
40th Legislative District
Baltimore City, Maryland

BARBARA A. ROBINSON
40th Legislative District
Baltimore City

Appropriations Committee

Subcommittees
Public Safety & Administration
Oversight Committee on Pensions

Joint Committee on Fair Practices and State Personnel Oversight

At-Large Executive Board Member
Women Legislators of Maryland

1st Vice Chair
Legislative Black Caucus of Maryland

The Maryland House of Delegates
ANNAPOLIS, MARYLAND 21401

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410-225-3620 · *Fax* 410-225-3621

Oct. 29, 2012

Dr. Joshua Sharfstein,
Secretary, Maryland Department of Health and Mental Hygiene
And John A. Hurson,
Chair, Maryland Community Health Resources Commission

Gentlemen,

I am writing today in strong support of the newly formed West Baltimore Primary Care Access Collaborative's (WBPCAC) application to be designated as a Health Enterprise Zone in Maryland.

The State of Maryland now has the opportunity to demonstrate to the nation a new approach to eliminating health disparities among racial and ethnic groups and between geographic areas.

The passage earlier this year of the Maryland Health Disparities and Reduction Act set the framework for an approach built around designated Health Enterprise Zones. And the creation of the WBPCAC offers real and tangible proof of what can be accomplished.

Prior to even applying for state support, the WBPCAC has brought together 17 health, wellness, education and community-based organizations and established three areas of focus for the residents of Central-West and Southwest Baltimore: care coordination; education and outreach, and the improvement and expansion of primary care capacity.

I am confident you will discover the WBPCAC's approach can make West Baltimore a healthy community. The WBPCAC deserves the State's support as a Health Enterprise Zone, which in turn will demonstrate to the nation the progressive leadership of Maryland's government leaders to make a difference.

Sincerely,

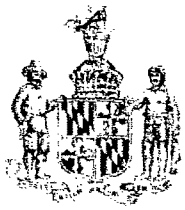
Delegate Barbara A. Robinson ad

Delegate Barbara A. Robinson
40th Legislative District

BAR/ad

SAMUEL I. "SANDY" ROSENBERG
41st Legislative District
Baltimore City

Vice Chair
Ways & Means Committee



RESPOND TO OFFICE INDICATED

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THE MARYLAND HOUSE OF DELEGATES
ANNAPOLIS, MARYLAND 21401

November 7, 2012

Dr. Joshua Sharfstein
Secretary, Maryland Department of Health and Mental Hygiene
Hon. John A. Hurson
Chair, Maryland Community Health Resources Commission

Dear Josh and John:

I write to endorse the efforts of the newly formed West Baltimore Primary Care Access Collaborative (WBPCAC) and to urge your serious consideration of the group's application to be recognized as a Health Enterprise Zone.

As you both are aware, the residents of Central-West and Southwest Baltimore long have been underserved by the city's health delivery system. Many families lack a primary care physician and suffer from chronic conditions, such as cardiovascular disease, diabetes, and asthma. The WBPCAC offers a realistic approach to addressing these problems, and the state of Maryland can play a beneficial role.

The WBPCAC has already brought together 16 health, wellness, education, and community-based organizations and completed a comprehensive health assessment of West Baltimore this summer. In addition, in order to ensure timely, appropriate strategies to address the needs of the community, the WBPCAC has, and continues to seek input and guidance from, a grass-roots perspective. That assessment, in turn, has helped the WBPCAC establish three areas of focus: care coordination, education and outreach, and the improvement and expansion of primary care capacity.

The WBPCAC is now preparing an application for a grant under Maryland's new Health Improvement and Disparities Reduction Act to support West Baltimore as a Health Enterprise Zone. This application deserves a serious and positive review.

I am confident you will discover that the WBPCAC offers an approach that can make West Baltimore a healthy community. WBPCAC already represents an unprecedented level of cooperation among providers, federally qualified health centers, community organizations and others, and the participants have made the long-term commitment necessary to transform our community. The WBPCAC deserves the State's support.

Yours truly,

Samuel I. Rosenberg

Bernard C. "Jack" Young
President
Baltimore City Council

100 N. Holliday Street, Room 400 • Baltimore, Maryland 21202
410-396-4804 • Fax 410-539-0647
E-Mail councilpresident@baltimorecity.gov

November 14, 2012

Dr. Joshua Sharfstein,
Secretary, Maryland Department of Health and Mental Hygiene
201 West Preston Street,
Baltimore, Maryland 21201

The Honorable John A. Hurson, Chair
Maryland Community Health Resources Commission
45 Calvert Street, Room 336
Annapolis, Maryland 21401

Gentlemen,

I am writing today in strong support of the newly formed West Baltimore Primary Care Access Collaborative application to be recognized as a Health Enterprise Zone.

It is not news that the residents of Central-West and Southwest Baltimore are underserved by the city's health delivery system. A health profile produced by the city's health department in 2008 found that residents of Southwest Baltimore had a higher jobless rate, a lower median household income and a higher infant mortality rate than the city as a whole.

The profile found that people living in Southwest Baltimore had an average lifespan almost seven years shorter than the average life expectancy of Baltimore City residents. And the communities served by Bon Secours Hospital have higher death rates from heart disease, cancer, HIV, stroke and diabetes than residents of the city overall.

The formation of the West Baltimore Primary Care Access Collaborative (WBPCAC) offers a realistic approach to addressing these problems. The WBPCAC has brought together 17 health, wellness, education and community-based organizations and established three areas of focus for the residents of Central-West and Southwest Baltimore: care coordination; education and outreach, and the improvement and expansion of primary care capacity.

Now, the WBPCAC is preparing an application for a grant under Maryland's new Health Improvement and Disparities Reduction Act to support West Baltimore as a Health Enterprise Zone. This application deserves a serious and positive review. I am confident you will discover the WBPCAC offers

an approach that can make West Baltimore a healthy community. The WBPCAC deserves the State's support.

Sincerely,

Bernard C. "Jack" Young, President
Baltimore City Council

BALTIMORE CITY COUNCIL

WILLIAM "PETE" WELCH

NINTH DISTRICT

COMMITTEE MEMBERSHIPS
EDUCATION
EXECUTIVE APPOINTMENTS
HEALTH
POLICY AND PLANNING

November 5, 2012

Dr. Joshua Sharfstein,
Secretary, Maryland Department of Health and Mental Hygiene
And John A. Hurson,
Chair, Maryland Community Health Resources Commission

Gentlemen,

I am writing today in strong support of the newly formed West Baltimore Primary Care Access Collaborative's application to be recognized as a Health Enterprise Zone.

It is not news that the residents of Central-West and Southwest Baltimore are underserved by the city's health delivery system. A health profile produced by the city's health department in 2008 found that residents of Southwest Baltimore had a higher jobless rate, a lower median household income and a higher infant mortality rate than the city as a whole.

The profile found that people living in Southwest Baltimore had an average lifespan almost seven years shorter than the average life expectancy of Baltimore City residents. And the communities served by Bon Secours Hospital have higher death rates from heart disease, cancer, HIV, stroke and diabetes than residents of the city overall.

The formation of the West Baltimore Primary Care Access Collaborative (WBPCAC) offers a realistic approach to addressing these problems. The WBPCAC has brought together 17 health, wellness, education and community-based organizations and established three areas of focus for the residents of Central-West and Southwest Baltimore: care coordination; education and outreach, and the improvement and expansion of primary care capacity.

Now, the WBPCAC is preparing an application for a grant under Maryland's new Health Improvement and Disparities Reduction Act to support West Baltimore as a Health Enterprise Zone. This application deserves a serious and positive review.

I am confident you will discover the WBPCAC offers an approach that can make West Baltimore a healthy community. This WBPCAC already represents an unprecedented level of cooperation among providers, federally qualified health centers, community organizations and others, and the participants have made the long-term commitment necessary to transform our community. The WBPCAC deserves the State's support.

Sincerely,

Councilman William "Pete" Welch
Baltimore City Council
9th District

100 NORTH HOLLIDAY STREET • ROOM 532 • BALTIMORE, MARYLAND 21202 • 410-396-4815 • FAX 410-545-3857
E-MAIL william.welch@baltimorecity.gov

BALTIMORE CITY COUNCIL

SHARON GREEN MIDDLETON
6th District

COMMITTEES:
- Urban Affairs and Aging - Chair
- Land Use and Transportation - Member
- Budget and Appropriations - Member
- Public Safety - Member
- Recreation and Parks - Member
- Parking Authority Board - Member
- Commission on Sustainability - Member

November 7, 2012

Dr. Joshua Sharfstein,
Secretary, Maryland Department of Health and Mental Hygiene
And John A. Hurson,
Chair, Maryland Community Health Resources Commission

Gentlemen,

As Councilmember representing the 6th District, I along with my colleagues Rochelle "Rikki" Spector (5th District) and Bernard C. "Jack" Young (Council President) jointly submit this letter of support for the newly formed West Baltimore Primary Care Access Collaborative and to urge your serious consideration of the group's application to be recognized as a Health Enterprise Zone.

As you both are aware, the residents of Central-West and Southwest Baltimore long have been underserved by the city's health delivery system. Many families lack a primary care physician and suffer from chronic conditions such as cardiovascular disease, diabetes and asthma. The formation of the West Baltimore Primary Care Access Collaborative (WBPCAC) offers a realistic approach to addressing these problems and the state of Maryland can play a significant role.

The WBPCAC already has brought together 16 health, wellness, education and community-based organizations, and a comprehensive health assessment of West Baltimore was completed this summer. In addition, in order to ensure timely, appropriate strategies to address the needs of our community, the WBPCAC has, and continues to seek input and guidance from the grass-roots perspective. That assessment, in turn, has helped the WBPCAC establish three areas of focus: care coordination; education and outreach, and the improvement and expansion of primary care capacity.

Now, the WBPCAC is preparing an application for a grant under Maryland's new Health Improvement and Disparities Reduction Act to support West Baltimore as a Health Enterprise Zone. This application deserves a serious and positive review.

Rm 516 City Hall, 100 North Holliday Street Baltimore, Maryland 21202 Phone: (410) 396-4832
Sharon.Middleton@baltimorecity.gov

We are confident that you will discover the WBPCAC offers an approach that can make West Baltimore a healthy community. This WBPCAC already represents an unprecedented level of cooperation among providers, federally qualified health centers, community organizations and others, and the participants have made the long-term commitment necessary to transform our community. The WBPCAC deserves the State's support.

Sincerely,

Sharon G. Middleton
Baltimore City Councilmember, District 6

Rochelle "Rikki" Spector
Baltimore City Councilmember, District 5

Bernard C. "Jack" Young
Baltimore City Council President

SGM/tcm

BALTIMORE CITY COUNCIL

WILLIAM H. COLE IV — Eleventh District

CITY HALL, ROOM 527
100 N. HOLLIDAY STREET, BALTIMORE, MARYLAND 21202
TELEPHONE: 410-396-4816
FAX 410-545-7464
william.cole@baltimorecity.gov

November 5, 2012

Dr. Joshua Sharfstein, Secretary
Maryland Department of health and Mental Hygiene
And
John A. Hurson, Chair
Community Health Resources Commission

Gentlemen:

I write today to endorse the efforts of the newly formed West Baltimore Primary Care Access Collaborative and to urge your serious consideration of the group's application to be recognized as a Health Enterprise Zone.

As you are both aware, the residents of Central-West and Southwest Baltimore long have been underserved by the city's health delivery system. Many families lack a primary care physician and suffer from chronic conditions such as diabetes and asthma. The formation of the West Baltimore Primary Care Access Collaborative (WBPCAC) offers a realistic approach to addressing these problems and the state of Maryland can play a significant role.

The WBPCAC is preparing an application for a grant under Maryland's new Health Improvement and Disparities Reduction Act to support West Baltimore as a Health Enterprise Zone. This application deserves a serious and positive review.

I am confident you will discover the WBPCAC offers an approach that can make West Baltimore a healthy community. This WBPCAC already represents an unprecedented level of cooperation among providers, federally qualified health centers, community organizations and others, and the participants have made the long-term commitment necessary to transform our community. The WBPCAC deserves the State's support.

Sincerely,

William H. Cole IV

Office of Nick J. Mosby
BALTIMORE CITY COUNCIL • SEVENTH DISTRICT

Committees: Vice Chair, Labor • Education • Executive Appointments • Housing and Community Development • Public Safety

November 1, 2012

Dr. Joshua Sharfstein
Secretary, Maryland Department of Health and Mental Hygiene
John A. Hurson
Chair, Maryland Community Health Resources Commission

Dr. Joshua Sharfstein and Mr. John Hurson:

It is with great enthusiasm that I support the West Baltimore Primary Care Access Collaborative (WBPCAC) to be designated a Health Enterprise Zone (HEZ).

Established in 2010, WBPCAC is a collaboration between 16 health, wellness, educational and community-based organizations that include Bon Secours Baltimore Health System, St. Agnes, Sinai, and Maryland General Hospitals, the University of Maryland Medical Center, People's Community Health Centers, Total Health Care, Inc., Baltimore Health System, Park West Health System, Coppin State University, University of Maryland Baltimore, Mosaic Community Services, Light Health and Wellness Comprehensive Services, The National Council on Alcohol and Drug Dependence of Maryland, Equity Matters, and the Baltimore City Health Department. The Collaborative was formed to act as a bridge between the community, many of which suffer from chronic illnesses, and health providers to ensure those that lacked access to adequate health services would receive it consistently.

Receiving Health Enterprise Zone status would enable WBPCAC to address and improve three key areas for patients in West Baltimore: Care coordination—improving how patients are transported between hospitals, medical homes, behavioral health, community-based providers and IT integration; Education and outreach—educating patients on certain diseases, importance of primary care, appropriate usage of emergency rooms, and medical home communication; and Primary care capacity—improving and expanding services that each of the 16 members are already providing to the community, increasing physician participation in medical homes, and leveraging and utilizing resources within WBPCAC.

It is my hope that the West Baltimore Primary Care Access Collaborative is provided the necessary funds to establish a Health Enterprise Zone in West Baltimore. WEBPCAC's plan to provide citizens there with viable health care options is an unprecedented effort that will be the foundation for other agencies, hospitals, and health care providers nationwide.

Sincerely,

Nick J. Mosby
Councilman, District No. 7

100 NORTH HOLLIDAY STREET • CITY HALL, ROOM 513 • BALTIMORE, MARYLAND 21202
PHONE 410.396.4810 • FAX 410.347.0537 • EMAIL NICK.MOSBY@BALTIMORECITY.GOV

COPPIN STATE UNIVERSITY

November 13, 2012

Dr. Joshua Sharfstein, Secretary
Maryland Department of Health and Mental Hygiene
and
John A. Hurson, Chair
Maryland Community Health Resources Commission

Gentlemen,

I am writing today to endorse the efforts of the newly formed West Baltimore Primary Care Access Collaborative and to urge your serious consideration of the group's application to be recognized as a Health Enterprise Zone.

The formation of the West Baltimore Primary Care Access Collaborative (WBPCAC) offers a realistic approach to addressing the health and social issues of the underserved residents of West Baltimore. Through our collaboration, Coppin State University has committed to being an active partner in improving the health of our residents, and aiding in reducing the prevalence of cardiovascular disease. To that end, Coppin State's Office of Community Development intends to partner with the WBPCAC to provide discounted gym memberships, and free access to Coppin State's walking track, for individuals that have been referred by the WBPCAC offices.

I am confident you will discover the WBPCAC offers an inclusive approach to care that can make West Baltimore a healthy community. The WBPCAC represents an unprecedented level of cooperation among providers, federally qualified health centers, community organizations and others, and the participants have made the long-term commitment necessary to transform our community.

The WBPCAC needs the State's support in implementing a robust, innovative approach to health care. This application to establish West Baltimore as a Health Enterprise Zone under Maryland's Health Improvement and Disparities Reduction Act deserves a serious and positive review.

Sincerely,

Gary Rodwell

Dr. Gary Rodwell,
Associate Vice President
Office of Community Development

GDR/vct

Office of Community Development
2500 West North Avenue
Baltimore, Maryland 21216
www.coppin.edu/

November 5, 2012

Dr. Joshua Sharfstein,
Secretary, Maryland Department of Health and Mental Hygiene
And John A. Hurson,
Chair, Maryland Community Health Resources Commission

Gentlemen,

I am writing today to endorse the efforts of the newly formed West Baltimore Primary Care Access Collaborative and to urge your serious consideration of the group's application to be recognized as a Health Enterprise Zone.

As you both are aware, the residents of Central-West and Southwest Baltimore long have been underserved by the city's health delivery system. Many families lack a primary care physician and suffer from chronic conditions such as cardiovascular disease, diabetes and asthma. The formation of the West Baltimore Primary Care Access Collaborative (WBPCAC) offers a realistic approach to addressing these problems and the state of Maryland can play a significant role.

The WBPCAC already has brought together 16 health, wellness, education and community-based organizations, and a comprehensive health assessment of West Baltimore was completed this summer. In addition, in order to ensure timely, appropriate strategies to address the needs of our community, the WBPCAC has, and continues to seek input and guidance from the grass-roots perspective. That assessment, in turn, has helped the WBPCAC establish three areas of focus: care coordination; education and outreach, and the improvement and expansion of primary care capacity.

Now, the WBPCAC is preparing an application for a grant under Maryland's new Health Improvement and Disparities Reduction Act to support West Baltimore as a Health Enterprise Zone. This application deserves a serious and positive review.

I am confident you will discover the WBPCAC offers an approach that can make West Baltimore a healthy community. This WBPCAC already represents an unprecedented level of cooperation among providers, federally qualified health centers, community organizations and others, and the participants have made the long-term commitment necessary to transform our community. The WBPCAC deserves the State's support.

Sincerely,

John K. Hoey
President/CEO

UNIVERSITY of MARYLAND
SCHOOL OF MEDICINE

Department of Family and Community Medicine

29 South Paca Street
Baltimore, MD 21201
410 328 8792 | 410 328 8726 FAX

www.medschool.umaryland.edu/familymedicine

November 1, 2012

Dr. Joshua Sharfstein,
Secretary, Maryland Department of Health and Mental Hygiene
And John A. Hurson,
Chair, Maryland Community Health Resources Commission

Dear Dr. Sharfstein:

This letter is in support of the newly formed West Baltimore Primary Care Access Collaborative (WBPCAC). We are pleased to support the dedicated effort by this group to infuse West Baltimore with systematic changes and the addition of targeted resources to enhance the health and wellbeing of all persons in the WBPCAC. The HEZ designation is a method to address and eliminate health-related disparities, and this application presents a systematic process for streamlining and bolstering the care process to achieve this goal.

The Maryland Learning Collaborative (MLC) is a partnership between the University of Maryland, Johns Hopkins Community Physicians and the Maryland Health Care Commission. Its mission is to develop a model of advanced patient-centered primary care in the State of Maryland which builds capacity within primary care practices that is accessible, continuous, comprehensive, coordinated and high quality.

The Maryland Learning Collaborative is currently working with primary care practices in this area that are participating in the Maryland Health Care Commission's PCMH program. As an adjunct to this program, we have been teaming with CRISP on the adoption of EHR technology and the health information exchange. The MLC is partnering with the Maryland Hospital Association on the AHRQ-funded IMPaCT program to work towards state innovation programs. Additionally, we have been working with the grantees of the CMS-funded CCTP (Community Care Transitions Program) in the West Baltimore area.

The WBPCAC has successfully brought together 16 health, wellness, education and community-based organizations over the last two years to streamline health care delivery and reduce utilization, as well as enhance care delivery, quality and health. In order to accomplish these goals, the coalition has defined three major pillars for the residents of Central-West and Southwest Baltimore: 1. care coordination; 2. education and outreach; 3. the improvement and expansion of primary care capacity. In anticipation of the implementation of the PPACA in Maryland in conjunction with expanded Medicaid and Maryland Health Connections covered lives, the WBPCAC efforts are timely and focused. The WBPCAC has a unique combination of

strengths that include grassroots workers and organizations and is supported by the state's medical school, University of Maryland, and several West Baltimore hospitals and organizations. The leadership of these groups is well known to me, and I have personally worked with several of the WBPCAC leadership team. I am confident that this leadership has the ability to organize care delivery and to utilize state resources optimally to implement cost effective and efficient measures. The Maryland Learning Collaborative is pleased to offer workforce training, as well as technical and logistical assistance upon request by the WBPCAC on relevant patient-centered concepts such as advanced access, care transitions, quality improvement and team-based care.

I am confident you will discover the WBPCAC's approach can make West Baltimore a healthy community and urge your serious consideration of the group's application to be recognized as a Health Enterprise Zone. The Maryland residents served by the WBPCAC deserve the State's support to have their neighborhoods recognized as a Health Enterprise Zone with reduction, and possibly elimination, of disparities related to health care access.

Sincerely,

NKhanna MD.

Niharika Khanna, MBBS,MD,DGO
Associate Professor Family and Community Medicine
University of Maryland School of Medicine
Director Maryland Learning Collaborative
Multi-Payer Program for Patient Centered Medical Home
410-328-5145; 410-328-3346; fax 410-328-8726

nkhanna@som.umaryland.edu

http://medschool.umaryland.edu/familymedicine/mdlearning/default.asp

http://mhcc.maryland.gov/pcmh/

UNIVERSITY of MARYLAND
SCHOOL OF MEDICINE

INSTITUTE *for a*
Healthiest
MARYLAND

RENEE FOX, MD
Executive Director

November 9, 2012

Dr. Joshua Sharfstein,
Secretary, Maryland Department of Health and Mental Hygiene
And John A. Hurson,
Chair, Maryland Community Health Resources Commission

Gentlemen,

On behalf of the Institute for a Healthiest Maryland ("*Institute*"), I am writing to extend our support of the application West Baltimore Primary Care Access Collaborative for the Health Enterprise Zones Call for Proposals.

As you well know, the University of Maryland Baltimore has joined with the Maryland State Department of Health and Mental Hygiene to form the *Institute for a Healthiest Maryland*. Dr. Joshua Sharfstein, Secretary of the Department of Health and Mental Hygiene, and Dr. Jay Perman, President of the University of Maryland Baltimore, are co-directors. The *Institute* is committed to a statewide movement to transform communities into healthy environments for all, especially recognizing the need to address health disparities. The *Institute* will support local coalitions in every region of the state with the technical assistance, guidance, and/or resources to improve Maryland's health.

With a successful WBPCAC HEZ, we look forward to potential collaborations serving the needs of our West Baltimore neighbors, in addressing the population health issues and precursors of chronic diseases including tobacco cessation, active living, healthy eating, obesity prevention and reducing health disparities.

Sincerely,

Renee Ellen Fox, MD

Renee Ellen Fox, MD
Executive Director
Institute for Healthiest Maryland
220 Arch Street 14th Floor
Baltimore, MD 21201
(410) 706-6579

cc: Jay A. Perman, MD, President UMB

UNIVERSITY of MARYLAND
THE FOUNDING CAMPUS

Stephen N. Davis, MBBS, FRCP, FACP
Alan R. Shuldiner, MD
Co-Directors

Clinical Translational Science Institute
22 S. Greene Street, Room N3W42
Baltimore, MD 21201
410 328 2488

November 13, 2012

Dr. Joshua Sharfstein, Secretary
Maryland Department of Health and Mental Hygiene

John A. Hurson, Chair
Maryland Community Health Resources Commission

Dear Dr. Sharfstein and Mr. Hurson:

I am writing today to both endorse the efforts of the West Baltimore Primary Care Access Collaborative (WBPCAC) as well as to commit as a partner in their proposal to be recognized as a Health Enterprise Zone (HEZ). I serve as one of two Principal Investigators on the University of Maryland's Clinical Translational Science Institute (CTSI). This is a major collaboration between the University of Maryland Baltimore, the University of Maryland College Park, the Veterans Administration, and the University of Maryland Medical System. The purpose of the CTSI is to ease the burden of translating basic medical science discovery into best practices in clinical and community preventive services care in the community. As such, community outreach and engagement for translational research is a critical component; for if we cannot assess community need, and refine our techniques and services in communities, we would be unable to complete our mission. It is in that context that the connection to the WBPCAC is so critical.

As you both are aware, the residents of Central-West and Southwest Baltimore long have been underserved by the city's health delivery system. Many families lack a primary care physician and suffer from chronic conditions such as cardiovascular disease, diabetes and asthma. The formation of the West Baltimore Primary Care Access Collaborative offers a realistic approach to addressing these problems and the State of Maryland can play a significant role. This is exactly the kind of community the CTSI must be engaged with collaboratively. But this is a bi-directional relationship in terms of the potential benefits. The assets of the CTSI will be brought to bear on the significant burden found in the community; which is as important as access to community is critical for the success of the CTSI.

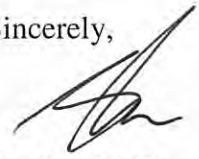
For example, the substantial informatics infrastructure available to CTSI researchers can be useful in many ways to the needs of the community as part of the HEZ. Perhaps more importantly, the CTSI has just issued an RFP for two $75,000 pilot studies that are intended to be submitted to address issues of community health that involve university investigators and community partners. The goals of this program are consistent with those of the proposed HEZ

and members of the WBPCAC are able to apply for these resources. We also anticipate the creation of a pilot studies program that members of the Collaborative will be eligible to compete for.

As a result, now that the WBPCAC is preparing an application for a grant under Maryland's new Health Improvement and Disparities Reduction Act to support West Baltimore as a Health Enterprise Zone, we are not only actively engaged but also advocates for State support of these efforts. We believe this application deserves a serious and positive review.

Thank you for your consideration.

Sincerely,



Stephen N. Davis, MBBS, FRCP, FACP
Co-Director, Clinical Translational Science Institute
Theodore E. Woodward Professor of Medicine
And Professor of Physiology
Chairman, Department of Medicine
University of Maryland School of Medicine
Physician-in-Chief
University of Maryland Medical Center

UNIVERSITY OF MARYLAND

Research and Development

620 West Lexington Street, 4th floor
Baltimore, Maryland 21201-1508

410 706 6723 410 706 1066 fax
www.ord.umaryland.edu

November 13, 2012

Bon Secours Baltimore Health System
2000 W. Baltimore Street
Baltimore
MD - 21223
USA

Dear Sir or Madam:

The University of Maryland, Baltimore proposes to participate in a project for which Bon Secours Baltimore Health System is seeking funding. The subcontract is for a project entitled, "West Baltimore Primary Care Access Collaborative (WBPCAC) HEZ", under the direction of Dr. Daniel Mullins at the University of Maryland, Baltimore, School of Pharmacy.

The University of Maryland has been established as a public, non-profit, tax-exempt educational institution and agency of the State of Maryland. Our DUNS number is 188435911; the cognizant Federal Agency contact information is DHHS, Stephen Hobday, at (202) 401-2808.

Should an award be made to Bon Secours Baltimore Health System, the University of Maryland, Baltimore is prepared to enter into a negotiated interinstitutional agreement for research to be performed under the award; such agreement will ensure compliance with all pertinent Federal regulations and policies.

If you have any questions or require further information, please contact me at 410-706-1938 or via email at vharris@umaryland.edu.

Sincerely,

Venzula Harris

Venzula Harris, Analyst

JOINT CENTER
FOR
POLITICAL AND ECONOMIC
STUDIES

November 13, 2012

Joshua M. Sharfstein, M.D.
Secretary of Health & Mental Hygiene
Department of Health & Mental Hygiene
201 West Preston St.
Baltimore, MD 21201

The Honorable John A. Hurson
Chair, Maryland Community Health Resources Commission
201 West Preston Street
Baltimore, MD 21201

Dear Dr. Sharfstein and Delegate Hurson:

I am writing to endorse the efforts of the newly formed West Baltimore Primary Care Access Collaborative and to urge your serious consideration of the group's application to be recognized as a Health Enterprise Zone.

As you both are aware, the residents of Central-West and Southwest Baltimore long have been underserved by the city's health care delivery system. Many families lack a primary care physician and suffer from chronic conditions such as cardiovascular disease, diabetes and asthma. The formation of the West Baltimore Primary Care Access Collaborative (WBPCAC) offers a realistic approach to addressing these problems, and the state of Maryland can play a significant role.

The WBPCAC already has brought together 16 health, wellness, education, and community-based organizations, and a comprehensive health assessment of West Baltimore was completed this summer. In addition, in order to ensure timely, appropriate strategies to address the needs of the community, the WBPCAC has, and continues to seek input and guidance from community based organizations and community residents. That assessment, in turn, has helped the WBPCAC establish three areas of focus: care coordination; education and outreach, and the improvement and expansion of primary care capacity.

The WBPCAC is preparing an application for a grant under Maryland's new Health Improvement and Disparities Reduction Act to support West Baltimore as a Health Enterprise Zone. I hope this proposal receives consideration.

As an active partner of Equity Matters, Inc., a community-based organization committed to improving health and equity in Baltimore and a partner in WBPCAC, the Joint Center for

805 FIFTEENTH STREET, NW, 2ND FLOOR, WASHINGTON, DC 20005
P: 202.789.3500 • F: 202.789.6390 • www.jointcenter.org

Political and Economic Studies will assist WBPCAC in finding support for the matching dollars anticipated to trigger grants under the Health Enterprise Zone. We anticipate that these resources would support the participation of Equity Matters, Inc., as proposed to promote integrated technology use for civic engagement with Equity Matters' partner, mdlogix. Intended sources for these matching funds include the Pew Foundation, the Annie E. Casey Foundation, the Open Society Institute, the W.K. Kellogg Foundation, and Kaiser Permanente of the mid-Atlantic States. In addition, the Joint Center, its consultants and partners, will provide $50,000 work of in-kind support in the form of research, policy analysis, and administrative support around integrating the training aspects of the CAREs center, particularly to address social determinants of health.

As you know, the Joint Center is one of the nation's leading research and public policy institutions and the only one whose work focuses primarily on issues of particular concern to African Americans and other people of color. Place Matters is a major initiative of the Joint Center to build the capacity of community leaders to address social, economic and environmental conditions in communities that shape health and health outcomes. Place Matters is designed to improve the health outcomes of participating communities through shared learning experiences. The program assists participating teams in developing and implementing community-based strategies to address the social factors that determine health. The Place Matters initiative aims to address health equity by cultivating new leadership and advancing the Health Equity Movement one community at a time.

I am confident you will discover the WBPCAC offers an approach that can make West Baltimore a healthy community. This WBPCAC already represents an unprecedented level of cooperation among providers, federally qualified health centers, community organizations and others, and the participants have made the long-term commitment necessary to transform our community. The WBPCAC proposal has our unqualified support.

Sincerely,

Brian D. Smedley, Ph.D.
Vice President and Director,
Joint Center Health Policy Institute

Medical Decision Logic, Inc.
1216 E. Baltimore St.
Baltimore, MD 21202

November 1, 2012

Dr. Joshua Sharfstein
Secretary
Maryland Department of Health and Mental Hygiene
&
John A. Hurson
Chair
Maryland Community Health Resources Commission

Gentlemen,

I am writing today to endorse the efforts of the newly formed West Baltimore Primary Care Access Collaborative and to urge your consideration of the group's application to be recognized as a Health Enterprise Zone.

As you both are aware, the residents of Central-West and Southwest Baltimore have long been under-served by the health delivery system. Many families lack a primary care physician and suffer from chronic and expensive conditions such as asthma, diabetes, and cardiovascular disease. The formation of the West Baltimore Primary Care Access Collaborative (WBPCAC) offers a realistic approach to addressing these problems – the incorporation of health science-based web technology and user-centered adaptations can be a major component of the envisioned innovation solutions.

The WBPCAC already has brought together 16 health, wellness, education, and community-based organizations, and a comprehensive health assessment of West Baltimore was completed this summer. In order to ensure timely and appropriate strategies to address the needs of our community, the WBPCAC has, and continues to seek input and guidance from the grass-roots perspective. That assessment, in turn, has helped the WBPCAC establish three areas of focus: care coordination; education and outreach, and the improvement and expansion of primary care capacity.

Now, the WBPCAC is preparing an application for a grant under Maryland's new Health Improvement and Disparities Reduction Act to engage West Baltimore as a Health Enterprise Zone.

I am deeply interested in and supportive of their efforts. By way of background, my firm mdlogix was established in 1997, and is located in downtown Baltimore. My team has leveraged over ten million dollars of NIH and DoD Small Business Innovation Research (SBIR) grants and contracts to develop a commercial portfolio of innovative health science informatics solutions.

A major part of our health science web technology platform is our flagship Clinical Research Management System (CRMS). CRMS is an enterprise-scale, web-based, end-to-end clinical research management solution; the largest CRMS deployment currently has over 6,000 studies (over 1,500 active) and over 90,000 research subjects. CRMS provides a high level of automation, assurance, and integration across the tasks, regulations, people, and roles in academic medical research, and at the same time, increases efficiency and productivity (in 2011, Dan Ford, Vice Dean of Clinical Investigation at Johns Hopkins School of Medicine, reported that since deployment of CRMS there in 2008, they are running 30% more studies with only 5% more staff, with user

satisfaction rated at least 75%). CRMS provides administrators with immediate access to a full set of reports on the status of the research enterprise. It also supports multi-site protocol-based workflows and tracking.

Once employed in one HEZ, a set of web tools as an integrated system based on this technology could easily be adopted and integrated with another HEZ. Integrating clinical medicine, clinical research, and public health with social media and civic engagement is something for which mdlogix has existing software capabilities, as well as established relationships. That said, the West side HEZ could be the first set of institutions to substantially integrate these components. With a proven client and user-centered agile software engineering approach, mdlogix would tailor a solution to fit those user tasks and integration aspects the HEZ Steering and Sub-Committees deem most appropriate.

The innovative solution possibilities in a process like are exceptional for the opportunity at hand. Our user-centered software process at the social determinants level is guided via Equity Matters, one of the coalition partners. This is a complementary fit as we are currently incubating them in our downtown office space. We are positioned to expand that as our work together grows to accommodate new additional productive jobs in the City of Baltimore and the State of Maryland.

I hope that you will discover that WBPCAC offers an approach that can accelerate movements towards making West Baltimore a healthy community. WBPCAC already represents an unprecedented level of cooperation among providers, federally qualified health centers, community organizations and others, and the participants have made the long-term commitment necessary to transform our community. To the best of my current knowledge, the WBPCAC deserves the State's support.

Sincerely,

Allen Y. Tien, MD, MHS
President and Director of Applied Research
Medical Decision Logic, Inc.
1216 E. Baltimore St.
Baltimore, MD 21202

Adjunct Associate Professor
Division of Health Sciences Informatics
Johns Hopkins University School of Medicine

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American Heart Association®

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November 7, 2012

Dr. Joshua Sharfstein,
Secretary, Maryland Department of Health and Mental Hygiene
And John A. Hurson,
Chair, Maryland Community Health Resources Commission

Gentlemen,

I am writing today to endorse the efforts of the newly formed West Baltimore Primary Care Access Collaborative and to urge your serious consideration of the group's application to be recognized as a Health Enterprise Zone.

As you both are aware, the residents of Central-West and Southwest Baltimore long have been underserved by the city's health delivery system. Many families lack a primary care physician and suffer from chronic conditions such as cardiovascular disease, diabetes and asthma. The formation of the West Baltimore Primary Care Access Collaborative (WBPCAC) offers a realistic approach to addressing these problems and the state of Maryland can play a significant role.

The WBPCAC already has brought together 16 health, wellness, education and community-based organizations, and a comprehensive health assessment of West Baltimore was completed this summer. In addition, in order to ensure timely, appropriate strategies to address the needs of our community, the WBPCAC has, and continues to seek input and guidance from the grass-roots perspective. That assessment, in turn, has helped the WBPCAC establish three areas of focus: care coordination; education and outreach, and the improvement and expansion of primary care capacity.

Now, the WBPCAC is preparing an application for a grant under Maryland's new Health Improvement and Disparities Reduction Act to support West Baltimore as a Health Enterprise Zone. This application deserves a serious and positive review.

I am confident you will discover the WBPCAC offers an approach that can make West Baltimore a healthy community. This WBPCAC already represents an unprecedented level of cooperation among providers, federally qualified health centers, community organizations and others, and the participants have made the long-term commitment necessary to transform our community. The WBPCAC deserves the State's support.

Sincerely,

Yvette C Mingo

Yvette Mingo
Executive Director/ Vice President Development
American Heart Association – Greater Baltimore

Please remember the American Heart Association in your will.

American Diabetes Association.

Cure • Care • Commitment

November 1, 2012

Dr. Joshua Sharfstein,
Secretary, Maryland Department of Health and Mental Hygiene
And John A. Hurson,
Chair, Maryland Community Health Resources Commission

Gentlemen,

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Sincerely,

Katherine Rogers
Executive Director, Maryland area

Maryland Office
2002 Clipper Park Road #110
Baltimore, MD 21211
Tel: 410.265.0075

HealthCare Access MARYLAND

COVERAGE. CARE. CONNECTIONS.

November 8, 2012

Dr. Joshua Sharfstein,
Secretary, Maryland Department of Health and Mental Hygiene
And John A. Hurson,
Chair, Maryland Community Health Resources Commission

Dear Secretary Sharfstein and Chairman Hurson:

I am writing in support of the West Baltimore Primary Care Access Collaborative (WBPCAC) and to urge your serious consideration of the group's application to be recognized as a Health Enterprise Zone.

As you both are aware, the residents of Central-West and Southwest Baltimore long have been underserved by the city's health delivery system. Many families lack a primary care physician and suffer from chronic conditions such as cardiovascular disease, diabetes and asthma. The formation of the WBPCAC offers a realistic approach to addressing these problems and the state of Maryland can play a significant role.

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Now, the WBPCAC is preparing an application for a grant under Maryland's new Health Improvement and Disparities Reduction Act to support West Baltimore as a Health Enterprise Zone. I is my hope that WBPCAC offers an approach that can make West Baltimore a healthy community. Thank you for your time and consideration of this worthy effort.

Sincerely,

Kathleen Westcoat

Kathleen Westcoat
President/CEO

MID-ATLANTIC ASSOCIATION OF COMMUNITY HEALTH CENTERS

Serving Maryland and Delaware

November 1, 2012

4319 Forbes Boulevard
Lanham, Maryland 20706

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Fax (301) 577-4789
www.machc.com

Dr. Joshua Sharfstein,
Secretary, Maryland Department of Health and Mental Hygiene
And John A. Hurson,
Chair, Maryland Community Health Resources Commission

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Sincerely,

H. Duane Taylor, Esq., MPP, MCPH
Interim CEO

Baltimore Substance Abuse Systems, Inc.
One North Charles Street, Suite 1600
Baltimore MD 21201-3718

P 410.637.1900
F 410.637.1911

www.bsasinc.org

bSAS
People.
Priorities.
Progress.

November 1, 2012

Joshua M. Sharfstein, M.D., Secretary of Health & Mental Hygiene
Office of Secretary

and

John A. Hurson, Esq., Chair
Maryland Community Health Resources Commission

Dear Gentlemen:

I am writing today to endorse the efforts of the newly formed West Baltimore Primary Care Access Collaborative and to urge your serious consideration of the group's application to be recognized as a Health Enterprise Zone.

As you both are aware, the residents of Central-West and Southwest Baltimore long have been underserved by the city's health delivery system. Many families lack a primary care physician and suffer from chronic conditions such as cardiovascular disease, diabetes and asthma. The formation of the West Baltimore Primary Care Access Collaborative (WBPCAC) offers a realistic approach to addressing these problems and the state of Maryland can play a significant role.

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Sincerely,

Gregory C. Warren, MA, MBA
President/CEO

Cc: Oxiris Barbot, M.D., Commissioner of Health, BCHD

November 6, 2012

Joshua Sharfstein, M.D., Secretary
Maryland Department of Health and Mental Hygiene
Office of the Secretary
201 West Preston Street, 5th Floor
Baltimore, Maryland 21201

John A. Hurson, Esq., Chair
Maryland Community Health Resources Commission
45 Calvert Street, Room 336
Annapolis, Maryland 21401

Dear Secretary Sharfstein and Mr. Hurson:

I am writing in strong support of the West Baltimore Primary Care Access Collaborative's (WBPCAC) application for designation as a Health Enterprise Zone. I believe the Collaborative is positioned to make optimal use of this opportunity to improve the health and well-being of residents in Southwest and Central-West Baltimore.

As the local mental authority for Baltimore City, Baltimore Mental Health Systems' mission is to develop and manage a system of care in which City residents have access to high quality behavioral health services. It oversees publicly-funded mental health services totaling almost a quarter of a billion dollars for City residents receiving Medicaid benefits as well as those who are uninsured.

Baltimore Mental Health Systems believes the WBPCAC's emphasis on care coordination, including behavioral health and primary care coordination, will promote better health outcomes in this underserved and economically disadvantaged urban area. There is a well-documented relationship between untreated mental health and addiction disorders and chronic diseases (e.g., cardiovascular and diabetes). By focusing on access to both behavioral health and primary care, and promoting coordination between all providers serving an individual, WBPCAC will promote better care and better outcomes at lower costs.

I am very impressed by WBPCAC's planning to-date and the engagement and commitment of its 16 diverse health, wellness, educational and community-based partners. Baltimore Mental Health Systems has a relationship with publicly-funded mental health providers in West Baltimore, including the anchor partner, Bon Secours Hospital, and is committed to using its relationships and resources to support WBPCAC in addressing the health disparities in Central-West and Southwest Baltimore. We have agreed to serve on the WBPCAC Resource Advisory Board and provide any additional assistance and support that is requested.

In conclusion, it is our hope that the State will favorably review this application, and select WBPCAC as one of the State's four Health Enterprise Zones.

Sincerely,

Jane Plapinger

Jane Plapinger, MPH
President & CEO

201 E. Baltimore Street, Suite 1340 • Baltimore, MD 21202 • (410) 837-BMHS (2647) • Fax (410) 837-2672
www.bmhsi.org

Behavioral Health Leadership Institute

November 9, 2012

Dr. Joshua Sharfstein,
Secretary, Maryland Department of Health and Mental Hygiene
And John A. Hurson,
Chair, Maryland Community Health Resources Commission

Gentlemen,

As the Executive Director of the Behavioral Health Leadership Initiative, I am writing to express our strong support of, and intent to participate in, the efforts of the newly formed West Baltimore Primary Care Access Collaborative (WBPCAC) and to urge you to affirm the group's application to be recognized as a Health Enterprise Zone.

BHLI has a long history of working with a recovery program in West Baltimore—Recovery in Community (RIC). BHLI is currently operating an innovative outreach program for buprenorphine induction and maintenance for persons not served by current services. RIC and BHLI together are working with Bon Secours to develop increased resources and to develop increased community partnerships and capacities for vulnerable populations. In that role, I have been meeting with representatives from Bon Secours and discussing the potential for the WBPCAC to reduce disparities and improve public health under the Health Enterprise Zone innovation.

The west side of the city is seriously underserved. Many families lack access to primary care and suffer from chronic conditions such as cardiovascular disease, diabetes and asthma. Frequently, there are co-morbid mental health and substance use disorders which exacerbate the somatic conditions and often create barriers to accessing treatment. Nonetheless, the west-side has many strengths as well, as exemplified by many strong community groups, community leaders, committed neighbors and a dedicated group of health care providers. That is why the members of the WBPCAC have been meeting for many months, even before applying for this state support, and has brought together 16 organizations to develop a plan to improve the public health of the community. The WBPCAC has and continues to seek input and guidance from the grass-roots perspective.

BHLI intends to partner with the WBPAC to develop training for community health workers and other lay leaders and to assist in developing an approach for integrated treatment and outreach to those who need extra support with engagement and disease management. We appreciate the opportunity to join with WBPAC and other community partners in the development and deployment of an innovative system of care delivery, utilizing a community-based workforce, and dedicated to the residents of West Baltimore. We are confident that together, we will achieve improved health for the most vulnerable among us.

The WBPCAC strongly deserves the State's support as a Health Enterprise Zone committed to Maryland's efforts to improve the public health through innovation and dedication.

Sincerely,

Deborah Agus, JD
Executive Director, Behavioral Health Leadership Institute, Inc.
Adjunct Faculty, Johns Hopkins Bloomberg School of Public Health

RECOVERY IN COMMUNITY, INC.

Substance Abuse Intervention and Outreach to Individuals, Families and

31 N Fulton Avenue • Baltimore, MD 21223 • Tel. 410-362-1400 • Fax 410-362-

November 12, 2012

Dr. Joshua Sharfstein,
Secretary, Maryland Department of Health and Mental Hygiene
And John A. Hurson,
Chair, Maryland Community Health Resources Commission

Gentlemen,

I am writing today to endorse the efforts of the newly formed West Baltimore Primary Care Access Collaborative and to urge your serious consideration of the group's application to be recognized as a Health Enterprise Zone.

As you both are aware, the residents of Central-West and Southwest Baltimore long have been underserved by the city's health delivery system. Many families lack a primary care physician and suffer from chronic conditions such as cardiovascular disease, diabetes and asthma. The formation of the West Baltimore Primary Care Access Collaborative (WBPCAC) offers a realistic approach to addressing these problems and the state of Maryland can play a significant role.

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Now, the WBPCAC is preparing an application for a grant under Maryland's new Health Improvement and Disparities Reduction Act to support West Baltimore as a Health Enterprise Zone. This application deserves a serious and positive review.

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Sincerely,

Lena M. Franklin
Executive Director

November 13, 2012

Dr. Joshua Sharfstein, Secretary
Maryland Department of Health and Mental Hygiene
John A. Hurson, Esquire, Chair
Maryland Community Health Resources Commission
c/o 201 West Preston Street
Baltimore, Maryland 21201

Gentlemen:

I am writing today to endorse the efforts of the newly formed West Baltimore Primary Care Access Collaborative (WBPCAC) and to urge your serious consideration of the group's application to be recognized as a Health Enterprise Zone.

The State of Maryland now has the opportunity to demonstrate to the nation a new approach to eliminating health disparities among racial and ethnic groups and between geographic areas.

Prior to even applying for state support, the WBPCAC has brought together 16 health, wellness, education and community-based organizations and established three areas of focus for the residents of Central-West and Southwest Baltimore: care coordination, education and outreach, and the improvement and expansion of primary care capacity. In addition, in order to ensure timely, appropriate strategies to address the needs of our community, the WBPCAC has, and continues to seek input and guidance from the grass-roots perspective.

I am confident you will discover that WBPCAC's approach can make West Baltimore a healthy community. The WBPCAC deserves the State's support as a Health Enterprise Zone, which in turn will demonstrate how coordinated and integrated care across institutions and in partnership with community can make a difference in the lives of citizens.

Sincerely,

Diane L Bell-McKoy

Diane Bell-McKoy
President and CEO

DBM:ct

Catholic Charities

November 1, 2012

Dr. Joshua Sharfstein,
Secretary, Maryland Department of Health and Mental Hygiene
And John A. Hurson,
Chair, Maryland Community Health Resources Commission

Gentlemen,

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Sincerely,

William J. McCarthy, Jr.
Executive Director

cc: Dr. Samuel Ross
Senator Verna Jones-Rodwell

320 Cathedral Street • Baltimore, MD 21201-4493 • 410-547-5495 Fax: 410-752-2873

CENTER FOR URBAN FAMILIES
HELPING FATHERS AND FAMILIES WORK

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2201 North Monroe Street
Baltimore, Maryland 21217

November 1, 2012

Dr. Joshua Sharfstein,
Secretary, Maryland Department of Health and Mental Hygiene
And John A. Hurson,
Chair, Maryland Community Health Resources Commission

Gentlemen,

I am writing today to endorse the efforts of the newly formed West Baltimore Primary Care Access Collaborative and to urge your serious consideration of the group's application to be recognized as a Health Enterprise Zone.

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Sincerely,

Joe Jones
President and CEO

Greater Baltimore Urban League

Empowering Communities. Changing Lives.

November 11, 2012

Dr. Joshua Sharfstein,
Secretary, Maryland Department of Health and Mental Hygiene
And John A. Hurson,
Chair, Maryland Community Health Resources Commission

Gentlemen,

On behalf of the Baltimore Urban League, I am writing to endorse the newly formed West Baltimore Primary Care Access Collaborative (WBPCAC). Furthermore, I would like to request your consideration and approval of their application for recognition as a Health Enterprise Zone.

Maryland has always been a progressive leader in health care and approaches to eliminate health disparities. The State of Maryland another medical area in which to demonstrate a novel approach to eliminate disparities based on racial, ethnic, and geographic groups, and their impact in health care access. The Maryland Health Disparities and Reduction Act established the framework of the Health Enterprise Zones; the creation of this body (the WBPCAC) is one proposed solution to achieving the goal of increased health care access for all Maryland citizens.

A significant demonstration of the seriousness of this group is the work that they have already put forth to ensure their success. The WBPCAC already unified 16 organizations, focused on areas such as: health, wellness, education and community-based work. The WBPCAC has also established three areas of focus for the residents of Central-West and Southwest Baltimore: care coordination, education and outreach, and the improvement and expansion of primary care capacity. Finally, the WBPCAC has also solicited feedback from organizations with a strong pulse on the community, such as the Baltimore Urban League, in order to assess the needs of the community. These strategic partnerships will work in synergy to develop approaches to best serve the community – specifically, the regions of Maryland most impacted by health care disparities.

I urge you to consider the work that this body has put forth, and approve the proposed approach of the WBPCAC. I believe that you share in their vision to create a healthier community in West Baltimore, and will find this strategy promising. It is my hope that you choose to support the WBPCAC as a Health Enterprise Zone.

Sincerely.

J. Howard Henderson
President?CEO

512 *ORCHARD STREET -BALTIMORE, MARYLAND 21201-PHONE (410) 523-8150-FAX (410-523-4022)* WWW.BUL.ORG

CHAI

November 1, 2012

Dr. Joshua Sharfstein, Secretary
Maryland Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201

John A. Hurson, Chair
Maryland Community Health Resources Commission
4201 Patterson Avenue, Room 315
Baltimore, MD 21215

Gentlemen:

I am writing today to endorse the efforts of the newly formed West Baltimore Primary Care Access Collaborative and to urge your serious consideration of the group's application to be recognized as a Health Enterprise Zone.

As you both are aware, the residents of Central-West and Southwest Baltimore long have been underserved by the city's health delivery system. Many families lack a primary care physician and suffer from chronic conditions such as cardiovascular disease, diabetes and asthma. The formation of the West Baltimore Primary Care Access Collaborative (WBPCAC) offers a realistic approach to addressing these problems and the state of Maryland can play a significant role.

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Now, the WBPCAC is preparing an application for a grant under Maryland's new Health Improvement and Disparities Reduction Act to support West Baltimore as a Health Enterprise Zone. This application deserves a serious and positive review.

I am confident you will discover the WBPCAC offers an approach that can make West Baltimore a healthy community. This WBPCAC already represents an unprecedented level of cooperation among providers, federally qualified health centers, community organizations and others, and the participants have made the long-term commitment necessary to transform our community. The WBPCAC deserves the State's support.

Sincerely,

Kenneth N. Gelula
Executive Director

cc: Martha Nathanson
Gary Rodwell

Healthy Neighborhoods

November 12, 2012

Dr. Joshua Sharfstein,
Secretary, Maryland Department of Health and Mental Hygiene
And John A. Hurson,
Chair, Maryland Community Health Resources Commission

Gentlemen,

I am writing today to endorse the efforts of the newly formed West Baltimore Primary Care Access Collaborative (WBPCAC) and to urge your serious consideration of the group's application to be recognized as a Health Enterprise Zone.

The State of Maryland now has the opportunity to demonstrate to the nation a new approach to eliminating health disparities among racial and ethnic groups and between geographic areas.

The passage earlier this year of the Maryland Health Disparities and Reduction Act set the framework for an approach built around designated Health Enterprise Zones. And the creation of the WBPCAC offers real and tangible proof of what can be accomplished.

Prior to even applying for state support, the WBPCAC has brought together 16 health, wellness, education and community-based organizations and established three areas of focus for the residents of Central-West and Southwest Baltimore: care coordination; education and outreach, and the improvement and expansion of primary care capacity. In addition, in order to ensure timely, appropriate strategies to address the needs of our community, the WBPCAC has, and continues to seek input and guidance from the grass-roots perspective.

I am confident you will discover the WBPCAC's approach can make West Baltimore a healthy community. The WBPCAC deserves the State's support as a Health Enterprise Zone, which in turn will demonstrate to the nation the progressive leadership of Maryland's government leaders to make a difference.

Sincerely,

Mark Sissman
President

2 East Read Street, Baltimore, MD 21202
410-332-0387 | Fax 410-837-4701
www.healthyneighborhoods.org

OPERATION REACHOUT
SOUTHWEST
26 North Fulton Avenue
Baltimore, MD 21223
(410) 362-3239

November 1, 2012

Dr. Joshua Sharfstein,
Secretary, Maryland Department of Health and Mental Hygiene
And John A. Hurson,
Chair, Maryland Community Health Resources Commission

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We are writing today to endorse the efforts of the newly formed West Baltimore Primary Care Access Collaborative and to urge your serious consideration of the group's application to be recognized as a Health Enterprise Zone.

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Sincerely,

Joyce C. Smith
President

Constance S. Fowler
Co-Chair

DRUID HEIGHTS
COMMUNITY DEVELOPMENT CORPORATION

November 1, 2012

Dr. Joshua Sharfstein,
Secretary, Maryland Department of Health and Mental Hygiene
And John A. Hurson,
Chair, Maryland Community Health Resources Commission

Gentlemen,

I am writing today to endorse the efforts of the newly formed West Baltimore Primary Care Access Collaborative and to urge your serious consideration of the group's application to be recognized as a Health Enterprise Zone.

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Sincerely,

Kelly D. Little
Executive Director

2140 McCulloh Street Baltimore, MD 21217 410-523-1350 410-523-1374 FAX www.druidheights.com

Panway Neighborhood Association

"Our Community, Our Responsibility"

Panway is an affiliate of the Greater Mondawmin Coordinating Council, Inc.

Panway Neighborhood Association
2324 Braddish Avenue
Baltimore, Maryland 21216

November 13, 2012

Dear Colleague,

I am writing today to endorse the efforts of the newly formed West Baltimore Primary Care Access Collaborative (WBPCAC) and to urge your serious consideration of the group's application to be recognized as a Health Enterprise Zone.

The State of Maryland now has the opportunity to demonstrate to the nation a new approach to eliminating health disparities among racial and ethnic groups and between geographic areas.

The passage earlier this year of the Maryland Health Disparities and Reduction Act set the framework for an approach built around designated Health Enterprise Zones. And the creation of the WBPCAC offers real and tangible proof of what can be accomplished.

Prior to even applying for state support, the WBPCAC has brought together 16 health, wellness, education and community-based organizations and established three areas of focus for the residents of Central-West and Southwest Baltimore: care coordination; education and outreach, and the improvement and expansion of primary care capacity. In addition, in order to ensure timely, appropriate strategies to address the needs of our community, the WBPCAC has, and continues to seek input and guidance from the grass-roots perspective.

I am confident you will discover the WBPCAC's approach can make West Baltimore a healthy community. The WBPCAC deserves the State's support as a Health Enterprise Zone, which in turn will demonstrate to the nation the progressive leadership of Maryland's government leaders to make a difference.

Sincerely,

Wanda Freeland

President

cc: Executive Committee

November 1, 2012

Dr. Joshua Sharfstein,
Secretary, Maryland Department of Helath and Mental Hygiene
And John A Hurson,
Chair, Maryland Community Health Resourances Commission
Gentlement,

I am writing today to endorse the efforts of the newly formed West Baltimore Primary Care Access Collaborative (WBPCAC) and to urge your serious consideration of the group's application to be recognized as a Health Enterprise Zone.

The State of Maryland now has the opportunity to demonstrate to the nation a new approach to eliminating health disparities among racial and ethnic groups and between geographic areas.

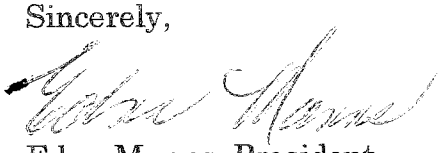
The passage earlier this year of the Maryland Health Disparities and Reduction Act set the framework for an approach built around designated Health Enterprise Zones. And the creation of the WBPCAC offers real and tangible proof of what can be accomplished.

Prior to even applying for state support, the WBPCAC has brought together 16 health, wellness, education and community-based organizations and established three areas of focus for the residents of Central-West and Southwest Baltimore: care coordination; education and outreach, and the improvement and expansion of primary care capacity. In addition, in order to ensure timely, appropriate strategies to address the needs of our community, the WBPCAC has, and continues to seek input and guidance from the grass-roots perspective.

2133 W. Fayette Street Baltimore, Maryland 21223 E-mail fayettestreetoutreach.org

I am confident you will discover the WBPCAC's approach can make West Baltimore a healthy community. The WBPCAC deserves the State's support as a Health Enterprise Zone, which in turn will demonstrate to the nation the progressive leadership of Maryland's government leaders to make a difference.

Sincerely,



Edna Manns, President
FAYETTE STREET OUTREACH ORGANIZATION, INC.

Newborn Holistic Ministries, Inc.

Oct. 29, 2012

Dr. Joshua Sharfstein,
Secretary, Maryland Department of Health and Mental Hygiene
John A. Hurson,
Chair, Maryland Community Health Resources Commission

Gentlemen,

I am writing today in support of the newly formed West Baltimore Primary Care Access Collaborative application to be recognized as a Health Enterprise Zone.

As a community based organization located in and serving Central-West and Southwest Baltimore, we know that the residents are yet underserved by the city's health delivery system. We deal directly with the higher levels of poverty, employment challenges, substance abuse, and multiple health ramifications of these challenges.

We understand that a 2008 health profile produced by the city's health department found that in addition to the daily challenges these issues present, these factors also leave residents with an average lifespan almost seven years shorter than the average life expectancy of Baltimore City residents. And the communities served by Bon Secours Hospital have higher death rates from heart disease, cancer, HIV, stroke and diabetes than residents of the city overall.

The formation of the West Baltimore Primary Care Access Collaborative (WBPCAC) offers a welcome approach to addressing these problems. The WBPCAC has brought together 17 health, wellness, education and community-based organizations and established three areas of focus for the residents of Central-West and Southwest Baltimore: care coordination; education and outreach, and the improvement and expansion of primary care capacity.

We support the WBPCAC and any efforts by it to seek grants under Maryland's new Health Improvement and Disparities Reduction Act to support West Baltimore as a Health Enterprise Zone. It is our hope this will lead to enhanced access to and utilization of services by our community residents.

Sincerely,

Todd Marcus

Todd Marcus
President

P.O. Box 12764 · 1947 Pennsylvania Avenue · Baltimore, Maryland 21217 · 410-728-2227

November 1, 2012

Dr. Joshua Sharfstein,
Secretary, Maryland Department of Health and Mental Hygiene
And John A. Hurson,
Chair, Maryland Community Health Resources Commission

Gentlemen,

I am writing today to endorse the efforts of the newly formed West Baltimore Primary Care Access Collaborative and to urge your serious consideration of the group's application to be recognized as a Health Enterprise Zone.

As you both are aware, the residents of Central-West and Southwest Baltimore long have been underserved by the city's health delivery system. Many families lack a primary care physician and suffer from chronic conditions such as cardiovascular disease, diabetes and asthma. The formation of the West Baltimore Primary Care Access Collaborative (WBPCAC) offers a realistic approach to addressing these problems and the state of Maryland can play a significant role.

The WBPCAC already has brought together 16 health, wellness, education and community-based organizations, and a comprehensive health assessment of West Baltimore was completed this summer. In addition, in order to ensure timely, appropriate strategies to address the needs of our community, the WBPCAC has, and continues to seek input and guidance from the grass-roots perspective. That assessment, in turn, has helped the WBPCAC establish three areas of focus: care coordination; education and outreach, and the improvement and expansion of primary care capacity.

Now, the WBPCAC is preparing an application for a grant under Maryland's new Health Improvement and Disparities Reduction Act to support West Baltimore as a Health Enterprise Zone. This application deserves a serious and positive review.

I am confident you will discover the WBPCAC offers an approach that can make West Baltimore a healthy community. This WBPCAC already represents an unprecedented level of cooperation among providers, federally qualified health centers, community organizations and others, and the participants have made the long-term commitment necessary to transform our community. The WBPCAC deserves the State's support.

Sincerely,

DOUGLAS MEMORIAL
COMMUNITY CHURCH
"Changing Lives, Building Legacies"

November 7, 2012

Dr. Joshua Sharfstein, Secretary
Maryland Department of Health and Mental Hygiene

and

Mr. John A. Hurson, Chair
Maryland Community Health Resources Commission

Gentlemen:

My name is Rev. S. Todd Yeary, and I serve as the senior pastor of the Douglas Memorial Community Church in west Baltimore. I am writing today to endorse the efforts of the newly formed West Baltimore Primary Care Access Collaborative (WBPCAC) and to urge your serious consideration of the group's application to be recognized as a Health Enterprise Zone.

The State of Maryland now has the opportunity to demonstrate to the nation a new approach to eliminating health disparities among racial and ethnic groups and between geographic areas. The passage earlier this year of the Maryland Health Disparities and Reduction Act set the framework for an approach built around designated Health Enterprise Zones. And the creation of the WBPCAC offers real and tangible proof of what can be accomplished.

Prior to applying for state support, the WBPCAC has brought together 16 health, wellness, education and community-based organizations and established three areas of focus for the residents of Central-West and Southwest Baltimore: care coordination; education and outreach, and the improvement and expansion of primary care capacity. In addition, in order to ensure timely, appropriate strategies to address the needs of our community, the WBPCAC has, and continues to seek input and guidance from the grass-roots perspective. These proactive steps are positive indications of the collaborative commitment to enhancing the health outcomes in our community.

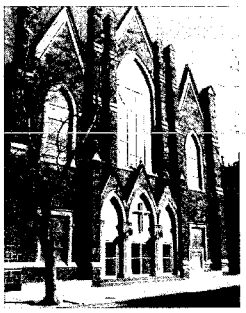
I am confident you will discover the WBPCAC's approach can make West Baltimore a healthy community. The WBPCAC deserves the State's support as a Health Enterprise Zone, and will serve as a national model for progressive leadership to be emulated in other jurisdictions. Your support will serve as a firm demonstration of the commitment of Maryland's government leaders to make a significant difference in the quality of life for all citizens.

Sincerely,

S. Todd Yeary

Rev. S. Todd Yeary, Ph.D
Senior Pastor

1325 MADISON AVENUE • BALTIMORE, MARYLAND 21217
Telephone 410- 523-1700 • FAX 410-523-1765
www.douglaschurch.org
Rev. *Dr. S. Todd Yeary, Senior Pastor*



Union Baptist Church

1219 Druid Hill Avenue • Baltimore, MD 21217
Tel. 410-523-6880 • Fax 410-523-3202
The Servant Church: To Worship, To Serve, and To Empower

November 1, 2012

Dr. Joshua Sharfstein,

Secretary, Maryland Department of Health and Mental Hygiene
And John A. Hurson,
Chair, Maryland Community Health Resources Commission

Gentlemen,

I am writing today to endorse the efforts of the newly formed West Baltimore Primary Care Access Collaborative (WBPCAC) and to urge your serious consideration of the group's application to be recognized as a Health Enterprise Zone.

The State of Maryland now has the opportunity to demonstrate to the nation a new approach to eliminating health disparities among racial and ethnic groups and between geographic areas.

The passage earlier this year of the Maryland Health Disparities and Reduction Act set the framework for an approach built around designated Health Enterprise Zones. And the creation of the WBPCAC offers real and tangible proof of what can be accomplished.

Prior to even applying for state support, the WBPCAC has brought together 16 health, wellness, education and community-based organizations and established three areas of focus for the residents of Central-West and Southwest Baltimore: care coordination; education and outreach, and the improvement and expansion of primary care capacity. In addition, in order to ensure timely, appropriate strategies to address the needs of our community, the WBPCAC has, and continues to seek input and guidance from the grass-roots perspective.

I am confident you will discover the WBPCAC's approach can make West Baltimore a healthy community. The WBPCAC deserves the State's support as a Health Enterprise Zone, which in turn will demonstrate to the nation the progressive leadership of Maryland's government leaders to make a difference.

Sincerely,

Rev. Dr. Alvin C. Hathaway, Sr.,
Senior Pastor

MICHELLE GOURDINE AND ASSOCIATES LLC

A Health Policy Consulting Firm

November 9, 2012

Gentlemen,

It is my pleasure to write a letter in support of the application being submitted by the West Baltimore Primary Care Access Collaborative (WBPCAC) to be recognized as a Health Enterprise Zone.

The WBPCAC existed prior to the passage of the Health Improvement and Disparities Reduction Act to address the disparities in health care and health outcomes experienced by the residents of Central-West and Southwest Baltimore, who disproportionately lack a regular source of health care and suffer from chronic conditions such as cardiovascular disease, diabetes and asthma, and who on average have a lifespan decades shorter than residents of Baltimore City who live in neighborhoods a mere five miles away. I am pleased to have provided assistance to this group at its inception. The WBPCAC is comprised of sixteen health, wellness, education and community-based organizations, and has established three areas of focus: care coordination, education and outreach, and the improvement and expansion of primary care capacity. Additionally, the WBPCAC seeks regular input and guidance from the residents of Central-West and Southwest Baltimore.

The WBPCAC has an already-established track record of coalition-building and multidisciplinary cooperation and collaboration—components essential to addressing the medical and social determinants that cause poor health in West Baltimore. By being recognized as a Health Enterprise Zone, the WBPCAC will be able to continue to contribute towards the State's goal of achieving health equity and the elimination of health disparities. The WBPCAC deserves the state's support.

Sincerely,

Michelle A. Gourdine, M.D.

P.O. Box 1765
Owings Mills, MD
21117

PHONE (443) 801-7932
E-MAIL michelle@michellegourdine.com
WEB SITE http://www.michellegourdine.com

November 6th, 2012

McInnis & Associates
Consulting, LLC

Transforming Organizations into 21st
Century Market Leaders

Dr. Joshua Sharfstein,
Secretary, Maryland Department of Health and Mental Hygiene
And John A. Hurson,
Chair, Maryland Community Health Resources Commission

Dear Secretary Sharfstein,

I am writing today to endorse the efforts of the newly formed West Baltimore Primary Care Access Collaborative (WBPAC) and to urge your serious consideration of the group's application to be recognized as a Health Enterprise Zone. As an initial participant in the planning efforts to develop a blue print for addressing health care needs in West Baltimore, I am proud of the evolution that has occurred to develop this working coalition. In my former capacity as CEO of the Mid-Atlantic Association of Community Health Centers, my team and I , in collaboration with Bon Secours Hospital and Senator Verna Jones-Rodwell's office, secured funding from the Kaiser Foundation to hire JSI, Inc to conduct an assessment of the health care needs of the West Baltimore Community which was completed in June of this year. This report identified and quantified that the residents of Central-West and Southwest Baltimore long have been underserved by the city's health delivery system. Many families lack a primary care physician and suffer from chronic conditions such as cardiovascular disease, diabetes and asthma. The formation of the WBPCAC offers a realistic "bottom up " approach to addressing these problems.

The WBPCAC already has brought together 16 health, wellness, education and community-based organizations to address the identified health concerns. The WBPCAC has establish three areas of focus: care coordination; education and outreach, and the improvement and expansion of primary care capacity. The WBPCAC is preparing an application for a grant under Maryland's new Health Improvement and Disparities Reduction Act to support West Baltimore as a Health Enterprise Zone to address the very concerns identified in the June assessment.

I am confident you will discover the WBPCAC offers an approach that can make West Baltimore a healthy community. This WBPCAC already represents an unprecedented level of cooperation among providers, federally qualified health centers, community organizations and others, and the participants have made the long-term commitment necessary to transform our community. The WBPCAC deserves the State's support and a serious and positive review.

Sincerely,

Miguel McInnis, MPH
Managing Director

15480 Annapolis Rd. Suite 202
#214
Bowie, MD 20715
1-866-227-9457 phone/fax
www.mcinnisassociates.com

Allan S. Noonan, MD, MPH
RADM USPHS (ret)
PO Box 273
Hunt Valley , MD 21030-0273

Joshua Sharfstein, MD
Secretary, Maryland Department of Health and Mental Hygiene
And John A. Hurson,
Chair, Maryland Community Health Resources Commission

Dear Sirs:

With a serious sense of responsibility and honor I request that you accept my endorsement of the newly formed West Baltimore Primary Care Access Collaborative and the efforts of its members to collaborate in the provision of comprehensive preventive and primary care to the people of West Baltimore. I urge you to support their efforts by approving their application to be a Health Enterprise Zone.

In my previous role as Dean of the School of Community Health and Policy, I was asked by Dr. Samuel Ross and Senator Verna Jones-Rodwell to share the resources of the school in this effort. Along with many faculty members, I was pleased to join them in planning for a healthier outcome for the citizens of West Baltimore and in working with that community to address this goal. Senator Jones-Rodwell, Dr. Ross, and the members of the collaborative have initiated a model of comprehensive health services that will be of benefit to the people of West Baltimore for generations - and one that other communities in Maryland will want to replicate.

It has been rewarding to share in the progress that has been made, but also challenging to realize the expanse of the health problems still needing to be addressed. Knowing the effort that has already been expended and the commitment of the members of the Collaborative, I believe that Maryland will always look back on this investment with pride. Please approve the application of the West Baltimore Primary Care Access Collaborative to be one of Maryland's first Health Enterprise Zones.

Sincerely:

Allan S. Noonan, MD, MPH

MECU
Baltimore's Credit Union

November 1, 2012

Dr. Joshua Sharfstein, Secretary
Maryland Department of Health and Mental Hygiene
And John A. Hurson, Chair
Maryland Community Health Resources Commission

Gentlemen:

I am writing today to endorse the efforts of the newly formed West Baltimore Primary Care Access Collaborative (WBPCAC) and to urge your serious consideration of the group's application to be recognized as a Health Enterprise Zone.

The State of Maryland now has the opportunity to demonstrate to the nation a new approach to eliminating health disparities among racial and ethnic groups and between geographic areas.

The passage earlier this year of the Maryland Health Disparities and Reduction Act set the framework for an approach built around designated Health Enterprise Zones. And the creation of the WBPCAC offers real and tangible proof of what can be accomplished.

Prior to even applying for State support the WBPCAC has brought together 16 health, wellness, education and community-based organizations and established three areas of focus for the residents of Central-West and Southwest Baltimore: care coordination, education and outreach, and the improvement and expansion of primary care capacity. In addition, in order to ensure timely, appropriate strategies to address the needs of our community, the WBPCAC has, and continues to seek input and guidance from the grass-roots perspective.

I am confident you will discover the WBPCAC's approach can make West Baltimore a healthy community. The WBPCAC deserves the State's support as a Healthier Enterprise Zone, which in turn will demonstrate to the nation the progressive leadership of Maryland's government leaders to make a difference.

Sincerely,

John R. Godwin

John R. Godwin
Vice President
Business Development/Strategic Alliances

Sojourner-Douglass College

200 N. Central Avenue - Baltimore, Maryland 21202 - (410) 276-0306 - Fax (410) 276-4086 - www.sdc.edu

November 1, 2012

Dr. Joshua Sharfstein,
Secretary, Maryland Department of Health and Mental Hygiene
And John A. Hurson,
Chair, Maryland Community Health Resources Commission

Greetings,

I am writing today in support of the efforts of the newly formed West Baltimore Primary Care Access Collaborative and to urge your serious consideration of the group's application to be recognized as a Health Enterprise Zone.

As you both are aware, the residents of Central-West and Southwest Baltimore long have been underserved by the city's health delivery system. Many families lack a primary care provider. These same families and suffer from chronic conditions such as cardiovascular disease, diabetes, obesity and asthma. The formation of the West Baltimore Primary Care Access Collaborative (WBPCAC) offers a realistic approach to addressing these problems and the state of Maryland can play a significant role.

The WBPCAC already has brought together 16 health, wellness, education and community-based organizations, and a comprehensive health assessment of West Baltimore was completed this summer. In addition, in order to ensure timely, appropriate strategies to address the needs of our community, the WBPCAC has, and continues to seek input and guidance from the grass-roots perspective. That assessment, in turn, has helped the WBPCAC establish three areas of focus: care coordination; education and outreach, and the improvement and expansion of primary care capacity.

Now, the WBPCAC is preparing an application for a grant under Maryland's new Health Improvement and Disparities Reduction Act to support West Baltimore as a Health Enterprise Zone. This application deserves a serious and positive review.

I am confident you will discover the WBPCAC offers an approach that can make West Baltimore a healthy community. This WBPCAC already represents an unprecedented level of cooperation among providers, federally qualified health centers, community organizations and others, and the participants have made the long-term commitment necessary to transform our community. The WBPCAC deserves the State's support.

Sincerely,

Maija R. Anderson

Maija Anderson, DNP, RN
Dean,
School of Nursing

Appendix M

Audit Report

Fiscal Year 2012 Financial Audit

Bon Secours Hospital Baltimore Inc. is a subsidiary of Bon Secours Baltimore Health Corporation which, in turn, is a subsidiary of Bon Secours Health System, Inc. (BSHSI).

BSHSI conducts a consolidated Audit of its entire health system operations in the United States. At the request of Mark Luckner to abbreviate the Audit submission- Selected pages from the BSHSI Audit (removing notes and schedules of non-Bon Secours Baltimore Health Corporation entities) are included in this Appendix.

For a full copy of the Audit – please contact Gregory Kearns at Gregory_Kearns@bshsi.org or 410-271-4314.

BON SECOURS HEALTH SYSTEM, INC. AND SUBSIDIARIES

Consolidated Financial Statements and Consolidating Schedules

August 31, 2012 and 2011

(With Independent Auditors' Report Thereon)

KPMG LLP
1 East Pratt Street
Baltimore, MD 21202-1128

Independent Auditors' Report

The Board of Directors
Bon Secours Health System, Inc. and Subsidiaries:

We have audited the accompanying consolidated balance sheets of Bon Secours Health System, Inc. and Subsidiaries (the System) as of August 31, 2012 and 2011, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended. These consolidated financial statements are the responsibility of the System's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the System's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Bon Secours Health System, Inc. and Subsidiaries as of August 31, 2012 and 2011, and the consolidated results of their operations, changes in their net assets, and their cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

KPMG LLP

October 30, 2012

BON SECOURS HEALTH SYSTEM, INC.
AND SUBSIDIARIES

Consolidated Balance Sheets

August 31, 2012 and 2011

(In thousands)

Assets	2012	2011
Current assets:		
Cash and cash equivalents	$ 138,781	159,635
Accounts receivable, net:		
Patient and third-party payors	394,359	385,296
Other	48,683	37,319
Total accounts receivable, net	443,042	422,615
Assets limited or restricted as to use	61,336	78,893
Inventories	56,853	54,628
Prepaid expenses and other current assets	29,562	18,134
Total current assets	729,574	733,905
Assets limited or restricted as to use, less current portion	950,128	869,845
Property, plant, and equipment, net	1,096,481	1,085,226
Goodwill and other assets, net	303,793	292,579
Total assets	$ 3,079,976	2,981,555
Liabilities and Net Assets		
Current liabilities:		
Current portion of long-term debt	$ 27,810	61,023
Accounts payable	182,458	182,491
Accrued salaries, wages, and benefits	127,413	158,424
Other accrued expenses	122,858	107,679
Total current liabilities	460,539	509,617
Long-term debt, less current portion	1,019,800	1,014,319
Other long-term liabilities and deferred credits	756,121	606,582
Total liabilities	2,236,460	2,130,518
Net assets:		
Unrestricted-controlling interest	608,843	638,462
Unrestricted-noncontrolling interest	180,780	164,810
Total unrestricted	789,623	803,272
Temporarily restricted	45,849	40,911
Permanently restricted	8,044	6,854
Total net assets	843,516	851,037
	$ 3,079,976	2,981,555

See accompanying notes to consolidated financial statements.

BON SECOURS HEALTH SYSTEM, INC.
AND SUBSIDIARIES

Consolidated Statements of Operations

Years ended August 31, 2012 and 2011

(In thousands)

	2012	2011
Revenues:		
Net patient service revenue	$ 3,330,158	3,166,054
Other revenue	118,344	142,821
Total revenues	3,448,502	3,308,875
Expenses:		
Salaries, wages, and benefits	1,618,264	1,540,009
Supplies	559,808	539,578
Purchased services and other	738,876	747,024
Provision for bad debts	242,587	235,887
Depreciation and amortization	128,614	119,801
Interest	42,358	41,099
Total expenses	3,330,507	3,223,398
Operating income from continuing operations	117,995	85,477
Nonoperating gains (losses), net:		
Nonoperating investment gains, net	33,032	65,518
Loss on early retirement of debt	(602)	(1,172)
Gain on sale of assets, net	2,836	967
Other nonoperating activities, net	(41,220)	(35,591)
Excess of continuing revenues over expenses	112,041	115,199
Gain on discontinued operations, net	2,872	—
Excess of revenues over expenses	114,913	115,199
Other changes in unrestricted net assets:		
Net change in unrealized gains on other-than-trading securities	438	1,563
Grants for capital	5,235	—
Net assets released from restrictions used for purchase of property, plant, and equipment	3,537	3,661
Transfers to affiliates and other changes, net	(4,063)	(7,132)
Net change in equity of joint ventures	3,301	3,060
Distributions to noncontrolling interest owners	(7,042)	(5,080)
Pension and other postretirement adjustments	(129,968)	46,882
(Decrease) increase in unrestricted net assets	(13,649)	158,153
Unrestricted net assets, beginning of year	803,272	645,119
Unrestricted net assets, end of year	$ 789,623	803,272

See accompanying notes to consolidated financial statements.

BON SECOURS HEALTH SYSTEM, INC.
AND SUBSIDIARIES

Consolidated Statements of Changes in Net Assets

Years ended August 31, 2012 and 2011

(In thousands)

	Unrestricted net assets	Temporarily restricted net assets	Permanently restricted net assets	Total
Balance at August 31, 2010	$ 645,119	33,381	6,755	685,255
Excess of revenues over expenses	115,199	—	—	115,199
Grants and restricted contributions	—	13,897	118	14,015
Net change in unrealized gains on other-than-trading securities	1,563	398	—	1,961
Investment income	—	129	—	129
Net assets released from restrictions used for purchase of property, plant, and equipment	3,661	(3,661)	—	—
Net assets released from restrictions used for operations	—	(3,136)	—	(3,136)
Net change in equity of joint ventures	3,060	—	—	3,060
Distributions to noncontrolling interest owners	(5,080)	—	—	(5,080)
Pension and other postretirement adjustments	46,882	—	—	46,882
Transfers to affiliates and other changes, net	(7,132)	(97)	(19)	(7,248)
Increase in net assets	158,153	7,530	99	165,782
Balance at August 31, 2011	803,272	40,911	6,854	851,037
Excess of revenues over expenses	114,913	—	—	114,913
Grants and restricted contributions	—	16,791	1,214	18,005
Grants for capital	5,235	—	—	5,235
Net change in unrealized gains on other-than-trading securities	438	290	—	728
Investment income	—	140	—	140
Net assets released from restrictions used for purchase of property, plant, and equipment	3,537	(3,537)	—	—
Net assets released from restrictions used for operations	—	(8,557)	(19)	(8,576)
Net change in equity of joint ventures	3,301	—	—	3,301
Distributions to noncontrolling interest owners	(7,042)	—	—	(7,042)
Pension and other postretirement adjustments	(129,968)	—	—	(129,968)
Transfers to affiliates and other changes, net	(4,063)	(189)	(5)	(4,257)
(Decrease) increase in net assets	(13,649)	4,938	1,190	(7,521)
Balance at August 31, 2012	$ 789,623	45,849	8,044	843,516

See accompanying notes to consolidated financial statements.

BON SECOURS HEALTH SYSTEM, INC.
AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years ended August 31, 2012 and 2011

(In thousands)

	2012	2011
Cash flows from operating activities:		
(Decrease) increase in net assets	$ (7,521)	165,782
Adjustments to reconcile increase (decrease) in net assets to net cash provided by operating activities:		
Gain on discontinued operations, net	(2,872)	—
Provision for bad debts	242,587	235,887
Depreciation and amortization, including $5,699 and $2,154 reported in nonoperating activities, net in 2012 and 2011, respectively	134,313	121,955
Amortization of deferred financing costs and bond discount, net	2,043	2,537
Equity in income of joint ventures	(27,261)	(32,649)
Distributions received from investments in joint ventures	25,197	25,429
Net realized/unrealized gains on certain investments and derivative instruments	(28,263)	(59,108)
Loss on early retirement of debt	602	1,172
Gain on sale of assets	(2,836)	(967)
Gain on sale of service line	—	(30,000)
Pension and other postretirement adjustments	129,968	(46,882)
Grants received for capital expenditures	(5,235)	—
Contributions restricted by donor	(18,005)	(14,015)
Cash distributions to noncontrolling interest owners	7,042	5,080
Cash (used in) provided by changes in assets and liabilities:		
Increase in accounts receivable	(263,014)	(294,957)
Increase in inventories, prepaid expenses and other current assets	(13,653)	(1,978)
Increase in goodwill and other assets, net	(8,086)	(7,038)
(Decrease) increase in accounts payable and other current liabilities	(13,465)	24,929
Increase in other long-term liabilities and deferred credits	13,965	60,922
Net cash provided by operating activities	165,506	156,099
Cash flows from investing activities:		
Investment in joint ventures	(4,666)	(21,511)
Proceeds from sale of joint venture	—	10,700
Purchases of securities, net of sales and maturities	(12,853)	(25,606)
Property, plant, and equipment additions, net of disposals	(143,976)	(131,364)
Proceeds from sale of assets	2,349	6,425
Proceeds from sale of service line	—	30,000
Cash paid for acquisitions	—	(8,891)
Payments related to interest rate swaps	(15,432)	(57,405)
Net cash used in investing activities	(174,578)	(197,652)
Cash flows from financing activities:		
Proceeds from issuance of long-term debt	72,460	214,095
Payments of long-term debt	(28,324)	(25,971)
Retirements of long-term debt	(70,880)	(173,355)
Payment of deferred financing fees	(1,236)	(2,771)
Grants received for capital expenditures	5,235	
Proceeds from contributions restricted by donors	18,005	14,015
Cash distributions to noncontrolling interest owners	(7,042)	(5,080)
Net cash (used in) provided by financing activities	(11,782)	20,933
Net decrease in cash and cash equivalents	(20,854)	(20,620)
Cash and cash equivalents, beginning of year	159,635	180,255
Cash and cash equivalents, end of year	$ 138,781	159,635

Supplemental disclosures:
(a) Cash paid for taxes was $892 and $517 for 2012 and 2011, respectively.

See accompanying notes to consolidated financial statements.

BON SECOURS HEALTH SYSTEM, INC. AND SUBSIDIARIES Schedule 1.2

Consolidating Schedule - Balance Sheet Information
(in thousands)

August 31, 2012
(with comparative totals for 2011)

	Bon Secours Baltimore Health Corporation							
	Bon Secours Hospital Baltimore	BS Community Health Services	Bon Secours of Maryland Foundation	Urban Medical Institute	BS Baltimore HS Foundation	Consolidating Eliminations	2012 Consolidated	2011 Consolidated
Assets								
Current assets:								
Cash and cash equivalents	$ (74,216)	-	802	-	(9)	73,795	372	294
Accounts receivable, net:								
Patient and third-party payors	18,775	-	-	-	-	0	18,775	19,541
Other	1,116	-	1,159	-	249	(11)	2,513	3,535
Total accounts receivable, net	19,891	-	1,159	-	249	(11)	21,288	23,076
Assets limited or restricted as to use	-	-	25	-	-	0	25	288
Inventories	1,344	-	-	-	-	0	1,344	1,179
Prepaid expenses and other current assets	1,424	-	3,413	-	-	(3,412)	1,425	19
Total current assets	(51,557)	-	5,399	-	240	70,372	24,454	24,856
Assets limited or restricted as to use, less current portion	10,352	-	39	-	6,377	0	16,768	15,665
Property, plant, and equipment, net	29,485	-	41,091	-	-	(39,357)	31,219	30,318
Goodwill and other assets, net	7,615	-	527	-	-	182	8,324	7,056
Total assets	$ (4,105)	-	47,056	-	6,617	31,197	80,765	77,895
Liabilities and Net Assets								
Current liabilities:								
Current portion of long-term debt	$ 707	-	540	-	-	(540)	707	700
Accounts payable	9,680	-	1,916	-	35	(1,875)	9,756	8,101
Accrued salaries, wages, and benefits	4,477	-	10	-	-	(10)	4,477	6,428
Other accrued expenses	4,804	-	3,798	-	-	(3,798)	4,804	4,364
Due to (from) affiliate	(940)	-	1,428	-	(506)	0	(18)	(583)
Total current liabilities	18,728	-	7,692	-	(471)	(6,223)	19,726	19,010
Long-term debt, less current portion	7,258	-	15,600	-	-	(15,498)	7,360	8,027
Due to affiliate, less current portion	17,485	-	5,522	-	-	74,578	97,585	94,361
Other long-term liabilities and deferred credits	37,432	-	-	-	-	0	37,432	28,949
Total liabilities	80,903	-	28,814	-	(471)	52,857	162,103	150,347
Net assets:								
Unrestricted-controlling interest	(84,867)	-	(2,314)	-	5,653	(1,129)	(82,657)	(74,156)
Unrestricted-noncontrolling interest	-	-	20,531	-	-	(20,531)	-	-
Total unrestricted	(84,867)	-	18,217	-	5,653	(21,660)	(82,657)	(74,156)
Temporarily restricted	(141)	-	25	-	1,435	0	1,319	1,704
Permanently restricted	-	-	-	-	-	-	-	-
Total net assets	(85,008)	-	18,242	-	7,088	(21,660)	(81,338)	(72,452)
	$ (4,105)	-	47,056	-	6,617	31,197	80,765	77,895

See accompanying independent auditors' report on supplementary information

BON SECOURS HEALTH SYSTEM, INC. AND SUBSIDIARIES

Schedule 2.2

Consolidating Schedule - Operating Information
(in thousands)

Year ended August 31, 2012
(with comparative totals for 2011)

	Bon Secours Baltimore Health Corporation							
	Bon Secours Hospital Baltimore	Bon Secours Community Health Services	Bon Secours of Maryland Foundation	Urban Medical Institute	BS Baltimore HS Foundation	Consolidation Eliminations	2012 Consolidated	2011 Consolidated
Revenues:								
Net patient service revenue	$ 136,084	-	-	-	-	0	136,084	132,055
Other revenues	3,418	-	4,923	-	-	(2,840)	5,501	6,014
Total revenues	139,502	-	4,923	-	-	(2,840)	141,585	138,069
Expenses:								
Salaries, wages, and benefits	61,920	-	1,357	-	0	0	63,277	65,780
Supplies	13,082	-	201	-	-	(65)	13,218	12,497
Purchased services and other	42,186	-	2,727	-	-	(2,385)	42,528	44,055
Provision for bad debts	15,716	-	-	-	-	0	15,716	11,156
Depreciation and amortization	3,331	-	1,696	-	-	(1,643)	3,384	4,171
Interest	2,045	-	717	-	-	(717)	2,045	1,408
Total expenses	138,280	-	6,698	-	-	(4,810)	140,168	139,067
Operating income (loss)	1,222	-	(1,775)	-	-	1,970	1,417	(998)
Nonoperating gains (losses), net:								
Nonoperating investment gains, net	640	-	250	-	121	0	1,011	1,166
Loss on early retirement of debt	-	-	-	-	-	-	-	-
Gain (loss) on sale of assets, net	565	-	-	-	-	0	565	(25)
Other nonoperating activities, net	(822)	-	(732)	-	(617)	0	(2,171)	(1,666)
Gain on discontinued operations, net	-	-	-	-	-	-	-	-
Excess (deficit) of revenues over expenses	1,605	-	(2,257)	-	(496)	1,970	822	(1,523)
Other changes in unrestricted net assets:								
Grants for capital	-	-	-	-	-	-	-	-
Net change in unrealized gains (losses) on other-than-trading securities	1	-	-	-	259	1	261	517
Net assets released from restrictions used for purchase of property, plant, and equipment	-	-	-	-	-	-	-	770
Transfers to affiliates and other changes, net	(19,345)	13,063	(3,852)	3,763	5,889	(1,789)	(2,272)	(1,794)
Distrinutions to noncontrolling interest owners	-	-	-	-	-	-	-	-
Net change in equity of joint venture	-	-	-	-	-	-	-	-
Pension and other postretirement adjustments	(7,312)	-	-	-	-	0	(7,312)	3,613
Increase (decrease) in unrestricted net assets	$ (25,051)	13,063	(6,109)	3,763	5,652	182	(8,501)	1,583

See accompanying independent auditors' report on supplementary information