COMMUNITY HEALTH RESOURCES COMMISSION

Mark Luckner, Executive Director
Community Health Resources Commission

Presented to:
House Appropriations Health & Human Resources Subcommittee
February 11, 2016
BACKGROUND ON THE CHRC

• The CHRC is an independent agency operating within the Maryland Department of Health and Mental Hygiene.

• Eleven Commissioners of the CHRC are appointed by the Governor (one current vacancy).

  John A. Hurson, Chairman
  Nelson Sabatini, Vice Chairman
  Elizabeth Chung, Executive Director, Asian American Center of Frederick
  Charlene Dukes, President, Prince George’s County Community College
  Maritha R. Gay, Executive Director of Community Benefit and External Affairs, Kaiser Foundation Health Plan of the Mid-Atlantic States Region
  William Jaquis, M.D., Chief, Department of Emergency Medicine, Sinai Hospital
  Sue Kullen, Southern Maryland Field Representative, U.S. Senator Ben Cardin
  Paula McLellan, CEO, Family Health Centers of Baltimore
  Barry Ronan, President and CEO, Western Maryland Health System
  Maria Harris Tildon, Senior Vice President for Public Policy & Community Affairs, CareFirst BlueCross BlueShield
BACKGROUND ON THE CHRC

The CHRC grants have focused on the following public health priorities:

- Reducing infant mortality
- Promoting ED diversion programs
- Expanding primary care access
- Increasing access to dental care
- Integrating behavioral health
- Investing in health information technology
- Addressing childhood obesity
- Building safety net capacity
IMPACT OF CHRC GRANTS

• Since 2007, CHRC has awarded 154 grants totaling $52.3 million. Most grants are awarded for multiple program years.

• CHRC has supported programs in all 24 jurisdictions.

• These programs have collectively served more than 260,000 Marylanders.

• Most grants are awarded to community-based safety net providers, including federally qualified health centers (FQHCs), local health departments, free clinics, and outpatient behavioral health providers.
The Community Health Resources Commission (CHRC) was created by the Maryland General Assembly in 2005 to expand access for low-income Marylanders and underserved communities.

Statutory responsibilities include:

- Increase access to primary and specialty care through community health resources
- Promote community-hospital partnerships and emergency department diversion programs to prevent avoidable hospital utilization
- Facilitate the adoption of health information technology
- Promote long-term sustainability of community health resources as Maryland implements health care reform
• Encourage programs to be sustainable after initial “seed” grant funding is expended.

• Utilize CHRC grant funding to leverage additional federal and private/non-profit funding.

$52.3M awarded to grantees

$18.8M in additional resources

$14.9M in private, nonprofit, or local resources

Weinberg Foundation
$250,000 to West Cecil Community Health Center

CareFirst
$447,612 to Access to Wholistic & Prod. Living

$3.8M in federal resources

HRSA New Access Point
$425,874 to Mobile Med
Chapter 328 in 2014 reauthorized the CHRC until 2025. This vote was unanimous.

- Demonstrated track record in distributing and managing public funds efficiently
  - 41 grants, totaling $13.4 million, under implementation
- Grantee accountability (both fiscal and programmatic)
- CHRC overhead is 7% of its $8 million budget
  - Monitored by CHRC staff of four PINs
- Pilot innovative ideas that are later replicated statewide
  - Way Station – Medicaid Behavioral Health Home Pilot
  - Allegany Health Right/WMHS Dental Partnership
CHRC GRANT MONITORING

- CHRC grants are monitored closely.
- Twice a year, as condition of payment of funds, grantees submit program narratives, performance metrics, and an expenditure report.
- Grantee progress reports (sample above) are a collection of process and outcome (some) metrics; grantees are held accountable for performance.
CONTINUED IMPORTANCE OF COMMUNITY HEALTH RESOURCES

• Health insurance does **not** always mean access.
  – FQHCs and other community health resources may be the best option for newly insured because many non-safety net providers do not accept new patients or have long wait times

• Historical mission of serving low-income individuals who are impacted by social determinants and have special health and social service needs.
  – Health literacy - critical role of safety net providers

• Demand for health services by the newly insured dramatically outpaces the supply of providers.
  – 81% of FQHCs nationally have seen an increase in patients in the last 3 years
• Assist ongoing health care reform efforts
  – Build capacity of safety net providers to serve newly insured
  – Assist safety net providers in IT, data collection, business planning
  – Promote long-term financial sustainability of providers of last resort

• Support All-Payer Hospital Model and health system transformation
  – Provide initial seed funding for community-hospital partnerships
  – Fund community-based intervention strategies that help achieve reductions in avoidable hospital utilization
  – Issued white paper, “Sustaining Community-Hospital Partnerships to Improve Population Health” (authored by Frances B. Phillips)

• Support population health improvement activities
  – Align with State Health Improvement Process (SHIP) goals
  – Build infrastructure of Local Health Improvement Coalitions
EXAMPLES OF CHRC GRANTS

Three-year grant to free clinic enabled grantee to implement financially sustainable dental program, serving 750 patients to date and generating $40,000 in program revenue.

Two-year grant enabled behavioral health clinic to add primary care services. Increased revenues from $1.3M to $4.4M. Also leveraged CHRC funding to attract $600,000 in federal funds.

Three-year ED diversion/care coordination grant targeted high utilizers, resulting in an 80% reduction in inpatient stays and 67% reduction in ED visits (4 months pre- vs. post-intervention) which translates into savings/avoided charges of $632,492.

Three-year grant to free clinic enabled organization to lay the ground work to transition to FQHC status and receive a $900,000 NAP award.
FY 2016 CALL FOR PROPOSALS

Key Dates:
November 10, 2015 – Release of Call for Proposals
January 11, 2016 – Applications due
January/February – Application review period
Mid-March – Presentations and award decisions

Three strategic priorities:
(1) Expand capacity;
(2) Reduce health disparities; and
(3) Support efforts to reduce avoidable hospital utilization.
FY 2016 CALL FOR PROPOSALS

• Generated 71 proposals totaling $14.8 million in year-one funding (FY 2016 budget - $1 million is available).

• Most proposals seek funding for multiple years. Total requested in RFP was $31.3 million.

• RFP includes 4 types of projects:
  1. Women’s health/infant mortality - 4 proposals, $1.7M
  2. Dental care - 12 proposals, $2.8M
  3. Behavioral health/heroin and opioid epidemic - 20 proposals, $9.8M
  4. Primary care and chronic disease management - 35 proposals, $17.0M
Demand for grant funding exceeds CHRC’s budget.
The Commission has funded approximately 19% of requests.