August 2007

# *Maryland Statewide Environmental Assessment: Final Report to the Bureau of Primary Health Care*

**Prepared by Mid-Atlantic Association of Community Health Centers**

## *Executive Summary*

Federally Qualified Health Centers provide essential services to insure high quality healthcare to the medically underserved and uninsured. Yet, as the demand for services increases, FQHCs find themselves competing for increasingly limited federal dollars. The paradigm is shifting and in order to thrive and continue to grow, new opportunities must be investigated. This scenario is no different for Maryland FQHCs.

The Mid-Atlantic Association of Community Health Centers (MACHC) conducted its Statewide Environmental Assessment (EA) as required by the Health Resources and Service Administration/Bureau of Primary Health Care. The purpose of this assessment was to analyze broad market, state issues and trends that present the greatest opportunities and/or threats to the underserved, unserved and Health Center safety net.

Beginning in March 2007 with a Kick- off Meeting, Maryland Health Centers were presented with trending data on Maryland FQHCs and the environment in which they operate. From this meeting MACHC was charged with the task of investigating potential service models for increasing revenue and expansion opportunities. Based on this analysis, strategies and actions that may result in increased access to preventative and primary care to underserved communities were identified and presented in a series of case models. The results of this analysis were presented at the Final Retreat held in August 2007. The Final Retreat concluded the EA process and Health Centers were asked to identify statewide priority areas they believed germane to the overall growth and survival of the centers.

This report will detail the process and methodology used by MACHC to complete the Maryland Environmental Assessment

## *Contents*

## *Summary of Opportunities and Threats*

The Final Retreat, held on August 14, 2007 in Annapolis, Maryland the health centers were asked to consider, based on the Case Studies and the PEST Analysis, their top priority opportunities and threats. A facilitator grouped these responses into priority areas based on the frequency of related issues that were individually identified. These Priority Areas were presented to the group. After discussion the group agreed on the top Priority Areas:

**Priority 1: Perception and Reputation.**
To be a preferred provider of choice; develop a branding strategy, communicate key messages to address misperceptions

**Priority 2: Growing Number of Uninsured and Underinsured.**
Balancing act between the payor mix, optimizing existing resources, opportunities to serve a greater percentage of these individuals

A number of other opportunities and threats were noted by individuals in the group that deserves note:

(1) Adapting Services to Changing Communities: Addressing dynamic communities, impact of BRAC Expansion, changing demographics of communities.

(2) Development of a Corporate EHR Strategy: Implementation of fully integrated system with other providers.

(3) Building Relationships: Establishing and maintaining partnerships with: hospitals, health, governments, business community and political leadership.

(4) State's deficit and the effect on Medicaid and competing funding priorities.

(5) Funding: Federal and state funding cuts in health care programs. Funding is program specific and does not fund capacity.

(6) Technology: Technology costs and use with patients

*(7)* External Data Communications: Develop common set of data on patient outcomes or "report card", communicate cost efficiencies

## *Strategic Options and Action Plans for Selected Priorities*

Working with the health centers and other key participants at the final retreat, the following strategies, actions steps, time frame and organizations responsible for achieving outcomes are summarized below. In order to set realistic goals and achieve positive outcomes without overextending the PCA, PCO and health centers capacities, MACHC and the health centers were able to commit to the strategies and action steps provided in the tables below for Priorities 1 & 2 identified in the preceding section.

TABLE 1: STRATEGY AND ACTION STEPS FOR MARYLAND PRIORITY 1

| Priority 1: Perception and Reputation | | |
|---|---|---|
| **Strategy:** Develop an image and branding strategy for the FQHC industry to enhance reputation and to enable the industry generate a sustained competitive advantage | | |
| **Action Steps** | **Time Frame for Completion** | **Responsible Organizations** |
| (1) Identify tools and resources that are available. | January 2008 | MACHC |
| (2) Develop the vision for FQHCs as a provider of choice and communications and branding strategy in which to market. | April 2008 | MACHC Strategic Planning Comm/FQHCs |
| (3) Identify target groups(audiences) that should be reached. | April 2008 | Board?MACHC strategic Planning Committee |
| (4) Conduct an internal and external assessment of perceptions, strengths and weaknesses | July 2008 | MACHC Strategic Planning Committee |
| (5) Incorporate FQHC and branding strategy into recruitment and hiring strategy. | August 2008 | MACHC/PCO/FQHCs |
| (6) Develop a cutting edge marketing campaign to market the benefits and uniqueness of the FQHC industry and other key messages relating to continuity and quality of care, individualized care, with the slogan: FQHCs are your one true medical home | August 2009 | MACHC |

TABLE 2: STRATEGY AND ACTION STEPS FOR MARYLAND PRIORITY 2

| Priority 2: Growing Number of Uninsured and Underinsured | | |
|---|---|---|
| **Strategy:** Develop a plan to pay for the uninsured and underinsured for FQHCs. | | |
| **Action Steps** | **Time Frame for Completion** | **Responsible Organizations** |
| 1. Investigate steps needed to create a risk pool for the under and uninsured to be funded by the legislature and/or Health Commission. | Overall Project Timeline: January 08 through January 2011 | MACHC |
| 2. Develop a business plan to accommodate the under/uninsured to determine how it will be paid. | See above | MACHC |
| 3. Identify a strategy for underserved communities that do not have FQHCs (rural areas) | See above | FQHCs/MACHC |
| 4. Develop a relationship strategy for FQHC (Local politicians, community organizations) | See above | FQHCs/MACHC |
| 5. Conduct a market analysis of patients' services, usage, needs and leverage existing data to determine the allocation of new funding. | See above | MACHC |

## *Maryland Environmental Assessment (EA) Methodology*

### *Summary*

MACHC undertook a number of sequential actions to complete the EA process. Over a period of 7 months, MACHC accomplished the following:

(1) Preliminary statewide qualitative interviews culminating in the Maryland Environmental Analysis Report. This report reviewed statewide trends for FQHCs, the healthcare industry, health care coverage, population demographics, and market changes in Maryland. The purpose of this analysis was to provide background information for strategic discussions.

(2) Organized the Statewide Environmental Assessment Kick-Off Event which was held on March 7th of this year. At the event, the purpose of the EA and quantitative data analysis were reviewed. Following this, guided discussions by MACHC moderators were held to identify priority issue areas for the health centers. The priority issue identified in the EA kick-off event as an area to be further researched by MACHC was:

> *"What potential sources for service expansion/increasing revenue for community health centers exist around different service strategies, uninsured risk pool and emergency department diversion and follow-up?"*

(3) Formation of a workgroup committee to assist in decision making and provide MACHC staff with guidance throughout the EA. Two workgroup conference calls were arranged by MACHC at key intervals in the process.

(4) Development of the research methodology which included a stakeholder analysis of key informants across five areas: payor-mix, patient expansion, (small) business insurance product, hospital relationship, and uninsured risk pool.

(5) Introductory letters were sent to all stakeholder offices prioritized by the FQHCs prior to beginning the interview process to help facilitate access to high-level personnel.

(6) The stakeholder analysis was completed by four members of the MACHC team preparing the analysis and reaching an internal consensus on issues and themes.

(7) Preparation and organization of final case studies and the Final Environment Assessment Retreat.

(8) The Final Retreat was held on August 14, 2007 in Annapolis, Maryland. The purpose of this retreat was to review the findings of the case studies report and through a moderated discussion, identify the opportunities and threats to FQHCs and the corresponding action strategies to achieve statewide results.

### *Participants*

In addition to the MACHC team, several key players in Maryland's FQHC industry were invited to participate in this process. The key participants who were involved in the Final Retreat process were:

(1) Allen Bennett, President and CEO, Park West Health Systems

(2) Walter Egerton, Chief Medical Officer, Family Health Centers

(3) Wayne Howard, Chief Executive Officer, Choptank Health Center

(4) Jeanette Jenkins, Primary Care Organization (PCO) Director, Maryland PCO

(5) Christopher King, Director of Programs, Greater Baden Medical Services

(6) Sheila Merriweather, Chief Operating Officer, Park West Health Systems

(7) Kim Murdaugh, Executive Director, Walnut Street Community Health Center

(8) Jay Wolvovsky, Chief Executive Officer, Baltimore Medical Systems

(9) Vicki Wynn, Chief Operating Officer, Total Health Care

Potential participants were identified in February 2007 and included representatives from each of Maryland's FQHCs and the primary care organization. Save-the-dates and formal invitations to the EA Kick-off event were sent to each of the potential participants with explanations of the EA, the process and the potential benefits to FQHCs in participating in the EA. In addition, a commitment letter was distributed to each of the potential EA participants which asked each organization to identify a central point of contact for the duration of the project and to commit itself to the EA process. Participants were also encouraged to invite other key staff or board members of their organization to attend.

Those with commitment letters were invited to participate in the EA workgroup. The workgroup's purpose was to engage the health centers and other key personnel throughout the EA process, providing feedback and direction to MACHC when needed. Furthermore, the workgroup sessions allowed MACHC to keep participants focused and connected to the process, which greatly contributed to the success of the Final Retreat. (APPENDIX ITEM 1) MACHC received seven signed commitment letters from the leadership of Baltimore Medical System, Walnut Street Community Health Center, Family Health Centers of Baltimore, Mountain Laurel Medical Center, Greater Baden Medical Services, Inc., Total Health Care Inc., and Park West Health System.

Participation with the health centers was maintained throughout the environmental assessment by engaging them in the process, specifically requesting input and feedback from the centers. This was accomplished through the following techniques:

(1) Workgroup conference calls held twice between the Kick-Off and Final Retreat Events;

(2) Asking health centers for specific priorities of interest;

(3) Requests to review and comment on research methodologies and meeting summaries;

(4) Relaying information and seeking input on status of the project.

### *Finalized Environmental Assessment Process*

The Maryland EA was a data-driven project with the health centers playing a key role in driving important information regarding the key threats and opportunities to FQHCs. At several points in the process data was gathered, analyzed and present to the FQHCs in order to create an accurate picture of the environment in which they operate. At all points, the FQHCs were asked to reflect upon the data and their own experiences before moving forward. The Kick-Off Event, Case Studies Analysis and Final Retreat are indicative of this fact.

#### *Kick-Off Event*

The data prepared for the Kick-Off meeting was pulled from the EA templates (T2) Patient User Market Share, (T5) Demographic and Socio-Economic Analysis, (T6) Economic Trends and (T11) Top Industries. A number of different government and private sources were used to fill the template charts where information was missing including data from the U.S. Bureau of Labor and Statistics, the U.S. Census Bureau, and the Henry J. Kaiser Family Foundation. Additional information was used to supplement the EA template data on health care consumer expenditures, African American women's health care access, emergency department usage, and information on the growing senior population in Maryland.

Using this information, a Maryland data-report was created and distributed to all the Kick Off meeting participants and health centers (a sampling of the report is found in APPENDIX ITEM 2).. Furthermore, highlights of this information were presented in a trending analysis PowerPoint at the meeting prior to the moderated discussion on hot issues/trends for further

analysis. During the Kick-Off Meeting participants were asked to identify, with the assistance of the trending data presented, those areas they deemed to present opportunities as well as threats that should be further investigated by MACHC. The opportunities and threats noted are:

(1) Market Penetration: Changing demographics and potential responses by FQHCs to meet population needs.

(2) Market Share: How do health centers increase their market share of patients with service models that will help generate revenue for health centers?

(3) Emergency room usage by potential health center patients: How can FQHCs work with hospitals to create medical homes with people who current use the ER inappropriately.

(4) Advocacy: Statewide and locally with leaders to promote FQHCs as the cost-effective means to providing healthcare. Local leaders and communities must be educated in areas where FQHCs are located and the communities are changing.

(5) Chronic Disease Management: Health centers are not receiving some of the same waivers that are currently going to Managed Care Organizations for chronic disease management, though the health centers already address chronic disease management with improved patient outcomes.

(6) Workforce Development: Improving the supply chain for primary care physicians and other workers.

The kick-off meeting was successful in directing MACHC to investigate the following priority areas as defined by the participating FQHCs:

**Priority 1:** What potential sources for service expansion/increasing revenue for community health centers exist around different service strategies, uninsured risk pool and emergency department diversion/follow-up?

**Priority 2:** Where do the coverage and/or access gaps for different population segment? For these identified population segments, what are the:

- 2.1 Buying patterns for health centers services
- 2.2 Health center staffing models that meet the needs and perceptions of these population segments
- 2.3 How can FQHCs better market their services to these particular population segments

It should be noted that after consideration of the timeframe for completion and resources available, the workgroup came to a consensus to pursue only Priority One.

*Case Studies Analysis*

MACHC developed research methodologies for the priority one which was then vetted through the first workgroup meeting. MACHC consulted with the national PCA and several state PCAs for referrals of appropriate service models implemented by health centers. The National and State PCAs were more knowledgeable of service models implemented by health centers nationwide, and were contacted for this reason. The priority area research methodology included a qualitative interview process completed by members of the MACHC staff. Executives of the health centers chosen to participate in the interview process were contacted and scheduled for a future interview with MACHC staff. Interviewees were contacted via telephone by MACHC staff. In addition to interviews, where available, data that could supplement the qualitative information was provided.

A total of nine health centers were contacted for interviews, while only five were included in the final case study report presented at the EA Final Retreat. Four health center service models were documented, but excluded in the final report. The models were excluded due to lacking sustainability, improper Return On Investment (ROI) data, or being implemented in an environment not conducive to Maryland FQHCs. The interview scripts were semi-structured, focusing on health center's political environment, demographics, service model implementation

process, return on investment data, and success factors. Qualitative interviews were completed with ten executives from nine health centers nationwide.

The interviews were complied and analyzed into a Final Case Studies Report which was distributed to the workgroup prior to the final retreat. Analysis was completed by MACHC staff. Individual case studies were completed for each health center's service model.

TABLE 3: SUMMARY OF CASES STUDIES IN FINAL REPORT

**Heart of Texas Community Health Center: Hospital-Health Center Relationships**

Heart of Texas Community Health Center (HTCHC) has worked to improve its payor-mix aimed at returning infants and Medicaid children (ages 1-5) to the CHC whose mothers had received prenatal care or had infant care to the CHC. HTCHC partnered with the local hospital to have a HTCHC Immunization nurse visit each new mother in the hospital that was either a prenatal care patient, a Medicaid patient or who fit the low-income qualifications. This model increase the number of Medicaid babies by 90%

A second model employed by HTCHC for increasing the number of Medicaid children. Using its electronic health records to send reminders to mothers, the health center was able to double the number of returning children ages 1 through 5.

**North Hudson Health Center: Hospital-Health Center Relationships**

North Hudson Health Center (NHHC) beginning in the 1990's worked with area hospitals to create referral systems for emergency room, pediatric and obstetric care patients. NHHC has contracted with area hospitals to provide pediatricians, obstetricians, Doctors of Osteopathic (DO), and residents to attend to the hospitals' 24-hour centers, emergency rooms, and in one model their obstetric department. Under this system, the hospital pays the health centers for doctor's time, while the doctors are able to connect with patients, make appointments and referrals with patients at the hospital sites to NHHC.

With these relationships, NHHC has been able to increase their patient base by 64% in four years, from 28,000 in 2002 to 46,000 in 2006.

**White River Rural Heath Centers, Inc: Finance and Redesign**

The concept of the Finance and Redesign change package involves the use of data to understand the practice of a health center and its business case. Once appropriate data is collected, it is compared to industry benchmarks and specific health center goals, a gap analysis is conducted, and then a plan for improvement to close gaps is developed and implemented. To complete an organizational transformation and solidify the business case, various dimensions of the practice should be measured and monitored. These dimensions include clinical processes and outcomes, financial health of the practice

White River Rural Health Centers, Inc implemented the Finance and Redesign program in 2003. Since that time they have been able to increase revenue by over $1 million dollars, improve staff retention, has saved over $2.3 million dollars, decreased patient cycle time.

**COVERTN: State Sponsored Small Business Insurance Product**

CoverTN is a statewide insurance program offered to small businesses. Working Tennessee residents now have an option for affordable, portable health insurance. It is partially subsidized by the state. The premium is evenly divided among the employee, employer and the state. Premiums amounts are determined by basic underwriting criteria such as age, weight and smoking status. Since there are plan limitations, no one is declined.

The program began pre-qualification of eligible employers in 2006 and has guaranteed subsidy from the state for 3 years. Currently there are 5000 people enrolled since March 2007 with an additional 2000 registered and ready to enroll in August 1, 2007.

**New Jersey FWHC Expansion Program: Uninsured Risk Pool**

In 1991 New Jersey state officials recognized there was an urgent need to curtail the spiraling costs of healthcare. Then Governor Jim Florio signed into existence the Health Care Reduction Fund, the first comprehensive act reform of New Jersey's health care system in over 10 years. The act allocated 0.53% of the monies from assessment on hospital operating revenues (disproportionate share funds) to support FQHCs in the state and implement an uninsured risk pool. The legislation in the bill initially included $10 million a year and in 2007 the fund has grown to $40 million. Two major components of the FQHC Expansion Program is the 1) increase in access for working people by expanding and promoting health center hours and services and 2) reimbursement to the FQHCs for uninsured visits.

Since implementation of the program, New jersey health centers have seen an additional 50,000 new primary care visits in the first year alone. The fund paid for 20,000 visits for the uninsured in 1992 that number has increased to 400,000 visits in FY2006.

*Final Retreat*

The final retreat was held in mid August and the format followed an agenda very similar to the Kick-Off Event. The overall goal of the retreat was to come to a consensus on critical issues and resources that can be devoted to making an impact on our industry, develop strategic actions, delegate responsibilities and determine timelines for actions. The final retreat included the overview of the EA process, case studies presentation, a moderated discussion, and strategic action items were identified, respectively.

The Final Retreat was designed to use the case studies information as a way to examine the current political, economic, socio-economic cultural and technology factors (PEST). Case studies were presented, followed by a facilitated PEST discussion, priority setting of opportunities and threats and strategic planning.

The PEST analysis is a parallel analytical tool to the Strengthens, Weaknesses, Opportunity and Threats (SWOT) analysis. The PEST enabled the participants to think critically about the case models within the context of the statewide industry of health centers. Table 4 details the results of the PEST Analysis.

TABLE 4: SUMMARY OF THE POLITICAL, ENVIRONMENTAL, SOCIO-ECONOMIC, and TECHNOLOGICAL FACTORS

| Political Factors |
|---|
| (1) Relationships with state health and local health departments in counties |
| (2) Healthcare is the bill payor of choice. When there are budgetary constraints at the state level, it takes the hi |
| (3) Medicaid program cost overruns can get attention |
| (4) Huge state budget deficit, especially in education. Legislature is looking at cost savings. Opportunity if we can show cost savings |
| (5) Relationships with local governments; they see FQHCs as lower cost providers |
| (6) More knowledgeable political leaders are needed |
| (7) Healthcare is political; it depends on who wants to take it on. The Governor wants to expand health care, but there is a deficit |
| (8) Political decisions pertaining to immigrants – law, housing and healthcare |
| (9) Many of political issues will have impacts |

## Environmental Factors

(1) More and more companies with reduced insurance benefits
(2) Employees share costs, and there are increased deductibles, affordability is issue for employers and employees
(3) Corporate responsibility for health insurance is lessening
(4) FQHCs are perceived as the lost cost provider
(5) Increased cost of labor
(6) Employers' marketplace. Competition for health practitioners:
(7) FQHCs recruitment challenges
(8) Gaps in service while waiting to fill positions
(9) Shortage of primary care doctors is impacting services; the trend is going toward specialties
(10) Medical profession is not as attractive
(11) Support staff is also an issue
(12) Health care issues for patients are complex and require a lot of time/costs
(13) People are less concerned with health when there are economic downturns. It is harder to be held accountable for outcomes because behaviors change
(14) Specialty care – hard to get patients from primary care to specialty care because of insurance limitations and perceptions of care and coverage
(15) Commercial insurance market – a handful of players are keeping small plans out. There is almost a monopoly in MD; it hurts to have so few
(16) Not enough regulation; rates are poor and can'tg et reimbursement
(17) Increase in the under and uninsured and costs of care. The new uninsured are workforce people

## Socio-Economic Cultural Factors

(1) Increasing number of Hispanics and immigrants and how they access care
(2) Growing aging population and disease management issues
(3) Unemployment and lack of high paying jobs, low benefits
(4) Part time employment, shift workers, who access care differently; Staff coverage is an issues
(5) Staff needs to be able to address cultural differences; must be trained in cultural competency
(6) Perception of FQHC as a last resort of care, need to change the perception of patient base by key stakeholders
(7) Situation of FQHCs in urban settings helps to reinforce negative perceptions
(8) Unstable, changing communities: When does this become medically underserved? Unstable affluent?
(9) More stable changing communities
(10) Success can create situations where underserved designation is removed and funds are withdrawn (the Feds are looking at this)
(11) Need to be sensitive to immigration shifts and the impact they have on catchments areas
(12) Debate on health care reform – double edged sword – must be cognizant on financial impacts. Must push for incremental reform; not drastic reform.
(13) Look at patients and reach them. Help them view FQHCs as their medical home
(14) One shop stop nature of FQHCs is an advantage
(15) Quality Care – large providers, make part of presentation to community
(16) FQHCs maintain data on outcomes and tie to image building

| Technology Factors |
|---|
| (1) EMR and affordability |
| (2) Health information exchange networks |
| (3) Latest for technology is available at the FQHCs |
| (4) Integration of data with other centers |
| (5) Patients are more involved with technology |
| (6) Patients should be able to access their own information |
| (7) Patients are getting smarter and expect more on demand; they use WebMD |
| (8) Wow factor – the trend is a higher expectation from patients, we need to Wow them with high quality service |
| (9) Patients want the latest and newest procedures |
| (10) Lots of opportunities to expand services |
| (11) Opportunity to promote a branding of the industry |
| (12) Technological advance increase expectations to report patient outcomes; more pressure to deliver. |
| (13) Achieving outcomes will help with FQHC reputation |
| (14) Information systems are expensive to maintain and must be replaces |
| (15) Staff trainings and cost of training on the new technologies |
| (16) Tele-medicines – a big opportunity to address rural areas |
| (17) Translation software for multicultural patients |

Following the collection of qualitative data from the PEST Analysis, priority setting of opportunities and threats occurred through a facilitated discussion and 'note-care' exercise. The 'note-card' exercise asked each participant was asked to list their top one or two priorities areas on note-cards which were then collected and ranked. MACHC used this technique to ensure full-participation by the health centers and other key players in priority setting. The priority areas presented earlier in this report were the top issues found using this technique.

Following the priority setting, the group dedicated the remainder of the time to devising strategies, action steps, timeline and delegating responsibilities.

## *Recommendations and Lessons Learned from the Environmental Assessment*

Overall, MACHC was very pleased with the involvement of the health centers and the outcomes of the EA process. Initial survey responses from the participants at the Final Retreat are also very favorable to the EA process and outcomes. MACHC's Strategic Planning Committee will be reviewing the priorities and strategies at their next meeting in September, 2007 in order to incorporate these tasks into MACHC's overall business plan.

MACHC's recommendations and lessons learned from this process:

(1) MACHC staff would like to share more responsibility with workgroup participants so there may be a stronger output and investment from health center participation

(2) Extend the period of time allotted to ensure adequate coverage of all necessary material for the Final Retreat in a timely manner.

(3) Involvement of the State Primary Care Organization and other key personnel beyond the FQHCs adds value and dimension to the environmental assessment process and should be encouraged to be involved in the EA.

(4) Engaging the FQHCs throughout the EA helps to ensure buy-in to the process, information and the strategic actions. Keep your health centers informed and request their input at every interval.

(5) Strong facilitation by an outside source was key to keeping the participants focused at the Final-retreat.

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***Mid-Atlantic Association of Community Health Centers***

4483-B Forbes Blvd
Forbes Center Building II
Lanham, MD 20706

(Tel) 301-577-0097
(Fax) 301-577-4789

www.machc.com

APPENDIX ITEM 1

Date_____

Chief Executive Officer
Mid-Atlantic Association of Community Health Centers
4483B Forbes Blvd
Lanham, MD 20706

Dear Miguel McInnis;

The _____ is fully committed to active participation in Round 3 of the Health Resources and Services Administration/Bureau of Primary Health Care (BPHC) and National Association of Community Health Centers (NACHC) continuing Environmental Assessment (EA) initiative.

The purpose of the EA is to provide Health Centers and the State Primary Care Association with the tools and processes to identify opportunities and threats that exist within the State Healthcare environment. We understand that through this process, the Mid-Atlantic Association of Community Health Centers (MACHC) will work with the Federally Qualified Health Centers to analyze broad state and market issues and/or trends and develop specific strategies and actions that can result in increased access to preventative and primary care to underserved communities.

As part of this endeavor, we commit the following individual to act as the central point of contact with MACHC throughout this initiative.

Name _____

Title _____

Email _____

Phone _____

Sincerely,

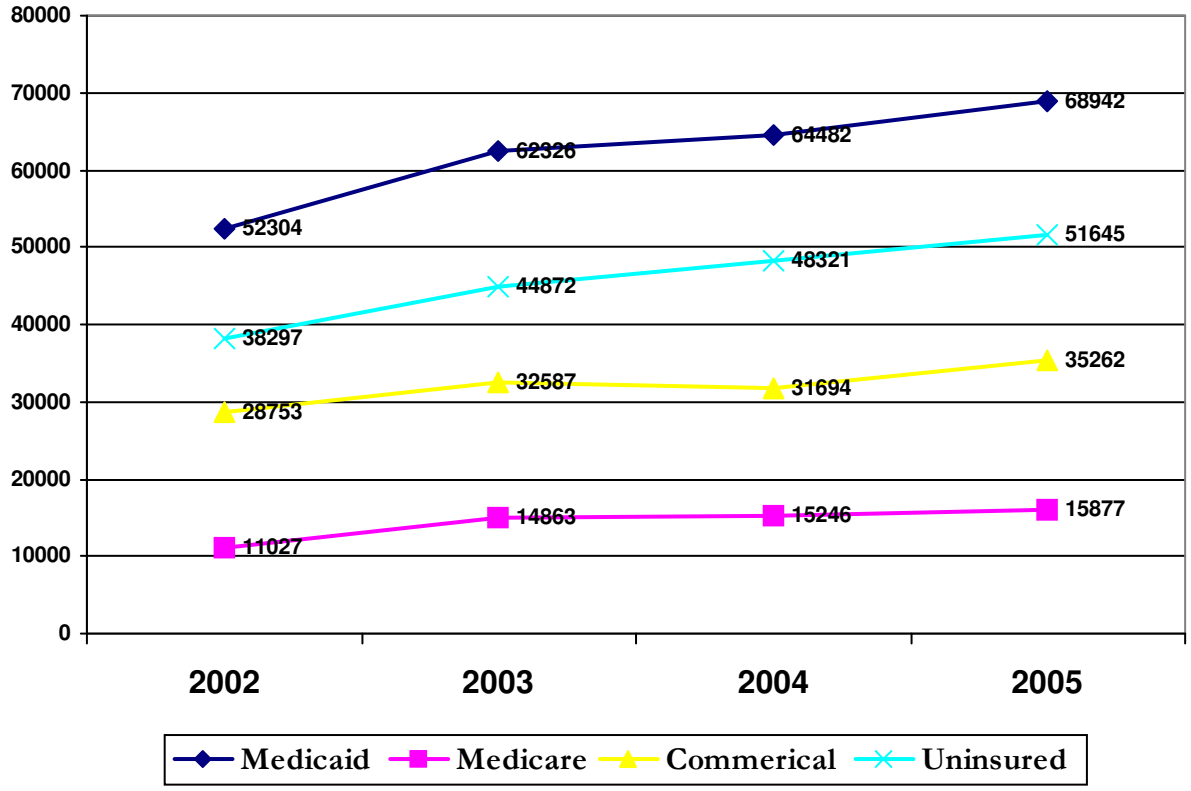
Maryland Health Centers have seen steady patient growth since 2002. Between 2002 to 2005, health centers patient load increased by slightly over 31%, adding 41,077 patients. The largest increase in patients occurred in Medicaid Managed Care patients (8,414) and in the uninsured (13,348) .

Despite gains overall in most payment cohorts since 2002, there has been a 53.4% decline in SCHIP patients (-2,415) since 2002.

HEALTH CENTER PERCENT CHANGE IN PATIENTS

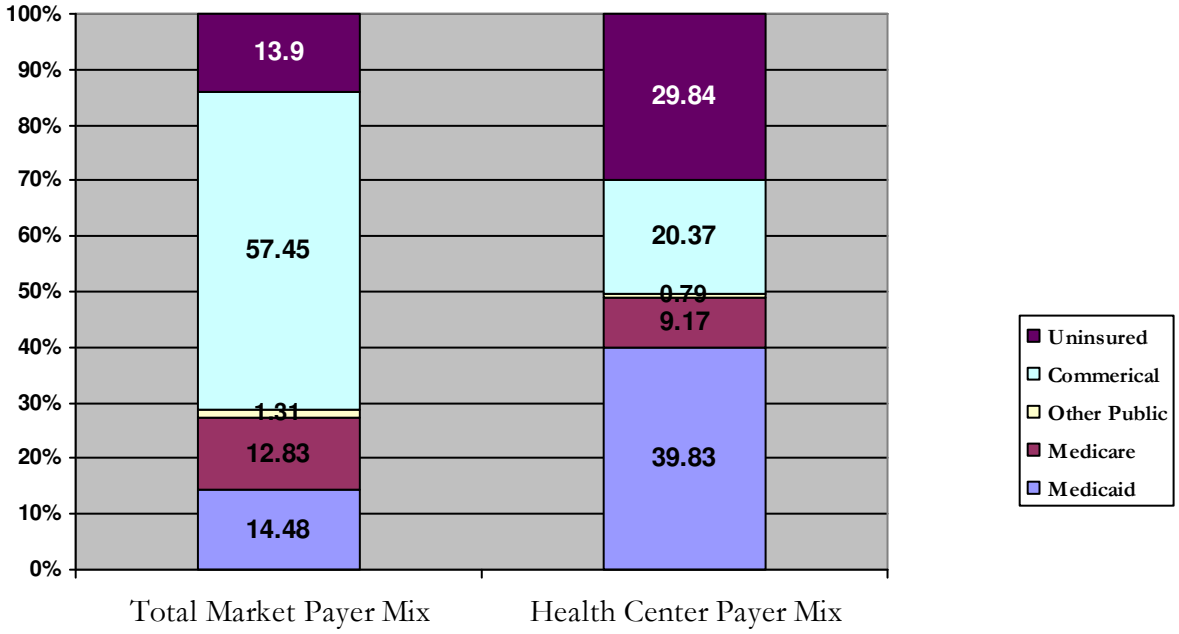
| | 2002-2003 | 2003-2004 | 2004-2005 |
|---|---|---|---|
| **Health Center Patient Increases** | 18.19% | 3.47% | 7.21% |

**HEALTH CENTER PATIENTS BY PAYMENT COHORT: 2002-2005**

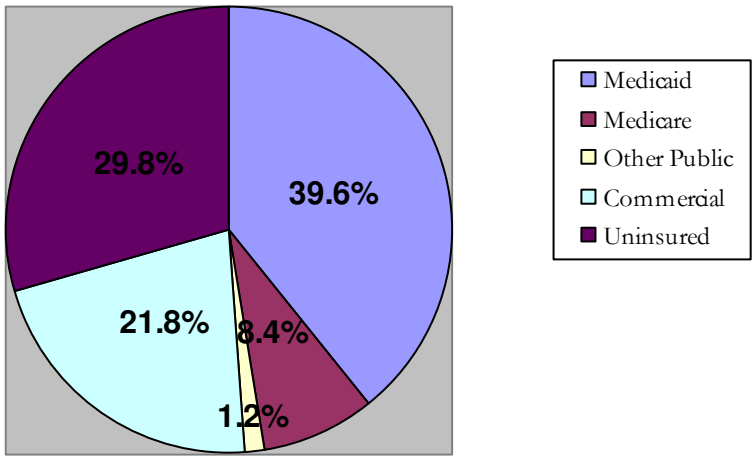


APPENDIX ITEM 2

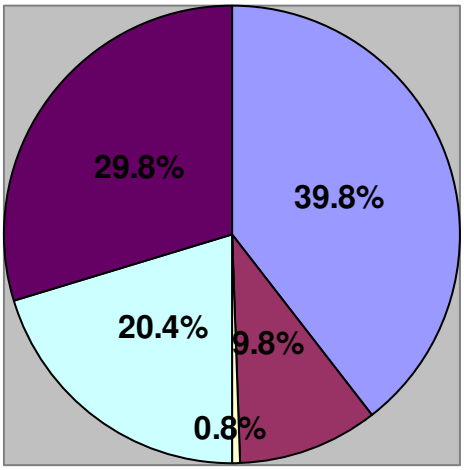
2005 COMPARISON OF PAYER MIX: State vs. Health Centers




2002 Maryland Health Center Payer-Mix




2005 Maryland Health Center Payer-Mix

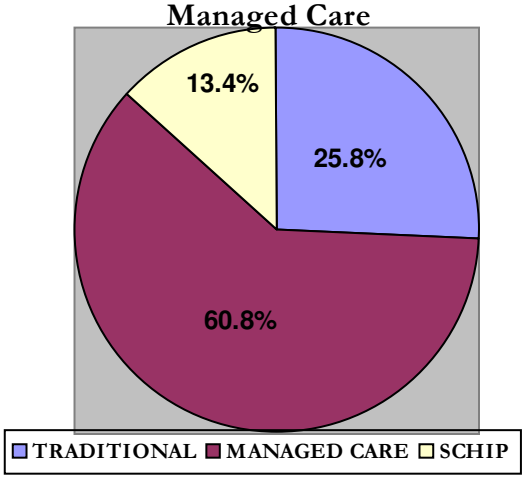


APPENDIX ITEM 2

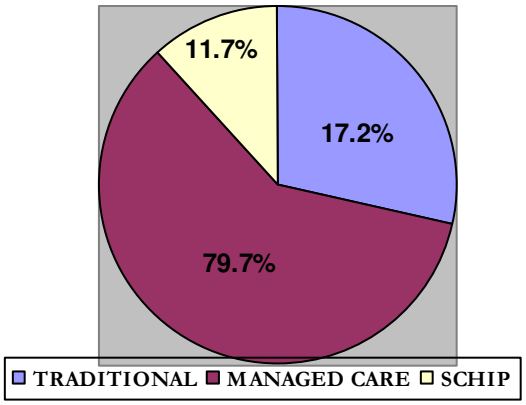


The following pie charts show the percentage of people enrolled in Maryland's Medicaid program by Traditional versus Managed Care plans Maryland's Health Center patients by the same break down for the years 2002 and 2005. Actual enrollment and patient numbers are also provided.

**2002 MARYLAND MEDICAID: Enrollment in Traditional vs. Managed Care**

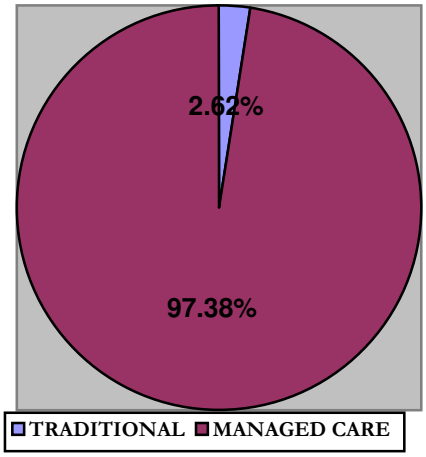



**2005 MARYLAND MEDICAID: Enrollment in Traditional vs. Managed Care**

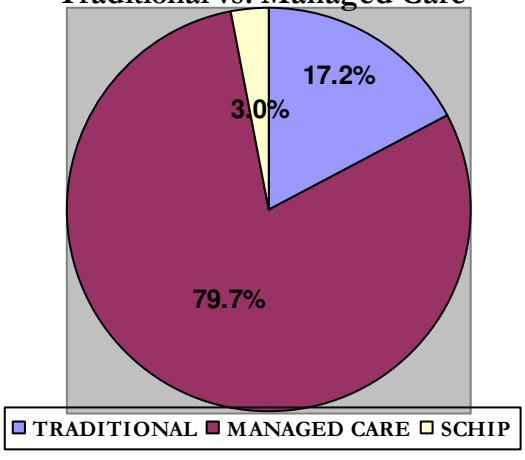



| MARYLAND ENROLLMENT | 2002 | 2005 | 2002-2005 Percent Change |
|---|---|---|---|
| Traditional | 197,212 | 233,409 | 18.35% |
| Managed Care | 465,543 | 482,749 | 3.7% |
| SCHIP | 102,408 | 95,018 | -7.8% |
| TOTAL | 765,163 | 811,176 | 6% |

**2002 MARYLAND HEALTH CENTERS MEDICAID: Patients in Traditional vs. Managed Care**



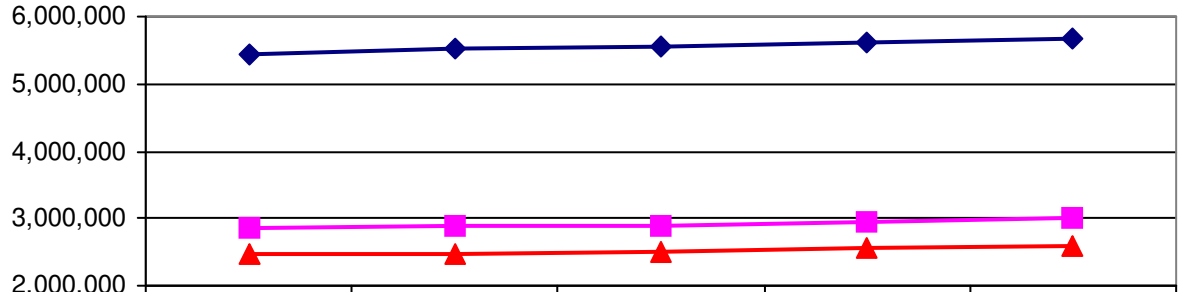

**2005 MARYLAND HEALTH CENTERS MEDICAID: Patients in Traditional vs. Managed Care**




| MARYLAND HEALTH CENTERS | 2002 | 2005 | 2002-2005 Percent Change |
|---|---|---|---|
| Traditional | 1,253 | 11,892 | 849% |
| Managed Care | 46,531 | 54,945 | 18% |
| SCHIP | 4,520 | 2,105 | -53.4% |
| TOTAL | 52,304 | 68,942 | 31.8% |

APPENDIX ITEM 2

Maryland Popoluation, Labor Force and Employed Trends: 2002-2005



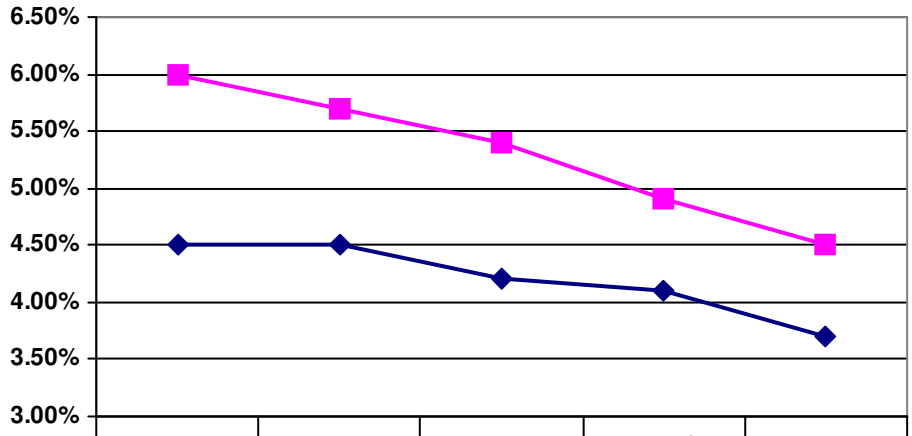

| | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|---|---|---|---|---|
| Population | 5,442,268 | 5,512,477 | 5,561,332 | 5,600,388 | 5,661,630 |
| Labor Force | 2,862,896 | 2,879,656 | 2,882,640 | 2,935,067 | 3,009,895 |
| Employed* | 2,482,100 | 2,488,600 | 2,512,700 | 2,551,400 | 2,581,700 |


*Employed data are estimates based on mid-year (June) employment information from the Current Employment Statistics Survey.

The U.S. Census Bureau defines Labor Force as all persons in the civilian labor force plus members of the U.S. Armed Forces. Employed are all civilians 16 years or older who either work at least 15 hours per week for wages or salary, or those who are not at work due to a temporary absence. Unemployed is defined as all civilians, 16 years or older, who are not at work and are currently looking for work, and are available for to start a job.

Maryland unemployment rate has been steadily decreasing since 2003. Maryland's unemployment rate has been consistently lower than the national unemployment rate.

U.S. vs. Maryland Unemployment: 2002-2006




| | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|---|---|---|---|---|
| Maryland Unemployment Rate | 4.50% | 4.50% | 4.20% | 4.10% | 3.70% |
| U.S. Unemployment Rate | 6% | 5.70% | 5.40% | 4.90% | 4.50% |

APPENDIX ITEM 2

The average health center patient in Maryland is likely to have the following characteristics. (Based upon 2005 UDS)

Gender: Female

Age: Between the ages of 25-49 years old.

Race/Ethnicity: Black

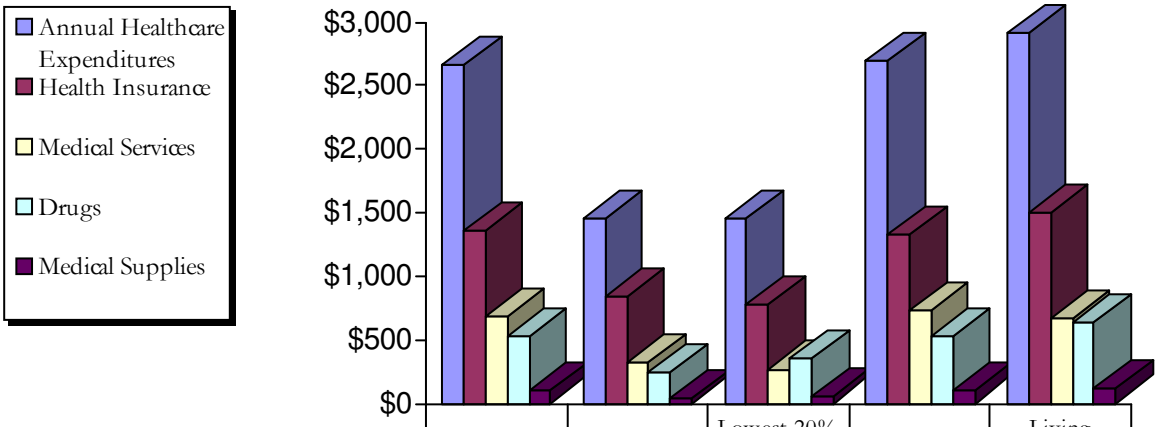
FQHC Location: Baltimore City

Income: 100% or Below Federal Poverty Level

Insurance Status: Uninsured

The following graph shows national consumer expenditure data on health care services for 2005. Cross tabulation of data was not possible, therefore a comparison is given of expenditures based upon the total population, and demographic characteristics of Maryland's health centers average patient.

2005 Consumer Expenditure Survey: Health Care Expenditures




| | Total | Black/African American | Lowest 20% Income Bracket | Living in Urban Area* | Living Outside an Urban Area |
|---|---|---|---|---|---|
| Annual Healthcare Expenditures | $2,664 | $1,448 | $1,448 | $2,693 | $2,919 |
| Health Insurance | $1,361 | $841 | $780 | $1,326 | $1,497 |
| Medical Services | $677 | $321 | $266 | $730 | $665 |
| Drugs | $521 | $244 | $351 | $529 | $639 |
| Medical Supplies | $105 | $43 | $51 | $108 | $118 |

APPENDIX ITEM 2
*Data for Urban Areas is based upon urban populations between 250,000 to 999,999.

**Facts on Black/African American Women Access to Quality Care**

- ∴ African American women have higher prevalence of hypertension, arthritis and diabetes as compared to white women.
- ∴ Black women are more likely to be uninsured and less likely to have employer based health insurance compared to white women.
- ∴ Nearly 1 in 10 Black women delay medical care because of transportation problems.

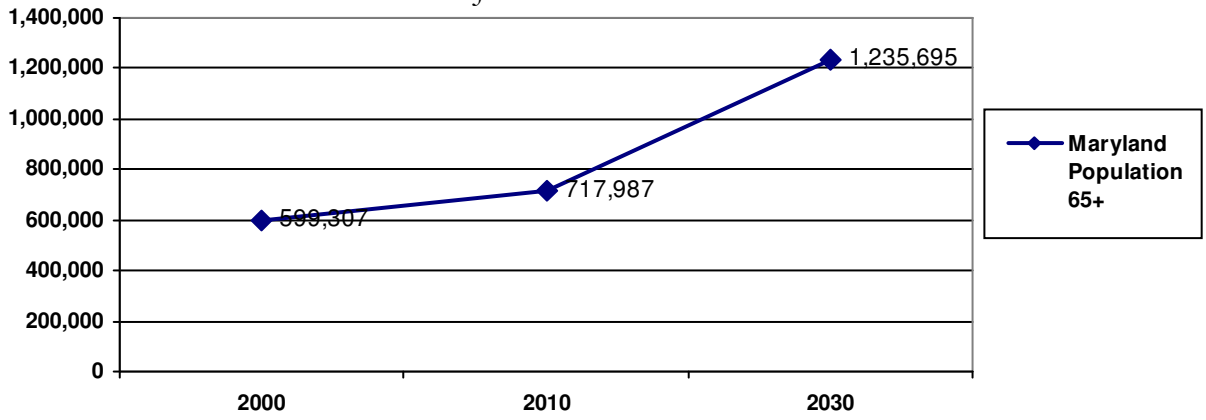
APPENDIX ITEM 2

**2005 Maryland Facts and Figures for the Population age 65 and Older**

| | |
|---|---|
| Population: | 609,450 |
| Households: | 391,488 |
| Gender: | 42.4% Male, 57.8% Female |
| Median Age: | 74.4 years |
| Race and Ethnicity: | 75.1% White |
| | 19.8% Black/African America |
| | 2.2% Hispanic/Latino |
| Language: | 9.8% Speak a language other than English |
| Disability: | 37.1% of persons 65 and older in Delaware have a disability |
| Mean Income: | $46,072 |
| Poverty Level: | 7.7% are below Federal Poverty Level (FPL) |
| | 9.0% are between 100%-149% FPL |
| | 83.4% are 150% or higher of the FPL |
| Rank: | 41st among U.S. states for the percentage of the population aged 65 and over. |
| *Percentage reporting difficulty in obtaining care: | 2.5% |
| *Percentage reporting delayed care due to cost: | 6.1% |
| **Percentage of population with supplemental insurance: | 86.6% |

* Data is only for people enrolled in Medicare, year 2002.
** Date is only for people enrolled in Medicare, year 2004.

MARYLAND POPULATION AGE 65 and OLDER
PROJECTIONS: 2000-2030




PERCENTAGE OF MARYLAND'S POPULATION THAT IS 65 YEARS AND OLDER: 2000-2030

| 2000 | 2010 | 2030 | Population percent change: 2000 to 2030 |
|---|---|---|---|
| 11.3% | 12.2% | 17.6% | 106.2% |

APPENDIX ITEM 2

Percentage of Population Age 65 and Older who reported having the following Chronic Conditions

| | Heart Disease | Hypertension | Stroke | Asthma | Any Cancer | Diabetes | Arthritis | Chronic Bronchitis |
|---|---|---|---|---|---|---|---|---|
| Total | 31.7 | 51.9 | 9.2 | 8.9 | 206.6 | 17 | 49.9 | 6 |
| White | 33.4 | 50.5 | 9 | 8.8 | 22.6 | 15.4 | 50.2 | 6.2 |
| Black | 24.1 | 67.6 | 10.3 | 9.5 | 11.8 | 26.6 | 52.2 | 5 |
| Hispanic/Latino | 23.7 | 49.3 | 9.7 | 8.8 | 9.4 | 24.5 | 44.8 | 5.5 |

APPENDIX ITEM 2

Maryland Data on Emergency Department Visits

Maryland Emergency Department Visits: 2002-2005

| 2003 | 2004 | 2005 | Percent Change 2003 to 2005 |
|---|---|---|---|
| 2,079,747 | 2,095,426 | 2,188,968 | 5.3% |

Potential Health Center Patients

*Non-Emergent:* Immediate Medical Care was not required within 12 hours

*Emergent/Primary Care Treatable:* Care was required within 12 hours, but could have been safely provided in a primary care setting

35.4% (~774,895patients) of emergency department patients in 2005 fall under these conditions.

True Emergency Department Patients

*Emergent-Emergency Department Needed-Preventable/Avoidable**: Emergency department care was required but the emergent nature of the condition was potentially preventable if adequate ambulatory care was received

*Emergent-Ed Care Needed, Not Preventable/Avoidable:* Emergency department care was required and ambulatory care could not prevent the condition.

*Other Categories of Emergency Department Visits*

64.6% (~1,414,073) of emergency department patients in 2005 fall under these conditions. *

Emergent-Emergency Department visits that could have been avoided if adequate ambulatory care was received represent another group of potential health center patients. Data on why care was delayed would be necessary for further analysis.

Metropolitan Baltimore region represents 54% of all emergency department visits for Maryland in 2005.

CLASSIFICATION OF HOSPITAL EMERGENCY DEPARTMENT VISTIS: MARYLAND 2005