



PRINCE GEORGE'S COUNTY

Primary Healthcare Strategic Plan

Our Health Matters!

Access

Quality

Customer Service

Health Promotion

County Executive Rushern L. Baker, III

Rushern L. Baker, III, is the seventh County Executive for Prince George's County. Executive Baker's vision for Prince George's County is for it to be a nationally recognized jurisdiction that will be a leader in the Washington Metropolitan Region because of its unique opportunity to provide a thriving economy, great schools, safe neighborhoods, and high quality healthcare. Since taking office, County Executive Baker has committed the County to addressing healthcare disparities and improving the healthcare delivery system and services for County residents. As a result of County Executive Baker's leadership and vision, a new world-class, state-of-the-art Regional Medical Center is under development as a part of a strategy to transform the County's healthcare system into an efficient, effective, and financially viable healthcare delivery system. In addition, the County is focused on creating new and innovative health programs, enhancing existing services, and making health system changes at the local level that will address the County's most pressing health concerns such as infant mortality, chronic conditions like diabetes and heart disease, HIV and other infectious diseases, access to care, substance abuse, and domestic violence.

County Council

All legislative powers of Prince George's County, Maryland, are vested in the Prince George's County Council. In addition, the County Council sits as the District Council on zoning matters and land use policy, and as the Board of Health to govern and guide health policy. The Prince George's County Council is committed to developing partnerships and encouraging public participation and engagement with our citizens, community leaders, and elected officials. The Council will exercise its oversight and legislative roles to improve services and programs for residents. The Council will manage County resources in an efficient and effective manner.

Council Members

Mary A. Lehman, 1st District

Dani Taveras, 2nd District

Dannielle M. Glaros, 3rd District

Todd M. Turner, 4th District

Andrea C. Harrison, 5th District

Derrick Leon Davis, 6th District, **Vice Chair**

Karen R. Toles, 7th District

Obie Patterson, 8th District

Mel Franklin, 9th District, **Chair**

Clerk of the Council, Redis C. Floyd





Contents

FOREWORD	V
EXECUTIVE SUMMARY	VII
I. PRIMARY HEALTHCARE STRATEGIC PLAN FOR TOMORROW	1
Introduction	1
Goals for the Primary Healthcare Strategic Plan	2
II. THE NEED FOR THE PRIMARY HEALTHCARE STRATEGIC PLAN	7
Assessment of the Current Conditions.....	7
Challenges and Opportunities.....	9
III. METHODOLOGY AND APPROACH	15
Project Leadership	15
Community Involvement.....	15
Research and Analysis	16
IV. PRIMARY HEALTHCARE STRATEGIC PLAN FOR PRINCE GEORGE'S COUNTY	19
Expanding Patient-Centered Primary Care in Health Investment Zones	19
Recruitment and Retention of Primary Care Physicians for Prince George's County	24
Developing a Work Force to Support Expanded Patient-Centered Primary Care in Prince George's County	30
Collaborating on Hospital Community Benefit Programs	35
Building a Sustainable Primary Healthcare System	41
Monitoring and Evaluation.....	42
V. PRINCE GEORGE'S COUNTY MARKETING AND BRANDING STRATEGY	47
Introduction	47
Vision and Goals.....	47
Marketing and Branding Strategies	48
Marketing Communication Campaign.....	50
Brand Community Campaign	50
Monitoring and Evaluation of Marketing and Branding Campaigns	51
Summary and Next Steps	51
Marketing and Branding Strategy: Sample Evaluation Questions, Metrics, and Sources.....	54
VI. PHASING PLAN FOR STRATEGY IMPLEMENTATION	55
APPENDIX A SUGGESTED PROTOTYPES: PRIMARY CARE PRACTICES IN HEALTH INVESTMENT ZONES	Appendix A-1
APPENDIX B INDEX OF RESOURCES.....	Appendix B-1
APPENDIX C WEB SITES.....	Appendix C-1
APPENDIX D GLOSSARY OF KEY TERMS.....	Appendix D-1
ACKNOWLEDGMENTS	E-1



List of Maps

Map 1. Health Investment Zones	3
Map 2. Race/Ethnicity and Poverty Distribution	12
Map 3: Suggested Prototypes for Primary Care Practices in Health Investment Zones ...	22

List of Tables

Table 1. Summary Table of Primary Care Practice Prototypes in Health Investment Zones.....	23
Table 2. High-Priority Health Professionals for Patient-Centered Primary Care	31
Table 3. Recommended Metrics for Monitoring and Evaluation for County Health Rankings	46

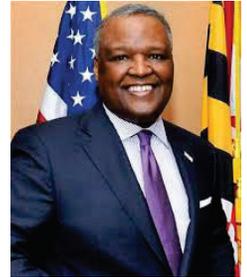
List of Figures

Figure 1. Primary Healthcare Strategic Plan Key Goals	2
Figure 2. Primary Healthcare Strategic Plan Leadership	17
Figure 3. Patient-Centered Care Model: Example of Care Team within a Patient-Centered Medical Home.....	32
Figure 4. Take Action Model for Improvement.....	43



FOREWORD

Primary Healthcare Strategic Plan for Tomorrow



For decades, Prince George's County, Maryland, has been grappling with the challenge of enhancing its healthcare delivery network. From hospitals to health clinics, Prince Georgians and other Marylanders living in the southern region of the state have been limited in their access to healthcare. According to a 2009 RAND Corporation report, it was critical that the County take strong and decisive action to improve access to quality healthcare. The County Council was the catalyst for the RAND report, which served as a basis to garner the support of other partners—state government, the University of Maryland Medical System, and Dimensions Healthcare.

It is clear that strong communities have excellent health indicators. A healthy community leads to positive health indicators including high academic outcomes, low crime, and a strong commercial tax base.

In order for Prince George's County to fulfill our destiny as a vibrant community, it is imperative that we focus on improving the health and wellness throughout the County. We must continue our emphasis on healthy living to ensure that our healthcare delivery system is equipped to address the needs of our residents. This will require us to accomplish the following key goals:

- Expand access to high-quality, patient-centered primary care
- Improve the health status of all Prince Georgians
- Advance healthcare as one of the economic drivers for the County

This strategic plan will guide us as we build a strong foundation for success. It is grounded by a tremendous collaboration between the State of Maryland, the University of Maryland Medical System, Dimensions Healthcare System, The Maryland-National Capital Park and Planning Commission, and Prince George's County. These partners and other stakeholders are committed to improving access to healthcare, improved health outcomes, and a high-quality system of primary care.

All stakeholders have worked diligently to advance our healthcare delivery system in Prince George's County. This strategic plan will provide us with a road map that will lead to a world-class healthcare system for all Prince Georgians and residents of Southern Maryland.

Rushern L. Baker, III
County Executive
Prince George's County





EXECUTIVE SUMMARY

Prince George's County, Maryland, is boldly moving forward with its mission to improve the health and quality of life for its residents. This effort began with the 2009 RAND report, *Assessing Health and Health Care in Prince George's County*. The report concluded that high rates of chronic conditions, social-economic disparities within the County, and limited primary care capacity made establishment of a primary care system an urgent concern. It also concluded that high numbers of residents traveling outside of the County for healthcare impeded economic development and that improving overall health required strengthening the public health system and addressing social determinants of health. Prince George's County Executive Rushern L. Baker, III, made healthcare one of his administration's top priorities and committed to the improvement of the County's healthcare delivery system in order to improve the health outcomes of County residents.

To inform the design of an improved system, the University of Maryland School of Public Health was commissioned to assess its potential public health impact. This work resulted in the 2012 report, *Transforming Health in Prince George's County, Maryland: A Public Health Impact Study*. The report presented three broad recommendations to support a successful new healthcare system:

1. Develop a County-led process to improve public health, expand access to high-quality primary care, and support systems integration.
2. Develop a clear brand that promotes a high-quality healthcare system, encourages residents to return to the County for care, and contributes to a successful and thriving system.
3. Establish a high-quality, academically affiliated Regional Medical Center with a strong and collaborative prevention-focused ambulatory care network.

In response to these recommendations, John Snow, Inc., a public health consulting company, was engaged to develop a primary healthcare strategic

plan for Prince George's County, focusing on a County-led process to improve public health and expand access to high-quality primary care while also creating a branding and marketing strategy. The establishment of a Regional Medical Center is proceeding in a parallel but separate process.

Development of the *Prince George's County Primary Healthcare Strategic Plan* (the Primary Healthcare Strategic Plan) was carried out under the direction of the Office of the County Executive, the Board of Health, and the Health Department. These project leaders defined goals for the Primary Healthcare Strategic Plan and convened an Advisory Committee and a Stakeholders Committee to guide and inform the strategy development. These goals are:

1. Expand access to patient-centered primary care services within Prince George's County.
2. Improve the health of all Prince George's County residents.
3. Advance the healthcare industry's contribution to Prince George's County's economic development.

The Advisory Committee, consisting of senior leaders from State and County agencies, healthcare organizations, and academic institutions, focused on the broader policy issues and ensured that the plan would meet the collective needs of Prince George's County. The Stakeholders Committee, with representatives from community providers, health plans, advocacy organizations, and Council appointees, brought the perspectives of their individual organizations and/or constituencies to plan development. Throughout the process, Advisory and Stakeholders Committee members provided input and feedback on research findings and preliminary recommendations through quarterly meetings and follow-up interviews. Advisory and Stakeholder members also served on workgroup committees that developed recommendations on three key areas: physician recruitment and retention, work force development, and community benefit. Contributions by the Advisory, Stakeholders, and



Workgroup Committees were invaluable in keeping the process focused and formulating a strategic plan that could achieve its goals. Further, the spirit of collaboration built among the participants was a hallmark of the planning process, and Prince George's County is committed to ensuring that stakeholder engagement and collaboration continue through plan implementation and into the future.

Significant contributions to the Primary Healthcare Strategic Plan also came from over 300 Prince George's County residents who participated in one or more of the five community meetings held throughout the County. Through guided discussions and polling, participants provided information about where they go for primary healthcare services, how they define quality healthcare, and barriers to primary care and good health. Findings from the community meetings were incorporated into presentations to the Advisory and Stakeholders Committees. Input from populations that may not have been as well represented at the community meetings (Hispanic/Latinos, young professionals and families, other recent immigrants) was obtained through follow-up interviews with representatives from these populations. Finally, the Primary Healthcare Strategic Plan recommendations were informed by prior studies, secondary market data, census data, and site visits to Prince George's County as well as by industry state-of-the-art best practices.

This collaborative and informed process resulted in recommendations for the Primary Healthcare Strategic Plan. The recommendations will collectively contribute to the County meeting the three goals as defined for the Primary Healthcare Strategic Plan.

In addition, the process resulted in a recommended marketing and branding strategy focused on physician recruitment and retention, getting residents to return to the County for their healthcare and building a culture of health that will inspire residents to engage in improving their own health and well-being.

Summary of Recommendations for the Primary Healthcare Strategic Plan

To achieve the goal of expanding access to primary healthcare services, the County would need a multipronged approach:

1. Increase patient-centered primary care practices in high-need areas.
2. Build capacity of existing primary care practices to operate as patient-centered medical homes.
3. Build collaboration among Prince George's County hospitals.
4. Develop work force to support patient-centered primary care.
5. Implement a marketing and branding campaign.
6. Establish a Prince George's County Primary Healthcare Alliance (Primary Healthcare Alliance).
7. Develop and implement a monitoring and evaluation plan.

Recommendation #1: Increase patient-centered primary care practices in high-need areas.

Provide incentives to recruit and retain primary care providers in high-need areas, designated as Health Investment Zones. Health Investment Zones have primary care provider shortages and socioeconomic indicators that impact health. Recommended incentives include but are not limited to:

- Establish Prince George's HealthAssure, a program that provides access to primary healthcare services for low-income patients.
- Secure reduced lease payments for primary care practices in the Health Investment Zones.
- Establish a plan to secure federal and state loan repayment to physicians and dentists that choose to practice in Prince George's County at sites located in federally designated health professional shortage areas or for health professional shortage area-designated organizations.



- Provide low-cost working capital loans to cover start-up costs. These include operating losses during ramp-up period (12 to 18 months), purchase of equipment such as an electronic medical record system, and income guarantees for physicians and midlevel providers.
- Establish a plan to subsidize malpractice costs for certain primary care practices. The County would promote hiring of primary care physicians and midlevel providers by federally qualified health centers, which usually have their malpractice costs covered.
- Establish opportunities for residency training (medical and dental) in Prince George's County provider organizations, and develop a program to compensate physicians who agree to serve as preceptors at these sites.

Recommendation #2: *Build capacity of existing primary care practices to operate as patient-centered medical homes.*

Operating as a patient-centered medical home requires significant resources that are often not available to primary care practices. Further, patient-centered medical homes require staff to support care coordination, mental health integration, and population health management. Recommendations to increase the number of patient-centered medical homes in the County include:

- Encourage the development of a private management service organization to provide services that enable primary care practices to operate as patient-centered medical homes.
- Expand clinical training opportunities within the County to accommodate training sites for the proposed work force.
- Prioritize improving the quality of customer service of all staff in healthcare fields, and provide customer service training to future clinical, public health, and administrative support staff.

Recommendation #3: *Build collaboration among Prince George's County hospitals.*

Build collaboration among hospitals within Prince George's County to develop complementary centers of excellence that would ensure residents have access to a full spectrum of high-quality healthcare services within an integrated delivery system.

- Support development of hospital-based integrated delivery systems, including the new Regional Medical Center.
- Work collectively to promote transitional care between hospitals and primary care providers to ensure appropriate primary care access and engagement among County residents.
- Achieve collaboration among Prince George's County hospitals and the Health Department to conduct community health needs assessment and carry out community health improvement programs.
- Create the Prince George's County Community Health Benefits Partnership to ensure collaboration among Prince George's County hospitals and the Health Department, to conduct community health needs assessment and to carry out community health improvement programs.

Recommendation #4: *Develop work force to support patient-centered primary care.*

- Convene stakeholders with a shared mission of increasing and improving work force capacity.
- Create a systematic work force development plan for the County designed to meet the needs and demands of the patient-centered medical home model.
- Give priority to County residents and educational resources to achieve the proposed work force.
- Prioritize quality customer service training.

(See Table 2: High-Priority Health Professionals for Patient-Centered Primary Care on page 31)



Recommendation #5: *Implement a marketing and branding campaign.*

Develop and implement a marketing and branding strategy to accomplish two targeted marketing goals: (1) recruit and retain primary care providers; and (2) increase the number of County residents that choose to receive healthcare services within Prince George's County.

- Create and carry out marketing campaigns designed for identified market segments.
- Use common branding across all marketing efforts. The proposed brand is **"Prince George's County, Our Health Matters!"**

Recommendation #6: *Establish a Primary Healthcare Alliance.*

Establish the Primary Healthcare Alliance, an independent, stakeholder-led entity, whose mission would be to transform health and healthcare in Prince George's County by leading, collaborating, and aligning efforts to improve primary care delivery. The initial priority for the Primary Healthcare Alliance would be to implement the Primary Healthcare Strategic Plan.

- Secure sustainable funding.
- Convene the initial Board of Directors to serve as the governing body of the Primary Healthcare Alliance.
- Hire the Primary Healthcare Alliance's executive director and launch operations.

Recommendation #7: *Develop and implement a monitoring and evaluation plan.*

Develop and implement a monitoring and evaluation plan to assess whether the Primary Healthcare Strategic Plan is being implemented successfully and achieving desired outcomes.

- Define the monitoring and evaluation process and outcome metrics, data sources, baseline values, and benchmark goals.
- Design report card or other way of reporting results.

Phasing Plan for Strategy Implementation

The Primary Healthcare Strategic Plan would be implemented in phases over a five-year period to balance resource requirements and align with supporting initiatives. An important step would be to convene the Board of Directors and establish the Primary Healthcare Alliance. The Primary Healthcare Alliance, an independent, stakeholder-led entity, whose mission would be to transform health and healthcare in Prince George's County by leading, collaborating, and aligning efforts to improve primary care delivery.

Roles and responsibilities of the Primary Healthcare Alliance would include:

- Facilitate implementation of the Primary Healthcare Strategic Plan.
- Administer the Prince George's HealthAssure Program.
- Create and provide support to Prince George's County Community Health Benefit Partnership.
- Oversee the monitoring and evaluation plan.

A broad implementation phasing plan is outlined below.

Initial Steps and Ongoing:

- Establish Primary Healthcare Alliance.
- Maintain collaboration between the Primary Healthcare Strategic Plan implementation and The Maryland-National Capital Park and Planning Commission on development of land-use plans that support building of healthy communities (walkable communities, planned medical office space, etc.).



Short-Term (0 to 3 Years)

- Recruit primary care providers to practice in Health Investment Zones.
- Establish program of funding for low-income uninsured and underinsured, referred to as Prince George's HealthAssure.
- Focus on customer service and clinical quality through training and quality improvement processes.
- Establish the Prince George's County Community Health Benefits Partnership.
- Establish a task force on care coordination.
- Carry out work force development.
- Roll out marketing campaigns.
- Develop, implement, and maintain monitoring and evaluation plan.

Short- to Medium-Term (3 to 5 Years)

- Continue recruitment in Health Investment Zones.
- Develop a Management Service Organization.
- Expand participation of Prince George's County healthcare organization in medical and dental residency programs.
- Expand primary care networks connected with all hospitals providing services within Prince George's County.

Medium- to Long-Term (5+ Years)

- Recruit and retain primary care physicians by promoting Prince George's County.
- Develop and promote Largo Town Center Life Sciences Center as "one-stop shopping for health"—medical care, social services, pharmacy, fitness centers, healthy food options, and other health-supporting products/services.

The Primary Healthcare Strategic Plan reflects the ongoing commitment of Prince George's County to improving the healthcare system and the health of its residents. The plan focuses both on expanding access to patient-centered primary care that is part of an integrated care system and on building a culture of health within the County. In order to achieve the "triple aim"—improving health outcomes, reducing per capita costs, and improving patient experience—it will be necessary to improve coordination of care within and across systems. The County must also continue to address the conditions that shape health in the environments where people live, work, and play. The Primary Healthcare Strategic Plan fully embraces these concepts of population health and is on the leading edge of healthcare reform in the United States. Once implemented in collaboration with all partners and stakeholders, the Primary Healthcare Strategic Plan will reach its goals of expanding access and improving residents' health while contributing to the County's economic development.

A matrix of a crosswalk between the summary recommendations and the detailed descriptions included in Sections IV and V of the Primary Healthcare Strategic Plan is provided on the following pages.



Matrix of Recommendations

SUMMARY OF RECOMMENDATIONS	FULLY DEVELOPED EXPLANATION OF RECOMMENDATIONS	CROSSWALK TO DETAILED DESCRIPTIONS
1. Increase patient-centered primary care practices in high-need areas.	Provide incentives to recruit and retain primary care providers in high-need areas, designated as Health Investment Zones.	Section IV, Page 28, 29
	Establish Prince George's HealthAssure program for uninsured	Section IV, page 28
	Secure reduced lease payments for primary care practices in the Health Investment Zones.	Section IV, page 26, 28
	Establish a plan to secure federal and state loan repayment to physicians and dentists that choose to practice in Prince George's County at sites located in federally designated health professional shortage areas or for health professional shortage area-designated organizations.	Section IV, page 26, 27
	Provide low-cost working capital loans to cover start-up costs. These include operating losses during ramp-up period (12 to 18 months), purchase of equipment such as an electronic medical record system, and income guarantees for physicians and midlevel providers.	Section IV, page 27
	Establish a plan to subsidize malpractice costs for certain primary care practices. Promote hiring of primary care physicians and midlevel providers by federally qualified health centers, which usually have their malpractice costs covered.	Section IV, page 27, 28
	Establish opportunities for residency training (medical and dental) in Prince George's County provider organizations, and develop a program to compensate physicians who agree to serve as preceptors at these sites.	Section IV, page 29
2. Build capacity of existing primary care practices to operate as patient-centered medical homes.	Encourage the development of a private management service organization to provide services that enable primary care practices to operate as patient-centered medical homes.	Section IV, Page 28
	Expand clinical training opportunities within the County to accommodate training sites for the proposed work force.	Section IV, Page 29, 34
	Prioritize improving the quality of customer service of all staff in healthcare fields, and provide customer service training to future clinical, public health, and administrative support staff.	Section IV, Page 35



SUMMARY OF RECOMMENDATIONS	FULLY DEVELOPED EXPLANATION OF RECOMMENDATIONS	CROSSWALK TO DETAILED DESCRIPTIONS
3. Build collaboration among Prince George's County hospitals.	Support development of hospital-based integrated delivery systems, including the new Regional Medical Center.	Section IV, Page 29
	Work collectively to promote transitional care between hospitals and primary care providers to ensure appropriate primary care access and engagement among County residents.	Section IV, Page 39, 40
	Achieve collaboration among Prince George's County hospitals and the Health Department to conduct community health needs assessment and carry out community health improvement programs.	Section IV, Page 39
	Create the Prince George's County Community Health Benefits Partnership to ensure collaboration among Prince George's County hospitals and the Health Department to conduct community health needs assessment and to carry out community health improvement programs.	Section IV, Page 39
4. Develop work force to support patient-centered primary care.	Convene stakeholders with a shared mission of increasing and improving work force capacity.	Section IV, Page 34
	Create a systematic work force development plan for the County designed to meet the needs and demands of the patient-centered medical home model.	Section IV, Page 34
	Give priority to County residents and educational resources to achieve the proposed work force.	Section IV, Page 34
	Prioritize quality customer service training.	Section IV, Page 35
5. Implement a marketing and branding campaign.	Create and carry out marketing campaigns designed for identified market segments.	Section V, Page 47-54
	Use common branding across all marketing efforts. The proposed brand is "Prince George's County, Our Health Matters!"	Section V, Page 50
6. Establish a Primary Healthcare Alliance.	Establish the Primary Healthcare Alliance, an independent, stakeholder-led entity, whose mission would be to transform health and healthcare in Prince George's County by leading, collaborating, and aligning efforts to improve primary care delivery. The initial priority for the Primary Healthcare Alliance would be to implement the Primary Healthcare Strategic Plan.	Section IV, Page 41
	Secure sustainable funding.	Section IV, Page 41



SUMMARY OF RECOMMENDATIONS	FULLY DEVELOPED EXPLANATION OF RECOMMENDATIONS	CROSSWALK TO DETAILED DESCRIPTIONS
6 (cont'd). Establish a Primary Healthcare Alliance.	Convene the initial Board of Directors to serve as the governing body of the Primary Healthcare Alliance.	Section IV, Page 42
	Hire the Primary Healthcare Alliance's executive director and launch operations.	Section IV, Page 42
7. Develop and implement a monitoring and evaluation plan.	Develop and implement a monitoring and evaluation plan to assess whether the Primary Healthcare Strategic Plan is being implemented successfully and achieving desired outcomes.	Section IV, Page 42-46
	Define the monitoring and evaluation process and outcome metrics, data sources, baseline values, and benchmark goals.	Section IV, Page 45, 46
	Design report card or other way of reporting results.	Section IV, Page 43,44



I. PRIMARY HEALTHCARE STRATEGIC PLAN FOR TOMORROW

Introduction

Prince George's County, Maryland, is boldly moving forward with its mission to improve the health and quality of life for its residents. This effort began with the 2009 RAND report, *Assessing Health and Health Care in Prince George's County*. In 2009, the Prince George's County Council, concerned about the relatively poor health status of the County's residents, engaged the RAND Corporation to study the healthcare needs of its residents and the capacity of the County's healthcare system to meet those needs. In response to the study findings, Prince George's County Executive Rushern L. Baker, III, placed healthcare as one of his administration's top priorities. In July 2011, leaders from Prince George's County, the Maryland Department of Health and Mental Hygiene, the University of Maryland Medical System, the Dimensions Healthcare System, and the University System of Maryland signed a memorandum of understanding to address longstanding challenges and gaps in the County's healthcare delivery system. Their goal was to achieve improved health for the County, including a Regional Medical Center supported by a comprehensive ambulatory care and primary care network. To inform the design of a new system to improve health and healthcare in Prince George's County, the University of Maryland School of Public Health was commissioned to assess the proposed system's potential public health impact while answering key questions. This work resulted in the 2012 report, *Transforming Health in Prince George's County, Maryland: A Public Health Impact Study* (Public Health Impact Study).

The report presented three broad recommendations to support a successful new healthcare system:

1. Develop a County-led process to improve public health, expand access to high-quality primary care, and support systems integration.
2. Develop a clear brand that promotes a high-quality healthcare system, encourages residents to

return to the County for care, and contributes to a successful and thriving system.

3. Establish a high-quality, academically affiliated Regional Medical Center with a strong and collaborative prevention-focused ambulatory care network.

In response to these recommendations, John Snow, Inc., a public health consulting company, was engaged to facilitate the development of the Primary Healthcare Strategic Plan while incorporating the above recommendations. The Primary Healthcare Strategic Plan project focused on two recommendations: expand access to high-quality primary care, and create a clear brand. The establishment of a Regional Medical Center is proceeding in a parallel but separate process. The Primary Healthcare Strategic Plan project was conducted under the joint leadership of the Office of the County Executive, the Prince George's County Board of Health, and the Prince George's County Health Department.

The Primary Healthcare Strategic Plan was developed through a collaborative process. Advisory and Stakeholders Committees provided feedback throughout the planning process. The Advisory Committee provided policy oversight to ensure that the Primary Healthcare Strategic Plan would meet the collective needs of Prince George's County, while the Stakeholders Committee brought the perspectives of their individual organizations and constituencies. Members of both committees provided input during regularly scheduled meetings, workgroups focused on key topics, and one-on-one interviews. Additionally, five community meetings were held to obtain direct input from County residents. While attendance at the community meetings was strong, not all County demographics were well represented, and input from other relevant stakeholders was sought. Data and information were gathered from local, state, and national sources to further inform strategy development and build upon work completed by the RAND Corporation and the



University of Maryland School of Public Health. A review was conducted of published industry best practices.

A hallmark of the planning process was the collaboration built among all stakeholders. Prince George's County is committed to ensuring that this collaboration continues and that there is an infrastructure to support successful implementation, in conjunction with monitoring and evaluation, of the proposed recommendations. Throughout planning, stakeholders emphasized the importance of developing a plan that would facilitate transition from strategy to implementation. Additionally, it was requested that this plan be developed to sustain the County's efforts while addressing healthcare needs into the future.

Goals for the Primary Healthcare Strategic Plan

Expanding Access, Improving Health Outcomes, and Economic Development

The goals for the Primary Healthcare Strategic Plan are to:

1. Expand access to patient-centered primary care.
2. Improve the health status of all Prince George's County citizens.
3. Advance healthcare as one of the economic drivers for Prince George's County.

Recommendations developed through the planning process were evaluated to ensure that they were practicable in achieving the overall goals.

Expanding Access to Patient-Centered Primary Care

The proposed Primary Healthcare Strategic Plan calls for a three-pronged approach to expanding patient-centered primary care:

1. Adding new primary care practices within areas of high primary care needs (referred to as Health Investment Zones).
2. Increasing the number of primary care practices operating as patient-centered medical homes.

3. Building hospital-affiliated primary care networks.

The Public Health Impact Study quantified the additional need of 61 primary care physicians in the County, resulting from the application of the Health Resources and Services Administration primary care physician-to-population ratios. Although the overall shortage of primary care physicians for Prince George's County was estimated to be 61, the need was not evenly distributed throughout the County. The shortage of primary care physicians was concentrated in the inner Beltway and the southern part of the County. In addition, the Public Health Impact Study created a measure of primary care that took into consideration health indicators (readmission rates and hospital discharges) related to patient-centered primary care and social determinants of health (household income, and education levels).

Those areas with high primary care needs and tending to high primary care needs are designated as Health Investment Zones and are of immediate priority for expanding access to patient-centered primary care.

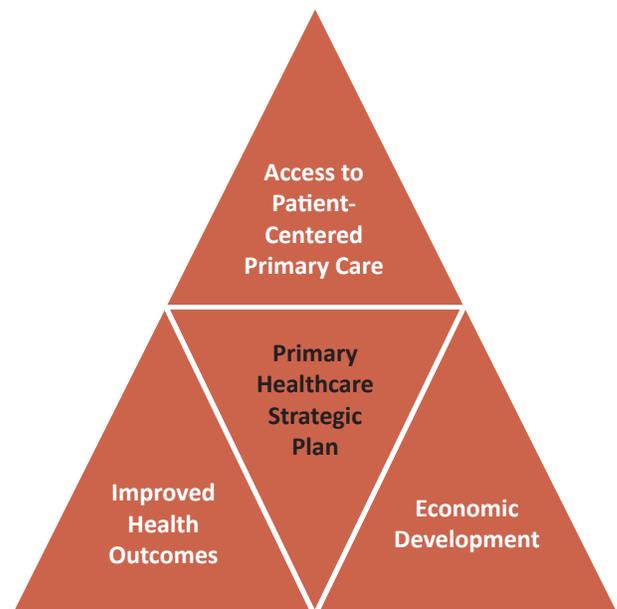
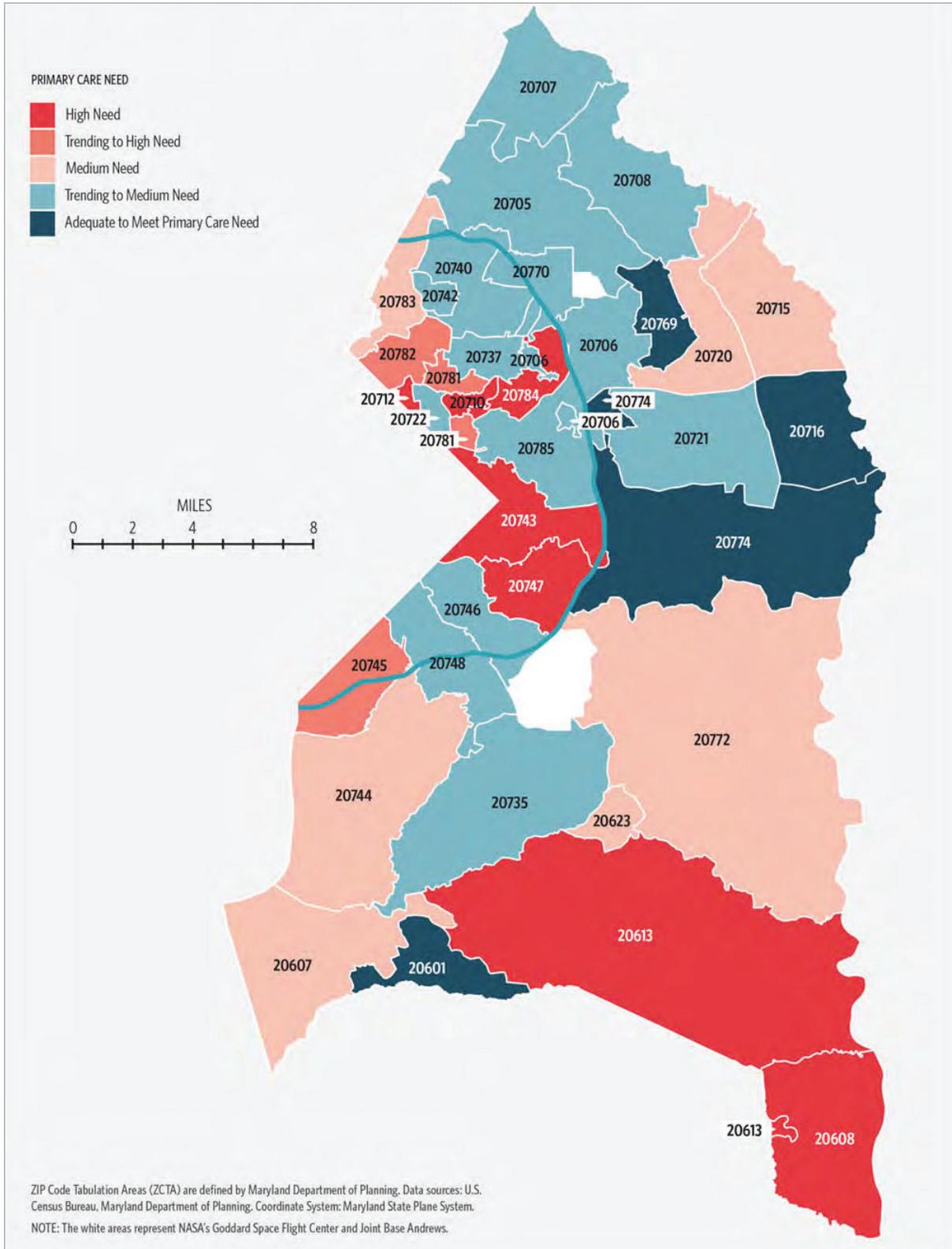


Figure 1. Primary Healthcare Strategic Plan Key Goals



Map 1. Health Investment Zones



Source: University of Maryland School of Public Health, Public Health Impact Assessment Workgroup (2012, July). Transforming Health in Prince George's County, Maryland: A Public Health Impact Study. Retrieved from <http://sph.umd.edu/princegeorgeshealth/Transforminghealth.pdf>



Recommendations will lay out suggested prototypes for patient-centered primary care practices that define:

1. Site selection.
2. A care program based upon demographics of the population.
3. A facility design to support the care program.
4. A business model to achieve financially viable practices.

Expansion of access to patient-centered primary care in Prince George's County means increasing the number of primary care physicians and midlevel providers, but it also means expanding the capacity of primary care practices to transform into patient-centered medical homes. Prince George's County lags behind neighboring jurisdictions in the number of physician practices accredited or certified as patient-centered medical homes. Transformation requires the model of care to become a team-based, integrated patient-centered medical home. Such transformation requires resources and also has implications for work force development as new types of professionals are needed to support patient-centered care and population health management. This plan's recommendations provide approaches on how to increase patient-centered medical home capacity within Prince George's County's primary care physician practices as well as how to strengthen a healthcare work force to support such transformation.

Improving Health Outcomes

Although some health indicators have improved, according to the 2014 Robert Wood Johnson Foundation County Health Rankings, Prince George's County was ranked 14th on health factors (health behaviors, clinical care, social factors, physical environment) out of the 24 Maryland counties. The County was ranked even lower (21st) in the category of clinical care that includes percentage measures of uninsured, physician-to-population ratios, preventable hospitalizations, and health screenings.

While access to patient-centered primary care is a key component of improving health outcomes, stakeholders, including local community members, stressed how important it is to identify contributing social determinants of health and population health management components. Hence, recommendations for the Primary Healthcare Strategic Plan were developed using a social-ecological approach to health promotion. A social-ecological model contextualizes individual behavior within social and physical environments, recognizing that sustaining changes in health behaviors require policies, environments, and social systems that address the determinants of health and support positive lifestyle habits. Further, the Primary Healthcare Strategic Plan would bridge primary care and public health to create an integrated system of care focused on population health.

Economic Development

The healthcare and life sciences industry has been identified as one of four industries targeted for economic development within the County. Based upon information collected from community meetings, a significant percentage of County residents continue to seek healthcare services outside of the County. Evidence-based literature or studies confirm that the reasons for leaving the County do not appear to pertain to race/ethnicity. A perceived lack of quality services was often noted as a reason for going elsewhere for services. In addition, County residents spoke of the perceived lack of board-certified physicians, customer-friendly staff, and pleasant physical facilities. The Primary Healthcare Strategic Plan focuses on building community-based primary care that will help to improve health outcomes while supporting economic development.

Primary care practices will provide employment to physicians, midlevel providers, and support staff and will keep healthcare dollars in the County. Strong primary care networks would be able to enhance the coordination of care with all County hospitals, including the new Regional Medical Center.

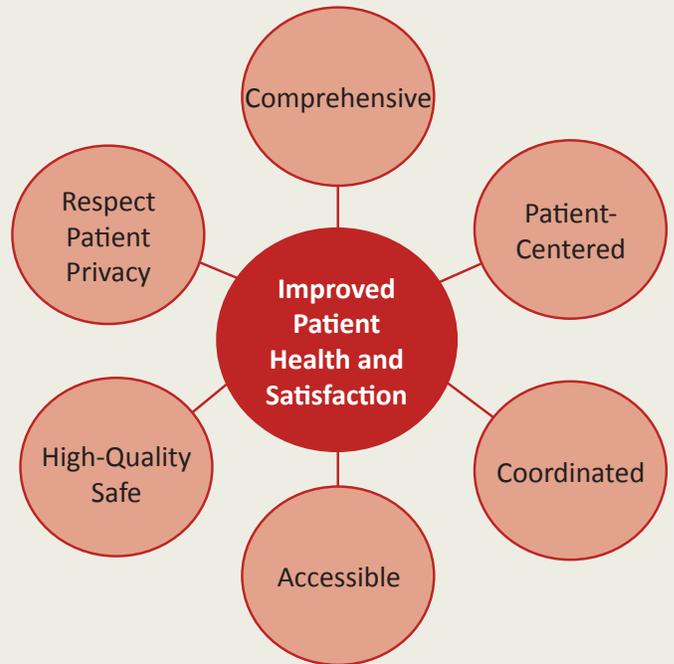


Patient-Centered Medical Home

The patient-centered medical home is a model of primary care that is patient-centered, comprehensive, coordinated, and accessible and focused on quality and safety. A patient-centered medical home is a place where patients are treated with respect, dignity, and compassion and where patients' privacy is maintained. The patient-centered medical homes improve healthcare delivery and health through innovative approaches to care coordination and chronic disease management, enabling strong and trusting relationships with providers and staff.

What Does it Mean to Be a Medical Home?

- 1. Comprehensive.** A team of care providers is wholly accountable for a patient's physical and mental health needs, including prevention and wellness and acute and chronic care.
- 2. Whole-Person, Patient-Centered Care.** A partnership among providers, patients, and their families/caregivers that respects patients' needs and preferences. Patients receive education and support to engage and participate in their own care.
- 3. Coordinated.** Care is organized across broader healthcare systems, including access to specialists, hospitals, home healthcare, community services, and public health.
- 4. Accessible.** Patients are able to access primary care services with shorter wait times for appointments and urgent care, 24 hours per day, 7 days per week. Patients are able to communicate with providers through health information technology innovations.
- 5. High Quality.** Clinicians and staff provide high-quality care and are committed to quality improvement to ensure that patients and families/caregivers make informed decisions about their health and to ensure patient safety.



Why Should Practices Choose to Become a Patient-Centered Medical Home?

Primary care practices transform to patient-centered medical homes to improve the care they provide to their patients and their overall health outcomes. Primary care practices recognized as patient-centered medical homes are seen as providing high-quality care by consumers and health plans. Many incentive programs exist to encourage practices to become patient-centered medical homes, including several within Maryland. These initiatives have shown positive outcomes, including fewer visits to the emergency room, improved access, increased prevention services, improved patient and clinician satisfaction, and improved health. Several national organizations provide patient-centered medical home recognition or accreditation. Those organizations are the Joint Commission, the Accreditation Association for Ambulatory Health Care, Inc., and the National Committee for Quality Assurance.

Sources: Agency for Healthcare Research and Quality. Defining the patient-centered medical home. <http://pcmh.ahrq.gov/page/defining-pcmh>

American Academy of Family Physicians. Patient-Centered Medical Home Incentive, Recognition, and Accreditation Programs. <http://www.aafp.org/practice-management/transformation/pcmh/recognition.html>

Patient-Centered Primary Care Collaborative. Maryland. <http://www.pccpc.org/initiatives/Maryland>



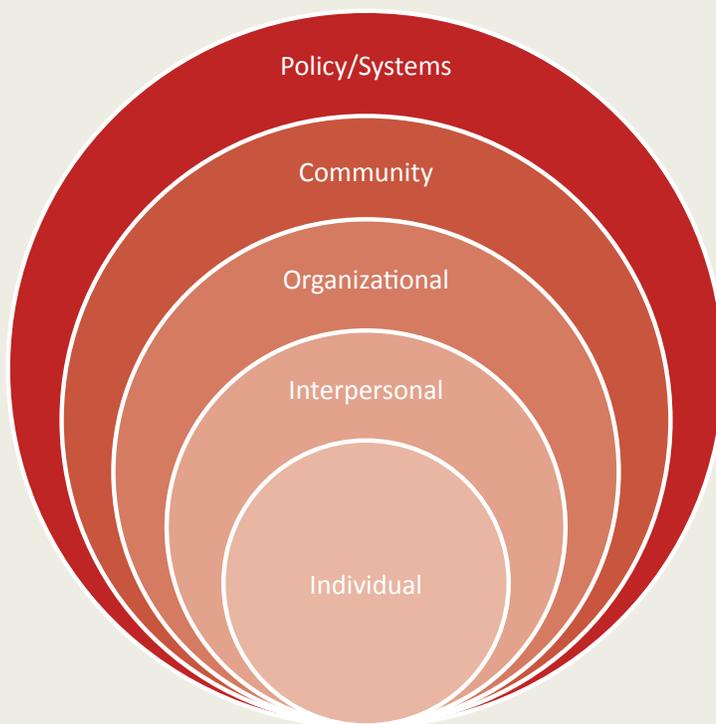
Social-Ecological Model for Health Promotion

The World Health Organization and the Centers for Disease Control and Prevention similarly define the social-ecological model as a framework that recognizes that no one factor is responsible for health.

What Are the Key Factors in the Social-Ecological Model?

The social-ecological model identifies various factors at multiple levels that come together to influence health, such as:

- Societal/Policy factors that include social and cultural norms; health, economic, educational, and social policies; and federal policies.
- Community factors that include availability and accessibility of places that promote health, for example where people live, work, and play.
- Organizational factors that include workplace policies, along with the availability of community-based and social service organizations.
- Interpersonal factors that include relationships with providers, family, friends, intimate partners, and peers.
- Individual factors that include personal history and biological factors such as age, gender, and race/ethnicity.



How Does Understanding the Social-Ecological Model Help to Promote Health?

The social-ecological model tells us that many factors influence our health. In recognizing this fact, we can make sure to target prevention efforts and solutions at all levels and especially at the interactions among levels. According to the Centers for Disease Control and Prevention, prevention efforts are more likely to be sustained if they are implemented across the continuum. A similar model is used for the County Health Rankings, a Robert Wood Johnson Foundation program.

Sources:

Centers for Disease Control and Prevention. The Social-Ecological Model: A Framework for Prevention.

<http://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html>

World Health Organization. The ecological framework. <http://www.who.int/violenceprevention/approach/ecology/en/>



II. THE NEED FOR THE PRIMARY HEALTHCARE STRATEGIC PLAN

The need for a primary healthcare strategic plan for Prince George's County was clearly identified in the research and technical studies conducted by the Public Health Impact Study. The more recent data and information obtained for the Primary Healthcare Strategic Plan continued to support this need. The following sections provide an overview of the current conditions that support the need for the Primary Healthcare Strategic Plan, the challenges that must be overcome or at least mitigated for the plan to be successful, and the opportunities for addressing challenges and successfully implementing the comprehensive Primary Healthcare Strategic Plan.

Assessment of the Current Conditions

The need for the Primary Healthcare Strategic Plan was driven by several factors summarized below.

Prince George's County residents experience higher rates of chronic diseases and poor health outcomes, both of which can be improved with access to quality primary care services provided within an integrated delivery system.

Prince George's County residents experience higher rates of asthma, diabetes, hypertension, heart disease, and cancer when compared to state averages, according to the findings from the Public Health Impact Study. Further, rates were found to be higher within the African-American population, despite Prince George's County being home to 5 of the 10 most affluent African-American communities in the United States. Although some improvements in health outcomes have been made according to the Prince George's County Health Department's *Health Report 2014*, County residents continue to have poorer health compared to the surrounding counties. A primary goal of the Primary Healthcare Strategic Plan is to improve health outcomes for all citizens of Prince George's County.

Compared to surrounding counties and the State of Maryland as a whole, Prince George's County has a substantially lower ratio of primary care providers-to-population (medical and dental). The areas of highest primary care needs are in the inner Beltway and southern part of the County. Prince George's County also has fewer midlevel providers, who are increasingly important, to meet the need for patient-centered primary care services.

The Public Health Impact Study indicated a need for 61 primary care providers and 31 dental providers. Although there have been new primary care practice sites established in the County since the study was completed, Prince George's County continues to lag behind the state and surrounding counties in population-to-primary care provider ratios for medical, dental, and mental health, according to the 2014 County Health Rankings. A major goal of the Primary Healthcare Strategic Plan is to provide the blueprint to increase the number and capacity of Primary Care physicians practicing in Prince George's County, while decreasing the demand for primary care providers through health promotion and disease prevention.

Prince George's County has relatively fewer primary care providers that have achieved patient-centered medical home recognition/accreditation from national accrediting organizations as well as fewer providers participating in the state-sponsored, patient-centered medical home program.

Achievement of patient-centered medical home recognition/accreditation indicates that a primary care practice has implemented policies, procedures, and systems to support patient-centered care and population health management. Primary care practices that have not transformed to a patient-centered medical home may be less able to contract with health plans and participate in alternative payment arrangements that include quality and shared



cost savings bonuses. Primary care practices that are not operating as patient-centered medical homes may also lack the ability to support population health management and achieve desired improvements in health outcomes for their patients or communities.

Patient-centered primary care is not only the best practice model within the healthcare industry currently but is the model of care desired by Prince George's County residents. Community meeting participants consistently expressed the desire to obtain services from patient-centered medical homes as well as the need for patient-centered medical homes that can serve persons with disabilities. A goal of the Primary Healthcare Strategic Plan is to encourage transformation to patient-centered medical homes among new and existing providers in Prince George's County.

Sufficiently sized space (minimum of 6,000 square feet) that can house primary care practices is lacking in Prince George's County generally and especially in low-income areas.

Not only are low-income areas disproportionately in need of primary care, they are also disproportionately less likely to have the physical space to accommodate a new primary care practice. This makes increasing the number and capacity of primary care practices a challenge.

A relatively large number of Prince George's County residents choose to access healthcare services outside of the County.

The fact that Prince George's County residents travel outside of the County for healthcare services has been substantiated through the household survey completed as a part of the Public Health Impact Study, the real-time survey of residents attending community meetings, and Maryland hospital patient-origin studies. On an average, 50 percent of the County residents, including many long-time residents who attended the four local community meetings, indicated that they travel outside of Prince George's County for primary healthcare services. A desire for timely

access to high-quality, patient-centered care was often noted as a reason for going elsewhere for healthcare services.

A disproportionate percentage of Prince George's County residents are uninsured relative to the County's population. It is expected that this situation will continue even after full implementation of the Patient Protection and Affordable Care Act, given the number of new immigrants that settle in Prince George's County, specifically in the communities located in the northern part inside the inner Beltway.

In 2011, the U.S. Census Bureau estimated that approximately 21 percent of Maryland's uninsured lived in Prince George's County, and 14 percent lived in Baltimore with the remaining living elsewhere around the state. Further, the Urban Institute estimates that 382,000 Maryland residents will remain uninsured postimplementation of the Patient Protection and Affordable Care Act, many of whom are undocumented immigrants. Assuming that the 21 percent uninsured remains constant, this equates to an estimated 80,000 Prince George's County residents being uninsured. The Primary Healthcare Strategic Plan includes developing an adequately funded and equitable program to provide access to primary care services for low-income, uninsured and underinsured residents.

Maryland is shifting to global payments for the state's hospitals.

On January 10, 2014, the Centers for Medicare & Medicaid Services and the State of Maryland jointly announced a new initiative to modernize Maryland's unique all-payer, rate-setting system for hospital services that will improve patient health and reduce costs. The state and the Centers for Medicare & Medicaid Services believe that the new model will provide an opportunity for Maryland to reform its delivery system to align with the goals of delivering better health and better care at a lower cost. Under the new arrangement, the Centers for Medicare & Medicaid Services will require Maryland to



generate \$330 million in Medicare savings over a five-year performance period. Maryland will shift virtually all of its hospital revenue over the five-year performance period into global payment models, providing an incentive for hospitals to work in partnership with other providers (including primary care providers) to prevent unnecessary hospitalizations and readmissions. This shift to global payment for hospitals will change the landscape of primary healthcare delivery in the state, creating the need for a clear patient-centered, integrated primary healthcare plan to support all hospitals to establish better quality and reduce total cost of care.

County where the average household income exceeds \$100,000. On the other end of the spectrum are the communities primarily located inside the Beltway where the average household income is less than \$60,000, and between 15 percent and almost 50 percent of the population are defined as low income (i.e., households below 200 percent of the federal poverty level). The lower-income geographic areas within Prince George's County are predominantly African-American and include Hispanics/Latinos, Caucasians, and, to a lesser extent, Africans and Asians.

The Primary Healthcare Strategic Plan's development took into consideration diversity and community health needs obtained from secondary data sources (including the Public Health Impact Study household survey results and census data) and during community meetings and stakeholder interviews. Additional targeted primary research will add valuable information needed to implement the Primary Healthcare Strategic Plan's multiple components. For example, families with young children, as well as Hispanic/Latino, Asian, and refugee populations, were not well represented at the community meetings. An effective marketing campaign must be developed and aimed at convincing residents within these population groups to choose Prince George's County providers for their healthcare. The following steps need to be carried out:

1. Conduct primary research (focus groups, interviews, survey) to gather information about perceptions, preferences, and needs of all population groups.
2. Develop potential marketing messages and materials and pilot test with target audience.
3. Finalize messages and materials and communication channels.
4. Evaluate results.

Challenges and Opportunities

Challenges in and opportunities for implementing the Primary Healthcare Strategic Plan and accomplishing the desired goals are summarized below. Some factors, such as Maryland's shift to global payment, represent both a challenge and an opportunity. The Primary Healthcare Strategic Plan was developed in the context of the existing conditions above with the challenges and opportunities discussed below.

Challenges

Prince George's County has a socially, culturally, and economically diverse population.

Prince George's County is a "majority minority" population. According to the 2013 American Community Survey 1-Year Estimates, Prince George's County's population is 63.7 percent Black or African-American, 16.2 percent Hispanic or Latino (any race), and 4.3 percent Asian—nearly an 85-percent minority. The population is also diverse in economic status. Map 2: Race/Ethnicity and Poverty Distribution on page 12 provides a demographic profile by race/ethnicity and poverty levels based upon the most recent U.S. Census Bureau data. Across the United States, 5 of the 10 most affluent African-American communities are located within Prince George



There is increasing competition for primary care providers and greater demands on primary care practices to become involved in population health management.

More insured people, more integrated delivery systems, and the proliferation of urgent care centers have all contributed to increased demand for primary care providers. Maryland's recent shift to global payment for hospitals with cost and quality targets will further increase the demand for primary care providers that have transformed to patient-centered medical homes and have well-developed population health management infrastructures.

Under this current environment, physicians are seeking more financially stable employment opportunities. The areas surrounding Prince George's County (the District of Columbia and Montgomery, Anne Arundel, and Howard Counties) offer opportunities for primary care physician employment in established and well-known healthcare organizations, including academic medical centers that offer teaching and research opportunities. Such opportunities are more limited in Prince George's County, although this is an issue the Primary Healthcare Strategic Plan seeks to address.

Significant resources are needed to transform primary care practices to patient-centered medical homes.

Prince George's County needs expanded patient-centered, primary care in a well-developed integrated delivery system. Currently, a relatively small number of primary care practices have received patient-centered medical home recognition/accreditation in Prince George's County. Primary care practices often lack the resources or capabilities (such as implementation of an electronic health-record system and the hiring of care coordinators and community workers) needed to transform to and operate as patient-centered medical homes.

Collaboration on service mix among Prince George's County hospitals could help to improve access for County residents.

Dimensions Healthcare Systems' Prince George's Hospital Center and Laurel Regional Hospital and MedStar Southern Maryland Hospital Center are the only hospitals in the County that provide obstetrics and pediatric services. Doctors Community Hospital and Ft. Washington Medical Center do not offer these services. The number of obstetric beds for the new Regional Medical Center will be reduced from current levels at the Prince George's Hospital Center, but the number of obstetric admissions is projected to remain constant with reduced lengths of stay. The new Regional Medical Center will have few general pediatric beds. Given the differences in services offered by these hospitals, collaboration among hospitals—while respecting competition and regional networks—is critical to having the full spectrum of services within the County.

Significant resources and effort are needed to improve quality of services and to change perceptions about the quality of services delivered in Prince George's County.

The Primary Healthcare Strategic Plan provides a blueprint to improve the quality of care as well as to change the perception of quality through a marketing campaign. Lower quality of care—real or perceived—has a negative impact on the County's ability to recruit and retain physicians. It has also contributed to the significant percentage of residents that travel outside of the County for healthcare services.

Prince George's County does not have a structured program to fund primary care services for low-income uninsured or underinsured individuals.

As previously noted, Prince George's County has many uninsured residents, but it does not have a program to pay primary care providers for services provided to this population. Such programs do exist within Montgomery County and the District of Columbia. Not having a



structured program for uninsured/underinsured residents makes recruitment and retention of primary care providers to low-income areas of high primary care needs more difficult. The lack of such a program also negatively affects County residents' ability to access patient-centered care and to achieve improved health outcomes.

Opportunities

The Primary Healthcare Strategic Plan is aligned with both the County's and the State of Maryland's priorities related to improving health and economic development.

The Prince George's County administration has identified healthcare as a top priority for health improvement and economic development. The Primary Healthcare Strategic Plan is aligned with several current initiatives being implemented within the State of Maryland and Prince George's County that include but are not limited to the *Plan Prince George's 2035 Approved General Plan*, the Transforming Neighborhood Initiative, Maryland's Health Enterprise Zone Program, and development of the Regional Medical Center to be located at the renovated Largo Town Center/ Life Sciences Center.

There is alignment between the Primary Healthcare Strategic Plan and a number of patient-centered medical homes, quality improvement, and care coordination initiatives.

Efforts to achieve the "triple aim" (improved patient experience, better health outcomes, and lower costs) across the healthcare industry are aligned with the Primary Healthcare Strategic Plan. A number of initiatives to expand access to patient-centered medical homes, improve quality, and increase care coordination are currently being implemented. These initiatives, for instance, are sponsored by health plans, the Maryland Department of Health and Mental Hygiene, The Maryland State Medical Society, and the Mid-Atlantic Association of Community Health Centers. As implementation of the Primary Healthcare Strategic Plan begins, Prince George's

County will be able to leverage work with aligned initiatives and build collaboration among the County, health plans, providers, social service organizations, state health exchanges, and other stakeholders to achieve the Primary Healthcare Strategic Plan's goals.

Primary care practice sites proposed in the Primary Healthcare Strategic Plan would meet a demand for residency training, including demand from the new Dimensions Family Practice Residency Program.

In July 2014, Dimensions Healthcare System's Family Medicine Residency Program at Prince George's Hospital Center commenced operations. Four residents will be accepted into the program annually for a total of 12 residents at full operation. The goal of the Family Medicine Residency Program is to develop outstanding family physicians capable of providing comprehensive and compassionate primary care in a variety of settings. The expanded primary care practices as part of the Primary Healthcare Strategic Plan can serve as residency training sites for the Dimensions Family Practice Residency Program as well as for programs with other academic institutions. The high demand for residency training sites for primary care providers (including physicians, dentists, and midlevel providers) suggests that the expanded primary care sites proposed in the Primary Healthcare Strategic Plan would be well utilized. Physicians often choose to practice where they complete their residency; hence, more residency slots support physician recruitment efforts.

A number of new entrant federally qualified health centers have committed to serving Prince George's County residents, especially low-income and culturally diverse populations.

Since completion of the Public Health Impact Study, two well-recognized federally qualified health centers have established practices in Prince George's County. Another federally qualified health center submitted a New Access Point Grant application to Health Resources



and Service Administration, the federal agency that oversees federally qualified health center funding, to establish a new site in Prince George's County. At the same time, Greater Baden Medical Services, an established federally qualified health center serving the County, is undertaking efforts to improve its quality and access. To optimize access and quality of services for patients, it will be important for federally qualified health centers to collaborate on alignment of service areas. A second challenge will be to prevent any one federally qualified health center from being overwhelmed with uninsured patients. Despite potential coordination challenges, federally qualified health centers represent a great opportunity for expanded access to services for low-income residents in Prince George's County. Federally qualified health centers operate across the United States and serve publicly and privately insured patients, including but not limited to low income populations.

The Patient Protection and Affordable Care Act provides funding for work force development. Existing training programs in the County and the state can be used to implement this funding effectively.

The Patient Protection and Affordable Care Act provides new opportunities to support development of the primary care work force nationwide. The National Health Service Corps has supported primary care through loan repayment since 1972. The stimulus package and the Patient Protection and Affordable Care Act combined provided \$1.8 billion in new funds over five years. By 2015, an increase of 18,000 providers nationwide is expected through the funding. For fiscal year 2014, \$283 million was dedicated to the program from Patient Protection and Affordable Care Act funding, providing more than 5,100 student scholarships and loan repayments in 38 states. Certainly this funding is a significant opportunity for federal resources to support loan repayment across the country and, in particular, in Prince George's County. Yet, mandatory funding continues only through 2015,

and it will be dependent on Congress to authorize continuation.

Prince George's Community College, the University of Maryland, and Bowie State University offer education and training programs for healthcare professionals. Within these programs, there are positions that support patient-centered primary care and population health such as community/public health nursing and health information management. These existing education and training programs can be used to implement additional funding available through the Patient Protection and Affordable Care Act. ***Maryland payment reform supports hospital affiliations with patient-centered primary care practices.***

Maryland's shift to global payment creates an opportunity for Prince George's County. The global payment provides hospitals and hospital-based systems with incentives to invest in patient-centered primary care, community benefit programs, and other health promotion initiatives. Not only do these initiatives improve quality and health outcomes but also help hospitals to realize cost savings. The shift to global payment also presents a challenge to the extent that it increases demand for primary care providers and creates urgency in building patient-centered primary care capacity within Prince George's County.

Prince George's County Health Department enhanced its ability to collect local-level data for Community Health Needs assessment.

The ability to collect and analyze local-area (town- or zip code-level) data on health indicators is essential for preparing community health needs assessment to inform the development of hospital community benefit programs. These data will help to target health improvement initiatives. The County Health Department's recent hiring of staff with expertise in health analysis and health information exchanges will enhance its ability to acquire, analyze, and use local-area data for



health planning and promotion as well as for monitoring and evaluation of the implementation of the Primary Healthcare Strategic Plan.

Maryland Health Connection, the state's health insurance marketplace, took steps to improve the enrollment process and committed to expanded resources for outreach and enrollment in Prince George's County.

In addition, the Maryland Health Connection has committed to increasing resources and strengthening collaboration with community-based organizations operating within Prince George's County for the purpose of increasing residents' enrollment in healthcare coverage.

There is a significant amount of key stakeholders' collaboration.

The healthcare strategic planning process was completed with a spirit of collaboration among all stakeholders, along with a high degree of transparency. Continued collaboration will ensure that the plan is implemented successfully and that its goals are achieved.



III. METHODOLOGY AND APPROACH

The Primary Healthcare Strategic Plan for Prince George's County was developed through a year-long process characterized by:

- Strong and collaborative leadership.
- Broad-based and deep stakeholder input and involvement.
- Structured activities with interim milestones and deliverables.
- Commitment to developing evidence-based recommendations.

The process resulted in a comprehensive plan that has broad-based support among project leadership and stakeholders and will serve as the blueprint for implementation and sustainability for improved primary healthcare for the residents of Prince George's County.

Project Leadership

The project leaders from the Office of the County Executive, The Maryland-National Capital Park and Planning Commission Planning Department, and the Prince George's County Health Department established clear project goals and worked to ensure collaboration among stakeholders throughout the process. They also served as members of the Advisory, Stakeholders, and Workgroup Committees.

The Advisory Committee, responsible for ensuring that the plan would meet the collective needs of Prince George's County, guided and supported the Primary Healthcare Strategic Plan. The Stakeholders Committee brought the perspectives of their individual organizations and constituencies to the plan. In combination, these committees included representation from hospitals, health plans, physicians, federally qualified health centers, advocacy organizations, County departments and agencies, state institutions and agencies, and County residents. During meetings, Advisory and Stakeholders Committee members provided input

and feedback to research findings and preliminary recommendations.

Smaller workgroups were convened with selected representatives of the Stakeholders and Advisory Committees to refine the recommendations tied to key issues. Through facilitated meetings, workgroup members discussed which resources could be mobilized and made recommendations on how the Primary Healthcare Strategic Plan should address physician recruitment and retention, hospital community benefits, and work force development. The outcome of each workgroup was a set of actionable strategies for both the short- and long-term that were integrated into the Primary Healthcare Strategic Plan for Prince George's County.

Community Involvement

One hallmark of the planning process was the desire to obtain input and feedback from the residents of Prince George's County. Multiple approaches were used to engage the community, which included open meetings and representation on the Stakeholders Committee. Community engagement should continue as the Primary Healthcare Strategic Plan is implemented.

Countywide Meeting

On March 1, 2014, The Maryland-National Capital Park and Planning Commission hosted a public meeting at the Jericho Christian Academy in Landover, Maryland, on the topic of primary healthcare and the new Regional Medical Center. The meeting objectives:

1. Ensured an understanding that the new Regional Medical Center and the County's community hospitals will serve as the anchor for the primary care integrated healthcare delivery system with the capacity to deliver high-quality, accessible primary health and prevention as well as hospital care.



2. Provided a forum for further discussion regarding residents' vision and expectations of the new Regional Medical Center.
3. Began a discussion focusing on and creating a culture of health promotion, wellness, and disease prevention.

Information regarding the Regional Medical Center design was provided. Survey cards were used to gather information about the attendees' healthcare use, and discussions were held regarding visions for the Regional Medical Center. Additionally, their visions for primary care services within Prince George's County were discussed. Polling of almost 200 participants was used to obtain general information; 136 community meeting attendees completed the survey cards.

Local Community Meetings

A series of four, two-hour community meetings were held to gather input regarding the Primary Healthcare Strategic Plan.

The objectives of the meetings were to confirm the major health concerns and access-to-care issues facing County residents as well as to get input from residents on what they believe to be the key factors associated with a strong primary care system. Meeting attendees participated in on-site polling, identifying for each community: (1) key determinants of health; and (2) factors associated with a strong primary care system. Data and information gathered during the four local community meetings provided valuable insights that were used to develop the overall strategic plan and the primary care prototypes.

Over 200 residents participated in the countywide meeting, and 100 residents participated in the four community meetings with many indicating that they had lived in Prince George's County for more than 20 years. Despite this level of engagement, few young African-American families and professionals attended. Members of the Hispanic/Latino, Asian, and immigrant communities were also underrepresented at the meetings despite numerous outreach efforts. The Primary Healthcare Strategic

Plan's marketing and branding strategy includes recommendations on gathering more information from these communities.

Summaries of the community meetings are available on the Prince George's County web site (princegeorgescountymd.gov) and the The Maryland-National Capital Park and Planning Commission Planning Department's web site (pgplanning.org).

Advisory and Stakeholders Committees Meetings

Prince George's County residents were well represented on the Advisory and Stakeholders Committees. Committee members resided and/or worked in the County. Further, two residents from each of the nine Council districts were appointed to serve on the Stakeholders Committee as representatives of their respective community. Interviews were conducted with individual Advisory and Stakeholder Committee members to explore community-related issues in more depth.

Findings from the Random Household Health Survey of the Public Health Impact Study: Technical Report 7

Results of the Random Household Health Survey were used to inform the strategy. Further, several questions used for the survey were also used for the on-site polling at the community meetings, providing insights on variations and trends.

Research and Analysis

John Snow, Inc. conducted research and analysis to develop a strategic plan that is unique to Prince George's County. Wherever possible, the extensive body of research on healthcare and planning in Prince George's County that had already been conducted was included. The research and analysis that is used for planning is outlined. More information regarding data and sources is included in Appendix B.



Building on Previous Work

- **2012 University of Maryland School of Public Health, the Public Health Impact Study:** This study identified geographic distribution of primary care providers and shortage areas, estimated an overall shortage of 61 primary care providers distributed throughout the County, described community perceptions of healthcare services available and preferences on where to get care, and recommended the development of a primary care strategy and implementation plan. John Snow, Inc. used this report extensively throughout the planning process and conducted follow-up interviews with several of the authors.
- **2009 RAND Report, *Assessing Health and Health Care in Prince George's County*:** This report studied residents' healthcare needs and the County's healthcare system's capacity to meet those needs.
- **Other Sources:** Findings from Prince George's Community College *Conversation on Building an Integrated Community-oriented Healthcare System in Prince George's County*, and certificate of need application for the new Regional Medical Center.

Literature Review

Peer-reviewed journal articles and other trusted sources were researched to identify industry-best practices and models that would be relevant for Prince George's County. A list of articles, reports, and web sites is included in Appendix C.

Primary Research

- **Follow-Up Interviews with Stakeholders and Industry Leaders:** Over 30 follow-up interviews were conducted with members of the Advisory Committee, Stakeholders Committee, and other industry leaders identified throughout the project. One-on-one interviews focused on gaining more in-depth understanding and information

regarding key topics that were identified during the larger committee or community meetings. These targeted discussions helped to inform primary care strategies, site selection, prototypes, and adjustments in the number of additional primary care providers needed in Prince George's County. A list of those interviewed is included in Appendix B.

- **Demographic and Health Data:** Data were obtained from several sources that included: (1) the U.S. Census Bureau, including the *American Community Survey*, for the County and zip code levels; (2) the Community Health Rankings, (3) the Chesapeake Regional Information System for our patients County-level data on hospital admissions for 2012/2013; and (4) live polling at community meetings. Data were captured to inform the overall plan and, more

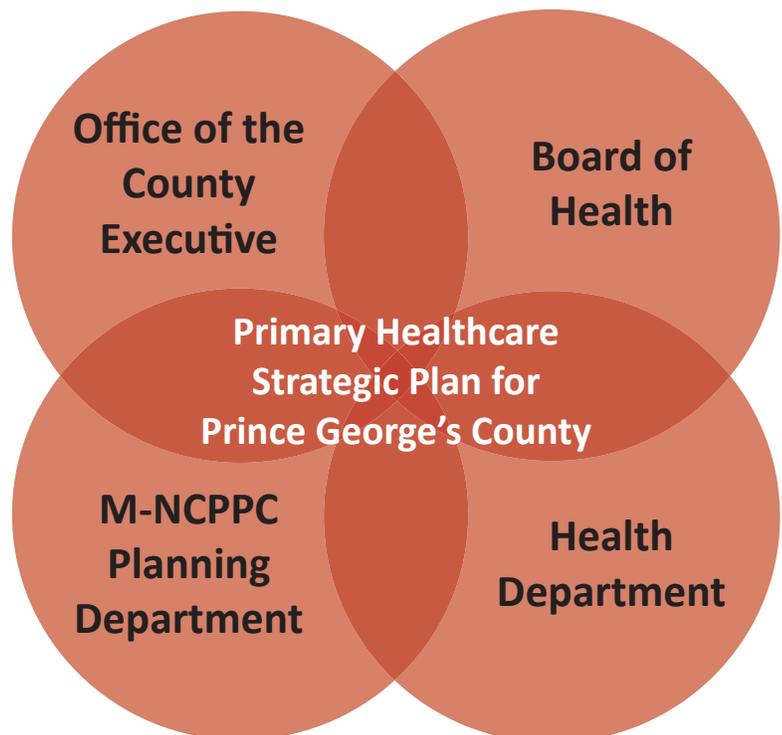


Figure 2. Primary Healthcare Strategic Plan Leadership



specifically, the primary care prototypes and marketing plan.

- **Market Data:** Data on the healthcare market within Prince George's County (in surrounding areas) and for the State of Maryland were obtained from several sources that included but were not limited to:
 1. Health Resource and Services Administration Uniform Data System Mapper.
 2. Maryland Managed Care Organizations enrollment statistics.
 3. Web sites of major healthcare providers.
 4. National Committee for Quality Assurance data request on patient-centered medical home certification within Prince George's County.

5. Medicare Geographic Pricing Cost Index.

Market data were used to inform the overall plan as well as to update physician shortage estimates and inform development of the primary care practice prototypes.

- **Site Visits:** In collaboration with The Maryland-National Capital Park and Planning Commission Planning Department staff, John Snow, Inc. conducted site visits to Prince George's County. Information and data obtained during the site visits were used to inform site selection and design for the primary care prototypes.



IV. PRIMARY HEALTHCARE STRATEGIC PLAN FOR PRINCE GEORGE'S COUNTY

Recommendations for the Primary Healthcare Strategic Plan for Prince George's County are provided in the following section of this report. Recommendations are provided to expand patient-centered primary care, recruit and retain primary care providers, develop a work force to support expansion of patient-centered care, build collaboration on community benefit programs, and build a sustainable model for implementation and monitoring and evaluation.

The matrix provided on page xii of the Executive Summary provides a crosswalk between the recommendations and the detailed descriptions included in Sections IV and V.

Expanding Patient-Centered Primary Care in Health Investment Zones

One of the first priorities of the Primary Healthcare Strategic Plan is to increase the number of primary care practices in high-need areas, designated as "Health Investment Zones." Taking into account community demographics and applying best practices, several recommendations for prototype primary care practices are offered.

Defining Health Investment Zones

Health Investment Zones are defined as those zip codes within the County that were identified by the University of Maryland School of Public Health in its Public Health Impact Study as having high primary care needs or tending to high primary care needs. The University of Maryland School of Public Health created a measure of primary care needs that takes into account physician-to-population ratios, health indicators related to patient-centered primary care (readmission rates and hospital discharges), and social determinants of health (household income and education levels). High primary care need areas meet each of the following criteria:

- Primary care physician-to-population ratio at or worse than 1:3,500 (federal guidelines for the adequate primary care physician-to-population ratio is 1:2,000).
- Population median-income and/or education level lower than the County average.
- Population 30-day readmission rate and/or hospital discharge ratio higher than the County average.

Additional levels of primary care needs were identified. Zip codes that were designated as tending to high primary care needs met the same population, socioeconomic, and hospital event criteria but had physician-to-population ratios between 1:3,500 and 1:2,000. Further levels were developed for medium needs, tending to medium needs, and adequate to meet primary care needs (see zip code-level analysis in Figure 2 on page 17). More information about the methodology behind this stratification can be found in the Public Health Impact Study.

Analysis of Determining Locations, Models of Care, and Facility Design for Primary Care Practices in Health Investment Zones

The Site Selection Committee convened to identify potential locations and models for added primary care practices within the Health Investment Zones. The Site Selection Committee included representatives from the Office of the County Executive, The Maryland-National Capital Park and Planning Commission, the Prince George's County Health Department, and Dimensions Health System. In addition to being within the Health Investment Zones, potential locations were evaluated on their ability to meet the following criteria:

- A federally designated and/or state-designated health professional shortage area.
- An area targeted by the County for economic development and/or health improvement.
- Availability of space to accommodate patient-centered primary care practices.



- Accessibility by private and public transportation that currently exists or is planned for the future.
- Potential to be co-located with community-based organizations, social service agencies, and/or private businesses involved in health promotion (for example, healthy grocer, yoga/pilates center).

Information and data to inform site selection, models of care, and facilities were gathered from several sources that included site visits, master plans, Public Health Impact Study technical reports, Health Resource and Services Administration data, census data, community meetings, and stakeholder interviews. A full list of sources is included in Appendix B.

Suggested prototypes for facility designs were developed to accommodate the models of care for each location. The designs were based upon best practices for patient-centered primary care, as described in the following sections. Visuals of the facility designs are included in Appendix A.

Best Practice Models for Patient-Centered Primary Care

The suggested prototype for primary care practice sites is developed based on the patient-centered medical home model. Best practice models for patient-centered primary care continue to evolve incorporating new research and learning collaborative efforts; all are based upon the core concepts of patient-centered care. (Refer to the Patient-Centered Medical Home diagram on page 5.)

The concept of the patient-centered medical home as a model for primary care is not new. The American Academy of Pediatrics introduced the medical home concept in 1967 as a single location for a patient's healthcare information and, in 2002, greatly expanded the medical home concept to include accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care. In 2007, the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Physicians, and

the American Osteopathic Association adopted the Joint Principles of the Patient-Centered Medical Home that have served as the basis for various patient-centered medical home initiatives and accrediting programs.

Refinements to the joint principles include certain non-physician healthcare personnel as primary care providers. The care team in a patient-centered medical home may include physicians, midlevel providers, medical assistants, clinical care coordinators, community health workers, and behavioral health providers. Patient-centered primary care also incorporates oral health and medication management. Larger primary care practices support on-site dental and pharmacy services with oral health providers and clinical pharmacists joining the care team.

A fully integrated approach to care reflects the social-ecological model for health promotion. The social-ecological model (also referred to as the whole-person care model) contextualizes individual behavior within social and physical environments. At the same time, the model is flexible and incorporates sustained changes in health behaviors that require revised policies, environments, and social systems to address social determinants of health while supporting individuals' positive lifestyle habits. (See the Social-Ecological Model for Health Promotion diagram on page 6.)

The social-ecological model is consistent with the model used for Robert Wood Johnson County Health Rankings that is based on a model of population health, emphasizing the many factors that, if improved, can help make communities healthier places to live, learn, work, and play. County Health Rankings provides benchmarks and comparisons for evaluating the health of a County's population and are used by the Health Department to produce the annual Health Report 2014. The County Health Rankings model was used at the four local community meetings to elicit input from County residents on their health and healthcare.



The Primary Healthcare Strategic Plan defines primary care to encompass primary prevention (health promotion), secondary prevention (screening), and medical care (chronic disease management and acute care). Further, the Primary Healthcare Strategic Plan recommends that primary care practices have integrated behavioral health, oral health, and care coordination. A list of services included as primary care is included in Appendix B.

Recommendations for Patient-Centered Primary Care in Health Investment Zones

Recommendations for patient-centered primary care practices in Health Investment Zones are solidly grounded in the patient-centered medical home and social-ecological models. Recommendations are consistent with the Community Integrated Medical Home model being implemented as part of Maryland's state innovation management grant. Further, the Prince George's County Health Department and The Maryland-National Capital Park and Planning Commission, through its planning, zoning, and review functions, support the social-ecological model and their efforts can strongly influence social determinants of health and health promotion. Their leadership and strong participation bodes well for achieving the goals of the Primary Healthcare Strategic Plan.

Recommendation: *Implement suggested prototypes for primary care practices in those areas identified as Health Investment Zones.*

Time Frame: Prototypes 1, 2, and 3 should be developed in the short-term; Prototype 4 should be developed within three to five years, consistent with the new Regional Medical Center opening.

Four prototypes for primary care practices were developed; one for each of the four geographic areas designated as a Health Investment Zones: Riverdale/New Carrollton/Langley Park, Brandywine, Oxon Hill, and Capitol Heights. (See Map 3: Suggested Prototypes for Primary Care Practices in Health Investment Zones on page 22).

Prototypes are summarized in Table 1, and additional information and visuals are included in Appendix A. The prototypes include site location, care program, facility plan, and a business model. A brief description of these suggested prototypes are given below.

- General site locations were identified within each of the Health Investment Zones, but specific locations are not being recommended with this report. The site location will be determined as the Primary Healthcare Strategic Plan moves to implementation and will depend upon several factors, including what space is available for medical practices and progress on planned developments.
- Program was based upon best practices for patient-centered primary care, modified to fit with the population demographics, community characteristics, and market conditions.
- Facility was based upon architectural design principles that support the patient-centered primary care model. These designs support a team-based approach to care; maximize patient time with providers throughout visit; eliminate physical barriers between patient and staff; allow for variations in demographics, practice methodologies, and future technologies; use natural lighting and other features to create inviting space; and provide sufficient square footage. The proposed facilities would be built to meet environmental standards and to accommodate people with disabilities.
- Business model was developed to support a financially viable primary care practice through start-up and for ongoing operations.



Map 3: Suggested Prototypes for Primary Care Practices in Health Investment Zones

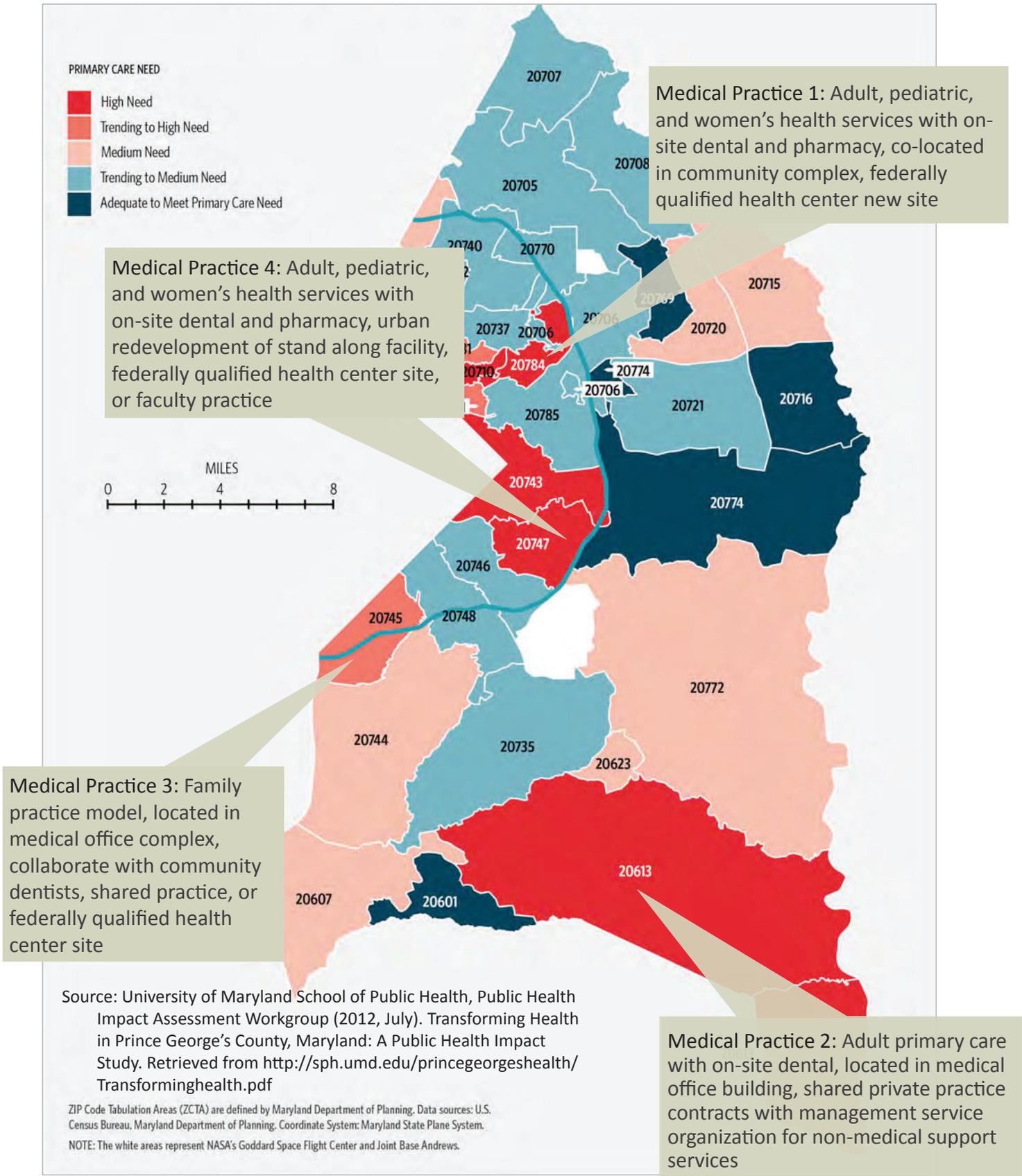


Table 1. Summary Table of Primary Care Practice Prototypes in Health Investment Zones

PROTOTYPE	COMMUNITY DESCRIPTION	PROGRAM	FACILITY	BUSINESS MODEL
1—Health Center in Community Complex	<ul style="list-style-type: none"> • Encompasses Riverdale/ New Carrollton/ Langley Park • High density • Largely low-income and uninsured • Culturally, ethnically diverse • Health professional shortage area 	<ul style="list-style-type: none"> • Primary care with family practice, internal medicine, pediatrics, and women’s health • Seven full-time equivalent physicians and midlevel providers • Same day appointments, extended hours • On-site dental and pharmacy • Residency program, specialty clinic rotation 	12,500 sq. ft. located within community-based complex	Federally qualified health center site
2—Shared practice in medical office building	<ul style="list-style-type: none"> • Encompasses Brandywine, southern region of County • Rural area, low density • Largely high-income, African-American • Health professional shortage area 	<ul style="list-style-type: none"> • Adult medicine primary care practice • Six full-time equivalent physicians and midlevel providers • Same day appointments • Collaboration with independent or hospital-based urgent care center for after-hours care • On-site adult dental 	7,800 sq. ft. located within medical office building	Health organization affiliated or independent practice association with management service organization-provided support services
3—Family practice in medical office building	<ul style="list-style-type: none"> • Encompasses Oxon Hill • Largely low-to-moderate income • Culturally, ethnically diverse • Underserved population 	<ul style="list-style-type: none"> • Family practice • Four full-time equivalent physician and midlevel providers • Same day appointments • Collaboration with independent or hospital-based urgent care center for after-hours care • Collaboration with community dentists 	6,800 sq. ft. located within medical office building	Health organization affiliated or federally qualified health center site
4—Health center in redevelopment area, near Regional Medical Center at Largo Town Center	<ul style="list-style-type: none"> • Encompasses Capitol Heights, District Heights • Concentration of low-income and uninsured • Predominantly African-American • Health professional shortage area 	<ul style="list-style-type: none"> • Primary care with family practice, internal medicine, pediatrics, and women’s health • Seven full-time equivalent physicians and midlevel providers • Same day appointments, extended hours • On-site dental and pharmacy • Residency program, specialty clinic rotation 	15,800 sq. ft. stand-alone facility, new construction on redeveloped site	Federally qualified health center or Regional Medical Center faculty practice



Recruitment and Retention of Primary Care Physicians for Prince George's County

This section provides an overview of quantifying the needs for primary care physicians in the County, barriers to physician recruitment and retention, as well as strategies to overcome those barriers. Based on needs and these best practices, recommendations specific to Prince George's County are outlined.

Need for Primary Care Physicians in Health Investment Zones

The University of Maryland School of Public Health conducted a rigorous analysis to quantify the number of primary care physicians needed for Prince George's County by geographically using the Public Use Microdata Area geographic units. The study indicated that a total of 61 primary care physicians and 31 dentists were needed to meet the primary care needs within the County, which are concentrated in the inner Beltway and southern part of the County. (The University of Maryland School of Public Health's methodology and results are included in the Public Health Impact Study.)

John Snow, Inc. used available sources of information (stakeholder interviews, web sites, etc.) to update its understanding of projected need. The information gathered indicated that healthcare organizations had moved into or expanded their services within the County's high-need areas, reducing the shortage by 13 primary care physicians. It should be noted that there are several limitations to the exactness of the University of Maryland School of Public Health's original estimate and to John Snow, Inc.'s updates, as well as the federal guidelines for physician-to-population ratios. Taking these limitations into account, the estimated number of physicians needed in the County should be used as a guide to the magnitude of need.

Based upon the information available, it is estimated that the remaining need for primary care physicians in the Health Investment Zones would range from 24 (assuming 50 percent outmigration) to 48 (with no outmigration). The proposed primary care practices

would add 15 physicians and 7 midlevel providers or 22 total primary care providers. Proposed practices would increase the number of dental providers by four (two dentists and two dental hygienists). These providers would constitute a critical start to meeting the demonstrated need in Prince George's County.

Analysis of Barriers to Physician Recruitment and Retention

Barriers to physician recruitment and retention were identified primarily through stakeholder meetings, interviews, and a review of market-related documents. Barriers can be grouped under financial security, professional opportunities, quality, and systems support.

Prince George's County has fewer opportunities for employment relative to the surrounding counties and the District of Columbia.

Today, many physicians are looking for financial security and are less interested in the risk that accompanies setting up private practices. Compared to surrounding counties, physicians in Prince George's County have set up more small private practices. In contrast, in the areas surrounding Prince George's County (District of Columbia, Montgomery, Anne Arundel, and Howard Counties) more primary care physicians practice in established and highly recognized healthcare organizations, including academic medical centers that offer teaching and research opportunities.

Prince George's County also has fewer opportunities for residency training, and as stated earlier, physicians often choose to practice where they complete their residency. Opportunities are particularly limited for pediatricians and obstetricians. Dimensions Healthcare System (includes Prince George's Hospital Center and Laurel Regional Hospital), along with MedStar Southern Maryland Hospital Center are the only hospitals in the County that provide obstetrics and pediatric services. Current plans for the new Regional Medical Center will reduce the number of obstetric beds (although obstetrical admissions are projected to



remain constant with reduced lengths of stay) and provide for a small number of pediatric beds.

Prince George's County does not have an established program to reimburse primary care providers for services provided to uninsured or underinsured low-income individuals.

Montgomery County and the District of Columbia have established programs to pay primary care providers for services provided to uninsured, low-income individuals. Primary care providers that practice in low-income communities often serve a disproportionate share of uninsured individuals as well as those who are underinsured (individuals who have health insurance plans with large deductibles or limited benefits). Given the lack of reimbursement for their services, there is little incentive for providers to work in these low-income communities of Prince George's County where, unfortunately, the need is often highest.

Solo/small practice primary care providers in Prince George's County do not have resources to transform into patient-centered medical homes.

There are relatively few primary care practices in Prince George's County that have transformed into patient-centered medical homes, as compared to those in surrounding counties and the District of Columbia. Solo or small practices often do not have the resources to hire staff (such as care coordinators) and implement systems (such as data analytic capabilities) to operate as a patient-centered medical home. In today's healthcare environment, physicians want to work for practices that have received patient-centered medical home recognition from one or more of the nationally recognized accrediting organizations (National Committee for Quality Assurance, The Joint Commission, or Accreditation Association for Ambulatory Health Care, Inc.) that have the operational support to participate in shared savings and quality contracts. Developing primary care practices to function as patient-centered medical homes will be even more important with Maryland's shift to global payment models for hospitals. Under its payment reform initiative, over the next five years

Maryland will shift virtually all of its hospital revenue into global payment models, providing incentives for hospitals to work in partnership with other providers (primary care providers, in particular) and preventing unnecessary hospitalizations and readmissions.

There is a general perception that healthcare services are of lower quality in Prince George's County.

The perception of lower quality adversely affects the ability to recruit and retain physicians. Not only do providers want to work in what is perceived as quality institutions, they are also concerned that, unless the quality of care within Prince George's County improves, the ability to develop a financially viable practice will be compromised.

Communities with high primary care needs often lack medical office space that can support new primary care practices.

Low-income areas often lack an inventory of sufficiently sized (minimum of 6,000 square feet) and affordable space needed to support primary care practices. Without existing space to support primary care practices, providers lack the incentive to even attempt to establish practices in these high-need areas.

Effective Strategies for Physician Recruitment and Retention

Effective strategies for recruiting and retaining physicians are those that offer opportunities for financial security and achievement of professional goals. Today, these strategies must respond to the increased demand for primary care providers and the accompanying responsibilities placed on them to support population health management.

The following strategies for physician recruitment and retention are based upon best practices considered most relevant to Prince George's County. Strategies specific to Health Investment Zones are also included:

- Recruit primary care providers into established organizations that provide reliable income and the infrastructure to support patient-centered



care. For example, a federally qualified health center located in Maine has grown by merging existing private physicians (solo practitioners and small groups) into the center. These physicians have exchanged autonomy for financial security (salary plus quality bonuses) and support from an organization (quality management, care coordination, and other support services).

- Recruit new physicians from residency training programs. Many organizations see participation in residency programs as crucial to their recruitment strategy. Physicians coming from residency programs already share in a panel of patients and have assimilated into the practice operations and culture. Federally qualified health centers and larger private practices that can serve as a residency practice site have an advantage for recruitment.
- Offer loan repayment and other incentives for physicians that agree to practice in a designated health professional shortage area. Medical school loans present a large financial burden to physicians; their ability to participate in federal and state loan repayment programs can be a major help. The most effective recruitment strategies offer loan repayment as part of a comprehensive package rather than the sole strategy.
- Create a “package deal” for recruitment. By necessity, rural health centers have developed physician recruitment and retention strategies that offer a package—great place to live, low cost of living, employment opportunity for working spouse, good schools for the children, and the opportunity to become an esteemed member of a small community. Prince George’s County can similarly be promoted as a diverse and historically rich community that offers a high quality of life for young professionals, growing families, and active seniors.

Health Investment Zone Incentives

Healthcare delivery overall and recruitment of primary care physicians, in particular, are shifting as

more and more physicians are employed by larger healthcare organizations that are part of integrated delivery systems. This major shift is attributed to the complexities of healthcare reform that require primary care physicians to operate as patient-centered medical homes and engage in population health management. Increasingly, physicians want the security and support of working with larger organizations that are better equipped to handle the new, complex, day-to-day operations of a practice.

Many see solo practitioners as a thing of the past. As there continues to be physician shortages, particularly in primary care medicine, the County must take measures to keep pace. The following recommended incentives enhance the County’s capabilities to recruit and retain primary care physicians.

- Establish and operate a program to reimburse primary care providers for services to low-income patients who are uninsured or underinsured (referred to as Prince George’s HealthAssure).

The County would develop and operate the program in collaboration with key stakeholders. Following successful models, including Montgomery Cares and the DC Alliance Program, the program would be funded through a combination of private and public sources.

Federally qualified health centers would also use some of their federal grant funds to subsidize the cost of services provided to uninsured patients, but the amount would not cover all costs. The recommended reimbursement per primary care encounter is \$85.00, an amount consistent with the amount paid by Montgomery Cares and Medicare reimbursement for a comprehensive primary care visit.

- Develop a plan that will provide adequately sized and affordable medical office space that will qualify as a patient-centered medical home and includes primary care practices making reduced lease payments.



- Build out medical office space in the Health Investment Zones that supports patient-centered medical home care models, for example shared space for care teams and talking rooms for behavioral health consultations. (See Section IV on page 19.) Funding would come primarily from negotiated cost secured by the County from private developers. Additional funding could come through grants for federally funded health centers and capital campaigns sponsored by nonprofit organizations. Estimated costs to build out medical office space within an existing building that supports the patient-centered medical home model averages about \$230 per square foot; estimated cost for ground-up (full facility) construction is \$425 per square foot.
- Secure reduced lease payments for primary care practices in the Health Investment Zones. The County would secure reduced lease payments from private developers and property owners. The proposed subsidy is \$10 per square foot or approximately half of the average lease cost for office space in Prince George's County (excluding utilities and leasehold improvements). In addition, the County would secure a minimum 15-year lease term from property owners.
- Establish a plan to secure federal and state loan repayment to physicians and dentists that choose to practice in Health Investment Zones in Prince George's County.
 - Work with federally qualified health centers and other eligible governmental and private nonprofit healthcare organizations serving the County to secure state and federal loan repayment for medical and dental school graduates who agree to work in sites located in Health Investment Zones.
 - Work with the Mid-Atlantic Association for Community Health Centers (represents Maryland's federally qualified health centers), The Maryland State Medical Society, and other stakeholders to promote the loan repayment program.
- Provide low-cost working capital loans to cover start-up costs such as operating losses during the ramp-up period (12 to 18 months), purchase of equipment such as an electronic medical record system, and income guarantees for physicians and midlevel providers. The Economic Development Corporation may provide the loans at favorable interest rates and have provisions for loan forgiveness for those providers that practice in the Health Investment Zones for the long term (10 to 15 years).
- Enable the ability of primary care practices to operate as patient-centered medical homes by having access to support services through management service organizations. Management services organization(s) would be developed and operated as a private organization, for example a joint venture among health plans serving Prince George's County or services offered through The Maryland State Medical Society. The management service organization could charge service fees for primary care practices to cover operating costs. Services could be provided to primary care practices operating in a Health Investment Zone at reduced rates with the goal being that the management service organization operates at break-even (or above).
- Develop a program to subsidize physician income for primary care practices that agree to serve as residency practice sites in Health Investment Zones. The subsidy would offset lost productivity for physicians serving as preceptors for medical and dental residents. Funding for income guarantees to preceptors would come from private sources and/or the residency program.
- Establish a plan to subsidize malpractice costs for primary care practices. The County would promote the hiring of primary care physicians and midlevel providers by federally qualified health centers, and/or primary care providers employed by federally qualified health centers usually have their malpractice costs covered.



Recommendations for Recruitment and Retention of Primary Care Physicians for Prince George's County

Based on effective strategies tailored to meet the goals of the Primary Healthcare Strategic Plan and evolving market conditions, the following recommendations developed through the Physician Recruitment and Retention Workgroup are proposed for Prince George's County.

Recommendation 1: *Provide financial incentives.*

Time Frame: Short- to Medium-Term

- Offer incentives to: (1) private physicians who are culturally competent, have desire to serve low-income or rural populations, and are willing to practice in sites located in Health Investment Zones; and (2) federally qualified health centers that are willing to expand capacity through opening new sites in Health Investment Zones.
- Offer low-cost working capital loans and two-year income guarantees to private primary care physicians who commit to establishing and maintaining practices in Health Investment Zones in Prince George's County.
- Establish an adequately funded program, such as Prince George's HealthAssure, to pay qualified providers for patient-centered primary care services to low-income uninsured and underinsured individuals. The program would apply to federally qualified health centers and to certain other primary care providers (as funding allows) in Prince George's County, including those practicing outside of the Health Investment Zones.

Recommendation 2: *Provide operational support.*

Time Frame: Short- to Medium-Term

Physicians should be recruited into an integrated system that includes medical, behavioral, and social services. Physicians need to believe they do not have to "do it alone." Systems include those inside the practice, such as staff that are trained in data analytics to support population health management and behavioral health providers, and those outside

the practice such as public health nurses and other community-based social service organizations. There are multiple approaches to building operational support for primary care practices. They are not mutually exclusive and, further, can be implemented over time.

- Encourage the development of a private management service organization that would offer services to primary care practices, in particular to solo practitioners and small practices. The management service organization would provide support services, including general administration, electronic health record implementation and maintenance, credentialing, contracting, population health management (quality analytics, care coordination), and legal services as well as technical assistance on transformation to patient-centered medical homes. There are various ways to structure and fund the management service organization. Given the resource requirements and needed expertise, it would be advantageous to work in collaboration with others that provide support to primary care practices, including but not limited to The Maryland State Medical Society, the Mid-Atlantic Association of Community Health Centers, and the Maryland Health Care Commission Management Service Organization Advisory Panel.
- Implement an infrastructure that can support the patient-centered medical home model for solo practitioners and small practices, in particular those operating in more rural parts of the County. One possible model is an Independent Physician Association. In this association, Physicians could practice in a shared model that purchases services through the management service organization. Physicians also could enter into joint contracts with health plans as well as form alliances with hospitals, home health agencies, urgent care centers, and other community-based organizations to improve transitional care and after-hours care. The Independent Physician Associations of a sufficient size could form an



accountable care organization that would enter into contracts with health plans.

- Expand opportunities for residency and employment in established healthcare organizations.
 - Establish opportunities for residency training (medical and dental) in Prince George's County provider organizations, and aggressively recruit within regional residency training programs to use practice sites within Prince George's County.
 - Support expansion of federally qualified health centers that offer employment, malpractice coverage, and organizational supports for physicians and midlevel providers that want to serve low-income and culturally diverse populations.
 - Support development of hospital-based integrated delivery systems, including the new Regional Medical Center.
 - Build strong collaboration between primary care sites in Health Investment Zones with the recently developed Family Practice Residency Program sponsored by Dimensions Health Systems.

Recommendation 3: Market Prince George's County as a "package deal."

Time Frame: Medium- to Long-Term

Recruit primary care physicians by offering Prince George's County as a package deal—a great place to live and work. The package includes employment for the physician (and his/her spouse if both are physicians) into a supportive and high-quality

healthcare system, employment opportunities for the spouse, access to good public schools, and ability to be part of the community. Implementation of this recommendation would require collaboration at local, County, and state levels, and includes:

- Making the necessary investments needed to build excellent healthcare at the Regional Medical Center. One tactic is to recruit a high-profile cluster of established, academically oriented specialists to the Regional Medical Center. Their arrival would reflect the County's commitment to improved quality, fulfill the original Memorandum of Understanding promise of a health sciences center and, most importantly, instill confidence within the medical community as well as with Prince George's County residents.
- Partnering with an academic institution to set up and pay for medical, dental, and allied health profession residency sites. Work with the state to implement the necessary policy changes that give priority to Maryland higher education institutions for residency and practicum slots.
- Working with State education officials, Prince George's County Public Schools, private schools, colleges, and universities located within the County to ensure quality education is provided in all schools.
- Working with businesses to find employment positions for physicians' spouses, including ones within medical practices and medical centers for spouses who are also physicians.
- Implementing the marketing and branding campaign to recruit primary care providers as outlined in Targeted Marketing Goal #1 on page 48.



Recommendation 4: Advance health promotion and disease prevention.

Time Frame: Medium- to Long-Term

The social-ecological model on which the Primary Healthcare Strategic Plan is based recognizes that much of healthcare takes place outside of physicians' offices. To further increase primary care capacity, efforts should focus on expanding resources for health promotion and disease prevention outside of the primary care setting. Thus, while other recommendations in this section have focused on bringing in and retaining new providers to the County, this recommendation takes a different approach to reducing demand for primary care medical services. Improving health and reducing disease prevalence will reduce pressure on the demand for primary care. The following recommendations support that trend:

- Continue to include health promotion as part of community development (for example, building more sidewalks and providing incentives to service and retail establishments that support healthy eating and exercising). Prince George's County, through The Maryland-National Capital Park and Planning Commission and the Health Department, has already implemented programs to support the development of healthy communities. Continuing these efforts in parallel with implementation of the Primary Healthcare Strategic Plan will advance the goal of improving the health of all County residents.
- Implement the health promotion campaign included as part of the marketing and branding plan, outlined in Section V on page 47.
- Provide adequate funding for the Health Department to conduct health needs assessment, and implement health promotion and disease prevention programs as indicated.
- Encourage health plans and employers to offer incentives to health plan enrollees and employees who engage in health promotion and disease prevention activities.

Developing a Work Force to Support Expanded Patient-Centered Primary Care in Prince George's County

Work Force Development under Healthcare Reform

The profession of primary healthcare is transforming into a new work force. The patient-centered medical home model of care demands dramatically different skills and staffing and requires collaborative teams of health professionals. Given that context, the work force recommendations for Prince George's County are to adapt the health professional work force to support a patient-centered medical home for every resident in the County.

With the expansion of healthcare coverage under the Patient Protection and Affordable Care Act, there is a need for expanded work force capacity to meet the needs of the newly insured and to fill gaps in access for existing insured residents. Under the Patient Protection and Affordable Care Act, federal funding for the National Health Service Corps, which has existed since 1971 to provide scholarship and loan repayment to providers who serve in areas with a provider shortage, has been expanded. The funding is available for physicians, nurse practitioners, physician assistants, nurse midwives, mental and behavioral health providers, and dentists.

New and existing primary care providers must be trained to build capacity of this new work force to align with the patient-centered medical home model. The new primary care work force will be composed of a range of health professionals who work together as a team to deliver high-quality primary care. Physicians cannot do it alone; clinical and non-clinical staff members ensure patients have support in many ways, such as helping them gain access to high-quality food, education on how to live a healthy lifestyle, and support to take medications. More and more, there is recognition that training on developing effective relationships among all members of the care team is needed, as well as training on practice-based population health. Practice-based population health



uses information on a group of patients within a practice or a group of practices to improve the care and health outcomes of those patients.

Analysis of Work Force Needs for Prince George's County

John Snow, Inc. analyzed work force needs in Prince George's County in two phases. During the first phase, an inventory of current training resources at local educational institutions, their capacity, and available degree programs was developed and is included in Appendix B. During the second phase, John Snow, Inc. reviewed best practices for delivering high-quality primary care, and based on these, a list of high-priority health professionals was developed (see Table 2).

Table 2. High-Priority Health Professionals for Patient-Centered Primary Care

MEDICAL	Physicians, nurse practitioners (family medicine, pediatric), physician assistants, pharmacists, medical assistants, nurses, advanced practice nurses, certified nurse midwives.
BEHAVIORAL HEALTH	Psychiatrists, psychologists, licensed clinical social workers, licensed alcohol and drug counselors, psychiatric nurse practitioners, family and health counselors.
OTHER HEALTH PROFESSIONAL STAFF	Community health workers, care coordination staff, reception staff, information technology specialists, advanced public health nurses, interpreters and translators, social workers.
DENTAL	Dentists, dental hygienists, dental assistants.

Table 2 demonstrates that there is a need for staff with qualifications in team management, data management, and information technology. This is in addition to the traditional medical staff usually thought of in a professional health work force. By having more members on a care team, a patient-centered medical home practice must manage more staff than a traditional practice. The need for information technology and data management staff is increasing, as providers move to electronic health records, and practices take a population health approach by actively managing their patients' preventive health needs.

Best Practices in Work Force Development

A work force that supports population health is diverse, involving not just physicians but a range of allied health professionals. While a comprehensive care team is a recognized requirement for patient-centered services, there is currently no single model, in terms of staffing configuration, to provide these supportive services. By prioritizing and investing in work force development, Prince George's County will be at the forefront of primary care. The work force

best practices to support a patient-centered medical home transformation and population health are discussed below.

- Encourage diversity of both clinical and non-clinical staff. By definition, the primary care work force to support patient-centered care is diverse. The work force to support population health and patient-centered medical homes includes individuals that have significant roles in care coordination, health education, and community outreach. The staff in these roles vary in their educational backgrounds and include nurses, public health nurses, social workers, licensed clinical social workers, pharmacists, and community health workers. Historically, these staff have been limited in their availability, because the current healthcare payment system has not paid directly for their services. With payment reform of both primary care and hospital systems, there are new financial incentives and mechanisms that encourage and allow for payment of these types of staff. The patient-centered medical home model increases



the ratio of staff per physician provider, and one study estimates this increase to be as much as 59 percent.

- Ensure all staff are working at the top of their license. Team-based care supports allied health professionals to work with physicians. This provides two benefits: better value and better access to patients. Delegation of tasks from physicians to other staff extends the available time of providers. A more diverse staff enhances the referral and supportive services available.
- Adjust staffing model for each practice. Since no single model exists for staffing, patterns will need to adjust to the individual practice based on practice size, patient population age and illness severity, and resources available in the community. For example, care coordination and health education staff are provided by the Health Department and/or the health plans in some communities. Health plans offer these services to providers as a way to support them, but each health plan does it differently. While there is agreement on the need for care coordination and health education staff, there is variation in how they are managed, paid for, and work as a team with other healthcare providers.

In the absence of consensus on the best staffing model for the ideal organization, there are excellent examples that can serve as models for others. One such example is Robert Wood Johnson Foundation's program to identify, support, and disseminate best practices in the primary care work force called LEAP (Learning from Effective Ambulatory Practices). This program is studying 30 high-functioning primary care practices nationwide. Among those is Unity Health Care, a federally qualified health center in Washington, D.C.

The LEAP project found that primary care roles are shifting. Non-physician providers are taking more responsibility over patient health as part of a comprehensive care team. The LEAP project identified the following shifts in primary care roles:

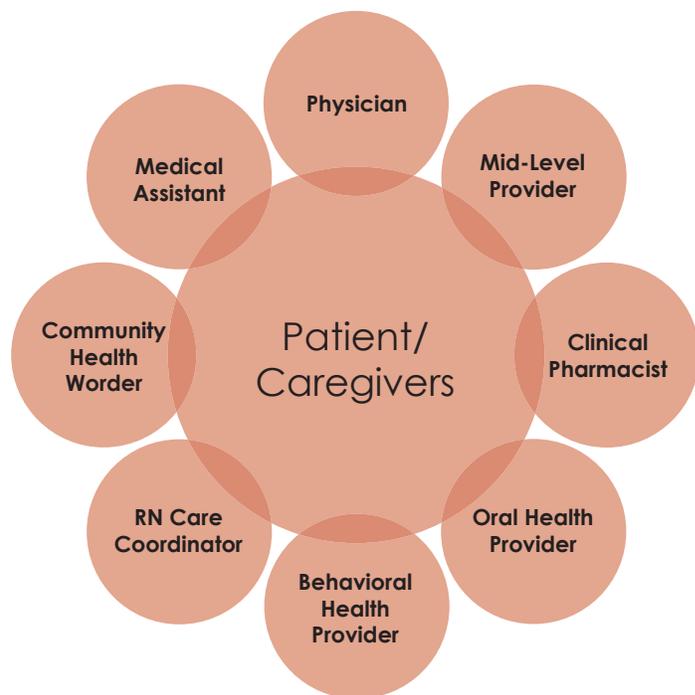


Figure 3. Patient-Centered Care Model: Example of Care Team within a Patient-Centered Medical Home

- The medical assistant's role is being elevated to include reviewing patient records prior to visits and ordering and administering immunizations based on protocols, making outreach calls, and coaching patients to set self-management goals.
- The nurse's role is shifting from triage to a focus on chronic care management and hospital-to-home transitions.
- Behavioral health workers include licensed, clinical social workers who are now co-located within primary care practices.
- Physicians may share a patient panel with team members who are empowered to provide portions of chronic and preventive care.

Figure 3 represents a care team with a patient-centered medical home model practice, highlighting that patients and their caregivers are a part of the team. Some team members may not be employed by the practice. For example, clinical pharmacists may be employed by a local pharmacy but participate in



the development of the care plan and attend team meetings when needed, or RN care coordinators may be employed by a management service organization contracted to provide services to a network of primary care providers.

To support the development of these best-practice care teams within Prince George's County, the University of Maryland, Baltimore, has introduced an interprofessional team-based care pilot program with a focus on chronic disease management in Prince George's County and Southern Maryland. The planning phase of the pilot will determine the chronic diseases of focus, determine the team-based care model, identify patient engagement strategies, identify sites for implementation, determine the appropriate payment model, and outline evaluation metrics and plan. The pilot program was designed to complement the ongoing work of the Prince George's Health Enterprise Zone and the Primary Healthcare Strategic Planning project. The University of Maryland, Baltimore, will work in collaboration with Prince George's County as the pilot program moves forward.

Work Force to Support Population Health

With increased focus on care coordination and team-based care, training will be essential for both new and existing providers. Training should focus on how to be part of an integrated team of providers and how to instruct all providers to deliver services at their highest level of training and license. Enhancing local training opportunities in Prince George's County has several benefits beyond simply increasing the number of providers. The County is developing a professional career ladder for those who enter the health professions, supporting those who want to live and work in the County with a dynamic, flexible, and rewarding career path.

Customer Service Training

Customer service training was identified, through the community meetings, as crucial to health professional work force development. Patient

experience of their healthcare, along with perception of quality of care, is very much informed by patients' interactions with all levels of staff at a healthcare organization. The caring touch and humane interactions were considered to be almost as important as having well-trained providers with excellent credentials.

The healthcare industry has lagged behind other service providers, such as grocery stores, hotels, and retailers, in providing the superb customer service that consumers have come to expect. In the healthcare world, people are often viewed more as patients than customers. In reality, consumers of healthcare are both customers and patients. As patients have choices in healthcare, they are also customers. However, healthcare choices are not the same as other retail ones as they are often made when consumers are vulnerable, and they may need input from providers and/or family members. Prince George's County is located in an extremely competitive healthcare environment where consumers can choose where to receive services in neighboring counties as well as the District of Columbia. Regardless of services available, poor customer service discourages patients from seeking out the preventive care and chronic disease management they need. The quality of customer experience is what will make some primary care options stand out for consumers and, in turn, make them loyal to those County providers who do prioritize customer service. Poor customer service turns patients away, regardless of the physicians', nurses', and other clinical staff's expertise.

Patients demand and deserve high-quality customer service; the establishment of such a service, which is provided by the Health Science Collegian Center at Prince George's County Community College, would ultimately contribute to residents opting to stay in the County for their care. We provide some specific recommendations for how to embed customer service training into the Primary Healthcare Strategic Plan.



Recommendations for Work Force Development for Prince George's County

The following recommendations were developed through the Work Force Development Workgroup.

Recommendation 1: *Convene stakeholders with a shared mission of increasing and improving work force capacity.*

Time Frame: Short-Term

As mentioned above, there is no consensus yet on the ideal staffing pattern or defined roles for the patient-centered medical home model. Thus, a learning community across the County on this work force topic would support dissemination of best practices. Convene stakeholders, including providers, health plans, the Health Department, County agencies such as the Economic Development Corporation, social service agencies, and educational institutions to discuss the topic of care coordination, health education, and community outreach.

Coordinate activities in developing and training the work force to serve these functions, share what is learned, and develop a joint plan for building capacity and financing these types of services. A state group focused on training community health workers and the Health Enterprise Zones are two initiatives that have potential for informing stakeholders. This topic requires ongoing coordination and collaboration.

Recommendation 2: *Develop a systematic work force development plan.*

Time Frame: Short- to Medium-Term

Develop a systematic work force development plan for the County designed to meet the needs and demands of the patient-centered medical home concept and the “ideal” primary care practice provides top-quality primary care. All primary care practices in the County should work toward achieving the components and functionality of a medical home for the purposes of providing high-quality and cost-effective care. Recommended actions are:

- Support practices with educational resources on how to transition to a patient-centered medical

home and train their staff/work force to meet the needs of an “ideal” primary care practice. This would include both the establishment of learning collaboratives across practices and the provision of technical assistance.

- Facilitate connections and collaborations with stakeholders, such as the Maryland Health Care Commission, that have resources and expertise.
- Ensure that the work force plan takes into consideration the broad spectrum of health professionals needed to link patients from primary care to the community and across the continuum of care (including ambulatory, inpatient, long-term care etc.).
- Recommend that all primary care practices in the County have the components of a patient-centered medical home that is currently tied to payment incentives.
- Engage a variety of stakeholders to invest in the work force. Hospitals could invest in or support partners to transform their work force, scope of service and/or operations through their community benefit plans. Health plans can support their network providers in various ways.

Recommendation 3: *Give priority consideration to residents and County educational resources to meet the recommended work force objectives.*

Time Frame: Short- to Medium-Term

Prince George's County has a number of healthcare organizations that can provide clinical training and act as preceptors in partnership with academic and vocational institutions. However, clinical placements are limited and highly competitive. Recent experience of the health profession programs in the County shows that many clinical placements are being given to students from programs outside of the County. Collaboration between educational institutions and other stakeholders, such as primary care providers and clinical training sites, is needed to align program needs with the County work force needs. High schools are important for preparing and leading students to careers in the health professions. In addition to health work force development at the



secondary, collegiate, and graduate levels, career ladders and continuing education are also needed.

- Expand clinical training opportunities within the County to accommodate academic training sites for the proposed work force. Support a stakeholder group to discuss clinical placements in the County that would include educational institutions, state representatives, and healthcare provider organizations.
- Include continuing education for existing professionals and programs to support a career ladder for those in health professions. Include current health professionals (private practices) in the discussion of competencies needed in the work force and how to train new professionals most effectively.
- Encourage the leadership of healthcare institutions to prioritize clinical placements for Prince George's County health profession programs.

Recommendation 4: *Prioritize quality customer service.*

Time Frame: Short-Term

Prioritize improving the quality of customer service of existing healthcare staff in the County and in all training of future clinical, public health, and administrative support staff. Utilize the best practices of customer service, both those in healthcare and in other industries, to set a new standard of patient experience in Prince George's County. Best practices in cultural competence are also critical for good quality customer service. Specific recommendations to help promote quality customer service follow:

- Develop a branding campaign to promote quality customer service in healthcare in collaboration with other County branding initiatives.
- Institutionalize high-quality customer service in all areas of operations. Quality customer service should be embedded in the performance reviews of all employees. An annual in-service training on customer service and cultural sensitivity is highly recommended as a requirement. Encourage

all organizations to monitor customer service through secret shopping and "spot checking" employee performance (secret shopping is the practice of marketing research where someone "poses" as a customer for research purposes).

- Identify resources to support practices investing in and training staff on customer service. Ensure that healthcare providers understand the importance of such training for their patients and for their business. The Small Business Administration, the Mid-Atlantic Association of Community Health Centers, and local medical society offer training on customer service return on investment that healthcare staff would benefit from attending.
- Work toward customer service training being part of the curricula for all health profession degrees provided in the County.
- Engage partners to pursue excellence in customer service. The Economic Development Corporation could partner with healthcare and educational institutions to fund customer service training and partner with private businesses in Prince George's County to be role models of excellent customer service.

Collaborating on Hospital Community Benefit Programs

In order to strengthen its primary healthcare system, the County needs to expand access to services as well as coordinate and collaborate on broader community health and population-based activities. These community health efforts are critical to promoting a deeper awareness of health and wellness issues, along with the associated risk factors. More importantly, these efforts target those residents most at risk.

This section provides an overview of community benefit programs under the Patient Protection and Affordable Care Act. It highlights the new requirements and best practices for conducting collaborative community health needs assessment. Recommendations for implementing collaborative



community health needs assessment and setting priorities based on community health needs assessment results in Prince George's County are also presented.

Hospital Community Benefit Programs under Healthcare Reform

Community Health Needs Assessment and Community Health Improvement Program

The Patient Protection and Affordable Care Act has many components that promote primary care strengthening and population-based health activities. One is the new Internal Revenue Service Schedule H regulations requiring that all hospitals work in collaboration with County Health Departments and other community health stakeholders to conduct both a community health needs assessment and develop an associated community health improvement program every three years. The process for the community health needs assessment and community health improvement program is designed to identify common priorities, encourage collective action, and maximize community impact. These new community health needs assessment and community health improvement program requirements present a significant opportunity for collaboration, not only among hospitals but also across the full breadth of other public and community health partners. They also align with the patient-centered primary care and social-ecological models presented earlier in this report.

Community benefit was identified as a natural source of collaboration among hospitals operating within Prince George's County and the Health Department and as one that would advance the goals of the strategic plan. A Community Benefits Workgroup was formed to explore the possibility of developing a collaborative, countywide community benefits strategy and how that would be carried out. First, the workgroup reviewed the hospitals' existing needs assessment reports and associated planning documents in order to understand the extent to which these earlier efforts had identified similar priorities and proposed common strategic

activities. Next, the workgroup assessed the desire and feasibility for collaboration with respect to an initial set of core priorities and action steps that members had conceived. Finally, the workgroup evaluated the prospect of creating a countywide structure for ongoing coordination and collaboration on community benefit program planning and implementation.

John Snow, Inc.'s review of existing plans indicated that there was substantial consistency across the hospitals' and the County Health Department's community health needs assessment. The Public Health Impact Study was a common source of data for the community health needs assessment. Overall, the workgroup concurred that significant opportunities exist for collaborating on future community benefit planning and programs and that future needs assessment will require that updated data be collected at both the County and community levels.

Best Practices for Hospital Community Benefit Programs

As mentioned above, new regulations require that nonprofit hospitals work in collaboration with the County Health Department and other community health stakeholders to conduct a community health needs assessment and to develop an associated community health improvement program every three years. Health departments are also being encouraged by the Centers for Disease Control and Prevention and other agencies to become fully accredited by the National Association of County and City Health Officials. This accreditation process requires that Health Departments engage in periodic needs assessment and planning activities in collaboration with their community health partners. Furthermore, health and social service agencies of all types are regularly involved in their own collaborative assessment and planning processes as part of their usual course of doing business. As a result, there is increasing interest and motivation to collaborate or at least coordinate with respect to community assessment and planning.



Hospital Community Benefit Program

Nonprofit hospitals have always played an important role in increasing access to healthcare. They provide “community benefit” in the form of health services for vulnerable or underserved populations, financial assistance or donations for public health programs, free health education programs to help individuals manage their health, and screenings and preventive services. Yet, in the past there has been variation in how and how much community benefit hospitals provide to their communities with little transparency regarding their practices.

In the U.S., 60 percent of hospitals—approximately 2,900—are nonprofit. They provide an estimated \$12.6 billion in community benefit each year (Robert Wood Johnson Foundation, 2012). According to the Maryland Hospital Association, Maryland hospitals provided \$1.5 billion in community benefit in 2013.

How Has the Hospital Community Benefit Program Changed under the Patient Protection and Affordable Care Act ?

As part of the Patient Protection and Affordable Care Act, nonprofit hospitals must now meet new standards to qualify for federal tax exemption.

They must:

- **Conduct a community health needs assessment** and develop an implementation plan every three years. They must use local data and meet with local community and public health experts to prioritize public health needs.
- **Adopt and publicize a financial assistance policy.** Limit charges, billing, and collections for individuals eligible for financial assistance under the financial assistance policy.

Why Do These Changes Matter?

Requiring hospitals to lead a community health needs assessment will ensure that care is targeted where the need is most. This means that resources will be used as efficiently as possible, with an overall result of improved quality of care at reduced cost. The regulations also promote transparency by requiring hospitals to adopt and publicize their financial policies.

Sources:

Maryland Hospital Association. Community Benefits. <http://www.mhaonline.org/community/community-benefits>

Robert Wood Johnson Foundation. What's New with Community Benefit. October 2012

<http://www.rwjf.org/en/research-publications/find-rwjf-research/2012/10/what-s-new-with-community-benefit-.html>

Somerville M, Nelson G, Mueller C. Hospital Community Benefits after the Patient Protection and Affordable Care Act: The State Law Landscape. The Hilltop Institute. Issue Brief March 2013.



There is considerable variation in the form of this coordination or collaboration, but typically it falls into three categories.

- **Data Sharing:** Leading community health stakeholders may opt to develop systems that make sure that each has easy access to the same quality, quantitative information that will drive their assessment and planning efforts to ease the data collection burden. A central agency, usually the Health Department, academic institution, or private foundation develops a data warehouse of health-related information and makes it readily available to community agencies. Once data are made available, individual agencies are then responsible for engaging their relevant partners and integrating consumer (qualitative) information.
- **Commission of Third Party Assessor:** Leading stakeholders or a lead public agency may opt to commission a third party to conduct comprehensive needs assessment and priority setting. They allow organizations to leverage resources and conduct a more rigorous assessment and lead to a series of recommendations for addressing the identified priorities.
- **Complete Integration of the Community Health Needs Assessment and the Community Health Improvement Program Process:** Leading health and social service providers may fully integrate their assessments and planning processes and pledge to develop one common community health needs assessment and community health improvement program. This is often accomplished through an existing collaborative structure such as a community health task force. It may also be accomplished as a separate collaborative effort. The goal is to collaborate on implementation of the community health needs assessment and creation of a short-, medium-, and long-term action plan that each entity pledges to incorporate into its organizational plan.

There are an increasing number of regions, counties, or municipalities that have built collaborative organizations responsible for conducting health needs assessment and planning activities as well as implementing joint community health programs. Typically, these organizations are funded by an array of public and private participants, including Health Departments, service providers, and philanthropic organizations. The Primary Care Coalition of Montgomery County, Maryland; Maine Quality Counts; the Community Health Partnership of Sarasota County, Florida; and San Diego Community Health Partners, Inc. are examples of such collaborations. They conduct needs assessment, establish a set of core and secondary regional priorities, develop a range of community programs, and are supported by all participating stakeholders who, in turn, implement detailed action plans that address community health issues and promote overall health and wellness. Often these collaborations have their own staff that conduct the work but may use the resources of their participating organizations. Typically, these efforts also need ongoing collaborative assessment, quality assurance, performance improvement, and reporting systems.

Recommendations for Hospital Community Benefit Programs for Prince George's County

Collaboration on community needs assessment and chronic disease program

The first recommendation supports more immediate collaboration using the hospitals' and Health Departments' current community benefit plans. Hospital community benefit plans are developed consistent with their fiscal years and, therefore, are in different places relative to planning and implementation. Longer-term collaboration (as outlined further in this section) will align planning and implementation processes.



Recommendation 1: *Work collectively to reduce the prevalence and burden of chronic disease.*

Time Frame: Immediate- to Short-Term

Work collectively to reduce the prevalence and burden of chronic disease with a particular emphasis on diabetes and hypertension by promoting general wellness and behavioral change, promoting appropriate engagement in primary care, and increasing the number of adults with diabetes/hypertension who receive evidence-based counseling, coaching, and treatment. The following are some specific activities that were considered as part of this recommendation:

- Develop, expand, or support evidenced-based programs that educate the public about health risk factors, health promotion, and basic wellness (e.g., obesity, fitness, physical activity, and healthy eating).
- Develop, expand, or support community screening events that identify and screen residents for diabetes, pre-diabetes, and hypertension with the goal of linking those with new or uncontrolled cases of diabetes and hypertension to appropriate education, behavior change, primary care, and/or specialty care services.
- Collaborate with community partners to develop targeted, evidence-based diabetes and hypertension education, health promotion, behavior change, care management, and treatment programs for those who are most at risk.
- Encourage collaboration between hospitals and other community partners to implement emergency department-based initiatives aimed at reducing inappropriate (preventable/avoidable) emergency department utilizations and promoting greater chronic disease management.
- Encourage hospitals and other community partners to implement care transition initiatives aimed at promoting better follow-up and care coordination for those with chronic disease.

- Work collectively to measure impact and ensure that measures are aligned with the Maryland State Health Improvement Process/Local Health Improvement Coalitions.

Creating Prince George's County Community Health Benefit Partnership

The following recommendations are intended for longer-term time frames and create an overarching community benefits planning infrastructure referred to as the Prince George's County Community Health Benefit Partnership. Future community benefit programs would be developed and implemented collaboratively through the Prince George's County Community Health Benefit Partnership. The following recommendations would be implemented over the next one to three years.

Recommendation 2: *Create the Prince George's County Community Health Benefit Partnership.*

Time Frame: Medium-Term

Create the Prince George's County Community Health Benefit Partnership made up of representatives from the five County hospitals and the Health Department. The Prince George's County Community Health Benefit Partnership could be a partnership with a Memorandum of Agreement or a nonprofit corporation. Some activities to form the Prince George's County Community Health Benefit Partnership are included here.

- Convene the County's five hospitals and Health Department in 2015, and agree on how to proceed in the short- and long-term with the assumption that the group will operate as the Prince George's County Community Health Benefit Partnership.
- Facilitate agreement on a series of short-, medium-, and long-term strategic community health initiatives on which the Prince George's County Community Health Benefit Partnership would agree to collaborate. Specific focus should be on identifying one or two initiatives that will be the focal points of the partnership.



- Coordinate the County's community benefits program activities, and over time the partners would implement a more collaborative agenda of activities that would be operated by the formal Prince George's County Community Health Benefit Partnership.
- Ensure that the activities that are implemented are aligned with best practices, and develop an evaluation plan that tracks the progress and impact of the collective community health activities.
- Promote awareness of the partnership's efforts, and work to build broader collective action among other stakeholders.

Recommendation 3: *Work collaboratively to conduct a Prince George's County community health needs assessment.*

Time Frame: Medium-Term

Prince George's County's five hospitals, in partnership with the County's Health Department, should work collaboratively to conduct a Prince George's County community health needs assessment and then work collectively to implement community health benefit activities. This process should start no later than 2016 so as to comply with the Internal Revenue Service requirements. Below are some specific activities that were considered as part of this recommendation.

- Create a broadly representative community health needs assessment steering committee to develop and implement a centralized community health needs assessment approach that collects quantitative and qualitative data on community need, service system capacity, barriers to care, possible strategic responses, and other relevant information.
- Engage residents and health and social service providers through surveys, interviews, community meetings, and/or focus groups.
- Facilitate a strategic planning process that identifies leading healthcare priorities, along with a series of agreed-upon community

health strategies addressing priority issues that community partners will strive to implement.

- Develop a centralized, countywide community health needs assessment report and community health improvement program that summarizes needs, priorities, and high-level strategic goals.

Recommendation 4: *Develop a shared measurement system.*

Time Frame: Short-Term

Develop a shared measurement system that facilitates program alignment, tracks progress and impact, and helps to hold programs accountable. There should be a series of measures established to track the core set of activities on which the Prince George's County Community Health Benefit Partnership has agreed. The County Health Department, hospitals, and other community stakeholders should first track a series of measures related to their community health strategies and, to the extent possible, ensure that measures are aligned with Maryland's community health improvement program. Once measures are defined or have an agreement, participants need to track and report data to a central entity (or individual) for aggregation and analysis.

Recommendation 5: *Work collectively to promote access to primary care within community benefit programs.*

Time Frame: Short-Term

Work collectively to promote access to primary care and ensure appropriate primary care engagement among County residents, particularly those most at risk. Specifically, hospitals should partner with the County Health Department, primary care providers, and other County partners to:

- Expand access to primary care in certain geographic areas and for low-income, Medicaid insured and uninsured residents more generally.
- Expand implementation of emergency department diversion programs.



- Facilitate appropriate, timely, primary care follow-up after discharge from the hospital so as to reduce inappropriate hospital readmission.
- Increase use of Chesapeake Regional Information System for our Patients data to identify “hot spots” for emergency department diversion, hospital-to-home transitional care, and patient engagement into primary care.

Building a Sustainable Primary Healthcare System

A Prince George’s County Primary Healthcare Alliance (Primary Healthcare Alliance) should be developed to ensure successful implementation of the Primary Healthcare Strategic Plan. This section provides an overview of a recommended structure for the Primary Healthcare Alliance, with examples drawn from two successful models. Recommendations for implementation of the Primary Healthcare Alliance have been informed by best practice models but are designed for Prince George’s County.

Primary Healthcare Alliance

Mission, Governance, and Operational Structure

The proposed structure for the Primary Healthcare Alliance is based upon industry best practices for community-based improvement initiatives and revolves around collaboration, engagement, and accountability. Throughout the planning process, project leaders, advisors, and stakeholders stressed the importance of moving from planning to action and establishing a structure to ensure sustainability. The Primary Healthcare Alliance would achieve that objective.

- **Mission:** To transform health and healthcare in Prince George’s County by leading, collaborating, and aligning efforts to improve primary care delivery. The initial priority for the Primary Healthcare Alliance would be to implement the Primary Healthcare Strategic Plan for Prince George’s County.

- **Governance:** Governed by an independent, volunteer Board of Directors and formed under the following guiding principles.
 - Board members should represent the wide range of key stakeholders, including consumers. Some members would be appointed to ensure appropriate representation and collaboration with key partners such as the Health Department.
 - Board members should reflect the socioeconomic diversity of the County.
 - The Board should operate independently and be able to authorize collaborations or partnerships with other entities that would help to fulfill its goals, carry out special projects, and/or improve healthcare in the County.
 - The Board should be of a manageable size but sufficient to have broad-based representation and carry out functions. Smaller subcommittees could be used to focus on specific areas.
 - The Board should be self-perpetuating with rules for nominations, elections, and appointments defined in the by-laws.
- **Organizational Structure:** The Primary Healthcare Alliance would be housed within the Office of the County Executive and would be appropriately and adequately staffed to carry out its functions. Initial funding would be needed for start-up, but the goal would be for the Primary Healthcare Alliance to be financially self-sustaining through public and private grants and contracts for services. Start-up funding would come through County appropriation and contributions from stakeholder organizations. The Primary Healthcare Alliance would be managed by an executive director who would report to the Board of Directors and be responsible for carrying out operations.



Primary Healthcare Alliance Initiatives

Several initiatives identified as part of the Primary Healthcare Strategic Plan would be managed through the Primary Healthcare Alliance. These initiatives would range from one-time efforts such as convening a task force on care coordination collaboration to ongoing functions such as administration of the Prince George's HealthAssure Program.

Best Practice Models for Sustainability of a Primary Healthcare Alliance

In reviewing models for sustainable health improvement initiatives, John Snow, Inc. found the following two organizations that have demonstrated success and that could serve as models for the Prince George's County Primary Healthcare Alliance.

1. The Primary Care Coalition of Montgomery County works with clinics, hospitals, healthcare providers, and other community partners to coordinate health services. Its mission is to be the catalyst for developing and coordinating a community-based healthcare system that strives for universal access and health equity for underserved community members. The Primary Care Coalition is a 501(c)(3) nonprofit organization. An all-volunteer Board of Directors governs the Primary Care Coalition, overseeing its business, affairs, funds, and property. The Board holds and exercises all power and authority of the Primary Care Coalition and consists of up to 24 elected members, each of whom is a voting director. The Primary Care Coalition's president and chief executive officer serve as ex officio members of the board.
2. Maine Quality Counts is an independent healthcare collaborative committed to improving the health and healthcare for the citizens of Maine by leading, collaborating, and aligning improvement efforts. Formed in 2003 and incorporated in 2006, Quality Counts provides leadership, advocacy, support for improving care, and has defined the following current strategic priorities: (1) further increase system alignment to transform health and healthcare; (2) promote a sustainable system of quality

improvement assistance to all providers in Maine; (3) foster meaningful consumer engagement in transforming health and healthcare; (4) promote integration of behavioral and physical health; and (5) assure the organizational success and sustainability of Quality Counts needed to meet its mission.

Quality Counts works through a diverse group of stakeholders to coordinate disparate efforts for supporting local, patient-centered care. Through an impartial forum, stakeholders in health and healthcare can view and exchange ideas.

Recommendations for Prince George's Primary Healthcare Alliance

Recommendation 1: *Convene the initial Board of Directors to serve as the governing body of the Primary Healthcare Alliance.*

Time Frame: Initial Steps and Ongoing

Develop board structure and by-laws consistent with guiding principles as outlined (see models for Primary Healthcare Authorities).

Recommendation 2: *Create the Primary Healthcare Alliance.*

Time Frame: Short-Term

Under the direction of the Board of Directors, establish the mission and organizational structure. Hire the executive director and launch operations.

Monitoring and Evaluation

Monitoring and evaluating is one of the key steps in any improvement process, such as the one being undertaken through the Primary Healthcare Strategic Plan. Figure 4 (see page 43), developed by Robert Wood Johnson Foundation, shows evaluation is the first step after taking action. Monitoring and evaluation activities are distinctly different. Monitoring is the ongoing review of data to inform whether a project, program, or initiative is on track. Evaluation is a point-in-time activity that asks questions about whether the initiative is having the intended impact and achieving desired goals.





Figure 4. Take Action Model for Improvement

Image: University of Wisconsin, Population Health Institute, County Health Rankings & Roadmaps 2014. countyhealthrankings.org

Need for Monitoring and Evaluation

Monitoring and evaluating the progress of the Primary Healthcare Strategic Plan's implementation is beneficial for many reasons. Community-level change is long-term and requires continued engagement of stakeholders and commitment of resources. The progress and success of the Primary Healthcare Strategic Plan should be measured using both process and outcome metrics. Process metrics track which components of the plan are being implemented and their progress. Outcome metrics show if the plan's goals are being achieved and would include those measuring access to patient-centered primary care, improvement in health outcomes, and contribution to the County's economic growth. Results of monitoring and evaluation are placed into the planning process so that changes can be made to the strategy, implementation of the strategy, or both.

Monitoring and evaluation is also a way to continue engagement and momentum with the community and stakeholders. Transparency and tracking increase the accountability of stakeholders and partners

to the community and to one another. This may motivate the community by raising awareness and engagement.

Best Practices in Effective Monitoring and Evaluation

Three general best practices for effective monitoring and evaluation include tracking community engagement, using available metrics, and creating a way to share results with the community.

- Track Community Engagement:** Monitoring the progress at the community level could happen in a number of different ways. For example, Robert Wood Johnson Foundation developed a tool that could be used as a self-assessment of a community's readiness to build a healthy community. This tool was developed out of Robert Wood Johnson Foundation's Building a Culture of Health initiative and County Health Rankings. The Primary Healthcare Alliance, having been given the responsibility of monitoring and evaluation, could use a similar assessment tool to track community engagement and progress toward achieving the Primary Healthcare Strategic Plan goals.
- Use Metrics That Are Readily Available:** Evaluation and monitoring can be costly and are time-intensive activities. For this reason, it is recommended that, to the extent possible, existing monitoring and evaluation metrics be used, since there is no additional cost to develop and collect primary data. For example, the monitoring and evaluation plan would use the Chesapeake Regional Information System for Our Patients data to measure improvement in emergency department utilization at the community and County levels.
- Create a Report Card as a Way to Share Results with Stakeholders and the Community:** One best practice in monitoring is to create a tool that is easily understood. The sharing of results can be done through a report card format (see page 44).



Monitoring and Evaluation Report Card Example



Healthy Aging

Colorado's older adults perform relatively well according to the measures used in this Report Card and compared to their peers in other states. Following national trends, Colorado's older adults are living longer and healthier lives. They have the highest rate of physical activity compared to older adults in other states, and are less likely to report poor physical health than seniors in all but four other states. Even though Colorado ranked fifth for flu and pneumonia vaccinations, a little more than half of older adults in the state were adequately vaccinated.

Health Indicator	Rank among states
94.0 percent of older adults had one (or more) person(s) they thought of as their personal doctor or health care provider	34 th
53.6 percent of older adults had a flu shot during the past 12 months and had a pneumonia vaccination	5 th
77.6 percent of older adults participated in any physical activity in the past 30 days	1 st
16.9 percent of older adults reported that their physical health was not good eight or more days in the past month	5 th
8.0 percent of older adults reported that their mental health was not good eight or more days in the past month	12 th
20.8 percent of older adults reported eight or more days of limited activity in the past month due to poor physical or mental health	6 th
Average Rank	10.5

Images: Courtesy of the Colorado Health Foundation
www.coloradohealth.org/report_card.aspx



Why Use a Report Card?

- People understand it. Most of us have experience with report cards. The language of grades communicates to a broad base of people.
- Selection of a few key issues or categories helps focus attention on problem solving.
- Report cards effectively communicate a general message, yet allow for more detail to be expressed.

Monitoring and Evaluation for County Health Rankings on page 46.)

Data collection and analysis for the monitoring and evaluation of the Primary Healthcare Strategic Plan would be coordinated with other initiatives. For example, data collected would also be used to develop the community health needs assessment and community health improvement program.

Metrics

Recommended metrics are outlined in Table 3 on page 46. Several of the metrics were drawn from Robert Wood Johnson Foundation's County Health Rankings for two reasons. First, County Health Rankings is consistent with the social-ecological model of health promotion used in developing the Primary Healthcare Strategic Plan for Prince George's County. Secondly, County Health Rankings provides comparative data for surrounding counties, the State of Maryland, and top performers around the nation. Although County Health Rankings is at the County level, it is recommended that measurement also happen at the local level. Local-area data are needed to evaluate the impact of the plan on specific communities to ensure that all residents benefit from the improvements. Recommended metrics from County Health Rankings, along with baseline measures for Prince George's County and sources used by County Health Rankings, are included in Table 3 on page 46. Following the table are additional metrics recommended for comprehensive monitoring and evaluation.

The monitoring and evaluation plan would also include metrics specific to implementation of the Primary Healthcare Strategic Plan. These metrics (and corresponding sources of data) are listed below:

- Number of primary care providers recruited to establish practices in Health Investment Zones (Primary Healthcare Alliance).
- Number of primary care practices in Prince George's County that have achieved patient-centered medical home recognition or accreditation (survey of primary care practices,

Recommended Monitoring and Evaluation Plan for Prince George's County

Data Collection, Analysis, and Reporting

Data collection, analysis, and reporting for the Primary Healthcare Strategic Plan would be consolidated under the Primary Healthcare Alliance. The monitoring and evaluation plan would include the following:

- **Process Monitoring:** Monitors which components of the strategic plan are being implemented, how successfully they are being implemented, and any changes that are needed for successful implementation. Progress of implementation would be monitored against a detailed implementation plan.
- **Outcome Monitoring:** Monitors the plan's achievement of the desired outcomes, including access to patient-centered primary care, improvement in health outcomes, and contribution to economic development. Further, outcome monitoring would happen at two levels: County and local area (defined community or zip code level). The monitoring and evaluation plan would define the metrics used for evaluation, data sources and collection process, baseline or target measures, and reporting format (report card). (See Table 3. Recommended Metrics for



- data request from accrediting organizations and state agencies).
- Consumer satisfaction (focus groups and/or patient satisfaction surveys).
- Percentage of residents that leave the County for healthcare services (Maryland Hospital Association and Maryland Health Care Commission patient origin/destination studies, consumer surveys).
- Number of graduates from educational and training programs for advance practice public health nurses, community health workers, and other patient-centered medical home-related occupations (reported by Prince George's County Community College, University of Maryland, and Bowie State).

- Economic growth attributed to healthcare and life science industries (Economic Development Corporation).

Performance based upon selected metrics would be reported annually on a Primary Healthcare Strategic Plan report card, produced by the Primary Healthcare Alliance, and shared publicly.

Time Frame: Monitoring and evaluation plan developed in the first year. Monitoring of the implementation of the plan would begin upon start of implementation and continue through completion. Report cards would be produced annually.

Table 3. Recommended Metrics for Monitoring and Evaluation for County Health Rankings

METRIC	BASELINE FOR PRINCE GEORGE'S COUNTY (2014)	DATA SOURCES USED BY COUNTY HEALTH RANKINGS
Primary Care Access		
Primary Care Providers	1,804: 1	Health Resource and Services Administration Area Resource File ¹
Dentists	1,762: 1	Health Resource and Services Administration Area Resource File
Mental Health Providers	1,483: 1	Centers for Medicare & Medicaid Services, National Provider Identification
Clinical Care Quality		
Preventable Hospital Stays	52 per 1,000 Medicare enrollees	Medicare/ Dartmouth Institute
Diabetic Screening	80%	Medicare/ Dartmouth Institute
Mammography Screening	61%	Medicare/ Dartmouth Institute
Health Behaviors		
Adult Smoking	14%	Behavioral Risk Factor Surveillance System
Adult Obesity	34%	National Center for Chronic Disease Prevention and Health Promotion
Excessive Drinking	10%	Behavioral Risk Factor Surveillance System

¹ Information from the Health Resource and Services Administration will not align with the University of Maryland report as it comes from a different source. Recommend this source as it would be updated and available on an annual basis.



V. PRINCE GEORGE'S COUNTY MARKETING AND BRANDING STRATEGY

Introduction

The Primary Healthcare Strategic Plan was created in part to assist the County in improving the health outcomes of its residents by building high-quality primary healthcare capacity (including mental/behavioral and dental services) within the County to enhance access and quality of our primary care services. The branding and marketing efforts will contribute to the creation of impactful communications that influence and motivate residents to take positive actions that drive healthy outcomes and improve the quality of their lives.

The branding and marketing strategies provide a road map that outlines the vision, audience, initial branding strategies, and focused campaign for the Primary Healthcare Strategic Plan. These strategies are intended to provide a focused approach to help facilitate changes in the knowledge and perception around the quality of, and access to, healthcare in the County. They are also intended to help reduce communications complexity among the diverse targeted communities and audiences.

The diversity of the communities within Prince George's County requires targeted messages that speak to a variety of cultures and circumstances. It is important to develop a customized marketing strategy that is rooted in acknowledging and respecting this diversity. There are two primary groups the marketing strategy is designed to reach:

- Community residents and patients.
- Physicians, dentists, mental health/behavioral, and other healthcare providers.

Within these two groups are subgroups for whom individual messages should be designed and targeted. For example, the messages that we communicate to providers who live in Prince George's County, but work elsewhere, may be different from those messages we develop for providers who neither live nor work in the community. Similarly,

among the patient and community residents, unique messages will be needed for different subgroups. For example, messages that resonate with individuals who were born and raised in Prince George's County may be different from messages geared toward young families setting up households in newly developed communities or for recent immigrants. With that in mind, the core audiences for this branding and marketing strategy are:

Community Residents and Patients

- Residents currently receiving their healthcare in the County.
- Residents currently receiving their healthcare outside the County.
- Recent immigrants.
- Young families with a single or dual professional parent(s).
- Older adults who have lived in the County 20 years or more.

Physicians, Dentists, Mental Health/Behavioral, and Other Healthcare Providers

- Healthcare providers who live in the County but work outside the County.
- Healthcare providers who live outside the County that we wish to encourage to live and work in the County.

Vision and Goals

The vision of the Primary Healthcare Strategic Plan is that the healthcare delivery system in Prince George's County will be noted for its commitment to ensuring the delivery of primary care is patient-centered; everyone has the opportunity to thrive by living a healthy lifestyle; good health is valued by all residents within our communities, whether medical, social, behavioral, and/or environmental; and insuring that our healthcare workers are well-trained



and customer-focused in order to meet the demands of the future.

The goals of the marketing strategy are to:

- Convey that good health matters and that quality primary and preventative healthcare is accessible in all communities of the County.
- Differentiate the messaging to accommodate the diversity and cultures.
- Monitor outcomes and adjust communication tactics accordingly.

Marketing and Branding Strategies

Changing community behaviors and social norms is more of a marathon than a sprint. Within any given population, individual members are at different stages regarding their readiness and/or willingness to adopt new behaviors. The marketing strategy explains the specific goals and desired outcomes of the marketing campaign. The branding strategy, which is one component of the marketing strategy creates a solid, consistent brand for healthcare in Prince George's County. It requires the development of a strong, positive, and emotional connection between Prince George's residents and the healthcare services available in the County.

Marketing Strategy

While the overall marketing strategy is to foster a positive change in the perception of healthcare in the County, it is imperative that we make substantive and essential improvements in the provision of our primary care providers and other essential healthcare workers. The increased access to primary care services will encourage residents to use these services in the County.

Two targeted marketing goals are recommended: one directed at healthcare providers and the other at County residents.

Targeted Marketing Goal #1: *Recruit and retain primary care physicians, dentists, and other healthcare providers.*

This goal is intended to encourage providers to work and live in Prince George's County. Marketing efforts will focus on investing in the community in which you live, opportunities for professional growth, and making a positive difference in the health outcomes provided to residents in Prince George's County. In addition, the marketing efforts will support and promote the financial assistance available to physicians who provide healthcare to patients in the Health Investment Zones.

The following messages will be targeted specifically for healthcare and allied health professionals:

- Affordable cost of living, housing, and a high quality of life with parks and recreation in the County and nearby beaches.
- Opportunities for professional growth and career advancement.
- Potential to make a positive impact in the community where you live and work.
- Economic opportunity commensurate with surrounding counties and the District of Columbia.
- Financial assistance in establishing practices within the County's Health Investment Zones.

Targeted Marketing Goal #2: *Recapture patients and reduce outmigration of residents seeking healthcare services.*

Many Prince George's County residents choose to receive care outside of the County for a variety of reasons including, but not limited to, a perception of poor-quality healthcare, inaccessible primary care services, inconvenience, and lack of available transportation. Messages should be designed to encourage patients to receive their primary and preventative healthcare services in the County.



The message should inform the consumers that Prince George's County provides patient-centered primary healthcare and preventative services that are accessible and customer focused; physicians and other healthcare professionals have the highest character, education, and skills; and our healthcare support staff are well trained with a focus that the patient is first!

The marketing strategy must include messages that speak to the various audience segments. Prince George's County residents are diverse socially, culturally, and economically. As noted by a participant at one of the four community meetings, "We talk about Prince George's County, but I feel there are two Prince George's Counties."

Five of the 10 most affluent African-American communities across the United States are located within Prince George's County. The average household income in these communities exceeds \$100,000. On the other end of the spectrum are the communities primarily located inside the Beltway. The average household income in these areas is less than \$60,000. Inside the Beltway, between 15 percent and almost 50 percent of the population is defined as low income (live in households below 200 percent of the federal poverty level). The lower-income geographic areas within Prince George's County are predominantly African-American and include Hispanics/Latinos, Caucasians, and, to a lesser extent, Africans and Asians. Market segmentation will be needed when developing campaigns to ensure that the marketing approaches and campaigns are effective in reaching the intended audience and successful in creating the desired response.

The marketing strategy includes the search for additional input from diverse audiences in order to ensure that the marketing efforts are appropriately tailored to all County residents. For example, 67 percent of residents attending the community meetings have lived in Prince George's County for more than 20 years. From the stakeholder interviews, we learned that families with young children are less

likely to attend the community meetings because of time commitments and conflicts with school and sporting activities. In addition, a small number of residents attending the community meetings indicated that they reside in the more affluent communities of Prince George's County. Despite outreach efforts with Hispanic/Latino, African, and Asian populations, their presence at the community meetings was minimal. Additional research will be required to develop an effective marketing campaign to recapture patients within these population groups.

Brand Strategy

Branding is one of the most important aspects of the marketing strategy for the primary healthcare system in Prince George's County. The brand is what the primary healthcare system stands for. It is a promise to the residents of the County that they will be provided with customer-focused, quality, primary healthcare and preventative services. It is a promise to ensure that healthcare professionals and support staff are highly trained and customer focused and that the patient is our first priority.

Everyone should be aware of Prince George's County's commitment to provide patient-centered primary healthcare and preventative services to community residents. This message should be applied to all written communication using the same logo, color scheme, and consistent look and feel throughout.

The brand is Prince George's County's promise to the community residents that provisions will be made to ensure that everyone has access to a quality healthcare system. The recommended brand is "**Prince George's County, Our Health Matters!**"

Clear, consistent visuals, tone, and messaging will support this brand and create a culture, expectation, and realization that good health is valued by all residents within our communities, whether medical, social, behavioral, or environmental—each is important!



Marketing Communication Campaign

The marketing campaign will utilize a range of communication channels. Selected communication channels will reflect findings from the formative research (though additional research is required to further segment the target audiences). The communication channels include print material disseminated through community organizations (i.e., churches, schools, and health fairs) and providers, digital media, outdoor advertising, and radio.

Creating multiple entry points for seeing and/or interacting with Prince George's County's marketing efforts allows increased opportunity for an individual to see the intended message. There are a number of benefits to this approach. First, it often takes multiple viewings for individuals to take the desired action. Second, from a community perspective, availability across various channels increases the overall probability that a message will be viewed by the broadest spectrum of people. Lastly, presenting the desired message in diverse locations creates the perception of the desired social norm before the behavior itself is routinely established.

Brand Community Campaign

The Brand Experience

The tone of the brand will be supportive, confident, proud, warm, and caring. It will emphasize the emotional benefits of receiving good healthcare in Prince George's County. Residents should come away with the feeling that the community cares about them and that they are proud to receive healthcare in Prince George's County.

The benefits of the brand and understanding from the targeted audiences include, but are not limited to:

- **Emotional Benefits**—Patients feeling respected, feeling cared for by their providers, and feeling comforted knowing their providers are well trained and have the expertise to care for them.

- **Structural or Institutional Benefits**—Providers having access to opportunities for professional growth and development, loan repayment, and provisions made for business support services.

Brand Positioning Statement

A brand positioning statement captures the essence of the brand—who we are, what we do, and for whom we do it, along with a key differentiator, which is our brand promise.

The goal of the Prince George's County brand strategy is to communicate the simple, singular idea that **we are committed to high-quality healthcare in Prince George's County.**

Visual Identity

By defining the key elements of our visual branding—**relevance** (do the visuals support our defined brand strategy and promise?), **quality** (are the visuals professionally designed with high-quality aesthetics?), and **consistency** (are the visuals consistent at all market touch points?)—we will ensure that our visuals reinforce our positioning and brand experience. *(See photos on page 52 for examples of the brand on billboards, in grocery stores, and in schools.)*

Brand Requirements

To ensure that we provide a consistent brand experience, we must guarantee that every interaction with our audience supports our brand strategy. Part of that results from exposure to the brand through consistent visual imagery, tone, placement, and message saturation. The patient experience, exposure to the messages, and interactions with healthcare staff providing the services reinforces the branding experience. It is critical that all staff who work directly with the patient, or on behalf of the patient, support the brand promise of Prince George's County. The brand will be displayed in how we greet and speak with the patient, how we share and discuss health concerns with the patient and their family (whether in person or on the telephone), and how we speak with each other regarding the



patient's private health concerns. Work force training in all aspects of customer service must be provided for all staff in Prince George's County. Reinforcement of good customer service to support the brand may occur during employee orientations, employee performance reviews, and staff meetings.

Monitoring and Evaluation of Marketing and Branding Campaigns

Initial evaluation activities will focus on tracking outputs and assessing short-term outcomes of the first phase of the branding strategy. The initial evaluation will determine if our branding and marketing efforts have helped facilitate changes in knowledge and perception of the access and quality of healthcare in Prince George's County.

The steps for evaluating the marketing efforts include:

- **Collect process data** such as the number of materials distributed, media buys, and/or people attending an event.
- **Conduct surveys** that assess the engagement, awareness, attitude, and behavior of our audiences for each of the target campaigns.
 - **Intercept Surveys:** Intercept surveys in the community may serve as a source to measure brand recognition and the potential reach of specific communication channels. Evaluators may conduct an intercept survey using a convenience sample of respondents from the target audiences recruited from sites where branding and marketing materials were placed and/or events were held. Evaluators may administer a short questionnaire to assess brand awareness, recall, client satisfaction, and whether the marketing effort triggered a decision to take any action (e.g., seek care in Prince George's County or explore career opportunities).
 - **Community Partner Survey:** In addition to tracking the number of materials distributed to community partners, evaluators can send

a follow-up survey to community partners who received materials and/or participated in events. The survey will collect quantitative information about distribution activities, as well as qualitative information about target audiences' responses to the materials.

- **Obtain data** to evaluate the desired outcomes of the Primary Healthcare Strategic Plan; for example, has the percentage of residents seeking care within Prince George's County increased, has outmigration decreased, and what is the actual customer experience. *(See page 54 for examples of questions and sources used for data collection.)*

Summary and Next Steps

Once the overall marketing and branding strategies have been determined, next steps for implementing the proposed marketing efforts will likely include the following:

- Finalize a time line for developing materials and the marketing plan.
- Finalize a time line for disseminating materials and implementing the marketing plan.
- Develop potential marketing messages and materials.
- Pilot messages and materials with members of the target audiences.
- Identify existing community meetings and events.
- Reach out to potential primary and secondary partners regarding marketing campaign venues and materials.
- Finalize messages and materials.
- Disseminate materials.
- Begin monitoring and evaluation activities.
- Refine marketing efforts based on evaluation of findings and resources.

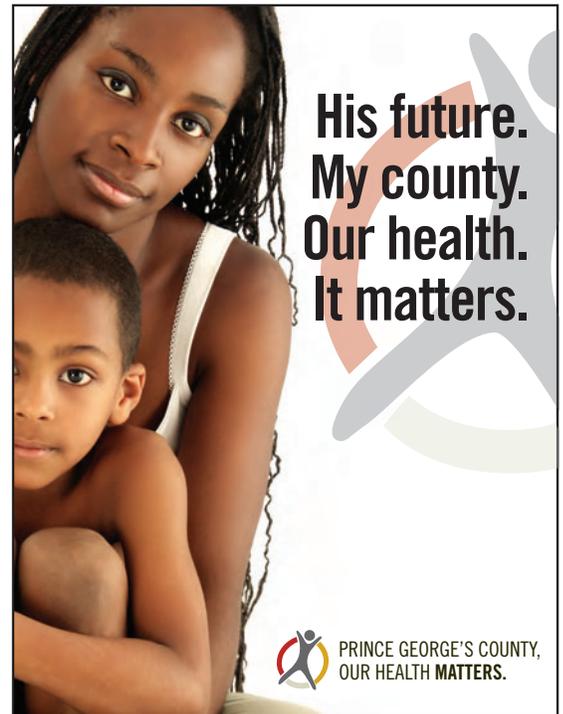
It is anticipated that the evaluation of marketing activities will be an iterative process and that



refinements will be needed, working with available resources.

In summary, the branding and marketing efforts set forth in this strategy will help contribute to the community's perception of the value of good health and the quality of healthcare resources in their community. These prospective marketing efforts include a menu of options focused on incremental

changes that build on each other and ultimately change environmental and cultural norms in Prince George's County. While the marketing and branding strategies will not, in and of themselves, change the quality of healthcare, they are one piece of a larger primary healthcare program that aims to provide quality healthcare in Prince George's County.





Marketing and Branding Strategy: Sample Evaluation Questions, Metrics, and Sources

EVALUATION QUESTIONS	POTENTIAL INDICATORS	DATA SOURCES
What was distributed, how much was distributed, to whom was it distributed, and where was it distributed?	<ul style="list-style-type: none"> • Number of materials distributed • Number of placements and potential impressions • Number of photos shared on Instagram, Facebook posts, tweets, etc. 	<ul style="list-style-type: none"> • Printing records • Distribution mailing list • Media placements • Community Partner • Survey
Were our target audiences aware of the branding/marketing effort(s)?	<ul style="list-style-type: none"> • Percent of those surveyed who report having seen marketing materials 	<ul style="list-style-type: none"> • Intercept surveys
Did members of the target audiences who were exposed seek care in Prince George's County? Did providers seek career opportunities?	<ul style="list-style-type: none"> • Percent of those surveyed who report seeking healthcare services as a result of the marketing effort 	<ul style="list-style-type: none"> • Intercept surveys • Intake forms



VI. PHASING PLAN FOR STRATEGY IMPLEMENTATION

Implementing the Primary Healthcare Strategic Plan will be done in phases to balance resource requirements and align with supporting initiatives. Preferably, one of the first steps would be to establish the Primary Healthcare Alliance. The Primary Healthcare Alliance will facilitate implementation of the Primary Healthcare Strategic Plan and guide

additional decisions that are needed to work out details and achieve successful implementation. Detailed implementation plans would be developed for each of the major components of the plan. A broad implementation phasing plan is outlined below.

Initial Steps and Ongoing

- Establish Primary Healthcare Alliance.
- Maintain collaboration between the Primary Healthcare Strategic Plan implementation and The Maryland-National Capital Park and Planning Commission on development of land use plans that support building of healthy communities (walkable communities, planned medical office space, etc.).

Short-Term (0 to 3 Years)

- Recruit primary care providers in Health Investment Zones.
- Establish program of funding for low-income uninsured and underinsured, referred to as Prince George's HealthAssure.
- Focus on customer service and clinical quality through training and quality improvement processes.
- Establish the Prince George's County Community Health Benefits Partnership.
- Establish task force on care coordination.
- Carry out work force development.
- Roll out marketing campaigns.
- Develop, implement, and maintain monitoring and evaluation plan.

Short- to Medium-Term (3 to 5 Years)

- Continue recruitment in Health Investment Zones.
- Develop private Management Service Organization.
- Expand participation of Prince George's County healthcare organization in medical and dental residency programs.
- Expand primary care networks connected with all hospitals providing services within Prince George's County.

Medium- to Long-Term (5+ Years)

- Recruit and retain primary care physicians by promoting Prince George's County.
- Develop and promote Largo Town Center Life Sciences Center as "one-stop shopping for health"—medical care, social services, pharmacy, fitness centers, healthy food options, and other health-supporting products/services.





APPENDIX A

SUGGESTED PROTOTYPES: PRIMARY CARE PRACTICES IN HEALTH INVESTMENT ZONES

This Appendix Includes:

- Summary Table—Location/Criteria for Selection, Facility, Program and Business Model for Each Prototype
- Suggested Prototype Architectural Design Principles, Space Plans, and Examples of Best Practices





Summary Table—Location/Criteria for Selection, Facility Prototype/Space Plan, Primary Healthcare Program, Primary Healthcare Program, Business Model

LOCATION/ CRITERIA FOR SELECTION	FACILITY PROTOTYPE/ SPACE PLAN	PRIMARY HEALTH CARE PROGRAM	BUSINESS MODEL
Suggested Prototype #1 – Federally Qualified Health Center Site, Riverdale			
<p>Health center co-located with health and social service related entities in a community complex.</p> <p>High primary care needs area</p> <p>Health professional shortage area — Medical (6)</p> <p>Public and private transportation access</p> <p>Buses from Riverdale MARC, Purple Line (future)</p> <p>East West Highway (MD 410) Kenilworth Ave (MD 201), Baltimore (Route 1)</p> <p>East Riverdale/Bladensburg Transforming Neighborhood Initiative)</p> <p>Community-oriented</p> <p>Diverse population, including recent immigrants</p>	<p>Urban redevelopment, health center space co-located in facility with complementary services, including fitness center, social service agencies, education, and cultural arts.</p> <p>Access to health center through common lobby area with access from street, Purple Line, and on-site parking</p> <p>Clinical/Support: Pods/team space</p> <p>Exam rooms (designed to accommodate patients of all ages, allow space for caregiver/family, and physically disabled) plus shared treatment room</p> <p>Behavioral health talking rooms included in pod, shared office space</p> <p>Laboratory (specimen collection, on-site labs)</p>	<p>Team-based, patient-centered primary care practice with family medicine, adult medicine, pediatrics, and women’s health, with co-located and integrated behavioral health and oral health. Medical specialists that support primary care rotate on a regular schedule and are part of the care team.</p> <p>Providers include physicians and midlevel providers.</p> <p>Urgent care provided through same-day appointments and extended hours with additional midlevel providers.</p> <p>On-site pharmacy that serves patients and local community. Pharmacists provide medication therapy management visits and are part of the care team.</p> <p>Teaching site supports medical residency program with up to six medical residents.</p>	<p>Federally qualified health center site within a larger federally qualified health center organization.</p> <p>Federally qualified health center reimbursement rates for Medicaid and Medicare.</p> <p>Participate in 340B pharmacy program.</p> <p>Providers covered under federal tort reform for professional liability.</p> <p>Physicians (medical) eligible for federal and state loan repayment programs.</p>





Summary Table—Location/Criteria for Selection, Facility Prototype/Space Plan, Primary Healthcare Program, Business Model

LOCATION/ CRITERIA FOR SELECTION	FACILITY PROTOTYPE/ SPACE PLAN	PRIMARY HEALTH CARE PROGRAM	BUSINESS MODEL
Suggested Prototype #1 – Federally Qualified Health Center Site, Riverdale (cont'd)			
	<ul style="list-style-type: none"> • Group visit room. • On-site pharmacy. • Health education (secure connection to larger community space with separate entrance). <ul style="list-style-type: none"> ◦ Classroom/learning space. ◦ Teaching kitchen with flow space around island. ◦ WIC consult rooms and offices. • Entryway, soft divide between adult and child area with sick child subwaiting area. • Back-to-back reception/call center and check out. <p>Building Support: Not required, space within facility.</p> <p>Total Square Feet: 12,500</p>		

Summary Table—Location/Criteria for Selection, Facility Prototype/Space Plan, Primary Healthcare Program, Business Model

LOCATION/ CRITERIA FOR SELECTION	FACILITY PROTOTYPE/ SPACE PLAN	PRIMARY HEALTH CARE PROGRAM	BUSINESS MODEL
Suggested Prototype #2—Shared Practice, Brandywine/Southern Prince George's County			
<p>Located in existing or planned medical office building with space available for build out/lease in close proximity to town center.</p> <ul style="list-style-type: none"> • High primary care needs area. • Health Professional Shortage Area (health professional shortage area)—Medical (11). • Medically underserved area. • Accessible by private transportation (Route 301). • Greatest shortage in adult providers. Area not seen as growth area in general, including for young families. 	<p>Build out primary care suite within new medical office building located within shopping complex that provides on-site parking.</p> <p>Individual providers with shared space and resources.</p> <p>Clinical/Support:</p> <ul style="list-style-type: none"> • Pods/team space. • Exam rooms (designed to accommodate patients of all ages, allow space for care giver/family, and physically disabled), plus shared treatment room. • Behavioral health talking rooms included in pod, shared office space. • Laboratory (specimen collection area, in office labs). • Group visit room. • Shared reception/check out. <p>Building Support: Not required—build-out clinical space within existing facility.</p> <p>Total Square Feet: 7,800</p>	<p>Polyclinic with coordinated and integrated care.</p> <p>Adult medicine providers (MD and mid-level providers) with half-time MDs; equate to six full-time equivalent providers.</p> <p>MD/midlevel work in team with shared panel.</p> <p>Shared reception, clinical support, and care coordination.</p> <p>Co-located and integrated behavioral health providers support primary care medical providers.</p> <p>Co-located adult dental or collaboration with community-based dental practice.</p> <p>Specialty providers support primary care medical providers and rotate through the practice.</p> <p>Providers and clinical support staff share patient information through a common medical record system or data exchange utility.</p> <p>Urgent care provided through same day appointments and collaborative agreements with urgent care centers located in area, for example, Patient First.</p>	<p>Healthcare organization (private entity, hospital) lease space, hire non-physician staff (including midlevel providers) and manage on-site operations. Healthcare organization contracts with private physicians to provide services.</p> <p>New physicians would be eligible to apply for federal and state loan repayment.</p> <p>Management service organization provides support services.</p> <p>Alternative model—care coordinators, community health workers, data analyst could be employed by the management service organization and costs incorporated into management service organization payment by the practice.</p>





Summary Table—Location/Criteria for Selection, Facility Prototype/Space Plan, Primary Healthcare Program, Business Model

LOCATION/ CRITERIA FOR SELECTION	FACILITY PROTOTYPE/ SPACE PLAN	PRIMARY HEALTH CARE PROGRAM	BUSINESS MODEL
Suggested Prototype # 3—Family Practice, Oxon Hill			
<p>Shared practice or health center site located in existing office buildings with medical space available for lease in office complex.</p> <ul style="list-style-type: none"> • High primary care needs area. • Not located in health professional shortage area but ½ mile from geo-health professional shortage area. • Medically underserved area. • Located across from community shopping area. • Public and private transportation access. <ul style="list-style-type: none"> ◦ On bus route. ◦ On Rt 414, close proximity to I-495 exchange. ◦ On-site free parking. 	<p>Build out primary care suite within existing office building.</p> <p>Clinical/Support:</p> <ul style="list-style-type: none"> • Shared space for care teams. • Exam rooms (designed to accommodate patients of all ages, allow space for care giver/family, and physically disabled), plus shared treatment room. • Behavioral health talking rooms included in pod, shared office space. • Laboratory (specimen collection area, in office labs). • Group visit room. • Access from main building lobby. • Waiting area soft divide between adult and child area with sick child subwaiting area. • Back-to-back reception/call center and check out. <p>Building Support: Not required—build out clinical space in existing facility.</p> <p>Total Square Feet: 6,800</p>	<p>Family practice group, team-based, patient-centered primary care practice, with co-located and integrated behavioral health.</p> <p>Four providers include family practice physicians and midlevel providers at a ratio of 3:1. Work in teams around adult care, women’s health, and pediatric care.</p> <p>Urgent care provided by same day appointments and extended hours as determined by patient needs.</p> <p>Medical specialists that support primary care rotate on a regular schedule and are part of the care team.</p> <p>Care coordinators provide linkages with area pharmacies and dental services.</p>	<p>Private or hospital-based group practice. Management service organization provides support services. Alternative to model-care coordinators, community health workers, and data analyst could be employed by the management service organization and the costs incorporated into management service organization payment by the practice.</p> <p>Alternative business model is a federally qualified health center practice site.</p>

Summary Table—Location/Criteria for Selection, Facility Prototype/Space Plan, Primary Healthcare Program, Primary Healthcare Program, Business Model

LOCATION/ CRITERIA FOR SELECTION	FACILITY PROTOTYPE/ SPACE PLAN	PRIMARY HEALTH CARE PROGRAM	BUSINESS MODEL
Suggested Prototype # 4 (Medium-Term 3 to 5+ Years)—Federally Qualified Health Center, Capitol Heights			
<p>Central Avenue, shopping center with potential for redevelopment, near I-95/495 exchange.</p> <ul style="list-style-type: none"> • High primary care needs area. • Health Enterprise Zone. • Prince George's County Health Corridor (Central Avenue). • Health professional shortage area—Medical (10). • Accessible by public and private transportation. <ul style="list-style-type: none"> ◦ MARC connecting to Largo Town Center/future Regional Medical Center. ◦ Central Avenue (MD 214). ◦ I-95/495 Beltway. 	<p>Clinical support space same as Prototype #1, except facility would be new construction on grey-field site and space needed for building support.</p> <p>Total Square Feet: 15,800</p>	<p>Same as Prototype #1</p>	<p>Same as Prototype #1</p>



Patient Centered Primary Care: The Medical Home Model



Harvard Vanguard Medical Associates, Concord, MA Level 3 Patient Centered Medical Home

- Supports team-based approach to care.
- Maximizes patient time with providers throughout visit.
- Eliminates physical barriers between patient and staff.
- Creates flexible spaces to allow for variations in demographics, practice methodologies, and future technologies.
- Uses natural lighting and other features to create friendly and inviting space.

Source: Steffian Bradley Architects



Principles of a Patient-Centered Medical Home

- **Personal Provider:** Each patient has an ongoing relationship with a personal primary care provider trained to provide first contact and continuous and comprehensive care.
- **Provider Directed Medical Practice:** The primary care provider leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- **Whole Person Orientation:** The primary care provider is responsible for all the patient's healthcare needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life, acute care, chronic care, preventive services, and end of life care.
- **Coordinated Care:** Care is coordinated and/or integrated across all elements of the complex healthcare system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public, and private community-based services).
- **Quality and Safety:** Providers practice evidence-based medicine and utilize technology-based clinical decision support tools. Patients actively engaged in decision-making regarding their treatment and care. Patient, families/caregivers, and staff participate in quality improvement activities.
- **Enhanced Access to Care:** Through systems such as open scheduling, expanded hours.

Source: Steffian Bradley Architects



Planning a Medical Home



Health First Family Care Center, Fall River, MA

The planning process should serve as a way to support your commitment to team-based care, patient-centered design, and provide optimal opportunities for staff and patient communication in a flexible design.

Source: Steffian Bradley Architects



Design Principles for a Patient-Centered Medical Home

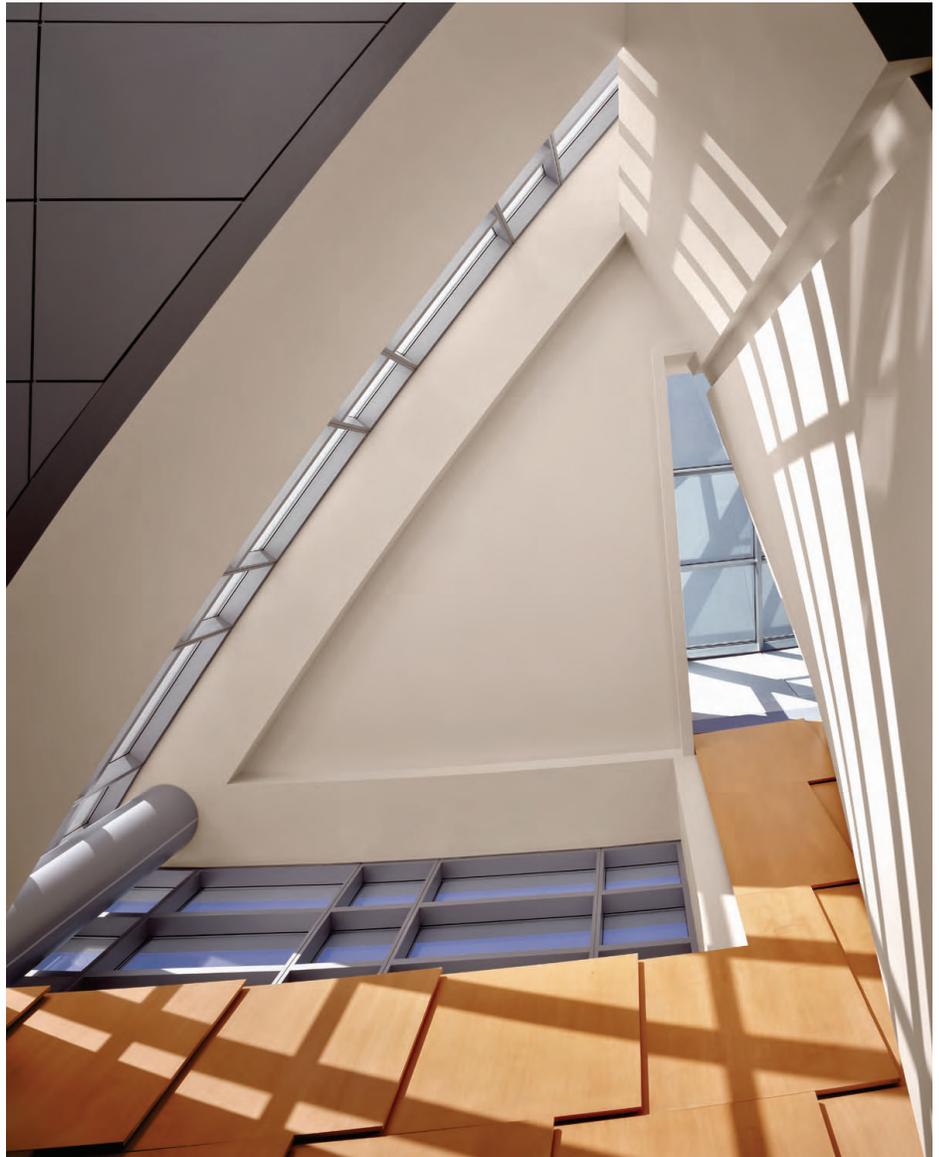
- Protect patient privacy throughout visit.
- Minimize travel time for the maximum number of patients through careful placement of departments, exam rooms, and auxiliary services.
- Minimize movement of patient when in clinical setting.
- Maximize patient's time with the provider through appropriate use of staff at each point in patient encounter.
- Maximize provider's time with patient through efficient support team and services.
- Create opportunities for staff communication both formal and informal settings.
- Create flexible spaces to allow for changes in demographics, practice methodologies, and future technologies.

Source: Steffian Bradley Architects



Creating the Patient Experience

- A connection to nature and a feeling of comfort.
- Access to natural lighting for patients and staff.
- Separation between front and back-of-house (on-stage/off-stage).
- A friendly and inviting interior.
- Variety in the interior environment.
- Areas of social and personal interaction.
- Eliminating/reducing visual clutter.
- Elimination of barriers such as glass windows between patients and staff.



Generic photo to show lighting aesthetics.

Source: Steffian Bradley Architects



Team-Based Care



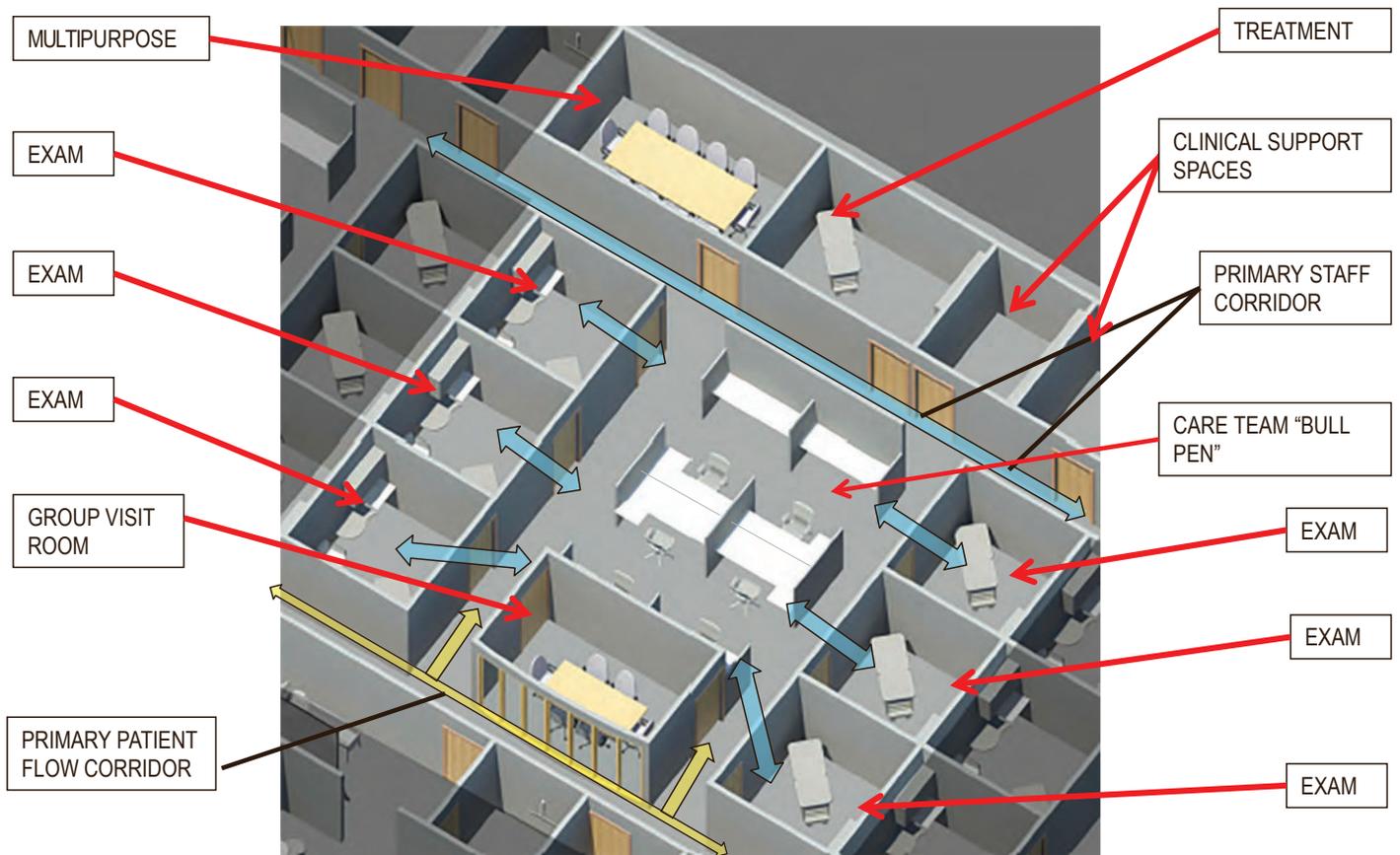
Mattapan Community Health Center, Boston, MA

	DESCRIPTION	CONSIDERATIONS
'Hub' Exam Room Structure	Exam rooms dedicated to single team of providers located in same location.	Assess care process stages to maximize throughput between pre-visit, visit, post-visit.
Cubicle Bullpen	Care team clinician desks clustered together in center of larger room.	Centrally located care team enables faster team communication; centralization may increase noise levels; optimally located close to hub of exam rooms to reduce wasted movement; team may conduct huddles in bullpen area; line of sight with reception area can positively inflect throughput.

Source: Steffian Bradley Architects



Team-Based Care Pod



Source: Steffian Bradley Architects



New Visit Types



D'Amour Cancer Center, Baystate Medical Center, Springfield, MA

“Talking Room”

Space dedicated to longer, more personable conversations with patients

- Less clinical setting for visits that do not require exam tables
- Space may reduce anxiety of being in clinical settings; increase comfort with clinical discussions
- Side-by-side consults that promote greater family participation
- Private clinician-clinician interactions
- Patient-clinician phone calls
- Accommodate waiting families

Source: Steffian Bradley Architects

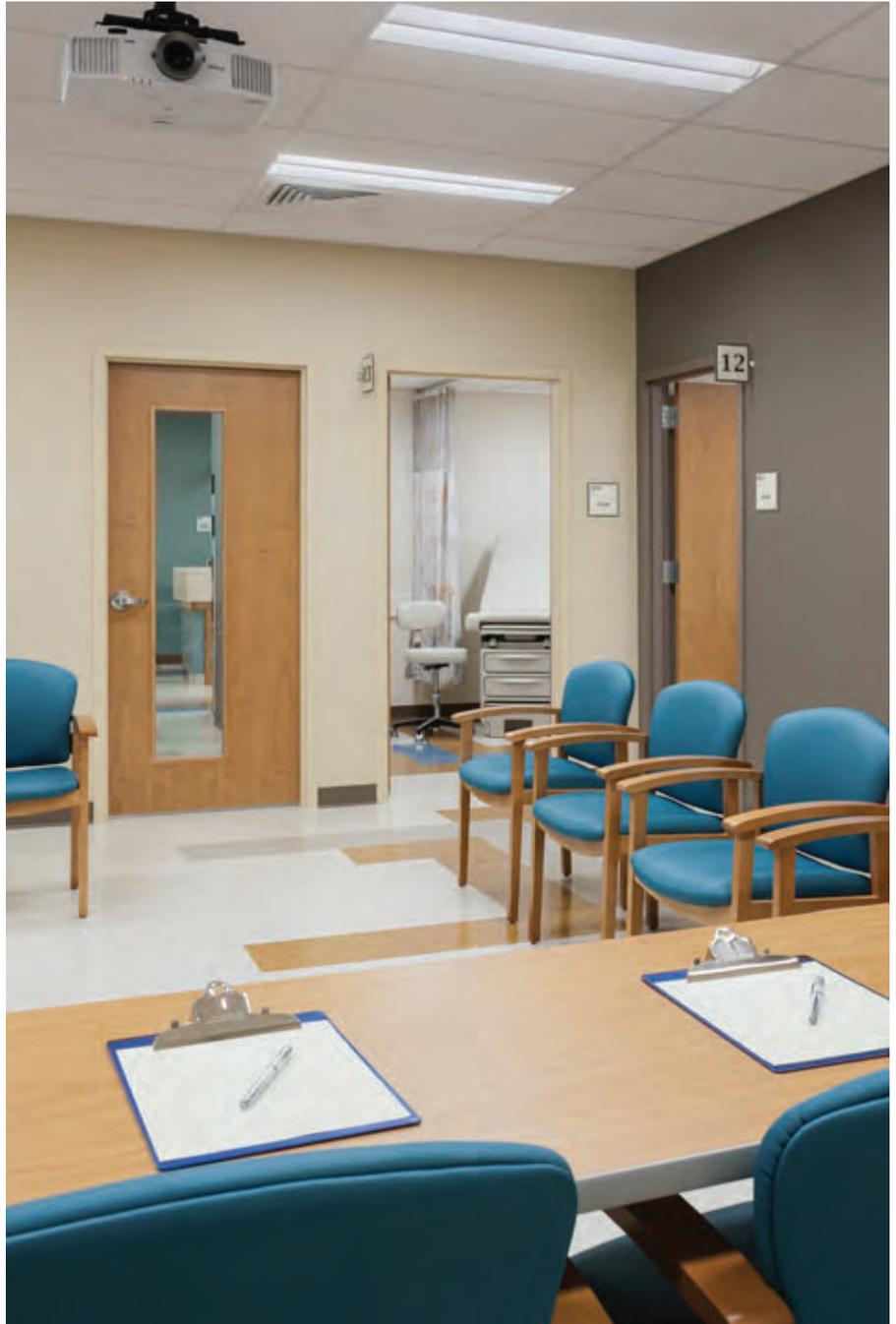


New Visit Types

“Group Visit Room”

Larger room can be used for group visits, conferences, education opportunities, care team huddles.

Potential for splitting when not used for groups; consider close or co-location of private exam rooms for individual attention during group visits.

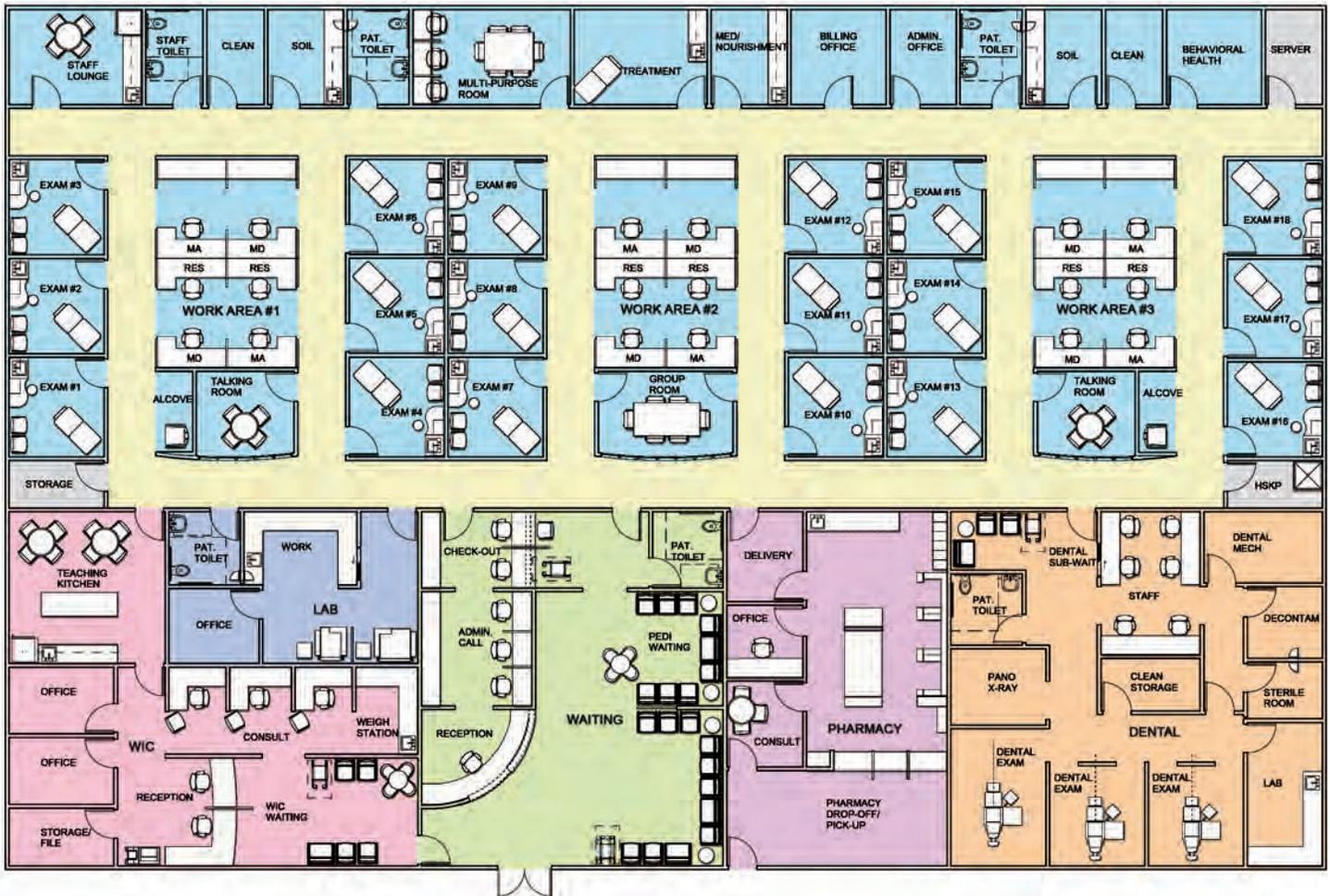


Harvard Vanguard Medical Associates, Concord, MA

Source: Steffian Bradley Architects



Prototype 1



Source: Steffian Bradley Architects



Waiting/Reception/Check-Out



Health First Family Care Center, Fall River, MA



Harvard Vanguard Medical Associates, Concord, MA



Health First Family Care Center, Fall River, MA

Source: Steffian Bradley Architects



Talking Room



D'Amour Cancer Center, Baystate Medical Center, Springfield, MA

Source: Steffian Bradley Architects



Dental Health



Fenway Community Health Center, Boston, MA

Source: Steffian Bradley Architects



Training Kitchen



Mattapan Community Health Center, Boston, MA



Source: Steffian Bradley Architects



Exam Rooms



D'Amour Cancer Center, Baystate Medical Center, Springfield, MA

Source: Steffian Bradley Architects



Pharmacy



Harvard Vanguard Medical Associates, Concord, MA

Source: Steffian Bradley Architects



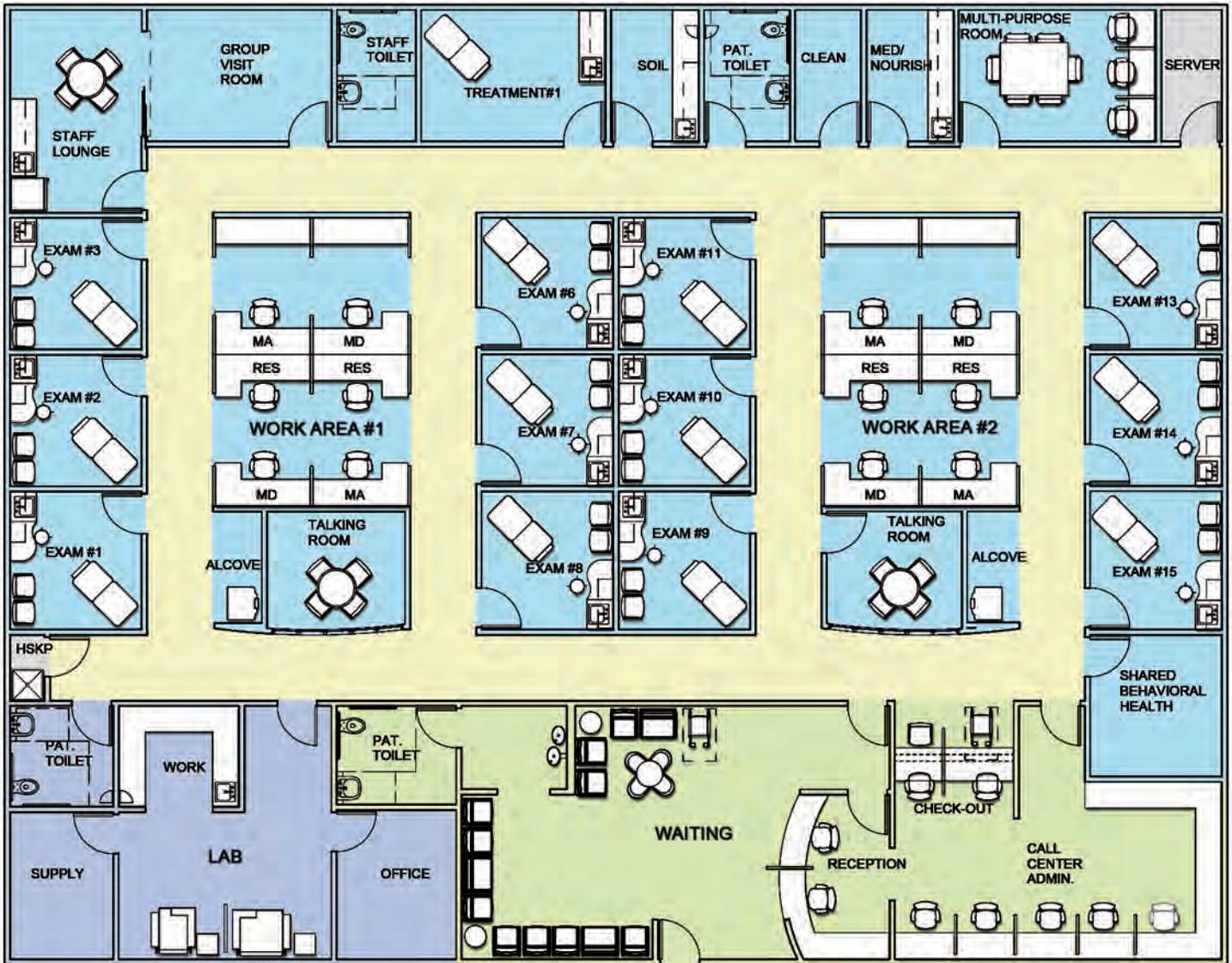
Prototype 2



Source: Steffian Bradley Architects



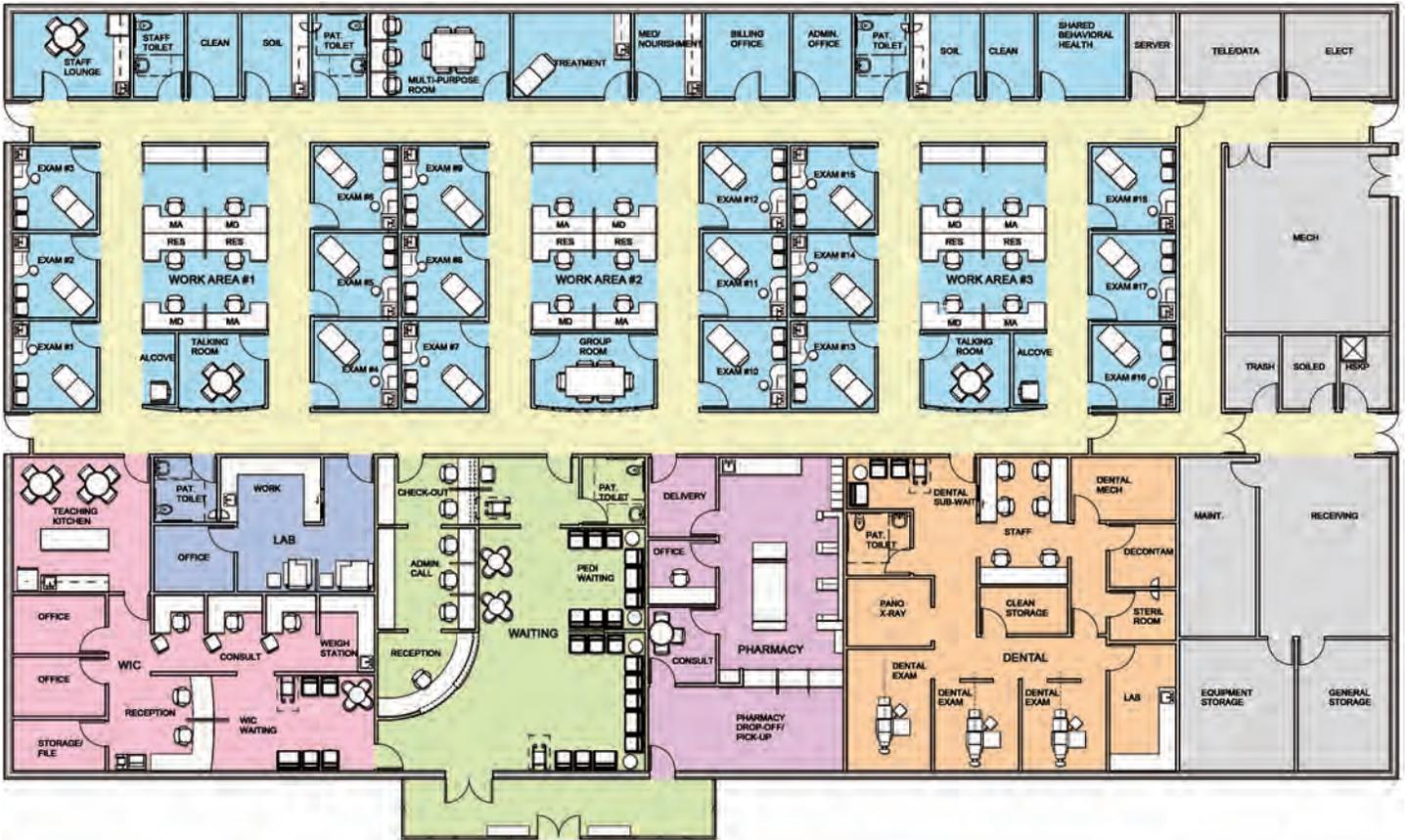
Prototype 3



Source: Steffian Bradley Architects



Prototype 4



Source: Steffian Bradley Architects



Grey Field Construction “Shopping Center”



After

Health First Family
Care Center, Fall
River, MA



Before

Source: Steffian Bradley Architects



Brownfield Construction: Urban Development/Mixed Use



Mattapan Community Health Center, Boston, MA

After



Before

Source: Steffian Bradley Architects



Grey field Construction: Urban Development/Renovation

Holyoke Health Center, Holyoke, MA



After



Before

Source: Steffian Bradley Architects





APPENDIX B

INDEX OF RESOURCES

This Appendix Includes:

1. Bibliography
2. Stakeholder Interviews
3. Data Sources and Supplemental Materials
 - Data Sources
 - Primary Healthcare Defined Services
 - Prince George's County Health Professional Programs





BIBLIOGRAPHY

Primary

Lurie N., Harris K.M., Shih R.A., Ruder T., Price A., Martin L.G., Acosta J., & Blanchard J.C. (2009) Assessing Health and Health Care in Prince George's County. Prepared for the Prince George's County Council, by RAND Corporation

University of Maryland School of Public Health. (2012) Transforming Health in Prince George's County, Maryland: A Public Health Impact Study. Retrieved from <http://sph.umd.edu/sites/default/files/files/TransformingHealth.pdf>

Literature Review

Locating Primary Care Sites

Pollack C.E., & Armstrong K. (2009) The Geographic Accessibility of Retail Clinics for Underserved Populations. *Archives of Internal Medicine*, 169(10), 945-9

Rubin M.H. (2008) Building A Medical Home for the Underserved in New York City: Lessons Learned from a Private Practice. *Journal of Health Care for the Poor and Underserved*, 19(2), 343-351

Rudavsky R., & Mehrotra A. (2010) The SocioDemographic Characteristics of the Communities Served by Retail Clinics. *Journal of the American Board of Family Medicine*, 23(1), 42-8

Consumer Engagement

Abraham J., Sick B., Anderson J., Berg A., Dehmer C., & Tufano A. (2011) Selecting a Provider: What Factors Influence Patients' Decision Making? *Journal of Healthcare Management*, 56(3), 99-115

Cheng S.H., & Song H.Y. (2004) Physician performance information and consumer choice: a survey of subjects with the freedom to choose between doctors. *Quality & Safety in Health Care*, 13(2), 98-101

Christianson J.B., Volmar K.M., Alexander J., & Scanlon D.P. (2010) A Report Card on Provider Report Cards: Current Status of the Health Care Transparency Movement. *Journal of General Internal Medicine*, 25(11), 1235-41

Chu-Weininger M.Y.L., & Balkrishnan R. (2006) Consumer satisfaction with primary care provider choice and associated trust. *BMC Health Services Research*, 23(6), 139

Fanjiang G., von Glahn T., Chang H., Rogers W., & Gelb Safran D. (2007) Providing Patients Web-based Data to Inform Physician Choice: If You Build It, Will They Come? *Journal of General Internal Medicine*, 22(10), 1463-6

Forrest C.B., Shi L., von Schrader S., & Mg J. (2002) Managed Care, Primary Care, and the Patient-practitioner Relationship. *Journal of General Internal Medicine*, 17(4):270-277

Fung C.H., Elliot M.N., Hays R.D., Kahn K.L., Kanouse D.E., McGlynn E.A., Spranca M.D., & Shekelle P.G. (2005) Patients' Preferences for Technical versus Interpersonal Quality When Selecting a Primary Care Physician. *HSR: Health Services Research*, 40(4), 957-977

Harris K.M. (2003) How Do Patients Choose Physicians? Evidence from a National Survey of Enrollees in Employment-Related Health Plans. *HSR: Health Services Research*, 38(2), 711-731

Martinco S.C., Kanouse D.E., Elliot M.N., Teleki S.S., & Hays R.D. (2012) A Field Experiment on the Impact of Physician-Level Performance Data on Consumers' Choice of Physician. *Medical Care*, 50, S65-S73

Sinaiko A.D. (2011) How Do Quality Information and Cost Affect Patient Choice of Provider in a Tiered Network Setting? Results from a Survey. *HSR: Health Services Research*, 46(2), 437-456



Other Published Material

Altschuler J., Margolius D., Bodenheimer T., & Grumbach K. (2012) Estimating a Reasonable Patient Panel Size for Primary Care Physicians with Team-Based Task Delegation. *Annals of Family Medicine*, 10(5), 396-400

American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. (2007) Joint Principles of the Patient-Centered Medical Home. Retrieved from http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf

Cigna Health and Life Insurance Company. (2014) Case Study: Loudoun County Government. Retrieved from http://icma.org/en/Article/104974/Cigna_Case_Study_Loudoun_County_Government

Institute for Healthcare improvement. (2000) Idealized Design of Clinical Office Practices. Retrieved from <http://www.ihl.org/Engage/Initiatives/Completed/IDCOP/Pages/default.aspx>

Ladden M., Bodenheimer T., Fishman N.W., Hsu C., Wagner E.H. (2013). The emerging primary care work force: preliminary observations from the primary care team: learning from effective ambulatory practices project. *Academic Medicine*. 88(12):1830-4

Peikes D.N., Reid R.J., Cornwall D.D., Dale S.B., Baron R.J., Brown R.S., Shapiro R.J. (2014). Staffing Patterns of Primary Care Practices in the Comprehensive Primary Care Initiative. *Annals of Family Medicine*, 12(2), 142-149

Patel M.S., Arron M.J., Sinsky T.A., Green E.H., Baker D.W., Bowen J.L., Day S. (2013). Estimating the Staffing Infrastructure for a Patient-Centered Medical Home. *American Journal of Managed Care*.

Prince George's County Health Department Office of the Health Officer. (2014) Health Report 2014. Retrieved from <http://www.princegeorgescountymd.gov/sites/Health/ContactUs/Publications/>

[Documents/2014%20health%20report%20v4-08-14%20no%20blank%20pages.pdf](http://www.princegeorgescountymd.gov/sites/Health/ContactUs/Publications/ Documents/2014%20health%20report%20v4-08-14%20no%20blank%20pages.pdf)

The Maryland-National Capital Park and Planning Commission. Prince George's County Planning Department. (2013) Economic Drivers and Catalysts: A Targeted Economic Development Strategy for Prince George's County, Maryland. Retrieved from <http://www.pgplanning.org/assets/planning/countywide+planning/research/teds-full.pdf>

McCarthy D., Mueller K., & Wrenn J. (2009) Kaiser Permanente: Bridging the Quality Divide with Integrated Practice, Group Accountability, and Health Information Technology. Case Study, Organized Healthcare Delivery System. The Commonwealth Fund. Retrieved from <http://www.commonwealthfund.org/publications/case-studies/2009/jun/kaiser-permanente>

McGinnis T., Crawford M., & Somers A. (2014) A State Policy Framework for Integrating Health and Social Services. Commonwealth Fund. Retrieved from <http://www.commonwealthfund.org/publications/issue-briefs/2014/jul/state-policy-framework-health-social-services>

Pollack C.E., Gidengil C., & Mehrotra A. (2010) The Growth Of Retail Clinics And The Medical Home: Two Trends In Concert Or In Conflict? *Health Affairs*, 29(5), 998-1003

Prince George's County Health Department. (2012) Prince George's County Health Enterprise Zone: Primary Care-Public Health Integrated Services Model. Retrieved from <http://dhmh.maryland.gov/healthenterprisezones/Documents/Prince%20Georges%20County%20HEZ%20Application%20-%20Redacted%20Version.pdf>

Silow-Carroll S. & Lamphere J. (2013) State Innovation Models: Early Experiences and Challenges of an Initiative to Advance Broad Health System Reform. The Commonwealth Fund. Retrieved from <http://www.commonwealthfund.org/publications/issue-briefs/2013/sep/state-innovation-models>



Somerville M.H., Nelson G.D., Mueller C.H., & Boddie-Willis C.L. (2013) Hospital Community Benefits after the Patient Protection and Affordable Care Act : Present Posture, Future Challenges. The Hilltop Institute. Retrieved from http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf408710

Somerville M.H., Nelson G.D., Mueller C.H., Boddie-Willis C.L., & Folkemer D.C. (2012) Hospital Community Benefits after the Patient Protection and Affordable Care Act : Community Building and the Root Causes of Poor Health. The Hilltop Institute. Retrieved from <http://www.hilltopinstitute.org/publications/hospitalcommunitybenefitsaftertheaca-schedulehissuebrief5-october2012.pdf>

Academic Publishing

Anderson G.D., & Grey E.B. Anderson. (2013) The management service organization's Prognosis After the Patient Protection and Affordable Care Act : A Viable Integration Tool? Physicians and Physician Organizations Law Institute

Carbaugh W. & Lang M. (2013) Medical Professionals in Prince George's County

Dimensions Healthcare System. (2011) Dimensions Healthcare Committee to County Executive Rushern Baker, III

Glover K.E., Wilson D.E., Brown S.D., Leahy-Fuchek A., Himler T.M., Saheed K.J., & Wright J.L. (2010) Prince George's County Hospital Authority Final Report and Recommendations. Retrieved from http://www.princegeorgescountymd.gov/sites/CountyCouncil/Services/BoardHealth/Documents/FINAL%20REPORT%20FINAL%20FOR%20DISTRIBUTION_1.pdf

Ladden M. (2013) Primary Care on the Front Lines of Innovation. September 23, 2013. Robert Wood Johnson Foundation. Retrieved from http://www.rwjf.org/en/blogs/human-capital-blog/2013/09/primary_care_on_the.html

Prince George's Community College. (2010) Conversation on Building an Integrated Community-oriented Healthcare System in Prince George's County

Prince George's County Health Department Office of the Health Officer. (2014) Building a Healthier Prince George's County: County Health Improvement Update Overview. Retrieved from <http://www.princegeorgescountymd.gov/sites/CountyCouncil/Resources/Documents/HealthUpdate.pdf>

Robert Wood Johnson Foundation. (2012) Robert Wood Johnson Foundation Announces New Program to Help Primary Care Practices Use Their Work Force More Effectively: Goal is to Identify, Share Work force Practices that Make Primary Care Accessible and Effective for More Patients." Retrieved from <http://www.rwjf.org/en/about-rwjf/newsroom/newsroom-content/2012/03/robert-wood-johnson-foundation-announces-new-program-to-help-pri.html>

Tobey R., Maxwell J., Bateman C., Barron C. (2014) Opportunities for Whole-Person Care in California. Prepared by John Snow, Inc., in collaboration with the California Association of Public Hospitals and Health Systems, and the California Health Care Safety Net Institute.

Unity Health Care. (2013) Unity Health Care's Upper Cardozo Health Center Recognized as a National Model of Innovative Primary Care Practice. Retrieved from <http://www.unityhealthcare.org/PDF/LEAPPressRelease.pdf>

University of Maryland School of Public Health. (2010) New UM Initiative Aims to Eliminate Md. Health Disparities. Retrieved from http://www.stategov.umd.edu/newslink/issues/july_10.html

Wright J. (2014) County Health Rankings: "A Rising Tide Lifts All Boats" Impacting and Improving Health in Prince George's County.

Web Sites

Community Care of North Carolina. <http://www.communitycarenc.com/about-us/>



DC Health Professional Loan Repayment Program.
<http://doh.dc.gov/service/dc-health-professional-loan-repayment-program-hplrp>

Maine Quality Counts. <http://www.mainequalitycounts.org/articles/54-134/what-is-community-care-team/2>

Maryland Multi-Payor Patient Centered Medical Home Program. <http://mhcc.maryland.gov/pcmh/>

Mount Auburn Cambridge Independent Practice Association. <http://www.macipa.com/macipawp/>

National Health Service Corps Loan Repayment Program. <http://nhsc.hrsa.gov/loanrepayment/nhscloanrepayment/index.html>

National Committee for Quality Insurance Patient-Centered Medical Homes. <http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx>

STAKEHOLDER INTERVIEWS

Amerigroup

Ken Satrom, Vice President, Provider Relations
Dr. Lelin Chao, Medical Director
Raquel Samson, Quality Management Program Manager
Michelle Gourdine, Consultant to Amerigroup

CareFirst BlueCross BlueShield

Dr. Malcolm Joseph III, Medical Director

Children's National Health System

Dr. Joseph Wright, Senior Vice President, Child Health Institute (currently Chair of the Department of Pediatrics at Howard University)
Dr. Marci White, Director, Children's Health Center at THEARC
Tina Lewis, Executive Director, Advocacy and Community Affairs

CIGNA Healthcare

Julia Huggins, President
Dr. Frank Brown, Market Medical Executive

Lee Malley-Lowe, Vice President, Provider Contracting
Beth Truffer, Vice President, Government & Education Segment

Community Clinic, Inc.

Kathleen Knoloff, Chief Executive Officer
Dr. Bill Flynt, former Chief Executive Officer

Community Representatives

Claudia Smith, Community/Public Health Nursing Educator and Consultant
Lisa Butler McDougal, SEED, Inc.
Madelein Golde, Progressive Cheverly
Margaret White

Dimensions Healthcare System

Dr. Carnell Cooper, Chief Medical Officer

Doctors Community Hospital

Paul Grenaldo, Executive Vice President and Chief Operating Officer

Greater Baden Medical Services

Colenthia Malloy, Chief Executive Officer

Health Services for Children with Special Needs, Inc.

Dr. Rhonique Harris, Chief Medical Officer

Kaiser Permanente/Mid-Atlantic Permanente Medical Group

Dr. Richard McCarthy, Physician-in-Chief
Dr. Shital Desai, Physician Site Lead, Kaiser Permanente Largo

Mary's Center

Maria Gomez, President

Maryland Department of Health and Mental Hygiene

Dr. Laura Herrera, Deputy Secretary for Public Health Services
Raquel Samson, Deputy Director Health Systems & Infrastructure Administration (currently



Maryland Economic Development Association

David Iannucci, Chief Administrative Officer for Economic Development and Public Infrastructure
Prince George's County

The Maryland State Medical Society

Gene Ransom III, Chief Executive Officer
Dr. Jagdeep Singh, President, Prince George's County Medical Society
Dr. George Bone, President of the Center for a Healthy Maryland

MedStar Southern Maryland Hospital Center

Richard Ardery, Vice President, Marketing and Community Relations

Nexus Health; Fort Washington Hospital

Verna Meacham, President and Chief Executive Officer (former)

Primary Care Coalition of Montgomery County

Steve Galen, Chief Executive Officer

Prince George's Community College

Charlene Dukes, Ph.D., President
Angela Anderson, Dean, Center for Health Studies

Prince George's County Health Department

Pam Creekmur, Health Officer
Dr. Ernest Carter, Deputy Health Officer

United Health Care Maryland

Richard Reeves, President and Chief Executive Officer

University of Maryland, School of Public Health

Dr. Dushanka Klienman, Associate Dean of Research and Academic Affairs

DATA SOURCES AND SUPPLEMENTAL MATERIALS

Data Sources

Robert Wood Johnson Foundation. (2014) County Health Rankings. Accessible at <http://www.countyhealthrankings.org/>

Quinn S.C., Thomas S.B., Passmore S. (2012) Random Household Health Survey. Technical Report of the University of Maryland School of Public Health Transforming Health in Prince George's County, Maryland: A Public Health Impact Study. Retrieved from <http://sph.umd.edu/sites/default/files/files/TransformingHealth.pdf>

Ting Lee M.L & Cruz-Cano R. (2012) Physician Count and Categorization and Characteristics of Physicians in the State of Maryland and Prince George's County. Technical Report of the University of Maryland School of Public Health Transforming Health in Prince George's County, Maryland: A Public Health Impact Study. Retrieved from <http://sph.umd.edu/sites/default/files/files/TransformingHealth.pdf>

Wang M.Q. (2012) Identification of Geographic Areas of Need for Primary Care: An Assessment of the Geographic Distribution of Selection Health Care Resources. Technical Report of the University of Maryland School of Public Health Transforming Health in Prince George's County, Maryland: A Public Health Impact Study. Retrieved from <http://sph.umd.edu/sites/default/files/files/TransformingHealth.pdf>

United States Census Bureau. 2007-2011 American Community Survey. U.S. Census Bureau's American Community Survey Office. Accessible at <http://ftp2.census.gov>

United States Census Bureau / American FactFinder. 2010 Census. Accessible at <http://factfinder2.census.gov>

National Committee for Quality Assurance. (February 2013). Report of the National Committee for Quality Assurance-Certified Primary Care Practices by Zip Code for all Zip Codes in Prince George's County. Provided by Chris Carrier, Director, Information Product through data request.

Health Resources and Services Administration. Find Shortage Areas: Health professional shortage area by State & County. Accessible at <http://hpsafind.hrsa.gov/>



American Academy of Family Physicians. Uniform Data System Mapper. Accessible at <http://www.udsmapper.org/>

Maryland Department of Health and Mental Hygiene. (2013). Managed Care Organizations Enrollment Data 2010-2012

HealthQuest Publishers. (2014). Accountable Care Directory 2014: Organizational Directory and Executive Profiles for Accountable Care Organizations

Medicare Geographic Cost Price Indices Localities for 2014. <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU14A.html?DLPage=1&DLSort=0&DLSortDir=descending>

Primary Healthcare Defined Services

PRIMARY CARE SERVICE	ON-SITE/DIRECT	OFF-SITE BY REFERRAL/COLLABORATION
Wellness, Disease Prevention, and Chronic Disease Management		
Primary Prevention: Health Promotion	Health educators, nutritionists, community health workers, acupuncturists, herbalists, other health and wellness providers	Health department, public health nurses, community based providers and organizations (YMCA, yoga instructors, etc.) community health workers, schools
Secondary Prevention: Screening and Patient Engagement	Clinical team, health educators, nutritionist, licensed behavioralist	Health department
Tertiary: Chronic Disease Management	Clinical team, licensed behavioralist	Board certified specialists as part of care management team
Medical Services		
Adult Care	Board certified internists, family practitioners, general practitioners, pharmacists, advance practice nurses (nurse practitioners, clinical nurse specialists), physician assistants, providers able to serve adults with developmental disabilities	
Elder Care	Same as adult care plus board-certified gerontologists	Certified PACE programs
Pediatric Care	Board certified pediatricians, family practitioners, general practitioners, advance practice nurses, physician assistants, providers able to serve children with developmental disabilities	
Obstetrical Care (prenatal care, labor and delivery, perinatal)	Board certified obstetricians, advanced practice nurses (clinical nurse midwives, nurse practitioners)	



PRIMARY CARE SERVICE	ON-SITE/DIRECT	OFF-SITE BY REFERRAL/COLLABORATION
Urgent Care	Board certified primary care physicians, nurse practitioners, physician assistants through extended hours/on call services	Community-based urgent care centers, pharmacy-based providers
Integrated Behavioral Health		
Mental Healthcare	Board certified psychiatrist, licensed psychologist, clinical social worker, other licensed mental healthcare providers	Community-based mental health providers
Substance Abuse Services	Clinical team, substance abuse counselors	Community-based substance abuse counselors
Chronic Disease Management	Pharmacists, licensed behavioralists, counselors	Board certified specialists as part of care management team
Oral Health		
Preventive and Restorative Dental Services	Dentists, dental hygienist	Community-based dental providers
Care Coordination/Enabling Services		
Care Coordination and Patient Engagement	Clinical team, care coordinators, note takers/scribes	Health plan care coordinators
Transitional Care	Clinical team, care coordinators	Home care providers
Outreach and Enrollment	Front desk staff, financial counselors, community health workers	Community health workers

Prince George's County Health Professional Programs

Prince George's Community College
(Source: http://www.pgcc.edu/Programs_and_Courses/Credit_Offerings.aspx)

Dietetics—Associate of Arts and Certificate

Health Care Management—Letter of Recognition

Health Education—Associate of Arts

Health Information Management

- Health Information Management, Associate of Applied Science
- Medical Coder/Billing Specialist
- Medical Assisting—Associate of Applied Science

Nursing

- LPN—Certificate
- RN—Associate of Science
 - Paramedic to Registered Nursing Transition Option—Associate of Science
 - LPN—RN Transition, Associate of Science

Paramedic—Associate of Applied Science and Certificate

Radiography—Associate of Applied Science

Respiratory Therapy—Associate of Applied Science

Nuclear Medicine—Associate of Applied Science and Certificate



University of Maryland

(Note: health professions are on the Baltimore campus)
(Source: <http://www.umd.edu/>)

Nursing

- BSN
- RN-BSN
- Clinical Nurse Leader
- Community/Public Health Nursing
- Health Services Leadership and Management
- Nursing Informatics
- RN-MS
- Ph.D.
- DNP

Pharmacy

- Ph.D.
- MS

Social Work

- MSW
- Ph.D.

Medicine

Dental

Masters in Public Health

Bowie State University

(Source: <http://www.bowiestate.edu/academics-research/departments/>)

Nursing

- BS
- RN to BS
- Masters of Science in Nursing
- Traditional BS Nursing Program

Bachelor of Social Work

Psychotherapy

Family Counseling Certificate



APPENDIX C

WEB SITES

This Appendix Includes:

Links for the Primary Healthcare Strategic Plan documents located on the Prince George's County Planning Department web site.





Documents Posted on the Web Page www.pgplanning.org/PHCSP.htm

DOCUMENTS
Community Benefits Program Committee Recommendations
Physicians Recruitment and Retention Committee Recommendations
Work Force Development Workgroup Recommendations
Findings from a series of local community meetings held this spring to gather input for the <i>Prince George's County Primary Healthcare Strategic Plan</i>
March 1, 2014, Community Meeting Summary
Responses to the Prince George's County Residents—March 1, 2014





APPENDIX D

GLOSSARY OF KEY TERMS





340B DRUG PROGRAM: A federal program that allows federally qualified health centers and other eligible organizations to purchase drugs at reduced prices.

ACCOUNTABLE CARE ORGANIZATION: A group of physicians, hospitals, and other healthcare providers that come together to give coordinated high-quality care to their Medicare patients, ensuring that they get the right care at the right time.

AMBULATORY CARE: Healthcare services offered on an outpatient basis.

AMBULATORY CARE-SENSITIVE CONDITIONS: Conditions that are preventable and treatable in a primary care setting and, when addressed, should prevent/avoid hospitalization.

BASELINE DATA: Data collected to establish and understand the existing conditions before any kind of intervention or experimental manipulation begins.

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM: Ongoing telephone health survey system conducted by the U.S. Centers for Disease Control and Prevention.

BUNDLED PAYMENT: A single payment to a provider, or a group of providers, for multiple healthcare services associated with a defined episode of care.

CENTERS FOR MEDICARE AND MEDICAID SERVICES: A federal agency within the U.S. Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program, and health insurance portability standards.

COMMUNITY HEALTH NEEDS ASSESSMENT/ COMMUNITY HEALTH IMPROVEMENT PLAN: The Patient Protection and Affordable Care Act requires that all hospitals conduct a community health needs assessment every three years and develop an improvement plan in order to maintain their tax-exempt status and to inform community benefits programs.

COMMUNITY BENEFIT: Investments to improve community health outcomes required of certain nonprofit hospitals (defined in the Internal Revenue Code) to maintain tax exempt status.

CHESAPEAKE REGIONAL INFORMATION SYSTEM FOR OUR PATIENTS: Maryland's statewide health information exchange.

DATA EXCHANGE UTILITY: Software that allows healthcare providers/organizations to share patient-level data securely, using standard data exchange protocols.

EVIDENCE-BASED PROTOCOLS (OR EVIDENCE-BASED HEALTH CARE): Conscientious use of current best evidence in making decisions about the care of individual patients or delivery of health services to a population. Current best evidence is up-to-date information from relevant, valid research about the effects of healthcare and health promotion efforts.

FEDERALLY QUALIFIED HEALTH CENTER: A healthcare organization that offers primary care and preventive health services to all patients regardless of their ability to pay. A federally qualified health center is a public or private nonprofit organization that has been reviewed by the federal government and meets specific criteria to receive government funding. It must serve a medically underserved area or population.

FEDERALLY QUALIFIED HEALTH CENTER LOOK-ALIKE: A healthcare organization that meets federally qualified health center requirements but does not receive community health center grant funding.

FEE FOR SERVICE: A payment model where services are unbundled and paid for separately.

GENERAL AND ADMINISTRATIVE: Operating costs that include such areas as general accounting, human resources administration, claims processing, and patient accounts management.

GLOBAL PAYMENT: A fixed payment to providers for all or most of the care that their patients may require over a contract period, such as a month or a year, adjusted for severity of illness.



GROUP VISIT ROOM: A room within a primary care facility used to provide medical consultations to a group of patients with common clinical conditions.

HEALTH DISPARITIES: Differences in the presence of disease, health outcomes, or access to healthcare that are closely linked with social, economic and/or environmental disadvantage based on race and ethnicity, religion, socioeconomic status, gender, age, mental health, disability (cognitive, sensory, or physical), sexual orientation or gender identity, geographic location, or other characteristics historically linked to discrimination or exclusion.

HEALTH ENTERPRISE ZONE: State-funded program to reduce health disparities through investment in primary care. Prince George's County was one of the first five Health Enterprise Zone initiatives funded in Maryland, and grant funds are being used to provide grant support to primary care practices in Capitol Heights.

HOSPITAL EVENTS: Several terms are used in this report to define hospital events:

A hospital discharge is the process by which a patient is released from the hospital at the time inpatient care is no longer needed. Discharges or hospital admissions can be defined by the specific conditions that stimulate them. If these conditions are related to ambulatory care-sensitive conditions (see D-3), then these can reflect adequacy of the primary care network.

Hospital readmissions are used to describe hospitalizations that result 7 to 30 days after a patient has been released from a hospital. Hospital readmissions reflect on the quality of the hospital discharge process and on the capacity of the primary care network.

HEALTH EQUITY: The state of achieving the highest level of health for all people. This requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and eliminate health and healthcare disparities.

HEALTH INFORMATION TECHNOLOGY: The area of information technology that involves the design, development, creation, use, and maintenance of information systems for the healthcare industry.

HEALTH LITERACY: The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. Health literacy is enhanced when providers give patients accurate and actionable health information in plain language and when health facilities include design and system changes that improve health information, communication, informed decision-making, and access to health services.

HEALTH OUTCOME: A measure of a health condition, such as disease status or death.

HEALTH RESOURCES AND SERVICES

ADMINISTRATION: An agency of the U.S. Department of Health and Human Services and the primary federal agency for improving access to healthcare services for people who are uninsured, isolated, or medically vulnerable.

HEALTH PROFESSIONAL SHORTAGE AREA: Designation developed by the Health Resources and Services Administration with separate designations for medical, dental, and behavioral health, based upon desired provider-to-population ratios.

HEALTH PROMOTION: The process of enabling people to increase control over and to improve their health. Health promotion not only strengthens the skills and capabilities of individuals but also involves changing social, environmental, and economic conditions that impede public and individual health.

LOCAL HEALTH IMPROVEMENT COALITION: Led by local health officers, these coalitions provide a forum for County Health Departments, nonprofit hospitals, and community-based organizations to analyze and prioritize community health needs.

MANAGEMENT SERVICE ORGANIZATION: An organization that provides management services to physician practices for a fee. Services provided



vary but usually include third party contracting and contract management, health information support services, and data analytics. Services can also include care coordination and care management.

MEDICALLY UNDERSERVED AREA/MEDICALLY UNDERSERVED POPULATION: Designated by Health Resource and Services Administration based on the Index of Medical Underservice. The Index of Medical Underservice involves four variables: ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over.

MID-ATLANTIC ASSOCIATION OF COMMUNITY HEALTH CENTERS: The federally designated primary care association for Delaware and Maryland Health Centers, representing federally qualified health centers.

MIDLEVEL PROVIDERS: Licensed non-physician providers of primary care services that include advance practice nurses, nurse practitioners, clinical nurse midwives, and physician assistants.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE: A nonprofit organization dedicated to improving healthcare quality. National Committee for Quality Assurance accredits and certifies a range of healthcare organizations, including patient-centered medical homes.

PATIENT PROTECTION AND AFFORDABLE CARE ACT: National healthcare reform law passed by the U.S. Congress in 2010.

PATIENT-CENTERED MEDICAL HOME: A team-based healthcare delivery model led by a physician that integrates patients as active participants and provides comprehensive and continuous preventive, acute, and chronic care to patients with the goal of obtaining the best health outcomes.

PHYSICIAN-TO-POPULATION RATIO: A measure used to determine the capacity of the number of providers available in a geographic region to serve the population size.

PODS: Physical configuration of primary care facility that allows team-based care.

POLYCLINIC (SHARED PRACTICE): A place where a wide range of healthcare services (including diagnostics) can be obtained without the need for an overnight stay.

POPULATION HEALTH: The health outcomes of a group of individuals, including the distribution of such outcomes within the group. The goal of population health is to reduce inequities and improve the entire population's health.

PRIMARY CARE: General healthcare services provided by clinicians who are accountable for addressing a large majority of personal healthcare needs. These clinicians are often the first point of contact for patients, will develop sustained partnership with patients, and will practice in the context of family and community.

PRIMARY CARE PHYSICIANS: A category of physicians that includes specialists in the general practice of family medicine, internal medicine, pediatrics, and obstetrics and gynecology.

PRIMARY PREVENTION: Efforts to keep diseases from occurring among susceptible people by reducing exposures or eliminating risk factors. These generally include health promotion and health education activities provided through public health, primary care, and community programs.

PUBLIC HEALTH: The art and science of protecting and improving the health of communities.

PUBLIC USE MICRODATA AREA: Areas containing approximately 100,000 people, as defined by the U.S. Census Bureau records. Public Use Microdata Areas are redefined every 10 years in conjunction with the decennial census.

SECONDARY PREVENTION: Efforts focused on detecting disease early and stopping its progression. These include screening, periodic health examinations, and reduction of risk factors through primary care and public health sectors.



STATE HEALTH IMPROVEMENT PROCESS:

This process's goal is to provide a framework for accountability, local action, and public engagement in order to advance the health of Maryland residents. The Maryland State Health Improvement Process's measures for improvement are aligned with the Healthy People 2020 objectives established by the Department of Health and Human Services.

STATE INNOVATION MODEL INITIATIVE: Initiative from the Center for Medicare and Medicaid Services provides support to states for development and testing of state-based models for multipayer payment and healthcare delivery system transformation with the aim of improving health-system performance for residents of participating states.

TALKING ROOM: Room within primary care facility used for patient-centered communication between patient and primary care provider or other member of care team. Room is shared among providers and care team members.

ZIP CODE: Mail delivery area used by U.S. Postal Service.

ZIP CODE TABULATION AREA: Geographic area used by the U.S. Census Bureau.



ACKNOWLEDGMENTS

Prince George's County Executive Office

Rushern L. Baker, III, County Executive

**Betty Hager Francis, Deputy Chief Administrative Officer for Health
and Human Services and Education**

Project Team

Pamela Creekmur, Health Officer and Director
Ernest Carter, MD, Deputy Health Officer
Vanessa C. Akins, Chief, Strategy and Implementation
Glendia Hatton, Project Manager

Project Resource Team

Maria Martin, Planning Supervisor
David Boston, Senior Planner
Yang Chen, Senior Planner
Dan Janousek, Planner Coordinator
Wendy Irminger, Planner Coordinator
William Washburn, Planner Coordinator
Tiffany Williams Jennings, Planner Coordinator
Zunilda Rodriguez, Planner Coordinator
Anika Jackson, Public Affairs Specialist III
Porlan Cummingham, Public Affairs Specialist III
Rae Wallace, Public Health Communication Officer
Kristen Franklin, Intern
Stephanie Williams, Administrative Assistant

Technical Assistance

Susan Kelley, Administrative Manager
M'Balu Abdullah, Senior IT Support Specialist
Mandy Li, Programmer Analyst III
Susan Smith, Publications Specialist
Michael Register, Publications Specialist
Robert Getz, Publications Specialist
Ryan Craun, Senior Visual Media and Imaging Specialist
Ralph Barrett, Supervisor, Office Services Support
Daisy Avelar, Prince George's County Office
of Community Relations
DeWayne Williams, Office Services Support
Loretta Tillery, Special Assistant to the
Deputy Chief Administrative Officer for Health, Human
Services and Education
Misty Milstead, Assistant to the Deputy Chief
Administrative Officer for Health,
Human Services and Education

Consultant Team

Ann M. Keehn, Project Manager
Natalie Truesdell, Project Coordinator
Sarah Genetti, Project Associate
Michelle Samplin-Salgado,
Marketing Lead, Creative Lead
Miguel McInnis, Senior Technical Advisor
Alec McKinney, Senior Technical Advisor
Steve Van Ness, Architectural Design Consultant

Council Members as the Board of Health

District 1: Honorable Mary A. Lehman
District 2: Honorable Deni Taveras
District 2: Honorable Will Campos (Former)
District 3: Honorable Danielle M. Glaros
District 3: Honorable Eric C. Olsen (Former)
District 4: Honorable Todd M. Turner
District 4: Honorable Ingrid Turner (Former)
District 5: Honorable Andrea Harrison
District 6: Honorable Derrick Leon Davis
District 7: Honorable Karen R. Toles
District 8: Honorable Obie Patterson,
District 9: Honorable Mel Franklin, Chair

Special Appreciation to:

County Elected Officials
Prince George's County Health Department
The Maryland-National Capital Park
and Planning Commission
Dimensions Health Care System
University of Maryland Medical System
University of Maryland School of Public Health
Prince George's County Med Chi Chapter
Jericho Christian Academy
St. Margaret's Catholic Church
Prince George's Community College
Volunteers

The Maryland-National Capital Park and Planning Commission

Elizabeth M. Hewlett, Chairman

Fern Piret, Planning Director

A special thanks to The Maryland-National Capital Park and Planning Commission for their assistance with this project.



SPECIAL APPRECIATION TO ADVISORY COMMITTEE

Nicholas A. Majett
Chief Administrative Officer
Office of the County Executive

Betty Hager Francis
Deputy Chief Administrative Officer
for Health, Human Services and Education
Office of the County Executive

David S. Iannucci
Assistant Deputy Chief Administrative Officer
for Economic Development and Public Infrastructure
Office of the County Executive

The Honorable Mel Franklin
Chair, Prince George's County Council

The Honorable Ingrid M. Turner
Prince George's County Council

Pamela B. Creekmur
Health Officer
Prince George's County Department of Health

Senator Joseph D. Tydings
Senior Counsel
Dickstein Shapiro LLP

Carnell Cooper
Chief Medical Officer
Dimensions Healthcare System

Joseph L. Wright
Professor and Chairman
Department of Pediatrics and Child Health
Howard University College of Medicine

Laura Herrera
Deputy Secretary
Public Health Services
Department of Health & Mental Hygiene
State of Maryland

Walter Ettinger, Jr.
Chief Medical Officer
University of Maryland Medical System

Jeff Johnson
Executive Office
Prince George's Hospital Center
Dimensions Healthcare System

John Ashworth
Senior Vice President
Network Development
University of Maryland Medical System

John Spearman
Interim Chief Operating Officer
Dimensions Healthcare System

Neil Moore
President and Chief Executive Officer
Dimensions Healthcare System

Paul R. Grenaldo
Executive Vice President and Chief Operating Officer
Doctors Community Hospital

Peter Gilbert
Vice President for Planning and Accountability
University of Maryland, Baltimore

Richard Ardery
Vice President
Marketing and Community Relations
MED STAR Southern Maryland Hospital Center

Charlene M. Dukes
President
Prince George's Community College

Dushanka Kleinman
Associate Dean for Research, Professor and Chair
Department of Health Services Administration
University of Maryland College of Health and
Human Performance

Natalie Eddington
Dean and Professor, School of Pharmacy
Executive Director, University Regional Partnerships
University of Maryland Baltimore

Verna Meacham
President and Chief Executive Officer
Nexus Health
Fort Washington Medical Center



SPECIAL APPRECIATION TO STAKEHOLDER'S COMMITTEE

Nicholas A. Majett Chief Administrative Officer Office of the County Executive	Tracy Douglas-Wheeler Chief Operating Officer Primary Care Association, State of Maryland
Betty Hager Francis Deputy Chief Administrative Officer for Health, Human Services, and Education Office of the County Executive	Helen Crosskey Cancer Patient Advocate
The Honorable Melony G. Griffith District 25, Prince George's County	Jagdeep Singh Dimensions Healthcare System
Ernest Carter Deputy Health Officer Prince George's County Health Department	Lisa M. Goodlett Chief Financial Officer Dimensions Healthcare System
Gloria Brown Director, Prince George's County Department of Social Services	Jean Drummond President, HCD International
Stacy Reid Swain Assistant Director, Prince George's County Department of Social Services, Child Adult and Family Services	Kathleen Knolhoff Chief Executive Officer Community Clinic, Inc.
Theresa Grant Director, Prince George's County Department of Family Services	Katina Lewis Maison Executive Director Advocacy and Community Affairs Children's National Health System
Gordon Barrow Special Assistant Prince George's County Health Department	Kelly G. Burks President Management Solutions Consulting Group
Gwen McCall President and Chief Executive Officer Prince George's County Economic Development Corporation	Lelin Chao Medical Director, Amerigroup
Pradeep Ganguly Executive Vice President Prince George's County Economic Development Corporation	Lisa Butler McDougal Executive Director, Sowing Empowerment and Economic Development, Inc. (SEED)
Barbara Guest Concerned Citizen, Progressive Cheverly	Malcolm Joseph Medical Director, CareFirst
Beth W. Truffer Vice President Government & Education Segment, Cigna	Maria Tildon Senior Vice President for Public Policy and Community Affairs, CareFirst
Julia Huggins President, Cigna	Marcee White Medical Director, Children's Health Project of DC/ Children's National Health System
Christopher Golson Human Capital Consultant, Simplistic Resources & Associates	Maria Gomez President, Mary's Center
Colenthia Malloy Chief Executive Officer Greater Baden Medical Center	Richard McCarthy Physician and Chief, Kaiser Permanente
Debra Ross Project Manager Prince George's Healthcare Action Coalition	Shital Desai Physician Site Lead, Kaiser Permanente
George Herbert Bone Integral Care	Richard Reeves President and Chief Executive Officer United Health Care Maryland
H. Duane Taylor Chief Executive Officer Primary Care Association, State of Maryland	Marvin Lang Managing Director and Board Chairman Guardian Realty Investors, Inc.
	William Carbaugh Sales and Marketing Manager Guardian Realty Investors, Inc.
	Alicia Wilson Executive Director LA CLÍNICA DEL PUEBLO



SPECIAL APPRECIATION TO STAKEHOLDER'S COMMITTEE (CONT'D)

District 1: Honorable Mary Lehman

District 2: Honorable Will Campos

Penny Mendoza

Chief of Staff

Prince George's County Council

Reverend Louise Malborn-Reddix

Concerned Citizen

District 3: Honorable Eric C. Olsen

Obie Pinckney, Jr.

Board Chair

End Time Harvest Ministries

Karoline Mortensen

Assistant Professor

University of Maryland's School of Public Health

Reverend Gail A. Addison

President and Chief Executive Officer

End Time Harvest Ministries

District 4: Honorable Ingrid Turner

Claudia M. Smith

Community/Public Health

Nursing Educator and Consultant

Retired Assistant Professor

University of Maryland School of Nursing

Jacqueline D. Byrd

Lawyer

Byrd & Byrd, LLC

District 5: Honorable Andrea Harrison

Madeleine Golde

Co-Chair

Progressive Cheverly Health Committee

Paula Davis

Concerned Citizen

District 6: Honorable Derrick Davis, Vice Chair

Bobby G. Henry, Jr.

Managing Attorney

Henry Legal Firm, LLC

Margaret A. White

President

Millwood-Waterford Citizens Association, Inc.

District 7: Honorable Karen Toles

Dwayne Mingo

Chief of Staff

Karen Jefferson

President

Brooke Road, Rollins Avenue

Walker Mill Road Civic Association

District 8: Honorable Obie Patterson

Nicholas B. Gordon

Yvonne Magee, Concerned Citizen

District 9: Honorable Mel Franklin, Chair

Brendon L. Laster

Chief of Staff

Rick Bryson

Glenda Hodges

Chief Executive Officer

Still I Rise, Inc.





Rushern L. Baker, III
County Executive



The Maryland-National Capital Park and Planning Commission
The Prince George's County Planning Department
www.pgplanning.org | 301-952-3594 | TTY: 301-952-4366